



## Review of

## Australia Indonesia Partnership for HIV (AIPH)

Report for AusAID

September 2011



## Aid Activity Summary

Aid Activity Name	Australia Indonesia Partnership for HIV (AIPH)		
AidWorks initiative number	INH 251		
Commencement date	1 July 2007	Completion date	31 December 2016
Total Australian \$	AUD 100,000,000		
Total other \$			
Delivery organisation(s)	<ul style="list-style-type: none"> <li>GRM International in consortium with Burnett Institute – HCPI: \$45 million 2008-2013</li> <li>Clinton Health Access Initiative (CHAI) - \$2.25 million 2010-2012</li> <li>National AIDS Commission (NAC) for:               <ul style="list-style-type: none"> <li>MSM \$1.5 million 2011-2013</li> <li>IPF – up to \$1 million annually 2011-2013</li> </ul> </li> </ul>		
Implementing Partner(s)	AIDS Commissions at national level and in targeted provinces and districts Ministry of Law and Justice Ministry of Health at national and sub-national level Diverse range of civil society organisations		
Country/Region	Indonesia		
Primary Sector	Health		

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In particular we are grateful to: the AIPH partners; staff from HCPI and CHAI; implementing partners and the beneficiaries with whom we spoke. We understand that AIPH means a lot to all of you and it is not always easy to have outsiders come to make a judgement. We hope that our report is helpful to you.

Finally, we say thank you to our wonderful interpreters, who provided us with excellent support. Lea Suganda did an amazing job in keeping the logistics of the mission on track. She was ably supported by Wowik Widawati and Annie Siregar – thank you ladies! Missions can never succeed without the wonderful back-room support.

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## Acronyms and Glossary

AIDS	Acquired Immuno Deficiency Syndrome
AIPD	Australia Indonesia Partnership for Decentralisation
AIPH	Australia Indonesia Partnership for HIV
APBD	Regional (provincial or district) budget: <i>Anggaran Pendapatan dan Belanja Daerah</i> .
APBN	National Budget: <i>Anggaran Pendapatan dan Belanja Negara</i>
ART	Antiretroviral Therapy: <i>Terapi obat ARV</i>
ARV	Antiretroviral: medication, which when taken consistently, as prescribed, suppresses the HIV virus and stops the progression of HIV related disease
AusAID	Australian Agency for International Development
Bappeda	Regional Development Planning Board (at provincial and district level): <i>Badan Perencanaan Pembangunan Daerah</i>
Bappenas	National Development Planning Board: <i>Badan Perencanaan Pembangunan Nasional</i>
BKKB	Family Planning Agency: <i>Badan Koordinasi Keluarga Berencana</i>
BNN	National Narcotics Board: <i>Badan Narkotika Nasional</i>
Bupati	District head
CSO	Civil Society Organisation
CCM	Country Coordinating Mechanism (GFATM)
CHAI	Clinton Health Access Initiatives
CST	Care, Support, and Treatment
DFID	Department for International Development: UK government agency responsible for international development assistance.
Dinkes	<i>Dinas Kesehatan</i> : Health Office at District and Province level

DKI Jakarta	Jakarta Province: <i>Daerah Khusus Ibukota Jakarta</i>
FHI	Family Health International: expatriate contractor working in the field of HIV in Indonesia. US headquartered.
GFATM	Global Fund to fight AIDS, TB, and Malaria
GOI	Government of Indonesia
GWL-INA	National Network of Gay: <i>Waria, dan Lelaki Seks dengan Lelaki Lain</i> - Indonesia
HCPI	HIV Cooperation Program for Indonesia: Australian supported HIV and AIDS program in Indonesia
HIV	Human Immunodeficiency Virus
HSS	Health Systems Strengthening program (funded by AusAID)
IBBS	Integrated Biological-Behavioural Surveillance
IDU	Injecting drug user: term replaced by People Who Inject Drugs (PWID)
IHPCP	Indonesian HIV/ AIDS Prevention and Care Project
IPF	Indonesian Partnership Fund: <i>Dana Kemitraan Indonesia AIDS</i>
IPPA-PKBI	Indonesia Planned Parenthood Association: <i>Perkumpulan Keluarga Berencana Indonesia</i>
Jamkesmas	<i>Jaminan Kesehatan Masyarakat</i> : Social Health Insurance for the poor
JOTHI	Indonesian Network of Positive People: <i>Jaringan Orang Terinfeksi HIV Indonesia</i>
KemKes	Ministry of Health
KPAK	City/ District AIDS Commission: <i>Komisi Penanggulangan AIDS Kabupaten dan Kota</i>
KPAN	National AIDS Commission: <i>Komisi Penanggulangan AIDS Nasional</i>
KPAP	Provincial AIDS Commission: <i>Komisi Penanggulangan AIDS Provinsi</i>
KPA	AIDS Commission (any level): <i>Komisi Penanggulangan AIDS</i>
KPAD	AIDS Commission for Provincial or District level



Lapas/ Rutan	Prison and Detention Centres: <i>Lembaga Pemasyarakatan/ Rumah Tahanan</i>
LJASS	Indonesian acronym for Needle-syringe program: <i>Layanan Jarum dan Alat Suntik Steril</i> (LASS)
MenKoKesra	Coordinating Minister for People's Welfare/ Chair of National AIDS Commission: <i>Menteri Koordinator Kesejahteraan Rakyat</i>
MMT	Methadone Maintenance Therapy: effective for treatment of injecting drug use through provision of regular doses of methadone for oral consumption
MSM	Men who have sex with men
MTCT	Mother to child transmission
NAC	National AIDS Commission
NASA	National AIDS Spending Assessment: Report on AIDS-related expenditures prepared following a global guideline/ format from UNAIDS. Indonesia took part in development and testing. Reports have been prepared since 2006.
NASAP	National AIDS Strategy and Action Plan 2010-2014
NSP	Needle and Syringe Program
PITC	Provider Initiated Testing and Counselling
PLHIV	People Living with HIV
Puskesmas	<i>Pusat Kesehatan Masyarakat</i> : Community / Primary Health Centre)
STI	Sexually Transmitted Infection: <i>Infeksi Menular Sexual</i>
Surveillance	Repeated data collection of data from specific populations to detect trends over time in behaviour and / or distribution of disease
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
USAID	US Agency for International Development

VCT	Voluntary Counselling and Testing
Waria	Indonesian language term for transgender person
WHO	World Health Organization
Yanmedik	Medical Services Unit

## Introduction to this report

### Background

This report outlines the findings of the Independent Progress Review of the Australia Indonesia Partnership for HIV (AIPH). The AIPH program seeks to:

- prevent and limit the spread of HIV;
- improve the quality of life of people living with HIV; and
- alleviate the socio-economic impacts of HIV/AIDS.

Indonesia has one of the fastest growing HIV epidemics in Asia. Since 2000, HIV prevalence has been consistently over 5% in several key populations such as injecting drug users, sex workers, transgender and men who have sex with men (MSM) leading to the classification of the Indonesian epidemic as a concentrated epidemic. However, the epidemiology of the HIV epidemic in Indonesia is showing a shift from injecting drug use as the main form of transmission to sexual transmission. In the two provinces of Papua and West Papua, the epidemic is categorised as a low-level generalised epidemic, where it is driven primarily by unsafe sexual intercourse.

The Partnership builds on over ten years of Australian assistance in the HIV sector in Indonesia. The \$100 million program, which spans from 2008 until 2015, currently operates in nine provinces (DKI Jakarta, West Java, Banten, Central Java, Jogjakarta, East Java, Bali, Papua and West Papua). It also supports up to eight other provinces through various national programs. There are three long term program objectives:

- strong Indonesian leadership of an effective and sustainable HIV response;
- an increased and good quality HIV response; and
- a strategic partnership between Australia and Indonesia that supports the national HIV response.

AIPH uses various aid modalities to implement a range of activities: managing contractor (private sector and international non-government organisation); pooled funding; and specific contributions to multilaterals or civil society. An outline of the program components can be found in the next chapter.

### This review

This independent progress review<sup>1</sup> was commissioned by AusAID to answer the following key questions:

1. How well is AIPH progressing towards the end-of-Program outcomes? What are the enabling or hindering factors?
2. How should AIPH best support the Government of Indonesia to effectively respond to HIV in a sustainable manner?
3. How can the individual components of the AIPH be better synchronised both administratively and programmatically?
4. What are the implications of the Health Services Strengthening program for the AIPH?
5. To what extent are the various partnerships contributing to end-of-Program outcomes? Should there be any rebalance of key partnerships?
6. How relevant and appropriate is the current response in Papua Province and West Papua Province? What are the priority program areas for future investment?

An initial scoping and planning phase for the review was conducted in June 2011, with the on ground activities of the review occurring over a three week period between 18 July and 9 August 2011. An evaluation plan<sup>2</sup> was developed to guide the review. The review was undertaken at both national and sub-national levels. In summary the methodology included:

- Document review
- Semi-structured interviews: individual and group with:

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<sup>1</sup> More details about the review can be found in Annex 5, Terms of Reference

<sup>2</sup> Available as Annex 6

- Government – national and sub-national
- Implementing partners
- Development partners and donors
- Community service organisations
- Beneficiaries
- Field visits: Jakarta, Papua, East Java
  - Selection of program locations: Hospitals; Puskesmas; Remand centre; Health clinics; and Outreach programs

Three presentations were made to key stakeholders where the preliminary findings, implications and suggested recommendations were discussed. These discussions helped inform the desk-based analysis.

The preliminary data analysis was undertaken jointly by the team assessing data against the key evaluation questions. Common themes and outliers were identified. The desk-based analysis incorporated a more in depth assessment against the key evaluation questions and the program outcomes. This was compared with data from progress reports and with the literature in relation to contemporary good practice.

As well as the limitations listed in Annex 6, the review team did not have access to the most recent epidemiological data because it had not yet been released by the Ministry of Health. The team compared older data with the informed professional views of the many respondents to reach the best understanding of the situation.

## Structure of the report

Report section	Outline of section	Key evaluation question
Chapter 1: Progress towards end-of-Program outcomes	Presents findings in relation to the end-of-Program outcomes. Progress was assessed against the stated AIPH outcomes found in the Program Monitoring and Evaluation Plan (refer to Annex 6). A small number of these are not included in this section : <ul style="list-style-type: none"> <li>• The Papua outcome is included in chapter 2</li> <li>• The most-at-risk-populations in Bali outcome was outside the scope of this review so was not addressed</li> <li>• The Partnership outcomes are in chapter 2</li> </ul>	Question #1: How well is AIPH progressing towards the end-of-Program outcomes? What are the enabling or hindering factors?
Chapter 2: Papua and West Papua	Provides the findings in relation to Papua and West Papua, including: <ul style="list-style-type: none"> <li>• Progress of the stated outcome</li> <li>• Comment on the extent that there is a comprehensive approach</li> <li>• Potential considerations for future investment</li> </ul>	Question #6: How relevant and appropriate is the current response in Papua Province and West Papua Province? What are the priority areas for future investment?  Part of Question #1
Chapter 3: Effectiveness of the partnerships	Comments on how well the partnerships are maturing and where the partnerships are making a difference  It provides the findings in relation to the three stated outcomes associated with the Partnership  The partnership assessment was guided by the "Partnership Evaluation Framework" (Hind, 2010) – refer to Annex 6	Question # 5: To what extent are the various partnerships contributing to end-of-Program outcomes? Should there be any rebalance of key partnerships?  Part of Question #1
Chapter 4: Management and administration of the AIPH	Provides an overview of the current situation and comment on possible changes to improve the management and administration of the Program	Question #3: How can the individual components of the AIPH be better synchronised both administratively and programmatically?
Chapter 5: Supporting the Government to effectively respond to HIV in a sustainable manner	Provides concluding statements about the future direction of the Program – drawing on the findings and the recommendations contained in the earlier sections.	Question # 2: How should AIPH best support the Government of Indonesia to effectively respond to HIV in a sustainable manner?  Question #4: What are the implications of the Health Systems Strengthening Program for the AIPH?

## Executive summary

### Overview

The Australia Indonesia Partnership for HIV (AIPH) seeks to prevent and limit the spread of HIV, improve the quality of life of people living with HIV, and alleviate the socio-economic impacts of HIV/AIDS. The partnership has been operating since 2008 and builds on more than 16 years of Australian assistance on HIV in Indonesia. It currently operates in nine provinces: DKI Jakarta, West Java, Banten, Central Java, Jogjakarta, East Java, Bali, Papua and West Papua. It also supports up to another eight provinces through various national programs. AIPH is comprised of a number of components. The most significant (and those subject to this review) are: *HIV Cooperation Program for Indonesia (HCPI)*<sup>3</sup>; *Clinton Health Access Initiative (CHAI)*<sup>4</sup>; *Indonesia Partnership Fund for HIV (IPF)*<sup>5</sup>; *MSM initiative*<sup>6</sup>; and *Contingency Funds*.<sup>7</sup>

This independent mid-term progress review was undertaken during July and August, 2011. Generally, good progress is indicated across all three of AIPH's objectives, which are focused on: strengthening leadership; improving service delivery; and working in partnership.

### Strengthening leadership

The strong leadership provided by the National AIDS Commission is providing a positive incentive for others, with key stakeholders from government agencies, civil society and business becoming more involved in the national HIV response. Increasingly, people living with HIV and AIDS are making a contribution to planning and decision making through various advocacy groups and networks. The capacity of Provincial and District AIDS Commissions is strengthening, although most are still in the early stages of development. AIPH's contribution, through funding and technical assistance, has been a critical means through which many of these stakeholders are being supported.

National and sub-national budget allocations and expenditures for HIV responses have, generally, been increasing each year. However, the majority of funds still come from international sources. As Indonesia moves towards being an upper middle income country it will not have the same access to donor funds and support. The National AIDS Commission, with support of HCPI, is working closely with the National Development Planning Board to advocate for more long term financial sustainability for the national HIV response. A similar process is beginning to take shape at the sub-national level with Regional Development Planning Boards. Scaling up of this effort over the next five years will be critical. Australia is likely to be best placed to take the major partner role during this process given its comparative advantage: a respected major donor with strategic influence in the HIV sector in Indonesia and an expected enduring relationship with Indonesia after other donors have left.

### Improving service delivery

*Supply chain management:* Patients are now more likely to be able to access antiretroviral (ARV) drugs as a result of the development of systems and capacity to ensure a reliable supply chain. As a result of collaborative work between AIPH and the Ministry of Health, the recurring issue of stock-outs is being addressed, with impressive results in a short space of time.

Notwithstanding the achievements, there is a need to find effective ways of bringing the distribution of ARV drugs closer to patients. Currently, there are too few outlets and accessing them is very costly.

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<sup>3</sup> Activities managed by HCPI subject to this review are: strengthening Indonesian leadership on HIV issues; reducing HIV transmission among injecting drug users and in prisons; and preventing the spread of HIV in Papua and West Papua. HCPI is managed by GRM.

<sup>4</sup> CHAI focuses on: improving procurement and supply chain management of antiretroviral drugs and HIV test reagents; builds capacity for better care, support and treatment in Papua; and provides technical assistance to enhance national level HIV policies and guidelines. The initiative is managed by the Clinton Foundation.

<sup>5</sup> IPF is an important source of financial support for AIDS Commissions at national and sub-national levels. Funds are currently managed through United Nations Development Programme (UNDP) and implementation is by the National AIDS Commission.

<sup>6</sup> MSM supports the development of the national MSM (men who have sex with men) action plan and piloting MSM outreach programs in 10 locations. The initiative is a collaboration of HCPI and the National AIDS Commission.

<sup>7</sup> These support ad hoc, short-term strategic projects and are currently managed by AusAID.

There would be benefits in AIPH and the Ministry of Health working collaboratively with advocacy groups to explore patient friendly access solutions. It is in this context that the review recommends an extension of the supply chain management project.

*Injecting drug users:* Injecting drug users have improved access to a comprehensive package of harm reduction services. There has been an increase in needle and syringe programs, methadone maintenance treatments and the distribution of condoms; all key parts of the package. Local health facilities are successfully taking up the challenge to provide harm reduction services with technical support from AIPH. Sustainability of the harm reduction programs is more likely as a result of embedding them in the regular health system.

An increasing number of outreach services operated by non-government organisations are helping to reach out to hard to reach injecting drug users. As such, they have an important role to play in increasing coverage. However, there are efficiency issues that need to be addressed.

Despite this overall progress, coverage rates for harm reduction services remain very low. Containment and reversal of HIV epidemics among injecting drug users is most unlikely to be achieved without a high level of coverage. There is an urgent need for AIPH to support the National AIDS Commission and for the Ministry of Health to find ways of improving coverage rates. A key part of the support is assisting the Ministry of Health take on an active national policy, oversight and coordination of needle and syringe programs. This will help ensure sustainability of effort.

*Prisons:* A significant increase in services has been achieved within the prison system, with an increasing number of prisoners having access to a broad range of HIV services. Innovative models of support to prison health facilities are being implemented to help increase service quality with limited resources.

*Men who have sex with men:* Whilst only in its early stage of implementation, good progress has been made in achieving key outputs and demonstrating good practice. The initiative's emphasis on promoting HIV testing and STI treatment is particularly important in terms of trying to halt the epidemic through sexual transmission.

*Changing face of the epidemic: sexual transmission:* The epidemiology of the epidemic has changed in recent years. It is now being driven through sexual transmission, particularly within at risk populations who then infect their regular sex partners. However, transmission through sharing of needles remains significant. Poor overall management of sexually transmitted infections (STI), which is a proven co-factor to HIV, is further complicating the situation. The change in the epidemic points to the need for a broader approach by harm reduction services. Along with regular harm reduction work there is a need to increase attention to sexual transmission between injecting drug users and their sexual partners; more assertive promotion of HIV testing; and earlier initiation of antiretroviral therapy (ART), including for injecting drug users. Likewise, extension of the current *MSM Initiative* would help stem the epidemic.

The changing epidemic also highlights the importance of AIPH changing its emphasis in the HIV response, generally. In recent years, AIPH has taken up an increasing level of responsibility for supporting efforts to address sexual transmission. Cross sectional studies have shown the potential for HIV epidemics to increase rapidly among men who have sex with men, sometimes to hyper epidemic levels. This suggests that there will be a need for further support to the *MSM Initiative* after the initial three year funding period.

*Papua and West Papua:* AIPH is currently supporting promotion and prevention through communication that is well grounded in behaviour change theory. A strong partnership has been formed with the two Provincial AIDS Commissions which, with the support of HCPI, are providing leadership and coordination,. A significant amount of resources has been provided to the Papua Provincial AIDS Commission by way of funded positions that are managed directly by the Commission. These positions have been in place for several years and it is now timely for the plan to transition to local funding of them to be put in place with a gradual transfer of the resources to West Papua.

Civil society organisations are implementing the work in relation to the communications strategy, with the view that their broad based networks will enable a widespread reach of the HIV messages. Some early signs of behavioural change are indicated, especially in relation to reducing the number of sexual partners. However, HIV testing rates remain low, so the messages about testing are not translating into action at the moment.

AIPH is working with health services in Papua to help address poor levels of HIV testing and treatment. Some excellent results are evident following training and support to institute provider initiated testing and counselling (PITC) in a number of selected hospitals and health facilities. By integrating HIV testing with TB testing, and incorporating it into antenatal clinics, outpatient clinics and inpatient wards, significant numbers of patients are being reached. Overall, there is a need for a more assertive promotion of HIV testing and treatment in Papua and West Papua, particularly in light of widespread concerns about the potential for significant growth in the HIV epidemic in these provinces. Suggestions are that more assertive approaches be incorporated into the *Strategic Communication Plan for HIV/AIDS*, and that the assertive approach to care, support and treatment as part of the work implemented by CHAI be scaled up.

CHAI has proposed an expansion of its care, support and treatment work in the highlands of Papua, where the bulk of the population lives. Its proposal builds on the impressive increases in HIV and STI testing and treatment that have been achieved by this work thus far. Scaling up this work, and placing a greater emphasis on improving service delivery and treatment as prevention, would provide Papua with the necessary 'combination prevention' – behavioural, structural and biomedical. It would allow AIPH to have an impact at country level. CHAI's work is taking a systemic approach and is helping to strengthen various aspects of the health system. If AusAID's Health System Strengthening program was to include Papua in its second stage of implementation, this would support AIPH efforts and gain added leverage from the proposed scale up.

The review team recognises the long term requirement for support in Papua and West Papua if the generalised epidemic is to be halted. Australia's major role as a donor and its situation in Indonesia's geographic neighbourhood gives Australia a distinct comparative advantage in terms of ongoing support. Given the nature of the epidemic and the results achieved thus far, scaling up in Papua provides Australia with the opportunity to make a real impact on the epidemic. A key consideration of such scale up will be the need to increase the presence of AusAID's Program Manager in the province. This need not be full time but current workload commitments need to be reviewed to ensure appropriate levels of attention to Papua and West Papua.

## **The partnership**

The review found that the AIPH partnership is maturing well. Essential prerequisites to an effective partnership are evident, as are both formal and informal processes. Needed structures are in place but might benefit from some refining. In particular, there would be advantages if the partnership was broadened to include the Ministry of Health. Further, refinement of the Partnership Coordinating Committee's role and function is merited so that it becomes more strategic in nature. As already noted, the partnership is beginning to realise its outcomes. The review found AIPH to be responsive to the needs of key stakeholders and beneficiaries, particularly through the AIPH grants mechanisms. The management and oversight of one of the grants, the Indonesia Partnership Fund, is soon to transfer from the UNDP to the National AIDS Commission. There could be benefits in gradually transferring the other grants: Contingency Funds and Partner Funds to the National AIDS Commission or another government agency such as the Ministry of Health.

AIPH is well aligned to national and sub-national processes. AusAID and its implementing partners are also contributing strongly to various national mechanisms to coordinate efforts in the HIV response and are respected and valued members of these mechanisms. The review highlights the issue of the number of mechanisms that have evolved over time. This has resulted in the need for key stakeholders to be engaged with multiple governing mechanisms, each requiring significant time and effort. Whilst it is acknowledged that each plays an important role, there is a need to explore if and how these might be better integrated and rationalised. Whilst these mechanisms are not the direct responsibility of AIPH, there would be value in AusAID using its respected position amongst its counterparts to initiate discussions.

Over time, AIPH has expanded to include a number of separate components. It has therefore been difficult for people to conceptualise the whole of AIPH. The review has found that it is timely to clarify AIPH's program theory and to refine the Monitoring and Evaluation Plan. Whilst there are good processes in place to oversight each of these, there is a need to bring the components together at a management level. This should include better coordination between the two service delivery components so that potential synergies can be achieved. Likewise, the review has found that there could be benefits to the partnership's overall efforts if closer links were made with relevant other Australia Indonesia partnership programs that operate in the same locations as AIPH.

## **Future direction**

The review concludes by suggesting how best AIPH can support the Indonesian HIV response in a more sustainable way. Four objectives have been suggested and each has a five year outcome proposed. The various recommendations contained in the body of the report are part of the means of reaching these outcomes. These suggested changes have implications for the current contracts. The review proposes that CHAI's contract be renegotiated to enable it to continue the supply chain management work and to expand its systems strengthening work for care, support and treatment to the Central Highlands in Papua. The situation is such in Papua that momentum should not be lost, hence the review recommends a rapid design stage to enable the new work to proceed immediately following the end of the current contract (June 2012). For HCPI a joint review of the contract conditions between AusAID and GRM (the implementing partner) is proposed to determine the impact of the suggested changes in emphases. This review should be undertaken to allow for any design changes to be made in time for a smooth transition when the current contract expires (March 2013).

A key concept for the future of AIPH is that it be brought together as a single integrated program aimed at supporting, through a partnership, the implementation of the Indonesian HIV response. This does not assume a single contract, rather that it be conceptualised, implemented and managed as a single program instead of individual fragments. The call for a revised program theory is part of this integrated whole-of-program approach to make clear the linkages between the various activities in achieving the desired outcomes. So too is the suggestion for the Program Manager to facilitate joint, regular program meetings with the organisations AusAID directly contracts to ensure planned, integrated and coordinated efforts, namely: HCPI, CHAI, and the National AIDS Commission (*MSM Initiative*). AusAID will bring to these joint meetings the necessary operational and strategic information in relation to the Indonesia Partnership Fund and the Contingency Funds, the remaining pieces of AIPH.

In supporting Indonesia's goals, all efforts by AIPH will be aimed at the five proposed objectives and their respective five year outcomes. AIPH will focus on supporting Indonesia to bridge the link between prevention and promotion, and care, support and treatment. More assertive approaches to testing and treatment will be pursued, as will more rapid coverage of harm reduction. AIPH's focus will remain on vulnerable groups in key locations. Papua will be the main focus of scale up. The review assumes that due to the severity of the epidemic in Papua and West Papua, AIPH will extend beyond 2016 in those provinces and a design phase has been recommended.

This review also assumes that by 2016 Indonesia will be financing the majority of the HIV response. Therefore, the need for ongoing funds from Australia should be significantly diminished. However, there may be need for some ongoing technical assistance in particular locations or for specific vulnerable populations. This review does not attempt to predict the level of need for AIPH more generally beyond 2016. A review of AIPH and a situational analysis in mid 2014 are likely to be required to inform strategic direction beyond the life of this current program.



## Key achievements

The AIPH has contributed significantly to the Indonesian HIV response. In particular it has contributed to strengthened leadership and improved service delivery. Some of the key service delivery achievements are as follows:

### Harm reduction

- In 2010, 25,884 injecting drug user clients received one or more HCPI supported harm reduction services – a 64% increase from the previous year.
- This number of clients was 31% of the estimated injecting drug users in the seven provinces covered.
- The number of needles and syringes distributed by HCPI supported services in 2010 was 632,436 – more than double the number for 2009. However, in 2011, the rate of increase slowed to only 4%.
- HCPI's annual behavioural survey among injecting drug users found that not sharing needles in the previous week increased from 64% in 2009 to 83% in 2011. This indicates significant behavioural change, which is plausibly attributable to HCPI supported interventions.
- There has been a 35% increase in the number of active methadone clients in HCPI supported services from January 2009 to June 2011.
- As of June 2011, HCPI supported services accounted for 1,584 or 62% of all active methadone clients in Indonesia.
- The number of condoms distributed to clients by HCPI supported services increased by 196% in the period from January 2009 to June 2011.
- HCPI's 2011 injecting drug user behavioural survey found that 67% of clients were satisfied with the methadone program and 71% with needle distribution programs.

### ARV supply chain management

- Stock-outs have reduced from 87 in the final quarter of 2008 to seven in the first six months of 2011. The target of less than 5% of treatment sites reporting a stock-out has been achieved.

### Prisons

- By mid 2011, HCPI was supporting HIV programs in 92 correctional facilities in 11 provinces.
- 6,152 prisoners participated in a peer education session. HIV education was provided to 44,478 inmates for the first time, representing a coverage rate of 82% of prisoners in 72 prisons.<sup>8</sup>
- By April 2011, 156 prison officers and 1,170 prisoners had been trained as HIV educators.
- 12,482 prisoners were tested for HIV, representing 23% of inmates in the 72 prisons reporting data. Ninety one percent received pre-test counselling and 80% received post-test counselling, with 6% testing positive.
- Nearly 50% of people living with HIV who had been tested in prison and who were eligible for ART were on therapy.

### Papua and West Papua

- 192,000 people in Papua and West Papua received information on HIV from HCPI partners. Further reach has occurred through public media and related events, advocacy activities and training.
- 67% of eligible men and women in CHAI supported services in Papua are receiving antiretroviral treatment (compared to 22% for Papua as a whole).<sup>9</sup>
- 88% of men know that condoms reduce the risk of HIV, up from 85% in 2008/09.
- 21% of men used a condom at last sex with a casual partner, up from 18% in 2008/09.

<sup>8</sup> On average, 72 prisons reported data on a monthly basis over the 10 month period.

<sup>9</sup> CHAI figures sourced from CHAI; Papua figures from MoH via CHAI. No figures for West Papua. CHAI calculation (on revised excel sheet) has an error for Q2 2011 (coverage given as 40% should be 67%)

## Recommendations

This report offers suggestions for the broad direction for AIPH for the coming five years in terms of how AusAID might best support the Government of Indonesia to respond effectively to HIV in a sustainable manner. The proposals have been articulated in terms of objectives and five year outcomes. The various recommendations contained in the report are part of the means of reaching these outcomes and are grouped here accordingly. The numbering of the recommendations refers to the particular chapter in which the recommendations can be found. The cost implications of these recommendations are included as Annex 1.

### Objective 1

Support partners to secure adequate national and sub-national budget allocation and expenditure to enable an effective response to HIV

**Five year outcome for AIPH:** The Government of Indonesia at both national and sub-national level funds the vast majority of the HIV response in key locations from its own resources and has the capacity and capability to ensure appropriate allocation and expenditure.

*Recommendation 1.1:* That AusAID, in collaboration with other key donors such as USAID, provide technical assistance to the National Development Planning Board and the National AIDS Commission (and their respective sub-national entities) to strategically plan and implement the needed transition from reliance on donor funds to local independence.

*Recommendation 3.3:* That, as a means of further strengthening government capacity in the management of HIV targeted resources, the Contingency Funds and Partner Grants be channelled through a government based mechanism that has proven capacity with such transfer being planned for March 2013. Furthermore, that AusAID and the relevant agency agree annually upon strategic priorities for use of these grants and establish an agreed joint monitoring process.

*Recommendation 3.6:* That AusAID, as an influential member of the Global Fund Country Coordinating Mechanism, support the Ministry of Health to address the current unintended negative consequences of some of the incentive arrangements in applications approved through the Global Fund Country Coordinating Mechanism by jointly advocating for any incentives to be aligned to existing health system incentive schemes and that they support, not hinder, needed health reforms.

### Objective 2

Support a scaled up response in Papua

**Five year outcome:** National and provincial implementing partners make a significant impact on the spread of HIV in Papua through implementation of 'combination prevention' and strengthening of the health systems.

*Recommendation 2.3:* That AusAID and CHAI jointly undertake a rapid design for the proposed expansion to the Central Highlands in Papua of the HIV services and strengthening of the health systems. That the rapid design be timed to enable the expansion to begin by July 2012.

*Recommendation 2.2:* That HCPI support the Provincial AIDS Commissions to make necessary adaptations of the Strategic Communication Plan for HIV and AIDS to raise awareness of STI, ensure people know where to go for both STI diagnosis and VCT, how this will occur, and the benefits of early treatment. Further, that HCPI through its support to Provincial AIDS Commissions advocate, and provide technical assistance for, strategies to radically increase VCT for people at risk and that HIV testing be integrated with STI testing.

*Recommendation 2.4:* That a review of workload of the HIV and Communicable Disease Unit of AusAID be undertaken to enable a stronger presence in Papua and closer oversight and adaptive management of activities related to the Central Highlands project.

*Recommendation 2.1:* That AIPH, through HCPI, develop a plan for a phased transfer to the Provincial AIDS Commission of West Papua resources currently funding four positions in the Provincial AIDS Commission in Papua. Further that HCPI continue to assist the Provincial AIDS Commission in Papua to identify means to resource positions currently funded by AIPH.

*Recommendation 2.5:* That during the remaining period of the AIPH, AusAID, in partnership with its national and sub-national partners, instigate a grass roots design process to develop the next AusAID funded program of support to Papua and West Papua.

*Recommendation 4.3:* That HSS include Papua as one of its provinces in the second stage roll out in order that a more systematic approach to strengthening health systems in Papua will support AIPH efforts and to gain added leverage from the proposed scale up.

### Objective 3

Support an enhanced focus on sexual transmission within a continuum from promotion and prevention to care, support and treatment

**Five year outcome for AIPH:** Implementing partners, by framing interventions for most at risk populations within a sexual transmission framework, make a significant impact on the spread of HIV in key locations.

*Recommendation 1.2:* That a more patient focussed approach be taken to supply chain management by incorporating attention to improving ease of access to ARVs and other drugs through hospitals and an increased number of satellite sites. The Ministry of Health should be encouraged to procure drugs in standard dosages and fixed dose combinations to avoid patient confusion. Civil society organisations should be invited to work collaboratively on exploring solutions to address access issues.

*Recommendation 1.11:* That AusAID continue to provide financial support for the National AIDS Commission's MSM Program for a further two years beyond the life of the existing initiative.

*Recommendation 1.6:* That HCPI supported harm reduction services place greater emphasis on behavioural change communication strategies and condom distribution for prevention of sexually transmitted HIV, especially in regard to HIV positive injecting drug users and their casual sexual partners.

### Objective 4

Support a more rapid coverage of comprehensive harm reduction programs

**Five year outcome for AIPH:** National and sub-national partners achieve a level of coverage of harm reduction services equivalent to the national target.

*Recommendation 1.4:* That AIPH support national and sub-national partners to increase significantly the coverage of harm reduction services, especially needle and syringe programs and methadone. This can be achieved through: advocacy to address the policy and practice issues that constrain distribution of needles by outreach; greater efficiency of current needle distribution channels, especially outreach; development of strategies to address barriers; targeting injecting drug user sub-populations not currently being reached; and through advocacy for higher levels of investment by the Government of Indonesia in harm reduction, especially needle distribution and methadone.

*Recommendation 1.8:* That the harm reduction model promoted by HCPI place greater emphasis on encouraging all injecting drug users to know their HIV status through regular HIV testing. This should be achieved by improving the application of PITC; encouraging health services to make HIV testing more accessible by provision of outreach testing services; provision of technical assistance which practically addresses current obstacles to HIV testing; and development of strategies on how to significantly increase demand for HIV testing.

***Recommendation 1.7:** That in light of the well documented research that highlights the substantial benefit of starting treatment earlier and studies that show good adherence to ART by injecting drug users, AIPH advocate for a change to current practice which limits access to ART to injecting drug users who are receiving opioid substitution therapy. Technical assistance in the development of appropriate standard operating procedures and capacity building to cater for the special needs of injecting on ART should be offered by HCPI and CHAI. This should be accompanied by a concerted effort by HCPI supported harm reduction services to promote uptake of treatment for those who meet equitable ART eligibility criteria.*

***Recommendation 1.9:** That in the interests of sustainability, AusAID advocate for the Ministry of Health to take on an active national policy, oversight and coordination role in relation to needle distribution, thus relieving the National AIDS Commission of the responsibility which it has taken up by default.*

***Recommendation 1.10:** That in light of the many challenges relating to inmate health that would benefit from a more integrated health approach, and the need for continuity of care whilst in prison and post release, HCPI, in consultation with the Directorate of Corrections, identify opportunities for its support of HIV programming in prisons to contribute to health system strengthening within correctional facilities and to help address health system issues at the interface between correctional facilities and health services.*

***Recommendation 1.5:** That, because injecting drug users use both outreach and fixed site health services and the absence of any reliable way of tracking such use, AIPH provide technical assistance to the Ministry of Health to establish a common client unique identifier code for injecting drug users to improve the accuracy and completeness of service utilisation data.*

## Objective 5

Manage the partnership effectively to ensure an integrated approach to AIPH

**Five year outcome:** That AusAID, as the delegated manager of the partnership, manages AIPH in an integrated way to successfully achieve program outcomes and coordination with other relevant programs.

***Recommendation 3.2:** That in order to more fully recognise the importance of all key parties of the partnership and to ensure all necessary high level partnership relationships are developed, AusAID and the Office of the Coordinating Minister for People's Welfare negotiate Memoranda of Understandings with the Ministry of Health, the Ministry of Justice and Human Rights, and the National Development Planning Board that clearly articulate their essential roles in the partnership, and the AIPH Subsidiary Agreement be amended accordingly.*

***Recommendation 4.1:** That AIPH Program Management staff achieve an integrated approach to AIPH by:*

- *facilitating six monthly joint meetings with CHAI, HCPI and the National AIDS Commission (MSM Initiative) to ensure the progress and issues of the major service delivery components are regularly considered together and understood, and more formal means of collaboration can be established; and*
- *bringing representatives of all the various components together on an annual basis to review AIPH progress and set, jointly, the priorities for the following year.*

***Recommendation 4.4:** That another iteration of the program theory be undertaken with key stakeholders to clearly articulate AIPH's theory of change, the causal links between the different outcomes of AIPH, and the underlying assumptions. The updated program theory should then inform the proposed rapid design for the Papua scale up and be used to refine the Monitoring and Evaluation Plan, including updating success criteria and measures where relevant. This should form the beginning of a continuing iterative process.*

***Recommendation 3.4:** That once the program theory for AIPH has been clearly articulated, a review of the cumulative effectiveness of the Partner Grants be conducted to ensure that they are contributing to the desired intermediate and longer term outcomes.*

***Recommendation 3.1:** That the Partnership Coordinating Committee membership be limited to representatives of the Subsidiary Agreement and its focus be on: i) matters pertaining to the various dimensions of an effective partnership; ii) strategic decisions; and iii) accountability for effective and efficient implementation of AIPH as a whole.*

***Recommendation 3.5:** That in the absence of a single high level policy forum and in recognition that AusAID would benefit from a more formalised approach to policy and strategic discussions with major stakeholders, AusAID facilitate regular policy and coordination discussions between its major stakeholders, namely: the National AIDS Commission, the Ministry of Health, National Development Planning Board, AIPH managing contractors, USAID (and its managing contractors) and the Global Fund Country Coordinating Mechanisms. Among other policy issues, this forum be used to initiate discussions about how the current national mechanisms might evolve to: i) be more integrated and streamlined; and ii) be adapted or merged to provide the needed overarching high level policy discussion and coordination.*

***Recommendation 4.2:** That, in recognition of the important interdependencies between the various AusAID programs, AusAID establish formal coordination mechanisms between AIPH, AIPD and HSS at the central level and at the local level in common provinces in which they are operating.*

**In regard to the current contract for HCPI**

***Recommendation 5.1:** That AusAID undertake a joint review of the contract conditions with GRM (the managing contractor) to determine the impact of the suggested changes in emphases contained in the recommendations relevant to HCPI. This review should be undertaken in time for any design changes to be made prior to the conclusion of the current contract (March 2013) to ensure a smooth transition and prevent loss of momentum.*

**In regard to the current contract for CHAI**

***Recommendation 1.3:** That AusAID negotiate a new contract with CHAI to come into effect July 2012 to provide financial and technical assistance to:*

- *consolidate improvements in the ARV drug supply chain management system; and*
- *extend the work to include some or all of: HIV rapid tests; extending the decentralisation work in up to six additional provinces; and improving supply chains for other HIV related health commodities such as opportunistic infection drugs and CD4 tests.*

In addition, a recommendation to scale up in Papua is proposed under objective 2.



## 1. Progress towards end-of-program outcomes

### 1.1. Strengthening Indonesian leadership

This section reports on the following Australia Indonesia Partnership for HIV (AIPH) outcomes:

- The National AIDS Commission is more effective;
- Provincial AIDS Commissions are more effective;
- The budget and policy context supported an improved HIV response;
- There are more national and local leaders who are advocates of HIV; and
- There is greater participation of civil society including people living with HIV/AIDS (men and women) in planning and decision making.

#### 1.1.1. *National and sub-national AIDS Commissions are more effective*

The considerable efforts and high profile of the Secretary of the National AIDS Commission, and the authority vested in her through Presidential decree, has established the Commission's position in Indonesia as a strong advocate for response to HIV/AIDS, and the planning and coordination of responses. The work of the Commission is guided by a strategy that has been developed collaboratively with key stakeholders, helping to ensure greater ownership of the national HIV response. The Commission has ensured that the plan (the most recent one being the *National Action Plan for HIV 2010 – 2014*), is linked to Indonesia's Mid-Term Development Plan.

AIPH is a partnership between Australia and Indonesia with AusAID recognised as a major partner of the National AIDS Commission. The contribution of AIPH, particularly through the Indonesia Partnership Fund and HIV Cooperation Program for Indonesia (HCPI) has been a critical means, along with the Global Fund, through which the National AIDS Commission has been able to implement its National Action Plan. Through technical assistance, funding of positions and other grants, the AIPH has significantly strengthened leadership within national, provincial and district commissions. For example, the Indonesia Partnership Fund has been successful, because of its flexible funding, for the strengthening of management systems at national, provincial and district levels, including finance systems and monitoring and evaluation and reporting systems down to the district level.<sup>10</sup> The Indonesia Partnership Fund is further discussed in Chapter 4.

A key indicator of success of a stronger, more effective National AIDS Commission is that the management of the Indonesia Partnership Fund will sit with the Commission after 2011. This Fund has enabled the building of the capacity to undertake this management at the same time as building ownership.<sup>11</sup> In turn, Provincial AIDS Commissions are supported through national strategies to develop and strengthen local structures, policies and processes.

At this sub-national level, provinces have been supported by the National AIDS Commission using HCPI technical resources and funding (together with funds from the Global Fund). Four Provincial AIDS Commissions are now able to plan, implement and evaluate programs with minimal support.<sup>12</sup> HCPI has worked with Provincial AIDS Commissions to identify needs, develop annual strategy plans and provide support through training, information and mentoring. It has also been working with the National AIDS Commission to plan and deliver training to provinces more broadly. It would seem the development of organisational capacity is enabled through the approach HCPI takes in working alongside the respective Provincial AIDS Secretariat, determining what is important to it and developing a tailored implementation plan.

A focus on Millennium Development Goals – HIV and AIDS has helped some provinces to develop an understanding of what is needed to achieve targets. The National AIDS Commission, collaborating with the National Development Planning Board, Ministry of Health and other sectors, supported by HCPI, has developed guidelines for a minimum package of HIV responses needed to achieve targets.

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<sup>10</sup> United Nations Development Program (2008) *The Indonesian Partnership Fund for HIV 2008 - 2015*

<sup>11</sup> *ibid*

<sup>12</sup> HCPI (2011) *Progress Report July – December 2010*

### 1.1.2. Budget and policy context supports an improved HIV response

Provincial AIDS Commissions and Regional Development Planning Boards, as well as other key stakeholders, have been working towards integrating HIV into planning and budgeting through the local consultation mechanisms (*Musrembang*). HCPI is supporting this process and, whilst the development is in its early stages, it would seem an excellent way to gain local ownership and, importantly, the necessary ongoing financial commitment from local government and agencies.

An important success has been a significant increase in funding for HIV responses in the five years from 2006 – 2010, with a greater proportion of Indonesian funding. In 2006 the total national AIDS budget was \$US56.6 million, with 27% being contributed by Indonesia. In 2010 the budget was \$US90.3 million, with 49% from Indonesia.<sup>13</sup> Some individual provinces had higher proportions of funding from local and national government: for example, for DKI Jakarta it is 65% and for Banten 68%.<sup>14</sup> It will be important for this trend to continue, with significant increases in funding at provincial and district level. In 2007, 23 provinces and 86 districts included HIV in their budgets. By 2009 this had increased to 33 provinces and 172 districts.<sup>15</sup> The National AIDS Commission, in collaboration with the National Development Planning Board, is working with provinces to assist them to ensure availability of local resources for HIV prevention and intervention.<sup>16</sup>

As Indonesia moves towards becoming an upper middle income country, international aid can be expected to decrease in coming years. It will be crucial that all levels of Indonesian government develop the capacity to increase budgets to fund HIV responses, and to manage budgets efficiently. Therefore, the work of HCPI through the National AIDS Commission to strengthen leadership in this area is important. HCPI reports that the National AIDS Commission has received more requests for facilitation of discussion between Provincial AIDS Commissions and Regional Development Planning Boards than it is able to meet. Finding a way to spread skills to other provinces and districts will be critical. HCPI intends to work with the National AIDS Commission to train cadres of local facilitators.<sup>17</sup>

The review team suggests that this effort will need to be guided by a more strategically planned approach, developed in conjunction with the National Development Planning Board and the National AIDS Commission. A similar process would need to occur in each of the sub-national equivalents in the relevant high priority HIV locations. Staged plans for the transition from donor reliance to local independence should be developed and include: advocacy to secure increased budget allocations from the national and sub-national governments and key implementing Government Agencies (that focuses on demand and supply); and technical assistance for budgeting and expenditure, where this is required.

This role is beyond the scope and responsibility of AIPH and perhaps best sits with the Australia Indonesia Partnership for Decentralisation (AIPD). Notwithstanding this, given that AIPH has established strong working relationships with the key stakeholders, AIPD might consider how it resources AIPH to expand its existing support. Regardless, AIPH should continue to actively advocate and support its current partners to increase HIV related budget allocation and expenditure. Furthermore, any sub-national budget and expenditure work by either AIPD or AIPH should be harmonised with the new USAID program SUM2, which will, among other activities, support local governments in such things as financial management.

**Recommendation 1.1:** *That AusAID, in collaboration with other key donors such as USAID, provides technical assistance to the National Development Planning Board and the National AIDS Commission (and their respective sub-national entities) to strategically plan and implement the needed transition from donor funds reliance to local independence.*

<sup>13</sup> National AIDS Commission Presentation (2011) *Government Policy & Resources to Accelerate HIV and AIDS Reduction*

<sup>14</sup> HCPI (2011) *Progress Report July – December 2010*

<sup>15</sup> National AIDS Commission Presentation (2011) *Government Policy & Resources to Accelerate HIV and AIDS Reduction*

<sup>16</sup> United Nations Development Program (2008) *The Indonesian Partnership Fund for HIV 2008 - 2015*

<sup>17</sup> HCPI (2011) *Progress Report July – December 2010*



The strong leadership of the new Directors of Disease Control and HIV/AIDS provides an opportunity to support the new policy development processes. AIPH, through CHAI, provides technical assistance to the Sub Directorate HIV/AIDS in the Ministry of Health to develop evidence based health sector policy and guidelines. Key outcomes have been significant improvements to key policies in line with international best practice, and development of new processes for the review and development of HIV health policies. CHAI's technical inputs have resulted in improved policies to: PITC; PMTCT; and ART. In addition, there are now new processes for policy development intended to improve the efficiency and effectiveness of national HIV health policy and guideline development. This will put in place a mechanism for applying international evidence of best practice within the Indonesian context.

Other areas where policies could be developed by the Sub Directorate HIV/AIDS include those to influence HIV testing rates among intravenous drug users, and not limiting treatment access for intravenous drug users to those in methadone treatment. HCPI and CHAI should collaborate to advocate with one voice to the Sub Directorate about these issues.

### **1.1.3. More national and local leaders who are advocates of HIV, including people living with HIV and AIDS in planning and decision making**

A number of key participants in the National AIDS Commission take leadership roles within their organisation and beyond. Those who are supportive of HIV responses include key ministries. For example, the Directorate of Corrections has developed a new five year action plan with support from HCPI, which has articulated roles, targets and indicators. The plan, which was developed through a process including all prison heads, the National AIDS Commission and major donors, outlines a comprehensive approach to HIV in prisons. A change of key personnel in the Ministry of Health has resulted in a revitalised interest in HIV and AIDS. This extends to departmental principals and has enhanced opportunities for AIPH to work collaboratively with the department. Successes such as those in supply chain management could not have been achieved without this support.

HCPI activities have enhanced leadership capacities for civil society organisations. Self assessment by these groups indicated increases in organisational capacity following capacity building strategies led by HCPI.<sup>18</sup> Whilst these results were reported to be better than mid-term targets, HCPI reports the rate of increase in capacity has slowed as some resources have been diverted to supporting Provincial AIDS Commissions.<sup>19</sup>

Civil society organisations are participating at a policy level through the National AIDS Commission, the Indonesia Partnership Fund and the Global Fund Country Coordinating Mechanism. Community society organisations provide an avenue for people living with AIDS to be involved. They also involve these people in their planning and decision making processes. Peersman et al<sup>20</sup> found that civil society is strongest when civil societies initiate action and organise themselves. A barrier to success is lack of experience in engaging at the national level. This would confirm the approach HCPI has taken in developing the capacity of community service organisations through funding and technical support.

The role of civil society organisations is promoted by the National AIDS Commission. It is taking a strong role in advocating and providing supports for people living with HIV and AIDS. This gives a voice to people living with HIV and AIDS. Spiritia and JOTHI have been actively advocating for improvements in the availability of drugs. This is similar to experiences in Thailand<sup>21</sup> where treatment activism has brought civil groups together to fight for a common cause, providing a platform for action. The role has been one of cooperation and advocacy.

An issue in Indonesia is that there are many civil society organisations that feel they are not heard. Perhaps the establishment of more networks and peak bodies may alleviate this. Much of this network building is being funded through the Indonesia Partnership Fund and HCPI's grant mechanism.

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<sup>18</sup> HCPI (2011) *Progress Report January – June 2011*

<sup>19</sup> HCPI response to draft report of the independent review

<sup>20</sup> Peersman et al. (2009). Increasing Civil Society Participation in the National HIV Response: The Role of UNGASS Reporting. *Journal of Acquired Immune Deficiency Syndrome*. 52, supplement 2, Dec. pp.97-103.

<sup>21</sup> Ford et al. (2009). Challenge and cooperation: civil society activism for access to HIV treatment in Thailand. *Tropical Medicine and International Health*. 14 (3), pp.258-266.

Faith-based organisations are also taking strong leadership roles. This is particularly so in Papua and West Papua where churches are delivering messages about prevention and recognising a responsibility to provide outreach support.

## **1.2. Supporting implementation of an increased and good quality HIV response**

This section reports on the following AIPH outcomes:

- supply of antiretrovirals is more reliable;
- men and women injecting drug users have increased access to good quality HIV programs; and
- men and women in prisons and other closed settings have increased access to good quality HIV programs.

It also reports on the *MSM Initiative*. This section of the report is complemented by a more detailed account of the findings, which can be found in Annexes 4A and 4B.

### **1.2.1. More reliable supply of antiretroviral medication**

Patients in need of antiretroviral medication are now more likely to have ready access to needed drugs as a result of the supply management chain project. Through the work CHAI is doing collaboratively with the Ministry of Health's Sub Directorate of HIV/AIDS, hospitals and a local warehouse, a sustained and dramatic reduction in stock-outs at treatment sites has been achieved. Stock-outs have reduced from 87 in the final quarter of 2008 to seven in the first six months of 2011.<sup>22</sup> Not only has this helped the overall HIV response, the success has highlighted the potential for other drug procurement. For example, the national TB program is now examining these improvements for possible replication.

An important factor in enabling the improvements to the supply chain has been a strong focus on establishing systems supported by technical assistance and a range of standard operating procedures. For example:

- being informed by contemporary good practice in supply chain management in the corporate sector has helped provide a systematic approach to the reform;
- improving central level forecasting, procurement and stock management. Efficiencies have been achieved by now having one central warehouse instead of two, and the Ministry of Health and Provincial Health Offices have been provided with tools to forecast antiretroviral demand and manage inventory, enabling a proactive approach;
- a focus on improving the timeliness and accuracy of site reporting, as these had become the leading causes of stock-outs<sup>23</sup>;
- establishing a decentralised system in six pilot provinces where there are multiple antiretroviral referral hospitals has enabled the holding of drug supplies at provincial warehouses. This has resulted in quicker distribution responses<sup>24</sup> as well as easier redistribution of stocks between hospitals within the pilot provinces;
- attention to communication systems has facilitated improved coordination within and between levels in the health system;
- a strong focus on strengthening capacity through site level training and mentoring, has improved hospital reporting; and
- a strong emphasis on applying the lessons from the first province where decentralisation was piloted as other provinces have come on line.

Despite the impressive improvements in the supply of ARVs, a number of challenges are still evident. Firstly, there are a few issues related to capacity:

- while there has been significant improvement in the number of hospitals providing accurate supply and demand information, more than half were still providing inaccurate data as of April 2011. This highlights the need for continued practical training; and

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<sup>22</sup> CHAI data

<sup>23</sup> Sub Directorate HIV/AIDS (April 2011) *CST Profile Indonesia*, Jakarta.

<sup>24</sup> CHAI and health system data

- the Ministry of Health has been able to procure ARVs at reasonable prices using the Global Fund's pooled procurement procedures. However, in the interests of sustainability, the capacity of the ministry to manage a bidding process needs to be developed.

Secondly, Global Fund monies have been used to employ four staff seconded to the Sub Directorate HIV/AIDS. These positions will be needed on an ongoing basis to manage supply chain systems. The Ministry of Health will need to find replacement funding for these positions. There is a need for CHAI advocacy to place this on the agenda of the Ministry of Health.

A third group of issues relates to patient access to drugs:

- currently, access by patients to ARVs is primarily through the 215 designated referral hospitals, with only 67 additional satellite treatment sites. Distance from the nearest referral hospital and the cost of transport are significant access barriers for patients, especially the poor. This is particularly the case when hospitals dispense limited supplies of ARVs due to low stock levels, necessitating more frequent hospital visits;
- in Indonesia, ARVs are, from time to time, procured in different dosages and in combination with other drugs or in a single dose formulation. This was reported in some locations as causing considerable patient confusion and to impact adversely on adherence. In other locations it was reported as impacting on efficiency because of the additional staff time needed to explain how to take the medicines that come in different dosage levels or single or fixed dose combinations; and
- civil society organisations continue to express concerns over the availability of ARVs. These organisations have legitimate advocacy roles which should be encouraged as part of feedback loops. While consultation with civil society organisations is primarily a responsibility of the Sub Directorate, CHAI, as the key technical assistance provider, needs to be involved in these consultations. There is merit in working collaboratively with civil society organisations to resolve access issues. Their patient focus could add a valuable perspective to potential solutions.

**Recommendation 1.2:** *That a more patient focussed approach be taken to supply chain management by incorporating attention to improving ease of access to ARVs and other drugs through hospitals and an increased number of satellite sites. The Ministry of Health should be encouraged to procure drugs in standard dosages and fixed dose combinations to avoid patient confusion. Civil society organisations should be invited to work collaboratively on exploring solutions to address access issues.*

There will be the need for some ongoing supply chain work following the end of CHAI's current contract in mid 2012. Beyond that time, AusAID funding could be redeployed to new areas of supply chain work. Possibilities include extending the work on supply chain systems for HIV rapid tests; extending the decentralisation work in up to six additional provinces; and improving the supply chain for other HIV related health commodities such as opportunistic infection drugs and CD4 tests.

**Recommendation 1.3:** *That AusAID negotiates a new contract with CHAI to come into effect in July 2012 to provide financial and technical assistance to:*

- *consolidate improvements in the ARV drug supply chain management system; and*
- *extend the work to include some or all of: HIV rapid tests; extending the decentralisation work in up to six additional provinces; and improving supply chain for other HIV related health commodities such as opportunistic infection drugs and CD4 tests.*

### **1.2.2. Increased access to good quality HIV programs for injecting drug users**

#### **Access to services:**

AIPH, in conjunction with Global Fund, has supported the Government of Indonesia to extend the geographic coverage of a comprehensive package of harm reduction services in seven provinces. With HCPI support since 2008, an additional 56 community health centres now operate needle distribution and a further 25 community health centres provide methadone maintenance therapy.<sup>25</sup>

<sup>25</sup> All data presented in this report relating to harm reduction services is only for services supported by HCPI, unless otherwise indicated.

The number of non-government organisations providing outreach services has also increased, with seven being added in the past two years. As a result, there has been a 64% increase in the number of injecting drug users being reached by HCPI supported harm reduction services between 2009 and 2010.<sup>26</sup> However, as outreach services and community health centres have an unknown number of clients in common, the number of individual clients (25,884) is an overestimate.

In 2010, this client reach by HCPI supported harm reduction services amounted to 31% of the estimated 83,103 injecting drug users in the seven provinces covered.<sup>27</sup> Nationally, a further 17% was reached by non-HCPI supported services.<sup>28</sup> While HCPI supported harm reduction services account for the largest portion of coverage, national coverage (48%) is well below the national target of 80%.<sup>29</sup> In addition, as a sizable number of injecting drug users being reached by harm reduction services are not receiving sterile needles or methadone, the potential impact of coverage at this level is significantly diminished.

**Access to and coverage of needle and syringe distribution:** The provision of a package of complementary harm reduction services is important. Within this, sterile needle distribution is the service with the potential to have the greatest impact in averting HIV infections.<sup>30</sup> HCPI data show that although the number of needles distributed has grown significantly, only a low percentage of clients actually received needles (42%), which amounted to only 13% of the estimated number of injecting drug users in the seven provinces. To the extent that there are shared clients between non-government organisations and community health centres, 13% is an overestimate.

There is no international consensus on the level of coverage needed to stabilise and reverse HIV epidemics among injecting drug users.<sup>31</sup> The World Health Organization (WHO) defines a high level of coverage as greater than 60% of users reached regularly.<sup>32</sup> Indonesia's target is 80% of injecting clients reached by behaviour change communication programs.<sup>33</sup> There is no data available to the review team that indicate the total number of sterile needles distributed or sold to injecting drug users per year from all sources. However, the low coverage levels for HCPI supported needle distribution, coupled with HCPI's high share of total coverage indicate that national coverage levels are likely to be significantly less than the Commission's target and international guidance. Containment and reversal of HIV epidemics among injecting drug users is most unlikely to be achieved without a high level of coverage.

It is desirable for needle distribution programs to supply sufficient needles so that a new, sterile needle is used on each occasion of injecting.<sup>34</sup> The number of needles distributed per client per month by HCP- supported services is significantly below this level: nine for those supported by non-government organisations and 19 for those supported by community health centres or hospitals. With 66% of participants in HCPI's 2011 behavioural survey injecting daily, and most injecting twice a day, there is a high need for sterile needles.<sup>35</sup> As non-government organisations and community health centres are the primary sources of needles for 77% of clients,<sup>36</sup> it cannot be claimed that a large proportion of needles are being obtained from other sources.

<sup>26</sup> The package comprises: sterile needle and syringe; methadone maintenance therapy; condoms; information, education and communication materials; one-to-one and small group education; HIV testing; primary health care, including TB and STI services; and linkages to HIV treatment and ARVs.

<sup>27</sup> National AIDS Commission, (2009). *Estimation of the size of the most at risk populations for HIV infection by province and sub-population*.

<sup>28</sup> National AIDS Commission, presentation to review team, July, 2011.

<sup>29</sup> National AIDS Commission, National HIV and AIDS Strategy and Action Plan 2010 – 2014, p.83.

<sup>30</sup> Health Outcomes International, (2002). *Return on Investments in Needle and Syringe Programmes in Australia*. Commonwealth of Australia.

<sup>31</sup> WHO et al. (2009). *Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*. p.16.

<sup>32</sup> *ibid*, p.18.

<sup>33</sup> National AIDS Commission, National HIV and AIDS Strategy and Action Plan 2010 – 2014, p.83.

<sup>34</sup> Bluthenal, R.N. et al. (2007). Higher syringe coverage is associated with lower odds of HIV risk and does not increase unsafe syringe disposal among syringe exchange program clients. *Drug and Alcohol Dependence*, 89: pp.214-222.

<sup>35</sup> HCPI, Injecting Drug User Behaviour and Service Satisfaction Survey, 2011. Draft. p.7.

<sup>35</sup> Health Outcomes International (2002). *op.cit*.

<sup>36</sup> HCPI, Injecting Drug User Behaviour and Service Satisfaction Survey, 2011. Draft. p.17.

Within this context, it is particularly concerning that the growth rate in the number of needles distributed in the first half of 2011 has reduced significantly to an overall growth rate of 4%. The growth rate in needle distribution by community health centres and hospitals was 20%, while needle distribution by non-government organisations reduced by 14%.<sup>37</sup> This appears to be because of the policy of favouring distribution by government health services, with non-government organisations being encouraged to refer clients to health centres for needles, rather than being involved in distribution directly. The low number of clients seen by outreach services raises the issue of whether outreach is being conducted efficiently.

Strategies are needed to significantly increase needle distribution coverage. Issues that need to be addressed include:

- determining the appropriate balance of needle distribution between health services and outreach;
- how to increase the efficiency of both fixed outlets and outreach through such actions as increasing the opening hours of fixed outlets, and increasing the number of clients reached by outreach and the proportion who receive needles;
- how to effectively reach sub-populations of injectors not currently reached, such as university students and new injectors<sup>38</sup>; and
- addressing obstacles to accessing needles identified in HCPI's behavioural surveys.

Because of social marginalisation, it is unlikely that many new injecting drug users will self-refer to government services. Outreach services are clearly essential to achieving higher coverage. There is a need for AIPH to engage in a policy dialogue with the National AIDS Commission, the health sector and police on rebalancing the needle and syringe program model so that the complementary key roles of both the health sector and non-government organisations in direct distribution is valued.

Given the importance of outreach services in engaging hard-to-reach populations, it is concerning that service utilisation data indicate a significant slowing in the rate of expansion of outreach harm reduction services operated by non-government organisations. The trends in data show that:

- although the number of outreach clients in 2010 was more than double compared to 2009, the client growth rate in the first six months of 2011 was only 8%;
- the average number of outreach clients seen per month in the first half of 2011 declined by 16% compared to 2010;
- the number of new needle and syringe clients seen by non-government organisations has declined from 66% of all clients in 2009 and 2010 to 36% in 2011;
- the average number of needles distributed per client by non-government organisations has remained static at nine between 2009 and 2011; and
- each of the 15 non-government organisations conducting outreach saw an average of 20 clients per day (based on 21 working days per month).

While outreach will no doubt be an important mechanism for increasing coverage, the effectiveness of current outreach strategies needs to be reviewed given the low number of clients seen per non-government organisation, per day and the even lower number of clients who receive needles.

There may also be potential for increasing the numbers of needles distributed by health services. In 2010, an average of 1,524 clients per month were given needles by 90 health services. Averaged out across the 90 health services this amounts to only 17 clients per month, or fewer than one a day. It should, however, be noted that the number of clients provided with needles by health services varies significantly by province. In DKI Jakarta, where 90% of needles are distributed by community health centres or hospitals, the number of clients seen per community health centre was higher and in some other provinces the number was lower.

**Methadone maintenance therapy:** There has been a 35% increase in the number of active methadone clients in HCPI supported services from January 2009 to June 2011. However, the number of new methadone clients has reduced from 72% of all clients in 2009 to 25% in the first six months of 2011. This indicates a slowing of the rate of methadone expansion.

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<sup>37</sup> However, the number of needles distributed by outreach in 2010 increased by 144% compared to 2009.

<sup>38</sup> The 2007 study found an HIV prevalence of 37% in injecting drug users in DKI Jakarta who had been injecting for 2 years or less.

As of June 2011, HCPI supported services accounted for 62% of all active methadone clients in Indonesia. This accounts for 2% of the estimated number of injecting drug users in the seven focus provinces, with the national methadone coverage at 2.5%. This is significantly lower than the national coverage target of 30% of those reached by needle distribution programs.<sup>39</sup> It is also significantly lower than WHO guidance for coverage of 40% or more of opioid-dependent people.<sup>40</sup>

The recent national opioid substitution review recommended that opioid substitution programs be dramatically scaled up and this is clearly needed. There is, however, the danger that opioid substitution therapy could be accorded higher priority than needle distribution as this strategy holds out the promise of reduced drug use and cessation. Needle distribution and methadone therapy should be seen as complementary strategies, with needle distribution having the potential, at least in the short to medium term, to avert a greater number of HIV infections.

**Recommendation 1.4:** *That AIPH support national and sub-national partners to increase significantly the coverage of harm reduction services, especially needle and syringe programs and methadone. This can be achieved through: advocacy to address the policy and practice issues that constrain distribution of needles by outreach; greater efficiency of current needle distribution channels, especially outreach; development of strategies to address barriers; targeting injecting drug user sub-populations not currently being reached; and advocacy for higher levels of investment by the Government of Indonesia in harm reduction, especially needle distribution and methadone.*

**Client unique identifier code:** The lack of a client unique identifier code across services means that it is not possible for HCPI to identify the extent to which the same clients are being reached by outreach and fixed site services at community health centres and hospitals. This in turn means it is not possible to calculate accurately the coverage rates for HCPI supported harm reduction services. The absence of a unique identifier code makes it difficult to track whether clients take up referrals to different types of health services such as HIV testing.

**Recommendation 1.5:** *That because injecting drug users use both outreach and fixed site health services and the absence of any reliable way of tracking such use, AIPH provides technical assistance to the Ministry of Health to establish a common client unique identifier code for injecting drug users to improve the accuracy and completeness of service utilisation data.*

### **Quality of services:**

**The model:** Integration of harm reduction services within the health sector has allowed a range of primary health care services to be provided to injecting drug users. A strength of the model is that harm reduction services are embedded in the health system. Site visits confirmed that, following initial reluctance by management and health care workers to adopt a harm reduction approach, there is now growing and often strong acceptance of the necessity and efficacy of this work. This will help with sustainability.

Overall, there appear to be quite high rates of client satisfaction with harm reduction services, with 67% of clients satisfied with the methadone program and 71% with needle distribution programs.<sup>41</sup> Obstacles identified by clients to accessing harm reduction services were: transport issues (25%); concerns regarding safety and the police (21%); too busy working (21%); opening hours (14%); confidentiality (12%); and the types of services on offer (8%).<sup>42</sup> Addressing these obstacles would help to improve the frequency of client access and possibly total coverage.

A weakness of the model is that many injecting drug users are not willing to attend mainstream health services. Outreach by non-government organisations is designed to counter this weakness. However, as noted above, there is a slowing in the rate of outreach services, highlighting a need to review why this is occurring.

<sup>39</sup> National AIDS Commission, National HIV and AIDS Strategy and Action Plan 2010 – 2014. p.83.

<sup>40</sup> WHO et al (2009). op. cit. p.21.

<sup>41</sup> HCPI Injecting Drug User Behaviour and Service Satisfaction Survey, 2011.

<sup>42</sup> *ibid.* p.31.

A further weakness is that different services such as HIV testing and STI services have been placed in different community health centres rather than taking a 'one-stop shop' approach. This requires referral of clients between health services, resulting in some clients dropping out. The lack of colocation of services, limited opening hours for needle distribution and methadone, and the varying levels of discouragement of needle distribution by non-government organisations collectively mean that services are not focused on ease of access for clients.

**Harm reduction and sexual transmission:** The package of harm reduction services includes attention to sexual transmission through distribution of condoms, information and education materials, HIV testing, and STI services. However, it is apparent that the effectiveness of this component of the package needs improving. For example, although the number of condoms distributed by HCPI supported services has increased significantly<sup>43</sup>, the level of safer sexual practices by injecting drug users remains low.<sup>44</sup>

**Recommendation 1.6:** *That HCPI supported harm reduction services place greater emphasis on behavioural change communication strategies and condom distribution for prevention of sexually transmitted HIV, especially in regard to HIV positive injecting drug users and their casual sexual partners.*

**Access to ART:** Currently, access to ART by injecting drug users in Indonesia is largely confined to those who have been stabilised on opioid substitution therapy. Most injecting drug users in Indonesia do not commence this therapy until reasonably late in their 'injecting careers' when many have been HIV positive for some years. It is not uncommon for injecting drug users to commence ART with CD4 counts significantly below 350, the recommended level for initiation of treatment. This means that many are not able to take advantage of the well documented, substantial benefit of starting treatment earlier. In addition, although all the evidence of treatment as prevention relates to sexual transmission, with no evidence as yet relating to blood-to-blood transmission, effective ART will significantly reduce the risk of HIV transmission by injecting drug users to their sexual partners.

Restrictions on access to ART for injecting drug users are based on the assumption that they are poor candidates for treatment because of their drug dependence and its effect on adherence, and other complications such as co-infection with hepatitis C. Achieving success in HIV treatment for injecting drug users does require attention to their special needs. However, extensive experience and numerous studies have documented good adherence to ART by injecting drug users without compromising the effectiveness of treatment.<sup>45</sup> Given the reluctance of many injecting drug users to use hospital services, improving their access to ART would best be accompanied by increasing the number of community health centres that can provide treatment. The WHO has recommended that the clinical and immunological criteria for initiating ART among HIV positive injecting drug users should not differ from its standard recommendation for initiation of treatment.<sup>46</sup>

It is recognised that provision of ART is a Government of Indonesia responsibility and outside the scope of HCPI support. Nonetheless, broadening current practice regarding when to initiate HIV treatment for injecting drug users, based on the personal and public health benefits to be gained and as part of a comprehensive, integrated approach to HIV programming is an issue that should be on AIPH's advocacy agenda.

**Recommendation 1.7:** *That in light of the well documented research that highlights the substantial benefit of starting treatment earlier and studies that show good adherence to ART by injecting drug users, AIPH advocates for a change to current practice which limits access to ART to injecting drug users who are receiving opioid substitution therapy. Technical assistance in the development of appropriate standard operating procedures and capacity building to cater for the special needs of injecting drug users on ART should be offered by HCPI and CHAI. This should be accompanied by a concerted effort by HCPI supported harm reduction services to promote uptake of treatment for those who meet equitable ART eligibility criteria.*

<sup>43</sup> 196% in the period January 2009 to June 2011

<sup>44</sup> HCPI Injecting Drug User Behaviour and Service Satisfaction Survey, 2011

<sup>45</sup> WHO (2005). *Evidence for action on HIV/AIDS and injecting drug use – Policy brief: Antiretroviral Therapy and Injecting Drug Users.*

<sup>46</sup> *ibid.*

**HIV testing:** The 2011 HCPI behavioural survey found that a low number (29%) of injecting drug users had never had an HIV test. Data were not collected on how recently respondents had been tested. The survey is not likely to be representative of all injecting drug users as the respondents were in contact with a health service or non-government organisation. In addition, 75% of respondents were currently on methadone. HIV testing is commonly associated with methadone enrollment. In contrast, the 2007 IBBS found that only 30% of injecting drug users had been tested for HIV in the previous year. It is not clear whether there has been a significant increase in the numbers tested since 2007. The yet to be released 2011 IBBS report will provide an update on this key indicator.

Data indicating increased safe sexual behaviour by HIV positive injecting drug users with their regular partners point to the importance of using an HIV diagnosis for delivery of safe behaviour messages. In addition, if HIV treatment for injecting drug users is to be scaled up, consistent with the recommendation above, this would require a greater emphasis on timely HIV diagnosis. This has started in a limited way through the adoption of a provider initiated testing and counselling (PITC) approach in some health services. However, in a number of health services visited by the review team the approach taken was a hybrid model with patients in particular clinics, such as the STI clinic, being assessed for HIV risks, rather than being routinely offered an HIV test. Only those with risk factors were considered candidates for testing and were then referred to another service, risking loss to follow up. Currently, HIV testing is generally only available in community health centres and hospitals and not on an outreach basis.

**Recommendation 1.8:** *That the harm reduction model promoted by HCPI place greater emphasis on encouraging all injecting drug users to know their HIV status through regular HIV testing. This should be achieved by improving the application of PITC; encouraging health services to make HIV testing more accessible by provision of outreach testing services; provision of technical assistance which practically addresses current obstacles to HIV testing; and development of strategies on how to significantly increase demand for HIV testing.*

**National policy and coordination:** Responsibility for national policy and oversight of opioid substitution therapy rests with the Health Improvement Unit in the Ministry of Health. There is, however, no similar national level 'policy home' within the Ministry for needle distribution. This is despite the significant involvement of the health sector in needle distribution at provincial, district and service delivery levels. By default, advocacy, policy leadership and national oversight for needle distribution has been taken up by the National AIDS Commission. The Commission, with AusAID support, has filled an important gap by promoting and protecting needle distribution programs. However, in the interests of sustainability it is important that a policy home for needle distribution be found in the Ministry of Health.

**Recommendation 1.9:** *That in the interests of sustainability, AusAID advocates for the Ministry of Health to take on an active national policy, oversight and coordination role in relation to needle distribution, thus relieving the National AIDS Commission of the responsibility which it has taken up by default.*

### **1.2.3. Increased access to good quality HIV programs in prisons**

#### **Access**

HCPI has supported the scale up of a comprehensive HIV program being implemented by the Directorate of Corrections and in doing so has helped to increase prisoners' access. By mid 2011, HCPI was supporting HIV programs in 92 correctional facilities in 11 provinces, which accounts for the largest portion of prison programming. Whilst the program is at a fairly early stage of implementation initial program data indicate relatively good rates of access.<sup>47</sup> However, access to means of prevention: condoms, bleach and sterile needles, was limited. Currently, regulations prohibit tattooing, piercing, insertion of genital accessories, sexual activities and drug use in correctional facilities. This causes a tension with HIV programming, which acknowledges these practices occur and seeks to make them safe. While availability of condoms in correctional facilities is part of the National Action Plan, condoms are not currently available in many facilities as the policy is yet to be universally accepted.

<sup>47</sup> HCPI, Progress Report January – June 2011. July 2011. HCPI's six monthly reports state that the data from the 2010 prisons IBBS data is being treated as baseline data.



HCPI has conducted an assessment on piloting needle and syringe programs within prisons. It remains to be seen whether sensitivities regarding the availability of these essential prevention products can be overcome.

### **Quality**

HCPI is supporting a number of key strategies to improve the quality of HIV programming in prisons. Firstly, it provided technical assistance to the Directorate of Corrections in the development of its new *National Action Plan for Control of HIV/AIDS and Drug Abuse in Correctional Units in Indonesia, 2010-2014*. This new plan is more detailed and provides specific guidance on the role and functions of different sections of the Directorate at national, provincial and prison level.

Secondly, it supported the development of an HIV curriculum which is being taught at the corrections pre-service training institution to ensure new graduates have appropriate HIV knowledge. By focusing on the knowledge and skills of graduates, the prison system is more likely to have an ongoing pool of staff who are adequately skilled in how to respond to HIV.

A third strategy is the support to seven correctional facilities designated by the Directorate of Corrections as providing a model for other prisons. Located in seven provinces, the facilities have the role of training, mentoring and supporting other prisons in their respective provinces. This provides a potentially cost effective and efficient way of deploying limited resources that could not stretch across all 92 prisons supported by HCPI. However, the Directorate has assessed that while three of the seven prisons have demonstrated good results, four have limited capacity to mentor other prisons in their province.<sup>48</sup> This will require HCPI to give some additional attention to enhancing the capacity of these particular facilities.

A strong feature of the technical support that has been provided for all program areas has been the emphasis on learning through mentoring, site visits, internships and case study discussions. This learning method has placed important emphasis on improving practice in practical and relevant ways.

A further strategy to improve quality has been a baseline integrated bio-behavioural surveillance survey in 2010<sup>49</sup>. Over time, the findings from such surveys will help in assessing the effectiveness of the HIV program in prisons. In the meantime, the baseline findings could be used as an adaptive management tool to review aspects of the program and to refine it if needed.

Given the many other challenges relating to inmate health, there is some concern within the Directorate of Corrections regarding the vertical approach to HIV programming. It is possible that the long term impact of the HIV program may be constrained unless broader health and other issues such as massive overcrowding are addressed.<sup>50</sup> The verticality of the HIV program has been mitigated to some extent by HCPI's support for joint programming addressing HIV and TB and an emphasis on the mental health of inmates. In addition, the approach of the Directorate of Corrections and HCPI has been to incorporate HIV programming within existing systems rather than establishing parallel systems. The strengthening of the capacity of correctional and health care worker staff, albeit HIV specific, is likely to have some spin-off benefits in development of skills that can be applied more broadly. Furthermore, HIV programming has helped with the upgrading of systems and human resources within the corrections system and has demonstrated that much can be done with limited resources. There also appears to be an increased level of management concern for health care in general which may be attributable to the HIV program. All of this is helping to strengthen the health system.

There are two other key areas for further strengthening. The first is the need for better collaboration between correctional facilities and local health services to improve access to HIV testing, opportunistic infections drugs, and ART. The second is the need to enhance pre and post release programs to ensure continuity of care. This is critical, not only for the prisoner's health, but within the context of an epidemic driven through sexual transmission, it is critically important in terms of halting the spread.

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<sup>48</sup> HCPI Progress Report January – June 2011. Annex H: Discussions for Future Directions – Prisons. p.3.

<sup>49</sup> Directorate of Corrections, Ministry of Justice and Human Rights, HIV and Syphilis Prevalence and Risk Behaviour Study among Prisoners in Prisons and Detention Centres in Indonesia. 2010.

<sup>50</sup> HCPI, Progress Report January – June 2011. July 2011. Annex H: p.2.

**Recommendation 1.10:** *That in light of the many challenges relating to inmate health that would benefit from a more integrated health approach, and the need for continuity pre and post release, HCPI, in consultation with the Directorate of Corrections, identify opportunities for its support of HIV programming in prisons to contribute to health system strengthening within correctional facilities and to help address health system issues at the interface between correctional facilities and health services*

#### **1.2.4. Men who have sex with men**

Given the *MSM Initiative* is at an early stage of implementation its outcome indicators have not yet been achieved, although good progress has been made in achieving output indicators. The program has also demonstrated good practice in a number of areas which should contribute towards achieving outcomes. For example, the communications strategy has been informed by previous experience and is underpinned by innovative use of social media, designed to appeal to hard to reach target populations. In addition, there has been a strong emphasis on promoting HIV testing and STI treatment to address low HIV testing rates and the extremely high rates of STIs which increase the risk of HIV infection. Research to document social and sexual networking among men who have sex with men in Indonesia is currently underway. Findings will inform: program design, in particular, optimal pathways and modes of engagement for the hard to reach; and the development of evidence-informed communication and anti-stigma strategies.

The initiative also has some key aspects that have the potential to inform other components of the HIV response. For instance:

- the client-friendly, one-stop service model being used might be transferable to other target populations. This model integrates HIV and STI testing and treatment to avoid loss to follow up and involves community groups in the selection of service providers. The model of integrated services and identifying the particular characteristics that make these services more client friendly could be very useful for helping other HIV services;
- the use of practical, hands-on clinical training (which is usually absent from clinical training in Indonesia) with post training clinical mentoring could provide lessons for other clinical training and post-training quality assurance; and
- STI management training for this initiative has been integrated within national STI training. MSM sexual health guidelines have been updated and will be integrated into national STI treatment policy documents. This work could provide the basis, more broadly, for integrating HIV and STI policies and services.

Given the lead times taken to get any project off the ground, the investment is far more likely to pay dividends if some additional years of project time are allowed. This would also allow for the results of the La Trobe University research to be applied to the program over a longer period of time, thereby maximising the utility of that investment.

While the *MSM Initiative* was not included in the original AIPH design, the epidemiology of HIV among this group in Indonesia was not well understood at the time of design. There have been a number of significant changes since then:

- in 2009 the Australian Government decided that Australia will focus prevention efforts in Asia on addressing the needs of two key populations at higher risk - injecting drug users and men who have sex with men;<sup>51</sup>
- the termination of USAID funded HIV programs left a sizable gap for this key population. Funding under USAID SUM 1 and SUM 2 will be significantly less than the previous program so this gap will only be partially filled;
- in 2008 the Commission on AIDS in Asia concluded that unless effective prevention measures are intensified it is estimated that by 2020 approximately 46% of new infections in Asia will be among men who have sex with men, up from 13% in 2008;<sup>52</sup> and
- cross-sectional studies have shown the potential for HIV epidemics among men who have sex with men to increase rapidly, sometimes to hyper epidemic levels.

<sup>51</sup> Commonwealth of Australia, (2009).

<sup>52</sup> Commission on AIDS in Asia. ( 2008).

For example, in Indonesia, HIV prevalence among men who have sex with men in Jakarta increased four-fold from 2% to 8% between 2003 and 2007.<sup>53</sup> Prevalence of rectal STIs in 2007 was 33%. Mathematical modelling using data from Indonesia's 2007 IBBS indicates that by 2014 the number of new cases of HIV infection among men who have sex with men will overtake those among injecting drug users.<sup>54</sup> HIV prevalence among men who have sex with men in Bangkok increased from 17% in 2003, to 28% in 2005, and then to 31% in 2007.<sup>55</sup> It is possible that Jakarta and other major Indonesian cities are following this same pattern. It will be important to examine trends in HIV prevalence levels in the soon to be released 2011 IBBS.

**Recommendation 1.11:** *That AusAID continue to provide financial support for the National AIDS Commission's MSM Program for a further two years beyond the existing life of the existing initiative.*

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<sup>53</sup> Indonesia National AIDS Commission, Integrated Biological and Behavioural Surveillance among Most at Risk Group in Indonesia, 2003 and 2007.

<sup>54</sup> HIV and STI Prevention and Care for GWL in Indonesia. Program Design Document for the AusAID-funded program to implement the National Action Plan for GWL. June, 2010.

<sup>55</sup> van Griensven (2009). *Epidemiology of HIV Infection among Men who have Sex with Men in Asia and the Pacific: the Gathering Storm*. Presentation to the Regional Consultation on Health Sector Response to HIV/AIDS among MSM, Hong Kong, 2009.

## 2. Papua and West Papua

This chapter reports on:

- the AIPH outcome 2.4: HIV programs in Papua and West Papua are improved and expanded. This outcome also includes the role of the Provincial AIDS and Health Offices; and
- key evaluation question number six – the relevance and appropriateness of the current response and priority areas for future investment.

### 2.1. A strengthened role of Provincial AIDS Commissions and Provincial Health Office

#### 2.1.1. AIDS Commissions

The Provincial AIDS Commissions in both Papua and West Papua have been strengthened through the support of HCPI. This has enabled them to take an active role in facilitating coordination between donors, development partners, civil society organisations, and implementing partners. The provinces worked collaboratively to develop a *Strategic Communication Plan for HIV and AIDS*, building on the lessons from previous HIV responses. Importantly, both provinces have incorporated the communication strategy as a critical part of their respective strategic plans for HIV and set clear targets to be achieved.

In West Papua HCPI has supported the establishment of the Provincial AIDS Commission, assisting it with organisational structure, job descriptions and monitoring and evaluation strategies. The province reported having been successful in engaging key local government agencies in the HIV response. However, it is a relatively young province with limited capacity and few health services.

Papua is a relatively more mature province. The group of respondents from the Provincial AIDS Commission reported unanimously that through the support of HCPI and the National AIDS Commission, the Provincial Commission has successfully engaged with the Regional Development Planning Board. This is a necessary collaboration if the province is to succeed in increasing HIV budget allocations and expenditures.

A key support for Papua has been the funding of four Commission staff positions. These staff have facilitated working groups to progress key aspects of the work of the Commission, with one of the positions working with District AIDS Commissions to help strengthen their capacity for local response. Provincial AIDS Commission staff expressed a high level of satisfaction with this support. The review team was advised by HCPI<sup>56</sup> that there is a plan in place for Papua Provincial AIDS Commission to take over funding of these four positions, which have been in place since 2005 (formerly funded through Indonesia HIV/AIDS Prevention and Care Project). However, representatives from the Provincial AIDS Commission indicated that whilst there is an intention there is no definite timeline in place for this to occur.

Given the less well developed stage of structures and systems in West Papua, the review team believes that AIPH would be wise to further support that province in its efforts to strengthen its capacity, to establish District AIDS Commissions, and to implement the Communication Strategy. Toward this end, it is suggested that a more definite planned phase out of the HCPI funded positions in the Papua AIDS Commission occur, with a subsequent transfer of those resources to West Papua. Naturally, any such transfer of funds would require the support of the West Papua Provincial AIDS Commission.

***Recommendation 2.1:*** That AIPH, through HCPI, develop a plan for a phased transfer to the Provincial AIDS Commission of West Papua resources currently funding four positions in the Provincial AIDS Commission in Papua. Further that HCPI continue to assist the Provincial AIDS Commission in Papua to identify means to resource positions currently funded by AIPH.

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<sup>56</sup> HCPI response to draft report of the independent review

### 2.1.2. Provincial Health

The Provincial Health Office in Papua is demonstrating a range of good leadership activities. For example, visits to districts are being implemented on a regular basis, and a planning process is currently being established to develop a five year strategic plan for the province. Examples were provided of collaboration with other agencies and with corporate organisations. A strong commitment was expressed to advocating to local government and helping it understand the importance of a well funded and coordinated HIV response. Capacity strengthening activities planned for health staff were discussed. There is the opportunity therefore for AIPH programs to support an integrated, multipronged response.

## 2.2. An improving and expanded level of services

### 2.2.1. Promotion and prevention

A major focus of HCPI work has been the delivery of HIV messages and health promotion programs. HCPI reports that in 2010, 133,324 people in Papua and West Papua received information about HIV for the first time from any source and, of these, 93% received information for the first time from HCPI partners.<sup>57</sup> Figures for the first half of 2011 show a similar trend in numbers reached. However, the total for the eighteen months is less than 6% of the combined populations of the two provinces.<sup>58</sup> Maximum reach is important given that studies show that promotion and prevention programs can avert significant numbers of HIV infections.<sup>59</sup>

A more widespread coverage is anticipated given HCPI's funding and support to non-government and civil society organisations. A key characteristic of these implementing partners is the level of their reach into the general population. Strong engagement with churches has been an important strategy because of the important leadership role they play in communities. In addition, the use of volunteers by the faith-based organisations has made this approach very cost effective.

This promotion and prevention work has been guided by a communication strategy. Key stakeholders were involved in its formulation and it was guided by relevant contemporary behavioural change theories and frameworks. The strategy has been developed within a sexual health framework rather than through a focus on disease, which is likely to assist in addressing the issue of stigma and people's receptiveness to the messages. The communication strategy appears to have widespread ownership, with implementing partners being drawn from civil society organisations, faith-based organisations, sporting associations, and commercial media operators. There has been important recognition of the particular context in the highlands and the development of a highland-specific communication strategy is soon to be completed.

There is evidence from behavioural surveys<sup>60</sup> that the communications strategy is resulting in an increase in knowledge about preventative factors. For instance there has been a decrease in the number of program participants reporting having sex with casual partners.<sup>61</sup> A drop of 17% was shown in a 2010 survey as compared with 2009.<sup>62</sup> Whilst the behavioural surveys have been limited to those who have participated in HCPI supported programs, and the overall reach of the program is relatively low, the results reflect studies that indicate that behavioural strategies are effective.<sup>63</sup>

However, the message about the use of condoms seems to have been less effective. The behavioural survey<sup>64</sup> conducted in 2010 indicated that although knowledge of the use of condoms to reduce risk of HIV was relatively high (88% of men and 84% of women), consistent use of condoms with casual sex partners remained low (21% of men and 10% of women).<sup>65</sup>

<sup>57</sup> HCPI (2011) *Progress Report July – December 2010*, Annex C

<sup>58</sup> [www.bps.go.id](http://www.bps.go.id)

<sup>59</sup> Merson et al. (2008). The History and Challenge of HIV. *The Lancet – Series HIV Prevention* 1, 372: pp.475-488.

<sup>60</sup> Behavioural surveys are conducted annually over a two week period with participants of programs delivered by HCPI supported organisations.

<sup>61</sup> HCPI (2011) *Progress Report July – December 2010*

<sup>62</sup> *ibid.*

<sup>63</sup> Merson et al. (2008). *op. cit.*

<sup>64</sup> HCPI (2011) *Progress Report July – December 2010*

<sup>65</sup> *ibid.*

Behaviour change communication is an essential element of the communication strategy.<sup>66</sup> It is based on a theory that people will change their behaviour as a result of a sustained interactive process that leads them through stages of understanding and acceptance of the risks, the need to change, and a decision to change. Whilst the low rate of consistent condom use is concerning, it could be reflecting that people are in early stages of the change process. As well, there have been difficulties with access to condoms. To address this, the Provincial AIDS Commission brought together stakeholders to develop a distribution network.

The partners in Papua and West Papua have incorporated a periodic monitoring and learning process into the communication strategy. Given that inconsistent use of condoms is one of the key factors in HIV transmission in Papua and West Papua<sup>67</sup>, it will be important for the partners to ensure specific attention to condom use when they monitor behavioural change and to develop alternative strategies where targeted change is not occurring.

### 2.2.2. Testing

A consistent message from health workers was that the take-up of VCT is poor throughout Papua and especially in the highlands, although encouraging people to be tested for HIV is one of the key messages of the *Strategic Communications Plan*. HCPI progress reports indicate that from January 2009 to December 2010, approximately 70,400 people received information about testing and treatment. The behavioural survey indicated that 66% of men and 65% of women who had participated in information disseminating programs knew where to go for VCT.<sup>68</sup> However, health services visited by the review team were doubtful that referrals to testing services from within the broader community had increased. HCPI has not been able to gather data on the percentages of men and women who are referred by implementing partners to VCT and who actually attend. This is reported as due to logistical issues and the absence of the service in many areas.<sup>69</sup>

It is possible that the passive nature of the messages about testing contained within the communications strategy might not be providing people with appropriate knowledge, motivation or direction to take action. For example, although people are encouraged to be tested, the very significant benefit of ART is not highlighted as a reason for people at risk to know their HIV status. It is understood that HCPI and CHAI have collaborated to develop material to increase awareness of available services for people who are HIV positive, and the benefits of using them. This is a positive step.

There is not a consistent assertive approach by HCPI's implementing partners to helping people access VCT, despite the literature highlighting that 'combination prevention' incorporating behavioural, structural and biomedical prevention "...offers the best hope for success in prevention."<sup>70</sup> It was evident from interviews with the full range of stakeholders that only a small selection of health providers and community service organisations are taking active steps to help people access testing facilities through such things as mobile clinics and escorting patients to testing services.

The review team was made aware of some excellent assertive outreach to direct and indirect sex workers. Based on what reviewers were told on site visits to karaoke bars and massage parlours, there appear to be high rates of testing for STI and HIV at these establishments, conducted by health services on an outreach basis. Combination prevention is best adapted and prioritised to particular local contexts. For Papua and West Papua this means integrating HIV testing with STI testing because the rates of STI, a proven co-factor in HIV transmission, are high in both provinces.<sup>71</sup>

<sup>66</sup> Strategic Communication Plan for HIV and AIDS: Prevention and Management in Tanah Papua, Indonesia. (2008)

<sup>67</sup> *ibid.*

<sup>68</sup> HCPI (2011) *Progress Report July – December 2010*

<sup>69</sup> HCPI (2011) *Progress Report January – June 2011*

<sup>70</sup> Merson et al. (2008). *op. cit.* p.485.

<sup>71</sup> Strategic Communication Plan for HIV and AIDS: Prevention and Management in Tanah Papua, Indonesia. (2008)

Given the increased potential for HIV transmission in the presence of STI<sup>72</sup>, assertive outreach that integrates prevention, testing and care and support, as is being done by the small number of providers, is important. There is merit in AIPH actively encouraging this practice more broadly. However, HIV testing amongst the large number of street based sex workers was said to be very low as it requires the sex workers to go to a health service. More frequent use of outreach and mobile testing services would increase access to testing for sex workers. Whilst it is acknowledged that support to indirect sex workers in the highlands is more challenging, the implementing partners will need to look for innovative ways to reach this group, many of whom are very young.

The communications strategy could be strengthened if a more assertive approach to HIV testing was incorporated, including clear messages about taking action. CHAI, as part of its work with health workers, is advocating strongly for STI services to be increased and for HIV/AIDS treatment and support to be integrated with these services. This approach should be incorporated in the communications strategy.

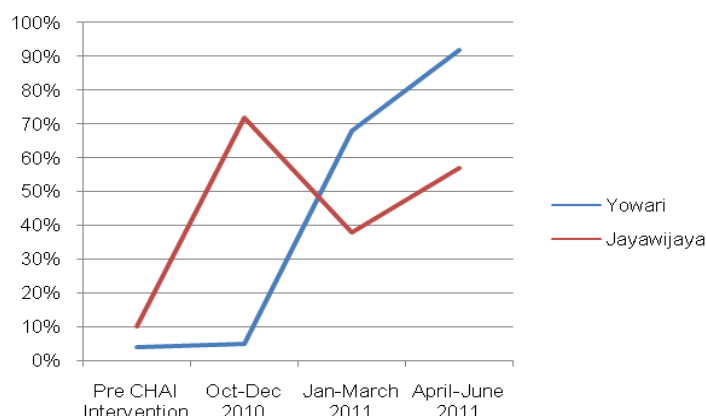
**Recommendation 2.2:** That HCPI support the Provincial AIDS Commissions to make necessary adaptations of the Strategic Communication Plan for HIV and AIDS to raise awareness of STI, ensure people know where to go for both STI diagnosis and VCT, how this will occur, and the benefits of early treatment. Further, that HCPI through its support to Provincial AIDS Commissions advocate, and provide technical assistance for, strategies to radically increase VCT for people at risk and that HIV testing be integrated with STI testing.

### 2.2.3. Care Support and Treatment

AIPH has been successful in increasing the extent and quality of care, support and treatment services in Jayapura City, Jayapura District and Jayawijaya District in the highlands. By integrating PITC in all parts of the hospitals in which CHAI is working, particularly into antenatal care, TB clinics and inpatients, significant increases have been achieved in the number of people presenting to health services who are tested for HIV. For instance, in Wamena 237 people were tested in the last two months of 2010, in contrast to just 31 from January to October.<sup>73</sup> In Jayapura, from 2008 until November 2010 only 280 people were tested at Yowari Hospital, in comparison to 1200 people from mid November 2010 until June 2011. Whilst CHAI staff indicated that there is further work needed to improve quality and to entrench PITC in all departments of the hospitals, this is an important example of how a more assertive and integrated approach to testing and treatment can make a difference.

There have also been significant increases in the numbers of people receiving ART since the implementation of CHAI's program, as illustrated in the following graph.

**Figure 1: Percentage of eligible people receiving ART<sup>74</sup>**



<sup>72</sup> World Health Organisation. (2006). *Treatment for sexually transmitted infections has a role in HIV prevention*, [www.who.int/mediacentre/news/releases/2006/pr40/en/index.html](http://www.who.int/mediacentre/news/releases/2006/pr40/en/index.html)

<sup>73</sup> Clinton Health Access Initiative (CHAI) Indonesian *Progress Report July 2010 – December 2010*

<sup>74</sup> Definition of eligible (provided by CHAI): stage III, IV, pregnant women, people co-infected with TB-HIV, CD4 < 350, HIV + Hepatitis B

For comparison with the above achievements, two sites not supported by CHAI indicate much lower coverage rates: RS Dok 11 Jayapura (with the highest number of eligible patients) was reported as 11% and 12% for the first two quarters of 2011, and for RS Paniai (with the lowest number of eligible patients) 9% and 12%.<sup>75</sup> However, it is important to note that direct comparison of these results is difficult because data for non-CHAI supported sites is sourced from the Ministry of Health using different reporting parameters.<sup>76</sup> Notwithstanding this, given that the coverage for the whole of Papua for the first two quarters of 2011 was 21% and 22% respectively, this suggests that CHAI-supported services are achieving considerably greater levels of coverage.

As well as increasing the number of people on treatment, health services supported by CHAI have significantly decreased the percentage of people on treatment who are lost to follow up: Yowari from 86% in October 2010 to 1% in July 2011; Wamena 56% in January 2011 to 11% in July 2011.<sup>77</sup> Improving treatment retention rates is critical not only for the health and wellbeing of individuals and their families but, on a broader scale, to avoid the evolution of drug resistant strains.

These various achievements in care, support and treatment have been enabled by a number of key factors. Firstly, the use by CHAI of a multi-pronged model to address barriers to the provision of an effective HIV response, as indicated in the following table.<sup>78</sup>

**Table 1: CHAI strategies to barriers to effective HIV response**

Barrier	Strategies
Poor identification	Assertive approach to PITC; training of health care workers about HIV leading to increase in screening and testing for HIV; integration with outpatients, antenatal care, TB and STI
Lack of standard operating procedures; limited quality assurance	Work with key hospital staff to develop standard procedures and quality assurance and quality control systems for laboratory testing, record keeping, finance and data management; development of site level tools for patient management; training of laboratory workers; implementation of clinical mentoring
Lack of District level service delivery models	In partnership with District Health staff, develop procedures for HIV services and referral pathways; improved management of supply chain
Poor linkages between hospital and community health centre	Develop communication pathways between hospital and community health centres; provide training and support to community health centres

Secondly, CHAI has worked with the Yowari Hospital, the District Health Office, the office of the District Head, and central Ministry of Health to clarify financial arrangements and develop simple standard operating procedures, thus simplifying processes for patients to have free access to treatment.

A third key factor is the use of satellite community health centres. By strengthening the links between hospitals and community health centres, and implementing capacity strengthening strategies, treatment and support is moving closer to patients. For instance, support to Kalvari Klinik in Wamena has enabled it to continue to treat patients although it currently has no doctor on staff. Medical advice is provided by doctors from a nearby hospital and CHAI has supported nursing staff with technical assistance and standard operating procedures. This type of support to satellites is critical if access to treatment is to be expanded. It provides an excellent example of how HIV care, support and treatment services can be provided in locations where it is difficult to attract doctors.

<sup>75</sup> Analysis provided by CHAI to HIV and Communicable Disease Unit of AusAID Indonesia

<sup>76</sup> Ministry of Health data reported by CHAI

<sup>77</sup> *ibid*

<sup>78</sup> Based on CHAI presentation to review team July 2011



### 2.3. Relevance and appropriateness

It is apparent that the focus and approaches of AIPH in Papua and West Papua are both relevant and appropriate. As noted in previous sub sections, the literature supports a focus on prevention where the epidemic is generalised, as it is in these two provinces. Further, AIPH's deliberate framing of HIV within sexual reproductive health rather than within a paradigm of disease falls in line with accepted good practice.<sup>79</sup> Likewise, as previously noted, the literature supports the use of multi-level and multi-structural approaches to behaviour change, which are features of the *Strategic Communication Plan for HIV and AIDS* being implemented in Papua and West Papua through the work supported by HCPI.

There is evidence that treatment is also a prevention strategy.<sup>80</sup> An international study has shown that ART can prevent the sexual transmission of HIV among heterosexual couples in whom one partner is HIV infected and the other is not. It showed a 96% reduction in the risk of HIV transmission. This is strong support for increased testing and early treatment,<sup>81</sup> both of which are being promoted through the work of CHAI. Similarly, contemporary good practice promotes the integration of HIV and STI testing, especially as most HIV infections are sexually transmitted.<sup>82</sup> This is also a strong feature of the approach being taken by CHAI.

In areas where organisational and individual capacity are not well developed it is important to deliver HIV interventions within a framework in which health services' people, processes and systems are strengthened. The AIPH in Papua and West Papua incorporates approaches to strengthening capacity that are promoted in the literature, including: a focus on leadership as a way of helping groups work together; an emphasis on learning and adapting; the use of systems thinking; understanding the local context; building relationships with the most appropriate partners; and strengthening endogenous change as a key means of ensuring ongoing sustainability.<sup>83</sup>

To ensure ongoing relevance and appropriateness, it is important to ensure a comprehensive response, from promotion and prevention through testing and all aspects of treatment, care and support. Likewise, the capacity strengthening of Provincial and District AIDS Commissions and government departments, particularly health services, is essential to maximise the impact of this work and ensure sustainability. It is therefore critical that HCPI and CHAI work in collaboration. However, there has been insufficient bridging of the two, with AIPH's work becoming fragmented. (This issue is discussed further in Chapter 4). A consistent theme from discussions with HCPI and CHAI staff involved in the Papua and West Papua program was that the interface between the two organisations, whilst being cordial and professional, is very informal and often ad hoc. The working relationship needs to be strengthened and formalised. A recommendation has been formulated in Chapter 4.

### 2.4. Priority areas for future investment

The situation in Papua and West Papua demands different responses from the rest of Indonesia. In these provinces there is a generalised epidemic that presents a public health emergency.<sup>84</sup> As the bulk of the population lives in the highlands, which is an area of high prevalence, this is a key area for intervention.

AIPH constitutes a major contributor to the donor landscape in Papua. Whilst the new USAID programs SUM 1 and SUM 2 will operate in Papua and West Papua, they will be limited in their scope and reach. AIPH's current work through CHAI and HCPI has put systems in place that provide a strong platform for further work. Given the extent of work still to be done and AusAID's comparative advantage as a donor it is appropriate that AIPH scale up.

<sup>79</sup> International HIV/AIDS Alliance. (2010). *Integration of HIV and sexual health and reproductive rights: Good Practice Guide*

<sup>80</sup> Cohen et al. (2011). Prevention of HIV-1 Infection with Early Retroviral Therapy. *New England Journal of Medicine*. Vol. 365, pp.493-505.

<sup>81</sup> Editorial, (2011). *The Lancet*, Vol. 377, (9779), p.1719.

<sup>82</sup> International HIV/AIDS Alliance. (2010). op. cit.

<sup>83</sup> Baser, H. and Morgan, P. (2008). *Capacity, Change and Performance: Discussion Paper No. 59B*. The European Centre for Development Policy Management.

<sup>84</sup> Statistics Indonesia and Ministry of Health (2007) *Risk Behaviour and HIV Prevalence in Tanah Papua 2006* indicated adult prevalence of 2.4% (compared to 0.2% in Indonesia as a whole). Easily accessible lowlands had a prevalence of 1.8%, whereas hard to access lowlands had a prevalence of 3.2% and highlands 2.9%.

In particular, additional investment is recommended in the area of care, support and treatment. Scaling up is important because:

- the magnitude of the problem presents a public health emergency that demands greater intervention;
- treatment as prevention is particularly applicable in the context of a generalised epidemic; and
- ART coverage is still very poor. In June 2011 there were twelve referral hospitals in Papua, with 1116 people on ART.<sup>85</sup> On a broader scale, in 2006 estimates were that 21,487 people were living with HIV in Papua.<sup>86</sup> This would indicate that both testing and uptake of ART are far too low.

As noted, CHAI's assertive and multi-pronged approach to care, support and treatment work in Papua is bearing significant results in a relatively short time. It provides the biomedical aspect needed to complement the strong behavioural aspect of 'combination prevention', employed by HCPI's implementing partners. Recent research suggests that donors should leverage their successes to scale up their efforts, particularly where an impact on country-level goals is likely.<sup>87</sup> Scaling up the innovative work in care, support and treatment provides such a case.

CHAI has proposed an extension to its work to increase access to HIV testing and to ART.<sup>88</sup> This involves the creation of six centres of excellence that will not only provide intervention at those sites but will serve as teaching facilities to provide access to knowledge and experience for the wider health system. Included are the two services in which CHAI is currently working in Jayapura and Wamena. CHAI has mobilised a skilled team of Indonesian staff comprising two doctors and two public health specialists based full time in Papua as well as a Senior Clinical Mentor and Senior Advisor, both doctors, who spend two weeks per month in Papua. This team is well regarded by the Provincial Health and Provincial AIDS Commission officers. They provide a strong foundation for an expansion of services. CHAI's successes have included: marked increases in PICT; strengthened laboratory facilities and extended hours for testing capacity to cater for pregnant women attending hospital; staff at all levels having awareness and skill relating to HIV; and case management and retention systems to significantly reduce the loss to follow up.

This is a health systems strengthening approach working with existing structures and embedding HIV and AIDS services into broader health services. It is an ideal way to maximise the potential for sustainability. Health services will include hospitals and community health centres, thus supporting decentralisation, and will focus on four key program components:<sup>89</sup>

- Laboratory Strengthening – strengthening PITC through training and protocols; mobile PITC to remote communities supported by care, support and treatment; development of Rapid HIV Test facilities; one point and time for diagnosis of HIV, TB and STI in remote communities.
- Clinical Mentorship – for care, support and treatment clinics to manage ART, TB and STI; data collection and communication with community health centres; regular support to community health centres; development of onsite rural teams for follow up, prevention of mother to child transmission, STI and TB services.
- Patient Support and Retention – implement evidence based practice for patient retention; share lessons from CHAI's Rural Initiative Program in PNG with active case management system.
- Monitoring and Evaluation, and Operational Research – strong monitoring and evaluation system to ensure accountability, quality improvement, and to add to the knowledge base.

It is apparent that there is local support for a scale up, particularly of the CHAI work in care, support and treatment. The review team understands that the Provincial Health Office has indicated to AusAID it is considering how to work towards supporting a scale up of HIV/AIDS response. During the review, the District AIDS Commission in Wamena indicated a similar willingness. Further, the Sub Directorate AIDS expressed support for a scale up of the care, support and treatment program in Papua and indicated its capacity to support this, including:

<sup>85</sup> Indonesia Ministry of Health (July 2011) 2<sup>nd</sup> quarter (June) report on situation of HIV and AIDS

<sup>86</sup> Statistics Indonesia and Ministry of Health. (2007). *Risk Behaviour and HIV Prevalence in Tanah Papua 2006*.

<sup>87</sup> Chandy, L. and Linn, J. (2011). *Taking Activities to Scale in Fragile and Low Capacity Environments*. Global Economy and Development at Brookings Institute.

<sup>88</sup> Clinton Foundation (2011) *Clinton Health Access Initiative: Papua Program Strategic Vision*

<sup>89</sup> *ibid*.

- supervision and support to the Provincial and District Health Offices;
- support to the District Health Office to advocate for resources from local government;
- assistance to the Provincial and District Health Offices to explore ways to address barriers to recruitment and retention of medical staff;
- participation in a joint coordination of any new initiative; and
- being the fund holder and manager for specific earmarked funds that might form part of any scale up.

**Recommendation 2.3:** *That AusAID and CHAI jointly undertake a rapid design for the proposed expansion to the Central Highlands in Papua of the HIV services and strengthening of the health systems. That the rapid design be timed to enable the expansion to begin by July 2012.*

AusAID has the potential to implement its most significant HIV work in Papua. This work is aimed at slowing or reversing sexual transmission of HIV (thereby having an impact at country level), and providing care, support and treatment as a preventative measure. In recommending a scale up, the reviewers emphasise the importance of ensuring integration of all aspects of the HIV response. As well, we acknowledge that there are risks in scaling up. These can be mitigated through close oversight and adaptive management. In order to achieve this level of management in Papua and West Papua during the remaining time of the AIPH, AusAID management needs to have a stronger presence in the provinces. This need not be full time but should allow the Program Manager (or other relevant position) to be in Papua on a regular basis.

**Recommendation 2.4:** *That a review of workload of the HIV and the Communicable Disease Unit of AusAID be undertaken to enable stronger presence in Papua and closer oversight and adaptive management of activities related to the Central Highlands project.*

There would also be merit in AusAID exploring the feasibility of a tri-partite oversight arrangement between AusAID, the Provincial AIDS Commission and Provincial Health Office. In this way, more regular day-to-day oversight of this significant piece of work could be provided by one of, or jointly by, the provincial partners. It would also build on and promote local ownership of the program.

Scaling up would indicate that AusAID is committed to making a difference to the critical public health issues that HIV/AIDS presents in Papua and West Papua. It is likely therefore, that AusAID will have a presence beyond that of the current AIPH. In order to design an intervention post 2016, AusAID is urged to take a developmental approach that is Papua and West Papua driven. This will involve analytical research to understand issues from a community perspective and to explore community-generated responses within the context of evidence-based practice. This will be an iterative process to develop, test and refine program responses.

**Recommendation 2.5:** *That during the remaining period of the AIPH, AusAID, in partnership with its national and sub-national partners, instigates a grass roots design process to develop the next AusAID funded program of support to Papua and West Papua.*

### 3. Effectiveness of the partnerships

The AIPH is a formal partnership between the Australian and Indonesian governments, specifically AusAID and the Office of the Coordinating Minister for People's Welfare. It is enacted at both the national and sub-national levels with the AIDS Commissions and the key ministries of: Health; Justice and Human Rights, and the National Development Planning Agency.

#### 3.1. Extent to which the partnerships are maturing

The following discussion is aligned to the four partnership aspects of the *Partnership Evaluation Framework*<sup>90</sup>: *prerequisites; structure; process; and outcomes*.

##### 3.1.1. Prerequisites

*Enabling environment, organisational and individual drivers, and institutional elements:* these necessary prerequisites are in place. There is an underlying political will from both governments. The partnership shares common goals and meets the current priorities of both governments. This is evident in: the formal Subsidiary Agreement between the parties; a Government of Indonesia Presidential decree that provides the official imprimatur for work of the National AIDS Commission; the inclusion of HIV in the *Australia Indonesia Partner Country Strategy: 2008-2013*; and the establishment of AIDS Commissions at provincial and district levels.

Both governments demonstrate leadership in relation to progressing the national HIV response, manifested in: the active participation in the many national mechanisms; their success in engaging with, and achieving involvement of, a wide range of key stakeholders; and sourcing of funds in order to be responsive to emerging needs. A Partnership Coordinating Committee acts as the governing body of the partnership, along with periodic meetings between the Office of the Coordinating Minister for People's Welfare and AusAID. Leadership was also evident at both national and sub-national levels, with personnel from both AusAID's managing contractors and provincial and district AIDS Commissions working together to promote and advocate for improved HIV responses.

##### 3.1.2. Structure

*Formal partnership dimensions:* The Subsidiary Agreement outlines the agreed fair share of resources and responsibilities. AusAID is delegated to manage the partnership, with the Partnership Coordinating Committee acting as the key decision making body.<sup>91</sup> AusAID and the National AIDS Commission share responsibility for chairing the Committee. Membership of the Committee includes the major partners and key stakeholders with whom the partnership implements the agreed work plan, ensuring that a broad collaborative approach is achieved.

Several respondents raised the concern that the Partnership Coordinating Committee is not serving an appropriate purpose in its current format. Whilst it is for strategic decision making, it appears from what was reported by respondents and viewed in the minutes, that it is largely a forum for exchanging information. As noted later in this chapter, there are already several national forums for this purpose, making the current focus of the Committee almost obsolete. It might be more suitable for the Committee's membership to be contained to representatives of the Subsidiary Agreement plus the stated key government ministries in order for it to focus on high level discussion of the partnership.

Rather than receiving reports from the various managing contractors, it would be more appropriate for the Program Manager from AusAID to provide a progress report of the overall Program and include: i) a summary of progress towards its outcomes; ii) any matters pertaining to the various dimensions of effective partnership (such as found in the Partnership Evaluation Framework); and iii) issues that need the attention of the partners, including strategic decisions. In this way, the Committee would be an instrument not only for accountability but also for overseeing the ongoing direction and health of the partnership itself, separate from the work of the partnership.

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<sup>90</sup>Hind, J. (2010) *The Partnership Evaluation Framework*: See Annex 6.

<sup>91</sup> Subsidiary Agreement

**Recommendation 3.1:** *That the Partnership Coordinating Committee membership be contained to representatives of the Subsidiary Agreement plus the key ministries and its focus be on: i) matters pertaining to the various dimensions of an effective partnership; ii) strategic decisions; and iii) accountability for effective and efficient implementation of the AIPH as a whole.*

Whilst the ministries of Health, Justice and Human Rights, and the National Development Planning Board form part of the partnership, by not being co-signatories to the Subsidiary Agreement their essential role is underplayed. It also means that although they may be counterparts for various components of the AIPH, the high level partnership relationships forged by AusAID have, largely, been with the National AIDS Commission and the Office of the Coordinating Minister for People's Welfare. Essentially, as the major government implementing agency, the Ministry of Health's role is significant, yet it has had a slow start in committing resources to the national HIV response.<sup>92</sup> All key respondents to this review highlighted the importance of a more concentrated commitment by the Ministry of Health. Senior personnel from the Ministry of Health reported a commitment and willingness within the Ministry to step up to this important role. This suggests that it is timely for the Ministry of Health to be brought more formally into the AIPH partnership. Likewise for the Ministry of Justice and Human Rights and the National Development Planning Board, given the current HIV situation in prisons and the need to increase national and sub-national HIV budget allocation and expenditure. This could possibly occur through a re-negotiated Subsidiary Agreement or Memoranda of Understandings with each of the agencies, that clearly establish their key roles in the partnership.

**Recommendation 3.2:** *That in order to more fully recognise the importance of all key parties of the partnership and to ensure all necessary high level partnership relationships are developed, AusAID and the Office of the Coordinating Minister for People's Welfare negotiate Memoranda of Understandings with the Ministry of Health, the Ministry of Justice and Human Rights, and the National Development Planning Board that clearly articulate their essential roles in the partnership, and the AIPH Subsidiary Agreement be amended accordingly.*

It appears that the partnership arrangements at the sub-national level are operating with more limited formal structures. The review did not find any adverse implications of this.

*Informal partnership dimensions:* The informal structural partnerships' dimensions are positive. It was apparent from the way that the partners discussed the partnership and working with each other that there is mutual trust and respect, and confidence that the partners will deliver on their commitments.

### 3.1.3. Process

*Partnership practice and performance:* There is a strong ethos of collaboration between the partners, with the work of the AIPH being structured around joint goals and the strategic priorities of the National HIV and AIDS Strategy and Action Plan. There are processes in place to review the work of the partnership using common monitoring and evaluation indicators. This can help indicate trends towards longer term outcomes, which is one important dimension of effective partnerships. However, focusing only on the longer term results of partnerships is not an effective management approach.<sup>93</sup> Outcomes cannot assist with tactical decision making or help in understanding how a partnership is performing over the shorter-term. In recognition of the importance of the partnership approach and the need to pay attention to its health, the AIPH Monitoring and Evaluation Plan includes three partnership-related outcomes. However, there are no processes in place to review these or other important dimensions of the partnership, other than through irregular processes such as this independent progress review.

Attention is being paid to ensuring mutual benefit and a fair share of resources is being provided by the respective partners. As well as being outlined in the Subsidiary Agreement, it is also the subject of negotiations as projects or new initiatives arise. Documents indicate that, generally, there is an acceptance that the Government of Indonesia will gradually take up an increasing share of the financial responsibility for the HIV response.

<sup>92</sup> National HIV budget information

<sup>93</sup> Brinkerhoff, (2002). Assessing and improving partnership relationships and outcomes: a proposed framework. *Evaluation and Program Planning*, 25, pp.215-231.

It is evident from reports that the percentage of budgets at national and sub-national levels targeted to HIV is increasing. This is an indication of a sharing of the risk relative to capacity.

### **3.1.4. Outcomes**

*Effectiveness and efficiency:* As outlined previously, progress is being made towards the agreed partnership objectives and as described in the next sub section, the partnership is generally responsive to needs and priorities. Notwithstanding these achievements, partnership outcomes are being constrained by efficiency issues. The sub section, “contributing to national mechanisms”, highlights some of these. Another is the currently limited capacity within the HIV and Communicable Diseases Unit of AusAID to undertake critical policy engagement with both the National AIDS Commission and the Ministry of Health. This is discussed in Chapter 4.

## **3.2. Progress towards the partnership outcomes**

### **3.2.1. Responsive support that enhances Indonesia's HIV response**

Almost without exception, respondents from across the broad range of stakeholder groups reported that AIPH has been responsive to the needs of beneficiaries and the systems that are central to effective delivery of the HIV response. For example, from the outset, AIPH has placed its focus and emphasis on particular priority needs agreed with key stakeholders and which were identified through evidence-informed processes.<sup>94</sup> This approach has continued throughout the implementation phase. A notable illustration is the way in which AIPH seeks to address systems issues rather than simply implement designated tasks.

Responding systemically, AIPH has often achieved added value. For instance, rather than simply helping to strengthen the capacity of health workers to test for HIV, AIPH has helped develop an integrated approach to testing by combining HIV, TB and STI. This has achieved important behavioural additionality by extending the scope.

It is also evident that AIPH has been responding to emerging or changing needs. An important instance highlighted by several respondents has been its capacity to offer financial support to a number of key projects which had lost funding when the initial donor put on hold its HIV commitments while undergoing a lengthy redesign. This capacity of AIPH to respond has meant that in Papua, for example, two civil society organisations have been able to continue to provide much needed HIV prevention programs through outreach to sex workers. A further outcome has been that these particular organisations are now an active part of broader systems improvements in Papua by playing an important role in the ongoing planning and implementation processes convened by the Provincial AIDS Commission.<sup>95</sup> They also work alongside health staff to help address service delivery and service quality issues related to HIV testing and treatment.<sup>96</sup> Consequently, AIPH and its counterparts have further strengthened their conduit to beneficiaries and, thus, their capacity to understand the needs of beneficiaries.

This financial support has been possible because there are three grants mechanisms within AIPH: the Indonesia Partnership Fund, which is currently jointly funded by AusAID and USAID; a Partner Grants program within HCPI; and Contingency Funds (currently managed directly by the AusAID Health Unit). The first two of these provide a regular grants process through which organisations apply for planned activities that are aligned to the National HIV and AIDS Strategy and Action Plan. A proportion of these funds are also set aside for ad hoc, short-term projects that are offered through a “fast and flexible process”.<sup>97</sup> Likewise, the Contingency Funds provide further capacity for AIPH to respond to issues of emerging or changing needs, or opportunistic, strategic initiatives.

It is apparent from the many favourable comments from respondents, that these grants mechanisms are highly valued. Several respondents reported that AIPH grants enable a level of responsiveness that is not possible with other grants programs such as the Global Fund.

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<sup>94</sup> From discussions with representatives of National AIDS Commission and review of Program design documentation

<sup>95</sup> The Provincial AIDS Commission is supported by technical assistance from the HCPI component of AIPH.

<sup>96</sup> The clinical meetings, convened by health facilities, are supported by technical assistance from the CHAI component of AIPH.

<sup>97</sup> HCPI Partner Grant Guidelines (2010), p.3.

A significant example of AIPH being able to respond to changing or emerging needs has been the inclusion of the *MSM Initiative* during the implementation phase of AIPH. With evidence to show that men who have sex with men and transgender people are increasingly at risk of HIV and are likely to make up almost half of new infections,<sup>98</sup> Australia committed funds to a short-term initiative. The grants mechanisms within AIPH and the strong partnership between AIPH and the National AIDS Commission provided not only a suitable platform for such an initiative but also one that allowed a rapid uptake.

Likewise, AIPH has demonstrated that it is able to respond in a timely way to opportunistic, strategic initiatives. One such example is the use of contingency funds to resource the soon to be established National Management and Technical Assistance Facility. Responding to recent research that highlighted a need to strengthen the technical capacity of principal recipients to effectively implement Global Fund monies, AIPH will fund a short-term facility project, which will be administered by the UNDP, to help the principal recipients better plan, coordinate and broker needed technical assistance.

The disadvantage of grant funds being managed directly by AusAID, for instance the Contingency Funds, is that time and energy are deflected from management of AIPH and strategic policy dialogue. The recent agreement to integrate these funds with the Partner Grant mechanism managed by the HCPI component of the Program addresses this particular issue whilst giving AusAID the flexibility of directing such funds to important, strategic, one-off pieces of work through conditional arrangements. However, even this solution raises issues.

The inclusion of Partner Grants within HCPI continues to risk some of the known difficulties associated with project-based aid.<sup>99</sup> For example, although the grants process involves HCPI working closely with the relevant AIDS Commissions, it nonetheless entails administering parallel systems. This presents a conundrum. On one hand, HCPI is providing significant levels of technical assistance to strengthen the capacity of the people and the systems within the various Commissions. On the other hand, by bypassing these same systems, it risks reducing the feasibility of improvement. Further, in some instances, HCPI and the Commissions are funding the same organisations through their respective grant mechanisms. Whilst the potential for duplication is being addressed by working closely together during the HCPI Partner Grants process, it nonetheless places additional accountability requirements on many organisations that are already stretched.

If the AIPH grants mechanisms (both the Contingency Funds and the Partner Grants) were to be integrated within existing or planned government based mechanisms these issues might be resolved. Possible grant mechanisms could be the Indonesia Partnership Fund, which is soon to be managed through the National AIDS Commission, or the proposed HSS Community Grant, which the review team understands will be integrated within the Ministry of Health. The technical advice that is currently provided by HCPI in relation to proposals could still be provided, but it would be in the context of directly strengthening relevant government systems. Similarly, if AusAID has strategic preferences for how some or all of these grants are directed, agreements about particular priorities could be negotiated on an annual basis. Studies suggest that conditionality can work when applied as annual assessments of performance against an agreed matrix of progress indicators that include some policy actions and some outcome measures.<sup>100</sup> Transfer of these grants to within a government system could be planned for the end of the current HCPI contract (March 2013).

**Recommendation 3.3:** *That, as a means of further strengthening government capacity in the management of HIV targeted resources, the Contingency Funds and Partner Grants be integrated with an existing or planned government based mechanism (such as the Indonesia Partnership Funds for management by the National Aids Commission or the HSS Community Grant for management by the Ministry of Health) with such transfer being planned for March 2013. Furthermore, that AusAID and the relevant agency agree annually upon strategic priorities for use of these grants and establish an agreed joint monitoring process.*

<sup>98</sup> MSM Initiative Program Description Document (2010).

<sup>99</sup> Williamson and Kizilbash Agha (2008). cited in Advisory Board for Irish Aid. (2008). *Good Governance, Aid Modalities and Poverty Reduction: Linkages to the Millennium Development Goals and Implications for Irish Aid*.

<sup>100</sup> Booth et al, (2006a), cited in Advisory Board for Irish Aid. (2008). *ibid*.

Another disadvantage of the current funding mechanisms is an impression that AIPH is fragmented or lacking in overall strategy. For example, several respondents spoke of AusAID as “*filling the gaps*”, implying that the Program simply responds to other agendas rather than having its own strategic intent. Furthermore, from discussions with various AusAID personnel it is apparent that there is a view in sections of AusAID that AIPH is “*bitsy*”. Despite this, the majority of the examples of responsive initiatives discussed with the review team appear to be well aligned with the Program’s broad intent.

However, as with all grants mechanisms and ad hoc project-type modalities there is a risk that well intentioned and well conducted activities might be successful in themselves, but collectively not help achieve the desired intermediate and longer term outcomes. Being clear about the overall program theory of AIPH and having ways to assess how individual grants activities contribute would minimise these risks. Likewise, unless the various components of AIPH are well integrated, both in terms of an overall program theory and administratively, then fragmentation is a real risk. As noted in Chapter 4, at present there is neither a well-defined program theory for AIPH nor a way of determining if the many parts effectively add up to the whole. Neither is there a well-structured management oversight of AIPH as a whole. The management issue is discussed in Chapter 4, along with a recommendation.

The vast majority of AIPH is implemented through HCPI. It is through this component that most project-type or ad hoc initiatives occur. Whilst HCPI has established extensive monitoring and evaluation of each of its activities, there is a need to review how these cumulatively fit together, particularly in light of the AIPH program theory.

**Recommendation 3.4:** *That once the program theory for AIPH has been clearly articulated, a review of the cumulative effectiveness of the Partner Grants be conducted to ensure that they are contributing to the desired intermediate and longer term outcomes.*

As well as a capacity to respond financially, AIPH has in place a range of engagement methods that help identify the needs of beneficiaries, understand the changes to the systems that are needed, and negotiate the most relevant responses. These include: participation in national planning and coordination mechanisms; direct liaison with civil society organisations; regular meetings with counterparts in the AIDS Commission, Ministry of Health, and other implementing partners; and ad hoc meetings with other donors and development partners. Such engagement is an important prerequisite of effective responsiveness and, generally, key stakeholders spoke favourably of the way in which AIPH worked cooperatively with others. This view appears to hold whether the staff are from AusAID’s Health Unit or from the two implementing agencies (HCPI and CHAI). Notwithstanding this, there are significant efficiency issues. These are discussed in the next sub section.

In summary, it was evident that by being responsive (in terms of engagement, financial support, and technical assistance), AIPH has earned an enviable donor reputation amongst the majority of the key stakeholders. This has strong branding potential for AusAID and AIPH.

### **3.2.2. Contribution to national mechanisms**

There are several relevant national and sub-national mechanisms that have been established to achieve a successful national HIV response. Some of these have been set up by the Government of Indonesia, namely the National AIDS Commission and its various Provincial and District equivalents. Others have been set up by the international community in conjunction with the government, specifically: the Country Coordinating Mechanisms of the Global Fund for AIDS, TB and Malaria; and the Indonesia Partnership Fund. In addition, civil society mechanisms are developing with the support of the government and the international community. For a list of the mechanisms and how AusAID is contributing refer to Annex 2.

Contributing to various national mechanisms is not an outcome in itself; rather it is one means of ensuring that AIPH is effective in terms of how the partnership operates and performs. Whilst these particular mechanisms are not explicitly those associated with the AIPH partnership, it is critical for AusAID to participate if it is to meet its partnership commitments, because they are the means through which the HIV response is effected.

The evidence suggests that by contributing to these mechanisms AIPH is reaping other benefits. For example:



- Involvement in building positive relationships and mutual respect. The contribution is highly regarded. By and large, respondents from across the partner and stakeholder groups spoke very favourably about AIPH's: consistency of participation; level of commitment; capacity to respond; and promotion of national ownership.
- Involvement reinforces AusAID's legitimacy. The contribution appears to have reputational benefit for the agency, placing it in a strong position in relation to strategic decision making.
- Involvement is enabling some degree of coordination of effort between government, development partners, donors and civil society. For example, one of the tasks of the Global Fund Technical Working Group is to ensure that proposals are complementing the work of other agencies and groups, not duplicating efforts.

However, despite the many mechanisms, there is no single central forum in which the contributions of all actors are discussed and aligned, under the leadership of the government.<sup>101</sup> For instance, donors are only represented at the working group level of the AIDS Commission, which is focused on technical advice not high level policy. As for the Global Fund, whilst donors are involved in the Country Coordinating Mechanism, the AIDS Commission and the Ministry of Health are not because they are Principal Recipients (however the Ministry of Health chairs the Country Coordinating Mechanism).

The absence of a single, overarching forum for policy discussion and coordination was raised as an issue by several respondents from varying stakeholder groups. The UNDP<sup>102</sup> has recently suggested that an overarching mechanism should be established. However, given the issues discussed below in the sub topic 'partnership efficiency', any such forum should be integrated with an existing mechanism rather than establishing a new one.

A consistent message from all levels of AusAID personnel and staff from the managing contractors was that contribution to the many mechanisms is very time consuming and resource intensive. In particular, the contribution to the Global Fund Country Coordinating Mechanism is reported as being extremely demanding, with staff advising that working group meetings are held as frequently as fortnightly during times when proposals are being developed. Other respondents reported similar concerns. Representatives from the Global Fund Country Coordinating Mechanism reported that several organisations and groups have pulled out of the processes because of the high demands on their time. As a consequence, the large workload is reported to fall on fewer and fewer people.

The work load and complexity issues are further complicated because the Country Coordinating Mechanism was established as a new mechanism, presumably because, at the time, there was not a sufficient existing national mechanism.<sup>103</sup> In addition, in the absence of strong national budgeting for HIV through regular government agencies, the Global Fund provides the bulk of HIV funding. So the Country Coordinating Mechanism as a key national-level process is heightened. However, as the National AIDS Commission has strengthened and matured, its role as the national planning and strategy coordination mechanism has taken on greater importance. Consequently, there are now two critical national processes to which key stakeholders, such as AusAID, need to contribute. Further complicating these issues for AusAID are the additional meetings and ad hoc forums it has with the Commission, other donors and development partners, seemingly because the current mechanisms do not provide the needed high level policy discussion and coordination.

There are further efficiency issues for government agencies. Not only do they need to participate in the aforementioned national mechanisms, they are now also contributing to a recently formed national HIV forum led by the National Development Planning Board. With more than 20 government agencies now operating some level of HIV activities, this forum aims to coordinate government HIV planning and budgeting efforts.

<sup>101</sup> UNDP. (2011). *National Coordination of AIDS Responses: The Case of Indonesia*, UNDP Indonesia

<sup>102</sup> *ibid.*

<sup>103</sup> *The Framework Document of the Global Fund to Fight AIDS, Tuberculosis and Malaria* states:

"The Fund will work with a country coordination and partnership mechanism that should include broad representation from governments, NGOs, civil society, multilateral and bilateral agencies and the private sector. The mechanism should be at the highest national level responsible for national multi-partner and multisectoral development planning. It should preferably be an already existing body. If no appropriate coordinating body exists, a new mechanism will need to be established." (p.5).

Despite the additional demands, such a forum led by the National Development Planning Board is an important one. As the country moves from lower middle to upper middle income status, there is an urgent need for government, at both national and sub-national levels, to transition from the current reliance on donor funds to become the primary financial contributor to the national HIV response. The National Development Planning Board is most likely the appropriate agency to lead this transition.

However, to ensure that the costs of contributing to such mechanisms do not outweigh the benefits, it will be important for the government to explore how to achieve the needed planning and coordination in a more integrated and streamlined way. It also needs to find a way to provide the much needed high level policy discussion and coordination. The review team cautions against establishing yet another mechanism. The solution is more likely to be found in some integrated or adapted version of the existing mechanisms. Given AusAID's status as one of the major donors, the counterpart to the National AIDS Commission, and a significant participant in the Global Fund Country Coordinating Mechanism, there is merit in it supporting joint discussions between key stakeholders to explore how the current mechanisms might evolve to: i) be more integrated and streamlined; and ii) be adapted or merged to provide the needed overarching high level policy discussion and coordination. These discussions could be chaired by either the National Development Planning Board or the Commission.

In the meantime, AIPH would benefit from more formalised policy and strategic joint discussions between the major stakeholders, namely: the National AIDS Commission, the Ministry of Health, the National Development Planning Board, AusAID (and its managing contractors), USAID (and its managing contractors), and the Global Fund Coordinating Mechanism. This would provide AusAID with the high level policy discussions and coordination it needs whilst the Government of Indonesia is being supported to develop a more comprehensive one.

**Recommendation 3.5:** *That in the absence of a single high level policy forum and in recognition that AusAID would benefit from a more formalised approach to policy and strategic discussions with major stakeholders, AusAID facilitates regular policy and coordination discussions between its major stakeholders, namely: the National AIDS Commission, the Ministry of Health, the National Development Planning Board, AIPH managing contractors, USAID (and its managing contractors) and the Global Fund Country Coordinating Mechanisms. Among other policy issues, this forum be used to initiate discussions about how the current national mechanisms might evolve to: i) be more integrated and streamlined; and ii) be adapted or merged to provide the needed overarching high level policy discussion and coordination.*

### **3.2.3. Alignment with Indonesia's systems and processes**

As reflected in the discussion throughout this report, AIPH is well aligned with Indonesia's systems and processes, for instance:

- monitoring and reporting is occurring using national indicators where possible;
- program-specific surveys are being adapted from national surveys;
- technical assistance is being provided directly to agencies to support the strengthening of local capacity rather than the Program providing a separate service;
- government systems and existing non-government organisations are being used for the distribution of needles and syringes, contributing to bringing distribution in line with general health care; and
- the supply chain management system has been able to find ways within government systems and processes to adapt and improve procurement channels.

The one exception to AIPH's positive alignment appears to be the Partner Grants, discussed earlier in this chapter. In a similar vein, but having more adverse impact is the Global Fund Country Coordinating Mechanism. Pooled funds are commonly viewed as a modality that encourages reduction in transaction costs and alignment of aid with country policies and plans. They are generally seen as a way to transition to budget support. The Global Fund has without doubt enabled much of the national HIV response and provided the National AIDS Commission with the means to implement many things that could not otherwise have been implemented. However, rather than reducing transaction costs, the need to contribute to both the Country Coordinating Mechanism as well as the National AIDS Commission mechanism, means an increase in transaction costs for key stakeholders.

Furthermore, respondents from the Country Coordinating Mechanism's Oversight and Plenary groups consistently reported that whilst the grants contribute to a large part of the national strategy, the County Coordinating Mechanism does not have enough capacity to see how the Global Fund programs fit with other programs, other than relying on the descriptions in grant submissions.

These issues echo research by Williamson and Kizilbash Agha<sup>104</sup> who found that parallel processes draw key stakeholder attention and energies to the modality itself and away from the systems that the funds are supposedly helping to strengthen. It is important, therefore, that key stakeholders work collaboratively to streamline the national mechanism, as suggested in *Recommendation 3.5*. On another point, Williamson and Kizilbash Agha<sup>105</sup> also found that parallel processes tend to "dwarf or replace any domestic service delivery systems that existed", an issue reported by the respondents of this review.

The most critical example is the adverse impact that incentive payments, incorporated in many of the Global Fund grant applications, are having on the Ministry of Health's efforts to reform and redevelop the service system. Respondents reported instances of staff being reluctant to undertake new, but appropriate, tasks and roles unless they received additional incentives similar to those they receive when being paid through Global Fund grant initiatives. Whilst incentive payments can offer positive inducements, it appears that an unintended consequence of these particular incentives has been to stymie reforms of regular processes and activities initiated by various health authorities. This is making reform even more difficult for the Ministry of Health. As an influential member of the Country Coordinating Mechanism, AusAID is in a position to support the Ministry of Health in trying to better align any incentives to the more general incentive schemes within the health system so that they reinforce, not hinder, needed health reforms.

***Recommendation 3.6:*** *That AusAID, as an influential member of the Global Fund Country Coordinating Mechanism, support the Ministry of Health to address the current unintended negative consequences of some of the incentive arrangements in applications approved through the Global Fund County Coordinating Mechanism by jointly advocating for any incentives to be aligned to existing health system incentive schemes and that they support, not hinder, needed health reforms*

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<sup>104</sup> Cited in Advisory Board for Irish Aid. (2008). *Good Governance, Aid Modalities and Poverty Reduction: Linkages to the Millennium Development Goals and Implications for Irish Aid*.

<sup>105</sup> *ibid*, p.13.

## 4. Management and administration of the AIPH

### 4.1. Oversight of AIPH

#### 4.1.1. Coordination of Program components

As noted in the “Partnership” section, AusAID’s AIPH program staff have developed positive working relationships with their relevant counterparts from each of the program components: HCPI, CHAI, the AIDS Commission and those administering the Indonesia Partnership Fund. They have put in place informal processes to discuss aspects of AIPH with relevant representatives and there are agreed, regular processes for monitoring each of the separate components. These actions help AusAID staff to stay abreast of program successes and issues, thus developing a good operational knowledge of the different components of AIPH.

However, AIPH is managed and administered as separate components rather than as an integrated whole. It appears that this might be a consequence of different components being included over time rather than being integrated from the outset. Contract periods have been set individually as new works were negotiated. As a consequence, the length of contracts varies, as do end dates. Oversight arrangements were put in place with each separate part of AIPH resulting in the critical programmatic links between the various parts not being made. Representatives from each of the components have not been brought together in any formal way with AusAID staff to review AIPH progress overall, discuss AIPH-wide issues, or set AIPH-wide priorities. Rather, the separate components are viewed as stand-alone by all respondents.

This stand-alone approach is one possible explanation for the fragmentation of service delivery observed in a number of locations visited. As discussed in chapters 3 and 5, there has been insufficient bridging between harm reduction or promotion and prevention services with care, support and treatment activities. The separate components are, generally, not delivered as part of a continuum, although success or failure may rest with any part of the spectrum.

The stand-alone nature of the separate components has resulted in AIPH having the appearance and feel of being fragmented and, as some respondents described it, *bitsy*. However, the review team is of the view that the various components are actually complementary and that each has an important part to play towards the longer term program objectives. With nothing helping drive integration the mutual contingency of the various components has not been well recognised. This could be addressed by managing AIPH as an integrated program. This could be achieved through a number of small changes to the way in which it is administered and managed, including:

- clarifying the overall program theory for AIPH (refer to more detail later in this chapter);
- bringing representatives of all the components together on an annual basis to review AIPH progress and set, jointly, the priorities for the following year; and
- facilitating six monthly joint meetings between CHAI, HCPI and the National AIDS Commission (for the *MSM Initiative*) to ensure the progress and issues of the major service delivery components are regularly considered and understood, and that more formal means of collaboration can be established.

**Recommendation 4.1:** *That AIPH Program Management staff achieve an integrated approach to AIPH by:*

- *facilitating six monthly joint meetings with CHAI, HCPI and the National AIDS Commission (MSM Initiative) to ensure the progress and issues of the major service delivery components are regularly considered together and understood, and more formal means of collaboration can be established; and*
- *bringing representatives of all the various components together on an annual basis to review AIPH progress and set, jointly, the priorities for the following year.*

#### 4.1.2. Coordination between AusAID Programs

Another important coordination matter relates to the intersection with other AusAID Programs. Currently, the most relevant one is the Australia and Indonesia Partnership for Decentralisation (AIPD), which is operating in at least two of the same provinces as is AIPH.

Given AIPD's role in supporting Regional Development Planning Boards at both the provincial and district levels, coordination with AIPD is critical if AIPH is to support local governments and agencies to increase their HIV budget allocations and expenditures. However, there is no current mechanism for this coordination.

Similarly, coordination with the pending Health Systems Strengthening (HSS) program will also be important, particularly given AIPH's current attention to strengthening the health system. Indeed, as noted elsewhere, some of the urgently needed health systems strengthening work is beyond the mandate of AIPH unless financially and technically supported by the HSS. In some instances, all three of these programs: AIPH, HSS and AIPD, will be operating in the same provinces, further raising the importance for coordination. Formal coordination mechanisms between these programs in priority locations should be established, with attention at both the national and sub-national levels to ensure a strategic approach.

**Recommendation 4.2:** *That, in recognition of the important interdependencies between the various AusAID programs, AusAID establish formal coordination mechanisms between AIPH, AIPD and HSS at the central level and at the local level in common provinces in which they are operating*

The importance of coordination between AusAID programs operating in the same locations goes beyond simply ensuring AusAID is not replicating efforts. It has the potential to increase the intensity of effort and therefore maximise gains from invested resources. It is for this reason that the review team strongly recommends that HSS includes Papua in its second round of roll out. Given that the HIV response in Papua is contingent on the strength of health systems, a coordinated, concentrated effort between all three programs would increase the likelihood of success in Papua.

**Recommendation 4.3:** *That HSS include Papua as one of its provinces in the second stage roll out in order that a more systematic approach to strengthening health systems in Papua will support AIPH efforts and to gain added leverage from the proposed scale up.*

#### 4.1.3. Modalities and instruments

For some respondents, AIPH's use of several aid modalities and instruments was suggested as an indicator of program fragmentation. However, it is important to note that this is an acceptable and typical practice for program-based approaches such as AIPH.<sup>106</sup> The number of aid modalities and instruments is not the issue but rather whether they are achieving what is sought and whether they are being managed efficiently. The effectiveness of these instruments is implied in the discussions found in Chapter 3. Similarly, efficiency issues identified by the review team have been outlined, particularly in this present chapter. Of particular concern is the workload demand of the Global Fund Country Coordinating Mechanism. Although this international pooled fund is not a direct modality of AIPH, AusAID is, nonetheless, a key stakeholder. However, limited staffing capacity in the HIV and Communicable Diseases Unit has meant that the demands of the Country Coordinating Mechanism, has diverted the Unit from sufficient levels of policy engagement. At the time of the review, a new management position was added to the Unit to help free up time of relevant senior personnel for important high level dialogue with counterparts in the National AIDS Commission and the Ministry of Health. The review team believes that this is a positive step.

## 4.2. AIPH Monitoring and Evaluation Plan

There have now been three versions of the AIPH Monitoring and Evaluation Plan. This is appropriate given that AIPH has a number of complex aspects and has been emerging over time. At the beginning of AIPH, there were fixed ultimate outcomes with some broad approaches to achieve these. Essentially, AIPH, along with its theory, was left to emerge. This is not unusual for complex programs.<sup>107</sup> With emergent programs, it is important to undertake regular iterative reviews of the program theory as the program evolves. This allows for the program and its monitoring and evaluation requirements to be captured more specifically over time.

<sup>106</sup> Handley, G. (2009). *Sector Budget Support in Practice: Literature Review*. Overseas Development Institute, UK.

<sup>107</sup> Funnell, and Rogers, (2011). *Purposeful Program Theory: Effective use of Theories of change and Logic Models*.

The most recent Monitoring and Evaluation Plan, developed in early 2010, attempted to draw together the whole of AIPH by articulating the program logic and the outcomes that feed into the longer term objectives. This process was important in helping establish, for the first time, a Program Monitoring and Evaluation Plan that captures all current components of AIPH. This latest Plan framed the work within the context of the *National AIDS and HIV Strategy and Action Plan* and the national processes and systems. It also considered the broader AusAID reporting requirements.

The purpose of iteratively clarifying a complex program's theory is to capture the best understanding at any point in time. Whilst the current program logic has provided AusAID with a basic understanding of what the intervention is meant to achieve as a whole, it was not able to capture the program theory, particularly the theory of change, the causal links between different outcomes and components of AIPH, and the underlying assumptions. Furthermore, given the way in which AIPH has changed over the past 12-18 months, the current logic does not capture things such as: the evolving partnership with the Ministry of Health; work related to care, support and treatment; and the added focus in relation to sexual transmission (*MSM Initiative* and sex worker projects).

During the review it was apparent that respondents can describe the interventions and how the components interface. This suggests that it should now be possible to more clearly articulate the theory of change. It might even be possible to articulate some of the theory of action, though it is likely that for some aspects of AIPH this might still be emergent for some time yet.

As part of the next iteration, the end-of-program outcomes should be re-articulated. Currently, the logic is guided only by broad based objectives that have not been expressed in outcomes terms. These objectives are too broad to provide the program with clear direction as to what is expected by the end of AIPH. Likewise, it will be important to determine the outcomes hierarchies that lead to the end-of-project outcomes and show how these link with each other. As part of this, the outcomes should be expressed, wherever possible, in terms of the desired changes to the beneficiaries' situation. For example, rather than 'Supply of antiretrovirals is more reliable', the outcome could be expressed something like: 'People living with HIV are able to access quality antiretrovirals in a timely and cost-efficient manner'.

Once the theory of change has been articulated, it can be used to inform the proposed rapid design for the Papua scale up. It will also assist in determining if AIPH has the right mix of components and activities and the degree to which they are necessary and sufficient to achieve the stated outcomes. Articulation of the program theory will help to emphasise the strategic intent to key stakeholders, particularly when considering requests for grants or ad hoc initiatives.

The final aspect of the next iteration should be a revision of the Monitoring and Evaluation Plan to reflect the theory of change. In addition, there would be merit in revisiting the success criteria of each of the outcomes and how they will be measured. In some instances, where the national or sector indicators are not sufficient, this will mean that additional criteria and measures will need to be agreed upon.

***Recommendation 4.4:*** *That another iteration of the program theory be undertaken with key stakeholders to clearly articulate the AIPH's theory of change, the causal links between the different outcomes of AIPH, and the underlying assumptions. The updated program theory should then inform the proposed rapid design for the Papua scale up and be used to refine the Monitoring and Evaluation Plan, including updating success criteria and measures where relevant. This should form the beginning of a continuing iterative process.*

As part of the re-articulation of the Monitoring and Evaluation Plan, a review of the data required from each of the AIPH components should be conducted. It was apparent from reading the many progress reports, that the Program Manager is inundated with excessively large reports. The volume of information is such that it is difficult to quickly ascertain progress or key issues. A combination of periodic discussions and shorter, more focused reports would benefit both the Program Manager and the managing contractors, who spend disproportionate amounts of time in preparing the current reports. Further, the Program Manager's task might be enhanced if on the job mentoring and assistance is provided in the use of monitoring and evaluation for program performance management. Technical assistance in analysing data could also be valuable.

## 5. Supporting the Government to effectively respond to HIV in a sustainable manner

This section offers suggestions for the broad direction for AIPH for the coming five years in terms of how AusAID might best support the Government of Indonesia to respond effectively to HIV in a sustainable manner. The proposals have been articulated in terms of objectives and five year outcomes. The various recommendations contained in the report are part of the means of reaching these outcomes. This chapter concludes with a discussion about suggested changes to the contracts so that recommendations and proposed outcomes can be achieved. All suggestions have been made within the following context:

### 5.1. Context

**National and sub-national leadership has strengthened:** As indicated in the report, leadership at both national and sub-national levels has strengthened in many areas. There is a strongly expressed commitment to addressing HIV/AIDS by all relevant agencies and organisations. The National AIDS Commission is providing strong leadership and increased levels of responsibility for planning and implementing needed services are evident in other key agencies and organisations.

**The Indonesian Government needs to make a significant transition:** At present, the national HIV response is very reliant on external financing from the international community. As Indonesia's status moves to an upper middle income country financial support from the international community is likely to reduce significantly. Indonesian government, at all levels, will need to increase HIV related budget allocations and expenditures significantly and rapidly if the HIV epidemic is to be halted and the effort sustained. It is not certain how prepared the relevant national and sub-national authorities are for this challenge both in terms of willingness to commit the needed levels of financing or the technical budgeting and expenditure capacity.

**AusAID holds an important and influential position:** Within the HIV arena, Australia is a major donor and source of technical assistance. It appears to have a strong reputation amongst key stakeholder groups. It is in an influential position both because of its size as a donor and because of the scope and quality of its work. Australia, because of its 'neighbourhood' ties to Indonesia, will likely have an ongoing important relationship with Indonesia. This suggests that Australia will play an increasingly important role, perhaps even as the government's lead partner for HIV.

**The epidemic in Papua and West Papua presents a public health emergency:** The situation in Papua and West Papua, where the epidemic is generalised, demands different responses from the rest of Indonesia. Prevalence rates in Papua and West Papua are significantly higher than elsewhere. The situation presents a public health emergency requiring an urgent expansion that builds on existing delivery platforms so that momentum is not lost. Addressing the epidemic in Papua and West Papua is needed to impact at a country level.

**Changes to the epidemiology mean different emphases and interventions are required:** Epidemiological data suggest that the epidemic is now being driven through sexual transmission. As noted in the report, the current division between harm reduction and sexual transmission has had a number of unintended consequences, including fragmentation and insufficient attention on testing and treatment as prevention. STI is a proven co-factor in HIV transmission. Insufficient attention to managing STI effectively is impacting on authorities being able to successfully reduce HIV transmission.

**Harm reduction services have not achieved the necessary coverage to make sufficient impact:** Despite attention to harm reduction for many years, including as part of the project that preceded AIPH, coverage of harm reduction services falls well below recommended levels.

## 5.2. Proposed five year objectives and outcomes

### **Objective 1: Support partners to secure adequate national and sub-national budget allocation and expenditure to enable an effective response to HIV**

A relatively rapid transition is required of Indonesia in the next five years. It requires a strategically planned approach, supported by key international partners. Australia, because of its comparative advantage in the HIV sector in Indonesia is well placed to take a leading, but not sole, role in this.

**Five year outcome for AIPH:** *The Government of Indonesia at both national and sub-national level funds the vast majority of the HIV response in key locations from its own resources and has the capacity and capability to ensure appropriate allocation and expenditure.*

### **Objective 2: Support a scaled up response in Papua**

The main emphasis of partners in Papua is currently on promotion and prevention. The literature has found that expansion of promotion and prevention programs can avert more than half of the projected HIV infections expected to occur by 2015.<sup>108</sup> The literature has also found that combination prevention (a combination of behavioural, structural and biomedical approaches) as the most successful.<sup>109</sup> CHAI's care, support and treatment work in Papua, which offers the biomedical aspect of combination prevention, is a key innovation that lends itself to expansion. Recent research suggests that donors should identify and leverage their successes to scale up their efforts, particularly where an impact on country-level goals is likely (as in this case).<sup>110</sup>

**Five year outcome:** *National and provincial implementing partners make a significant impact on the spread of HIV in Papua through implementation of 'combination prevention' and strengthening of the health systems.*

### **Objective 3: Support an enhanced focus on sexual transmission within a continuum from promotion and prevention to care, support and treatment**

Over time, AIPH has accepted some responsibility for responding to sexual transmission issues, primarily through:

- its role in supporting the *MSM Initiative*;
- having filled the gap in funding of and support to civil society organisations that occurred when the previous USAID program finished;
- the comprehensive approach for most at risk populations in Bali;
- the prevention work in Papua and West Papua; and
- the integrated approach to testing as a means of prevention that is helping to strengthen the systems for PITC; PMTCT; and integration of HIV, TB and STI testing.

Indeed, AIPH is now viewed by many key stakeholders as a critical player in the overall response to address the sexual transmission issues, along with the Global Fund.<sup>111</sup> Ultimately, if other donors and development partners reduce their level of support to Indonesia, it is likely that Indonesia will look to Australia to take even more of a role.

The need for a focus on the continuum is not to suggest that any single donor or provider must take responsibility for the whole, rather that each must see its part in the continuum and work collaboratively to better link the various aspects. It also means, given the state of the epidemic, that all activities need to be designed and implemented within a sexual transmission framework. Whilst the emphasis needs to be placed on sexual transmission, this does not mean that the intervention should be a universal one for the general population. The focus should remain on most at risk populations.

<sup>108</sup> Merson et al (2008). op. cit

<sup>109</sup> ibid.

<sup>110</sup> Chandy, L. and Linn, J. (2011).op. cit.

<sup>111</sup> Whilst it seems that USAID's new program SUM 1 will provide technical assistance to local government and civil society organisations in matters pertaining to sexual transmission, it is apparent that this program will not be as extensive as its previous program.



For AIPH this means a difference in emphasis rather than a radical change in direction. Within the body of this report, various recommendations have been made to sharpen AIPH's focus in relation to both the continuum and helping address the issue of sexual transmission. Essentially, these are related to taking a more assertive approach to: HIV testing; integration of STI and HIV testing; and safe sexual practices.

***Five year outcome for AIPH: Implementing partners, by framing interventions for most at risk populations within a sexual transmission framework, make a significant impact on the spread of HIV in key locations.***

#### **Objective 4: Support a more rapid coverage of comprehensive harm reduction programs**

The overall coverage rates of harm reduction programs are too low. The non-AIPH supported contribution is only about one-third of the total coverage. The Ministry of Health and non-government agencies need to be supported to rapidly scale up their efforts and for national and sub-national budgets to support this. Unless there is greater coverage, abatement of the epidemic amongst injecting drug users will not be achieved.

***Five year outcome for AIPH: National and sub-national partners achieve a level of coverage of harm reduction services equivalent to the national target.***

#### **Objective 5: Manage the partnership effectively to ensure an integrated approach to AIPH**

The synergies of AIPH are not being fully realised because of the fragmented approach to the management and oversight of the program. Over the next five years, there will be an increasing need to better coordinate with other relevant programs such as AIPD and HSS. To maximise the partnership and its outcomes, it is timely to expand it to include the Ministry of Health.

***Five year outcome for AIPH: AusAID, as the delegated manager of the partnership, manages AIPH in an integrated way to successfully achieve program outcomes and coordination with other relevant programs.***

### **5.3. Proposed changes to the current contracts**

The recommendations in this report have implications for the current contracts. In the body of the report recommendations have been made in respect to extension of CHAI's contract. For HCPI, however, the number of recommendations means that an overarching contract-related recommendation is necessary in this section of the report, as follows:

***Recommendation 5.1: That AusAID undertakes a joint review of the contract conditions with GRM (the managing contractor) to determine the impact of the suggested changes in emphases contained in the recommendations relevant to HCPI. This review should be undertaken in time for any design changes to be made prior to the conclusion of the current contract (March 2013) to ensure a smooth transition and prevent loss of momentum.***

### **5.4. Overview of the revamped AIPH**

A key concept for the future of AIPH is that it be brought together as a single integrated program aimed at supporting, through a partnership, the implementation of the Indonesian HIV response. This does not assume a single contract, rather that it be conceptualised, implemented and managed as a single program instead of individual fragments. The call for a revised program theory is part of this integrated whole of program approach to make clear the linkages between the various activities in achieving the desired outcomes. So too is the suggestion for the Program Manager to facilitate joint, regular program meetings with the organisations it directly contracts to ensure planned, integrated and coordinated efforts, namely: HCPI, CHAI, and the National AIDS Commission (*MSM Initiative*). AusAID will bring to these joint meetings the necessary operational and strategic information in relation to the Indonesia Partnership Fund and the Contingency Funds, the remaining components of AIPH.

In supporting Indonesia's goals, all efforts by AIPH – be they through HCPI, CHAI, the National AIDS Commission, Contingency Funds, or Indonesia Partnership Funds – will be aimed at the five proposed objectives and their respective five year outcomes. AIPH will focus on supporting Indonesia to bridge the link between prevention and promotion, and care, support and treatment. More assertive approaches to testing and treatment will be pursued as will more rapid coverage of harm reduction. AIPH's focus will remain on vulnerable groups in key locations. Papua will be the main focus of scale up. The review assumes that due to the severity of the epidemic in Papua and West Papua AIPH will extend beyond 2016 in those provinces and a design phase has been recommended.

This review also assumes that by 2016 Indonesia will be financing the majority of the HIV response. Therefore, the need for ongoing funds from Australia should be significantly diminished. However, there may be need for some ongoing technical assistance in particular locations or for specific vulnerable populations. This review does not attempt to predict the level of need for AIPH more generally beyond 2016. A review of AIPH and a situational analysis in mid 2014 are likely to be required to inform strategic direction beyond the life of this current program.

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## Annex 1: Cost implications of recommendations

Recommendation 1.1: That AusAID, in collaboration with other key donors such as USAID, provide technical assistance to the National Development Planning Board and the National AIDS Commission (and their respective sub-national entities) to strategically plan and implement the needed transition from reliance on donor funds to local independence.

The review team has assumed that this does not require additional funds but rather a refocus of existing budget capacity. The recommendation will be the responsibility of the Senior Program Manager, AusAID.

Recommendation 1.2: That a more patient focussed approach be taken to supply chain management by incorporating attention to improving ease of access to ARVs and other drugs through hospitals and an increased number of satellite sites. The Ministry of Health should be encouraged to procure drugs in standard dosages and fixed dose combinations to avoid patient confusion. Civil society organisations should be invited to work collaboratively on exploring solutions to address access issues.

The review team has been advised by AusAID that this recommendation will require additional funds estimated at between \$600,000 and \$1 million, depending on the number of satellite sites.

Recommendation 1.3: That AusAID negotiate a new contract with CHAI to come into effect July 2012 to provide financial and technical assistance to:

- consolidate improvements in the ARV drug supply chain management system; and
- extend the work to include some or all of: HIV rapid tests; extending the decentralisation work in up to six additional provinces; and improving supply chain for other HIV related health commodities such as opportunistic infection drugs and CD4 tests.

The review team assumes that the AusAID component of this would form a regular part of program and contract management and be the responsibility of the Program Manager. AusAID has advised that additional resources to cover a consultant for CHAI would be required at a total cost of \$11,600.

Recommendation 1.4: That AIPH support national and sub-national partners to increase significantly the coverage of harm reduction services, especially needle and syringe programs and methadone. This can be achieved through: advocacy to address the policy and practice issues that constrain distribution of needles by outreach; greater efficiency of current needle distribution channels, especially outreach; development of strategies to address barriers; targeting injecting drug user sub-populations not currently being reached; and through advocacy for higher levels of investment by the Government of Indonesia in harm reduction, especially needle distribution and methadone.

The review team assumes that this recommendation will fall within the regular work of the Senior Policy and HIV Advisor, AusAID.

Recommendation 1.5: That, because injecting drug users use both outreach and fixed site health services and the absence of any reliable way of tracking such use, AIPH provide technical assistance to the Ministry of Health to establish a common client unique identifier code for injecting drug users to improve the accuracy and completeness of service utilisation data.

The review team assumes additional resources will be required for this recommendation and suggest a half-time technical officer for one year at an estimated cost of \$25,000. The responsibility should then fall within the role of the program monitoring and evaluation staff.

Recommendation 1.6: That HCPI supported harm reduction services place greater emphasis on behaviour change communication strategies and condom distribution for prevention of sexually transmitted HIV, especially in regard to HIV-positive injecting drug users and their casual sexual partners.

The review team assumes that this requires a refocus of existing work rather than additional resources.

Recommendation 1.7: That in light of the well documented research that highlights the substantial benefit of starting treatment earlier and studies that show good adherence to ART by injecting drug users, AIPH advocate for a change to current practice which limits access to ART to injecting drug users who are receiving opioid substitution therapy. Technical assistance in the development of appropriate standard operating procedures and capacity building to cater for the special needs of injecting on ART should be offered by HCPI and CHAI. This should be accompanied by a concerted effort by HCPI-supported harm reduction services to promote uptake of treatment for those who meet equitable ART eligibility criteria.

The review team assumes that this would form part of regular policy dialogue work by the Unit Manager, HIV and Communicable Diseases, AusAID and the Senior Program Manager, AusAID. Further, the technical advice should form part of regular work of CHAI and HCPI. The review team does not believe that this requires additional resources.

Recommendation 1.8: That the harm reduction model promoted by HCPI place greater emphasis on encouraging all injecting drug users to know their HIV status through regular HIV testing. This should be achieved by improving the application of PITC; encouraging health services to make HIV testing more accessible by provision of outreach testing services; provision of technical assistance which practically addresses current obstacles to HIV testing; and development of strategies on how to significantly increase demand for HIV testing.

The review team assumes that this requires a re-emphasis of HCPI's work rather than requiring additional resources.

Recommendation 1.9: That, in the interests of sustainability, AusAID advocate for the Ministry of Health to take on an active national policy, oversight and coordination role in relation to needle distribution, thus relieving the National AIDS Commission of the responsibility which it has taken up by default.

The review team assumes that this work forms part of the regular policy work for AusAID with the responsible position being the Senior Program Manager.

Recommendation 1.10: That, in light of the many challenges relating to inmate health that would benefit from a more integrated health approach, and the need for continuity of care whilst in prison and post release, HCPI, in consultation with the Directorate of Corrections, identify opportunities for its support of HIV programming in prisons to contribute to health system strengthening within correctional facilities and to help address health system issues at the interface between correctional facilities and health services.

The review team assumes that this does not require additional resources but rather requires a greater emphasis or refocus.

Recommendation 1.11: That AusAID continue to provide financial support for the National AIDS Commission's MSM Program for a further two years beyond the life of the existing initiative.

This recommendation would require additional resources of \$500,000 per year for two years.

Recommendation 2.1: That AIPH, through HCPI, develop a plan for a phased to the Provincial AIDS Commission of West Papua resources currently funding four positions in Provincial AIDS Commission in Papua. Further that HCPI continue to assist the Provincial AIDS Commission in Papua to identify means to resource positions currently funded by AIPH.

The review team assumes that this could be done within existing resources as it is part of the ongoing support to the Provincial AIDS Commission.

**Recommendation 2.2:** That HCPI support the Provincial AIDS Commissions to make necessary adaptations of the *Strategic Communication Plan for HIV and AIDS* to raise awareness of STI, ensure people know where to go for both STI diagnosis and VCT, how this will occur, and the benefits of early treatment. Further, that HCPI through its support to Provincial AIDS Commissions advocate, and provide technical assistance for, strategies to radically increase VCT for people at risk and that HIV testing be integrated with STI testing.

The review team assumes that this can be achieved within existing resources.

**Recommendation 2.3:** That AusAID and CHAI jointly undertake a rapid design for the proposed expansion to the Central Highlands in Papua of the HIV services and strengthening of the health systems. That the rapid design be timed to enable the expansion to begin by July 2012.

This recommendation will require additional resources. AusAID has advised the following:

	Fees	Airfares	Accommodation	Total
Team leader – 21 days	25,200	3,500	2,100	
SPM		1,000	750	
CHAI delegate		1,000	750	
HIV/Design expert	25,200	3,500	2,100	
<b>Total</b>	<b>50,400</b>	<b>9,000</b>	<b>5,700</b>	<b>\$65,100</b>

**Recommendation 2.4:** That a review of workload of the HIV and Communicable Disease Unit of AusAID be undertaken to enable stronger presence in Papua and closer oversight and adaptive management of activities related to Central Highlands project.

The review team assumes that this could be undertaken by the HIV and Communicable Diseases Unit by setting aside one or two days to work together to review this.

**Recommendation 2.5:** That, during the remaining period of the AIPH, AusAID, in partnership with its national and sub-national partners, instigate a grass-roots design process to develop the next AusAID-funded program of support to Papua and West Papua.

This recommendation will require additional resources. AusAID has advised this will be in the vicinity of \$200,000 (as of 2014).

**Recommendation 3.1:** That the Partnership Coordinating Committee membership be limited to representatives of the Subsidiary Agreement and its focus be on: i) matters pertaining to the various dimensions of an effective partnership; ii) strategic decisions; and iii) accountability for effective and efficient implementation of the AIPH as a whole.

This does not require any additional resources.

**Recommendation 3.2:** That, in order to more fully recognise the importance of all key parties of the partnership and to ensure all necessary high level partnership relationships are developed, AusAID and the Office of the Coordinating Minister for People's Welfare negotiate Memoranda of Understandings with the Ministry of Health, the Ministry of Justice and Human Rights, and the National Development Planning Board that clearly articulate their essential roles in the partnership, and the AIPH Subsidiary Agreement be amended accordingly.

The review team assumes that this would form part of the regular work of the Health Counsellor, Unit Manager and Senior Policy and HIV Advisor, AusAID.

Recommendation 3.3: That, as a means of further strengthening government capacity in the management of HIV-targeted resources, the Contingency Funds and Partner Grants be channelled through a government-based mechanism that has proven capacity with such transfer being planned for March 2013. Furthermore, that AusAID and the relevant agency agree annually upon strategic priorities for use of these grants and establish an agreed joint monitoring process.

The review team assumes that that this would form part of the regular work of the HIV and Communicable Disease Unit Manager, AusAID and the Team Leader, HCPI.

Recommendation 3.4: That, once the program theory for AIPH has been clearly articulated, a review of the cumulative effectiveness of the Partner Grants be conducted to ensure that they are contributing to the desired intermediate and longer-term outcomes.

The review team assumes that this review could be done by AusAID and HCPI using a jointly developed set of rubrics against which the effectiveness of the grants could be assessed. This should not require additional resources but rather a commitment of time.

Recommendation 3.5: That, in the absence of a single high level policy forum and in recognition that AusAID would benefit from a more formalised approach to policy and strategic discussions with major stakeholders, AusAID facilitate regular policy and coordination discussions between its major stakeholders, namely: the National AIDS Commission, the Ministry of Health, National Development Planning Board, AIPH managing contractors, USAID (and its managing contractors) and the Global Fund Country Coordinating Mechanisms. Among other policy issues, this forum be used to initiate discussions about how the current national mechanisms might evolve to: i) be more integrated and streamlined; and ii) be adapted or merged to provide the needed overarching high level policy discussion and coordination.

The review team assumes that this will not require additional resources but rather the re-prioritising of current efforts and meetings. It is recognised that refreshments and venue might requires some additional funds.

Recommendation 3.6: That AusAID, as an influential member of the Global Fund Country Coordinating Mechanism, support the Ministry of Health to address the current unintended negative consequences of some of the incentive arrangements in applications approved through the Global Fund Country Coordinating Mechanism by jointly advocating for any incentives to be aligned to existing health system incentive schemes and that they support, not hinder, needed health reforms.

The review team assumes that this would form part of the regular policy work of the Senior Policy and HIV Advisor, AusAID.

Recommendation 4.1: That AIPH Program Management staff achieve an integrated approach to AIPH by:

- facilitating six monthly joint meetings with CHAI, HCPI and the National AIDS Commission (MSM Initiative) to ensure the progress and issues of the major service delivery components are regularly considered together and understood, and more formal means of collaboration can be established; and
- bringing representatives of all the various components together on an annual basis to review AIPH progress and set, jointly, the priorities for the following year.

The review team assumes that this could be achieved within existing resources through adapting the existing schedules of meetings. The recommendation would be responsibility of the Program Manager, AusAID.

Recommendation 4.2: That, in recognition of the important interdependencies between the various AusAID programs, AusAID establish formal coordination mechanisms between AIPH, AIPD and HSS at the central level and at the local level in common provinces in which they are operating.

The review team assumes that does not require additional resources as it should form part of regular work.



**Recommendation 4.3:** That HSS include Papua as one of its provinces in the second stage roll out in order that a more systematic approach to strengthening health systems in Papua will support AIPH efforts and to gain added leverage from the proposed scale up.

The review team assumes that this would form part of the proposed HSS budget and workload.

**Recommendation 4.4:** That another iteration of the program theory be undertaken with key stakeholders to clearly articulate the AIPH's theory of change, the causal links between the different outcomes of AIPH, and the underlying assumptions. The updated program theory should then inform the proposed rapid design for the Papua scale up and be used to refine the Monitoring and Evaluation Plan, including updating success criteria and measures where relevant. This should form the beginning of a continuing iterative process.

This recommendation will require additional resources. AusAID has advised that this would form an additional component of the rapid design (recommendation 2.3) and have estimated the costs as follows:

	<b>Fees</b>	<b>Airfares</b>	<b>Accommodation</b>	<b>Other</b>	<b>Total</b>
Consultant	16,000	5,000	1,200		22,200
Workshop				1,000	1,000
					<b>\$23,200</b>

**Recommendation 5.1:** That AusAID undertake a joint review of the contract conditions with GRM (the managing contractor) to determine the impact of the suggested changes in emphases contained in the recommendations relevant to HCPI. This review should be undertaken in time for any design changes to be made prior to the conclusion of the current contract (Mar 2013) to ensure a smooth transition and prevent loss of momentum.

The review team assumes that the AusAID component of this would form a regular part of program and contract management and be the responsibility of the Program Manager. AusAID has advised that additional resources to cover a consultant for HCPI would be required at a total cost of \$11,600.

## Annex 2: Current situation

### Overview of the epidemiology

Indonesia is a lower-middle income country with a concentrated but highly heterogenic national HIV and AIDS epidemic. The epidemiological context varies greatly from population to population as well as from one geographical region to another. Indonesia, with an estimated 186,000 adults<sup>112</sup> living with HIV, has an overall adult prevalence of approximately 0.1 percent. However, the epidemic is concentrated among most-at-risk groups with the exception of Papua and West Papua where the epidemic is generalised.

With regard to the trajectory of the epidemic (the affected populations and geographical areas) it is possible to note that:

- HIV is especially prevalent (in several parts of the country) among: female commercial sex workers; waria (male-to-female transgender people); and, men who have sex with men.
- HIV is sexually transmitted and generalised in the two eastern provinces known together as Tanah Papua (Papua and Papua West).
- HIV is especially prevalent among injecting drug users and prisoners, mostly located in four provinces on the island of Java. The number of HIV infections is, however, rapidly spreading to and increasing in other provinces.<sup>113</sup>
- Unsafe injecting is no longer the dominant mode of infection; rather the dominant mode is now unsafe sex.

### Overview of the current national HIV response

The Government of Indonesia has made a commitment to addressing the HIV/ AIDS epidemic through:

- *National HIV and AIDS Strategy and Action Plan*;
- The 2006 Presidential Decree no 75 in which the National AIDS Commission secretary was made responsible directly to the President;
- Taking a whole-of-government approach by incorporating key stakeholders on the National AIDS Commission, including, 18 relevant ministries and agencies, and five civil society organisations, including some that represent people living with HIV; and
- Identifying 100 priority districts to have their own local AIDS Commissions and Secretariats.

In response to the epidemic, the strategy of the AIDS Commission is focused on:

- i. Coverage – with a view to achieve the widest possible coverage of HIV-related information, supplies and services;
- ii. Effectiveness of activity in reducing new infection and improving the quality of life for those already infected; and
- iii. Sustainability of the national response across the country.

Services have been gradually expanding over the past decade, with a more rapid increase since 2006, when the National AIDS Commission's status was enhanced. This expansion has been mainly due to the support of the international community. Key services include:

- *PMTCT*, the program for the prevention of vertical transmission from a woman to her unborn child, has been integrated in public health services in 79 locations with plans to scale up availability of these services.
- *VCT* (voluntary counselling and testing) sites have increased from 51 in 2004 to 388 by June 2011. These sites are located in hospitals, public health clinics, and in the prison system.
- *PITC* (Provider Initiated Testing and Counselling) which is already underway and scheduled for expansion, is helping to increase access to HIV testing.

<sup>112</sup> Ministry of Health estimation 2009

<sup>113</sup> Global Fund AIDS, TB and Malaria Round 8 reported that the HIV prevalence spread from 10 to 33 provinces within a four years period. Ministry of Health reported that in 2003, only 25 provinces reported HIV cases, now in 2011, all provinces in Indonesia (33) have reported AIDS cases.

- *ART* (antiretroviral therapy) services have increased from 25 hospitals in 14 provinces (2004) to 207 hospitals with 69 associated satellite public health centres by June 2011. Using resources from Global Fund to purchase the drugs, ART is provided free of charge in those locations. By 2010, the costs for antiretroviral (ARV) drugs were covered jointly by the national budget (70%) and Global Fund (30%), an important step toward sustainability of service.
- *Needle and Syringe Programs*: in 2002 there were no public services available to injecting drug users in 2002. By mid 2011 there were nearly 200 (194) needle syringe programs located in public health centres and non-government organisation facilities across the country.
- *Methadone maintenance treatment* services have also increased from only three sites 2005 to a total of 65 sites in 2011.
- There is now a widespread condom distribution program, particularly in key locations. As of July 2011 more than 13 million male condoms and nearly 550 thousand female condoms were distributed through 4,066 condom outlets.

## Overview of AIPH

Australian HIV activities in Indonesia are guided by the Australian Government's global strategy on HIV, the overall goal of which is to achieve the millennium development goal target of halting and beginning to reverse the spread of HIV and AIDS by 2015. Australia has provided support to Indonesia for addressing HIV since 1995. Since 2008, all Australian HIV activities in Indonesia have been framed within a new partnership, the Australia–Indonesia Partnership for HIV (AIPH). The \$100 million Program, which spans from 2008 until 2015, currently operates in nine provinces (DKI Jakarta, West Java, Banten, Central Java, Jogjakarta, East Java, Bali, Papua and West Papua).

The goals of the partnership, which mirror the Government of Indonesia goals in the National Strategy and Action Plan, are: to prevent and limit the spread of HIV; improve the quality of life of people living with HIV; and alleviate the socio-economic impacts of HIV/AIDS.

There are three long-term program objectives which aim to help achieve these goals:

- i. Strong Indonesian leadership of an effective and sustainable HIV response.
- ii. An increased and good quality HIV response.
- iii. A strategic partnership between Australia and Indonesia that supports the national HIV response.

AIPH uses various aid modalities to implement a range of activities: managing contractor (private sector and international non-government organisations); pooled funding; and specific contributions to multilaterals or civil society. It includes the following components:

- *HIV Cooperation Program for Indonesia* (HCPI) (\$45 million 2008-2013), which incorporates: strengthening Indonesian leadership on HIV issues; reducing HIV transmission among injecting drug users and in prisons; preventing the spread of HIV in Papua and West Papua; developing effective behaviour change approaches; and supporting a comprehensive program to address the sexual transmission of HIV in Bali. HCPI is managed by GRM.
- *Clinton Health Access Initiative* (CHAI) *Phase 2* (\$2.25 million 2010-2012) focuses on: improving supply chain management of anti-retroviral drugs and HIV test reagents; builds capacity for better care, support and treatment in Papua; and provides technical assistance to enhance national level HIV policies and guidelines. The initiative is managed by the Clinton Foundation.
- *Indonesia Partnership Fund for HIV* (IPF) *Phase 3* (up to \$1 million annually 2011-2013) is an important source of financial support for AIDS Commissions at national and sub-national levels. Funds are currently managed through United Nations Development Programme (UNDP) and implementation is by the National AIDS Commission.
- *MSM initiative* (\$1.5 million 2011-2013) supports the development of the national MSM<sup>114</sup> action plan and piloting MSM outreach programs in 10 locations. The initiative is a collaboration of HCPI and the National AIDS Commission.

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<sup>114</sup> MSM – an initiative for men who have sex with men

- *Contingency Funds* that support ad hoc, short-term strategic response projects. These funds are currently managed by AusAID.

More broadly, the AIPH also supports HIV mainstreaming within AusAID programs. It is also affiliated with the HIV Consortium for Asia and the Pacific and the HIV Alliance which build capacity of civil society and support HIV research.

## Annex 3: Contribution to national mechanisms

AusAID, both through participation of its own staff and that of its managing contractors, is contributing to each of these various mechanisms through a mix of time, financial resources and technical expertise. Specifically the contribution occurs in the following ways:

- National Aids Commission and selected Provincial and District Commissions:
  - Provision of intensive technical administrative support at both national and sub national in areas such as planning, coordination, budgeting and financing, monitoring and evaluation
  - Regular participation of AusAID personnel and staff from the managing contractors in a number of the Commissions' 12 working groups at the national level. These working groups assist with technical advice and cross-sector coordination for particular HIV issues
  - Provision of funds (initially through HCPI and later direct to the Commission) to support the development of the *National MSM Plan* and its implementation.
- Country Coordinating Mechanisms of the Global Funds for Aids, Tuberculosis and Malaria:
  - Regular participation of AusAID personnel in the 'Plenary' committee, which the key decision-making body
  - Regular participation of AusAID personnel in the 'Oversight' committee, which allows for decisions and actions between Plenary meetings
  - Regular participation of AusAID personnel in the 'core' component of the HIV Technical Working Group
  - Ad hoc participation of staff from the managing contractors on the broader HIV Technical Working Group
- Indonesia Partnership Fund:
  - Financial grant of \$1 million paid annually to support capacity strengthening of: i) AIDS Commissions and Secretariats in relation to oversight, coordination and facilitation of the National HIV Strategy and Action Plan; and ii) civil society organisations to implement HIV prevention and support services for HIV positive people
  - Regular participation of AusAID personnel in the Fund's Steering Committee, which provides oversight, makes policy decisions on strategic direction of the Fund, approves broad allocations, and reviews and approves financial and program reports
  - Regular participation of AusAID personnel in the Fund's Management Committee, which has responsibility for operational decision-making, approval of specific fund disbursement, and oversight of performance of Fund
- Civil society mechanisms:
  - Provision of funds through the HCPI component of the Program, which, among other things, support initiatives by civil society to: coordinate their efforts; strengthen their capacity to participate in national mechanisms; strengthen their capacity to participate in national mechanisms; and deliver HIV prevention programs and provide peer support for HIV positive people.

## **Annex 4A: Service delivery outcomes - Harm reduction**

### **Overview of HCPI's harm reduction work**

AIPH's support for HCPI's harm reduction programming aims to increase access by injecting drug users to good quality HIV programs and thereby prevent and reduce HIV transmission and improve the quality of life of people living with HIV. The package of harm reduction activities comprises:

- sterile needle and syringe distribution;
- methadone maintenance therapy;
- distribution of condoms;
- distribution of information, education and communication materials;
- one-to-one and small group education;
- HIV testing;
- primary health care, including TB and STI services; and
- linkages to HIV treatment, including antiretroviral therapy (ART).

These services are provided by community health centres, a small number of hospitals, and non-government organisations conducting outreach. Outreach services by non-government organisations include: needle and syringe distribution; condom and information, education and communication materials distribution; HIV and drug education; and referral to health services for HIV testing, needles, methadone, and primary health care.

HCPI is supporting harm reduction programming in seven provinces. All services are provided directly by the health sector and non-government organisations. HCPI's role is funding to either Provincial Health Offices or Provincial AIDS Commissions and technical support and capacity building to these organisations and District Health Offices, health services and non-government organisations.

The package of harm reduction services is comprehensive and consistent with international practice. There are, however, some recommendations for adjusting the approach taken to implementation and re-prioritisation regarding the balance of investment for some activities.

### **Scale up, coverage and quality of services**

Given the importance of providing programs at scale for achieving control over HIV epidemics among injecting drug users, this annex examines utilisation and coverage data for HCPI supported harm reduction services, with a particular focus on the key services of needle distribution and methadone.<sup>115</sup> The data presented only relates to HCPI-supported harm reduction services. Data related to harm reduction services supported by other sources of funding and technical assistance is not included in the data presented in this annex. The analysis assesses performance in relation to the two key outcomes of increased access to services and the quality of the harm reduction program.

### **Access to services**

Although there has been significant scale up of the number of health services providing harm reduction services and a significant increase in the number of clients being reached, coverage levels for needle distribution and methadone are at low levels.

### ***Geographic and service scale up***

In DKI Jakarta, West Java and Bali, where AusAID was supporting harm reduction programming under the previous bilateral program, HCPI is supporting an additional 21 community health centres operating needle distribution and 13 community health centres providing methadone. AusAID support for harm reduction programs in Central Java, East Java, Jogyakarta and Banten commenced with HCPI in 2008. By mid 2011, there were 35 community health centres conducting needle distribution and 12 offering methadone in these new provinces.

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<sup>115</sup> See Annex 4B for additional data for HCPI supported harm reduction programs. All data presented in this section is outlined in more detail in that Annex.

In total, as of August 2011, there were 91 community health centres conducting needle distribution, 31 community health centres or hospitals providing methadone, and 15 non-government organisations, linked to community health centres, providing outreach harm reduction services. The number of non-government organisations conducting outreach increased from 8 in 2009 to 15 by mid-2011.

### ***Access to and coverage of all harm reduction services***

There has been a significant increase in the number of injecting drug users being reached by HCPI supported harm reduction services. In 2010, 25,884 injecting drug user clients received one or more HCPI supported harm reduction services. This was a 64% increase in the number of clients who received harm reduction services in the previous year. Sixty seven percent of clients were seen by outreach services and 33% by community health centres or hospitals. However, as outreach services and community health centres share an unknown number of clients in common, the number of individual clients is an overestimate. This observation applies to all subsequent analysis regarding coverage levels for the harm reduction program as a whole and needle distribution.

In 2010, the number of clients seen by HCPI supported harm reduction services amounted to 31% of the estimated 83,103 injecting drug users in the seven provinces covered.<sup>116</sup> Total coverage achieved by non-government organisations outreach services was 21% and total coverage achieved by community health centres or hospital services was 10%. HCPI does not report data on the number of injecting drug users who receive particular types of services, with the exception of needles and methadone, so a breakdown of client utilisation and coverage for all services is not possible.

The National AIDS Commission estimates that the national coverage achieved by all harm reduction services has increased significantly in recent years and in 2010 was 48% of all injecting drug users.<sup>117</sup> This figure includes coverage by HCPI supported services. This represents an additional 17% coverage by non-HCPI supported services on top of the coverage of 31% achieved by HCPI supported services. While HCPI supported harm reduction services account for the largest portion of coverage, national coverage is well below the National AIDS Commission target of 80%.<sup>118</sup> In addition, as significant numbers of injecting drug users being reached by harm reduction services are not receiving sterile needles or methadone, the potential impact of coverage at this level is significantly diminished.

### ***Access to and coverage of needle and syringe distribution***

Although the number of needles distributed by HCPI supported services has grown significantly, only a low percentage of clients in contact with services actually received needles, which contributed to a low level of coverage for needle distribution. The number of needles and syringes distributed by HCPI supported services in 2010 was 632,436 which was more than double the number for 2009. However, in 2011, the rate of increase slowed to only 4%.

Of the 25,884 clients of harm reduction services in 2010, less than half (42%) received sterile needles. It is desirable for needle distribution programs to supply sufficient needles to clients so that a new, sterile needle is used on each occasion of injecting.<sup>119</sup> While this constitutes a high level target which could be considered aspirational, the number of needles distributed per client by HCPI supported services is significantly below this level.<sup>120</sup> The average number of needles distributed per month per client to the 42% of injecting drug users who received needles was 9 for non-government organisations and 19 for community health centres and hospitals.

<sup>116</sup> National AIDS Commission, Estimation of the size of the most at risk populations for HIV infection by province and sub-population. 2009. The estimated total number of injecting drug users in Indonesia was 105,784. The 83,103 injecting drug users in the seven provinces covered by HCPI represents 79% of the national estimate.

<sup>117</sup> National AIDS Commission, presentation to review team, July, 2011. The services provided as part of this coverage were not specified.

<sup>118</sup> National AIDS Commission, National HIV and AIDS Strategy and Action Plan 2010 – 2014. p. 83.

<sup>119</sup> Bluthenal, et al. (2007)

<sup>120</sup> Reuse of needles by the one injecting drug user does not constitute an HIV infection risk provided the needle has not been used by another person.

The 2011 HCPI behavioural survey found that 66% of participants who injected in the last year injected daily, with most of these injecting twice a day. This adds up to a high need for sterile needles.<sup>121</sup> As non-government organisations and community health centres are the primary sources of needles, it cannot be claimed that a large proportion of needles are being obtained from other sources. The 2011 HCPI behavioural survey found that the primary source for needles for 77% of clients was non-government organisations and community health centres, with other sources such as pharmacies and peers being the primary source for only 23% of clients.<sup>122</sup>

In 2010, needle distribution coverage by HCPI supported harm reduction services was only 13% of the estimated 83,103 injecting drug users in the seven provinces. Six percent of injectors were reached by a non-government organisations outreach service and 7% by a community health centre or hospital. To the extent that there are shared clients between non-government organisations and community health centre or hospitals, 13% is an overestimate. To the extent that some clients received needles on behalf of others who were not in contact with HCPI supported services, this is an underestimate. It is not possible to quantify these factors.

Provision of a package of complementary harm reduction services is important. However, the one service with the potential to have the greatest impact in terms of HIV infections averted is sterile needle distribution.<sup>123</sup> There is, however, no international consensus on the level of coverage for needle distribution needed to stabilise and reverse HIV epidemics among injecting drug users. Significant differences in key factors particular to the program setting means there is no coverage figure that is universally applicable.<sup>124</sup> Relevant factors include existing HIV prevalence levels among injecting drug users (with higher coverage needed to control high prevalence HIV epidemics such as in Indonesia), the quality of the needle distribution program, and the existence, quality and coverage of other harm reduction services which collectively contribute to reducing risk. WHO defines a high level of coverage as being greater than 60% of injecting drug users being reached regularly.<sup>125</sup> Containment and reversal of HIV epidemics among injecting drug users is most unlikely to be achieved unless there is a high level of coverage. The target in Indonesia's National AIDS Action Plan for needle distribution coverage is 80% of injecting clients reached by behaviour change communication programs.<sup>126</sup>

There is no data available to the review team which indicates the total number of sterile needles distributed/sold to injecting drug users per year from all sources. However, the low coverage levels for HCPI supported needle distribution, coupled with HCPI's high share of total coverage indicate that total national coverage levels are likely to be significantly less than the National AIDS Commission target and international guidance. It is particularly concerning that the growth rate in the number of needles distributed in the first half of 2011 has reduced significantly to an overall growth rate of 4%. The growth rate in needle distribution by community health centres and hospitals was 20%, while needle distribution by non-government organisations reduced by 14%.<sup>127</sup> This appears to be because of the government policy of favouring distribution by government health services, with non-government organisations being encouraged to refer clients to health centres for needles rather than being involved in distribution directly. The low number of clients seen by outreach raises the question of whether outreach is being conducted efficiently.

<sup>121</sup> HCPI, Injecting Drug User Behaviour and Service Satisfaction Survey, 2011. Draft. p. 7. This is an annual behavioural and service satisfaction survey conducted with different most at risk populations. All clients attending HCPI supported services over a three week period are asked to complete a self-administered questionnaire. As no sampling technique is used, the survey cannot be regarded as representative. Survey results should therefore be treated cautiously. Nonetheless, these surveys provide a mechanism for tracking key indicators over time. HCPI's process of feedback to service providers promotes opportunities for analysis and quality improvement.

<sup>122</sup> Health Outcomes International. (2002).

<sup>123</sup> HCPI, Injecting Drug User Behaviour and Service Satisfaction Survey, 2011. Draft. p. 17.

<sup>124</sup> Health Outcomes International. (2002).

<sup>125</sup> WHO, UNODC, UNAIDS. (2009). p. 16.

<sup>126</sup> *Ibid*, p.18. This is based on a retrospective analysis of the coverage required to reverse the HIV epidemic among injecting drug users in New York.

<sup>127</sup> National AIDS Commission, National HIV and AIDS Strategy and Action Plan 2010 – 2014. p. 83.

<sup>128</sup> However, the number of needles distributed by NGO outreach in 2010 increased by 144% compared to 2009.



The low overall coverage rates highlight the importance of reaching new clients. Because of the social marginalisation it is unlikely that many new injecting drug use clients will self-refer to government services. Outreach services are clearly essential to achieving higher coverage. There is a need for AIPH to engage in a policy dialogue with the National AIDS Commission, the health sector and police on rebalancing the needle and syringe program model so that the complementary key roles of both the health sector and non-government organisations in direct distribution is valued.

Strategies need to be devised to significantly increase needle distribution coverage. Issues that need to be addressed include:

- determining the appropriate balance of needle distribution between community health centres /hospitals and outreach, with a view to significantly increasing the number of needles distributed by outreach;
- how to increase the efficiency of both fixed outlets and outreach (e.g. increasing the opening hours of fixed outlets and increasing the number of clients reached by outreach and the proportion who receive needles);
- how to effectively reach sub-populations of injectors not currently being reached (e.g. university students and new injectors, particularly given the high incidence of HIV among new injectors<sup>128</sup>); and
- addressing obstacles to accessing needles identified in HCPI's behavioural surveys.

Service utilisation data indicates a significant slowing in the rate of expansion of outreach harm reduction services, especially compared to services provided by community health centres or hospitals. The trends in data are:

- Although the number of non-government organisation outreach clients in 2010 was more than double compared to 2009, the client growth rate in the first six months of 2011 was only 8%.
- The average number of non-government organisation outreach clients seen per month in the first half of 2011 declined by 16% compared to 2010.
- The number of new needle and syringe clients seen by non-government organisations has declined from 66% of all clients in 2009 and 2010 to 36% in 2011.
- The average number of needles distributed per client by non-government organisations has remained static at nine between 2009 and 2011.
- Each of the 15 non-government organisations conducting outreach saw an average of 20 clients per day (based on 21 working days per month).

While outreach will no doubt be an important mechanism for increasing coverage, the effectiveness of current outreach strategies need to be reviewed given the low number of clients seen per non-government organisation, per day and the even lower number of clients who receive needles.

There may also be potential for increasing the numbers of needles distributed by community health centres/hospitals. In 2010, an average of 1,524 clients per month were given needles by 90 community health centres/hospitals. Averaged out across the 90 health services, this amounts to only 17 clients per month or fewer than one a day. It should, however, be noted that the number of clients provided with needles by health services varies significantly by province. In DKI Jakarta, where 90% of needles are distributed by health services, the number of clients seen per community health centre was higher and in some other provinces the number was lower.

### ***Methadone maintenance therapy***

There has been a 35% increase in the number of active methadone clients in HCPI supported services from January 2009 to June 2011. However, the number of new methadone clients has reduced from 72% of all clients in 2009 to 25% of all clients in the first six months of 2011. This indicates a slowing of the rate of methadone use expansion.

As of June 2011, HCPI supported services accounted for 1,584 or 62% of all active methadone clients in Indonesia. The methadone coverage rate for HCPI supported services was 2% of the estimated number of injecting drug users in the seven focus provinces. The national methadone coverage rate is 2.5%.

<sup>128</sup> The 2007 found an HIV prevalence of 37% in injecting drug users in DKI Jakarta who had been injecting for 2 years or less.

The coverage target for methadone in Indonesia's National AIDS Action Plan is 30% of those reached by needle distribution programs.<sup>129</sup> WHO guidance is that a high level coverage for opioid substitution therapy is 40% or more of opioid-dependent people.<sup>130</sup>

Rates of methadone client retention are too low. In the first half of 2011, monthly client drop-out rates by province varied from 2 – 6% of all clients. However, many of these have ceased drug use or subsequently return to the methadone program as a new client.

The recent national opioid substitution review recommended that opioid substitution programs be dramatically scaled up and this is clearly needed. There is, however, the danger that opioid substitution therapy could be accorded higher priority than needle distribution as this strategy holds out the promise of reduced drug use and eventual cessation of drug use and is hence less sensitive. Needle distribution and methadone therapy should be seen as complimentary strategies, with needle distribution having the potential, at least in the short to medium term, of averting a greater number of HIV infections.

***Proposed recommendation:*** That AIPH support national and sub national partners to increase significantly the coverage of harm reduction services, especially needle and syringe programs and methadone. This can be achieved through: advocacy to address the policy and practice issues that constrain distribution of needles by outreach; greater efficiency of current distribution channels, especially outreach; development of strategies to address barriers; targeting injecting drug user sub-populations not currently being reached; and through advocacy for higher levels of investment by the Government of Indonesia in harm reduction, especially needle distribution and methadone.

### **Client unique identifier code**

The lack of a client unique identifier code across services means that it is not possible for HCPI to identify the extent to which the same clients are being reached by outreach and fixed site services at health services. This in turn means it is not possible to accurately calculate coverage rates for HCPI supported harm reduction services. The absence of a unique identifier code makes it difficult to track whether clients take up referrals to different types of health services such as HIV testing.

***Proposed recommendation:*** That HCPI provide technical assistance to health services and NGOs working with injecting drug users to establish a common client unique identifier code to improve the accuracy and completeness of service utilisation data.

## **Quality of services**

### ***The model***

Integration of harm reduction services within the health sector has allowed a range of primary health care services, in addition to sterile needles and methadone, to be provided to injecting drug users. A strength of the model is that harm reduction services are embedded in the health system. Site visits confirmed that, following initial reluctance by management and health care workers concerning adoption of a harm reduction approach, there is now growing and often strong acceptance of the necessity and efficacy of this work. This will help with sustainability. A weakness of the model is that many injecting drug users are not willing to attend mainstream health services. The deployment of non-government organisations to conduct outreach work is designed to counter this weakness.

Another weakness is that different harm reduction services have been placed in different community health centre rather than taking a 'one-stop shop' approach. For example, one community health centre might have methadone and HIV testing but no needle distribution and STI services, while another community health centre might have needle distribution and STI services but no methadone and HIV testing. This requires referral of clients between health services which results in some clients dropping-out.

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<sup>129</sup> National AIDS Commission, National HIV and AIDS Strategy and Action Plan 2010 – 2014. p. 83.

<sup>130</sup> WHO, UNODC, UNAIDS, Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users. 2009. p. 21.

The lack of co-location of services, the limited opening hours for needle distribution and methadone in community health centres and the varying level of discouragement of needle distribution by non-government organisations, collectively means that services are not focussed on ease of access for clients.

### **Behavioural outcomes**

HCPI's annual behavioural survey among injecting drug users found that not sharing needles in the last week increased from 64% in 2009 to 83% in 2011. This indicates significant behaviour change, which is plausibly attributable to HCPI supported interventions.<sup>131</sup>

### **Condoms and sexual risk behaviour**

Although the number of condoms distributed by HCPI supported services has increased significantly, the level of safer sexual practices by injecting drug users remains low. The number of condoms distributed to clients by HCPI supported services increased by 196% in the period January 2009 to June 2011. In the first half of 2011, each client in contact with a service received an average of one condom per month.

HCPI's behavioural surveys found that consistent condom use by injecting drug users who have regular partners declined from 32% in 2009 to 21% in 2011 and for casual partners increased marginally from 24 – 27% over the same period. There was, however, significantly greater consistent condom use with regular partners by injecting drug users who knew they were HIV-positive compared to those who had tested HIV-negative. In 2011, 42% of respondents who knew they were HIV-positive reported consistent condom use with regular partners, while only 10% of those who reported they had tested HIV-negative consistently used condoms use with regular partners.<sup>132</sup>

For casual partners, there was little difference in the rates of consistent condom use by HIV-positive and HIV-negative injecting drug users. It should be remembered that HCPI's behavioural surveys only capture clients of HCPI supported services. The 2007 IBBS that samples all injecting drug users found that knowledge of HIV status did not appear to influence condom use.

***Proposed recommendation:*** *That HCPI supported harm reduction services place greater emphasis on behaviour change communication strategies and condom distribution for prevention of sexually transmitted HIV, especially in regard to HIV-positive injecting drug users and their casual sexual partners.*

### **Methadone**

A number of issues relating to the quality of methadone maintenance therapy services need to be addressed. Key issues raised by the recent national opioid substitution review included: methadone doses are often too low, resulting in a continuation of needle use; there is a wide range in program quality; and the cost of treatment is unaffordable for some patients.

### **Client satisfaction**

Overall, there appear to be quite high rates of client satisfaction with harm reduction services. HCPI's 2011 injecting drug user behavioural survey found that 67% of clients were satisfied with the methadone program and 71% with needle distribution programs. Obstacles identified by clients to accessing harm reduction services were transport issues (25%); concerns regarding safety and the police (21%); too busy working (21%); opening hours (14%); confidentiality (12%); and the types of services on offer (8%).<sup>133</sup> Addressing these obstacles would help to improve the frequency of client access and possibly total coverage.

<sup>131</sup> It should be noted that the HCPI surveys are not fully comparable. For example, the 2009 survey was conducted in three provinces and the 2011 survey in seven provinces. As the IBBS surveys use sampling techniques data from these surveys give a more reliable indication of the extent to which behaviour change has taken place. The results of the 2011 IBBS were not available at the time of writing.

<sup>132</sup> HCPI, Injecting Drug User Behaviour and Service Satisfaction Survey, 2011. Draft. p. 29. The question on knowledge of HIV status and its effect on behaviour was asked for the first time in 2011.

<sup>133</sup> HCPI, Injecting Drug User Behaviour and Service Satisfaction Survey, 2011. Draft. p. 31.

## Referrals

A higher number of referrals to other health care services is needed to take advantage of the involvement of community health centres in harm reduction services. Although the number of injecting drug users referred by non-government organisations to health services for HIV testing increased at a rate of 182% from January 2009 to June 2011, this was from a small base. The 1,094 clients referred for HIV testing in the first six months of 2011 represented only 12% of clients reached by non-government organisation outreach services. While referral rates to other services have also increased, they too are at quite low rates: (January to June 2011 - methadone: 5% of outreach clients referred; primary health care: 27% of outreach clients referred). HCPI does not collect data on the number of clients who attend the services to which they are referred.

## Access to ART

Currently, access to ART by injecting drug users in Indonesia is largely confined to those who have been stabilised on opioid substitution therapy. Most injecting drug users in Indonesia do not commence on opioid substitution therapy until reasonably late in their 'injecting careers' when many have been HIV-positive for some years. It is not uncommon for injecting drug users to commence ART with CD4 counts significantly below 350, the recommended level for initiation of treatment. This means that many are not able to take advantage of the well documented, substantive benefit of starting treatment earlier. In addition, although all the evidence of treatment as prevention relates to sexual transmission, with no evidence as yet relating to blood-to-blood transmission, effective ART will significantly reduce the risk of HIV transmission by injecting drug users to their sexual partners.

Restrictions on access to ART for injecting drug users are based on the assumption that they are poor candidates for treatment because of their drug dependence and its effect on adherence, and other complications such as co-infection with hepatitis C. Achieving success in HIV treatment for injecting drug users does require attention to special needs. However, extensive experience and numerous studies have documented good adherence to ART by injecting drug users and the ability to cater to special needs without compromising the effectiveness of treatment.<sup>134</sup> Given the reluctance of many injecting drug users to use hospital services, improving their access to ART would best be accompanied by increasing the number of health services that can provide treatment. WHO has recommended that the clinical and immunological criteria for initiating ART among HIV-positive injecting drug users should not differ from its standard recommendation for initiation of treatment.<sup>135</sup>

It is recognised that provision of ART is a Government of Indonesia responsibility and outside the scope of HCPI support. Nonetheless, broadening current practice regarding when to initiate HIV treatment for injecting drug users, based on the personal and public health benefits to be gained and as part of a comprehensive, integrated approach to HIV programming is an issue that should be on HCPI's advocacy agenda.

**Proposed recommendation:** *That AIPH advocate for a change to current practice which limits access to ART to injecting drug users who are receiving opioid substitution therapy. Technical assistance in the development of appropriate standard operating procedures and capacity building to cater for the special needs of injecting drug users on ART should be offered by HCPI and CHAI. This should be accompanied by a concerted effort by HCPI harm reduction services to promote uptake of treatment for those who meet equitable ART eligibility criteria.*

## HIV testing

The 2011 HCPI behavioural survey found that a reasonably low number (29%) of injecting drug users had never had an HIV test. Data was not collected on how recently respondents had been tested. The survey is not likely to be representative of all injecting drug users as the respondents were in contact with a health service or a non-government organisation. In addition, 75% of respondents were currently on methadone. HIV testing is commonly associated with methadone enrollment. In contrast, the 2007 IBBS found that only 30% of injecting drug users had been tested for HIV in the previous year. It is not clear whether there has been a significant increase in the numbers tested since 2007. The yet to be released 2011 IBBS data will provide an update on this key indicator.

<sup>134</sup> World Health Organization, Evidence for action on HIV/AIDS and injecting drug use. Policy brief: Antiretroviral Therapy and Injecting Drug Users. 2005.

<sup>135</sup> *Ibid.*

Data indicating increased safe sexual behaviour by HIV-positive injecting drug users with their regular partners points to the opportunity of using an HIV diagnosis for delivery of safe behaviour messaging. In addition, if HIV treatment for injecting drug users is to be scaled up, consistent with the recommendation above, this would require a greater emphasis on the importance of HIV testing. This has started in a limited way through the adoption of a provider initiated testing and counselling approach in some health services. However, in a number of health services visited by the review team the approach taken was a hybrid of provider initiated testing and counselling and voluntary testing and counselling. Patients in particular clinics (e.g. the STI clinic) would be assessed for HIV risks, rather than being routinely offered an HIV test. Only those with risk factors were considered candidates for testing. They were referred to the voluntary testing and counselling clinic for counselling and possible testing. Brief counselling and testing did not occur in the clinics where clients were first seen. Currently, HIV testing is generally only available in community health centres and hospitals and not on an outreach basis.

***Proposed recommendation:*** *That the harm reduction model promoted by HCPI place greater emphasis on encouraging all injecting drug users to know their HIV status through regular HIV testing. This should be achieved by improving the application of provider initiated testing and counselling; encouraging health services to make HIV testing more accessible by provision of outreach testing services; provision of technical assistance which practically addresses current obstacles to HIV testing; and development of strategies on how to significantly increase demand for HIV testing.*

### **National policy and coordination**

Responsibility for national policy and oversight of opioid substitution therapy rests with the Health Improvement Unit in the Ministry of Health. There is, however, no similar national level 'policy home' within the Ministry of Health for needle distribution. This is despite the significant involvement of the health sector in needle distribution at provincial, district and service delivery levels. By default, advocacy, policy leadership and national oversight for needle distribution has been taken up by the National AIDS Commission. The Commission's role in needle distribution has been cemented as a Global Fund principal recipient. The National AIDS Commission, with AusAID support, has filled an important gap by promoting and protecting needle distribution programs. However, in the interests of sustainability it is important that a policy home for needle distribution be found in a mainstream ministry such as Ministry of Health.

***Proposed recommendation:*** *That AusAID and HCPI advocate for the Ministry of Health to take on an active national policy, oversight and coordination role in relation to needle distribution.*

## Annex 4B: Data on HCPI supported harm reduction services

This Annex contains an analysis of the harm reduction program data in HCPI's six monthly progress reports. While the data in the tables below is drawn from the progress reports, additional analysis has been conducted and new data derived from these reports is presented.

In calculating the percentage increase for some service activity levels between the 12 months in 2009 – and the first six months in 2011, (i.e. the most recently available data), it has been assumed that the rate of increase in the level of activity for the first six months of 2011 will be maintained in the second half of the year. In other words, for some activities the data for 2011 has been doubled to give a full year effect. Where this is the case, the percentage increase is highlighted in yellow. Nonetheless, the service activity data in the columns headed '2011 January - June' is the actual activity level recorded for those six months only.

### Overview of coverage of HCPI supported harm reduction services

In 2010, a total of 17,456 individual IDUs received one or more of the range of HCPI supported harm reduction services from non-government organisation outreach.<sup>136</sup> In the same year, 8,428 individual injecting drug users received one or more of the range of HCPI supported services available from health services (fixed sites). There has been rapid although uneven growth in the number of injecting drug user clients of non-government organisation outreach and health services. For health services, if the rate of increase for the number of individual injecting drug user clients seen in the first half of 2011 is maintained in the second half of the year, the annual growth rate will be 252%. The client growth rate for non-government organisation outreach services for the same period is only 8%, although the number of outreach clients more than doubled from 2009 to 2010 (Table 1).

Although the total reach for all types of non-government organisation outreach services in 2010 was 17,456, the average number of clients seen per month was significantly lower at 6,164 (Table 1). This translates to each of the 15 non-government organisation conducting outreach seeing 20 injecting drug users per day (based on 21 working days in a month). Data on the monthly average of injecting drug user clients seen by health services is not available.

**Table 1: Number of IDUs reached by HCPI supported harm reduction services: non-government organisation outreach services\* and health services ^ by year, January 2009 – June 2011**

	2009 Jan – Dec		2010 Jan – Dec		2011 Jan – June		% Increase 2009 - 2011
	Monthly average	Annual total #	Monthly average	Annual total #	Monthly average	6 month total #	Monthly average
<b>Clients of outreach services</b>	1905	8151	6164	17456	5206	9431	173
<b>Clients of health services</b>	Not available	7591	Not available	8428	Not available	14830	Not available

\* This includes all outreach services such as NSP, condom and IEC distribution and referral to health services.

^This includes all PKM services such as NSP, condom distribution, HIV tests, and primary health care.

# The annual total is the number of individual clients seen in that year. Many clients will access services on more than occasion per year. The monthly average is the total number of client visits for the year divided by 12.

Table 2 outlines the coverage achieved by HCPI supported harm reduction services. In the seven provinces where HCPI is undertaking harm reduction work there are an estimated 83,103 injecting drug users. Coverage has been calculated by a number of variables:

1. For all non-government organisation outreach services: 21%
2. For all health services: 10%

Taking these two figures together, total coverage for all harm reduction services (outreach and health services) was 31%. As non-government organisation outreach services and health services have some clients in common (i.e. the same people would be accessing both types of services) the coverage level of 31% is an overestimate. There is no data to indicate the extent to which these services share clients.

<sup>136</sup> Outreach services are predominantly provided by non-government organisations, working in liaison with community health centres

Injecting drug user coverage for needle distribution was 6% for outreach services and 7% for health services, giving a total coverage of 13%. Needle and syringe program coverage is a subset of the coverage for all harm reduction services. In other words, the 13% is part of the 31% total coverage and not additional coverage. As outreach services and health services would distribute needles to the same clients, the coverage level of 13% is an overestimate.

**Table 2: Coverage achieved by HCPI supported harm reduction services, 2010**

Est No. IDU: 7 Provinces*	No. IDU reached by all outreach^ (1)	No. IDU reached by NSP outreach (2)	No. IDU reached by all PKM/Hosp services** (3)	No. IDU reached by PKM/Hosp NSP (4)	No. IDU reached by all outreach & PKM/Hosp services (1 + 3)	No IDU reached by all HCPI supported NSP (2 + 4)
83,103	17456 (21%)	4997 (6%)	8428 (10%)	5776 (7%)	25884 (31%)	10773 (13%)

\* This is the estimate of the number of IDU in the 7 provinces where HCPI is supporting harm reduction work.

^ This includes all outreach services such as NSP, condom and IEC distribution and referral to health services.

\*\* This includes all PKM services such as NSP, condom distribution, HIV tests, and primary health care.

Coverage has been calculated for 2010, the most recent year for which full year data is available. The reason 2010 data has been used is that the significant number of new clients per month in 2011 means that coverage estimates using only the first 6 months data from 2011 would be an underestimate of annual coverage.

## Needles and syringes

From January 2009 to June 2011, the average number of needle and syringe program clients seen per month by outreach services increased by 106% and for health services by 73%. However, the percentage of new clients for needle and syringe program services has been declining, indicating a slowing of growth rates for coverage. New clients made up 66% and 71% of clients for outreach and fixed site services respectively in 2009. In the first half of 2011, the percentage of new clients declined to 36% and 58% respectively for outreach and fixed sites (Table 3).

The average number of needle and syringe program clients<sup>137</sup> seen each month by outreach services in 2010 was 3,308 (Table 3). This is 54% of the monthly average number of clients for all types of outreach service. This meant that on average, only 11 out of 20 injecting drug users seen by an outreach worker received sterile needles.

The total number of needle and syringe clients of health services in 2010 was 5,766 which was 69% of all harm reduction clients for this type of service. However, these clients were seen relatively infrequently, with the monthly average number of clients being 1,524. HCPI has not provided data on the monthly average number of clients for all types of health services harm reduction services. This means it is not possible to calculate the percentage of the monthly average number of clients who received needles.

In 2010, health services had a higher number of needle and syringe program clients (5,766) than outreach services (4,997). The health services share of these clients was 54% and the outreach share was 46%. The reason for this may relate to the preference to refer injecting drug users to health services for needle distribution and/or could relate to the level of efficiency of outreach services.

In summary, health services have a higher number of needle and syringe program clients than outreach services, but outreach services see their clients more frequently.

<sup>137</sup> That is, the number of IDU provided with needles and syringes.

**Table 3: Number of NSP clients of HCPI supported NGOs NSP outreach services and PKM/Hospital NSP sites by year, January 2009 – June 2011**

	2009 Jan – Dec		2010 Jan – Dec		2011 Jan – June		% Increase 2009 - 2011
	Monthly average	Annual total #	Monthly average	Annual total #	Monthly average	6 month total #	Monthly average
<b>NSP outreach</b>	1092	2960	3308	4997	2251	2943	106
<b>NSP PKM/Hosp</b>	997	2736	1524	5766	1726	3441	73
<b>NSP outreach</b>	66		66		36		-
<b>NSP PKM/Hosp</b>	71		89		58		-

# The annual total is the number of individual clients seen in that year. Many clients will access services on more than occasion per year. The monthly average is the total number of client visits for the year divided by 12.

The number of needles distributed from 2009 to 2011 has grown by 130%, assuming the growth rate achieved in the first six months of 2011 is maintained for the remainder of the year. Growth in needles distributed was higher for health services (144%) than for outreach (109%).

In 2010, 54% of needles were distributed by health services fixed sites and 46% by outreach. In the first six months of 2011, fixed sites increased their share of total needle distribution to 62%. In the first six months of 2011, the number of needles distributed by non-government organisations doing outreach reduced by 14% (Table 4).

**Table 4: Number of needles and syringes distributed by HCPI supported PKM/Hospital NSP sites and NGOs/PKM NSP outreach by year, January 2009 – June 2011**

Type of service	2009 Jan – Dec	2010 Jan – Dec	2011 Jan – June	% Increase 2009 - 2011
<b>NGO outreach</b>	118913	290418	124464	109
<b>PKM/Hospital sites</b>	167856	342018	204681	144
<b>Total</b>	286769	632436	329145	130

The share of needles distributed between health sector and outreach varies significantly between provinces. For example, in DKI Jakarta, 90% of needles are distributed through the health sector. In Yogyakarta and Banten, needles and syringes are provided by the public health sector, with no involvement of non-government organisations. However, in West Java and East Java, non-government organisations accounted for 75% and 64% respectively of needle distribution in 2010. (See Table 5.)

The proportion of needles distributed by province is reasonably similar to each province's proportionate share of the estimated IDU population, indicating that scale up in the four new provinces has been achieved in a relatively short period of time. There is, however, a somewhat higher proportion of needles distributed in provinces where AusAID was supporting harm reduction work prior to AIPH, especially DKI Jakarta, and a somewhat lower proportion in the newer provinces, especially Baten. (See Table 5.)

**Table 5: Number of needles and syringes distributed by NGO outreach and PKM/Hospitals by province, 2010**

	N&S distributed	% Distributed by NGO outreach	% Distributed by PKM/Hospitals	% of N&S distributed	% share of estimated IDU population*
<b>DKI Jakarta</b>	248327	10	90	40	34
<b>West Java</b>	146508	75	25	23	21
<b>Bali</b>	32110	64	36	5	4
<b>Central Java</b>	56953	86	14	9	10
<b>East Java</b>	135552	64	36	22	27
<b>Yogyakarta</b>	2521	0	100	0.5	1
<b>Baten</b>	465	0	100	0.1	4
<b>TOTAL</b>	622436	46	54	100	100

\* The total estimated IDU population in the 7 HCPI provinces is 83,103. This column shows the percentage share of this population by province.

The average number of needles and syringes distributed per injecting drug users per month by HCPI supported outreach services remained static at nine over the period January 2009 to June 2011. Over the same period, health services fixed sites increased the average number of needles distributed per month from 14 to 20, an increase of 43% (Table 6).



**Table 6: Average number of needles and syringes distributed to IDU per month by HCPI supported PKM/Hospital NSP sites and NGO outreach by year, January 2009 – June 2011**

Type of service	2009 Jan – Dec	2010 Jan – Dec	2011 Jan – June	% Increase 2009 - 2011
NGO outreach	9	9	9	0
PKM/Hospital (2009 & 2010)	14	19	20	43
Hospitals (2011)	-	-	10	-

The data in Table 7 is a subset of the data in Table 2, above. The data in Table 7 is for coverage of NSP services only based on the total number of NSP clients on an annual basis.

**Table 7: Coverage achieved by NSP outreach and fixed services, 2010 (based on total client numbers for the year)**

Est No. IDU: 7 Provinces	No. IDU NSP outreach clients	% IDU covered by NSP outreach	No. IDU NSP fixed site clients	% IDU covered by NSP fixed sites	Total IDU NSP clients: outreach + fixed	% IDU covered by fixed & outreach NSP services*
83,103	4997	6	5766	7	10773	13

\* As some clients of NSP outreach would also be clients of NSP fixed sites this may be somewhat of an over-estimate. Also, the monthly average of clients receiving needles and syringes is significantly less than the total number of clients receiving needles and syringes for the year. See the next Table for data on coverage measured by the monthly average of clients.

The data in Table 8 presents needle and syringe program coverage for both outreach services and health services based on the average number of clients receiving needles and syringes per month. The coverage for all types of needle and syringe program services, using the average monthly number of clients in 2010 was 6%.

**Table 8: Coverage achieved by NSP outreach and fixed services, 2010 (based on the average number of clients receiving needles and syringes per month)**

Est No. IDU: 7 Provinces	No. IDU NSP outreach clients: monthly average	% IDU covered by NSP outreach: monthly av	No. IDU NSP fixed site clients: monthly average	% IDU covered by NSP fixed sites: monthly av	Total IDU NSP clients: outreach + fixed: monthly av	% IDU covered by fixed & outreach NSP services: monthly av
83,103	3308	4	1524	2	4832	6

## Methadone

The number of active methadone clients in HCPI supported services has increased by 35% from January 2009 to June 2011. Over this same period, the number of new clients as a percentage of all active clients has reduced from 72% in 2009 to 25% in 2011. This indicates a slowing in the growth rate of the methadone program. However, HCPI supported methadone services have been growing at a faster rate compared to other methadone services. In 2009, methadone clients in HCPI supported services accounted for 56% of all methadone clients in Indonesia. By 2011, the share of clients in HCPI supported services had increased to 62% (Table9).

**Table 9: Active and new Methadone clients in HCPI supported services by year, January 2009 – June 2011**

	2009 Jan – Dec	2010 Jan – Dec	2011 Jan – June	% Increase 2009 - 2011
Active clients: HCPI	1170	1542	1584	35
New clients: HCPI	840	980	395	-
% New clients: HCPI	72	64	25	-
Total clients: Indonesia	2086	2545	2536	22
% HCPI contribution	56	61	62	-

## Condoms, information, education and communication, and referrals

There has been a significant increase in the number of condoms distributed to injecting drug users by HCPI supported services, from a low baseline figure. Total growth from 2009 to 2011 was 196%, assuming that the growth rate achieved in the first six months of 2011 is maintained in the second half of the year.

**Table 10: Number of condoms distributed to IDUs per year by HCPI supported PKM, Hospitals and NGOs, January 2009 – June 2011**

	2009 Jan – Dec	2010 Jan – Dec	2011 Jan – June	% Increase 2009 - 2011
Number of condoms	88679	158498	131213	196

There has been a significant increase in the number of information, education and communication packets distributed to injecting drug users by HCPI supported services. Total growth from 2009 to 2011 has been 101%, assuming that the growth rate achieved in the first six months of 2011 is maintained in the second half of the year.

**Table 11: Number of IEC packets distributed to IDUs by HCPI supported NGOs by year, January 2009 – June 2011**

	2009 Jan – Dec	2010 Jan – Dec	2011 Jan – June	% Increase 2009 - 2011
Number of IEC packets	29657	52934	29764	101

Table 12 presents data on the number of injecting drug users referred by HCPI outreach services to health services for different types of services. There has been significant growth from 2009 to 2011 in referrals for all types of services, particularly for HIV testing and methadone. However, the total number of referrals as a percentage of total clients of outreach services is quite low. Data on referrals to other services health services is not available. This means it is not possible to get a full picture of the extent to which injecting drug users are referred to other services.

**Table 12: Average number of IDUs referred per month to health services by HCPI supported NGOs by year, January 2009 – June 2011**

Type of service referred to	2009 Jan – Dec	2010 Jan – Dec	2011 Jan – June	% Increase 2009 - 2011
HIV testing	775	1590	1094	182
Methadone	357	645	476	167
NSP in Community health centre	3322	4580	2875	73
Health care (not ARV)	2779	2554	2517	81

### **Level of activity by outreach services (all outreach)**

- In 2010, HCPI was supporting 15 non-government organisations.
- During 2010, on average a total of 6,164 injecting drug users were reached each month by the 15 non-government organisations (note: data is for all types of outreach services).
- The average number of injecting drug users reached per month per non-government organisation for all types of outreach services was 411.
- The average number of injecting drug users reached per day per non-government organisation for all types of outreach services was 20 (based on 21 working days per month)

### **Level of activity by Needle and Syringe Program outreach**

Note: this analysis is based on the number of clients who received a needle and syringe from an outreach worker in 2010.

- In 2010, on average a total of 3,308 clients were seen each month by the 15 non-government organisations.
- This means that each non-government organisation distributed needles to an average of 221 injecting drug user per month.
- The average number of injecting drug users who received needles and syringes from an outreach worker per day per non-government organisation was 11 (based on a 21 day working month).

### **Level of activity by health services Needle and Syringe Program fixed sites**

Note: this analysis is based on the number of clients who received a needle and syringe from a health service in 2010.

- In 2010, an average of 1,524 clients were seen each month by the 90 health services doing needle and syringe exchange.
- The average number of injecting drug users given needles and syringes per month per health service was 17.
- The average number of injecting drug users given needles and syringes per day per health service was 0.8.

## Annex 5: Terms of Reference

### 1. Background

Indonesia has one of the fastest growing HIV epidemics in Asia. Since 2000, HIV prevalence has been consistently over 5% in several key populations such as injecting drug users, sex workers, transgender and men who have sex with men (MSM) leading to the classification of the Indonesian epidemic as a concentrated epidemic. However, the epidemiology of the HIV epidemic in Indonesia is showing a shift from injecting drug use as the main form of transmission to sexual transmission. In the two provinces of Papua and West Papua, the epidemic is categorized as a low-level generalised epidemic, where it is driven primarily by unsafe sexual intercourse. In 2006 it was estimated that there were 193,000 adults living with HIV in Indonesia. By 2009 the estimated number of people living with HIV (PLHIV) increased to 333,200. Although Indonesia is making progress, it is unlikely to achieve MDG 6 (halting and beginning to reverse the spread of HIV).

The Indonesian National AIDS Commission (NAC) under the Coordinating Ministry for People's Welfare is responsible for leading and coordinating the response to HIV in Indonesia, involving other government agencies, international partners and civil society organisations. The National HIV Strategy and Action Plan 2010-14 was developed incorporating lessons from and findings from the previous action plan and contains a comprehensive set of strategies and prioritized activities and is in line with Indonesia's Mid-Term National Development Plan. The document provides a reference for all actors involved in aiding the Indonesian Government to implement a well focused, intensive and comprehensive response to HIV and AIDS. The strategy will also be used as an instrument to direct and mobilize funds from the national international level.

### 2. Program Description

AIPH uses various aid modalities: managing contractor (private sector and international NGO), pooled funding and specific contributions to multilaterals or civil society to implement a range of activities. The Partnership builds on over ten years of Australian assistance in the HIV sector in Indonesia. The \$100 million program which spans from 2008 until 2015 seeks to prevent and limit the spread of HIV, improve the quality of life of people living with HIV and alleviate the socio-economic impacts of HIV/AIDS. By the end of 2010 AIPH covered a total of six provinces (West Java, Central Java, East Java, Bali, Papua and West Papua).

Despite the fact that a lot of the funding for the HIV response in Indonesia is externally sourced, the program takes a partnership approach to development, requiring a substantial amount of time and effort to develop mutual understanding between implementing teams and the partner government. Past programs have taken more of a 'project' approach where activities are decided by the program funder rather than in coordination with the partner government. The approach requires a different way of working and interacting to ensure that the government is in the driver's seat. It is hoped that over time this approach will help to ensure the government is able to source and manage more of their own funds for the response.

The main elements of the Partnership are:

- *HIV Cooperation Program for Indonesia (HCPI)* (\$45 million 2008-2013) focuses on strengthening Indonesian leadership on HIV issues and reducing HIV transmission among injecting drug users and in prisons. In addition it also has a focus on preventing the spread of HIV in Papua and West Papua on developing effective behaviour change approaches and supporting a comprehensive program to address the sexual transmission of HIV in Bali. The Cooperation is managed by GRM on behalf of AusAID.
- *Clinton Health Access Initiative (CHAI) Phase 2* (\$2.25 million 2010-2012) continues to improve supply chain management of anti-retroviral drugs (ARV) and HIV test reagents, builds capacity for better care, support and treatment in Papua and provides technical assistance to enhance national level policies and guidelines. The initiative is managed by the Clinton Foundation.

- *Indonesia Partnership Fund for HIV (IPF) Phase 3* (up to \$1 million annually 2011-2013) is an important source of financial support for AIDS Commissions at national and sub-national levels. Funds are managed through UNDP and implementation is by the National Aids Commission (NAC).
- *MSM initiative* (\$1.5 million 2011-2013) supports the development of the national MSM action plan and piloting MSM outreach programs in 10 locations. The initiative is a collaboration of HCPI and the NAC.
- HIV mainstreaming within AusAID programs, for example, in the infrastructure and education sector through provision of technical inputs.

AusAID Regional Initiatives managed in Canberra (HIV Consortium for Asia and the Pacific and the HIV Alliance<sup>138</sup>) which build capacity of civil society and support HIV research also have relevance to AIPH.

AIPH program objectives are:

- strong Indonesian leadership of an effective and sustainable HIV response.
- an increased and good quality HIV response.
- a strategic partnership between Australia and Indonesia that supports the national HIV response.

### 3. Context and Key Issues

It is difficult to provide a concise overview of the context in which the HIV program is operating. However, there are some contextual factors that have come to light during the initial stages of AIPH implementation which are worth considering as background for this IPR.

Donor funding accounts for about 40% of the overall spend on the HIV response in the country. The role of donor funds remains very high for HIV relative to other diseases or programs in the health sector in Indonesia. While Indonesia intends to reduce this amount to 30% by 2012, it is not clear if this can be achieved. However it is likely that national and local budget allocations will continue to increase. Against this scenario, it is timely to consider the role of donors in the HIV response in Indonesia.

In considering the role of donors in the HIV response it should be recognized that since the initiative commenced, the role and scope of Global Fund activities has grown. At the same time, DFID has ceased funding for the response in Indonesia and USAID has reoriented its program.

National policy development for HIV is progressing both at the peak level (with the National HIV Strategy and Action Plan 2010-2014) and in line ministries, however policy developments remain slow. At the sub-national level, there is poor progress in the development and implementation of HIV policy.

It is worth noting that the focus of AIPH is on injecting drug users and prisons. Yet, there is seemingly a change in the epidemic emerging; moving from injecting drugs as the main form of transmission to sexual transmission. In Papua, West Papua and Bali, AIPH has a broader focus, particularly with the care, support and treatment (CST) work by the Clinton Foundation and we will need to consider the future of this work.

Other key issues which arise in reference to the HIV response in Indonesia include the drivers for HIV policy development in Indonesia and the respective roles of the NAC and MOH in policy and service delivery as well as the involvement of sub-national governments and civil society. The roles of NAC and Ministry of Health (MOH) are evolving, but the policy direction is not entirely clear. Sub-national commitment to the HIV response is growing but results are not all that evident on the ground. The role of civil society has not been pivotal but it is important to the HIV response.

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<sup>138</sup> A review of the Consortium was carried out in 2010.

AIPH has a significant component on “Leadership”, and this has mainly been focused on the National AIDS Commission. This has contributed to the National HIV and AIDS Strategy and Action Plan. However, broader policy responses in national line agencies and at the sub-national level are needed for the realisation of a sustainable and effective HIV response. While it is not possible for AIPH to address these broad policy demands, it would be useful to assess our role and impact in this area.

There is substantial ownership of AIPH by the Indonesian government and the Partnership Coordinating Committee is jointly chaired by NAC and AusAID. The Indonesian government’s vision for its HIV response is largely driven by MDG targets and is expressed in the HIV Strategy and Action Plan 2010-14. There is a need to further deepen ownership of AIPH by the government of Indonesia and for example, HCPI is implemented with an intention for progressive integration with government systems.

Scaling up the HIV response in Papua and West Papua is an imperative of the government and is also an intention of AIPH. The review should offer an analysis of AIPH work in Papua and Papua Barat to date and whether it provides a strong platform for more work in this area.

Under the Australia-Indonesia Partnership, Australia supports a range of health sector programs apart from AIPH. These include maternal and neonatal health in Eastern Indonesia and emerging infectious diseases programs. A new activity, currently in the design phase, aims to strengthen health systems, initially in the area of health financing and health workforce. This new health systems strengthening (HSS) program will potentially become the main health sector activity supported by Australia. AIPH and other activities will to varying extents link in to the HSS program where it would bring about greater efficiencies and effectiveness.

#### **4. Objectives of the Evaluation**

It is timely to have an evaluation of the program in its fourth year of implementation to track progress towards the objectives, and to determine whether changes need to be made within the program. Essentially, the overall purpose of the Independent Progress Review (IPR) is to provide recommendations to AusAID on the progress of the program and what may be required to improve it. Key evaluation questions which will help to reach some of these broader conclusions are outlined in their own section below.

Key dates are:

- End of 2015: the Subsidiary Arrangement between the GOA and the GOI expires at the end of 2015.
- The fifth year of Presidential Regulation No. 75/2006 on establishment of Indonesia National AIDS Commission to response AIDS in Indonesia.
- 2012: Current contracts for the IPF and CHAI will end.
- April 2013: The current contract between AusAID and the implementation service provider (ISP) for HCPI will end with an option to extend for up to three years.

AusAID will consider the recommendations of this review when deciding the future of the program. The primary audience of the evaluation will be the management team within AusAID and the members of the AIPH Partnership Coordination Committee (PCC): the NAC, Ministry of Health (MOH), Coordinating Ministry for People’s Welfare, Ministry of Law and Human Rights and civil society organisations.. All members of the PCC are aware of the review.

#### **5. Scope**

The Independent Progress Review will assess and rate the program’s performance against a number of AusAID’s evaluation criterion of relevance, effectiveness & efficiency, sustainability, monitoring & evaluation and gender equality by giving priority to examining the following key questions:

##### **Key Evaluation Questions:**

##### ***Future Direction***

- How well is the partnership aligned with Indonesian policies and goals?
- Do activities reflect the priority needs at the national and sub-national levels?

- How might this partnership be improved to meet the future needs of Government of Indonesia and Government of Australia's policies?
- What are the expectations of the partnership into the future:
  - From AusAID;
  - From Gol (National, Provincial, District) and civil society;
  - From implementation partners; and
  - From other stakeholders such as multilateral agencies and other donors?

### **Partnership**

- What does the current partnership model look like and how effectively is the model working?
  - What are the challenges?
- What is the capacity of the implementing partners (national, sub-national and civil society) to implement and spend the funds effectively and efficiently?
  - Should the partnership reorient its co-financing and partner grants approach?
- How well is the partnership progressing towards achieving the end of partnership outcomes?
  - What information is available from the monitoring and evaluation system to inform such progress?
  - What are the appropriate indicators for the achievement of a strategic partnership between Australia and Indonesia?
- Are the end-of-partnership outcomes achievable within the timeframe?
  - Do we need to re-articulate the end of partnership outcomes?
  - Are there any changes required to the existing program logic model?
- What is the likely sustainability of the end of partnership outcomes?
- Have there been any unintended outcomes from the partnership?
- Are the implementing partners appropriately resourced to implement this partnership approach?

### **Papua Province and West Papua Province**

- How appropriate is the partnership model for implementation in a low capacity environment like Papua Province and West Papua Province?
- Are there areas of work that should be continued and what are the prospects of scaling up in these areas of work?

### **Gender**

- How well is gender integrated into the partnership?
- How well is the chain of influence between AusAID, implementing partners and beneficiaries?

## **6. Required Expertise**

The Independent Progress Review will have three external members. In addition it will include an AusAID representative and representative from the GOI:

### **Team leader – (Evaluation Specialist)**

The team leader will lead the evaluation team. They will play a management role within the team, determining roles and responsibilities of the other team members and taking responsibility for the final deliverables which are submitted to AusAID. The team leader will coordinate and liaise with the other team members on the allocations of assignments and reporting arrangements.

The team leaders will:

- Lead a team for the review of the Australia Indonesia Partnership for HIV.
- Coordinate and liaise with the team members on allocation of assignment and reporting arrangements.
- Participate in a telecon briefing with AusAID and other team members prior to an in-country briefing.
- Develop a draft evaluation plan in consultation with the HIV expert
- Participate in a briefing meeting (up to one week) in country prior to the in-country mission and finalize the evaluation plan upon receiving feedback from AusAID
- Read and review all relevant partnership and activity documentation provided by AusAID and advise AusAID of any additional documents or information required prior to the in-country-visit
- Develop the draft evaluation plan in consultation with the other team members; and finalise the draft evaluation plan upon receiving feedback from AusAID.
- Lead the in-country fieldwork and ensure the team fulfils the evaluation plan
- Lead data analysis of the review
- Participate in the initial briefing in Jakarta and lead sessions to present preliminary findings in the field and in Jakarta
- Provide the draft and final reports with input from other team members and incorporate comments from AusAID and other key stakeholders

The Team Leader should have the following skills:

- Demonstrated practical experience and skills in evaluation, including the development of a sound evaluation methodology.
- Demonstrated practical experience as team leader on program reviews and preferably some experience on AusAID reviews.
- Demonstrated ability to breakdown and communicate complex concepts simply with a range of stakeholders including in multi-cultural settings;
- A very high standard of report writing and oral communication skills;
- Strong leadership and facilitation skills.

### **Team Member – (HIV Expert)**

The HIV expert will support the team leader throughout the evaluation. The HIV expert should be able to provide up-to-date technical expertise on HIV, international best practise development responses to HIV and analysis of the effectiveness and relevance of AIPH's contribution to the HIV response in Indonesia. They will also provide input into the review as requested by the team leader. The role of the Indonesia Health / HIV Specialist:

The HIV expert will:

- Work, coordinate and provide analysis to the team leader during the review process.
- Participate in a telecon briefing with AusAID and other team members prior to an in-country briefing.
- Provide comments to the team leader on the evaluation plan; especially on the evaluation questions.
- Undertake in country field work
- Provide inputs to the evaluation as requested by the team leader
- Participate in the initial briefing in Jakarta and present preliminary findings at sessions in the field and in Jakarta

- Contribute to the preparation of the draft and final report under the Team Leader's coordination.

The HIV expert should have the following skills:

- Relevant qualifications and demonstrated experience in technical aspects of HIV responses in developing countries;
- Demonstrated understanding of policy development, institutional strengthening, capacity development and implementation of HIV programs in a national and sub-national context and in a low-capacity environments;
- Good knowledge of gender issues in the context of HIV programs;
- Sensitivity to the full range of concerns impacting on the quality of life and utilization of services by positive people and key most at risk populations;
- Previous experience on reviews; and
- A high standard of report writing and oral communication skills.

#### **Team Member – (Indonesia Health/Governance Expert)**

The Indonesia health/Governance Expert will support the team leader throughout the evaluation. They should be able to provide contextual issues relating to the health system (with specific relevance to NAC/MOH) in the decentralized context. They should be able to provide the nuances of the Indonesian experience in their response to HIV and the role of civil society as well as the alignment of AIPH to Indonesia's HIV goals and policies. They will also provide input into the review as requested by the team leader.

The Indonesia Health/Governance Expert will:

- Work, coordinate and provide analysis to the team leader during the review process.
- Participate in a telecon briefing with AusAID and other team members
- Provide comments to the team leader on the evaluation plan
- Undertake in-country fieldwork
- Participate in the initial briefing in Jakarta and present preliminary findings at sessions in the field and in Jakarta
- Contribute to the preparation of the draft and final report under the Team Leader's coordination.

The Indonesia Health/Governance Expert should have the following skills:

- Technical expertise in HIV issues in Indonesia;
- Understanding of the health system in Indonesia's decentralisation context; and
- Demonstrated experience in institutional building processes in Indonesia related to effective response to HIV.

Apart from the independent consultants, staff from AusAID and the Government of Indonesia will also participate in the review:

**AusAID Program Manager for HIV / Evaluation Manager.** The role of the program manager in this review will be to:

- Liaise and coordinate with the Review Team, Implementation service provider and AusAID management on both technical and administrative aspects of the review
- Participate in parts of the field work, in order to manage the evaluation process, ensure the evaluation is of high quality and fulfils the evaluation plan and to learn more about the program and issues facing implementation.
- Ensuring administrative and logistical support for the review process



- Manage comments from internal and external stakeholders on the draft report.
- Prepare the management response and learning and dissemination plan for the evaluation.

**Representative from the Government of Indonesia may also participate.** The role of the Government of Indonesia Representative will be to:

- Provide insights on the national policies in relation to HIV
- Provide location specific information relating to the government's HIV response
- Comment on the partnership model

### Evaluation Method and Process

The assignment will start on 4 July 2011. For this evaluation, the team will have five day work week in-country. There will be a total of up to 32 home-based days and up to 28 days of input in Indonesia (for the Team Leader). Other team members will have less work days, but total effort will not be more than 44 person days, subject to negotiation of work plan during the inception phase. The assignment is expected to have a total of up to seven weeks intermittent work (an overall duration of approximately fifteen weeks), and be completed by the week of September 2011 (i.e. the submission date of the Final Independent Completion Report). The Team will commence in 1<sup>st</sup> week of July to complete inputs associated with the inception phase (i.e. the Evaluation Plan). Total work days and the completion dates will vary according to each position

The review will be undertaken between July and August 2011. The in-country mission will take around 3 weeks and is planned for 25 July to 12 August 2011. The exact date and timeline of the review is to be confirmed based on the evaluation plan (including methodology) that will be developed by the evaluation specialist.

Activity	Days				Dates
	Team Leader	HIV Expert	Indo Health / Gov Expert	GOI Rep	
Background research	10	6	6		
Draft Evaluation Plan	2				
Final Evaluation Plan	3	2	2		
Implementation of Plan	28	28	28		
Review Meeting with AusAID	3	1	1	1	
Present key findings to AusAID	1	1	1		
Draft Report	9	4	4	1	
Final report	4	2	2		
<b>Total days</b>	<b>60</b>	<b>44</b>	<b>44</b>	<b>2</b>	

In undertaking the review, the team will:

#### ***Prior to the in-country visit***

##### Briefing:

Participate in a verbal briefing with AusAID at the outset of the evaluation process, to discuss background, issues and priorities for the evaluation and AusAID's expectations for development of the evaluation plan (up to 1 day)

The briefing process may involve an in-country visit prior to the review by some or all of the team members (up to 7 days)

##### Familiarisation with Program Documents:

Familiarise themselves with all relevant partnership and activity documentation provided by AusAID and advise AusAID of any additional documents or information required prior to the in-country-visit (these documents are listed below). (up to 4 days). At the same time the AIP M&E Plan should be reviewed (0.5 days).

##### Development of an Evaluation Plan (up to three days for TL and 1 day for team members):

This plan will outline the approach and methodology the review team will employ, describing the methods that will be use to gather information and answer each evaluation question as well as identifying key respondents and stakeholders to be consulted.

The plan may refine the evaluation questions based on the terms of reference. The plan should also indicate the delegation of responsibilities between team members. The plan will need to be submitted three weeks prior to the field visit. AusAID will oversee the final clearance of this plan.

### ***In-country***

#### **In-country Briefing:**

Participate in an AusAID briefing session at the start of the in-country field visit (up to 0.5 day). For three weeks the team will conduct meetings in Jakarta and AIPH activity sites in Java and Papua as required. They may also be required to undertake debriefing sessions with district and provincial governments in the areas visited (21 days).

The team leader will be required to present the initial findings of the IPR to AusAID Jakarta, the activity implementation team and partnership agencies in separate sessions and locations. (1 day)

### ***Post country Visit***

Following the in-country work the team will be required to process their evaluation data and prepare a draft IPR (up to 8 days for the team leader and 5 days for team members). This report should be submitted to the AusAID HRF and a quality assured draft to be submitted AusAID within three weeks after the in-country visit. AusAID will provide consolidated comments on the report and recommendations for finalisation. The final IPR should be submitted within two weeks of receipt of AusAID's comments on the draft report (up to 4 days for the team leader and 2 days for other team members).

Total estimated consultant input is: TL up to 60 days; Members up to 44 days.

### **Reporting Requirements**

The review team will submit to AusAID the following:

- Evaluation plan (including methodology) – to be submitted in July 2011.
- Draft Independent Progress Report – to be submitted within three weeks of completing the in-country field visit.
- Final Independent Progress Review report – to be submitted within two weeks of receipt of AusAID's comments on the draft report.

Both the draft and final reports should be no more than 30 pages of text excluding appendices. The Executive Summary, with a summary list of recommendations, should be no more than 2-3 pages. Where possible, recommendations should be costed.

AusAID will seek comments from internal and external stakeholders on the draft report. The draft report will also be reviewed by a member of the AusAID M&E Panel and a health sector specialist. AusAID will provide consolidated comments to the Evaluation Team within three weeks of receipt of the draft report from the Team Leader. AusAID will also arrange for translation of the final report into Bahasa Indonesia.

**TIMEFRAME & KEY MILESTONES**

No	Stages	Timing
1.	IPR TOR developed	March - May 2011
2.	Contracting of Review team	May to June 2011
3.	Review design and methodology approved by AusAID	June - July 2011
4.	Review team conduct fieldwork in Java and Papua	July – August 2011
6.	Draft Report submitted to AusAID	September 2011
7.	Final Report submitted to AusAID	September - October 2011

**REFERENCES**

AusAID sectoral policy and HIV documents include:

1. AIPH Program Design Document
2. AIPH M&E Plan
3. HCPI M&E Plan
4. HCPI Progress Reports
5. CHAI Phase 1 and 2 Program Designs
6. CHAI Progress Reports
7. AusAID's guidelines on conducting an Independent Progress Review (IPR)
8. ICR of CHAI
9. AIPH QAIs
10. Indonesia Country Program Strategy: AusAID
11. AusAID HIV Strategy
12. PNPM Program Brief
13. AIPD Program Brief
14. Education Program Brief
15. AusAID HIV policy – Intensifying the response: Halting the spread of HIV

Government of Indonesia

1. National HIV and AIDS Strategy and Action Plan 2010-2014

## Annex 6: Evaluation plan

### 1. What is this document?

This document outlines the evaluation plan for the independent progress review of the Australia Indonesia Partnership for HIV (AIPH). It has been guided by the review's terms of reference and informed by discussions held with a range of key stakeholders during an orientation visit in June 2011. Review team members have helped inform the plan.

An evaluation plan is an important first milestone that determines the direction and design of an evaluation. Therefore, this document is to assist further discussions and negotiation about the review with the AIPH partners and the evaluation team, in particular: its focus; how information will be collected; how information will be used; and the management of the evaluation. It is anticipated that, through the plan, agreement will be reached about how the review is to proceed and what can reasonably be achieved.

It is a flexible document that will be reviewed regularly by the AIPH partners and the review team throughout the review. This will enable appropriate adaptations to be made should circumstances change.

### 2. What is being evaluated?

The review will be conducted on the AIPH program, which is a partnership between Australia and Indonesia that seeks to:

- prevent and limit the spread of HIV;
- improve the quality of life of people living with HIV; and
- alleviate the socio-economic impacts of HIV/AIDS.

Indonesia has one of the fastest growing HIV epidemics in Asia. Since 2000, HIV prevalence has been consistently over 5% in several key populations such as injecting drug users, sex workers, transgender and men who have sex with men (MSM) leading to the classification of the Indonesian epidemic as a concentrated epidemic. However, the epidemiology of the HIV epidemic in Indonesia is showing a shift from injecting drug use as the main form of transmission to sexual transmission. In the two provinces of Papua and West Papua, the epidemic is categorized as a low-level generalized epidemic, where it is driven primarily by unsafe sexual intercourse.

The Partnership builds on over ten years of Australian assistance in the HIV sector in Indonesia. The \$100 million program, which spans from 2008 until 2015, currently operates in nine provinces (DKI Jakarta, West Java, Banten, Central Java, Jogjakarta, East Java, Bali, Papua and West Papua). There are three long-term program objectives:

- Strong Indonesian leadership of an effective and sustainable HIV response.
- An increased and good quality HIV response.
- A strategic partnership between Australia and Indonesia that supports the national HIV response.

AIPH uses various aid modalities to implement a range of activities: managing contractor (private sector and international NGO); pooled funding; and specific contributions to multilaterals or civil society. It includes the following components:

- *HIV Cooperation Program for Indonesia (HCPI)* (\$45 million 2008-2013), which focuses on strengthening Indonesian leadership on HIV issues and reducing HIV transmission among injecting drug users and in prisons. It has an additional focus on: preventing the spread of HIV in Papua and West Papua; on developing effective behaviour change approaches; and supporting a comprehensive program to address the sexual transmission of HIV in Bali. HCPI is managed by GRM on behalf of AusAID.
- *Clinton Health Access Initiative (CHAI) Phase 2* (\$2.25 million 2010-2012) focuses on: improving supply chain management of anti-retroviral drugs (ARV) and HIV test reagents; builds capacity for better care, support and treatment in Papua; and provides technical assistance to enhance national level policies and guidelines. The initiative is managed by the Clinton Foundation.

- *Indonesia Partnership Fund for HIV (IPF) Phase 3* (up to \$1 million annually 2011-2013) is an important source of financial support for AIDS Commissions at national and sub-national levels. Funds are managed through UNDP and implementation is by the National Aids Commission (NAC).
- *MSM initiative* (\$1.5 million 2011-2013) supports the development of the national MSM action plan and piloting MSM outreach programs in 10 locations. The initiative is a collaboration of HCPI and the NAC.
- HIV mainstreaming within AusAID programs, for example, in the infrastructure and education sector through provision of technical inputs.
- AusAID Regional Initiatives managed in Canberra (HIV Consortium for Asia and the Pacific and the HIV Alliance<sup>139</sup>) which build capacity of civil society and support HIV research also have relevance to AIPH.

### 3. What is the purpose of the evaluation?

From the terms of reference and subsequent discussions with the partners, it is apparent that this review is, primarily, an impact evaluation, as described by Owen.<sup>140</sup> The major purpose of the review is to:

- assess progress of the AIPH against the end-of-Program outcomes; and
- identify what changes, if any, might need to be made to the Program for the next phase.

However, there is also a need for a proactive evaluation of the Program in Papua Province and West Papua Province.

Proactive evaluations provide information to inform future or projected program development. In this instance, whilst the Program is already operating in these provinces, information is sought to inform decisions about a projected scale up.

### 4. What is the focus of the review?

It is important to understand where an evaluation is to focus because this will have a bearing on the scope and design. The AIPH review is focused on the 'macro' level of the overall AIPH Program, that is, how the various components, collectively, help bring about the end-of-AIPH Program outcomes. This is not a review of the specific individual components that comprise AIPH.

As part of the impact evaluation, the partners have requested specific advice in relation to:

- What is enabling or hindering Program outcomes, particularly in relation to:
  - Strengthening local capacity of policy makers and civil society organisations;
  - The extent to which HIV policy initiatives are being integrated within Government agencies and systems;
  - Supporting the Government of Indonesia to meet its responsibility for an effective HIV response;
  - Meeting needs of the target groups; and
  - The most effective modalities used for this Program.
- The future direction of the Program, particularly in relation to:
  - How the Program can best contribute to a continuum of prevention to care, and treatment, especially in light of the changing epidemiology;
  - The sustainability of the prevention components of the Program;

<sup>139</sup> A review of the Consortium was carried out in 2010.

<sup>140</sup> Owen, J. (2006). *Program Evaluation: Forms and Approaches* (3<sup>rd</sup> Edn.). Crows Nest, NSW: Allen and Unwin. Owen identifies five forms of evaluation: proactive; clarificative; interactive; monitoring and impact. Impact evaluation is concerned with:

- "determining the range and extent of outcomes of a program;
- determining whether a program has been implemented as planned and how implementation has affected outcomes;
- providing evidence to funders, senior managers and politicians about the extent to which resources allocated to a program have been spent wisely; and
- informing decisions about replication or extension of a program"... (pg.253)

Owen uses 'impact' to mean both immediate and longer-term effects, both intended and unintended

- The role of donors, especially given that currently donor funding accounts for about 40% of overall spend in the HIV response; and
  - The structure, maturity and capacity of civil society organisations in the HIV response.
- How the various components of the Program might be better integrated and coordinated both administratively and programmatically, particularly in relation to strengthening Program synergies.
- The implications for the Program of the pending Health Systems Strengthening (HSS) Program that will, essentially, provide the future platform for health service delivery funded by AusAID.
- The effectiveness of the partnership approach, particularly in relation to:
  - The difference the partnership approach is making, particularly in helping to strengthen local capacity and leveraging further Government of Indonesia investment in the response to HIV; and
  - Coordination and ongoing sustainability of effort, particularly the respective roles of the National Aids Commission and the Ministry of Health in the partnership.

For the proactive evaluation of the Program in Papua Province and West Papua Province, the partners seek specific advice about the extent to which the Program: meets local needs; is aligned with Government of Indonesia and Government of Australia policy and direction; and has the appropriate balance of activities.

The purposes and foci of the review indicate that the review is, essentially, about providing the partners with information that will assist them in future investment decisions. It is not about rating the Program's performance against a number of AusAID's evaluation criteria. However, the data and findings from this review will provide the Program Manager with important information to inform such ratings.

The initial terms of reference included specific questions about gender equity. However, discussions during the scoping stage indicated that this is not a separate aspect of the review. Rather, it will be incorporated in the general consideration of the outcomes and whether the Program is meeting the needs of the target group.

## **5. Who is the audience?**

The primary users of the findings of this review will be the management team within AusAID<sup>141</sup> and the members of the AIPH Partnership Coordination Committee: the National Aids Commission; the Ministry of Health; the Coordinating Ministry for People's Welfare; the Ministry of Law and Human Rights; and civil society organisations. The findings will help them make decisions about future investment for the Program. The audience includes the implementing partners and related development partners, whose interest will be in findings of particular relevance to their specific roles.

## **6. What resources are available?**

AusAID Indonesia has contracted an external team of reviewers: a team leader, who is a monitoring and evaluation specialist; a HIV specialist; and a governance specialist. The fees and disbursements for these external reviewers will be paid by AusAID at negotiated rates. In addition, AusAID Indonesia has agreed to the inclusion of a second monitoring and evaluation team member to support the team leader. AusAID will provide resources to engage two translators, who will support the review team members who do not speak Bahasa Indonesia.

In addition the following resources will be made available to support the review:

- The AIPH Program Manager will form part of the review team and will be provided with time and disbursements to participate in all aspects of the review.

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<sup>141</sup> It is assumed that management within AusAID includes the AusAID HIV and Communicable Diseases Unit who will use the review findings to inform future program design and to rate current performance against AusAID's evaluation criteria.

- The National Aids Commission will provide one senior staff member to accompany the review team and participate in all aspects of the review.
- Implementing partners will support relevant staff to participate in particular aspects of the review and will assist with local logistics.
- AIPH Partnership Coordination Committee agencies and organisations will support relevant staff and other stakeholders to participate in particular aspects of the review and will assist with local logistics, including such things as hire of local venues.

## 7. What are the key evaluation questions?

Six key evaluation questions have been identified:

- How well is AIPH progressing towards the end-of-Program outcomes? What are the enabling or hindering factors?
- How should AIPH best support the Government of Indonesia to effectively respond to HIV in a sustainable manner?
- How can the individual components of the AIPH be better synchronised both administratively and programmatically?
- What are the implications of the Health Services Strengthening program for the AIPH?
- To what extent are the various partnerships contributing to end-of-Program outcomes? Should there be any rebalance of key partnerships?
- How relevant and appropriate is the current response in Papua Province and West Papua Province? What are the priority program areas for future investment?

## 8. Approach

### **Overarching approach**

The review will adopt a mixed-methods approach. In essence, this will involve the use of available quantitative data and the gathering of qualitative data in a sample of districts where the Program operates. The use of mixed methods will assist with triangulation of data, thus strengthening the review study.<sup>142</sup> The triangulation methods that will be applied match the four basic types of triangulation identified by Denzin:<sup>143</sup>

- Data triangulation – the use of a variety of data sources;
- Investigator triangulation – the use of different evaluators;
- Theory triangulation – the use of multiple perspectives to interpret the data; and
- Methodological triangulation – the use of multiple methods and samples.

Using mixed methods enables the inclusion of: induction (discovery of patterns), deduction (testing of theories), and abduction (uncovering explanations) forms of inquiry.<sup>144</sup> This mix will enable the team to test for consistency of findings. Consistencies and any inconsistencies will provide deeper insights into the program.

### **Approach for the impact evaluation component of the review**

The impact evaluation component of this review will adopt both an outcomes and a needs-based approach.

#### *Outcomes*

The HIV and Communicable Disease unit of AusAID has recently developed a monitoring and evaluation plan for the Program overall. That plan identified a series of end-of-Program level outcomes (refer to Appendix 1).

<sup>142</sup> Patton, M.Q. (2002). *Qualitative Research & Evaluation Methods (3<sup>rd</sup> Edn)*. Thousand Oaks, CA: Sage Publications. Sections available on [www.books.google.com](http://www.books.google.com) or check with AusAID P&Q Unit or university library

<sup>143</sup> Cited in Patton, *ibid*.

<sup>144</sup> Burke-Johnson, R., and Onwuegbuzie, A.J. (2004). Mixed Methods Research: A Research Paradigm Whose Time Has Come. *Educational Researcher*. 33 (7), pp. 14-26.

It will be against these outcomes that this review will assess questions about progress using a combination of: the quantitative sector and AIPH-specific indicators outlined in the AIPH Monitoring and Evaluation Plan; and specific qualitative indicators developed for this review. In applying AusAID's newly developed outcomes, it is anticipated that this review will be able to form some view of their applicability and either confirm them or suggest some alternatives.

In assessing progress against outcomes, baseline data will be used, where it exists. Where it does not, the review will use 'shadow controls'<sup>145</sup>. In assessing the contribution of the partnerships to the end-of-Program outcomes, the review will apply a lens of 'additionality'.<sup>146</sup>

#### *Needs-based*

Whilst the initial Program was designed on the then existing need, current epidemiology suggests that priority needs might have changed since the Program's inception. Therefore, the Program's worth will also be considered in light of current need by using Bradshaw's<sup>147</sup> classification of needs to guide interview questions, review of data and analytical discussion:

- Felt – individual perceptions of need
- Expressed – service demand
- Normative – expert opinion of need
- Comparative – comparison of need between different populations

#### ***Approach for the proactive evaluation component of the review***

This aspect of the review will be undertaken using an evidence-informed approach based on a model by Davies<sup>148</sup> that uses information from six areas to build up the needed evidence:

- The logic model – how is the policy/program supposed to work?
- Existing evidence – what is already known to be effective?
- Descriptive and experiential evidence – what is the nature, size and dynamics of the problem?
- Evidence of proven effectiveness – what has been shown to work elsewhere?
- Economic and econometric evidence – what is the cost, benefit, and effectiveness of interventions?
- Ethical evidence – what are the ethical implications of the policy/program?

Given the nature of this review, it will not be possible to undertake a comprehensive, in-depth gathering of data for each of these areas. Rather, they will help guide interviews, review of existing data, literature review, and analytical discussion.

## **9. What are the limitations and constraints?**

For quantitative data, the review team will rely on available data from relevant Government of Indonesia systems and the implementing service providers. The extent and quality of this data will not be fully understood by the review team until the review begins. For example, existing data is gathered to inform monitoring requirements of the individual Program components. It is uncertain how well such data informs the composite of the Program. Nonetheless, it is important to use the available data for the following reasons:

- It will prevent placing undue pressure on the partners to gather new data solely for this review.

<sup>145</sup> Shadow controls use estimates of net impact, which are sought from a selection of people with insight into the Program, for example: those with particular expertise in the field; program administrators; participants – Vedung, 1997 cited in Jørgensen, M. (2006). Evaluating cross-sector partnerships. Working paper presented at the conference *Public-private partnerships in the post WSSD context*. Copenhagen Business School, August 14, 2006. Available:

[http://www.unrisd.org/unrisd/website/events.nsf/d063b7f4013ddaeb80256b59004b47a3/bc20f4baffcf713c1257219004abb34/\\$FILE/Mette.pdf](http://www.unrisd.org/unrisd/website/events.nsf/d063b7f4013ddaeb80256b59004b47a3/bc20f4baffcf713c1257219004abb34/$FILE/Mette.pdf)

<sup>146</sup> Additionality is a mixed-method framework developed by Buisseret et al 1995, cited in Georghiou, L., *Impact and Additionality of Innovation Policy*, paper presented to Six Countries Programme on Innovation Spring Conference, 2002. It is a means of evaluative comparison of the counterfactual. For further information refer to Hind, J. (2010). Additionality: a useful way to construct the counterfactual qualitatively? *Evaluation Journal of Australasia*. 10 (1). pp. 28-35. <http://www.aes.asn.au/publications/>

<sup>147</sup> Cited in Hawe, P. (1996). Needs assessment must become more change focused. *Australian and New Zealand Journal of Public Health*. 20 (5), 473-478.

<sup>148</sup> Davies, P. (2009). *The Importance of Evaluation for Evidence-Based Policy and Practice*. Key note address to Australasian Evaluation Society International Conference, Canberra, Australia, 4 September, 2009.



- It respects the partnership decision to operate, wherever possible, with Government systems.
- With limited in-field time it is more effective for the review team to place its efforts on data techniques that will provide added richness, breadth and depth.
- It will allow some testing of the applicability of the data at the whole of Program level.

Time and resource constraints mean that it is not possible to visit West Papua province. Therefore, the review team will rely on secondary data and key informants from the implementing teams and civil society organisations who provide service in that province. Similarly, a visit to Bali is not possible so will limit the team's capacity to assess the specific outcome: *MARPs in Bali increasingly practice safe behaviours and more PLHA receive VCT and CST services*. Any assessment of this outcome will rely solely on secondary data from progress reports.

Given that the focus of the review is at the macro level of the Program, the involvement of beneficiaries as key informants will be limited to where their perspectives and experiences will help inform the assessment of particular outcomes or needs. The review team will be reliant on implementing partners to help them access beneficiaries.

Some of the review team do not speak Bahasa Indonesia so will need to rely on interpreters. Although the team will be supported by highly skilled interpreters, possible implications include:

- a risk that the nuances of reviewers' questions and people's responses might not be fully captured. This will mean that the reviewers and interpreters will need to be very diligent in clarifying the meaning of what people say through the use of process feedback during interviews, discussions and workshops; and
- evidence in the form of quotes is likely to be indicative of people's comments rather than precise word-for-word quotes.

There are potential political sensitivities around the future direction of the program, particularly how and where it might be scaled up. It will be important for the review to obtain perspectives about future direction from a wide range of stakeholders. However, it will be important that these stakeholders are made aware that their perspectives will help inform future direction but that the decision rests with the national partners.

## **10. How will data be collected and analysed?**

### ***Data methods***

Data methods are provided in Appendix 2. Team members will be allocated to various data methods and tasks according to their particular expertise. For example, the HIV specialist, among other tasks will have a lead responsibility for sourcing literature of contemporary good practice in HIV service delivery. Similarly, the governance specialist will have prime (but not sole) responsibility to interview informants responsible for managing and administering various government systems and processes. The National Aids Commission representative has particular expertise in quantitative research so will provide leadership in relation to analysis of quantitative data.

Document reviews will be recorded according to agreed themes. Interviews will be conducted using a semi-structured method. Team members will be responsible for developing an appropriate list of specific questions for each interview relevant to their particular expertise and the particular broader evaluation questions being addressed. Team members will be required to make extensive notes of all interviews and document reviews. Each team member will be responsible for typing these and sharing them with other team members.

### ***Data collection***

#### **Gaining access to data**

Because the implementing partners have the relationships with all the key stakeholders it is proposed to negotiate access to stakeholders and data through them. Some data might require translation from Bahasa Indonesia to English. Where time and resources permit, a written translation will be sought. In some instances, a verbal translation will suffice the review team's needs.

### ***Data measures***

The following measures will be used:

- End-of-Program outcomes, as per the AIPH Monitoring and Evaluation Plan, 2010

- Partnerships will be assessed using the Partnership Evaluation Framework – Appendix 3
- Capacity development will be assessed using the UNDP Capacity Development Results framework as a guide.<sup>149</sup> Taking the lessons from research by Watson,<sup>150</sup> the review team's approach will include encouraging key stakeholders to identify key success indicators and to make self-assessments of performance.

### **Data analysis**

Data triangulation will occur as outlined earlier in this plan. Analysis of the data will occur on an ongoing, iterative basis during the in-field activities. Team members will record and track analytical insights during the data collection phase. Wherever possible, time at the end of each day will be set aside for team members who have been working together to briefly discuss their major observations, impressions and emergent sense-making of the data.

Once during the in-field phase, the whole team will come together for half a day to undertake joint iterative data analysis. Analysis will be structured in two ways: a) against the key evaluation questions; and b) according to emerging themes. This process will:

- Help successfully manage the large quantities of data;
- Identify emerging patterns, themes and hypotheses;

At the end of the data gathering phase, the team will convene together for two and a half days to:

- Continue the analysis; and
- Jointly draw conclusions, make judgements in relation to the six key evaluation questions and consider preliminary recommendations.

## **11. What is the schedule of review activities?**

The in-field phase of the review will occur between the 18 July and 8 August 2011. Some desk-based activities will be undertaken both prior to and following the in-field activities. A draft report will be submitted to AusAID by 16 September 2011 for comment by the partners. The final report is due by 30 September 2011.

The full itinerary is available as a separate document to this plan. However a summary is as follows:

<b>Review activity</b>	<b>Timeframe</b>
Scoping of review	27 June – 1 July
Evaluation plan	8 – 13 July
Document analysis and review	2 July – 3 August
Literature review	2 July – 3 August
In-field activities (interviews, observational visits, discussion groups)	18 July – 3 August
Data analysis – preliminary	Ongoing
Data analysis – in-depth	4-7 August
Preliminary findings presented to various stakeholders	8 August
Data analysis – further discussion and follow-up between team	11 August – 11 September
Draft report	15 August – 16 September
Report considered by AusAID and partners	19 – 26 September
Final report submitted	30 September

## **12. How will findings be disseminated?**

The findings will be disseminated in the following ways:

- The partnership workshops in the Provinces are designed to be interactive. Hence, information will be shared through plenary-type activities with the group.
- At the conclusion of the in-field phase, all those who have been involved on the review team (not only the independent team members) will jointly prepare and present a series of feedback sessions for:

<sup>149</sup> [UNDP Defining and Measuring Capacity Development Results/content/undp/en/home/librarypage/capacity-building/undp-defining-and-measuring-capacity-development-results---one-page-summary.html](http://undp.org/undp-defining-and-measuring-capacity-development-results/content/undp/en/home/librarypage/capacity-building/undp-defining-and-measuring-capacity-development-results---one-page-summary.html)

<sup>150</sup> Watson, D. (2006). *Monitoring and evaluation of capacity and capacity development: Discussion paper No. 58B*. European Centre for Development Policy Management.

- AusAID management;
  - AIPH partners;
  - Implementing teams and the HIV team; and
  - AusAID staff.
- All team members will input to an Independent Progress Review report for consideration by the AIPH partners. The drafting will be overseen by the team leader. This report will not be structured according to AusAID's evaluation criteria. Rather, its structure will align (but not necessarily follow exactly) the key evaluation questions.

### **13. What codes of behaviour will be put in place?**

The work will be conducted in accordance with the Code of Ethics of the Australasian Evaluation Society. The team leader will provide a copy to each of the team members (independent and internal).

Key practices will include:

- Ensuring all those who participate in the review as informants are provided with clear information about the review and what will happen to the information.
- Confidentiality will be assured.
- Data will be displayed in ways that do not permit identification of the informant.
- People will be asked for permission before photos are taken and advised about how these will be used. Copies of photos will be provided to the implementing partners for relevant distribution.
- Where negative findings emerge, these will be discussed with the relevant partners (as a courtesy) prior to the sessions to present the findings.

## Appendix 1 – End-of-Program outcomes

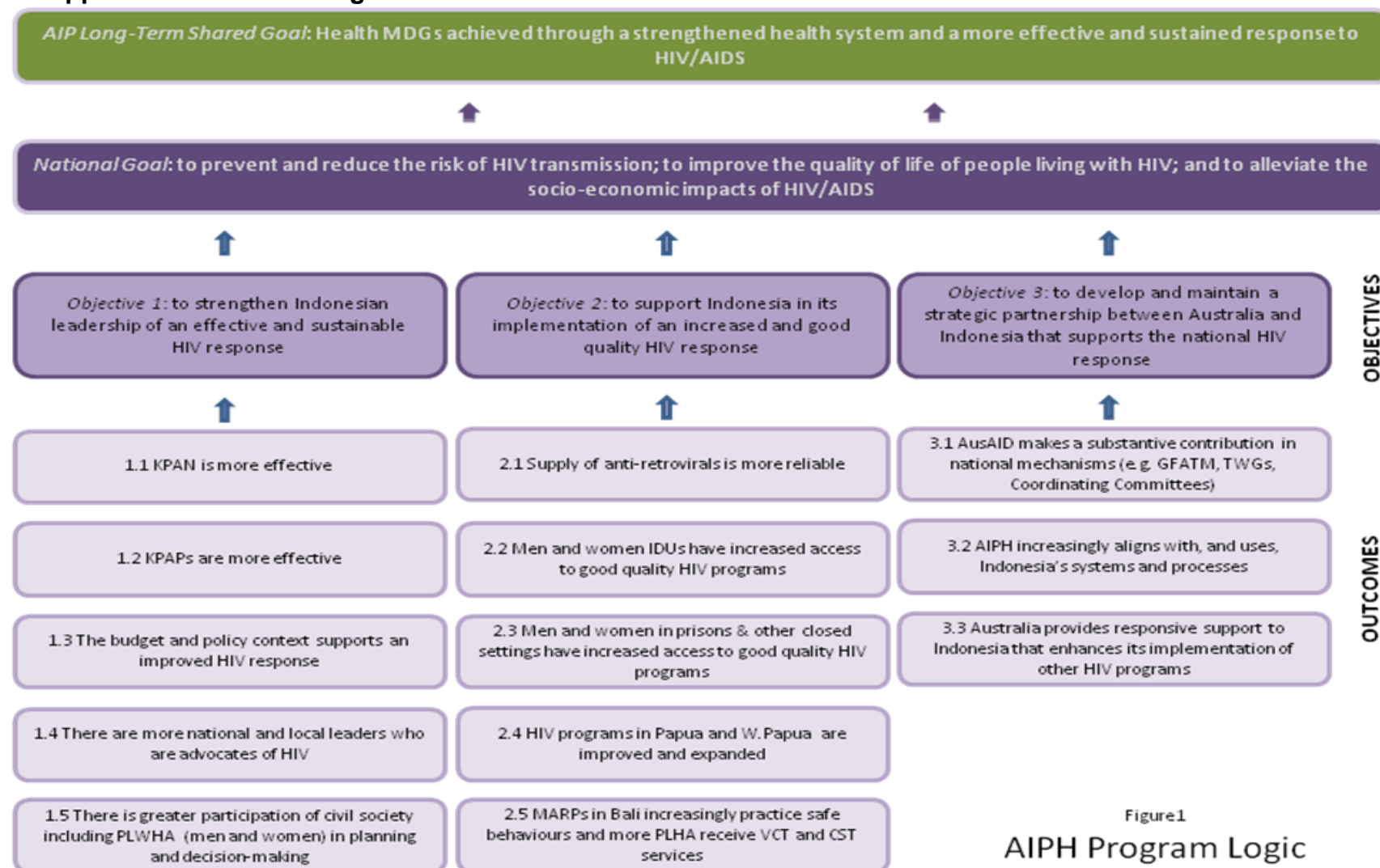


Figure 1  
AIPH Program Logic

## Appendix 2 – Key evaluation questions and data methods

Key evaluation question	Second level questions	Particular areas of interest	Data methods
How well is AIPH progressing towards the end-of-Program outcomes? What are the enabling or hindering factors?	What evidence exists of more effective leadership by Government of Indonesia in the HIV response?	KPAN, KPAP, MoH <ul style="list-style-type: none"> <li>• policy and regulation changes</li> <li>• planning changes</li> <li>• investment changes</li> <li>• whole-of-government coordination</li> </ul>	Progress reports Budget information - Commissions Interviews with: KPAN; KPAP; MoH; implementing partners; donors; CSOs
	How well is national HIV policy reflected and being implemented at sub national level?	What is happening at sub national level in relation to strengthening capacity in: policy making; monitoring implementation of policy; quality control	GoI policy documents and National Strategy Sub national policy and regulation Progress reports Interviews with: KPAN; KPAP; MoH; implementing partners; donors; CSOs
	What is currently happening and what is effective in gathering, analysing and using data as evidence for policy making and service delivery?	Links between research institutes and policy makers and service providers Contribution to knowledge base needed to guide and refine programs (e.g., HIV surveillance, M&E, operations, research)	Interviews with: KPAN; KPAP; MoH; implementing partners; donors; CSOs Progress reports
	How well is the Program contributing to the strengthening of civil society organisations?	Evidence of growing cadre of active national and local advocates Participation of people living with HIV/AIDS in decision-making processes Effect of participation of civil society on Government decision-making	Interviews with: KPAN; KPAP; MoH; implementing partners; donors; CSOs Discussion groups with beneficiaries
	How well is AIPH aligned to the needs of target groups?	Levels of coverage for target populations Access How HIV-related discrimination is being addressed Procurement and supply chains AIPH contribution to key outcomes for particular target groups, for example, knowledge and behaviour change; prevalence; mortality rates	Quality of Life data – Spiritia Interviews with: KPAN; KPAP; MoH; implementing partners; donors; CSOs Discussion groups with beneficiaries Progress reports Needs data from CHAI and anthropologists project Observational visits
	Is there an appropriate mix of activities to ensure continuum of prevention to care and treatment?	Alignment with needs of target groups Alignment with contemporary good practice	Review of data re: normative, expressed and comparative needs Discussion groups with beneficiaries Interviews with: KPAN; KPAP; MoH; implementing partners; donors; CSOs Literature

Key evaluation question	Second level questions	Particular areas of interest	Data methods
How should AIPH best support the Government of Indonesia to effectively respond to HIV in a sustainable manner?	How well does the Program align with policy and direction of Government of Indonesia and Government of Australia?	Changes in commitment by Government of Indonesia Scaling up intentions of Government of Australia	Review of Government policy and National Strategy Review of AusAID's country strategy; delivery strategy Interviews with: KPAN; MoH; AusAID senior management
	Which aid modalities are working well now and which might work well in the next phase?	Investment, technical assistance, service delivery Contemporary good practice	Interviews with: AIPH partners; Program Managers; implementing partners; AusAID senior managers Literature
	What role should AIPH have in the future in relation to funding and delivery of the continuum of prevention to care and treatment?	What other donors and CSOs are doing now and their future plans Effectiveness of interface between AIPH , other donors and CSOs Sustainability of efforts - Government of Indonesia, CSOs Evidence of scaling up of investment and effort by Government of Indonesia Contemporary good practice capacity development Maturity, organisational capacity and technical capacity of CSOs	List of CSOs, funding level and service provision Interviews with: KPAN; KPAP; MoH; implementing partners; donors; CSOs Progress reports Literature WHO epidemiology reports HIM Uni NSW
How can the individual components of the AIPH be better synchronised both administratively and programmatically?	What is the current situation?	Contract administration and funding mechanisms Integration/coordination/interface between program components Monitoring and reporting at AIPH level Mechanisms for decision-making Program leadership Synergies the individual components bring to the whole	Situational analysis - interviews with: AusAID Program contract, procurement, and finance staff Review of PD for new coordinator and Interview with Tim
	What efficiencies might be possible?	"Other" funds Governance and management of AIPH	
What are the implications of the Health Systems Strengthening program for the AIPH?	What is AIPH doing to strengthen health systems? How effective is this?	National and sub national levels Policy and service delivery levels What other donors are doing to strengthen health systems How AIPH is working with other donors to strengthen health systems and how this could be improved Level of coordination and coherence between AIPH components	Briefing and review of HSS documents Interviews with: KPAN; KPAP; MoH; implementing partners; donors; CSOs

Key evaluation question	Second level questions	Particular areas of interest	Data methods
	How could AIPH align with and contribute to AusAID's planned Health Systems Strengthening Program?	Potential synergies	
To what extent are the various partnerships contributing to end-of-Program outcomes? Should there be any rebalance of key partnerships?	How well are the partnerships maturing?	Partnership pre-requisites; structure and processes	Workshop activities with sub national partners Interviews with partners, national and sub national
	To what extent are the HIV initiatives being integrated within Government agencies, systems and processes	Level of alignment with Indonesia's systems and processes – KPAN, KPAP, MoH Coordination between KPAN and MoH and its implications for how AIPH works	Interviews with: KPAN; KPAP; MoH; implementing partners
	What evidence is there that the partnerships are making a difference?	Opportunities and risks – how they are being addressed Evidence of capacity development Added benefits of partnership approach - partnership outcomes AIPH contribution in national mechanisms Value of AIPH contribution by key partners AusAID's work with the Global Fund to maximise synergies and the effectiveness of GF investments in Indonesia	Interviews with: KPAN; KPAP; MoH; implementing partners; donors; CSOs Progress reports Additionality lens Workshop activities with sub national partners
How relevant and appropriate is the current response in Papua Province and West Papua Province? What are the priority program areas for future investment?	To what extent do AIPH and the activities of other partners collectively constitute a comprehensive response to meet key needs?	Current situation – AIPH; other donors Effectiveness of coordination between AIPH and with others	Interviews with: KPAN; KPAP; MoH; implementing partners; donors; CSOs Stakeholder map Meta analysis of yearly reports – NAC; MoH, Global Funds
	What difference is the investment making? Why is it working or not?	Added benefit Current and potential need	Interviews with: KPAN; KPAP; MoH; implementing partners; donors; CSOs Additionality lens Group discussions wit beneficiaries Observational visits
	What in-depth analytical work is needed to inform future investment decisions?	Information and data requirements	Lessons from PNG (Clinton Foundation)

### Appendix 3: Partnership evaluation framework

This evaluation framework was developed by Julie Hind, Evolving Ways. It has been adapted from Brinkerhoff (2002) but drew upon a range of other authors, particularly Jobin (2008), Caplan et al (2007) and Atkinson (2005).<sup>151</sup>

The framework has been designed to be used flexibly. An evaluator may choose to assess all aspects or selected aspects, depending on the given situation. Similarly, an evaluator may choose some or all of the dimensions (listed in Table 2 on the next page), according to the situation.

**Table 1: Partnership aspects**

PREREQUISITES	STRUCTURE	PROCESS	OUTCOMES
<b>Enabling environment</b> <ul style="list-style-type: none"> <li>Political attitudes</li> <li>Preoccupations and priorities</li> <li>Commitment</li> <li>Expectations</li> <li>Stability of environment</li> </ul>	<b>Formal partnership dimensions</b> <ul style="list-style-type: none"> <li>Legitimacy</li> <li>Resources</li> <li>Responsibilities</li> <li>Decision-making</li> <li>Contribution</li> <li>Compliance</li> </ul>	<b>Partnership practice</b> <ul style="list-style-type: none"> <li>Nature of Interaction</li> <li>Capacity development</li> <li>Mutuality and equality</li> </ul>	<b>Effectiveness</b> <ul style="list-style-type: none"> <li>Achieving desired results – including Influence on: <ul style="list-style-type: none"> <li>Administrative capacity</li> <li>Service delivery capacity</li> <li>Community capacity</li> </ul> </li> <li>Responsiveness</li> </ul>
<b>Drivers: Organisational &amp; individual</b> <ul style="list-style-type: none"> <li>Incentives</li> <li>Obligations</li> </ul>	<b>Informal partnership dimensions</b> <ul style="list-style-type: none"> <li>Social capital <ul style="list-style-type: none"> <li>Reputation</li> <li>Trust</li> </ul> </li> </ul>	<b>Partnership performance</b> <ul style="list-style-type: none"> <li>Relationships</li> <li>Performance of representatives</li> <li>Conflict resolution</li> <li>Creating and strengthening success factors</li> </ul>	<b>Efficiency</b> <ul style="list-style-type: none"> <li>Make good use of partner resources</li> <li>Benefits</li> <li>Costs</li> <li>Added value</li> </ul>
<b>Institutional elements</b> <ul style="list-style-type: none"> <li>Common objectives – public policy purpose</li> <li>Shared governance</li> <li>Written agreement</li> </ul>			

<sup>151</sup> Brinkerhoff, J.M. (2002). Assessing and improving partnership relationships and outcomes: a proposed framework. *Evaluation and Program Planning*, 25, pp. 215-231.

Jobin, D. (2008). A Transaction Cost-Based Approach to Partnership Performance Evaluation. *Evaluation*. Vol. 14 (4), pp. 437-465.

Caplan, K., Gomme, J., Mugabi, J., and Stott, L. (2007). *Assessing Partnership Performance: Understanding the Drivers for Success*. UK. Building Partnerships for Development.

Atkinson, M. (2005). The Development of a Evaluation Framework for Partnership Working. *The Electronic Journal of Business Research Methodology*. Vol. 3, issue 1, pp. 1-10. [www.ejbrm.com](http://www.ejbrm.com)



Table 2: The specifics of the framework's dimensions

Aspect	Dimension	Key areas of assessment
Prerequisites	Enabling environment	Extent to which: <ul style="list-style-type: none"> <li>partnership is supported politically; has the backing of key stakeholders; there are real opportunities for collaboration; partners tolerate and encourage power-sharing</li> <li>partnership meets current priorities</li> <li>partners are able to focus on the partnership given other work/priorities/demands</li> <li>partners provide leadership; there are champions; partners are willing to adapt; partners are future oriented</li> <li>there are clear and reasonable expectations; expectations are similar between partners</li> <li>environment is stable and conducive to collaborative working; key individuals are in place to facilitate partnership; external context is understood</li> </ul>
	Drivers: organisational and individual	Extent to which: <ul style="list-style-type: none"> <li>purpose, mandate, vision of partner organisations supports/facilitates partnership</li> <li>partners have inbuilt organisational culture, processes, systems, demands to facilitate partnership</li> <li>partners have legal and/or organisational requirements to partner</li> <li>decision making processes are clear and sufficient to facilitate partnership</li> <li>partners have processes in place to address lapses in commitment</li> </ul>
	Institutional elements	Extent to which: <ul style="list-style-type: none"> <li>there are common, shared goals linked to relevant public policies; partners articulate what they want to achieve from the partnership</li> <li>formal and informal governance structures are in place and work; processes and structures have been developed collaboratively</li> <li>the partnership is articulated in writing yet flexible to adapt as required</li> </ul>
Structure	Formal partnership dimensions	The extent to which: <ul style="list-style-type: none"> <li>the partnership structures and processes enable effective decision making; partnership is recognised and accepted by stakeholders</li> <li>partners contribute and allocate a fair share of resources (financial and non-financial)</li> <li>roles and responsibilities are clear, agreed, and documented</li> <li>decision-making processes are transparent, understood, agreed, appropriate, facilitate the work of the partnership</li> <li>partners deliver on their commitments</li> </ul>
	Informal partnership dimensions	The extent to which: <ul style="list-style-type: none"> <li>partners trust and respect each other to commit and deliver on commitments</li> <li>partners have a reputation that promotes confidence in other partners</li> <li>decision making and accountability processes promote trust and respect</li> </ul>
Process	Partnership practice	The extent to which: <ul style="list-style-type: none"> <li>interactions between partners are positive, appropriate, as agreed, subject to review</li> <li>there are processes for review and evaluation of the partnership and the partners</li> <li>there is an ethos of collaboration, communication and learning</li> <li>there is mutual benefit; each partner's capacity is acknowledge, respected and strengthened further; partnership practices are subject to continuous improvement</li> <li>there is equality in decision making, resource exchange, partner representation and participation</li> <li>partners perceive even benefits</li> <li>there is reciprocal accountability</li> <li>there is shared risk; level of risk appropriate to situation</li> </ul>
	Partnership performance	The extent to which: <ul style="list-style-type: none"> <li>positive partner relationships are forming and being maintained</li> <li>partnership effectiveness is being reviewed and practices adapted as required</li> <li>partners address issues effectively, efficiently and ways that are supportive of ongoing partnership effort</li> <li>partners are aware of what makes for good practice and performance and work to creating and strengthening these</li> </ul>

Aspect	Dimension	Key areas of assessment
Outcomes	Effectiveness	<p>The extent to which:</p> <ul style="list-style-type: none"> <li>agreed objectives and outcomes are being met</li> <li>the partnership is having a positive influence on relevant administrative, service delivery and community capacity</li> <li>partners understand the needs of beneficiaries and work toward responding to these</li> <li>effectiveness of processes of engagement with stakeholders and beneficiaries</li> </ul>
	Efficiency	<p>The extent to which:</p> <ul style="list-style-type: none"> <li>partners use all available resources efficiently for the correct purposes</li> <li>partners perceive mutual benefits; the extra benefits outweigh the costs of the partnership; partners are satisfied with the partnership and what it is achieving; obligations and drivers are being met; reputation is enhanced</li> <li>the partnership costs are appropriate to the level of outcomes and other benefits</li> <li>gains in social capital forms of transaction costs outweigh administrative transaction costs</li> <li>the partnership achieves things that would not otherwise be achieved ; there are multiplier effects</li> </ul>