Rapidly Expanding Access to Care for HIV in Tanah Papua (REACH) 2012 – 2016

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Acknowledgements

Contents

Figures, tables and boxes

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AIP	Australia Indonesia Partnership
AIPD	Australia Indonesia Partnership for Decentralisation
AIPH	Australia Indonesia Partnership for HIV
AIPHSS	Australia Indonesia Partnership for Health System Strengthening
ANC	Antenatal care
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASHM	Australasian Society for HIV Medicine
AusAID	Australian International Development Agency
BAPPEDA	Regional Development Planning Agency
CEPAT	Community Empowerment of People against Tuberculosis
CHAI	Clinton Health Access Initiative
CoE	Centre of Excellence
CSO	Civil Society Organisation
CST	Care, Support and Treatment
DFO	District Finance Office
DHO	District Health Office
DOTS	Directly Observed Therapy Short (course)
EDL	Essential Drugs List
EQA	External Quality Assurance
FSW	Female Sex Worker
GIPA	Greater Involvement of People Living with HIV/AIDS
GoI	Government of Indonesia
HCPI	HIV Cooperation Program for Indonesia
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
IBBS	Integrated Biological-Behavioural Surveillance
IHPCP	Indonesia HIV/AIDS Prevention and Care Project
IMAI	Integrated Management of Adult Illness
IPR	Independent Progress Review
IT	Information Technology
MARPs	Most-at-Risk Populations
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDG	Millennium Development Goals
MoH	Ministry of Health
MOU	Memorandum of Understanding
MSM	Men who have sex with men
MWM	Medical waste management
NIH	National Institutes of Health (US)
NIHRD	National Institute of Health Research and Development
NTP	National Tuberculosis Program
OI	Opportunistic Infections
PCC	Partnership Coordination Committee (AIPH)

PCR	Polymerase Chain Reaction
PFO	Provincial Finance Office
PHO	Provincial Health Office
PHL	Provincial Health Laboratory
PITC	Provider Initiated Testing and Counselling
PKM	Puskesmas (primary health care centre)
PLHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
PNG	Papua New Guinea
PPT	Periodic Presumptive Treatment
PSC	Provincial Steering Committee (REACH)
QC	Quality Control
RDT	Rapid Diagnostic Test
RPR	Rapid Plasma Reagin
SCM	Supply Chain Management
SOP	Standard Operating Procedures
STI	Sexually Transmitted Infection
SUM	Scaling Up for Most-at-Risk Populations
TB	Tuberculosis
TPHA	Treponema Pallidum Haemagglutination Assay
UNICEF	United Nations Fund for Children
USAID	United States Agency for International Development
VCT	Voluntary Testing and Counselling
WHO	World Health Organisation

Executive summary

The Rapidly Expanding Access to Care for HIV in Tanah Papua Program (REACH) is a technical assistance program in the area of HIV care, support and treatment (CST). The end of program goal is increased access to and increased number of people on HIV-related[1] care and treatment in Papua and West Papua, Indonesia's two highest HIV prevalence provinces. This funding proposal for REACH outlines how the Clinton Health Access Initiative (CHAI) will work with AusAID and partners to support rapid scale up of the Indonesian Ministry of Health's (MoH) national Care, Support and Treatment Program in Tanah Papua[2]. The budget for the four year REACH program is A$ 24,990,417.

The most effective way of increasing access to HIV treatment in Tanah Papua is to make quality treatment available closer to where infected people live. REACH will provide technical assistance to Indonesian government health services so that they can decentralise and expand quality care. To maximise the impact of service delivery, it is necessary to simultaneously ensure the supply chain for key commodities, and central government policies around HIV-related treatment and care, are evidence based. REACH will be directed by data about what works best in a challenging setting. Technical support for service provision will be underpinned by a substantial investment in solid monitoring systems and operational research.

REACH will have four program components. These components and their objectives are:

Care, support and treatment in Tanah Papua: To increase the number of Government of Indonesia (GoI) supported health facilities that are well staffed and equipped and providing quality HIV-related clinical services in Tanah Papua.

Supply chain management (SCM) for HIV-related commodities: To decrease stock outs and increase efficiency of strengthened supply chain management of HIV-related commodities.

Policy support to the MoH: To develop, disseminate and implement an evidence-based MoH national policy framework relevant to HIV-related care, support and treatment.

Operational research: To generate and apply knowledge that contributes to achieving the program goal of increasing access to high quality HIV-related treatment in Tanah Papua.

The most recent population prevalence survey (2006) found that 2.4 per cent of adults in Tanah Papua were infected with HIV. This is over 18 times the HIV prevalence for the rest of Indonesia. It is estimated that in 2009, 38,000 adults were living with HIV: 9,000 in West Papua and 24,000 in Papua. Of those, some 24,000 live in districts that have not previously had access to HIV testing and treatment but that will be covered by REACH. Although poor access to treatment will have resulted in many HIV-related deaths since 2006, the limited coverage, intensity and efficacy of prevention programs means it almost inevitable that new infections have outstripped deaths and that the number of people living with HIV has risen since 2006 and is now greater than 38,000.

Although HIV has spread among men and women in the general population, commercial sex continues to contribute disproportionately to the epidemic in all areas. In 2011, HIV prevalence rates among sex workers ranged from 3.2 to 25 per cent, with 35 to 60 per cent of sex workers being infected with at least one sexually transmitted infection (STI)[3]. However, given the already elevated

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[1] HIV-related is an inclusive term referring to HIV, TB, STIs and PMTCT.
[2] Tanah Papua refers to the 'land of Papua', including both Papua and West Papua provinces.
[3] MoH AIDS Sub Directorate, Indonesia 2011 IBBS.

levels of HIV in the general population, coupled with high levels of multiple sex partners, especially in the highlands, it is very plausible that the HIV epidemic is now self-sustaining even without the contribution of commercial sex.

HIV testing rates are low, with a cumulative total of only 13,305 people having been diagnosed with HIV, many of whom have already died. Access to HIV treatment is particularly low with only 1,897 people currently on antiretroviral therapy (ART) in Tanah Papua. This represents only 15 per cent of an estimated 12,540 people in need of treatment. Though Tanah Papua accounts for over a quarter of estimated HIV infections in Indonesia, it accounts for only 6per cent of Indonesians on HIV treatment. Most present with late stage disease making effective treatment more difficult, increasing stigma and increasing dependency as they are unable to work. REACH will expand and promote access to HIV testing and treatment before the onset of symptoms.

The current AusAID supported CHAI Phase II program has shown that decentralisation of HIV CST to primary care through puskesmas[4] is effective, with a rapid increase in the number of patients on treatment, improved treatment adherence and a significant decrease in patients lost to follow up. Under REACH, the program will be rapidly scaled up, expanding from three to 21 districts (15 in Papua and 6 in West Papua). CHAI will support Provincial Health Offices (PHOs) to establish nine Centres of Excellence (CoE). The CoE will serve as both regional referral centres for complicated cases and as base for expert teams that will facilitate the decentralization process through training, mentoring and monitoring in puskesmas. They will support the expansion of HIV CST services in 17 hospitals in Papua and three in West Papua and an additional 120 satellite puskesmas. CoE will come on-line progressively over 18 months and the 120 puskesmas over four years. CHAI's role will be technical assistance rather than direct service delivery.

Key indicators and targets will be set in the first quarter of the program. Initial numbers of people that will benefit from REACH over the four years of the program include:

- An estimated 640,800 people will be tested for HIV. Of those tested, an estimated 25,200 people will be found to be HIV positive and provided with ongoing monitoring and care, with 20,160 people commencing on antiretroviral (ARV) drugs. The 615,600 people found to be negative will have access to prevention counselling, condoms, STI services and repeat HIV testing in the future.
- An estimated 2,600 people will be diagnosed with TB and receive treatment.
- An estimated 80 per cent of sex workers at target sites will receive routine STI and HIV examinations and related treatment every three months.
- An estimated 80 per cent of pregnant women attending antenatal care at target sites will receive HIV and syphilis screening and treatment as needed.

The model takes an integrated approach to service delivery which will include HIV, tuberculosis (TB) and STI testing and treatment and prevention of mother to child transmission (PMTCT). Other sub-components will include strengthening of laboratory capacity and puskesmas infrastructure and medical waste management.

The assessment of the team developing this proposal is that there is more than adequate fiscal space in provincial and district budgets to significantly increase funding for health services. The two key issues that need to be addressed are the priority accorded to health and efficient and effective use of funds. As districts will be responsible for health service delivery costs, REACH will work actively with all levels of government to advocate for increased funding for health services and assist in

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[4] Puskesmas are primary health care centres and are the backbone of primary health care in Indonesia.

improving planning, resource allocation and ensuring adequate staffing of health facilities. AusAID funding will support the CoE for the first three years, with PHOs being responsible for funding from year four.

Success in achieving the end of program goal ("increased access to and increased number of people on HIV-related care and treatment in Tanah Papua") will contribute to the long term goal of reduced HIV-related morbidity and mortality in the two provinces.

In addition to strengthened HIV, TB, STI services and PMTCT through maternal and child health services, the benefits of REACH will have a broader effect through enhanced management, planning, budgetary and supervisory capacity for PHOs and District Health Offices (DHOs); improved communication and linkages with Regional Development Planning Agencies (BAPPEDA) and Provincial and District Finance Offices (PFOs, DFOs); strengthened links and referral pathways between district hospitals and puskesmas; strengthened laboratory capacity and puskesmas infrastructure; potential demand creation for HIV and a broader range of services at the primary health care level; and potential application of findings from operational research to other areas of health care in Indonesia.

Effective SCM of HIV-related drugs and commodities is a prerequisite for adherence and the provision of clinical services. Under REACH, CHAI's technical support to the MoH will focus on four areas: 1) strengthening of SCM systems for HIV-related commodities, including reagents and medications for tuberculosis and STIs in Papua and West Papua; 2) extending the decentralised model of ARV SCM to 12 provinces, including West Papua; 3) further strengthening of the MoH's national HIV SCM system; and 4) undertaking work with the MoH's Pharmaceutical Directorate to promote realisation of the One Gate policy for integration of all SCM systems in Indonesia in the medium to long term. CHAI will also develop a transition plan that will result in progressive hand-over of SCM functions and technical assistance to the MoH's AIDS Sub Directorate, with a full exit by the end of REACH in mid-2016.

Under REACH, CHAI will strengthen its technical support to the AIDS Sub Directorate for development, dissemination and implementation of evidence based national policies relevant to HIV CST. This will be done through establishment of a small Policy Secretariat within the Sub Directorate to assist policy review and development by expert panels. The Secretariat will work to ensure that MoH and partner training curricula are consistent with national policy, and to establish a distribution system for policies to the health sector and professional associations. CHAI, through its technical assistance, will promote implementation of national policies in the Papuan provinces and bring lessons from the field to the national level to inform policy development.

REACH includes a strong operational research component, linked to a robust program monitoring system, that will focus on what works and what does not when trying to increase provision and access to HIV-related services through routine health systems in a challenging context. Findings are likely to have application to both HIV and non-HIV services in the Papuan provinces and other parts of Indonesia. The research agenda will be developed using inclusive processes which seek to ensure that research questions are program-relevant and that research results are likely to be used. Research will be undertaken in partnership with GoI and other partners such as the Australia Indonesia Partnership for Decentralisation (AIPD). There will be a strong focus on both provincial level dissemination and rapid use of findings in program implementation and sharing findings with a broad range of partners at the national level to inform HIV and other health programming.

REACH is an ambitious project that faces multiple programmatic and external risks in a challenging environment. This proposal has placed a strong emphasis on identification of risks and controls to mitigate impact. CHAI will implement a cascading issues management framework that regularly

monitors issues and risks from site level upwards. The management and staffing of CHAI has been enhanced and restructured to support the significant effort required for this program scale up. A proactive approach will be taken to staff recruitment through networking, with a focus on maximising recruitment of Papuan staff.

In the course of designing this proposal the team identified multiple areas where strong synergies exist between REACH, other AusAID programs, and other donor programs where outcomes for all programs could be enhanced through a collaborative approach. Key areas where consistency or synergies exists are: 1) facilitation of decentralisation processes; 2) health system strengthening; 3) demand creation for HIV testing and treatment, and prevention; 4) policy support for the MoH; 5) technical assistance for health programs; and 6) operational research.

Key features of this proposal are:

- REACH is fully aligned with the GoI HIV CST program.
- Technical assistance will be based on international best practice for HIV CST, with a particular focus on evidence from resource poor settings.
- REACH is based on a CST technical assistance model that has proven to be successful in CHAI Phase II, but which has been modified to incorporate lessons learned.
- REACH represents an urgent response by seeking to rapidly scale up access to life-saving HIV-related CST; transitioning over the life of the program to a sustainable response as provincial and district health authorities take on progressively more responsibility.
- REACH will promote Indonesian leadership based on a partnership with the GoI at the national and sub-national levels, with defined areas of responsibility and accountability.
- The aid modality is based on provision of technical assistance with leverage of sustainable health investments from government.
- REACH is ambitious but realistic and flexible. CoE and puskesmas will come on line progressively and there is scope to vary the roll-out schedule if needed.
- REACH focuses on strengthening primary health care provision to improve access by poor and vulnerable people.
- Strengthening of primary health care will contribute to overall system cost effectiveness.
- The end of program goal is clear, measurable, quantifiable and focussed on beneficiaries (that is, number of people on treatment). Other measures of success will also be quantifiable or measurable: for example, number of health facilities better equipped and providing quality services, contribution to reduced mortality and morbidity, reduced stock outs, and policy and programming replication.
- REACH will leverage off other development partners in Tanah Papua through more effective partnerships.
- REACH will place a strong emphasis on robust data collection, analysis and application for continuous program improvement and potential use of findings for HIV CST programming in other parts of Indonesia and other areas of health care.
- REACH will benefit from sharing of lessons learned by CHAI's AusAID funded Rural Initiative in Papua New Guinea which has been focussed on increased access to HIV-related CST in the highlands.
- REACH has defined sustainability mechanisms through identification of responsibility by government for funding contributions.

1.   Situation analysis and strategic context

Section 1 provides a situational analysis of relevant issues considered in the design of this funding proposal. The analysis is organised into six categories:

1. Indonesian health sector overview and decentralisation
2. Papua and West Papua overview
3. HIV in Indonesia and the response
4. Programmatic needs
5. Consistency with AusAID and other donor programs
6. Rationale for AusAID's involvement

1.1   Indonesian health sector overview and decentralisation

1.1.1   Indonesian health sector overview

Government of Indonesia (GoI) funding to the health sector is low by international standards. Total health spending in 2008 accounted for only 2.2 per cent of GDP.[5] The low levels of government spending on health are reflected in weak service delivery and poor health indicators in a number of key areas. However, the GoI has strengthened its resolve to reform, placing health high on its development agenda and devoting more funds to the sector. Government expenditure on health increased from 4.5 per cent to 6.5 per cent of total government expenditure between 2000 and 2007.[6]

Out of pocket expenses on health care are high and are a potential cause of poverty. In 2008, almost 60 per cent of Indonesians did not have health insurance. The GoI is committed to achieving universal coverage for health insurance that will include HIV care, support and treatment (CST), although plans for how this will be achieved are under development.

Primary health care has become increasingly reliant on central government funding and user fees, with limited support from district governments, although the level of district support is variable. While the government has increased funding for a number of priority health issues, targeted funding is primarily directed to hospitals rather than primary care for the poor. The Ministry of Health's (MoH) Strategic Plan includes targets to strengthen primary health care, including HIV CST, through enhancing the role of puskesmas.[7]

Although there is an extensive infrastructure of primary health care facilities, they are under-funded, poorly staffed and often not well maintained, particularly in more remote sites. A significant number of puskesmas do not have doctors and shortages of nurses are common. Many do not have laboratory technicians to support even rudimentary testing. Shortages of health workers are particularly severe in rural and remote areas in the Papuan provinces. Service utilisation of primary health care in Indonesia is low, particularly in rural and remote areas. Poor access to health care can be both a cause and consequence of poverty. Barriers to accessing health care include distance from services, especially in rural and remote areas; user fees and the cost of transport; lack of knowledge of entitlements under health financing schemes; cultural barriers, including a preference for traditional therapies; health seeking behaviours; and consumer perceptions of the quality of care.

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[5] WHO, World Health Statistics 2010.

[6] *ibid.*

[7] Puskesmas are primary health care facilities at the sub-district level. They are the backbone of primary health care in Indonesia.

1.1.2 Decentralisation and health care

Decentralisation in Indonesia has resulted in much of the responsibility for health care service delivery resting largely with provincial and district governments. However, many provinces and districts have not yet developed the capacity to identify local health needs, take a population health approach to service planning, manage their health budgets, or set targets, establish accountability and monitor progress.[8] As a result, decentralisation has not yet resulted in improved health outcomes. Districts are constrained by multiple funding channels with different reporting requirements, delays in funding disbursements both centrally and locally, and by the centralised control over health workforce regulations. Service delivery capacity has been further weakened by the creation of new provinces and districts, which has been particularly common in the Papuan provinces. There is a high likelihood that additional provinces and/or districts will be created in Tanah Papua in coming years[9].

From a supply-side perspective, effective strategies to make decentralisation work require interventions at the national, provincial and district levels. The national government still sets policies and decides on program directions and has a strong influence over the bulk of funding. Provincial governments are expected to play important support, capacity building and monitoring/accountability roles in relation to service delivery. District governments have primary responsibility for delivery of health services and are key in resource allocation and local programming. From a demand side perspective, civil society organisations could have a key role to play in advocating for services and in monitoring delivery and community mobilisation but their voice has not been heard in the Papuan provinces to any great extent. Local parliaments could also play a key 'watchdog' role but need service delivery targets and data to effectively perform that function. Both of these roles are currently underdeveloped.

1.2 Papua and West Papua overview

The total population of Papua and West Papua is 3.65 million people, with 79 per cent living in Papua. (Table 1 below, outlines the demographic data.) It is estimated the proportion of ethnic Papuan and non-Papuan people living across the two provinces is now roughly equal,[10] although there are significantly more Papuans living in the highlands and hard to access lowlands, with larger numbers of non-Papuans living in the cities and easy to access lowlands. There is significant ethnic diversity among Papuans, reflected in 250 different spoken languages. Social, cultural and economic systems are also hugely varied.[11]

The Papuan provinces have the highest levels of poverty in Indonesia, with the proportion of people living below the poverty line being almost three times the national average. Ranking on the Human Development Index in relation to Indonesia's 33 provinces is 30 for West Papua and 33 for Papua.[12]

Christianity is the dominant religion, particularly among Papuans. The extensive reach of both Protestant and Catholic churches to the village level provides potential opportunities for community mobilisation around health and social issues.

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[8] World Bank, Making the New Indonesia Work for the Poor (Overview), 2006

[9] Tanah Papua means the land of Papua and refers to both Papua and West Papua provinces.

[10] Elmslie, J., *West Papuan Demographic Transition and the 2010 Indonesian Census*. CPACS Working Paper 11/1. University of Sydney. 2010.

[11] GRM, Papua Assessment. USAID/Indonesia. p. 32.

[12] UNDP, Human Development Report, 2009.

Health standards in the Papuan provinces are considerably worse than in other parts of Indonesia. Special autonomy for the Papuan provinces is designed to devolve authority on funding to boost spending in key sectors such as health. Government spending on health in Papua Province in 2008 was 2.4 per cent of the total provincial budget, significantly below the level of national government expenditure on health (6.5%).[13] The central government has made considerable additional financial resources available to the Papuan provinces to accelerate development though these funds are mostly being used for infrastructure projects in preference to human services. There is a need for provincial and district government in the Papuan provinces to give considerably higher priority to health services and to use funds more effectively by improved prioritisation, planning, resource allocation, management and accountability.

Extensive development of health service infrastructure in the 1970s is reflected in the existence of 460 puskesmas across the two provinces. However, these facilities suffer from understaffing, underfunding, problems with medical supplies, poor planning and coordination, limited infrastructure and poor maintenance. A lack of staff housing makes it difficult to attract staff to remote areas. Access to primary health care is poor, especially in rural areas, where villages are scattered throughout mountainous and forested areas, with very limited transport infrastructure.

There is a significant sex industry in urban areas and the shipping ports of Papua and West Papua and also in more isolated parts, usually associated with natural resource extraction sites and infusion of development funds.

Table 1: Key demographic and other indicators: Papua and West Papua provinces

Key demographic and other indicators	Papua	West Papua
Total population	2.9 million	0.75 million
People living below the poverty line (national average 14%)	38%	36%
Human Development Index (national average 72)	65	69
Provincial ranking for Human Development Index	33	30
People who nominate Christianity as their religion	83%	61%
Districts	29	11

Source: Indonesia Census, 2010 and CHAI

1.3 HIV in Indonesia and the response

1.3.1 National overview of epidemiology and the national response

Estimated adult HIV prevalence in Indonesia in 2009 was 0.15 per cent[14]. If the Papuan provinces are excluded, prevalence drops to 0.13 per cent. In the non-Papuan parts of Indonesia, HIV infection is concentrated primarily in drug injectors, female and transgender sex workers, men who have sex with men, prisoners and men in mobile occupations. An overview of the epidemiology of HIV in Indonesia is in Annex 1. A description of the HIV epidemic in Papua and West Papua is in section 1.3.2.

The goal of the *National AIDS Strategy and Action Plan 2010-2014* is "to prevent and reduce transmission of HIV infection; improve the quality of life for people living with HIV; and to reduce

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[13] GRM, Papua Assessment. USAID/Indonesia. p. 32.

[14] This figure is commonly rounded up in national documents to 0.2 per cent.

the socio-economic impact of the AIDS epidemic on individuals, families and society."[15] The CST objective is to "provide quality care, support and treatment services that are accessible, affordable and client friendly for all people living with HIV who need services."[16]

The access target for antiretroviral (ARV) drugs is for all eligible people living with HIV/AIDS (PLHA) to be on treatment. Strategies to reach this target are increased HIV testing as an entry point to treatment, increasing the number and quality of hospitals and community health centres providing CST, increasing the number and quality of health care providers; strengthening supply chain management (SCM) of essential medicines; and strengthening the role of community based health services. The target for prevention of mother to child transmission (PMTCT) is for all HIV positive pregnant women and their children to receive ARV prophylaxis as appropriate. For PMTCT the strategies are to significantly increase the number of pregnant women and their partners who test for HIV and expanded availability of PMTCT through existing maternal and child health (MCH) services. The national strategy proposes integration of HIV into sexually transmitted infection (STI), MCH and tuberculosis (TB) services.

There has been significant scale up of access to antiretroviral therapy (ART) over the last six years, but coverage is low by global standards. At June 2011, a total of 21,775 people were receiving ART which is estimated to be around one-third of those eligible. ART is primarily available from hospitals, although the MoH is starting to decentralise ART to puskesmas satellite sites. The model of decentralised CST adopted by the MoH's AIDS Sub Directorate is outlined in Annex 2. Continued scale up is planned along with a focus on patient retention, adherence and service quality. Coordination and supervision at the provincial and district levels needs to be improved, including better training and mentoring.

Indonesia is currently not on track to meet the Millennium Development Goals (MDG) targets for HIV. However, improvement of performance in relation to the MDG targets is a high priority for the GoI. The Government's *Road Map to Accelerate Achievement of the MDGs in Indonesia* has explicit targets through to 2014 to increase HIV testing and the percentage of PLHA who receive ART. Strategies identified to meet those targets include improving the number and quality of health care facilities providing diagnosis and treatment and care; mobilising additional financial resources through integrating HIV into development programs financed at both the national and local levels; and defining the respective roles of national provincial and district health authorities.

Many of the key building blocks for STI control programming are in place. There are National STI Guidelines, a National STI Control Strategy (2008-2012) and a national Essential Drug List (EDL). Unfortunately, the current National EDL does not include a number of STI drugs that are listed in the National STI Guidelines including cefixime, azithromycin and metronidazole.

1.3.2 Papua and West Papua

Epidemiology

Altogether, the two Papuan provinces are home to just one per cent of adult Indonesians, but 26 per cent of the Indonesians estimated to be living with HIV, according to national estimates made in 2009 and revised with more complete data by the design team.

Ethnographic studies and other surveys have suggested that patterns of sexual networking among Papuans have fuelled a more widespread epidemic; young Papuans report starting to have sex earlier than non-Papuans in the same province, Papuan men are more likely than non-Papuans to

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[15] National AIDS Commission, *National AIDS Strategy and Action Plan 2010-2014*. p. 19.
[16] National AIDS Commission, *National AIDS Strategy and Action Plan 2010-2014*. p. 19.

report buying sex, multiple concurrent partnerships are more frequently reported, and alcohol consumption before sex is much more common.

STIs and HIV among female sex workers

The 2011 national Integrated Biological-Behavioural Surveillance survey among key affected populations found HIV prevalence rates among FSW varied from 3.2 per cent to 25 per cent, depending on geographic location and type of sex worker. The highest prevalence rate was among street-based FSW in the highlands town of Wamena. Of those with HIV, three quarters were currently infected with at least one other STI (syphilis, chlamydia or gonorrhoea). Among the HIV negative, two thirds had another STI. (See Table 10 in Annex 1 for more data on HIV and STI prevalence among FSWs.)

With such high rates of HIV, STI infection and unprotected sex, it is certainly the case that commercial sex continues to contribute disproportionately to new infections throughout the Papuan provinces. In order to reduce the ongoing spread of HIV stronger and more effective prevention among sex workers and their clients will be needed. Effective STI and HIV treatment for infected sex workers provided under REACH will contribute to preventing the ongoing spread of the virus.

HIV in the general population

In 2006, 2.4 per cent of the 6,217 adults in Tanah Papua aged 15-49 tested for HIV in the population prevalence survey were infected with the virus. That is over 18 times the prevalence of 0.13 per cent estimated in 2009 for the rest of Indonesia. In the area that is now Papua province prevalence was 2.5 per cent, and in West Papua, 2.1 per cent. HIV prevalence was significantly higher among men than among women, (2.9% vs. 1.9%) and higher among ethnic Papuans than among non-Papuans in West Papua, (4.1% for male Papuans and 1.8% for female Papuans vs. 1.8% for male non-Papuans and 0.4% for female non-Papuans).[17] Among men, the recorded prevalence of HIV was slightly greater in the highlands than in the rest of Tanah Papua. Among women, the reverse was true. The differences between highland and lowland areas were not, however, statistically significant. HIV prevalence was nearly twice as high in areas classified as "rural" than in urban areas (2.9% vs. 1.5%). (See Table 11 in Annex 1 for more data on HIV prevalence in the general population.)

It is plausible, at the levels of HIV prevalence found in the 2006 IBBS and given what is known about sexual networking, that HIV could continue to circulate among the general population in Tanah Papua even in the absence of commercial sex. This is especially true in the highlands; 27 per cent of men and 11 per cent of women in the highlands reported multiple sex partners in the previous year in the 2006 IBBS survey compared with 18 per cent of men and four per cent of women in non-highland areas (see Table 4 in the section on gender for more details).[18] Applying the district-level prevalence measured in 2006 to the 2009 population projections from the Central Bureau of Statistics and adding the number of brothel-based sex workers estimated to be infected with HIV (since these women, unlike other higher risk groups such as men who buy sex or women who sell sex on the streets, would not be captured in a household survey) gives an estimated 38,000

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[17] The difference in prevalence between ethnicities reached statistical significance at the 95% level only in West Papua.

[18] The rates of extramarital sex reported in the 2006 IBBS is far higher than that reported in the 2007 Demographic and Health survey. Just 2.8 per cent of currently married men in Papua and no currently married men in West Papua reported extramarital sex in the previous 12 months in the DHS survey, compared with 18.6 per cent and 11.2 per cent respectively in the far larger IBBS sample.

adults living with HIV in Tanah Papua: 9,000 in West Papua and 29,000 in Papua. Of those, some 24,000 live in districts that will be covered by REACH. [19]

No data on behaviour among the general population have been collected since 2006. It seems unlikely that prevention campaigns using non-specific slogans such as "HIV is important", which appear to form the bulk of prevention messages currently reaching the general population in Papua, will lead people to have sex with fewer partners, or to use condoms more frequently. Although access to treatment has been poor and many of those who were already HIV infected in 2006 will have died, it is almost inevitable that new infections have outstripped deaths and that the number of people living with HIV has risen since 2006 above 38,000, but it is not possible to make a meaningful estimate of the number of people currently living with HIV.

The Ministry of Health is planning another round of household-based HIV and behavioural surveillance in Papua and West Papua in 2012. The survey will include an oversampling in the highland areas where REACH will concentrate its activities, and should provide more reliable information on the number of people likely to be in need of HIV and STI treatment and related services in program areas.

HIV and gender

In Indonesia as a whole it is estimated that four out of five people living with HIV are male. In the Papuan provinces, both sex workers and other women are at higher risk for HIV than their counterparts elsewhere in Indonesia, in part because HIV prevalence among the men they have sex with is higher. Representative household surveys on extramarital sex among women are not available for other areas of Indonesia, but Papuan women are almost three times more likely to report multiple sex partners compared with non-Papuan women living in the Papuan provinces (see Table 2). However Papuan and non-Papuan women alike are still far less likely to report multiple partners than men are - a common feature of historically polygamous societies. Women are also much less likely to report selling sex than men are to report buying it, though the proportions reporting selling sex are remarkably high for a household survey, particularly among ethnic Papuan women.

Table 2: Sexual behaviour in Tanah Papua, by gender and ethnicity, 2006

Sexual behaviour	Men		Women	
	Papuan	Non-Papuan	Papuan	Non-Papuan
Two or more sex partners in last year	21.2	10.3	8.2	3.2
Men who bought sex in last year	11.3	5.5		
Women who sold sex in last year			2.7	1.4

Source: IBBS, 2006

In the 2006 IBBS survey, men in Papua province were 30 per cent more likely to be infected with HIV than women. This sex ratio is identical to that in the Papuan case report data, suggesting that there are no major biases in case detection by gender, at least when aggregated over time. However it is also interesting to note that late detection (cases reported once they had already progressed to AIDS) is more common for men than for women. Some 63 per cent of cases ever reported among

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[19] These estimates differ from the official 2009 national estimates because they use more detailed district level prevalence (which raises the estimate slightly compared with the previous mid-value) and adjust for previous double counting (which lowers it). The official mid-level estimate for HIV infections among high risk populations and the general population in Papua in 2009 was 32,700.

men in Papua were detected when the person already met the case definition for AIDS, compared with 53 per cent among women. There are two likely reasons for this: proactive HIV testing of female sex workers, and the fact that women are more likely to come into contact with the health system than men are (and therefore potentially to get tested earlier in the course of their infection). The differential is likely to grow over time as more sites begin provider-initiated testing in settings such as ante-natal clinics.

In West Papua, the sex ratio of HIV infection recorded in the 2006 IBBS was far higher than in Papua province: men were nearly three times as likely as women to be infected. If women's extramarital sexual relations do indeed support the spread of HIV through heterosexual networks independent of commercial sex in West Papua, this differential will be eroded over time.

Papuan women suffer from gender inequality which can take multiple forms, including rape and other forms of gender based violence and generally lesser access to social services such as education and justice. While women are more frequent users of health services than men, their access to health services can be reliant on male permission. There is a need for health services to have a strong gender sensitivity and to develop strategies to deal with gender inequality.

The HIV response

Papua and West Papua provinces have developed strategic plans for HIV which are consistent with the *National AIDS Strategy*. The Provincial AIDS Commissions have developed a joint *Communications Plan for HIV and AIDS Prevention and Management in Tanah Papua* and more recently a draft communications plan for the highlands. While both plans refer to the need to increase HIV testing and utilisation of CST services, the plans and implementation have been criticised for a lack of specificity and efficacy in their strategic approach on these issues.

HIV awareness and prevention programming in the Papuan provinces is conducted by the Provincial AIDS Commissions and local civil society organisations, some of which are donor funded, and consists of general awareness raising and communication campaigns around themes such as HIV testing for the general population and targeted interventions for most-at-risk populations (MARPs). Overall, HIV prevention work lacks sufficient coverage and intensity, with vague messages about the need to test and an insufficient focus on key populations such as FSWs and their clients.

A description of the current state of HIV CST in Papua and West Papua is in section 1.4.1.

1.4 Programmatic needs

This sub-section gives an overview of programmatic needs and the Clinton Health Access Initiative's (CHAI) current work under Phase II in three areas:

1. HIV care, support and treatment needs in Papua and West Papua
2. Supply chain management for HIV-related[20] commodities nationally and in the Papuan provinces
3. HIV care, support and treatment policy support to the Ministry of Health

1.4.1 HIV care, support and treatment in Papua and West Papua

Issues and current situation

HIV

Since testing began in Tanah Papua in the mid-1980s, approximately 13,305 people are recorded as having been diagnosed as HIV-infected[21] (Table 3). Most are either known to be dead, (1,235) or

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[20] For the purposes of this proposal, HIV-related is an inclusive term referring to HIV, TB, STIs and PMTCT.

been lost to follow-up and presumed dead (>8,000) by the medical centres where they were diagnosed. Of the current 38,000 plus individuals thought to be living with HIV in the Papuan provinces, 1,879 are currently on ARVs and another 1,300 in Papua are taking antibiotic prophylaxis for pneumocystis pneumonia and diarrhoea. Of those diagnosed with HIV, an unknown number are awaiting CD4 testing or clinical signs of AIDS before initiating treatment.

Table 3: Key HIV indicators, Papua and West Papua

Key HIV indicators	Papua	West Papua	Totals
Cumulative HIV diagnoses	10,552	2,873	13,305
Known deaths from AIDS	369	866	1,235
Lost to follow up	7,293*	1,598*^	8,891
Currently on ARV	1,560	319	1,879

* May include some patients followed but no CD4 results or clinical signs

^ Unknown number on cotrimoxazole and may not be LTFU

Direct and indirect sex workers in Jayapura included in the 2011 IBBS reported the highest level of HIV testing in Indonesia (89% and 74% respectively). Motor-bike taxi drivers in the same city also topped the charts for male groups: nearly one in four reported an HIV test, over three times the national average for men in mobile occupations. Less encouragingly, just a third of the street-based sex workers in the highland town of Wamena had ever been tested for HIV. In 2006, before any significant efforts had been made to scale up testing, just 2.4 per cent of adults in Tanah Papua reported ever having been tested for HIV and less than one per cent said they had received their test result. Few people who are at risk for HIV, or know they have been HIV exposed, come in for an HIV test of their own accord, a necessary first step in the VCT model. If a patient does get tested at a site other than an ART satellite clinic, they will often have to travel to a distant HIV referral centre for clinical staging and initiation of treatment.

If a patient is diagnosed HIV positive and asymptomatic, laboratory testing to establish immune status (CD4) is often not available in rural areas. Patients are eligible to start on treatment if their CD4 count drops below 350 cells/mm. In the absence of CD4 testing, ART is postponed until symptoms appear or an AIDS defining opportunistic infection (OI) is diagnosed as a result of a damaged immune system. Wider access to HIV and CD4 testing would allow early initiation of treatment before significant immune system damage occurs. Most symptomatic HIV positive individuals present with pulmonary or extra-pulmonary tuberculosis or diarrhoea and wasting, stage three or four HIV disease, and nearly all are eligible for beginning ART. Unfortunately, ART is often not initiated because of adherence concerns by care providers and the possibility of the development of antiretroviral drug resistance due to irregular dosing of medications. In addition, the distance between home and the limited number of treatment sites are simply too far for patients to return for all the necessary follow-up visits and monthly collection of medications. Decreasing distance from home to treatment sites would ease patient burden. Improved training for health care providers and community support could improve adherence.

Tanah Papua is vast covering 415,000 square kilometres, over three times the size of Java. Transportation infrastructure is underdeveloped and the cost of transport is expensive. Of 38 public, private and military hospitals in Tanah Papua, only 16 are designated ART sites (Table 4). Of the 460 puskesmas, only 50 are registered as ART site satellites. Most of these are in large coastal

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[21] Since there is no unique identifier system, these data will double or multiple-count anyone who has had more than one positive test, for example at different service providers or in different cities.

cities. In West Papua there is only one satellite in Fak Fak, one in Manokwari and four in Sorong. All these satellites are in the respective West Papuan cities and do not serve more isolated populations. In the Papuan highlands, home to nearly 60 per cent of the Papuan population and an estimated 15,000 HIV-infected people in potential need of treatment, there are three hospital ART sties and only two puskesmas satellite ART sites.

Tanah Papua accounts for over 25 per cent of the total national estimate of PLHA, but, with only 1,879 people on treatment, accounts for only 6% of the total number on ARV within Indonesia (5% in Papua and 1% in West Papua).

Table 4: Health services in Papua and West Papua

Health services	Papua	West Papua	Total
Total hospitals	26	12	38
Total puskesmas	334	126	460
VCT sites	59	17	76
ART sites	12	4	16
Satellite ART sites	44	6	50
Hospitals providing TB diagnosis and care	20	6	26
Puskesmas providing TB diagnosis and care	147	6	153

Many of those HIV infected in the highlands live far from the four hospitals that serve the region. Many of the 180 highlands puskesmas are either non-functional or unable to provide testing, provision of ARV, medications for OIs and monitoring of health status for those HIV infected because of staffing, training or facilities issues.

HIV positive highlands residents with the will, financial means and deteriorating health often seek care in coastal cities like Jayapura, Sentani, Timika, and Nabire. Healthcare providers in these areas indicate that many of their HIV patients originate from the highlands (Table 5). Many of those that are able to go to other distant coastal health centres for treatment stay as long as resources last, only to return and die because continuity of care cannot be sustained.

Table 5: Source of HIV patients in Jayapura hospitals

Hospital	Highlands patients (%)	Coastal patients (%)	Non-Papuan patients (%)	Unknown (%)
Dian Harapan Hospital Jayapura	36	33	12	19
Abepura Hospital Jayapura	30	37	11	22
Yowari Hospital Jayapura District	38	52	4	5

Tuberculosis

TB is the primary opportunistic infection of HIV individuals. Most HIV-related deaths are from TB. Given widespread prior TB infection, pulmonary and extra pulmonary TB have emerged as the primary opportunistic infections among HIV infected individuals in Papua. Only half the hospitals and a third of puskesmas are able to diagnose and treat active TB infections and not all match sites providing ART, (Table 6, above).

Sexually transmitted infections[22]

Managing STIs is a problem at a village level where diagnostic and treatment facilities in puskesmas are limited or non-existent. Shame, and/or lack of access to care drive many to pharmacies where 'syndromic' management by non-clinicians is inappropriate and may only mask symptoms and not result in cure.

STI laboratory capacity: Most district hospital laboratories and puskesmas have limited existing capacity to provide simple diagnostic tests for gonorrhoea, syphilis and trichomonas.[23] Other weaknesses include SCM for laboratory reagents and supplies, inappropriate testing practices, weak laboratory quality assurance systems and standard operating procedures (SOPs), and poor infection control. Laboratory capacity appears weaker in West Papua than in Papua. While there are many areas of STI laboratory capacity that need strengthening at hospital and puskesmas level in Tanah Papua, the required level of capacity is within reach. The more sophisticated STI diagnostic tests (polymerase chain reaction, gonococcal culture) are carried out at the Provincial Health Laboratory and, at this stage, are not planned to be provided at district hospital or puskesmas level.

Syphilis: There is quite a large amount of testing going on in Tanah Papua – often on the wrong people, with the wrong combination of test kits, wrong diagnoses, overtreatment among sex workers, reluctance to use the first line drug (Penicillin) and patient non-compliance with the alternative (Doxycycline). Routine use of rapid plasma reagin (RPR) testing with confirmatory Treponema Pallidum Haemagglutination Assay (TPHA) for syphilis diagnosis appears low.

Key policies and experience: STIs are not reportable illnesses making data collection difficult outside of MARP surveys. Clinics do not always have the latest version of the national guidelines and there are standard STI drugs that are not on the EDL. On the positive side, there is valuable experience in Papua in the use of enhanced syndromic management and periodic presumptive treatment in FSWs.

Medical waste management

Medical waste is poorly managed in Papua and West Papua with inadequate separation of infectious waste (sharps, rapid diagnostic tests (RDTs), surgical waste) and non-infectious waste (drink containers, plastic bags, paper), open burning at both puskesmas and hospital levels, inappropriate and poorly performing incineration technology, disposal of infectious waste through the municipal waste stream and untrained staff without personal protective equipment or vaccination. There also appears to be little awareness of new non-incineration technologies which avoid dioxin and furan production.

What has CHAI done?

Overview

Addressing the systemic weaknesses in the HIV care delivery systems for those in remote, underserved areas is essential to the health and well-being of many. CHAI's Phase II approach has provided a framework for scale up that could reach and serve those underserved populations.

In Phase II of its AusAID contract, CHAI's Papua CST program initially reviewed the treatment situation in Jayawijaya District in the highlands and Jayapura District and City on the northern coast, its two current sites, and developed plans of action to:

- improve data management

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[22] A fuller description of the existing issues and challenges in STI control programming in Tanah Papua is provided in Annex 7.

[23] AusAID-CHAI REACH Design Mission, February 2012

- begin provider initiated testing and counselling (PITC) for HIV
- offer HIV testing to all pregnant women
- screen all new TB patients for HIV
- provide CD4 testing
- remove barriers to initiation of HIV treatment
- improve overall laboratory quality
- provide comprehensive, one-stop services for HIV, TB and STIs
- task shift to nurses wherever possible.

CHAI established support teams, based in the Yowari Hospital, Jayapura District, and Wamena Hospital, Jayawijaya District. Teams analysed data to confirm the actual number of HIV cases detected, their current status, and where they were being followed if alive and under care. Data management plans were put in place to ensure patients could be tracked, referred and followed up without violating confidentiality. Staff refresher training was held with an emphasis on early testing, treatment benefits, and early initiation of treatment. HIV positive individuals who had not yet initiated ART were encouraged to come for CD4 testing. Training on PITC was conducted and staff encouraged to offer HIV testing to all new TB and STI patients, all pregnant mothers and all hospitalized patients and outpatient clinic clients. In house training programs were developed and **all** hospital staff trained on HIV issues with special attention to stigma reduction, occupational health, early testing and treatment. Laboratory procedures were reviewed in hospitals and puskesmas. The Provincial Health Laboratory was contracted to assist in setting up standard operating procedures in Jayawijaya and to provide training and external quality control for HIV testing. Staff at 14 puskesmas were trained in HIV testing, counselling and comprehensive ART and these puskesmas were established as satellite ART sites of Jayawijaya and Yowari Hospitals. Where there was no doctor, nurses were trained and can now initiate ART under the direction of the hospital.

These activities have formed the basis of the Centres of Excellence (CoE) concept where additional personnel, not current hospital staff, will form support teams that focus first on establishing high quality referral HIV-related services at their base hospital and then will extend that support in the form of training, mentoring and monitoring to puskesmas in the surrounding region. These are technical assistance teams who do not provide services but rather support those who are providing services at the different facilities.

Key achievements

In an 18 month period, CHAI- supported sites dramatically eclipsed HIV screening and treatment rates achieved in the previous five-year period at the same sites. There was a 10-fold increase in the number of cases on treatment, (Table 6). No similar increases were seen in sites not supported by CHAI over the same 18 month period.

Table 6: Comparison of key outcomes following commencement of CHAI Phase II

Pre-CHAI Phase II (2006 – September 2010)		CHAI Phase II (October 2010 – February 2012)	
HIV positive diagnoses	997	HIV positive diagnoses	2,115
Ever on treatment	128 (13%)	Ever on treatment	912 (43%)
Lost to follow up	26 (20%)	Lost to follow up	36 (4%)
Currently on treatment	83 (8%)	Currently on treatment	876* (41%)

* includes 499 patients on cotrimoxasole antibiotics

Additional achievements include:
- Improved early diagnosis through PITC: Patients diagnosed in Stage 1-2 (early infection with intact immune systems) increased from 15 to 24 per cent in Jayawijaya and 31 to 52 per cent in Yowari Hospital.
- Earlier diagnosis allows for earlier initiation of treatment: These patients do not develop OIs. This results in cost savings to the health system and stigma is reduced as there are no visible signs of illness.
- Established task-shifting model: nurse-care models have been developed in two Jayawijaya puskesmas which care for two-thirds of the ART patients for that district.
- Decentralized care: shifting care from hospital to puskesmas provides easier access to care and has resulted in patient lost to follow-up dropping from 20 to four per cent.
- Increased clinical skill and confidence in counseling, diagnosing, staging and treating HIV infection evidenced by the dramatic increases in patients enrolled on treatment and the low lost to follow-up rate. Also, monitoring by CHAI shows that patients are appropriately staged and national guidelines followed.
- Decreased occupational health and safety concerns at health facilities through facility-wide training. This has also resulted in a decrease in HIV-related stigma in health facilities. Hospital staff are comfortable in dealing with HIV-positive patients and patients are open about their HIV status at various care points as they are treated with care and respect.
- Comprehensive care achieved through an integrated care model for HIV – OIs – TB – STI – PMTCT at CHAI-supported sites.
- Stronger partnerships: Successful program implementation has strengthened partnerships with GoI at national, provincial and district levels.
- Increased demand: Success has resulted in additional districts requesting CHAI support.
- Supply chain management work by CHAI has reduced stock outs of ARVs.
- While the focus of CHAI has primarily been on supply side factors, the significant increase in those initiated and retained on treatment indicates that the development of effective HIV services has resulted in creation of community demand for services.

Key challenges
- Testing policy and promotion: Uptake of VCT is limited. PITC in health care has been shown by CHAI to be viable but needs expansion. Strategies for mobile testing and testing in Posyandu[24] need to be developed. Promotion of early testing at the community level through media, churches and tribal groups needs to be pursued aggressively.
- Treatment policy: Current GoI treatment guidelines is to start individuals on ART if they have clinical AIDS or CD4 <350. Most health services do not have ready access to CD4 testing and transport of blood is not viable. More and easier access to CD4 testing needs to be made available.
- Laboratory testing: quality assurance schemes need to be strengthened to ensure the quality of HIV-related laboratory results.
- Personnel: Rotation of HIV trained staff from hospitals and puskesmas results in service gaps if replacement staff have not been trained. Planning of staff rotations with Provincial Health Offices (PHOs) and District Health Offices (DHOs) is needed to ensure continuity of services. DHOs and PHOs and District Governors (Bupati's) need to address staff accountability.

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[24] Posyandu are centres for pre and post natal health care and children under 5 years health care.

- Financing: There are multiple funding streams from national, provincial and district levels covering costs of care and laboratory testing but financing rules are complicated and applied in inconsistent ways in different districts. A review of health financing at provincial and district levels is essential to finding sustainable support for all health programs.
- Communication is key to an integrated health care delivery program. Sending data, online mentoring, and patient referral and information sharing are difficult in the absence of cell phone or internet accessibility.
- Tuberculosis must generally be diagnosed and treated before initiation of ART. Only one-third of puskesmas and half the hospitals are capable of diagnosing and managing TB.

Lessons learned

- Mentoring and monitoring is a PHO function. PHOs, as the ultimate owners of the CoE model, need to provide dedicated staff to undertake these roles.
- Comprehensive CoE support needs to be developed to cover laboratory, data and monitoring functions which have not been adequately addressed in CHAI Phase II.
- Effective advocacy to provincial and district governments is needed to increase funding allocated to the health sector. This needs to be accompanied by support to PHOs and DHOs in planning and budgeting, data management, analysis and problem solving so that funding is used efficiently and effectively.
- CHAI's management, finance and reporting systems need to be strengthened to support implementation of REACH.
- In expanding the program it is more efficient to work with clusters of Puskesmas in a district rather than on a serial assistance basis.
- More systematic data collection is needed using simple information technology (IT) systems.
- Current monitoring systems do not provide sufficient information on what is working and what is not. Improved monitoring and operational research with a focus on improved service delivery is essential.
- Multiple demands for training and reporting by donors affects service delivery negatively. Real donor coordination that addresses overlapping activities and enhances synergies is essential to reduce the training burden on limited staff and ensure consistency of approach.

Future need

- Expansion of HIV-TB, STI and PMTCT services to 120 puskesmas in Tanah Papua through intensified training, mentoring and monitoring by PHO staff.
- The number of people being tested for HIV needs to be significantly increased beyond PITC which only captures patients presenting at health facilities.
- Data management needs to be simplified and automated. Analysis and data use needs to start at the care site and be used by PHOs and DHOs for program management.
- Diagnosis and management of STIs needs to be improved along with STI surveillance.
- SCM assistance needs to be expanded to include laboratory reagents for STI diagnostics and STI drugs and to cope with the increased demand for HIV drugs and commodities.
- Internal and external quality control is needed for all hospital and puskesmas laboratories.
- Development of a provincial health laboratory in West Papua for monitoring and mentoring of hospital and puskesmas laboratories.
- Development of district medical waste management plans.

1.4.2 Supply chain management for HIV-related commodities

Issue and current situation

CHAI Indonesia has been involved in supply chain management since 2007. Working together with the AIDS Sub Directorate and GFATM, CHAI's goal in SCM is to assist the government to improve

access to HIV commodities by ensuring stock availability. Specifically, the AIDS Sub Directorate has prioritized the reduction of ARV stock outs at treatment sites. CHAI has used a two-track strategy to strengthen the centralised national SCM system managed by the MoH's AIDS Sub Directorate and a decentralised SCM pilot in four provinces.

This work has resulted in significant reductions in ARV stock outs at treatment sites, increased timeliness and accuracy of treatment site reporting, and increased coordination among stakeholders at the national, province and district levels in managing HIV commodities.

What has CHAI done?

Overview

CHAI has worked with the AIDS Sub Directorate on the following initiatives:

- Developing a routine process for planning and procurement of HIV commodities by analysing demand and consumption
- Simplifying a complex procurement process
- Monitoring the storage and distribution of stock at the national level
- Decentralizing the distribution of ARVs in four provinces so that provinces manage supply chain data reporting, storage, and distribution
- Building a performance measurement system for reporting and analysis of accuracy of reporting on a regular basis
- Building capacity for supply chain management at treatment sites.

Key achievements

CHAI's work has resulted in a dramatic and sustained reduction of ARV stock outs, with less than two per cent of the 315 treatment sites nationwide experiencing stock outs during Phase II. A key contributing factor is increased timeliness and accuracy of ARV ordering by sites, with 57 per cent of sites now reporting on time and accurately, up from 25 per cent at the beginning of Phase II.

Key challenges

The key remaining challenges that REACH will seek to address are:

Staff capacity: Of the 13 staff who work on SCM in the AIDS Sub Directorate, only two are civil servants—the remaining 11 are donor-funded, mostly by the Global Fund. Moreover, the two civil servants also have other responsibilities apart from SCM. There is a need for government funded staff to progressively take over SCM work.

Procurement policy and funding: Seventy per cent of funding for ARVs is provided by the GoI and 30 per cent by the Global Fund. In 2012, the GoI plans to fund 100 per cent of ARV purchases; however, this may not be realistic.

Coordination and communication: Program roles and responsibilities at the national, provincial, and district levels are not clearly defined. Without clear processes, there is significant confusion and misunderstanding, which can lead to stock outs.

Monitoring and evaluation: The AIDS Sub Directorate performs regular monitoring and evaluation of treatment sites. While SCM problems have been identified, sites are often not given guidance and support in how to improve performance.

Parallel system: The SCM system, which has been established specifically for ARVs, is not sustainable in the long term. Options for how to effectively integrate HIV SCM with mainstream MoH systems need to be explored.

Lessons learned

Policies and procedures: In terms of policy, the HIV treatment guidelines set by the AIDS Sub Directorate have the most impact on SCM. Changes to the guidelines have major supply chain consequences that are not often considered when policy changes are recommended.

Infrastructure: The physical infrastructure (provincial and district warehouses) has been established but needs strengthening at the provincial and district levels in the areas of management, human resource skills and capacity and systems.

Decentralisation: The decentralisation of SCM has been successful, with these provinces achieving better performance on key indicators compared to provinces in the centralised system. Although decentralisation is only feasible for provinces with higher HIV caseloads, there is scope for further decentralisation to additional provinces.

Future need

There are still a number of challenges that remain to be addressed in REACH in order to ensure that the investment to date results in lasting and sustainable outcomes, with a particular focus in Tanah Papua. REACH's work in SCM will seek to ensure that:

1. Tanah Papua has a well-managed supply chain system for HIV-related commodities, including TB and STI commodities
2. The AIDS Sub Directorate is equipped to continue its SCM activities
3. The MoH's Pharmaceutical Directorate becomes increasingly involved in HIV SCM.

1.4.3 HIV care, support and treatment policy support to the Ministry of Health

Issue and current situation

The AIDS Sub Directorate in the MoH is responsible for setting national policies and guidelines in relation to HIV CST. Health services provided by DHOs are meant to follow national policies and guidelines. There is a need to institutionalise a MoH led process for evidence based policy review and development in support of the MoH's national HIV CST program, aimed at increasing access to treatment, including decentralisation of ART to puskesmas.

What has CHAI done?
Overview and key achievements

CHAI Phase II has provided assistance to the AIDS Sub Directorate in the development of policies on ARV, PITC, STIs and PMTCT. In Papua, CHAI has collaborated with MoH, PHO and health services to support a task shifting policy where trained nurses and midwives at puskesmas and posyandu levels provide HIV testing and treatment initiation for pregnant women in order to increase PMTCT uptake.

CHAI and the Australasian Society for HIV Medicine (ASHM) have developed a concept for a MoH led process for evidence based policy review and development which has been endorsed by the AIDS Sub Directorate. That concept forms the basis for CHAI's policy support for the Sub Directorate under REACH, (see section 2.7).

Key challenges

The ad hoc approach to policy development through a MoH-convened large expert panel has been irregular and slow. Decision making processes have not been clear nor sufficiently evidence-based. There has been advocacy by some senior clinicians for policies not based on evidence; training and clinical practice are not always consistent with policies; some health services follow different guidelines (for example, MoH, World Health Organisation (WHO) or FHI guidelines); and dissemination has been poor. Due to limited resources, the AIDS Sub Directorate lacks capacity to more effectively lead policy development.

Lessons learned

Even within Indonesia's highly decentralised health system, national policies and guidelines can be an important vehicle for driving change in how services are provided. For example, after PITC was adopted as national policy, CHAI was able to use the new national policy to successfully advocate for the adoption of PITC in the health services it is supporting in Papua. This has resulted in all patients in these services being offered an HIV test and a significant increase in earlier diagnosis of HIV and initiation of treatment as clinically appropriate. It is unlikely that these health services would have commenced PITC if it was not national policy. This also points to the important roles of dissemination and technical assistance in adoption of national policies in clinical practice.

Future need

There is a need for a MoH led system for regular, evidence based review and revision of HIV policies and guidelines, coupled with a greater emphasis on application through training, mentoring and dissemination. In addition, the operations research and monitoring aspects of REACH will provide a mechanism to bring lessons learned from implementation in the Papuan provinces to the national level for consideration in policy, guidelines and program development.

A summary of key achievements by CHAI Phase II is in Annex 3.

1.4.4 Lessons learnt from other programs

CHAI is implementing an AusAID funded HIV program in Papua New Guinea which has some similarities to REACH. A list of lessons learned from CHAI's AusAID supported Papua New Guinea (PNG) program of relevance to REACH is in Annex 4. These include, to give just some examples, the potential of orienting services towards patient retention vs. clinician convenience, use of clinical job-aides in improving quality and the involvement of PLHA in peer counselling.

A lesson learned from the Australia Indonesia Partnership for Maternal and Neonatal Health is that weak capacity at district and puskesmas level can be addressed by using donor funding and technical assistance to improve health care delivery through a focus on planning, budgeting and workforce quality and availability.[25]

Lessons from international health systems strengthening programs which can be applied to REACH are that quality, accessible primary health care is cost effective and appropriate for a program that aims to improve the health of the poor; and that programming in a decentralised system requires interventions at the policy level (national) as well as the service delivery level (district), with strong linkages between national policy work and district implementation.[26]

1.5 Synergies and linkages with AusAID and other donor programs

In the course of designing this funding proposal the team identified multiple areas where strong synergies exist between REACH, other AusAID programs and other donor programs where outcomes for all programs could be enhanced through a collaborative approach. Key areas where consistency or synergies exists are: 1) facilitation of decentralisation processes; 2) health system strengthening; 3) demand creation for HIV testing and treatment and prevention; 4) technical assistance for health programs; 5) policy support to the MoH; and 6) operational research. However, at present coordination between donor programs in the Papuan provinces is generally poor. This includes coordination within the Australia Indonesia Partnership for HIV (AIPH). Strategies for improving program coordination are outlined in sections 3.3.2 and 3.3.3.

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[25] AusAID, *AIPHSS Program Design Document*, p. 4.

[26] *ibid*.

1.5.1 Facilitation of decentralisation

The Australian Indonesia Partnership for Decentralisation (AIPD) supports national, provincial and local governments to improve the provision of effective services in health, education and infrastructure by dual track strategies addressing supply side issues such as resource management and planning and demand side issues such as community mobilisation and effective democratic processes. REACH is consistent with AIPD in that it is seeking to make decentralisation work through advocacy for increased funding for health and improved health sector planning, service delivery and accountability. Many of the core supply side issues that REACH will need to address with provincial and district governments are the same as those being addressed by AIPD through a health sector wide focus. REACH will work closely with AIPD at the provincial level and in the districts where both programs will be working. Those districts are Pegunungan Bintang in Papua and Manokwari and Fak Fak in West Papua. AIPD is undertaking public expenditure analyses, including for HIV, in these districts, which can be used by AIPD and REACH for advocacy. The two government relations positions on CHAI staff will work closely with AIPD at the provincial level and in the districts where both programs are working. They will undertake similar work to that of AIPD in respect of advocacy, HIV CST-related planning, financial management and programming in non-AIPD districts where REACH is working.

The Indonesian National Program for People's Empowerment (PNPM) which is co-funded by AusAID has reach to the village level in the Papuan provinces and is a vehicle that can facilitate community mobilisation around HIV and demand creation for services, as can AIPD's work with civil society organisations.

1.5.2 Health system strengthening and governance

Kinerja Papua is a new USAID health governance activity that will overlap geographically with REACH in Jayapura City and District and Jayawijaya District. The program aims to improve delivery of public health services (especially related to TB, HIV and MCH) in Papua by strengthening health sector management and good governance, including increased participation, accountability, and access to information. Information on Kinerja's work was not available at the time this funding proposal for REACH was being developed due to USAID contractual requirements. USAID has indicated that it is keen for close collaboration between Kinerja and REACH.

The Australian Indonesia Partnership for Health System Strengthening (AIPHSS) 2011-2016 focusses on improving MCH outcomes through addressing workforce and health financing issues. An additional three provinces will join the program in 2014, with the Papuan provinces being possibilities. Both REACH and AIPHSS have been designed on the basis of a common problem analysis that concluded that improving health outcomes of the poor requires interventions and capacity development at the puskesmas level, enhancing the management and supervision capacity of PHOs and DHOs, and effective policy stewardship by the MoH. By the time AIPHSS possibly starts work in the Papuan provinces, REACH will be at an advanced stage of implementation and would be able to share lessons learned with AIPHSS, in addition to ongoing program collaboration. There is potential for REACH and AIPHSS to work in tandem with the MoH, PHOs and DHOs on common policy and operational issues.

1.5.3 Demand creation for HIV testing and treatment, and prevention

AIPH (2008-2016) seeks to prevent and reduce the risk of HIV transmission, improve the quality of life of people living with HIV and alleviate the socio-economic impacts of HIV. AIPH works at the national level and in six provinces, including the two Papuan provinces. REACH will come under the umbrella of AIPH, as does CHAI Phase II. The HIV Cooperation Program for Indonesia (HCPI)

is AIPH's largest program. HCPI's work in the Papuan provinces focusses on strengthening local leadership on HIV and HIV prevention.

By treating both HIV and STIs, REACH will reduce the infectiousness of people with HIV, thus reducing the likelihood that they will infect others. But treatment programmes can never be a substitute for effective primary prevention, especially in groups with high partner turnover. There is an opportunity for AIPH to reconceptualise its Papuan programming within a continuum of prevention to care, support and treatment approach. Synergies between the work of HCPI and REACH primarily relate to effective communication and community mobilisation strategies to create demand for HIV testing to increase early diagnosis and as an entry point to treatment, coupled with assertive promotion of the benefits of treatment. Support for adherence to ARV treatment as well as treatment seeking for STIs can also be addressed by HCPI. The programming interface could operate at two levels; through the civil society organisations (CSOs) and faith based organisations supported by HCPI and through the HCPI supported mass media communications work being undertaken by the Provincial AIDS Councils. The other key interface is HCPI's work in support of provincial, local government and civil society leadership on HIV which is critical for government support of CST programming and community mobilisation.

USAID's Scaling Up for Most-at Risk Populations I and II programs (SUM), provide assistance in technical areas and organisational performance to scale up HIV behaviour change interventions among most-at-risk populations, including FSWs and their clients. SUM I and II primarily work with CSOs. In Papua Province, SUM I and II will overlap geographically with REACH in Jayapura City and District and Jayawijaya and in West Papua in Sorong. Synergies between SUM and REACH primarily relate to STI diagnosis and treatment; effective communication and community mobilisation strategies to create demand for HIV testing to increase early diagnosis as an entry point to treatment, coupled with assertive promotion of the benefits of treatment with a focus on most-at-risk populations, particularly FSWs. CSOs supported by SUM may also play a role in patient support. To take advantage of these synergies, there will need to be close collaboration between SUM supported CSO's and REACH at the site level. While USAID's programs are mostly focused on CSO interventions, linkages to GoI health facilities need to be more strongly supported. REACH can assist in facilitating this type of linkage.

UNFPA is in an early stage of planning a small scale sexual and reproductive health and HIV program in Papua that will include comprehensive condom programming and HIV prevention for FSWs and their clients. The only area of geographic overlap with REACH will be in Jayapura. The program will commence in 2013. UNFPA has indicated a willingness to collaborate and discussions with CHAI will take place when more detailed planning commences.

1.5.4 Technical assistance for health programs

At the national level, REACH will bring lessons learned from its field work in the Papuan provinces to inform WHO's technical support for the MoH in areas such as revisions to the National STI Control Strategy, national STI guidelines and the EDL for STIs.

REACH will be taking a comprehensive, multi-component approach to HIV CST. There are two quite small donor technical assistance programs, one for PMTCT and the other for TB, that are or will be doing work similar to specific components of REACH. CHAI will also seek to maximise a common approach between REACH and other donor programs through promoting alignment in donor supported work with relevant national programs such as PMTCT and TB and look for efficiencies such as joint trainings, using common curricula.

The United Nations Fund for Children (UNICEF) is currently planning a small scale PMTCT program through puskesmas in the Papuan provinces. REACH will collaborate with UNICEF in site

selection to avoid working in the same sites. Discussion between the team developing this proposal and UNICEF indicated a high degree of willingness for inter-program collaboration if the two programs are working in the same areas.

USAID's TB Care Project provides technical support to four districts in the Papuan provinces through FHI 360. Where REACH and the TB Care Project are working in common districts (Sorong, Jayapura and Jayawijaya) there will be collaboration to avoid overlap.

A Global Fund grant to Papua Province of A$1.05 million will support STI, PMTCT and HIV CST activities through government health services from July 2012 - June 2015. No data on Global Fund support to West Papua was available. REACH will collaborate with Global Fund activities through its support for HIV-related services through government systems. However, REACH will not be providing any incentive payments to health staff.

1.5.5 Supply chain management

The successful Indonesian proposal for health systems strengthening interventions under Global Fund Round 10 included training and human resource capacity building for SCM, providing the potential opportunity for REACH and the Pharmaceutical Directorate to collaborate. However, the grant has since been modified, with these activities being dropped. The grant will now be used for physical infrastructure improvements at district warehouses, but this does not include warehouses in the Papuan provinces. Therefore, there are no opportunities for collaboration between REACH and this Global Fund supported project.

1.5.6 Policy support to the Ministry of Health

The proposed support by REACH for the development of an evidence-based MoH national policy framework on HIV-related CST, (see section 2.7), will be provided in close collaboration with other development partners such as WHO, FHI 360 and ASHM. These partners have indicated their support for the establishment of an AusAID/CHAI supported Policy Secretariat in the MoH.

1.5.7 Operational research

The MoH research arm, The National Institutes of Health Research and Development (NIHRD/LitBangKes) has an office in Jayapura. They work mostly in areas of basic science. While the REACH operational research program will focus on learning that helps to improve service delivery, possibilities for collaboration exist around areas such as genotyping of HIV specimens. NIHRD has indicated an interest in discussing this and other possible areas of collaboration.

The WHO is supporting a program of research around the use of ARVs for HIV prevention, with funding from the US National Institutes of Health. Though protocols have not yet been developed, there is a possibility that some of this research could be embedded within REACH's knowledge generation activities. There are currently no other operational research components of other development partner funded programs of relevance to REACH.

1.6 Rationale for AusAID's involvement

There is a strong degree of coherence between this funding proposal for REACH and AusAID's overarching aid policy, sector strategies and the Indonesia Country Strategy. REACH will be in alignment with AusAID's overarching policy statement *An effective aid program for Australia: Making a real difference – Delivering real results* and Australia's International HIV Strategy. Table 7 sets out the key areas of alignment.

Australia's international development strategy for HIV states that given Australia's comparative advantage in prevention programming, strategic priorities and gaps in donor support, AusAID will not usually provide direct assistance for treatment and care. An exception is the Pacific region,

including Papua New Guinea, where Australia is a major donor and does support comprehensive responses, including treatment and care.[27] A similar rationale applies in the Papuan provinces of Indonesia where AusAID is a major donor and there are no other donors currently in a position to support comprehensive HIV CST programming. The low level generalised epidemic in the Papuan provinces (2.4%: IBBS, 2006) is similar but larger than that of PNG, where HIV prevalence is estimated to be 0.9 per cent.[28] These levels of prevalence in both PNG and Indonesia's Papuan provinces point to the need for comprehensive HIV programming.

Table 7: Alignment between AusAID's international development objectives and REACH

AusAID development objectives	Contribution by REACH
Saving lives is one of the five strategic goals of Australia's aid program. A key mechanism of achieving this goal is improving public health for poor people *(Making a real difference – delivering real results)*	REACH will work through public services to increase the number of people in the Papuan provinces on effective HIV treatment and related care which will reduce HIV-related morbidity and mortality and may contribute to reduced transmission risk
A 'value for money' perspective—one that balances effectiveness, efficiency and economy in decision-making—will drive improvements across the aid program. This focuses on results and returns for poor people, rather than just input costs. (Making a real difference – delivering real results)	REACH will focus on measurement of results to determine the effectiveness and efficiency of the program. Measurement of cost-effectiveness is a priority area for operational research, subject to partner agreement.
Working in partnership with government and within government systems *(Paris Declaration, Accra Agenda for Action and Jakarta Commitment)*	REACH is a technical assistance program fully aligned with the MoH's Care, Support and Treatment program. It will support the delivery of services by technical assistance to government health services
Integration of HIV CST services into primary health care *(Australia's International HIV Strategy)*	REACH will support decentralisation of HIV CST by developing the capacity of puskesmas linked to referral hospitals
Stronger linkages between HIV services and other health services *(Australia's International HIV Strategy)*	REACH will take an integrated approach to service delivery incorporating HIV, TB, STIs and PMTCT in hospitals and puskesmas
Strengthening coordination and capacity to scale up HIV responses to overcome barriers to universal access, including strengthening of health systems and improving workforce development and health financing systems *(Australia's International HIV Strategy)*	In partnership with AIPD, REACH will support provincial and district health offices in planning and mobilising funding to scale up HIV CST. The development of the capacity of puskesmas to provide HIV and related CST will strengthen the overall primary health capacity of puskesmas. Training and mentoring of health care workers (HCWs) will result in a more skilled workforce
Building the evidence base for an effective HIV response *(Australia's International HIV Strategy)*	REACH includes an operational research component and strong monitoring focus that will be used for program improvement and to feed into evidence informed national and provincial policy and programming development

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[27] AusAID, *Intensifying the response: Halting the spread of HIV. Australia's international development strategy for HIV*. 2009. p. 3 and 20.

[28] National AIDS Council, *Papua New Guinea National HIV and AIDS Strategy 2011-2015*. p. 13. An IBBS has not been conducted in PNG.

The design of REACH outlined in this funding proposal is also consistent with AusAID's health strategy (*Saving Lives*), with direct alignment with five of the six pillars for AusAID's investment in health (see Table 8[29]).

Saving Lives also provides that in fragile or humanitarian situations, Australia may provide targeted support, including HIV programming, to improve specific health outcomes among poor and vulnerable groups.[30] However, the rationale for AusAID funding of REACH is not as a traditional donor in an aid dependent environment. Rather, REACH is a partnership with Indonesia which seeks to ensure that government funding is used effectively to secure positive health outcomes for PLHA, while contributing to the development of stronger primary health care services overall. Different levels of government will be responsible for meeting particular components of service delivery costs, (excepting some start up equipment and infrastructure costs), with AusAID funding being used primarily for technical assistance, training and mentoring.

Table 8: Correlation between the six pillars for AusAID investment in health and REACH

AusAID's six pillars for investment in health	Contribution by REACH
1. Supporting partner countries to deliver more and better quality health services for poor and vulnerable people	REACH will increase the number of people on HIV-related treatment, increase the number of trained GoI HCWs in primary health care, and reduce stock outs of HIV-related medicines.
2. Closing the funding gap to provide essential health services for all	The national and district governments will be responsible for financing of service delivery costs from program commencement. REACH will work with provincial and local governments to address planning and financing, with provinces taking over funding for technical assistance (the Centres of Excellence) from year four.
3. Empowering poor and vulnerable people to improve their health	REACH will collaborate with other donor programs and CSOs to increase supply of and demand for HIV testing and treatment and to address HIV-related stigma and discrimination
5. Reducing the impact of global health threats, particularly in Asia and the Pacific	By increasing the number of people on effective HIV-related treatment, REACH will reduce HIV-related morbidity and mortality in the Papuan provinces and contribute to reduced transmission risk
6. Maximising the impact of Australia's total health ODA investment in partner countries	REACH is based on international best practice (demonstrated efficacy of providing effective HIV-related treatment through primary health care in resource poor settings). Operational research and monitoring will be used to improve programming at service delivery and national levels.

Pillar 2, 'Investing in People', in the *Australia Indonesia Partnership Country Strategy 2008-2013*, (AIP), states that Australia will work with Indonesia to deliver better health access and systems. HIV prevention and care, especially in the Papuan provinces, is one of the AIP's high priority areas. REACH is consistent with the AIP health access and systems objective and priority areas. Modalities for support outlined in the AIP are technical assistance, direct funding of key Indonesian programs, trialling innovative pilot activities in support of GoI programs, and working with local government

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[29] AusAID, *Saving lives. Improving the health of the world's poor*. p. 1. The contribution of REACH in Table 10 is in part based on indicative health indicators in Appendix A of *Saving lives*. The 4th pillar – working with other sectors to address the causes of poor health – will not be addressed by REACH.
[30] *ibid*. p. 4.

to implement policies and develop long-term capacity. The REACH funding proposal is consistent with these approaches.

Papua and West Papua are two of Australia's five focus provinces for development assistance in Indonesia. The AIP identifies the need for AusAID engagement at national as well as provincial levels, with national activities informing work at provincial and district level, and practical support at these levels feeding into national level engagement. This dual national-provincial focus is reflected in this proposal. The proposal is consistent with *AusAID's Strategy for Assistance to Indonesia's Papuan Provinces*, particularly in regard to partnership with the GoI at national and provincial levels and a focus on improved service delivery in key sectors such as health. The strategy identifies HIV as a priority area, including expansion of HIV CST programming, particularly in the highlands.

In summary, the design of this REACH funding proposal is consistent with AusAID's approach to development of its health portfolio in Indonesia in that it:

- is evidence based
- will be supporting the government to improve the effectiveness of its national program, with a focus on decentralisation
- will be implemented through a partnership with the GoI at national, provincial and district levels
- will result in increased GoI investment in HIV CST at the level of primary care
- is focussed on improving access to primary care for poor and vulnerable people
- has clearly defined outcomes meaning measurable results will be available
- is coherent with and complementary to other AusAID programs
- seeks to leverage off the work of other development partners through identification of synergies and collaboration; and
- reflects the priority AusAID is placing on development assistance to the Papuan provinces.

2. Program description

2.1 Overview

There is now a wealth of international evidence that demonstrates that ART, when provided effectively, both restores and maintains the health of PLHA, resulting in a significant extension of life. These benefits will be maximised if PLHA commence treatment at a clinically appropriate time rather than waiting till they become ill [31]. This emphasises the importance of early diagnosis through HIV testing of people at risk and ongoing monitoring of their health. There is also a solid body of evidence that demonstrates that it is cost-effective to provide quality HIV-related treatment in resource poor settings, including through a primary health care model linked to hospitals.

There is also strong evidence that effective HIV treatment reduces viral load to undetectable levels which significantly reduces the risk of sexual transmission, as long as the HIV-infected partner does not have another STI [32].

The most effective way of increasing access to HIV treatment in Tanah Papua is to make quality treatment available closer to where infected people live. REACH will provide technical assistance to Indonesian government health services so that they can decentralise and expand quality care.

Key indicators and targets will be set in the first quarter of the program. Initial numbers of people that will benefit from REACH over the four years of the program include:

- An estimated 640,800 people will be tested for HIV. Of those tested, an estimated 25,200 people will be found to be HIV positive and provided with ongoing monitoring and care, with 20,160 people commencing on antiretroviral (ARV) drugs. The 615,600 people found to be negative will have access to prevention counselling, condoms, STI services and repeat HIV testing in the future.
- An estimated 2,600 people will be diagnosed with TB and receive treatment.
- An estimated 80 per cent of sex workers at target sites will receive routine STI and HIV examinations and related treatment every three months.
- An estimated 80 per cent of pregnant women attending antenatal care at target sites will receive HIV and syphilis screening and treatment as needed.

REACH aims to help people infected with HIV in the Papuan provinces to live longer and healthier lives, and to reduce the likelihood that they will pass on their infection. REACH will do this by supporting improved HIV and related health services that are available in more sites that people can reach more easily. Better access to quality services should lead to:

- earlier diagnosis of HIV infection
- earlier initiation of treatment
- more frequent monitoring of patients, with less treatment drop-out.

Supported by work to ensure a strong supply chain and community engagement to increase adherence to ARVs, these achievements will lead to less HIV-related illness, less HIV transmission, and fewer deaths.

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[31] The current WHO recommendation is for treatment to commence at 350 CD4 cells.

[32] Cohen, Myron S, Ying Q Chen, Marybeth McCauley, et al. 2011. Prevention of HIV-1 infection with early antiretroviral therapy. The New England Journal of Medicine 365 (6) (August 11): 493-505. doi:10.1056/NEJMoa1105243.

REACH will work through government health systems. It will provide intensive technical support through nine Centres of Excellence based in district hospitals. The expert teams in these CoE will cascade knowledge and competence in practice through the hospitals and puskesmas they support, in large part through hands-on, in-service training and active mentoring of health staff. They will support health workers to provide friendly, high-quality services for the diagnosis of HIV, TB and STIs, and for case management and treatment. Services to reduce HIV transmissions from infected women to their infants will also be supported.

In addition to strengthening of capacity to provide these services, the benefits of REACH will have a broader effect through strengthening of:

- the management, planning, budgetary and supervisory capacity of PHOs and DHOs;
- links and referral pathways between district hospitals and puskesmas;
- links between puskesmas and community organisations;
- laboratory capacity;
- puskesmas infrastructure, (including staff housing that should increase staff retention);
- waste management; and
- information management.

All of these activities will strengthen provision of primary health care services across the board. Although the focus of REACH is on the supply side, the strengthening of services may result in demand creation for HIV and a broader range of services. REACH will also leverage off the work of partners in relation to demand creation for HIV testing and HIV treatment.

The implementation of REACH will be guided by strong monitoring systems, with built in analysis and feed-back loops. Monitoring information will be supplemented by operational research which will seek to generate and publish knowledge about expanding HIV treatment in difficult contexts that will be of value in other areas of health service provision in areas outside of Papua.

An underlying objective of REACH is to further test the model of decentralised HIV CST through primary care, supported by CoE, which can be replicated by the MoH in other parts of the Papuan provinces and other parts of Indonesia. Analysis of data from the monitoring system and operational research will be fed back by CHAI to the MoH to promote broader replication.

2.2 Goal and objectives

The **REACH end of program goal** is increased access to, and increased number of people on HIV-related care and treatment in Tanah Papua. The overarching program outcome will be 17 hospitals and some 120 puskesmas with trained staff providing HIV-related clinical services. The **long term goal** is reduced HIV-related morbidity and mortality in Tanah Papua.

More specifically, REACH will have four program components. These components and their objectives are:

Component 1: Care, support and treatment
To increase the number of GoI supported health facilities that are well staffed and equipped and providing quality HIV-related clinical services in Tanah Papua.

There are seven sub-components, each with a specific objective:

- **1.1 Antiretroviral therapy:** To increase access to ART at puskesmas and hospitals in Tanah Papua, and adherence to ART among patients treated.
- **1.2 Tuberculosis:** To improve the quality of TB diagnosis and treatment in Tanah Papua.
- **1.3 Sexually Transmitted Infections:** To reduce STI prevalence in high prevalence populations in Tanah Papua.

- **1.4 Laboratories:** To strengthen laboratory capacity to provide HIV, TB and STI related diagnostic testing and monitoring.
- **1.5 Infrastructure:** To strengthen health infrastructure at puskesmas level to support provision of primary health services including HIV-related care, support and treatment.
- **1.6 Support for effective decentralised systems:** To support policies that increase the efficiency, transparency and sustainability of service delivery in a decentralised health system.
- **1.7 Medical Waste Management:** To strengthen safe management of infectious medical waste in Tanah Papua.

Component 2: Supply chain management for HIV-related commodities

To decrease stock outs and increase efficiency of strengthened supply chain management of HIV-related commodities.

There are three sub-components:

- **2.1 Provincial level:** To strengthen supply chain management systems for HIV-related commodities in Tanah Papua.
- **2.2 National level:** To strengthen national and decentralised supply chain management systems for HIV-related commodities.
- **2.3 One gate:** To support the medium to long-term shift towards a national one gate policy in supply chain management of HIV-related commodities in Indonesia.

Component 3: Policy support to the Ministry of Health

To develop, disseminate and implement an evidence-based MoH national policy framework relevant to HIV-related care, support and treatment.

There is one sub-component:

- **3.1 National level policy:** To strengthen the national policy framework relevant to HIV-related care, support and treatment.

Component 4: Operational research

To generate and apply knowledge that contributes to achieving the program goal of increasing access to high quality HIV-related treatment in Tanah Papua.

There are two sub-components:

- **4.1 Operational research:** To undertake research that generates reliable knowledge with the potential to contribute to the program goal.
- **4.2 Local engagement:** To increase the use of operational research data to achieve program goals

A diagram outlining the programmatic structure of REACH appears in Annex 5.

2.3   Program logic

The program logic is presented in Figure 1 on the next page.

Figure 1: REACH program logic

Component	Sub-Objectives and Activities	Outcomes	End of Program Goal	Long Term Goal
1. CARE, SUPPORT & TREATMENT *Objective: To increase the number of Government of Indonesia (GOI) supported health facilities that are well staffed and equipped and providing quality HIV-related clinical services in Tanah Papua*	**1.1 Antiretroviral Therapy:** *To increase access to antiretroviral therapy (ART) at puskesmas and hospitals in Tanah Papua, and adherence to ART among patients treated. Activities: adapt/develop SOP & curricula, decentralize training, mentoring, referral & QC systems*	**Outcome 1.1:** *Increased proportion of HIV-infected people know status, decreased proportion of new HIV diagnoses at late stage, increased proportion of eligible HIV-infected people on treatment, increased number / geographic spread of health facilities providing ARVs, increased retention of ARV patients in care, increased adherence to ART among patients treated*	*Increased access to, and increased number of people on HIV-related care & treatment in Tanah Papua*	*Reduced HIV-related morbidity and mortality in Tanah Papua*
	1.2 TB: *To improve the quality of TB diagnosis and treatment in Tanah Papua. Activities: adapt/develop SOP & curricula, decentralize training, mentoring, referral & QC systems*	**Outcome 1.2:** *Increased number health facilities providing effective TB/HIV treatment and care services, increased number of people living with HIV/AIDS knowing TB status and on treatment, decrease loss to follow up, increase early diagnosis and adherence, TB diagnostic and treatment capacity at PKM improved for all patients*		
	1.3 Sexually Transmitted Infections: *To reduce sexually transmitted infection (STI) prevalence in high prevalence populations in Tanah Papua . Activities: adapt/develop SOP & curricula, decentralize training, mentoring, referral & QC systems*	**Outcome 1.3:** *Gonorrhoea, chlamydia and syphilis prevalence reduced among sex workers, STI prevalence reduced among HIV-positive sex workers, quality of STI diagnosis and treatment services improved at hospital and PKM level in Tanah Papua, increased uptake of standardized STI services for MSM and transgender people (waria) in selected sites*		
	1.4 Laboratories: *To strengthen laboratory capacity to provide HIV, TB and STI related diagnostic testing and monitoring. Activities: adapt/develop SOP and curricula, decentralize training, mentoring, referral & QC systems*	**Outcome 1.4:** *Number of health facilities with functioning laboratories participating in external quality control programs and producing accurate and reproducible results increased*		
	1.5 Infrastructure: *To strengthen health infrastructure at puskesmas level to support provision of primary health services including HIV-related care, support and treatment. Activities: assess sites, develop plan with Infrastructure Unit at AusAID*	**Outcome 1.5:** *Health facilities have electricity, water, adequate staff housing, safe waste management and appropriate information technology systems*		
	1.6 Support for effective decentralised systems: *To support policies that increase the efficiency, transparency and sustainability of service delivery in a decentralised health system. Activities: health financing, local program and policy development and national policy adaptation, dissemination, and socialization*	**Outcome 1.6:** *Partners contribute to achieve End of Program Goal, provincial and district budgets and plans support decentralized HIV-related service funding, national policies adapted to local context*		
	1.7 Medical Waste Management: *To strengthen safe management of infectious medical waste in Tanah Papua. Activities: develop model waste management demonstration sites, develop training package for puskesmas, provide routine supervision, assess autoclave technology*	**Outcome 1.7:** *Health facilities have equipment and systems for safe management of infectious medical waste*		
2. SUPPLY CHAIN MANAGEMENT FOR HIV COMMODITIES *Objective: To decrease stockouts and increase efficiency of strengthened supply chain management of HIV-related commodities*	**2.1 Provincial Level:** *To strengthen supply chain management systems for HIV-related commodities in Tanah Papua. Activities: adapt/develop SOP & curricula, decentralize training, mentoring, referral & QC systems*	**Outcome 2.1:** *Functioning and sustainable decentralized supply chain management for HIV-related commodities in Tanah Papua*		
	2.2 National Level: *To strengthen national and decentralised supply chain management systems for HIV-related commodities. Activities: further decentralization, ongoing training and mentoring, refinement of systems, QA/QC*	**Outcome 2.2:** *Functioning and sustainable supply chain management for HIV-related commodities at national level and in 12 decentralized provinces*		
	2.3 One Gate: *To support the medium to long-term shift of incorporating supply chain management of HIV-related commodities within the national one gate policy. Activities: policy development, human resources for health support, pilot strategy in Papua*	**Outcome 2.3:** *Ensure future long-term sustainability by engaging the Pharmaceutical Directorate on the development and implementation of the One Gate policy*		
3. POLICY *Objective: To develop, disseminate and implement an evidence based MoH national policy framework relevant to HIV-related care, support & treatment*	**3.1 National Level Policy:** *To strengthen the national policy framework relevant to HIV-related care, support and treatment. Activities: establish secretariat, develop functional team, develop evidence-based policies*	**Outcome 3.1:** *Evidence-based policies approved and disseminated*		
4. OPERATIONAL RESEARCH *Objective: To generate and apply knowledge that contributes to achieving program goal of increasing access to high quality HIV-related treatment in Tanah Papua*	**4.1 Operational Research:** *To undertake research that generates reliable knowledge with the potential to contribute to program goal. Activities: develop OR agenda, conduct research, analysis, and dissemination*	**Outcome 4.1:** *International standard operational research conducted and published*		
	4.2 Local Engagement: *To increase the use of operational research data at achieve program goals. Activities: collection, analysis, and dissemination of data for late diagnosis, adherence, referral, LTFU*	**Outcome 4.2:** *Results of operational research incorporated into policy and delivery of HIV-related services in Tanah Papua, and in supply chain management nationally*		

Overarching Assumptions

* GOI will be willing and able to absorb program and recurrent cost into their national, provincial and local budgets * Policies can be developed and approved to support this integrated model * Creation of new provinces and districts will be supported by appropriate budgeting, infrastructure and manpower * Staffing shortages and other HR issues can be overcome * Safety and security concerns can be mitigated * Partner organizations (including AIPH-HCPI, AIPD, USAID-SUMs, UN Agencies, international nongovernmental organizations, faith-based organizations) undertake work that is complementary and necessary to achieve this program goal and objectives * Infrastructure is available * CHAI management can support the large scale-up effort

Monitoring Cycle

Data collection / Analysis and Interpretation / Programmatic Adjustment

26

2.4 Guiding principles

REACH will be guided by the following seven key principles:

1. **Engagement with national, provincial and district counterparts:** REACH is aligned with national strategies and plans and will engage with national, provincial and district counterparts, supporting them as they build their leadership and ownership in increasing access to, and increased number of people on, HIV-related care and treatment in Tanah Papua.
2. **Build existing government health systems:** REACH will provide technical support, through CoE, to build the capacity of the existing government health system in Tanah Papua.
3. **Maximize recruitment, training and retention of local staff:** REACH will proactively work to maximize recruitment and retention of Papuan program staff while avoiding drawing skilled staff away from local health facilities and counterpart agencies.
4. **Data and evidence-led programming:** REACH will base its strategies on evidence of what works, and will rapidly modify strategies if monitoring data suggest expected outcomes are not being achieved.
5. **Flexibility and responsiveness:** – REACH will maintain a flexible and responsive strategic approach that will draw on new data, evidence and research to make full use of every opportunity.
6. **Collaboration and coordination:** REACH will build close coordination and collaboration with civil society groups working in HIV in Tanah Papua and with other donor-funded programs including Global Fund, HCPI, AIPD, USAID, UNFPA and UNICEF to maximize impact.
7. **Capacity building for sustainability:** REACH, through the CoE, will provide structured clinical, technical and public health capacity building for district hospitals, puskesmas and counterparts with transition to provincial-level funding to sustain capacity. A key contribution to sustainability will be REACH's emphasis on increasing the efficiency and cost-effectiveness of treatment, care and support models that can be maintained and replicated.

2.5 Component 1: Care, support and treatment in Tanah Papua

Component objective: To increase the number of GoI supported health facilities that are well staffed and equipped and providing quality HIV-related clinical services in Tanah Papua.

Sub-Component 1.1: Antiretroviral therapy

Sub-component objective: To increase access to ART at puskesmas and hospitals in Tanah Papua, and adherence to ART among patients treated.

Outcomes:
- Increased proportion of HIV-infected people know their status
- Decreased proportion of new HIV diagnoses made at late stage
- Increased proportion of eligible HIV-infected people on treatment
- Increased number and geographical spread of health facilities providing ARVs
- Increased retention of ARV patients in care
- Increased adherence to ART among patients treated

Why are we doing this?

There are an estimated 38,000 plus individuals living with HIV in Papua and West Papua. Approximately one-third are likely to be eligible for ART: some 12,500 plus people. Currently, only 1,879 are receiving ARVs and another 1,300 of these are on cotrimoxazole as the first step to ART.

While HIV testing rates are currently low, experience from CHAI Phase II suggests that where HIV testing is actively promoted through PITC, uptake is high. The other most prominent obstacle to treatment is accessibility: services are currently concentrated in cities. Legitimate concerns about drop-out and poor drug adherence means some service providers are reluctant to start people on ARVs. However, an overemphasis on these concerns has become an obstacle for getting more people on treatment. Making HIV medication available nearer to people's homes will reduce some of these barriers.

ARVs will keep adults with young families alive and economically active. But they have a secondary benefit too. When they are taken consistently and where other STIs are controlled, ART significantly reduces the likelihood that an infected person will pass on HIV.[33] Better treatment in Papua could therefore mean less ongoing spread of HIV.

How will we do it?

REACH will first review and compile all current training materials for CST, VCT, PITC, TB and HIV management, PMTCT, and integrated management of adult illness (IMAI) and create efficiencies by consolidation to reduce training time. Provincial and district staff selected from hospitals and puskesmas will be trained as trainers so that the province and districts can train locally and are not dependent on Jakarta to send training teams for new staff. Draft SOPs for all aspects of care and treatment will be reviewed and adapted for each type of treatment site. CHAI's SCM team and the AIDS Sub Directorate will review the supply chain needs of the expanded ART program as well as the need for TB and STI laboratory and treatment commodities and ensure that there are appropriate projections, budgets and logistic arrangements in place.

Current data collection systems will be reviewed with the AIDS Sub Directorate to create a leaner system which only collects data that will be used. Opportunities for consolidation of databases and automation of reporting will be identified.

REACH will establish seven new CoE for HIV, TB and STI care and PMTCT that will serve as referral centres for complicated cases in addition to the existing two CoE in Jayapura and Wamena. The CoE team will be additional to the normal hospital staffing contingent and will include doctors, nurses, midwives, laboratory technicians, data management specialists, a communication specialist and an administrator. Compared to CHAI Phase II, the CoE staffing has been strengthened by inclusion of positions for laboratory, data management and communication. Priority tasks for this team will be to develop the hospital staff where the CoE is located as 'experts' and improving clinical, laboratory and data management systems and establishing patient friendly management systems. The CoE mentoring function will allow the immediate adaptation of national policy changes into local policy. CoE will be a PHO owned facility, but working at the district level. Selection criteria for the CoE and puskesmas are in Annex 6 along with a map showing locations. The new CoE will be established progressively over an 18 month period. Table 19 in Annex 9 provides a timeline for the roll-out of the CoE and REACH supported hospitals and puskesmas.

Special areas of focus for hospitals based care will be:

- Comprehensive, one-stop services for HIV, TB, and STIs. (PMTCT will be provided through MCH services)
- Improved HIV testing strategies:

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[33] Cohen, Myron S, Ying Q Chen, Marybeth McCauley, et al. 2011. *Prevention of HIV-1 infection with early antiretroviral therapy.* The New England Journal of Medicine 365 (6) (August 11): 493-505. doi:10.1056/NEJMoa1105243.

- o HIV testing offered to all hospital and puskesmas patients using a PITC approach
        - o HIV testing offered to all pregnant women
        - o HIV screening all new TB patients
        - o HIV screening of all STI patients
        - o Promotion of HIV testing for the partners of HIV positive people
    - Removal of barriers to initiation of treatment:
        - o Establishing reasonable adherence targets
        - o Monitoring of treatment delays
        - o ART for all HIV positive mothers
        - o Early ART treatment of TB positive people
    - Provide CD4 testing to facilitate early treatment of asymptomatic cases
    - Improve overall quality of laboratories
    - Task shifting to nurses wherever possible
    - Improvement of data management and use by hospital and districts
    - Establishment of SOPs for linkages between hospitals and puskesmas for:
        - o Referral of patients
        - o Laboratory examinations
            - CD4
            - Viral load for treatment monitoring
            - Nucleic acid amplification testing for early infant diagnosis
            - GeneXpert testing for TB diagnosis
            - Promotion of PITC and TB screening in Posyandu and community based VCT and TB screening.
    - Establish linkages with churches, mosques and NGOs to provide adherence and social support for infected and affected individuals and to promote testing and reduce disease associated stigma
    - Hiring communication specialists to work with HCPI to ensure wider understanding of the value of knowing ones HIV and TB status, the importance of adherence, and treatment seeking for STIs.

CHAI in collaboration with PHOs and DHOs will conduct a puskesmas facilities assessment to develop a prioritized list of puskesmas where ART will be initiated. Training needs for both hospital and puskesmas staff will be identified (VCT, CST, PITC, PMTCT, IMAI, TB-HIV, STI). Training will occur progressively, linked to the roll-out schedule for inclusion of new puskesmas. The focus issues addressed at hospitals/CoE sites (see list above) will also be addressed at puskesmas but at a service level appropriate to a puskesmas. As puskesmas come on-line, the CoE teams and PHOs/DHOs will make regular joint mentoring and monitoring visits.

Will it work?

Where the CoE model has been piloted to date, there has been remarkable success with dramatic increases in the number of people on treatment. Still there are many challenges to increasing access to ART. HIV testing needs to increase and this needs to happen close to where people live. Effective communication, assured confidentiality, and easy access to testing and treatment will be needed. Patient friendly, responsive health systems with quality laboratories, adequate drug supply and necessary community support will need to be in place. Missteps will occur and damage control and corrective action will be needed. Staff motivation will be key and CoE and DHO teams will need to provide encouragement and recognition of success.

How will we know?

This proposal prioritises strong monitoring and analysis as a core part of the REACH design, (see section 3.4). Indicators will be finalised in the first quarter of REACH when the monitoring framework is developed in consultation with the AIDS Sub Directorate. Indicative indicators include:

- number of people tested for HIV through PITC and VCT
- number of health services outside of major urban areas providing ARVs
- average CD4 count at first diagnosis, by gender (an indicator of earlier testing)
- number of people initiated on ARV treatment
- percentage of people eligible initiated on ARV treatment
- average time from diagnosis to initiation on ARV treatment
- percentage of people on treatment who are adherent
- percentage remaining in treatment at 12, 24, 36 and 72 months
- mortality among people diagnosed HIV positive
- mortality among people on treatment.

Will the benefits last?

Sustainability will be enhanced by establishing provincial, and potentially district, training teams that provide training for rotating staff. SOPs will ensure consistency. Provincial budgets will include funds for CoE and continued training, mentoring and monitoring from year four. The continuity of the program over the long term will depend on provincial governments taking over the funding for CoE. This will be difficult to achieve, not least because there is currently no operational agreement between provincial and district governments about who should pay for what. REACH anticipates this hurdle, and will be working with AIPD and other partners from the start to promote GoI assumption of CoE financing by year four of the program.

Sub-Component 1.2: Tuberculosis

Sub-component objective: To improve the quality of TB diagnosis and treatment in Tanah Papua.

Outcomes:
- Early diagnosis of TB increased
- Number of health facilities providing effective TB-HIV treatment and care services increased
- TB diagnostic and treatment capacity at puskesmas improved for all patients
- Number of people living with HIV/AIDS knowing their TB status and on treatment increased
- Loss to follow up decreased and adherence increased

Why are we doing this?

TB is the most common opportunistic infection among those infected with HIV and the most common cause of death among HIV patients. HIV prevalence among new TB patients in Tanah Papua averages 13%[34,35]. TB among HIV patients varies from 9-100% depending on the site where the examination is done and the stage of HIV disease. Activities under this sub-component will promote adherence to TB treatment and result in a reduction in cases of TB drug resistance.

Only 24 of 38 hospitals and 153 of 460 puskesmas in Tanah Papua are able to provide TB diagnostics and care. Not all VCT sites provide TB diagnostics and treatment and not all TB treatment facilities

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[34] Monitoring and Evaluation presentation, TB-HIV, Jayapura, 13-16 July 2011.

[35] Pontororing, *et al. The burden and treatment of HIV in tuberculosis patients in Papua Province, Indonesia: a prospective observational study.* BMC Infectious Diseases 2010, 10:362

can provide HIV testing. To reduce morbidity and mortality of TB-HIV co-infected patients, both HIV and TB diagnostic and treatment facilities need to be co-located and easily accessible. Early initiation of ART in TB-HIV co-infected patients reduces death rates, preserves failing immune systems and enhances TB cure rates if patients are adherent to both TB and HIV medications.

TB diagnosis can be difficult in patients with low bacterial counts in their sputum despite severe disease. Some clinicians are unwilling to start treatment if sputum is negative. Laboratory skills need to be sharpened, equipment in working order and external quality control in place in order to make an accurate diagnoses. In some circumstances, molecular techniques are necessary to confirm a diagnosis in highly suspect cases.

How will we do it?

During preliminary assessments of hospitals and puskesmas to be part of REACH, we will check SOPs and records for TB screening. This will include the extent to which screening of TB patients for HIV and HIV patients for TB is occurring, sputum positivity rates, treatment initiation rates, use of directly observed treatment short course therapy (DOTS), adherence, sputum clearance rates, cure rates and TB therapy completion rates. Staff capacity will be reviewed and training plans developed. Training materials prepared for the TB-HIV program will be used. REACH will collaborate with the USAID funded Community Empowerment of People against Tuberculosis (CEPAT) in Indonesia program which will work with churches, mosques and NGOs to support patients in treatment completion and advocate for more support for TB programming.

The work of CoE in relation to TB are outlined above in sub-component 1.1. Special attention will be paid to laboratory staffing and facilities, (see sub-component 1.4 below).

Will it work?

As with ART, TB diagnosis and treatment is fraught with many challenges. Like ART, patients must be tested close to where they live in patient friendly, easy to access, professional facilities where they are assured of confidentiality and easy access to treatment if tests are positive. Results must be reproducible from high quality laboratories, adequate drug supply must be assured and necessary community support will need to be in place. Adherence rates must be high to assure a cure and reduce the possibility of resistance developing. Staff motivation will be key and CoE, PHO and DHO teams will need to provide encouragement and recognition of success. Similar one-stop facilities set up and managed by members of the CHAI team in Timika achieved high sputum conversion rates, with 85 per cent cure and medication completion rates. With CoE support, mentoring and monitoring, similar results should be achievable.

How will we know?

REACH results will be measured by NTP program indicators:
- percentage of TB patients tested for HIV
- percentage of HIV patients tested for TB
- the number of people sputum positive and initiating treatment
- percentage converting their sputum from positive to negative
- percentage of TB patients completing treatment
- percentage of TB patients cured

Will the benefits last?

Part of the CEPAT project is focused on advocacy to district and provincial decision makers regarding support for sustained TB and TB-HIV programming. REACH will also work with Kinerja and AIPD to ensure both financing and leadership for TB control. Sustainability will be further enhanced through training for rotating and new staff. Routine monitoring will highlight successes and correct under performance.

Sub-Component 1.3: Sexually transmitted infections[36]

Sub-component objective: To reduce STI prevalence in high prevalence populations in Tanah Papua
Overarching outcome: STI prevalence reduced in high prevalence populations in Tanah Papua
Outcomes: • Gonorrhoea, chlamydia and syphilis prevalence reduced among sex workers   • STI prevalence reduced among HIV-positive sex workers   • Quality of STI diagnosis and treatment services improved at hospital and puskesmas level in Papua and West Papua   • Increased uptake of standardized STI services for men who have sex with men (MSM) and transgender people (waria) in selected sites

How will we do it?

To reduce the prevalence of STIs in the Papuan provinces we need to use a combination of strategies; those that rely on laboratory diagnosis and those that rely on presumptive diagnosis. The key components of these strategies are outlined in Box 2 in Annex 7.

We need to use most of the STI control strategies in the toolbox. Countries with good access to high quality laboratory diagnosis can afford to focus on improving access to services. Countries with weaker laboratory systems, including Indonesia, need to include strategies that rely on presumptive diagnosis.

Two broad strategic approaches are needed in the Papuan provinces:

- Targeted STI interventions for high prevalence populations including PPT, enhanced syndromic management and syphilis screening.
- Improved quality of STI diagnosis and treatment at district hospital and puskesmas level.

Targeted STI interventions for high prevalence populations

Targeted STI interventions based on presumptive diagnosis are designed as transition strategies to achieve rapid reductions in STI prevalence in high prevalence populations that have poor uptake of services. The plan over the longer term is to shift to strategies that rely on laboratory diagnosis as prevalence drops and laboratory capacity improves.

The emphasis in targeted STI interventions is on the population rather than the individual. The challenge is to achieve high population participation rates rather than individual demand for services. The interventions are not based on waiting for individuals to decide to go to a clinic for a check-up. For example, health staff need to go to brothels with a supply of doxycycline and cefixime for PPT and condoms. NGO partners (for example, SUM sub-grantees) can map street sex work sites and work with health staff to provide PPT medications every three months.

The puskesmas and district hospitals , in partnership with local NGOs, will have a key role to play in the scale-up of targeted STI interventions for high prevalence populations including presumptive treatment on arrival, three monthly PPT, regular syphilis screening and PPT for sex workers' boyfriends and husbands. REACH will work with staff at selected puskesmas to build their ability to implement targeted STI interventions with FSWs, MSM and waria. This will be in partnership with NGOs that have existing relationships with FSWs, waria, and especially with harder to reach groups such as MSM and street-based sex workers . Specific attention will be given to providing STI diagnosis and treatment for HIV-positive FSWs. Table 17 in Annex 7 lists the recommended key

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[36] Additional details on REACH's approach to STI programming are in Annex 7.

strategies for each high prevalence population. Additional background is given in Annex 7 on four of the recommended strategies – PPT, syphilis screening, enhanced syndromic management and use of surveillance activities for STI control.

Improve the quality of STI diagnosis and treatment

There are three reasons why it is important to improve the quality of STI diagnosis and treatment at the level of the puskesmas and district hospital:

- The targeted STI interventions for high prevalence populations depend on the quality of STI diagnosis and treatment at puskesmas level. It will be puskesmas staff who provide the PPT drugs. The syphilis blood samples taken in a syphilis screening program for FSWs will be tested in a puskesmas or district hospital laboratory. Registers of syphilis tests results and treatment details (to improve the accuracy of diagnosis and reduce overtreatment) will be maintained by clinic staff.
- This is a long term investment in improving the quality of and demand for STI services. The vision for the future is all individuals with STIs, including FSWs and MSM, attend STI clinics at the local puskesmas.
- STI treatment during surveillance activities will rely on the quality of STI diagnosis and treatment at puskesmas and district hospitals.

Key activities will be:

- Work at the national level with MoH Pharmaceutical Services Department to review the National EDL to ensure inclusion of key STI drugs including cefixime, azithromycin and metronidazole in the EDL. In the interim, work with the District Legislative Assemblies to approve procurement of STI drugs under district health budgets.
- Improve the supply and availability of a standardized list of STI laboratory reagents and supplies in puskesmas and district hospital laboratories (see Table 18, Annex 7).
- Ensure provision of STI testing for all PLHA attending puskesmas and district hospitals and routine HIV testing (PITC) for all STI patients at puskesmas and district hospitals.
- Improve the quality of syphilis diagnosis and treatment. The network of CoE will provide training and mentoring for HCWs in hospitals and puskesmas with attention to:
    - Early diagnosis of infectious cases
    - Standard use of penicillin injections addressing anaphylaxis
    - Rapid treatment, with prioritization of high-titre cases
    - Individual records of serial titres and treatment held by patients
    - Provide technical input to WHO Indonesia and the AIDS Sub Directorate in the next revision of the National STI Guidelines with particular attention to:
        - Need for TPHA RDT to be used in conjunction with RPR for syphilis diagnosis
        - Clear case definition for active syphilis that uses both TPHA and RPR tests
        - Inclusion of a stand-alone section on serological diagnosis of syphilis
    - Ensure STI clinics and puskesmas perform serial RPR titres on all TPHA positive /RPR reactive samples.
    - Establish registers of serial syphilis results and treatment details in clinics providing sexual health services to sex workers to reduce the likelihood of over-diagnosis and unnecessary repeat treatments.
- Scale-up routine syphilis screening of antenates at first visit.
- Advocate for, and support, inclusion of sites in Tanah Papua in gonococcal antimicrobial sensitivity surveys conducted in Indonesia.

- Develop/adapt standardized algorithms for STI diagnosis and treatment for MSM and waria and support two puskesmas to act as demonstration sites delivering minimum package of services for MSM and waria
- Strengthen diagnosis and treatment for trichomonas at puskesmas and district hospitals and work with the MoH to ensure supply and availability of metronidazole
- Adapt and distribute a training manual (based on the Thai manual) for laboratory technicians on STI diagnosis.
- Provide training in public health approaches to STI control.
- Work with pharmacists and pharmacists association in Papua and West Papua to refer patients to STI treatment centres for appropriate examinations and treatment. Use syndromic management when patients are not willing to attend clinical services.
- Publicize a list of health facilities providing high quality STI diagnosis and treatment as puskesmas are trained, equipped and functioning.
- Work with HCPI and the Provincial AIDS Commission's communication groups to raise awareness about STIs, the need for treatment and the location of quality diagnosis and treatment facilities.

Will it work?

The MoH looks to WHO for leadership on STI technical issues. WHO support will be needed to move ahead with these strategies.

The success of targeted STI interventions in high prevalence populations depends on how well the strategies are implemented. PPT works best:

- With well-defined populations
- Where there is a high prevalence of STIs[37]
- Where there is limited population mobility and turn-over
- Where high coverage of PPT is achieved
- With high rates of condom use (ideally in conjunction with a 100% condom use program).

The effectiveness of PPT will be undermined if FSWs have low condom use rates with clients and do not use condoms at all with their boyfriends. Similarly, the effectiveness of PPT will be undermined if the boyfriends of FSWs are not treated as well.

How will we know?

The IBBS rounds will provide prevalence data for syphilis, gonorrhoea and chlamydia. CoE and REACH staff will monitor the standard of STI care provided by health services and provide mentoring during regular visits. STI-related policy changes, such as additions to the EDL, can be easily measured.

The REACH monitoring system will record key information for each puskesmas. Examples include:

- percentage of sites that have consistently had key STI-related reagents and drugs in stock over the previous six months
- percentage of pregnant women and neonates screened for syphilis
- percentage of syphilis tests which correctly distinguish between active and former infection.

The monitoring system will use clinic and quality control records to report on:

- percentage of sex workers correctly diagnosed and treated according to protocols

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[37] Steen R, Chersich M, de Vlas SJ. Periodic presumptive treatment of curable sexually transmitted infections among sex workers: recent experience with implementation. Curr Opin Infect Dis. 2012 Feb;25(1):100-6.

- change in STI prevalence between new patients and repeat patients
- percentage of sex workers whose regular partners receive PPT.

Will the benefits last?

The benefits of changes to the national EDL and guidelines will last. Accurate syphilis diagnosis and effective treatment will require ongoing low cost support from districts. The best sustainability strategy for STI diagnosis and treatment for MSM and waria is increased demand from those communities for the services.

The turnover of FSWs in the Papuan provinces is high. This means that programmes must work consistently to maintain benefits. REACH has chosen to work principally with government rather than NGO clinics for MARPs in the expectation that they are more likely to continue support for programming when external funding is not available.

Sub-Component 1.4: Laboratories

Sub-component objective: To strengthen laboratory capacity to provide HIV, TB and STI related diagnostic testing and monitoring.

Outcome: Number of health facilities with functioning laboratories participating in external quality control programs and producing accurate and reproducible results increased.

Why are we doing this?

HIV, TB and STI diagnosis and treatment are all dependent on accurate, reproducible laboratory results. A false negative result may lead to unprotected sex and infection of a partner and delayed treatment. A false positive result may lead to unnecessary stress and worry, potentially harmful medications and discrimination. No diagnosis of HIV or TB can happen without a laboratory. STIs can be managed by syndromic treatment but often with over treatment, and with asymptomatic infections, most often among women, going untreated. Many puskesmas in REACH targeted areas do not have laboratory staff or staff trained to perform HIV, TB and STI diagnostics. Facilities are also often lacking. A functioning microscope is necessary for TB and STI diagnosis and syphilis testing needs a rotator that requires electrical power. Refrigeration may be necessary for some reagents and a constant supply of laboratory reagents and consumables will be necessary to safely and accurately conduct testing.

How will we do it?

During REACH's preliminary assessment of hospitals and puskesmas, laboratory capacity and quality will be assessed by CoE laboratory staff and Provincial Health Laboratory (PHL/BLK) staff. Staff capacity will be reviewed and training plans developed. Training materials used for HIV, TB and STI will be reviewed and laboratory trainers prepared. Draft SOPs will be developed for all laboratory procedures, shipment of specimens, data management, record keeping, external quality assurance (EQA), occupational safety and health, waste management, and supply chain management, including inventories and forecasting. CoE laboratory staff will make periodic visits to ensure SOPs are being followed. Initially, REACH will target puskesmas that already have laboratory technicians while it lobbies PHOs and DHOs to provide laboratory technicians to other priority puskesmas. HIV and syphilis testing can be task shifted to nurses. Microscopy for TB and STI requires significant experience both in specimen preparation and use of a microscope. Task shifting for these tests may be attempted with some nurses on a case by case basis.

CoE sites will have CD4 testing, both fixed and mobile. Blood samples for CD4 testing must be examined within 24 hours. It is much more practical to bring a portable CD4 machine to the field to test a group of patients rather than attempt to send patients or blood to distant laboratories. Allere PIMA point of care portable CD4 machines have proved themselves durable, and produce reliable results. They are used extensively by CHAI in PNG with good results and will be used by REACH.

Conventional TB sputum exams can be insensitive if TB bacterial load in sputum is low. Making an early diagnosis of TB in HIV infected patients is critical. X-ray examinations that might provide indirect evidence of TB infection are not available in puskesmas. Molecular polymerase chain reaction (PCR) testing for TB DNA has been simplified through new technology. The GeneXpert performs PCR assays which are significantly more sensitive for TB detection than conventional light microscopy. It is battery operated, with self-contained cartridges for safe specimen management. The GeneXpert has revolutionized resistance testing as it also provides information on whether the organism is resistant to rifampin, one of the primary antibiotics used in TB treatment. GeneXpert equipment will be placed in each of the CoE and suspect negative samples from conventional microscopy will be re-examined in CoE laboratories.

Will it work?

The technology is available to ensure accurate and reliable laboratory results. To employ that technology, space, equipment, reagents, consumables, electricity, water and, above all, trained and dedicated staff will be needed to make accurate laboratory diagnoses. Facilities improvements should ensure space, power and water, (see sub-component 1.5 below). Advocacy around budgets and staffing and SCM work (see sub-component 1.6 and section 2.6 below) will be essential. Equipment will be purchased with three year warranties and maintenance plans will be developed. REACH will work with PHOs and DHOs to ensure long term maintenance plans are developed and that the capacity exists to implement these plans.

How will we know?

The key indicator will be the number of health facilities with laboratories providing comprehensive HIV, TB and STI services. Monitoring visits will confirm adherence to SOPs. EQA will confirm the accuracy of HIV and STI testing. GeneXpert results will confirm negative and positive conventional microscopy for TB.

Will the benefits last?

Results of laboratory strengthening will be sustained if advocacy for program support, (see sub-component 1.6 below), is successful in ensuring sufficient budget, necessary staffing and reduced rotation of key laboratory personnel.

Sub-Component 1.5: Infrastructure

Sub-component objective: To strengthen health infrastructure at puskesmas level to support provision of primary health services including HIV-related care support and treatment

Outcome: Health facilities have electricity, water, adequate house staffing, safe waste management and appropriate information technology systems.

Why are we doing this?

Key infrastructure required to enable provision of effective health services includes water, electricity, sanitation, safe medical waste disposal, information technology systems, communication and adequate housing for staff at remote sites. Water, electricity and staff housing are usually already available in urban health facilities but are commonly not available in rural and remote puskesmas. There is a need to upgrade sanitation and medical waste disposal at all health facilities, including hospitals. Transmission of data to CoE, PHOs and DHOs will be optimized by sites using hard copies, SMS, email, single side band radio or telephone. Laptops, printers and print supplies, UPS, solar charger and data collection software will be provided to each site. In rural and remote areas, staff housing is required to attract and retain staff to work in puskesmas. All aspects of infrastructure development will strengthen the capacity of health facilities to provide both HIV-related and non-HIV services.

How will we do it?

It will be necessary to undertake a sub-design to quantify the type and extent of infrastructure needs as the team developing this proposal did not have the expertise nor time to do this. Specialists in infrastructure will be engaged by AusAID to conduct the sub-design, in close consultation with CHAI. A national survey of all health facilities has recently been completed by the MoH's NIHRD and the results may be available shortly. Data from the survey will be used for the REACH infrastructure sub-design. Puskesmas that were surveyed will need to be visited for structural assessments and identification of local suppliers and labourers/contractors that can implement facilities improvements. Twenty-eight active puskesmas were not included in the NIHRD survey and will need a more comprehensive assessment.

Prior to the infrastructure sub-design, CHAI will identify the proposed hospital and puskesmas sites that will be involved in the REACH program, using the selection criteria outlined in Annex 6. The infrastructure sub-design will:

- Through site visits, identify and prioritise the infrastructure needs for health facilities that will be part of REACH. This will include an assessment of the reliability of data from the NIHRD survey, particularly in regard to puskesmas in rural and remote areas. Concurrent with the infrastructure site assessments, CHAI will assess the capacity of staff. This will result in the development of harmonised timelines for facilities improvements and staff training, where possible.
- Identify the most appropriate types of infrastructure development, taking account of the rural and remote locations of many puskesmas. For example, the type of electrical support (mini-hydro, solar cell, generator set), water supply (piping from springs, wells, rain water catchment) and medical waste management technology to be used.
- Assessment of non-incineration technology for medical waste disposal.
- Identify strategies to minimise the risk of infrastructure theft, (for example, solar cells).
- Include plans for ensuring quality standards are applied in infrastructure development.
- Formulate an infrastructure development plan which sets out a phased approach, aligned with the roll-out of REACH which will progressively extend to new puskesmas over four years.
- Develop a plan for how infrastructure will be maintained by health services and DHOs, including budget estimates.
- Develop a plan for government to meet operational costs such as electricity and water, fuel for generators, including budget estimates.
- Quantify the level of funding required for the different components of infrastructure work and development of budget sharing plans with districts.
- Include plans for development of local capacity in infrastructure development and maintenance, including employment of PLHA.
- Make recommendations on the appropriate aid modality for the infrastructure development (for example, project contract), including technical oversight of the work.

REACH will cover 120 puskesmas. In keeping with the flexible adaptive management approach to implementation, it may prove possible to extend the program to additional puskesmas as the program rolls out. The infrastructure sub-design should incorporate flexibility; with the option of additional infrastructure development should funding be available. However, the initial assessment of infrastructure needs will be confined to 120 puskesmas.

In the interests of promoting mutual obligation and responsibility, it would be desirable to cost-share the infrastructure component with district governments. However, given the lead times for development of district budgets and the scope of REACH (21 districts) it is not feasible to reach

agreement with a large number of districts within the timelines for the first wave of facilities improvements. However, district investment may be able to be leveraged for infrastructure development in the second and third years. The infrastructure sub-design should incorporate clear plans for DHOs to be responsible for operational and maintenance costs and seek the agreement of districts for this to be their responsibility.

To ensure expert technical oversight of the infrastructure component of REACH, it is proposed that the Infrastructure Unit in AusAID, Indonesia be involved in two ways:

- Developing the terms of reference for the infrastructure sub-design with CHAI and in consultation with AusAID's Health Unit.
- Technical oversight of the sub-design and subsequent infrastructure development work by a contractor.

These functions most appropriately rest with the Infrastructure Unit, given their technical expertise, rather than the Health Unit.

Will it work?

There may be significant delays in the release of data from the NIHRD survey of health facilities. If this is the case, AusAID and CHAI will negotiate with the MoH for access to the data prior to its broader release. If access is not possible it will be necessary for the infrastructure sub-design to undertake more comprehensive assessments when it visits sites.

Completion of even the early stages of infrastructure work will not occur until well after REACH has commenced implementation. However, CoE will come on-line over 18 months and the first puskesmas to be involved will primarily be those in urban areas where there will be a lesser need for infrastructure development. CHAI Phase II has demonstrated that it is feasible to decentralise HIV CST to puskesmas lacking in key areas of infrastructure, although this limits their capacity to provide some services such as those laboratory tests which require electricity or specialized equipment. As the infrastructure work is completed, the range of services provided by puskesmas will be enhanced. Some puskesmas, particularly those in rural and remote areas, will only start to provide HIV CST services in years 2 – 4 which should allow sufficient time for infrastructure development.

The sub-design will identify infrastructure needs for specific puskesmas. As REACH is rolled out puskesmas selection may change because of emerging factors such as emerging security concerns or lack of sufficient staffing. If different puskesmas are chosen for inclusion in REACH, their infrastructure needs are likely to be similar to those of puskesmas dropped from expansion plans, so this should not have a significant budgetary effect. Prior to any infrastructure work taking place in puskesmas not yet part of REACH, CHAI will update its assessment that inclusion of that facility in REACH remains viable.

How will we know?

AusAID's Infrastructure Unit or its contractor will monitor design and construction to ensure quality. CHAI and CoE staff will monitor maintenance planning, budgeting and implementation of facilities maintenance. This will be included in the checklist for routine monitoring visits, as well as in regular reporting forms used in the monitoring system.

Will the benefits last?

Sustainability will be enhanced by choosing infrastructure solutions with feasible maintenance requirements in rural and remote areas, development of anti-theft strategies and realistic maintenance plans with a requirement for budget allocation by DHOs for facilities monitoring and

maintenance. Problems with maintenance will be addressed through technical advice and advocacy to DHOs.

Sub-Component 1.6: Support for effective decentralised systems

Sub-component objective: To support policies that increase the efficiency, transparency and sustainability of service delivery in a decentralised health system

Outcomes:
- Partners contribute to achieve the end of program goal
- Provincial and district budgets and plans support decentralized HIV-related service funding
- National policies adapted to local context

Why are we doing this?

Despite national and local policies for universal access to HIV CST, access in Tanah Papua primarily exists only in coastal urban areas in a limited number of hospitals and even more limited number of puskesmas. DHOs have neither focused on nor invested in the expansion of HIV CST. This may be due a lack of understanding of the long-term financial burden that will arise if little is done now.

Decentralisation has complicated the picture. There are a number of different funding streams for health services; some money comes from Jakarta, often (but not always) routed through vertical programs. ARVs and some HIV-related laboratory supplies are funded centrally but systems are not responsive to rapid scale up. Special autonomy funds are routed through the province, with an earmark for health. A portion remains at the provincial level, but the bulk is passed on to districts who also allocate funds to health. A number of different health insurance schemes are provided from different sources for different levels of care. The bureaucracy around reimbursement for these schemes is highly variable and not always patient friendly.

Understanding at the district level of whose responsibility health care is under decentralization may be limited. District Governors (Bupatis) and DHOs need to understand their care obligations, and should have CST targets based on MDGs, and be held accountable by the Ministry of Home Affairs.

There is no shortage of government funds in the Papuan provinces. The key issues are the low priority accorded to health sector funding, limited capacity for planning and budgeting, and the efficiency and effectiveness of how money is spent. What is needed is advocacy around funding for the health sector and more efficient and effective planning, budgeting, monitoring and accountability. This includes clarification of budgets and lines of responsibility, both between levels of government, and between major players in health within provinces and districts. Procedures need to be worked out so that they are transparent and simplify access to care for patients. Mechanisms for local emergency budgetary responses need to be in place in the event that central systems fail. Achieving progress in this area would have important benefits for the health system as a whole.

In the interest of sustainability and replication of the decentralised model in other parts of Tanah Papua beyond the scope of REACH, it will be critical to develop a financing model that is lean and uses funds efficiently.

How will we do it?

REACH will assign a government relations officer to be placed in the PHOs or Regional Development Planning Agencies (BAPPEDA) in Papua and West Papua. These officers will work with provincial and district governments and AIPD and Kinerja to develop health financing plans that include prevention and care for HIV, TB and STIs. This will include the operational cost of scaling up these services and funding by PHOs of CoE from year four. The plans will explore the possibility of multiple districts contributing to the cost of the CoE that supports their puskesmas.

Plans will be developed in Jayapura and Jayawijaya districts first where CHAI has strong working relationships and a better understanding of existing policies and procedures. These plans will serve as working models for other districts in the future.

The government relations officers will also work with provincial governments and AIPD and Kinerja to:

- Help District Governors and DHOs understand the financial implications of inaction in terms of care costs, loss of productivity and disease related morbidity and mortality of untreated HIV, TB and STIs.
- Develop the capacity of PHOs and DHOs to undertake effective health services planning, linked to budgeting.
- Explain and justify the need for continuing CoE mentoring and monitoring functions in the long-term, post-REACH to ensure high quality of service delivery.
- Ensure continued provincial funding for HIV-related care and support through the Papuan Native Community Health Insurance Scheme (JAMKESPA).
- Develop clear, transparent policies on patient charges, if required.
- Reduce overlap and duplication between development partners.

CoE mentors will take new national policies and work with PHOs, DHOs and health facilities for local adaptation and implementation, as was done successfully in Jayapura and Jayawijaya by CHAI Phase II with the new PITC policy.

Will it work?

Senior provincial and district government officials consulted during the development of this proposal clearly understood that REACH is designed around the principle of mutual responsibility, with governments being responsible for the cost of service delivery and funding for CoE from year four. In principle commitments were received. A clear health financing strategy at the provincial and district level with transparent public policies for access to care will be reassuring to facilities responsible for service delivery. Early discussions with the Regional Development Planning Agencies and PHOs in Papua and West Papua indicate a commitment to resolve the confusion around payments, continuity of service for chronic illness and quality assurance. AIPD and Kinerja have extensive experience in working with local governments on decentralization and will support REACH's technical efforts to ensure financing for long term sustainability and health service quality assurance.

How will we know?

The monitoring system will pioneer the use of relationship mapping as a tool for assessing the success of efforts to strengthen, streamline and clarify relationships between different actors in the health system. This tool can also be used to map financial flows.

Concrete outcomes we expect are 1) provincial and district health financing strategies and plans that include care costs, personnel, mentoring and monitoring; 2) actual flow of funds to PHOs, DHOs and to health facilities; 3) clear and widely publicised policies for patients on costs for services; and 4) local policies, rapidly and appropriately adapted from the national level.

Will the benefits last?

Inclusion of the cost of HIV-related CST into the annual budget planning cycle will provide the greatest assurance that the programs will be sustained. However this is subject to the political cycle. Provincial elections are overdue in Papua and district elections are due in several areas. Progress made in this area will be most secure for the term in office of the head of local government under whom commitments were made.

Sub-Component 1.7: Medical waste management

Sub-component objective: To strengthen safe management of infectious medical waste in Tanah Papua.

Outcome: Health facilities have equipment and systems for safe management of infectious medical waste

Why are we doing this?

Medical waste is poorly managed in Papua and West Papua with consequent health and safety and environmental problems.

How will we do it?

- Support the development of the nine CoE as model medical waste management (MWM) demonstration sites
  - Conduct baseline site MWM assessments in CoE as part of the infrastructure sub-design
  - Develop a standardized package of guidelines and facility-level regulations for MWM covered by site-level MOUs in CoE
  - Support introduction in all CoE of non-incineration technology appropriate to local conditions, protective equipment and waste stream separation bins
  - Conduct routine MWM compliance monitoring
- Develop a MWM training package to be delivered by the CoE at puskesmas level that includes segregation of infectious and non-infectious waste, use of protective equipment, and vaccination for staff handling medical waste.
- Include installation of non-incineration technology in the REACH puskesmas infrastructure upgrade activities. (The specific type of technology will be identified in the infrastructure sub-design – see sub-component 1.5 above.)
- CoE to provide routine environmental supervision and monitoring to reinforce safe MWM practices at puskesmas level.
- Assess the feasibility of centralized MWM in Sorong, Manokwari and Jayapura using industrial autoclave technology as part of the infrastructure sub-design.

Will it work?

There is minimal awareness or interest in district hospitals and puskesmas in the potential occupational health and environmental risks and consequences associated with poor management of infectious medical waste. Medical waste is usually incinerated. There is no awareness of the consequences of persisting organic pollutants. REACH will need to create this awareness and change the existing waste management culture. Based on global experience, approaching MWM as occupational health and safety issue is the most successful in building health staff commitment.

How will we know?

The CoE will supervise transition to non-incineration technology and REACH will monitor medical waste handling and disposal in accordance with SOPs.

Will the benefits last?

The infrastructure sub-design will draw on international MWM technical expertise to identify non-incineration technologies that are appropriate for the conditions in urban-based, rural and isolated health facilities in including electricity, water and maintenance requirements to maximize sustainability. REACH will work with DHOs and PHOs to ensure commitments for maintenance.

Community empowerment

The Catholic Dioceses of Jayapura, Timika and Sorong-Manokwari and the protestant Christian Gospel Church of Tanah Papua have submitted a community empowerment funding proposal to USAID, called Community Empowerment of People Against Tuberculosis (CEPAT), which is designed to complement REACH. The proposal seeks to use the broad reach of the churches to mobilise communities to support better detection of HIV, STI and TB and TB-HIV cases, promote treatment and to advocate for better services. The two components of this program are:

1. Community mobilisation: volunteers recruited and supported by parishes will undertake community awareness building and promote HIV and TB testing as an entry point to treatment, and assist with referral, contact tracing and adherence support.
2. Advocacy for increased resources and improved services at district, provincial and national levels.

A copy of this proposal concept is in Annex 8. The outcome of the funding proposal should be known in the near future. On the assumption the proposal will be successful, community mobilisation and support activities have not been included in this REACH funding proposal. However, these activities are essential to the success of REACH. Should USAID funding not be available, CHAI will seek funding for these activities from AusAID.

REACH will also work with CSOs supported by HCPI and SUM I and II.

REACH will seek to incorporate gender-related issues into all aspects of the CST sub-component. As noted in section 1.3.2, men are more likely to be HIV infected than women, particularly in West Papua, although it is likely that this differential will be eroded over time. However, women appear to have better access to HIV testing, with a higher number of men being diagnosed only when they have developed HIV-related symptoms. Increasing access to HIV testing for all people will be a priority for REACH, and this will particularly be the case for men.

REACH will be guided by an understanding of the unequal place of women in Papuan society. For example, gender based violence, including rape, increases the vulnerability of women to HIV infection; males may determine when and how women are able to access health services; and women who are diagnosed as HIV infected through PMTCT may be reluctant to inform their male partners of the result for fear of the consequences.

As part of the progressive development of the REACH model, CHAI will consult with males and females on gender-related aspects of the program. Training provided by CHAI and CoE will incorporate an understanding of gender-related issues and how this may impact on access to services. Health staff at hospitals and puskesmas will also be trained in basic trauma counselling skills to deal with domestic violence, and referral networks with gender based violence services, where they exist, will be developed.

Programmatic needs for Papua and West Papua post 2016

HIV care, support and treatment

While the primary focus in developing this proposal has been on program implementation over the next four years, a longer term program approach (5 – 10 years) needs to be considered for the achievement of medium to long term outcomes. Within this context there is the option of a further program phase beyond mid-2016, upon completion of a satisfactory mid-term assessment. Future programming needs to be based on an assessment of what can realistically be achieved by REACH in four years and the likely shape form of AusAID's Indonesian health program in 2016 and beyond.

Characteristics of AusAID's health sector support by mid-2016 relevant to the Papuan provinces may be:

- A stronger and more mature partnership with the MoH and PHOs which includes policy dialogue and leverage of government and other donor commitments.
- A focus on health systems strengthening which engages with the GoI at all levels on diagnosis of system weaknesses and solutions, with a particular focus on access for the poor and vulnerable groups to primary health care. This may be within the context of the AIPHSS, (AusAID's HSS program), having extended its scope to the Papuan provinces and a possible follow-on HSS program.
- While the scope of AusAID's health portfolio may have broadened to new areas (for example, non-communicable diseases) ongoing health system strengthening work would underpin Indonesia's advancement in relation to MDG targets to reinforce the sustainability of Australia's considerable historical investment in HIV programing.
- A continuing strong focus on support for the health sector in the Papuan provinces which would include enhanced prevention programming with a particular focus on those who contribute disproportionately to the generalised Papuan epidemic, (for example, FSWs and high risk men).
- Possible continuation of AusAID programming to facilitate effective decentralisation in key program areas such as health.

The end of program goal is increased access to and increased number of people on HIV-related care and treatment in the Papuan provinces. The long-term goal is for reduced HIV-related morbidity and mortality in the Papuan provinces. The long-term goal will be able to be partially measured by mid-2016. However, the phased roll-out of HIV-related CST to puskesmas, some of which will come on line in the last year of the program, will mean that full measurement of the long-term goal will take place post-REACH. This proposal recommends that AusAID conduct a sustainability evaluation two years after the end of REACH, (see section 3.4.6).

Assuming that REACH achieves its end of program goal in its 21 focus districts, it is likely that there will be demand from other districts to provide similar support. Mid-term review should provide insight into the program's successes, strengths and weakness and should inform the planning process for beyond 2016.

In addition, a second phase of REACH could provide higher level technical support and monitoring function to the nine CoE to ensure they remain on track, although it is anticipated they would be largely self-supporting by this stage and that REACH would concentrate its activities in new districts.

Sexually transmitted infections

AusAID could consider providing post-program support for STIs including:

- Technical inputs to critically review the quality and interpretation of STI data
- Periodic technical inputs to support effective population-based approaches to STI control. The key strategies outlined for targeted interventions in FSWs are specifically designed for high prevalence populations. As STI prevalence falls the strategies need to be revised.

2.6 Component 2: Supply chain management

Overarching objective: To decrease stock outs and increase efficiency of strengthened supply chain management of HIV-related commodities.

Sub-Component 2.1: Provincial level

Sub-component objective: To strengthen supply chain management systems for HIV-related commodities in Tanah Papua.

Outcome: Functioning and sustainable decentralized supply chain management for HIV-related commodities in Tanah Papua.

Why are we doing this?

The scale up of HIV-related services in the Papuan provinces as a result of REACH will put pressure on supply chain systems for drugs and other commodities required for TB and STI services. REACH will need to ensure that supply chain systems for TB and STI drugs and commodities are adequate. SCM work for these types of commodities is not currently being undertaken by CHAI Phase II.

How will we do it?

CHAI will conduct a preliminary assessment of the adequacy of existing provincial level SCM systems for TB and STI commodities. The assessment will document existing work processes and responsibilities, identify barriers to effective coordination and management and propose new ways of working. REACH will work with current supply chain mechanisms rather than create new ones. This will include working with MoH programs to ensure alignment and resolve disease-specific supply chain constraints. Key activities for REACH will be:

- collaboration with PHOs and DHOs to improve coordination, especially for planning, quantification and forecasting; and

- training and mentoring of treatment sites on best practice for quantification, storage, inventory recording and reporting and drug handling.

Will it work?

Building good coordination and cooperation among stakeholders will be essential to achieve this objective since CHAI will be building upon current supply chain systems. If these relationship are managed well, the risk of failure is largely mitigated.

How will we know?

Existing methods used by CHAI to evaluate HIV-related SCM effectiveness will be used such as recording incidences of stock outs at treatment sites. CHAI staff in the Papuan provinces and CoE staff will monitor the adequacy of supplies in health facilities.

Will the benefits last?

By using existing supply chain systems the likelihood of sustainability will be enhanced.

Sub-Component 2.2: National level

Sub-component objective: To strengthen national and decentralised supply chain management systems for HIV-related commodities

Outcome: Functioning and sustainable supply chain management for HIV-related commodities at national level and in 16 decentralized provinces.

Why are we doing this?

As national efforts to scale up HIV treatment continue, ensuring availability of drugs through effective SCM systems continues to be a high priority for the AIDS Sub Directorate. In the interest of

sustainability, CHAI will plan and implement a phased transition of its SCM support to the AIDS Sub Directorate, with a full transition being achieved by the end of REACH in mid-2016. Completion of technical assistance projects that began in Phase I and Phase II will put the national program on a good footing for the future.

There will need to be a particular focus on strengthening SCM for ARVs in the Papuan provinces to cope with the expected significant increase in the number of people on treatment.

How will we do it?

CHAI has used a two-track SCM strategy which has involved improving the centralised national SCM system managed by the MoH's AIDS Sub Directorate and a decentralised pilot in four provinces.

REACH will conduct the following activities:

- Expansion of the final phase of decentralised ARV SCM to an additional 12 provinces, including West Papua. (Papua is one of the existing decentralised provinces.)
- Development of best practices methods (SOPs, templates and tools) for forecasting and quantification of HIV commodities including ARVs, OI and STI drugs, and HIV rapid tests, accompanied by detailed training.
- Provision of training to provinces and districts that will not be a part of ARV SCM decentralization to improve the quality of site reporting.
- Strengthened reporting and recording of HIV data and improved utilization of the online Inventory Order Management System to monitor hospital performance.
- Implementation of a national reporting system to manage the supply chain for HIV rapid tests.
- Improvement of supply planning and stock out avoidance.
- Establishment of indicators for SCM performance to monitor the quality of work carried out by implementing agencies.

In the Papuan provinces, intensive efforts will be needed to improve supply chain management. While the decentralised system in Papua Province is working effectively, the significant expansion of treatment sites will pose challenges. CHAI's core SCM activities for HIV-related commodities conducted at the national level will be replicated in the Papuan provinces through strengthening of the decentralization model in Papua and establishment of the decentralised model in West Papua. An assessment and gap analysis will be conducted at a sample of treatment sites to identify the best methods to improve SCM capacity. Key activities will be to:

- Establish a SOP for SCM processes in the Papuan provinces, based on the national SOP and training curricula.
- Train and assist treatment sites to improve the quality of SCM.
- Train PHOs and DHOs in managing HIV-related commodities, including best practices methods of forecasting and quantification and site reporting.
- Establish indicators for SCM performance to monitor the quality of work carried out by implementing agencies.

Will it work?

The activities under REACH build on the work undertaken in CHAI Phases I and II which have proven to be successful. Given the long history between CHAI and the AIDS Sub Directorate, relationships and trust are in place to jointly implement these activities. The AIDS Sub Directorate is aware of the transition plan and that they will need to take full responsibility for SCM from mid-2016. They will need to operationalize their commitment by securing adequate resources.

For the work focussed on SCM in the Papuan provinces, CHAI will apply lessons learned from its national level experience in implementing SCM capacity building during CHAI Phase II and at CHAI-supported sites in Jayapura and Wamena.

How will we know?

At the national level, the major measure of success for this objective will be how many of the activities CHAI has outlined will be able to be driven and led by the AIDS Sub Directorate, rather than driven and led by CHAI with the endorsement of the Sub Directorate. The key indicator will be strong leadership from the AIDS Sub Directorate in SCM, with use of CHAI technical assistance as needed.

For the work in the Papuan provinces, the key outcome will be an effective and efficient SCM system that will be measured by key performance indicators. Increased awareness on SCM management at treatment sites and emergence of strong commitment and leadership from PHOs and DHOs will also be monitored.

Will the benefits last?

At the national level, done properly, the long-term benefit will be an effective system and processes in place that ensure commodity availability. This includes management methods, best practise, SOP working process and monitoring performance indicators to ensure the quality of work. By working to ensure that the system builds in the right mechanisms to manage the supply chain, the benefits will last.

In the Papuan provinces, the benefits can be sustained by ensuring that local capacity building for SCM is aligned and integrated with the broader health system supply chain systems and by building the commitment of PHOs and DHOs to SCM.

Sub-Component 2.3: One Gate

Sub-component objective 1 To support the medium to long term shift of incorporating supply chain management of HIV-related commodities within the national one gate policy.

Outcome: Ensure future long term sustainability by engaging the Pharmaceutical Directorate on the development and implementation of the One Gate policy.

Why are we doing this?

The MoH's Pharmaceutical Directorate is continuing to develop its One Gate policy, which is intended to coordinate drug procurement and possibly other supply chain activities across the MoH. The One Gate policy has the potential to be a unifying theme to drive integration. However, the extent to which One Gate will integrate with other supply chain systems within the MoH has not been decided. The AIDS Sub Directorate will increasingly need to rely on the Pharmaceutical Directorate and its ability to manage health commodities across Indonesia as the number of its donor supported supply chain staff is likely to decrease. By focusing on strengthening SCM in the broader health system, the national HIV CST program will be better positioned to deal with waning donor support for HIV SCM.

How will we do it?

The parameters of the One Gate policy require development and definition. The implication is that this area of work is exploratory in nature. Decisions on future directions will need to be made at senior levels within the MoH, with input from the Pharmaceutical Directorate and national programs. The key activity under REACH will be provision of technical assistance to develop a road map that identifies the major issues that need to be considered in developing and defining the One Gate policy. The road map will identify options and a process for how they can be further explored and developed.

If good progress is made, CHAI could then conduct the following type of indicative activities:

- Work with the Pharmaceutical Directorate and the AIDS Sub Directorate to define how planning, procurement and drug management can be coordinated or integrated at national, provincial, and district levels and with vertical programs such as HIV, TB, and malaria.
- Improve human resources for supply chain management at the provincial and district level by strengthening the network and providing training for warehouse managers as HIV and other program areas are better coordinated with or integrated into the mainstream drug management system.
- Pilot a One Gate policy standard in the Papuan provinces to:
  - Establish and implement a standardized planning method for commodities in PHOs and DHOs
  - Establish and implement standardised order processing, distribution and storage systems at the province and district levels.

Will it work?

CHAI began working with the Pharmaceutical Directorate in 2011. Increasingly, the Pharmaceutical Directorate views CHAI as a useful partner to address some of its key challenges in working with vertical programs and integrating them into the mainstream drug management system. CHAI is well-positioned to assist both the Pharmaceutical Directorate and the AIDS Sub Directorate. It is, however, recognised that progress in this areas will be dependent on decision making within the MoH. While CHAI can facilitate that process by assisting with the development of a high quality road map, the MoH will be responsible for decisions and timelines for this will be beyond CHAI's control.

How will we know?

The major measure of success for this objective will be agreed, clear definition of responsibilities for the coordination or integration of planning, procurement, and distribution and translation of these responsibilities into a realistic implementation plan. If successful, the Pharmaceutical Directorate will take a stronger leadership role in overall drug management for all programs, including HIV.

Will the benefits last?

There is significant potential for long-lasting benefits under this initiative. The Pharmaceutical Directorate has the mandate, human resources, and financial resources to improve the health supply chain system. Its current leadership is committed to bringing things in order, and can lay the groundwork for a solid future.

Programmatic needs for supply chain management post 2016

As indicated in 2.6.2 above, it is expected that the AIDS Sub Directorate and PHOs and DHOs will have taken on full responsibility for SCM by the end of REACH in mid-2016. There may be a possible need for higher level, non-day-to-day technical assistance in SCM. The most likely area where this would apply would be further development of the One Gate policy and its implementation.

2.7   Component 3: Policy support to the Ministry of Health

Overarching objective: To develop, disseminate and implement an evidence-based MoH national policy framework relevant to HIV-related care, support and treatment.

Outcome: Evidence based policies approved and disseminated

Why are we doing this?

The current process for MoH HIV CST policy review and development is slow, cumbersome and not always evidence based. To address this situation, REACH will provide technical assistance to

the MoH's AIDS Sub Directorate to support an evidence based process for policy review and development, linked to training and dissemination. More effective, evidence based policies will facilitate the roll-out of the MoH's HIV CST program in the Papuan provinces and nationally.

How will we do it?

REACH will support the establishment of a small Policy Secretariat within the AIDS Sub Directorate to assist policy review and development by expert panels. The Policy Secretariat will be accountable to the Sub Directorate. Staffing will be one policy analyst and one program officer.

The policy analyst will:

- Review literature and international policies and guidance for policy implications in Indonesia.
- Review operational research and monitoring data from REACH's work in the Papuan provinces for policy and programmatic implications.
- Develop evidence based white papers setting out how key findings from the literature, international policies and guidance and operational research can be applied to policies and guidelines in Indonesia. These papers will form the basis of discussion and review by expert panels.
- Provide technical support to working groups in drafting policies and guidelines.
- Identify the programmatic and cost implications of policy options (in broad terms).
- Promote dissemination.

The program officer will:

- Provide secretariat functions to expert panels convened by the Sub Directorate.
- Review existing MoH HIV CST training materials to ensure consistency with policy and update training materials as new policies are developed.
- Develop links with universities and organisations conducting health worker professional development to promote incorporation of MoH policies into training curricula.
- Establish a system for dissemination of policies and guidelines through both MoH systems and through professional associations.

Priorities for policy review and development will be set by the Sub Directorate in consultation with stakeholders and be reflected in an annual results-based work plan developed by the Policy Secretariat and approved by the Sub Directorate. The Secretariat will work with the Sub Directorate to develop and publish a protocol for transparent decision-making about policy development that is evidence led and gives equal weight to all informed opinions. Final approval for policy will remain with the Sub Directorate, on the advice of expert panels.

Currently, policy is developed by a panel of experts which has 25 members. A more streamlined approach will be taken by forming time limited smaller expert panels to develop policy in particular areas. Membership of these expert panels will be drawn from a list of experts who are willing to contribute to policy development. This flexible approach will ensure that appropriate expertise is drawn on, relevant to the policy under development. As needed, membership of the expert panels will include a broader range of expertise.

CHAI will continue to work with ASHM in supporting the Sub Directorate's policy work. Lessons drawn from ASHM's support for policy development in Australia will be applied as appropriate.

National policies and guidelines will form the basis for technical assistance by CHAI and CoE staff in the Papuan provinces in training and mentoring.

The Policy Secretariat provides a vehicle for increased dialogue between AusAID and the MoH on policy and programming issues relating to the health sector's response to HIV. In the medium term,

the National AIDS Commission and MoH may agree to a transfer of the coordinating and programming responsibilities for all aspects of the health sector response to the MoH, including health sector prevention activities. Should this occur the Policy Secretariat could broaden its focus beyond HIV CST.

Funding for Secretariat salaries and some operating costs will be provided by AusAID through REACH. Due to the civil service staffing freeze it will be necessary for CHAI to employ the Secretariat staff who will be seconded to the Sub Directorate. Staff selection will be a joint decision of the Sub Directorate and CHAI. The Sub Directorate will be responsible for payment of expert panel meeting expenses.

Will it work?

The AIDS Sub Directorate supports the establishment of the Policy Secretariat. The Secretariat will be physically located in the Sub Directorate to promote ownership and integration of its work with the Sub Directorate's other functions.

It will be important that the Secretariat ensures the continuing involvement of a broad range of national and international partners in policy development to promote ownership, validation and consensus. WHO's Indonesia office has indicated strong support for establishment of the Policy Secretariat. Stakeholder management will be a priority of the Secretariat. In the past, where there have been different opinions on policy directions, some of which have not been evidence based, the expert panel has had difficulty in coming to decisions by consensus. The strong focus on the weight of evidence should help in the forging of consensus.

How will we know?

The key indicators for success will be:

- Recruitment of Policy Secretariat staff with the requisite skill sets and development of effective systems for policy review and development.
- The number of existing policies reviewed for consistency with evidence.
- The number of new policies developed.
- Incorporation of policies into MoH CST training and training by professional bodies.
- Establishment of an effective dissemination system.
- Implementation of national policies in the Papuan provinces. (This can be monitored by CHAI. Measurement of implementation on a national basis will not be possible.)

Will the benefits last?

CHAI will work with the Sub Directorate on a plan for a full transition of the Policy Secretariat into the Sub Directorate by mid-2016. This will include the Sub Directorate taking on full budgetary support for the work of the Secretariat.

Programmatic needs for policy support post 2016

Should AusAID support a continuation of HIV programming by CHAI post-June 2016, this could include a continuation of higher level technical inputs by CHAI into policy development.

2.8   Component 4: Operational research

Overarching objective: Generate and apply knowledge that contributes to achieving the program goal of increasing access to high quality HIV-related treatment in Tanah Papua
Sub-component objective - Operational research: Undertake research that generates reliable knowledge with the potential to contribute to the program goal.
Outcome: International standard operational research conducted and published
Sub-component objective - Local engagement: Increase the use of operational research data to achieve program goals
Outcome: Results of operational research incorporated into policy and delivery of HIV-related services in Tanah Papua, and in supply chain management nationally.

Why are we doing this?

REACH is essentially about technical assistance for service provision, not research. However, an operational research component is needed to generate reliable evidence on how to deliver these services most effectively in a geographically and politically fluid landscape where governance is weak and human resources are at a premium.

Operational research is also often referred to as implementation research because it focuses on how interventions work when they are implemented in the real world, rather than in ideal trial conditions. The lessons the program will generate about implementation and service delivery will be of use to service providers in fields other than HIV, and in contexts other than Tanah Papua. This learning can be generated at relatively low additional cost because the vast majority of the data that will be used in systematic studies under this program will be collected as part of the robust monitoring system implemented by REACH, (see section 3.4).

It is one thing to generate rigorous operational research; it is another thing to ensure that it results in rapid changes in policies and procedures, so that service delivery improves. REACH will design and conduct its operational research in ways that will maximise the likelihood that the results translate into better care for more Papuans during the life of this program.

How will we do it?

The first step in REACH's operational research activity, and the one most likely to ensure that results are used rapidly to improve program outcomes, is an inclusive process to set the operational research agenda.[38] The early inclusion of the MoH's AIDS Sub Directorate, PHOs, DHOs, CoE, puskesmas and CHAI program managers will ensure that research questions are program-relevant and that those most likely to use the results know (and, we hope, care) about the research from the start. Where appropriate, members of communities among whom research will be conducted will be included in the agenda setting and research design discussions. AusAID will also be asked to contribute to discussions as an important end-user of research data.

This process means that it is not possible to determine at the design stage what questions will be answered in operational research. However an indicative list of the sorts of issues that may be addressed is included in Box 1 below. REACH is not planning to conduct randomised controlled trials. Study designs that maximise the use of routine data (including rigorous relationship

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[38] Zachariah R, Ford N, Maher D, et al. *Is operational research delivering the goods? The journey to success in low-income countries.* The Lancet Infectious Diseases [Internet]. 2012 Feb [cited 2012 Apr 3];Available from: http://www.thelancet.com/journals/laninf/article/PIIS1473-3099(11)70309-7/fulltext and Zachariah R, Harries AD, Ishikawa N, , et al. *Operational research in low-income countries: what, why, and how?* The Lancet Infectious Diseases. 2009 Nov;9(11):711–7.

mapping) will be favoured. The design of the program lends itself well to implementation research: regional autonomy has led to different approaches to health financing and service provision. By working through these varied systems REACH will be able to compare costs and effectiveness of different models and approaches to implementation. And because we are starting from scratch and working in a virtual vacuum in so many areas, changes over time are more easily attributable to interventions than might otherwise be the case.

Box 1: Indicative research questions

What are the major reasons for loss to follow-up among those started on ARV treatment?

Is adherence to cotrimoxazole a good indicator of adherence to ARVs, and if so, over what time period?

How do media campaigns, SMS broadcasts and public events compare in increasing the uptake of HIV testing?*

What contribution can cell-phones make to promoting adherence to ARVs in areas of universal cell phone ownership but patchy electricity and signal coverage?

Does provider-initiated testing increase gender differences in access to treatment?

Can outreach at football matches and other male gathering places reduce the gender disparity in access to HIV-related care?

Can we estimate the extent of duplicate reporting of the same HIV infections, and reduce them through a unique identifier system?

Is provision of HIV-related CST through a decentralised model of care, involving puskesmas linked to district hospitals, a cost-effective model in the Papuan provinces?

Are there differences in cost-effectiveness of HIV-related CST services between REACH sites that are have adapted the model in different ways?

Can innovative models of co-financing with existing district services (*kabupaten induk*) increase service provision in newly-established districts (*kabupaten pemekaran*)?

How representative are reported Health Facility Survey data of actual service availability?

Can church burial records be used to estimate changes in age-specific mortality in Papua and if so has young adult mortality increased in HIV-affected areas?

Does attendance by key policy-makers at regular analysis meetings affect the speed or direction of changes in program implementation?

Does treatment literacy training for church volunteers decrease loss to follow up in ARV treatment?

Does immediate ARV treatment of infected sex workers reduce ongoing transmission of HIV?*

Is distribution of resources for HIV more rational in districts where AIPD is active than in other districts?*

Are there fewer stock outs of drugs and reagents in a province where distribution is decentralised, compared to one with central distribution?

Is advocacy at the national, provincial or district level most likely to lead to changes in policy and practice around delivery of effective HIV-related treatment?

What proportion of infections in a highland area can be traced to commercial sex?*

* Examples of questions addressed by research that might be externally funded or co-funded with other programs, but embedded in the REACH program

The REACH operational research and monitoring manager will have primary responsibility for translating the research agenda into a program of high quality research studies. This role will include active guidance on research design, co-ordination of protocol development, ensuring approval by relevant ethics committees and quality control for research implementation. S/he will also be responsible for appropriate dissemination of results. The REACH provincial program analysts will oversee much of the day-to-day operational of research, and will be centrally involved in data analysis and interpretation, although CoE program analysts may take the lead on specific studies.

Operational research will be undertaken in partnership with other organisations as appropriate. MoH, PHOs, DHOs and the CoE will be the core partners in most studies. REACH will also partner with AIPD to answer questions around budgetary planning and its effect on service delivery in a decentralised health system. HCPI will be likely to play a key role in research related to adherence support and demand creation for services, in particular HIV testing and STI treatment. REACH will seek opportunities to embed within its knowledge generation program research funded by other sources (for example planned National Institutes of Health (NIH)/WHO research on antiretroviral therapy as an HIV prevention intervention). Although we do not propose to drive basic science research ourselves, we may form partnerships with other institutions in this area. REACH expects, for example, to collaborate with the Jayapura office of the MoH's NIHRD to genotype HIV samples collected during routine service provision in the Papuan highlands, providing potentially important information about the relationship between geography, ethnicity, risk and the spread of HIV. Phylogenetic analysis may, for example, provide an indication of the proportion of infections originating in commercial sex. This information should help to inform prevention programming, and may lead to better targeting of HIV testing. Embedded research will leverage REACH's contribution to knowledge creation at minimal cost to AusAID.

As appropriate, operational research data will be disaggregated by sex and analysed to determine if there are any gender based differences. Strategies to deal with gender-related findings will be developed.

Operational research is more likely to be discovered and taken seriously both locally and internationally if it is published in a peer reviewed journal. Planning for publication also often improves the quality of research in the field. Yet this type of research often falls at the publication hurdle simply because people focused primarily on service delivery do not have the time (and sometimes do not have the skills) to write papers for journals. From the third year of the program, when publishable results can realistically be expected, REACH plans to include on its team a professional medical editor to support and manage the publication process. Since REACH is committed to maximising data use, all research will be published in open access journals/formats.

Will it work?

In the past, operational research has been undervalued; academics have not considered it rigorous enough to be 'real science', while program implementers think it takes up time that would be better spent delivering services. It's now apparent that research around what we need to do (basic science) is of little value if we do not know how to do it. In other words, implementation research is vital. But the second objection -- the opportunity cost of doing and publishing research -- remains a real one in the context of REACH. We believe that we will minimise that risk by:

- Appointing a strong research manager. Finding an appropriate person to fill this post will be critical to the success of the operational research program
- Having the program analysts responsible for research working with program implementers on a daily basis at the provincial and CoE levels.
- Using simple research designs based on existing, properly staffed data collection systems.

The other major risk is that research will get done, but its results will not be used to improve HIV-related treatment in Papua. Since the most important users are going to be defining the questions they want answered and will be involved in ongoing discussion of the implications of emerging findings every six months at a minimum, we believe this likelihood is low.

Both the monitoring and the governance structures are designed to maximise the rapid use of emerging data in program implementation at local and national levels. The regular 'live analysis' meetings described in the monitoring section (see 3.4.2) are designed to ensure that the findings and

implications of operational research will be quickly taken up in the form of program refinements and adjustments. These live analysis meetings are linked to an annual meeting of the two REACH Provincial Steering Committees (see the governance section – 3.3.1) which provides a feedback loop to PHOs and other provincial level partners. Findings will also be shared with health donor implementing agencies through the proposed Coordination Groups (see section 3.3.2). At the national level, operations research and analysis from the monitoring system will be shared with the AIPH Partnership Coordination Committee which is co-chaired by the National AIDS Commission, (see section 3.3.1). This will ensure that findings are shared beyond just the health sector. For example, given the Global Fund's push for national investment approaches, information on the costs and effectiveness of decentralised treatment delivery and other key areas of operational research will be of interest to a broad range of partners. Where operations research and monitoring data has policy implications, this will be fed back to the Policy Secretariat in the MoH's AIDS Sub Directorate.

How will we know?

On a national level, we would expect to see research results incorporated into the work undertaken under component 3 (Policy). Locally, we can track whether results of operational research have been presented and discussed at the regular program analysis meetings described in section 3.4.

Since every analysis meeting will start with a report on actions taken (or not taken) as a consequence of discussions at the previous meeting, the minutes of these meetings should provide a built-in measure of the success of operational research in generating knowledge and changing practice.

Will the benefits last?

Newly generated knowledge is valuable until it is superseded by newer, more valuable knowledge. The extent to which the ability to continue to generate new knowledge outlasts the REACH program will depend in large part on the success of larger transition plans discussed under programmatic needs post 2016 (above), as well as on the career choices made after the end of the program by program analysis staff.

2.9 Programming areas from the AIPH IPR not addressed

The program description outlined above is consistent with the recommendations of the AIPH Independent Progress Review (IPR) and AusAID's management response with the following exception:

Supply chain issues in correctional facilities

In its management response to the IPR, AusAID tasked HCPI and CHAI to formulate a supply chain management plan with the Ministry of Health and Ministry of Justice and Human Rights to address the ARV, STI and TB supply chain issues for diagnostics and drugs within the correctional health system.

The SCM system in correctional facilities for these diagnostics and drugs is operated through a system which is managed by the Ministry of Justice and Human Rights. Addressing SCM issues in correctional health is therefore not something that can be easily grafted onto CHAI's existing SCM work with the MoH's AIDS Sub Directorate. Designing CHAI support for this separate SCM system would have been a substantial task. In discussions between CHAI and AusAID, it was agreed that for the foreseeable future CHAI would be fully committed with the roll-out of REACH and that work on SCM in correctional facilities should be postponed for the time being. Depending on progress with the roll-out of REACH, AusAID and CHAI could make a future assessment on whether it is feasible for CHAI to undertake work on SCM in the correctional health system. This could be examined in the first quarter of 2014.

2.10 Form of aid proposed

Criteria for assessing a suitable form of aid were:

- Most likely to support achievement of program outcomes and the end of program goal.
- Most likely to support national ownership and leadership.
- Based on international best practice.
- Provides an opportunity for policy dialogue between AusAID and the MoH.
- Can start quickly – that is, in July 2012.
- Flexible to allow scale up with possible additional resources in the life of the program.
- May involve a future phase of programming beyond the four years.
- Includes robust financial risk management to protect AusAID funds from misuse or leakage.

The type of program that best fits these criteria is technical support by CHAI to a government-led program to facilitate implementation of national, provincial and district level activities, accompanied by a sub-grant from CHAI to the PHOs to support salaries for the nine CoE.

REACH is the next stage of the current AusAID funded CHAI Phase II program which is due to end on 30 June 2012. The AIPH IPR recommended a follow-on phase involving a scale up of CHAI's HIV CST program in the Papuan provinces and a continuation of SCM and policy support activities. AusAID accepted this recommendation.

The three main components of work (Papua, SCM and policy support) are a continuation of existing programming where CHAI has considerable expertise. REACH will build on the achievements of CHAI Phase II. The only new component of work is operational research. CHAI brings to REACH considerable international experience, technical knowledge, programming skills, established relations with the GoI and other partners at the national, provincial and district levels, and knowledge of the operating environment. In particular, CHAI has forged good relations with the Ministry of Health and other key partners at the national level in relation to all three components of work. In Papua, CHAI has developed strong relations with a broad range of partners and is well respected. All these factors provide a solid basis for the third phase of CHAI's AusAID supported work in Indonesia. It will be important to ensure continuity and a seamless transition between CHAI Phase II and REACH so that momentum is not lost.

Given the challenging operating environment, a flexible approach to program implementation is recommended. In development of this proposal, care has been taken to develop a design that is realistic in terms of scope (that is, the number of CoE and satellite puskesmas). If REACH encounters substantial obstacles the pace of roll-out might need to be slowed down. Alternatively, it may be possible to increase the number of puskesmas if funds are available. Variations such as this can be easily accommodated by modification of CHAI's contract with AusAID.

CHAI considered two options regarding how AusAID funds could be channelled to support the CoE:

1. CHAI employs all CoE staff and pays for salaries from the AusAID grant for the first three years before the PHOs take over responsibility for CoE funding in year four; or
2. CHAI sub-grants the two PHOs for CoE staff salaries for the first three years.

If it does not prove possible to enter into a sub-grant agreement with the PHOs prior to commencement of REACH or to establish appropriate financial risk mitigation strategies in a timely manner, a third option would be for CHAI to employ all CoE staff in the first year, with a sub-grant being made to PHOs to cover salaries for years two and three.

CHAI recommends option two or three as this will result in a greater sense of PHO ownership and increase the likelihood of ongoing support for the CoE after AusAID funding ends. These options are explored in more detail in Annex 17.

Substantive consideration was not given to broader budget sector support for HIV CST programming in addition to AusAID support for technical assistance through the CoE. This type of support is not needed as there is adequate funding available at the national level for drugs and reagents and within provincial and district budgets to pay for the scale up of HIV CST in the Papuan provinces. Although there is the issue of ensuring adequate provincial and district level budgetary allocations are made for HIV CST and this has been incorporated into the program design for this proposal. Similarly, the scale-up of CST services in Tanah Papua will put pressure on the supply chain for HIV-related commodities. It will be necessary for CHAI to work closely with the AIDS Sub Directorate and PHOs and DHOs to ensure adequate supplies of commodities, especially test kits and drugs. Accordingly, the focus of REACH will be technical support and some initial program establishment costs (that is, infrastructure and equipment) to build the capacity of services, with service delivery costs being paid by government.

Partnering with another development agency was also considered, however there are currently no other agencies with a track record or expertise in technical support for HIV CST programming in Papua.

3.   Implementation arrangements

3.1   Implementation plan

Implementation of REACH will benefit from the current CHAI Phase II program and operations. Some implementation costs will not be incurred by REACH, as they will be covered by CHAI Phase II transition activities. These include key staff recruitment and training and some operational costs. However, with the growth in the program and the staffing needed to implement REACH at multiple new sites, CHAI will need to make a significant investment of time for various start up activities for the first year of the program.

REACH implementation activities for the first 24 months of the program fall in two categories: start up activities and ongoing program implementation.

Start-up activities include:

- **Managerial activities:** building and strengthening teams and supervisory systems; orientation for new managers; negotiating financial arrangements with GoI partners; and establishing provincial advisory committees.
- **Administrative activities:** strengthening, promoting, and implementing fiscal, human resource, and administrative policies and systems; and hiring new CHAI and CoE staff.
- **Operational activities:** setting up new CoE and CHAI sites and developing strong safety and security policies and procedures.
- **Programmatic activities:** collecting baseline data; developing the program monitoring system; selecting and prioritising puskesmas for REACH assistance, promoting REACH; and developing relationships.

Ongoing program implementation that will continue through the life of the program includes:

- **Trainings:** developing new curricula and revising existing ones and conducting training for CoE staff, hospitals and puskesmas.
- **Mentoring:** partnering with CoE staff to implement ongoing mentoring for health services.
- **Technical assistance and support:** developing job aides, systems, and tools to help sites with implementation.

The implementation plan in Annex 9 gives a broad level outline of activities REACH will undertake in the next 24 months and those targets already identified. Specific targets, key indicators, and means of verification will be developed in REACH's first quarter as part of the monitoring framework. A detailed work plan for the first year will also be developed. Given the dynamic political and social situation in Tanah Papua, the plan is flexible and may vary if situations in each CoE area change. The Regional Program Manager will communicate regularly with staff at the CoE level (using the cascading issues matrix approach) to refine the program roll-out. This adaptive management approach will allow the pace of roll-out to align within any specific constraints encountered.

3.2   Budget

The total budget request for REACH is A$24,990,417 over the period July 2012 to June 2016. The majority of funding is allocated to the scale up of CST in the two Papuan provinces. In Phase II, CHAI directed 51 per cent of its program resources to CST in Papua Province. Under REACH, resource allocation to the Papuan provinces will increase to 78 per cent of the total budget. REACH has been designed in a way that other program components will contribute directly and indirectly to the outcomes in Tanah Papua. For example, national-level activities that support evidence-based

policy decisions will help health facilities provide better services on the ground; and scaling up access to more treatment sites in the Papuan provinces will only succeed if SCM of ARVs and other HIV-related commodities at national and provincial levels are functioning properly. Details of the budget are in Annex 10.

3.3   Governance, coordination, management and structure

3.3.1   Governance

REACH will be a program component of AIPH, as is the current CHAI Phase II program. AusAID has indicated that the current Subsidiary Agreement between the Office of the Coordinating Minister for People's Welfare and AusAID, which provides the foundation for AIPH, is sufficiently broad to cover the work of REACH and does not require amendment.

CHAI will be accountable to AusAID for the effective implementation of REACH. At the national level, CHAI's key partner will be the MoH's AIDS Sub-Directorate. The Clinton Foundation has a Memorandum of Understanding (MoU) with the MoH covering CHAI's work in Indonesia. The MoU, which expires in January 2013, is sufficiently broad to cover REACH. CHAI has commenced discussions with the MoH to develop a new MoU and will consult with AusAID on key issues to be covered in this MoU.

Mechanisms that promote inputs by partners will be utilised to assist with governance. The governance mechanism for REACH at the national level will be the AIPH Partnership Coordinating Committee (PCC). Given the strong Papuan focus of REACH, a mechanism is needed that promotes provincial government leadership in the governance of REACH. Involvement of provincial government representatives in AIPH PCC meetings in Jakarta would be too costly and time consuming. A group that meets more frequently than the AIPH PCC, particularly in the early years of implementation, focussed on the roll-out of REACH at the provincial level is needed. The mechanism for achieving this at the provincial level will be two new AIPH Provincial Steering Committees (PSCs), one in Papua Province and the other in West Papua Province. Mechanisms to ensure the AIPH PCC and the PSCs operate in tandem are outlined below.

National level

To date, the AIPH PCC has primarily focussed on the work of HCPI. AusAID has identified that the significant scale up of its CST work in the Papuan provinces and the need for a more integrated programmatic approach by AIPH will require the PCC to strengthen its focus on REACH. This will include ensuring that synergies between the work of REACH and HCPI in the Papuan provinces are realised. A key finding of the 2011 AIPH IPR, which AusAID has accepted, was the need for a more integrated approach to the implementation of AIPH, particularly in regard to a continuum of prevention to care, support and treatment. AusAID has also identified the need for the PCC to have a stronger strategic and accountability focus in preference to information sharing. AusAID will be requesting the MoH to provide more senior level representation on the PCC. CHAI will also play a more significant role in PCC meetings.

National components of REACH's annual work plan (primarily SCM and policy support to the MoH), will be approved by the PCC. The work plan for the CST component in the Papuan provinces will be approved by the AIPH Provincial Steering Committees, (see below).

Provincial level

Establishment of the AIPH PSCs will promote closer collaboration between the work of REACH and HCPI at the provincial level. The AIPH PSCs will be co-chaired by AusAID, the Provincial AIDS Commissions and the PHOs. However, in West Papua the PSC may be co-convened by the Regional Development Planning Agency (BAPPEDA) which is responsible for donor coordination

in that province. Additional membership will include the Provincial Finance Office (PFO), the MoH's AIDS Sub Directorate, CHAI, HCPI and AIPD. Secretariat functions will be provided by the government convening body, with support from CHAI and HCPI.

The two PSCs will hold a joint annual meeting to foster sharing of lessons learned between the provinces. This will be timed to coincide with one of the two annual Program Analysis meetings which are an integral part of REACH's monitoring structure (see section 3.4). This will allow the PSCs to be given a thorough overview of current progress and challenges faced by REACH in the field.

Linkage between the AIPH PCC and the two AIPH PSCs will be achieved by AusAID, CHAI and HCPI representatives reporting to the respective committees on the work of the PCC and the PSCs. Work plans for REACH in each province will be approved by the respective PSC. The PSCs will meet shortly before AIPH PCC meetings so that reports from the PSCs can be considered at the PCC meeting. Should there be differences in the strategic directions recommended by the AIPH PCC and the AIPH PSCs which cannot be resolved, the PCC and ultimately AusAID will be final arbiter.

In the Papuan provinces, CHAI's key partners will be the PHOs, although there will also be substantive relationships with DHOs. As suggested by AIPD, REACH will enter into Technical Arrangements with appropriate government entities at the provincial and/or district level. These agreements will articulate roles and cost sharing responsibilities.

There was strong support for REACH from all levels of district government consulted during site assessments. CHAI will hold discussions with districts not visited during the proposal design phase in the coming months. All 21 district governments will be invited to participate in the provincial REACH launch ceremonies to further signify their commitment to the program.

3.3.2 Roles and responsibilities and reporting and communication channels of key parties

The key roles and responsibilities of AusAID, CHAI and partners are set out in Table 24 in Annex 11. Figure 7 in Annex 11 presents a key relationships flowchart between CHAI and all partners. The relationship flowchart should be read in conjunction with the description of CoE in section 2.5, governance arrangements in section 3.3.1, and mechanisms for coordination with other programs in section 3.3.3. There are large number of partners and stakeholders. CHAI will invest significant time in relationship management.

3.3.3 Mechanisms for coordination with other programs

AusAID is committed to strengthening integration of all its programming in the Papuan provinces and improved collaboration with the work other development partners. AusAID has decided to facilitate two joint meetings of all AIPH program components at the national level, including REACH and HCPI, every February and August to foster greater collaboration within AIPH. AusAID has indicated that it will strengthen management and supervision of AIPH's work in the Papuan provinces, including more regular monitoring visits. This will include convening of two joint meetings each year between AusAID, and the Tanah Papua staff of REACH and HCPI to foster closer collaboration. AIPD will be invited to participate in these meetings.

AusAID and USAID have a strong level of commitment to improving donor coordination. In the absence of a GoI led forum to coordinate the work of health donors, AusAID and USAID, the two major bilateral health sector donors, have forged an informal partnership to achieve a greater level of harmonisation in their programs and cohesion in interactions with the GoI. At the national level, twice yearly meetings between AusAID, USAID and their health sector implementing agencies have commenced.

During meetings with the team that designed this proposal, the PHOs in both Papua and West Papua and BAPPEDA in West Papua strongly emphasised the need for improved coordination between donor implementing agencies and with provincial governments. This was also a key finding of the proposal design team. Effective coordination is particularly important for REACH as its success will, to a significant degree, be dependent on the work of other agencies in areas such as demand creation for HIV testing and treatment.

Although the current situation of poor donor coordination clearly needs to be addressed, this is a difficult task, with no easy solutions. We have outlined below a proposal for establishment of two Provincial Health Donor Implementing Agencies Coordinating Groups, one in each province. We recognise that this will, of itself, be insufficient to achieve the intended outcome. To achieve progress, a shift needs to take place in the importance donors and their implementing agencies place on coordination. Donors need to make it clear to their implementing agencies that effective coordination is a key accountability and that constructive and meaningful inputs to the proposed provincial Coordination Groups are expected. As the bulk of donor supported health programming in the Papuan provinces is supported by AusAID and USAID, both partners are well placed to provide leadership and require greater accountability by their implementing agencies. This can be reinforced by AusAID and USAID with the national offices of their implementing agencies and monitored against clearly articulated expectations by AusAID and USAID during field monitoring trips.

While CHAI will devote considerable energy to working with other donor implementing agencies on a one-to-one basis, the HIV response in the Papuan provinces would benefit considerably through a more comprehensive approach to harmonisation of the health programming of development partners. It is therefore recommended that AusAID propose the establishment of Provincial Health Donor Implementing Agencies Coordinating Groups. Separate Coordinating Group would be established in each province. The purpose of the Coordinating Groups will be to provide a forum for **forward planning** (not just information sharing) and improved coordination of all donor support to the health sector, not just HIV. There would be a strong emphasis on identification of synergies and leveraging off the work of other implementing agencies in support of the provincial health sector. The Coordination Groups would develop a results framework, a harmonised technical assistance plan for each province, and an agreed division of labour for training, using common curricula, to eliminate duplicative training.

The Coordinating Groups would be convened by the PHO in Papua Province and co-convened by BAPPEDA and the PHO in West Papua. The Provincial AIDS Commissions would also be represented. Given the operational focus and the difficulty in scheduling meetings when donors could be present, membership of the Coordinating Groups will be all donor implementing agencies. Health sector implementing agencies include the following:

- For HIV-related programs:
  - AusAID: CHAI and HCPI
  - USAID: FHI (SUM I and TB Care), RTI (SUM II), Kinerja, Serasi (IRD)
  - UN: UNICEF (PMTCT and school education) and UNFPA– Papua only (sexual and reproductive health)
- For other programs with broader health components:
  - AusAID: AIPD and AIPHSS if it extends its work to the Papuan provinces
  - USAID: RTI (Kinerja – health system strengthening)
  - UN: UNICEF (maternal, neonatal and child health – Papua only; nutrition – Papua only)
  - Netherlands Leprosy Relief – Papua only

Secretariat functions would be the responsibility of the PHOs and BAPPEDA. To assist with the foundation and development of the Coordinating Groups, the REACH government relations positions, (one in each province), would actively support the PHOs and BAPPEDA with secretariat functions for the first two years, with a plan for full transition of these functions to government.

3.3.4 Annual planning

CHAI will hold two annual planning meetings each year (in March and September). The first meeting is designed to ensure REACH's annual plan aligns to AusAID's fiscal year (July-June). The second meeting will be for alignment with the GoI's fiscal cycle (January – December). The annual plan will be approved by AusAID as well as through the PCC and PSC processes. CHAI will utilize quarterly, bi-annual, and yearly mechanisms to monitor and modify ongoing program implementation. Monitoring data, for example, will be collected and analysed on a quarterly basis. Ongoing processes like this will feed into the development of REACH's annual plan and target setting.

3.3.5 CHAI's management, technical, finance and administrative capacity

A description of staffing for REACH and the organizational chart is shown in Annex 12 . The Annex also outlines the support that will be provided by CHAI's South East Asia Regional Team, the CHAI PNG program and the CHAI Global Teams and CHAI's procurement procedures. Key considerations in developing the staffing structure included 1) maximizing staff placed in Papua and West Papua in preference to the national office; 2) integrating most human resources for operational research and monitoring and some SCM and policy human resources within the CST teams in the Papuan provinces; 3) increasing monitoring capacity in the program overall; 4) supporting the partnerships with PHOs with resources; 5) strengthening of CHAI's management capacity and 6) ensuring finance and administrative systems have adequate support. Efficient management processes have been established to ensure adequate oversight and quality of the program especially at the service delivery level.

To support the significant program scale up, the number of CHAI staff will double from 27 to 57 staff, with a majority of these positions in the Papuan provinces. Recruitment of a significant number of additional staff for CHAI and the CoE will be challenging, although new positions will be recruited progressively over an 18 months period, aligned with the phased expansion of the program. To maximise recruitment of good staff, CHAI has commenced proactive recruitment through formal and informal channels. CHAI's technical staff who collectively have over 80 years of work experience in healthcare in Papua are using their extensive networks to find suitable applicants. Through a rolling hire process, CHAI is able to hire new staff as opportunities are presented. For example, AusAID transition funding will be used to employ seven Medecin Du Monde staff whose program in Nabire is ending in May. CHAI is seeking to fill many positions with Papuan staff. While the supply of qualified healthcare workers in the Papuan provinces is limited, if needed, CHAI may recruit less qualified staff and upgrade their skills through on-the-job training and intensive mentoring. This is included in the year one budget.

One of the criteria for staff selection will be an understanding of gender-related issues and the ability to integrate the principle of gender equality into program work.

3.4 Monitoring and evaluation

A guiding principle of REACH is that the program will be guided by the best available data. The majority of these data will be collected during the course of service delivery through routine monitoring systems. The monitoring system will ensure that data are appropriately analysed,

regularly fed back to decision-makers and service providers, and used actively to manage the program and keep it on course towards its goals.

The focus of REACH monitoring systems is very clearly on ongoing program management and improvement, and no full-scale internal evaluations are planned during the life of the program. However CHAI strongly believes that transparency contributes to credibility and encourages high quality service delivery; monitoring data will be made available to anyone with a legitimate interest in the provision of HIV-related services in Papua. This will allow external evaluators to judge the contribution of the program, should AusAID wish to fund a comprehensive evaluation either during or after the program.

Eight per cent of the program budget has been allocated for operational research and monitoring activities.

3.4.1 The monitoring framework

Monitoring systems are most useful when they measure things that program implementers want to know; the people best placed to decide on information needs are not proposal writing teams, but program managers and implementing staff. After discussion with AusAID's Health Unit, it was therefore decided that a full monitoring framework would be developed at a very early stage of REACH implementation, rather than as part of this proposal. The monitoring system will be developed in accordance with the standards of design stipulated by AusAID Indonesia.

The process of developing a framework and set of indicators will be led by an Operational Research and Monitoring Advisor who will be contracted to oversee these functions over the life of the program. The Advisor will work with the Operations Research and Monitoring Manager, in tandem with the process of defining operational research questions described in section 2.8 as a priority task in the first quarter of implementation. Reporting frequencies, data sources and indicators will be decided for each program component in consultation with program staff, CoE, MoH, PHOs, DHOs and AusAID. (Indicative indicators are suggested in the 'How will we know?' sections of the program description: sections 2.5 – 2.8. REACH will also monitor how HIV-related services are raising standards and uptake of other non-HIV services.) The monitoring framework will, where appropriate, choose indicators that are already required by the MoH and its other international partners. We will, however, review existing indicators for utility, and will guard against letting the indicator tail wag the implementation dog.

One of the most common weaknesses of monitoring systems is that they are focused on mandated reporting requirements rather than on program management. They typically overinvest in collecting data that fit into predetermined boxes, underinvest in data management, and completely neglect rapid analysis of data and use of those analyses to guide program implementation in the field. REACH will avoid these pitfalls by structuring monitoring systems to prioritise flexible analysis and feedback.

Key service utilisation data will disaggregated by sex and analysed for gender differences. As needed, strategies to deal with gender inequality will be developed.

The monitoring structure for REACH and description of staffing support is in Annex 13.

3.4.2 Data feedback and use mechanisms

In order to ensure that data are actively used in program management, regular 'live analysis' sessions will be scheduled. These meetings will be structured as follows:

- Report by program managers of changes made to program implementation as a result of the findings of the previous program analysis session

- Presentation by analysts of any changes in service provision indicators subsequent to those changes in program implementation
- Presentation by analysts of:
  - thematic analysis (for example, one session might concentrate on STI services, the next on TB-HIV)
  - core progress indicators
  - any operational research results
- Discussion of implications of analysis for programming (this is the 'live analysis' part: analysts may interrogate the data on the spot to support or refute points raised in the discussion and to ensure that decisions are informed by the facts).
- Necessary changes to program strategies and implementation are decided. Program managers will report back on the implementation of these changes at the start of the next analysis session.

The provincial program analysts will be responsible for recording the outcomes of these meetings, and for systematically tracking changes in program implementation that take place as a result.

These meetings will be scheduled as follows:

- At the **CoE level**, every month. These meetings will include REACH program managers and monitoring staff, CoE analysts and monitoring staff, CoE managers and service providers and DHO staff, and puskesmas program managers where possible.
- At the **provincial level**, every three months. These meetings will include REACH provincial program managers and monitoring staff, CoE analysts and monitoring staff, and CoE managers and service providers where possible, PHO staff, DHO staff where possible, and members of the Provincial AIDS Commission CST working group. Other members of the Provincial Steering Committees will be invited to attend.
- At the **cross province level**, every six months. Every second provincial meeting will be held jointly between the two provinces, alternating in location between Papua and West Papua.
- **Nationally**, once a year. The Jakarta-based M&E specialist and staff managing the supply chain, policy and operational research components of the REACH program will join the Tanah Papua meetings once a year to review their progress and program synergies. The members of both PSCs will also be invited to attend one joint meeting annually.

3.4.3 Baseline data

Most of the data used in the REACH monitoring framework will come from routine reporting of service delivery. We recognise the importance of having solid baseline data against which we can measure progress. Good baseline data also help to refine program implementation. Baseline data will be collected shortly after completion of the monitoring framework. There are three important sources of baseline data in existence or planned and budgeted:

- **Existing service provision recording systems**. Record keeping in most sites - hospitals, puskesmas and laboratories is relatively thorough. The ledgers kept by service providers are the most important source of baseline data for REACH. However none of it is computerised. To build the foundation of the REACH monitoring system, the program will provide short-term contract staff that will enter all the existing HIV-related ledger data into standardised databases that can be maintained at the puskesmas level. Where necessary, REACH will provide puskesmas with laptops and software to enable them to perform these tasks. Routine site visits will verify that equipment is being used.
- The **2011 Health Facilities Survey**, conducted by the MoH. Though this focuses mainly on physical infrastructure and official staffing levels, CHAI Phase II was able to add questions

of relevance to the REACH program. These data should be made available shortly. The operational research component of REACH will carry out validation research on these data.

- The 2012 **HIV and STI IBBS** survey should provide important data on HIV and syphilis prevalence levels, as well as on HIV testing history and other important HIV-related issues. AusAID is planning to provide extra funding for this survey, to allow for robust estimates to be made in the highland areas where REACH will work. A guarantee of access to raw data as well as strong quality control will be essential.

An important output of the REACH program will be strong networks and relationships between policy makers and service providers at different levels. We will measure progress towards building these networks through relationship mapping. This monitoring method is new. REACH will provide technical assistance to build skills in this area, and to develop baseline maps.

3.4.4 Longer term evaluation: a recommendation to AusAID

"Sustainability" is on everyone's lips, but in no-one's evaluation plans. This is in part because a program's monitoring systems and evaluation budget die with the program. The REACH program aims to ensure that the various governments of Tanah Papua take responsibility for services funded under REACH before the end of the program. However sustainability can only realistically be measured after a reasonable delay. The team that developed this proposal strongly recommends that AusAID schedules a sustainability evaluation two years after the REACH program ends. REACH will endeavour to set up data management systems that will allow changes to be measured beyond the life of the program.

3.5 Critical issues and risk management strategies

The significant scale up planned under REACH will pose new risks. The Issues Management Register (Annex 14) details the key program risks, potential impact, rating, controls to mitigate these risks, and residual levels of risk after the control intervention. Risks are grouped into three main categories: 1) **overarching risks** relating to the program as a whole, 2) **implementation risks** relating to specific program components; and 3) **external risks** such as the operating environment.

The top critical issues for REACH are related to human resources, government systems and other external factors. The huge scale up in staffing at CHAI and at the CoE and the related management responsibilities pose a significant challenge for the program. The government's ability and willingness to absorb costs beyond the life of the program also is a concern for long-term sustainability. Safety and security concerns will be an ongoing issue. While these risks are substantial, CHAI has already implemented measures to address some of these concerns in Phase II. CHAI also has developed new controls that mitigate other issues to acceptable levels.

The identified risks fall under the following themes:

- **Human resources issues** including the ability to recruit, hire, train, and retain qualified new staff; reinvigorate and motivate existing health facility staff; and address civil servant rotation, understaffing, and absenteeism
- **GoI willingness and capacity** to absorb and sustain new positions and related operational and programmatic costs
- **Technical challenges** such as low ART initiation rates for fear of poor adherence and potential loss to follow up
- **Political challenges** such as mobilising government funding, the volatile political landscape and changing leadership
- **Budgetary inflexibility** to respond to unexpected demands for drugs, reagents, or other commodities beyond current projections

- **External factors** that will affect REACH's HIV-related CST outcomes but are not fully within CHAI's area of responsibilities, including downstream activities (like the need for HIV testing campaigns that include the benefits of treatment) and upstream efforts (like better policies on HIV testing or realistic civil servant pay scales)
- **Other supply-side risks** like multi-stream SCM systems for HIV-related commodities and donor coordination-related concerns; and coordination with stakeholders
- **Other demand-side risks,** for example, patient demand may outstrip supply
- **Safety and security issues** including tribal conflicts and political instability

The set of responses listed in Annex 14 represent a broad and flexible mix of controls:

- **Create realistic budgeting** for human resources along with non-monetary career-related incentives like training and mentoring opportunities
- **Work towards sustainability** through planned and negotiated transition between CHAI and GoI partners; broaden number of training and mentoring recipients to institutionalise interventions at the health facility level
- **Prioritize heightened engagement with GoI** to advocate and support public finance interventions that affect health facilities, their patients, and staff; integrate CoE budgeting into government systems and recurrent budgeting process; assist with evidence-based policy development and dissemination
- **Promote policies at local levels** to enhance acceptance and uptake at health facilities
- **Provide ongoing technical assistance and capacity building** to support interventions and future program absorption into GoI systems
- **Support regular coordination**, communication, and networking with partners to ensure harmonization of services; engage closely with AIPH and AIPD and other donor programs
- **Implement ongoing program monitoring** through a strong focus on data collection and analysis with regular feedback loops to programs and stakeholders
- **Increase local engagement** including prioritisation of local Papuan hires; partner with local NGOs and faith-based organizations
- **Implement robust safety and security protocols** to mitigate risks to acceptable levels

CHAI will implement a cascading issues management framework that regularly monitors issues or risks from site level upwards as a standard management tool. This structured framework will be integrated into an adaptive management approach. CHAI will develop this tool in quarter one of the program in consultation with AusAID's Risk Management Unit.

3.6 Sustainability

This section gives an overview of the sustainability of REACH. More specific details on the sustainability of particular program sub-components are outlined in section 2: Program description, under the sub-headings 'will the benefits last?'

Sustainability is defined as "the continuation of benefits after major assistance from a donor has been completed"[39] and is assessed in relation to the end of program goal and long term goal. They are "increased access to and increased number of people on HIV-related care and treatment in Tanah Papua" and "reduced HIV-related morbidity and mortality in Tanah Papua."

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[39] AusAID, *Promoting practical sustainability*. 2000. p. 1.

The key elements to ensuring sustainability of REACH will be:

- improved planning for HIV CST services, reflected in continuing funding of health service delivery from national, provincial and district budgets
- adequate ongoing technical support for service delivery from the CoE
- generation of demand for HIV CST services.

Factors that will enhance the sustainability of REACH's CST component are:

- The program is fully aligned with the MoH's national HIV CST program.
- Decentralisation of HIV CST to puskesmas has been shown to be a viable in the current CHAI Phase II program and has resulted in a significant increase in the number of people on treatment. Program improvements based on lessons learned in Phase II will improve the model.
- REACH is based on mutual responsibilities and accountabilities in regard to who pays for what. During the life of the program the MoH will pay for most drugs and reagents; PHOs will take over funding for CoE in year four; DHOs will pay for the operating costs of health services; and AusAID will pay for CHAI technical assistance and the cost of CoE for the first three years, some equipment and reagents and share in some facilities upgrade costs.
- The key focus of REACH's CST component will be training and ongoing mentorship of health care workers to develop their skills. Due to staff turnover and the need for ongoing mentoring, there will be a need for the CoE to continue beyond four years, with funding being provided by PHOs. While PHO commitments need to be cemented during the course of the program, early indications from PHOs are positive.
- REACH has a strong emphasis on improving the implementation of decentralisation by working with provincial and district governments in collaboration with AIPD to ensure that there is improved planning by PHOs and DHOs, linked to adequate budget support for HIV CST service delivery. Provinces and districts have the fiscal space to increase health service funding. Consultations during the development of this proposal indicated that there is strong support for REACH from provincial and district governments, accompanied by an understanding that they will be responsible for the cost of health service delivery and technical support.
- REACH will only provide technical assistance to puskesmas if Districts are prepared to provide sufficient staffing for the provision of services and the facility itself can support the provision of high-quality service.
- This proposal has a strong focus on identifying risks that will affect sustainability and effective management of these risks.
- A potential AusAID follow-on program post-REACH would involve higher level technical assistance to CoE to facilitate sustainability.
- While the focus of REACH is primarily on supply side factors, the development of effective HIV services and demonstrable benefits in terms of restoring and maintaining people's health will result in creation of community demand for services, as has been demonstrated by CHAI Phase II, (see section 1.4.1).
- Monitoring will be aligned with government monitoring systems which mean that ongoing monitoring of service delivery should be feasible, post-REACH.

In summary, all these factors will contribute positively to the sustainability of the CST component.

The SCM and policy support work will involve a clearly articulated phased transition for withdrawal of AusAID funded CHAI technical support, with these functions to be fully supported by the MoH by the end of the program. A mid-point IPR will determine whether the program is on-track for a full transition of SCM and policy support to the AIDS Sub Directorate by mid-2016. The

IPR will also assess progress with sustainability of the CST component and make recommendations for any necessary corrective action.

The operational research component of REACH will cease at the end of the program. However, findings from operational research will be used for program improvement, which should contribute to the sustainability of the program. This component may also create demand post-REACH for evidence and application of results. Development of the local capacity of researchers to provide evidence in accessible formats to policy makers may also contribute to sustainability. Through data analysis of the broader implications of Papuan data, REACH will also seek to influence national HIV CST policies and programming where replication is appropriate.

This proposal has recommended that AusAID schedules an evaluation to assess the sustainability of REACH benefits two years after the program ends, (see section 3.4.4).

Annex 1: Overview of the epidemiology of HIV in Indonesia

This Annex provides a more detailed analysis of the epidemiology of HIV in Indonesia as a whole and in the two Papuan provinces.

A1.1 The HIV epidemic in Indonesia

Indonesia's extraordinary geographical and cultural diversity is reflected in the diversity of its HIV epidemic. Although concerns were raised as early as 1992 about the potential for an explosive HIV epidemic driven by commercial sex[40], HIV prevalence among female sex workers remained low -- largely below one per cent -- across the majority of the country for the decade that followed. This was very probably because of a combination of the following: high rates of male circumcision, relatively low consumption of commercial sex (in population-based surveys in Java in the mid-1990s under five per cent of adult men in urban areas and one per cent of men in rural areas reported having *ever* bought sex) and low partner turnover among sex workers.[41] It was not until HIV shot through drug injectors in urban areas in the late 1990s that the epidemic became firmly entrenched in Java, home to two thirds of Indonesia's population. Since then, significant rates of HIV have been recorded among transgender, male and female sex workers in many urban areas outside of Papua, as well as among men in prison and gay men.

Table 9 shows HIV rates recorded in surveillance in 2011. The quality of these data, especially the sampling procedures and thus representativeness of the data, have not been independently verified. However they give the best available indication of the current status of the epidemic in Indonesia.

Table 9: HIV prevalence rates recorded in cities outside of Tanah Papua in 2011

Population	Number of cities	Sampling	% HIV positive Range	% HIV positive Average
Brothel/street based female sex workers	14	Mapping and PPS	3.6 – 20.7	9.2
Massage/bar based female sex workers	12	Mapping and PPS	0.4 – 8.8	2.8
Transgender sex workers	5	Mapping and PPS	14.4 – 30.8	21.8
Men who have sex with men*	5	Snowball/Web	2.4 – 17.2	8.4
Drug injectors	6	Snowball	1.2 – 56.4	36.4
Prisoners	5	PPS	0.8 – 8.0	3.0
Men in mobile occupations	11	Time-location/PPS	0 – 2.3	0.7

PPS: Probability proportional to size
* The MSM sample appears to be a mixture of gay men and male sex workers: 49 per cent of the sample reports selling sex in the last year, mostly to other men.
Source: Indonesia MoH 2011

While the sex partners of the sub-populations in Table 9 are clearly also at risk for HIV, there is no indication that the virus is circulating widely outside of these groups in most of the Indonesian archipelago. The mid-point estimate for the number of people living with HIV in Indonesia in 2009, the most recent national estimates, was 186,000, some 150,000 of them living in provinces west of Tanah Papua. This equates to adult HIV prevalence in Indonesia of 0.13 per cent, excluding the

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[40] Linnan, M., *AIDS in Indonesia: The Coming Storm*. 1992, USAID: Jakarta.
[41] Kambodji, A., M. Linnan, and M. Kestari, *Adult sexual behaviour and other risk behaviours in East Java*. 1995, Yayasan Prospektiv: Surabaya.

Papuan provinces. Including the Papuan provinces, national prevalence rises to 0.15 per cent. In other words, around one adult in 650 is infected with HIV.

A1.1.2 HIV and gender

In Indonesia as a whole, four out of five people estimated to be living with HIV are male. HIV is transmitted primarily during sex between two men or between men and transgenders, or through the sharing of needles during drug injection. The 2011 IBBS omitted to collect information on the gender of drug injectors, but ethnographic evidence suggests that the overwhelming majority of injectors are men. In heterosexual commercial sex, women are clearly at higher risk than men, because their partner turnover is higher and because they have very high rates of untreated STIs that increase the probability of acquiring HIV. In cities for which we have data for both sex workers and occupational groups in which an average of 23 per cent of men buy sex, direct sex workers are 20 times more likely to be infected with HIV than "high risk" men.[42]

Female sex workers account for an estimated 0.3 per cent of the adult female population, according to national estimates. Outside of Tanah Papua, the other 99.7 per cent of the female population is at risk largely to the extent that they have sex with men who inject drugs, men who have anal sex with other men, and men who regularly buy sex from sex workers -- the latter group by far the largest, but with the lowest HIV prevalence by an order of magnitude compared with other high risk male groups. The best estimate that can be derived from currently available data is that in Indonesia west of Tanah Papua, one woman in 1,000 is currently at high risk for HIV infection because of her sex partner's behaviour.

A1.2 The HIV epidemic in Papua and West Papua

Altogether, the two Papuan provinces are home to just one per cent of adult Indonesians, but 26per cent of the Indonesians estimated to be living with HIV, according national estimates made in 2009 and revised with more complete data by the team that developed this proposal.

There is no indication of significant levels of HIV infection outside the key affected populations in most of the Indonesian archipelago. The exceptions are Papua and West Papua, where a different pattern of HIV infection began to emerge in the late 1990s. It was among female sex workers (FSWs) in the port city of Sorong, West Papua, that HIV was first recorded as crossing the five per cent threshold considered by WHO to warn that a nation's HIV epidemic may be escalating. That was in 1990/2000. By 2004, HIV prevalence ranged between five and 16 per cent in FSWs in the five Papuan cities in which it was measured, while in most of the western part of Indonesia, HIV rates remained much lower. Ethnographic studies and systematic surveys among civil servants and teenagers suggested that patterns of sexual networking among Papuans may fuel a more widespread epidemic; young Papuans reported starting having sex earlier than non-Papuans in the same province, Papuan men were more likely than non-Papuans to report buying sex, multiple concurrent partnerships were more frequently reported, and alcohol consumption before sex was much more common.

This raised concerns at both provincial and national levels that HIV might become established and begin to circulate widely among men and women in the general population in Papua. In 2006, a

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[42] The occupational groups included in surveillance have relatively low incomes and are more likely to buy from direct sex workers than from the more expensive sex workers working in bars and massage parlours. It would be more useful to compare HIV prevalence in sex workers and the men who say they buy sex from sex workers. These data have been collected with funding from GFATM, but the Ministry of Health's AIDS Sub Directorate has declined to make this data available to partners for analysis.

household based survey of HIV prevalence and related knowledge and risk behaviours was conducted in Tanah Papua. The results of this survey are discussed in the section on HIV in the general population, below.

STI and HIV among female sex workers

Since that time, ongoing surveillance among FSWs has shown that HIV has remained high, as Table 10 shows. One in four street-based sex workers in the highlands town of Wamena was found to be infected with HIV in surveillance in 2011 - the highest rate recorded among FSWs anywhere in Indonesia; of those with HIV, three quarters were currently infected with at least one other STI (syphilis, chlamydia or gonorrhoea). Among the HIV negative, two thirds had another STI. Three quarters of Wamena's FSWs said they did not use a condom with all of their clients in the past week. Among motorcycle taxi drivers who buy sex in Jayapura, just 15 per cent report using condoms consistently.[43]

Table 10: HIV, gonorrhoea and chlamydia data for Papua and West Papua, IBBS 2009 and 2011

	Location	HIV (%)	Gonorrhoea (%)	Chlamydia (%)	Gonorrhoea and/or chlamydia (%)
2009 IBBS					
Brothel-based sex workers	Sorong	21	35	41	58
Club/bar-based sex workers	Sorong	3	23	46	55
Brothel-based sex workers	Mimika	14	22	23	38
Club/bar-based sex workers	Mimika	4	18	28	35
2011 IBBS					
Brothel-based sex workers	Jayapura	16.0	32.4	31.2	47.2
Club/bar-based sex workers	Jayapura	3.2	18.8	31.2	39.6
Street-based sex workers	Wamena	25.0	35.4	44.8	56.3

Source: MoH AIDS Sub Directorate

Gonorrhoea and chlamydia: Table 10 summarizes the HIV, gonorrhoea and chlamydia data for Papua and West Papua from the Integrated Biological-Behavioural Surveillance (IBBS) rounds in 2009 and 2011. On any one day, 35-60 per cent of FSWs in Tanah Papua will have either gonorrhoea or chlamydia. The data suggest that rates may have been lower in sites that had implemented periodic presumptive treatment (PPT) in the period before the surveillance, for example, in Jayapura.

Syphilis: While we have syphilis data from multiple rounds of IBBS conducted in Tanah Papua the syphilis results have often been poorly interpreted with inclusion of all past syphilis infections, resulting in overestimates of the prevalence of active infection. This is a common problem in Indonesia but could be easily corrected by review of raw data using the MoH standardized case definition for active syphilis (TPHA positive, RPR greater than or equal to 1:8). Of the recent reported IBBS data the 2007 data are the most reliable and indicate that syphilis is concentrated

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[43] Inconsistencies in responses to behavioural questions in this data set suggest the results should be interpreted with caution.

among FSWs with less than 10 per cent prevalence of active infection among brothel-based FSWs in Jayapura and Sorong.[44]

Other STIs: There are a number of other STIs (that are known cofactors for HIV transmission) that are likely present in the Papuan provinces but are under-diagnosed, under-treated and under-reported, including chancroid, donovanosis, genital herpes and trichomonas (see Annex 7).

With such high rates of HIV, STI infection and unprotected sex, it is certainly the case that commercial sex continues to contribute disproportionately to new infections throughout the Papuan provinces. In order to reduce the ongoing spread of HIV (and thus to contain the number of people who will ultimately be in need of treatment) stronger and more effective prevention among sex workers and their clients will be needed. Effective STI and HIV treatment for infected sex workers provided under REACH will contribute to preventing the ongoing spread of the virus. But HIV treatment services differ from prevention services in that they are harder to concentrate geographically; by the time people are symptomatic and/or in need of treatment they have often moved on from the high-risk settings in which they were exposed to the virus. Note, too, that few highland towns currently have the kind of structured, venue-based sex industries which are common in larger coastal cities such as Jayapura or Sorong. Women are more likely to regard the sale of sex as a supplement to other income-generating activities than as a full-time job, and are less likely to be consistently reachable in locations where they prospect for partners.

HIV in the general population

The WHO makes a distinction between HIV epidemics in which HIV transmission is concentrated primarily among sub-populations with significantly higher than average partner turnover such as sex workers and their regular clients, and those in which HIV is "generalised". In a generalised epidemic, HIV would continue to spread in a sustained way among heterosexual adults even in the absence of highly exposed sub-populations. It is clear that Indonesia west of Tanah Papua falls into the first group. The status of the Papuan epidemic is less clear.

In 2006, 2.4 per cent of the 6,217 adults in Tanah Papua aged 15-49 tested for HIV in the population prevalence survey were infected with the virus. That is over 18 times the population prevalence of 0.13 per cent estimated in 2009 for the rest of Indonesia. In the area that is now Papua province prevalence was 2.5 per cent, and in West Papua, 2.1 per cent. As Table 11 shows, HIV prevalence was significantly higher among men than among women, (2.9% vs. 1.9%) and higher among ethnic Papuans than among non-Papuans in West Papua (4.1% for male Papuans and 1.8% for female Papuans vs. 1.8% for male non-Papuans and 0.4% for female non-Papuans).[45] Among men, the recorded prevalence of HIV was slightly greater in the highlands than in the rest of Tanah Papua. Among women, the reverse was true. The differences between highland and lowland areas were not, however, statistically significant. HIV prevalence was nearly twice as high in areas classified as "rural" than in urban areas (2.9% vs. 1.5%).

So is the Papuan epidemic "generalised"? We cannot say for certain. Embedded research potentially undertaken under Component 4 of REACH might help clarify the contribution that commercial sex makes to the epidemic. But it is plausible, at the levels of HIV prevalence outlined in Table 11 and

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[44] Nurholis Majid, Liesbeth Bollen, Guy Morineau, et. al. *Syphilis among female sex workers in Indonesia: need and opportunity for intervention.* Transm Infect 2010; 86:377-383 doi:10.1136/sti.2009.041269.

[45] The difference in prevalence between ethnicities reached statistical significance at the 95% level only in West Papua.

given what is known about sexual networking, that HIV could continue to circulate among the general population in Tanah Papua even in the absence of especially high risk behaviours such as

Table 11: HIV prevalence in the general population, Papua and West Papua, 2006

Population (Sample size)	Location	% HIV +ve
Papua province		
Papuan women (792)	Papua lowlands	2.2
Papuan women (817)	Papua highlands	2.6
Non-Papuan women (505)	Papua Province*	1.8
Papuan men (811)	Papua lowlands	3.0
Papuan men (885)	Papua highlands	3.2
Non-Papuan men (509)	Papua Province*	1.8
West Papua province		
Papuan women (507)	West Papua	1.8
Non-Papuan women (465)	West Papua	0.4
Papuan men (476)	West Papua	4.1
Non-Papuan men (450	West Papua	1.8

* Virtually all the non-Papuans in the sample were in lowland areas
Source: IBBS, 2006

commercial sex. This is especially true in the highlands; 27 per cent of men and 11 per cent of women in the highlands reported multiple sex partners in the previous year in the 2006 IBBS survey compared with 18 per cent of men and four per cent of women in non-highland areas (see Table 2 on gender in section 1.3.2 for more details[46].) Applying the district-level prevalence measured in 2006 to the 2009 population projections from the Central Bureau of Statistics and adding the number of brothel-based sex workers estimated to be infected with HIV (since these women, unlike other higher risk groups such as men who buy sex or women who sell sex on the streets, would not be captured in a household survey) gives an estimated 38,000 adults living with HIV in Tanah Papua: 9,000 in West Papua and 29,000 in Papua. Of those, some 24,000 live in districts that will be covered by REACH. [47]

No data on behaviour among the general population have been collected since 2006. It seems unlikely that that prevention campaigns using non-specific slogans such as "HIV is important", which appear to form the bulk of prevention messages currently reaching the general population in Papua, will lead people to have sex with fewer partners, or to use condoms more frequently. Although access to treatment has been poor and many of those who were already HIV infected in 2006 will have died, it is almost inevitable that new infections have outstripped deaths and that the number of people living with HIV has risen since 2006, but it is not possible to make an estimate of

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[46] The rates of extramarital sex reported in the 2006 IBBS is far higher than that reported in the 2007 Demographic and Health survey. Just 2.8 per cent of currently married men in Papua and no currently married men in West Papua reported extramarital sex in the previous 12 months in the DHS survey, compared with 18.6 per cent and 11.2 per cent respectively in the far larger IBBS sample.

[47] These estimates differ from the official 2009 national estimates because they use more detailed district level prevalence (which raises the estimate slightly compared with the previous mid-value) and adjust for previous double counting (which lowers it). The official mid-level estimate for HIV infections among high risk populations and the general population in Papua in 2009 was 32,700.

the number of people currently living with HIV. Other sources of data, including the results of testing of pregnant women in CHAI-supported clinics in highland areas, suggest that among those who currently access health services routinely, HIV prevalence remains well below five per cent. These data do not, of course, reflect prevalence rates in those who do not access health services, including many at-risk men. In the 2007 Demographic and Health Survey, some 69 per cent of married women in Papua reported some antenatal care by a skilled provider, the lowest rate in Indonesia (the national average was 93%). Of those who did report any skilled care, a relatively high 40 per cent reported having a blood sample taken during antenatal care (compared with a national average of 29%).

The Ministry of Health is planning another round of household-based HIV and behavioural surveillance in Papua and West Papua in 2012. The survey will include an oversampling in the highland areas where REACH will concentrate its activities, and should provide more reliable information on the number of people likely to be in need of HIV and STI treatment and related services in program areas.

Annex 2: Ministry of Health model of decentralised HIV CST

The Ministry of Health's model of decentralised care for HIV CST, centred on the role of puskesmas linked to hospitals is outlined in Figure 2. The design of REACH's CST component is based on this model.

Figure 2: Indonesian Ministry of Health model of decentralised HIV care, support and treatment
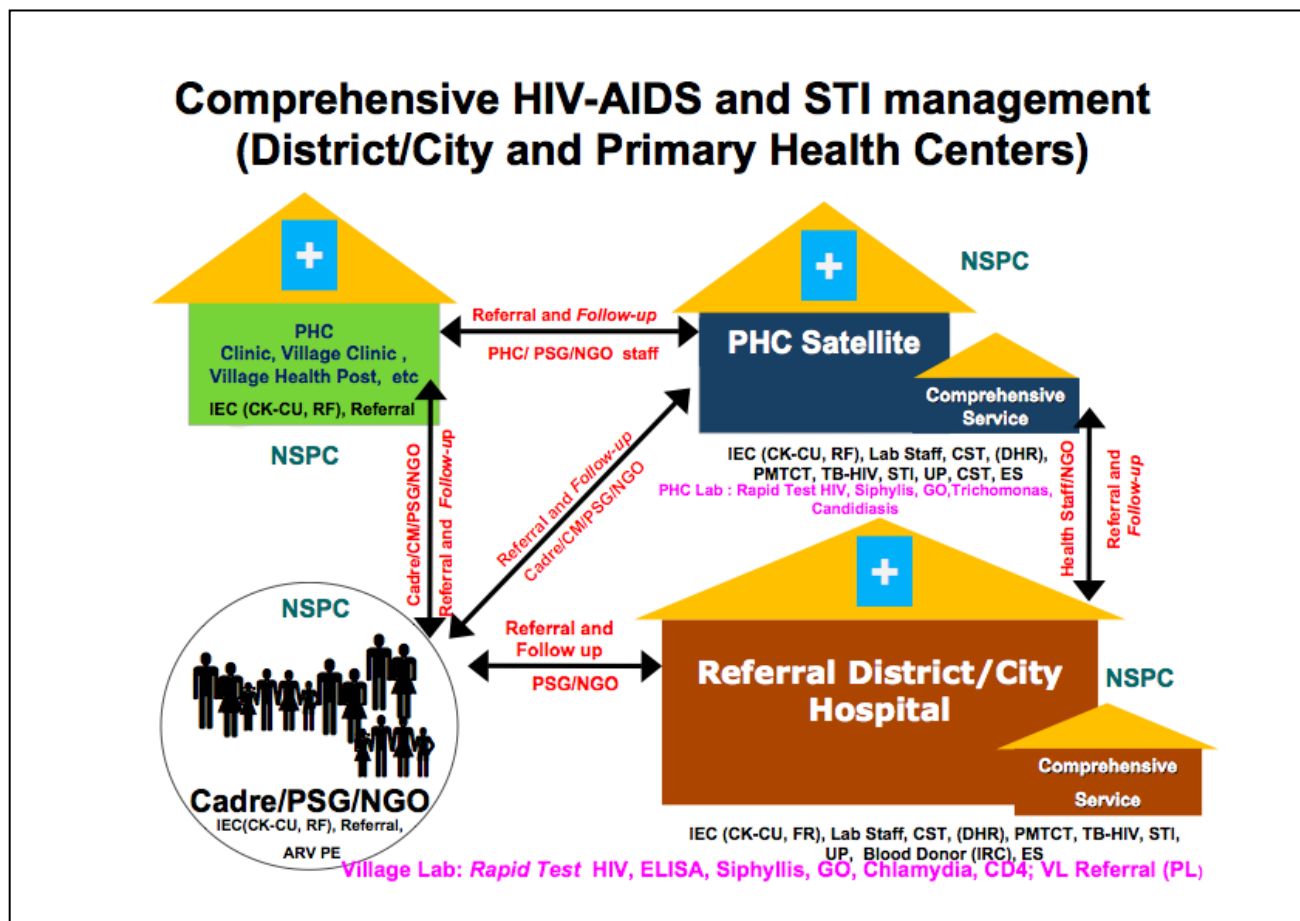
Annex 3: Key achievements in CHAI Phase II

Table 12: Summary of key achievements in CHAI Phase II

Project area	Achievements in CHAI Phase II
Care, Support & Treatment	▪ **More new patients detected and with early diagnosis, more new patients on treatment at CHAI-supported sites** (on treatment before CHAI = 83, after 17 months of CHAI in two sites = 876) ▪ **Successful decentralization of HIV services / more sites providing ART and/or follow-up services for HIV positive patients**: In Jayapura, Yowari hospital and 3 puskesmas are now providing ART, with 5 other puskesmas trained and starting to follow up patients. In Wamena, Wamena hospital and 2 puskesmas are now providing ART, with 4 other puskesmas trained and starting to follow up patients ▪ **Low rates of loss to follow up of patients on ARVs**: 20 per cent LTFU cases before CHAI, N=128; 7 per cent after CHAI, N=498 ▪ **Better rates of care support**: 100 per cent of positive patients at both sites receiving care support from health facility or family ▪ **Increased PMTCT access**: Facilitated policy change in Yowari hospital, where pregnant women now have 24 hour access to HIV testing ▪ **Increased PITC implementation**: Facilitated agreement from Yowari and Wamena hospitals on PITC implementation and standard operating procedures; ▪ **Better program and service coordination**: Reactivation of the CST working Group of Papua Province AIDS commision, which had not been active for almost 5 years; ▪ **Successful TOT implementation leading to GoI-run mentoring plan**: Staff mentored and trained local clinicians and public health officers as trainers in Jayapura, resulting in Yowari hospital and District Health Office now conducting regular Puskesmas mentoring visits ▪ **Introduction of Task-shifting**: strong nurse-care models in Kalvari Klinik and Puskesmas (PKM) Kota Wamena ▪ **Demand creation**: many new districts requesting CHAI technical assistance for their HIV-related services
Supply Chain Management	▪ **Drastic reductions in stock outs**: since the program's inception in 2009, the number of site level ARV stock outs dropped to 0.9 per cent, with only two sites reporting a stock out in the last six months. Incidence of stock outs reduced from 87% to < 1% ▪ **Successful decentralization of ARV management:** East Java, West Java, Bali, and Papua are now managing ARVs for their provinces, constituting 33 per cent of Indonesia's patient population ▪ **Increased number of sites trained on reporting, recording, and inventory management**: Cumulatively, CHAI has trained 181 ART sites, representing 60 per cent of the total sites and 69 per cent (16,799 patients) of the total population currently on treatment. This has helped increase the number of ART sites now reporting to 86 per cent ▪ **Successful launch of a nationally managed HIV rapid test supply chain**: 16 pilot sites trained in Central Java and Papua provinces

Project area	Achievements in CHAI Phase II
Policy	▪ **Significant technical support on guidelines development and finalization**: Staff edited final versions of the ARV and Provider Initiated Testing and Counselling guidelines and provided input on the STI and Prevention of Mother to Child Transmission guidelines ▪ **Implement Task-shifting at province level**: Collaborated with the Papua Provincial Health Office, WHO, and UNICEF to develop and implement institutional and professional task-shifting to ensure accessibility of HIV testing for pregnant mothers and support the prevention of mother to child transmission ▪ **Successful implementation of national policies to local-level**: National policies have facilitated CHAI's technical assistance in Papua, including Provider Initiated Testing and Counselling ▪ **Sub Directorate AIDS-endorsed policy review process**: CHAI developed with the Australasian Society for HIV Medicine an evidence-based guideline and policy review process initially endorsed by the AIDS Sub Directorate AIDS and the Ministry of Health

Annex 4: Lessons learned from CHAI Papua New Guinea

In PNG, the AusAID funded CHAI Rural Initiative project has been supporting the decentralisation of HIV CST in rural provinces since 2006. While PNG's overall HIV prevalence is 0.9 per cent, prevalence in the highlands is estimated to be between 2-3 per cent, based on antenatal surveillance.

CHAI has been working with the PNG National Department of Health in development of a model for rural care and treatment that has met with considerable success. When CHAI PNG began their pilot program in late 2007 in the Eastern Highlands Province, access to ART was very limited. As of March 2012, there were over 2,000 registered HIV patients with over 1,200 on ART. These patients were being seen at 10 rural district level facilities (similar to a puskesmas) with rates of lost to follow-up under 10 per cent at 12 and 24 months. CHAI's approach in PNG is similar to that of REACH in that it works with the government health system to decentralise services by providing technical assistance in key areas such as supply chain management, laboratory, data collection, clinical mentoring and quality assurance.

While there are distinct differences between PNG and Indonesia in terms of health systems and operational contexts, there are a number of inherent similarities that result in a high potential for effective cross border sharing of lessons learned. Of particular interest may be cultural approaches to testing in rural areas. For example, through an innovative outreach model, CHAI has tested over 15,000 rural people in clan-based settings and linked those testing HIV positive to care and treatment. The CHAI PNG experience has been that many remote communities are more likely to test *en masse* than to seek HIV testing services individually. Patient retention activity, through an innovative case management model has sought to address barriers posed by factors such as the rugged terrain in remote areas. Similarly, program implementation has thoughtfully paid attention to the cultural significance of gender relations in terms of the status of highland's women and issues related to partner disclosure following a positive diagnosis in PMTCT and partner testing. Table 13 below summarizes ways in which CHAI's efforts in PNG may usefully inform REACH.

Specific PNG program activities which may be applied to REACH will be clearly defined and integrated into REACH annual work plans. The approach to sharing will depend on the task specified and could range from sharing of curricula for expert clients to training of trainers in models of patient retention, targeting clinic based health workers.

As REACH develops, especially with its intensive efforts in operational research, it too will have valuable lessons to share with CHAI's PNG program. There will be close, on-going collaboration and information sharing between both CHAI teams, facilitated by CHAI's regional office.

Table 13: Lessons learned from CHAI Papuan New Guinea of relevance to REACH

Component approach	Positive experiences	Challenges	Tools that could be Shared with the Papua Program
Health Systems Strengthening approach to HIV service delivery	Using HIV as a vehicle for HSS couches HIV appropriately within the Health System, thereby building capacity for HIV as well as other services and optimizing investment.	It is best to use this approach from the beginning of an initiative; this is the most demanding approach and therefore can be difficult.	Model to map HIV investment for HSS. Adopting the PIH Four Pillars Approach.

Component approach	Positive experiences	Challenges	Tools that could be Shared with the Papua Program
Decentralization of care with centralized coordination	Decentralization of services reaches more patients and builds capacity of more HCWs. Centralized coordination creates a network where resources of all kinds can be pooled and shared. Network of HCWs creates unity and affords opportunity for standard quality assurance that individual clinics could not achieve.	Requires unification by an accepted lead authority of disparate facilities that may or may not be under the same health administration.	Model of functional unit with a referral facility as the hub with higher technical expertise based there to create Centres of Excellence where best practices are modelled. Sharing of experiences of increasing ownership of the program by HCWs and administrators.
Uniform and centralized data collection	Uniform use of job aids-clinical and other patient evaluation forms assists with consistent quality of care. Entry of forms into comprehensive HIV database that includes both clinical and psychosocial data creates electronic medical records to manage missed appointments, drug ordering, as well as program planning for any number of variables, such as access to clean water or food insecurity.	Requires a centralized data manager and solutions for data entry and merging multiple databases into one	Job aids including all clinical and other forms can be adapted for use in Indonesia through translation and other modifications as necessary. The Rural Initiative database is access-based and is easily shared, as is information about networking and generating reports.
Clinical services oriented towards patient retention vs. clinician convenience	Higher patient retention rates Increased clinician satisfaction from more efficient clinics and improved patient outcomes	Patient retention strategies for pre-ART are not the same as for ART patients. Strategies must be reviewed and renewed at least annually based on program evaluation and informed by on the ground experience	Models of patient flow-high throughput and low throughput Task-shifting models SOPs for patient retention
Laboratory strengthening	Centralized coordination of consumables, QA and reporting creates excellent data for the catchment area, accurate consumption rates, and illustrates locations where program is strong or weak. Movement toward point of care technology esp. for antenatal HIV, Hb, Syphilis, HIV, CD4, and TB.	Government involvement and support of POC testing is important for sustainability	Templates for Laboratory record keeping Site Consumption Reports QA for laboratory work done by HCWs Data from study of PIMA CD4 point of care trial in the field in rural PNG (most other validation are laboratory-based) GeneXpert-based algorithm for IPT implementation and SOP for preparation to implement. SOP for one-finger-prick POC antenatal testing

Component approach	Positive experiences	Challenges	Tools that could be Shared with the Papua Program
Creation of patient pathways between facilities and clinical areas	Creating linkages between clinical areas and different facilities with SOPs, information sharing, and or capacity-building in clinical areas of greater significance for HIV detection and referral such as STI, TB, peadiatrics and ANC	A patient pathway is only as good as the linkages between the sites; in order for this component to work, personnel understanding and motivation as well as the capacity to follow through has to be assured.	Models of patient pathways used in PNG Rural Initiative
Greater Involvement of PLHA	Using carefully selected trained expert clients in HIV peer counseling, in adult, PPTCT and pediatric settings can increase patient satisfaction and adherence and provide needed assistance to HCWs.	Providers must be involved in developing selection criteria for expert client candidates, and clinic infrastructure must be assessed for implementation. If peer counseling is relegated to outside waiting areas the intervention could have the opposite effect of creating patient loss.	CHAI Expert Client Training Curriculum, TORs, Time and Tally Sheets, and Code of Conduct for Expert Clients.
Appropriate technologies for health			Plans for high through-put, low cost and low operating cost medical waste incinerator, personal rain catchment. Other site appropriate technology, such as headlamps for pelvic exams, container clinics, solar LED lighting for health centres.

Annex 5: Programmatic structure of REACH

Figure 3: Programmatic structure of REACH

LONG TERM GOAL:
Reduced HIV-related morbidity and mortality in Tanah Papua

END OF PROGRAM GOAL:
Increased access to, and increased number of people on HIV-related care & treatment in Tanah Papua

Component 1: Care, Support & Treatment
To increase the number of Government of Indonesia supported health facilities that are well staffed and equipped and providing quality HIV-related clinical services in Tanah Papua

**Support:
Management and Fiscal/HR/ Administration**

Component 2: Supply Chain Management for HIV Commodities
To decrease stockouts and increase efficiency of strengthened supply chain management of HIV-related commodities

Component 3: Policy
To develop, disseminate and implement an evidence based MoH national policy framework relevant to HIV-related care, support & treatment

Component 4: Operational Research
To generate and apply knowledge that contributes to achieving program goal of increasing access to high quality HIV-related treatment in Tanah Papua

**Support:
Monitoring and other Program Analytics**

Annex 6: CoE and puskesmas site selection criteria

A6.1 Centres of Excellence – selection criteria

Selection of the location of CoE was done in collaboration with the PHOs and based on:

- Geographic location
- Proximity to large population centres
- Logistics and accessibility to surrounding districts with lower levels of HIV, TB and STI care capacity
- Class D, C or B referral hospitals with a laboratory
- Interest on the part of hospital and district to host the CoE
- Currently designated as ART sites (Pegunungan Bintang is an exception)
- PHO support for establishing a team at the site

Table 14 lists the sites for the CoE and the broader geographic areas they will service.

Table 14: Centre of Excellence sites and service areas

REACH CoE sites	Service area
Papua Province	
Pegunungan Bintang District Hospital	Pegunungan Bintang and adjacent Bovendugal areas
Wamena District Hospital	Jayawijaya, Tolikara, Yahukimo, Membramo Tengah, Yalimo, Lanny Jaya, Nduga
Puncak Jaya District Hospital	Puncak Jaya District and parts of Puncak
Enarotali District Hospital	Paniai, parts of Intan Jaya, Deiyai and Dogiyai
Nabire District Hospital	Nabire District, Nabire City and parts of Deiyai and Intan Jaya
Jayapura District and City	Jayapura City and districts and supports Keerom and Sarmi
West Papua Province	
Fak Fak District Hospital	Fak Fak, Kaimana and Bintuni Districts
Sorong District and City	Sorong Kota, Sorong Kabupaten and Sorong Selatan
Manokwari District	Manokwari city and district

The success of CHAI Phase II and the support provided has generated many requests by other districts for CHAI support. The PHOs and Provincial Steering Committees will work with CHAI and AusAID regarding any possible program expansion beyond the current sites. Expansion beyond the current sites will only considered if it is judged to be feasible in the light of experience with the roll-out of REACH and if funds are available.

The CoE in Jayapura and Wamena have already been established under CHAI Phase II. The other seven CoE will be established progressively over an 18 month period. Timing and priorities are as follows:

- CoE in will be established order: Sorong, Nabire, Enarotali, Mulia, Pegunungan Bintang, Fak-Fak and Manokwari.
- Sorong and Nabire will have CHAI offices established in the first six months of the program. Sorong in West Papua will be prioritised since it is also one of the MoH's 'test and treat' sites. Nabire has a large underserved HIV positive population.
- Other immediate CoE expansion will include Enarotali and Mulia. Enarotali has strong political will to implement and it shares with Nabire a large underserved HIV positive population. While it is the centre of political unease in Papua, Mulia has a highly motivated hospital team and Medecins du Monde staff that are willing to transition to CHAI and continue working there when their program ends in May.
- The other CoE sites in Pegunungan Bintang, Fak-Fak, and Manokwari will be established later, but technical assistance with hospitals and health facilities in those areas will be ongoing.

Table 19 in Annex 9 provides a timeline for roll-out of the CoE and REACH supported hospitals and puskesmas.

A6.2 Puskesmas selection criteria

REACH will targeted 120 puskesmas for delivery of comprehensive HIV, TB, STI and PMTCT services. Currently 41 puskesmas are designated ART satellites in Tanah Papua. Those puskesmas falling within the REACH program area will be reviewed for comprehensiveness of services, training, record keeping, reporting and needs for facilities upgrading and staff training.

Prioritization for upgrading additional puskesmas for service delivery and the necessary training and support and facilities improvements will depend on a number of factors:

- Geographic location and accessibility
- Population need
- Facilities and equipment
- Staffing
- Interest in the program
- Agreement and commitment by PHOs and DHOs.

There is insufficient data of a detailed nature on the geographical spread of HIV in Tanah Papua to make HIV or TB prevalence an criteria for puskesmas site selection. However, the 2006 IBBS indicated that there is significantly greater HIV prevalence in the highlands region and this region will be prioritised by REACH.

The results of the Health Facilities Research survey (Riset Fasilitas Kesehatan – RIFASKES) are not available at this the time of writing. Data on facilities and equipment in the original survey will help inform decisions on prioritization. CHAI proposed additional questions on staffing, training and programs such as TB and MCH that was completed for most of the 300 puskesmas in Papua Province. That information will be key in selecting sites that pose minimal challenges to implementation given facilities and adequate staff with minimal training needs. It will also allow for planning for facilities improvements for other high-priority sites that would not be able to provide services until repairs or new installations are made.
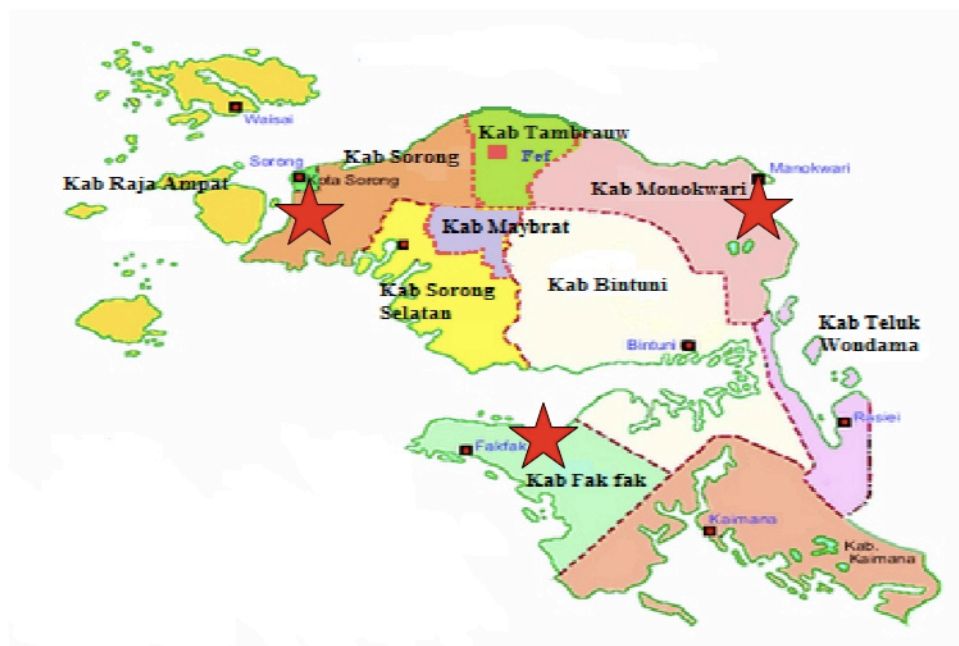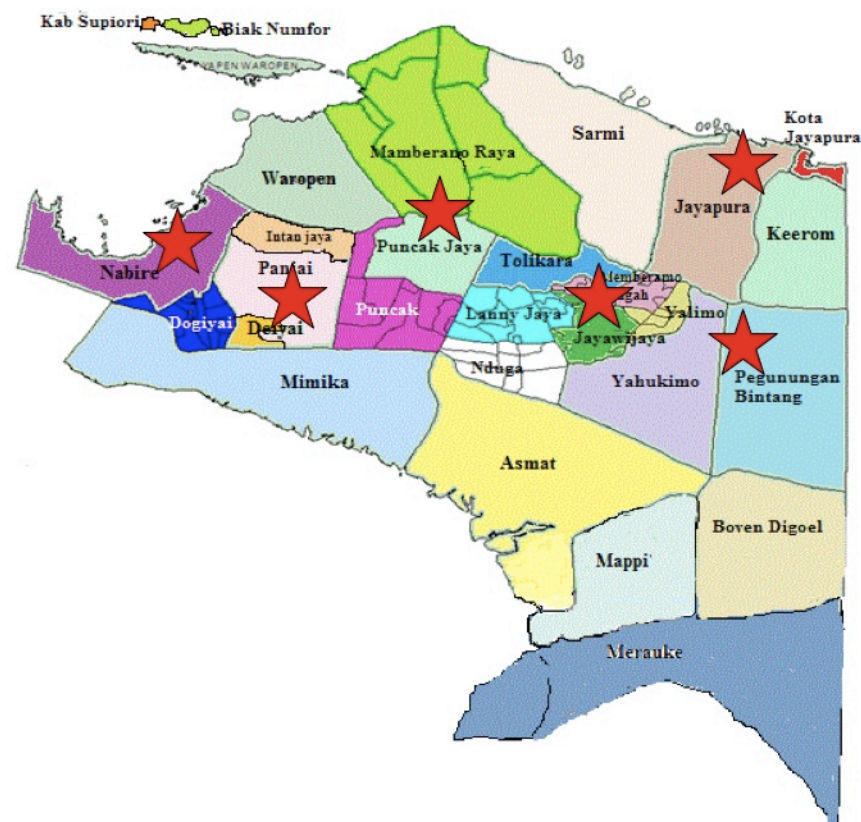
Annex 7: Sexually transmitted infections programming

This annex is designed as a stand-alone document on STI control in Tanah Papua. It is provided as background to the STI section of the program description, (see section 2.5). It will also be used as for strategic planning on STI control with local counterparts at provincial and district level in Tanah Papua during the REACH program.

There are three sections. Section 1 provides a brief background on general approaches to STI control and describes the toolbox of STI control strategies that we will use for designing STI control activities in Tanah Papua. Section 2 looks at what we know about STIs and existing STI control programming in Tanah Papua. Section 3 covers strategic approaches and key activities and maps out two broad strategic approaches: Improve the quality of STI diagnosis and treatment at district hospital and puskesmas level (3.1); and targeted STI interventions for high prevalence populations including PPT, enhanced syndromic management and syphilis screening (3.2).

A7.1 Background on approaches to STI control

There are three big-picture things we know about STIs:

- STIs are not all the same
- STIs tend to be unevenly spread in the community
- Populations with high rates of STIs are not all the same

We need to remember these three points when we are designing STI control programs. Table 15 looks at what each of these three things means for STI control.

Table 15: What we know about STIs and what that means for STI control

What we know about STIs	Explanation	What it means for STI control
STIs are not all the same	Gonorrhoea, chlamydia, syphilis chancroid, donovanosis and herpes, all have different patterns of transmission, different patterns of distribution, and are linked with different laboratory, diagnosis and treatment issues.	Strategies need to target each of the high prevalence STIs e.g., gonorrhoea, chlamydia and syphilis
STIs tend to be unevenly distributed in the community	People have different levels of risk of getting STIs. STI rates tend to be higher in some populations, and in some locations, than others.	Strategies need to target high prevalence STI populations
Populations with high rates of STIs are not all the same	Sexual risk behaviours, condom use, numbers of sexual partners and treatment seeking behaviour all vary across populations with high rates of STIs.	Strategies need to be tailored for FSWs, boyfriends of FSWs, MSM, waria and clients

There is a toolbox of evidence-based STI control strategies that we will use (see Box 2). The tool box has two parts:

- Strategies that rely on laboratory diagnosis
- Strategies that do not rely on laboratory diagnosis.

These strategies rely on treatment without a laboratory diagnosis. This is called presumptive treatment. We will now look at the situation in Tanah Papua and draw on the tool box of STI strategies to design a program of STI control activities most likely to reduce STI prevalence in Tanah Papua.

A7.2   STIs and STI programming in Tanah Papua

Based on available data, gonorrhoea, chlamydia and syphilis are the highest documented burden STIs in Tanah Papua with particularly high prevalence rates among FSWs.

A7.2.1   Gonorrhoea and chlamydia

Table 16 summarizes the gonorrhoea and chlamydia data for Papua and West Papua from the IBBS rounds in 2009 and 2011. On any one day 35-60 per cent of FSWs in Tanah Papua will have either gonorrhoea or chlamydia. The data suggest that rates may have been lower in sites that had implemented PPT in the period before the surveillance e.g., Jayapura.

A7.2.1.1   *Gonococcal resistance to antibiotics*

Indonesia has recent data on gonococcal antimicrobial sensitivity in Tanah Papua. In 2004, seventy two gonococci isolates from Papua were tested by the WHO Collaborating Centre in Sydney and confirmed resistance to penicillins, tetracyclines and fluoroquinolones.[48] Following this survey the recommended treatment for gonorrhoea in National STI Guidelines was changed to cefixime. A further survey in Wamena in May 2011, linked to the IBBS, confirmed current sensitivity to

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[48] Sutrisna A, Soebjakto O, Wignall FS *et al*. Increasing resistance to ciprofloxacin and other antibiotics in Neisseria gonorrhoeae from East Java and Papua, Indonesia, in 2004 – implications for treatment. Int J STD AIDS. 2006 Dec;17(12):810-2.

cefixime.[49] At a country level gonococcal antimicrobial sensitivity surveys are recommended on a three-yearly basis.

Table 16: Gonorrhoea and chlamydia data for Papua and West Papua, IBBS 2009 and 2011[50]

		Gonorrhoea (%)	Chlamydia (%)	Gonorrhoea and/or chlamydia (%)
2009 IBBS				
Direct sex workers	Sorong	35	41	58
Club/bar-based sex workers	Sorong	23	46	55
Direct sex workers	Mimika	22	23	38
Club/bar-based sex workers	Mimika	18	28	35
2011 IBBS				
Direct sex workers	Jayapura	32.4	31.2	47.2
Club/bar-based sex workers	Jayapura	18.8	31.2	39.6
Street-based sex workers	Wamena	35.4	44.8	56.3

A7.2.2   Syphilis

Control of syphilis is more achievable than control of gonorrhoea, chlamydia or other STIs. The tests for syphilis are cheap and can be easily conducted at the clinic level. Effective drugs (injectable penicillin) are available and effective control strategies have been demonstrated internationally.

While we have syphilis data from multiple rounds of IBBS conducted in Tanah Papua, the syphilis results have often been poorly interpreted with inclusion of all past syphilis infections leading to overestimates of the prevalence of active infection. This is a common problem in Indonesia but could be easily corrected by review of raw data using the Government of Indonesia standardized case definition for active syphilis (TPHA positive, RPR greater than or equal to 1:8). Of the recent reported IBBS data, the 2007 data are the most reliable and indicate that syphilis is concentrated among FSWs, with less than 10 per cent prevalence of active infection among direct FSWs in Jayapura and Sorong.[51]

Effective syphilis control is achievable in Tanah Papua and the key is to focus on the early diagnosis and treatment of infectious syphilis. In terms of syphilis, there are four groups in the population:
- People who have never been exposed to syphilis
- People who have had syphilis in the past but been treated
- People who have non-infectious syphilis and require treatment
- People who have infectious syphilis (can transmit the infection) and require treatment

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[49] Personal communication Steve Wignall, February 2011

[50] Data provided by MoH AIDS Sub Directorate, February 2011.

[51] Nurholis Majid, Liesbeth Bollen, Guy Morineau *et al.* Syphilis among female sex workers in Indonesia: need and opportunity for intervention. Transm Infect2010;86:377-383 doi:10.1136/sti.2009.041269

We need to keep in mind that clinicians and public health physicians have different priorities in the management of syphilis. From a clinical management perspective the priority is to treat all people with syphilis whether it is infectious or non-infectious. Public health physicians' priority is to stop the transmission of infectious syphilis. This means they give priority to early diagnosis and treatment of people with infectious syphilis with high titre RPR results. While clinicians should continue to provide treatment for all people with syphilis whether infectious or not, public health strategies designed to reduce the transmission of syphilis in Indonesia should focus on the control of infectious syphilis through the identification and treatment of people with infectious syphilis.

To control infectious syphilis we will need to overhaul current clinical practice in Tanah Papua (and Indonesia) regarding diagnosis and management of syphilis. There is quite a large amount of testing going on – often on the wrong people, with the wrong combination of test kits, wrong diagnoses, overtreatment among sex workers, reluctance to use the first line drug (Penicillin) and non-compliance with the alternative (Doxycycline). Routine use of RPR testing with confirmatory TPHA for syphilis diagnosis appears low. This may be an unforeseen consequence of the introduction of TPHA RDT and the unfortunate misrepresentation of the TPHA RDT as a syphilis RDT in the National STI Guidelines[52].

Treatment: Following a court case in Semarang many doctors in Indonesia have been reluctant or have refused to give intramuscular Penicillin injections – the first line treatment for syphilis – due to the possibility of anaphylactic shock. Common practice is to prescribe doxycycline twice daily for 30 days. Compliance with this treatment is often poor, especially among sex workers, in part due to the common side effect of nausea and diarrhoea. A small study conducted by Yayasan Kerti Praja in Bali in 2001-2002 found zero compliance with a full course of doxycycline treatment amongst a sample was approximately 100 FSWs. Fortunately, health staff in Papua and West Papua appear more willing to give Penicillin injections than health staff in other parts of Indonesia.

A7.2.2.1 What about yaws?

Yaws is often raised as an issue in interpreting data on the prevalence of treponemal seropositivity (TPHA positive). The same tests that are used for the diagnosis of syphilis (TPHA and RPR) are also used to diagnose yaws and people who have been exposed to yaws in the past will have the same serological pattern as people who have been exposed to syphilis in the past (TPHA positive). Yaws is not an STI but it is caused by different subspecies (pertenue) of the same family of organisms that causes syphilis - Treponema pallidum. Yaws is mainly found in humid rural tropical regions and is also known as Frambusia.

There is some evidence that yaws may still be present in Indonesia in small residual foci of infection in isolated rural areas ("where the highway ends").[53] In a survey of 37,000 people in West Sumatra in 1988, 114 cases of early yaws were diagnosed clinically, with 100 being treponemal seropositive. Whilst continued low level transmission of yaws in isolated areas would contribute to the prevalence of treponemal seropositivity in those areas there is no logical basis to suggest that yaws contributes to the higher treponemal seropositivity amongst FSWs and waria compared to low risk populations in Indonesia. It seems reasonable to assume that the higher treponemal seropositivity amongst FSWs and waria is due to sexual exposure to syphilis.

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[52] Pedoman Penatalaksanakaan Infeksi Menular Seksual 2011, page 95.

[53] Engelkens HJ, Stolz E. A small yaws survey on the island of Sumatra, Indonesia. Acta Leiden 1992; 60(2):19-29.

A7.2.3 Other STIs

There are a number of other STIs (that are known cofactors for HIV transmission) that are likely present in Tanah Papua but are under-diagnosed, under-treated and under-reported, including chancroid, donovanosis, genital herpes and trichomonas. Chancroid, donovanosis, genital herpes and syphilis are all genital ulcer diseases and therefore are strong cofactors for HIV transmission. A review of the results of enhanced syndromic management in brothel-based FSWs could provide valuable data on the prevalence of genital ulcer disease in Tanah Papua.

Chancroid (Haemophilus ducreyi) is a genital ulcer disease. There are no data available on the prevalence of chancroid in Tanah Papua. Chancroid is treatable with single dose azithromycin. This means the PPT program for gonorrhoea and chlamydia among FSWs would also be effective for chancroid.

Donovanosis is a chronic genital ulcer disease with low infectivity. There are no current data available on the prevalence of donovanosis in Tanah Papua however donovanosis was historically endemic in Tanah Papua and PNG. The largest recorded epidemic of donovanosis occurred in Merauke in Papua between 1922 and 1952 where 10,000 cases were identified from a population of less than 15,000. [54] Since the introduction of antibiotics, donovanosis is less common and tends to occur in small endemic foci in populations with poor access to STI diagnosis and treatment.[55]

Trichomonas – Trichomonas is under-diagnosed and under-treated throughout Indonesia. The recommended treatment, metronidazole (single 2gm oral dose), needs to be added to the national EDL so it can be available at puskesmas level. There is also scope to train private pharmacists (apoteks) to prescribe metronidazole for symptoms of vaginal infection in women who are not pregnant.

A7.2.4 STI laboratory capacity, diagnosis and treatment

A7.2.4.1 STI laboratory capacity

Most district hospital laboratories and puskesmas can conduct simple diagnostic tests for gonorrhoea (gram stain, methylene blue), syphilis (TPHA, RPR) and trichomonas (wet mount).[56] There are definite areas of weakness including very weak supply chain management for laboratory reagents and supplies, use of the TPHA rapid diagnostic test as a stand-alone diagnostic test without running RPR titres, weak laboratory quality assurance systems and SOPs and poor infection control. Laboratory capacity appears weaker in West Papua than in Papua. While there are many areas of STI laboratory capacity that need strengthening at district hospital and puskesmas level in Tanah Papua, the required level of capacity is within reach. The more sophisticated STI diagnostic tests (PCR, gonococcal culture) are carried out at the Provincial Health Laboratory and, at this stage, are not planned to be provided at district hospital or puskesmas level.

A7.2.4.2 Key policies and experience

Many of the key building blocks for STI control programming are in place. There are National STI Guidelines, a National STI Control Strategy (2008-2012) and a national Essential Drug List (EDL). Clinics do not always have the latest version of the national guidelines and there are standard STI

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[54] Vogel IC, Richens J. Donovanosis in Dutch South New Guinea: History, evaluation of the epidemic and control. PNG Med J 1989: 32; 203-218.

[55] Miller P. Donovanosis: control or eradication? A situation review of donovanosis in Aboriginal and Torres Strait Islander populations in Australia. Office for Aboriginal and Torres Strait Islander Health, 2000.

[56] REACH Design Mission, February 2012

drugs that are not on the EDL (see 2.4.3). On the positive side, there is valuable experience in Papua in the use of enhanced syndromic management and periodic presumptive treatment in FSWs.

A7.2.4.3 National Essential Drug List

WHO issues a model list of 350 essential drugs, including basic STI drugs, which many countries use as a basis for their National Essential Drug List (EDL). National EDLs are used as a basis for procurement and supply of standardized generic drugs with selection based on disease burden and cost-effectiveness. The current EDL in Indonesia does not include a number of STI drugs that are listed in the National STI Guidelines including cefixime, azithromycin and metronidazole. The National EDL is reviewed by the Indonesian MoH approximately every four years. The last revision was in 2011. In 2003, the Indonesian HIV/AIDS Prevention and Care Project (IHPCP) and FHI sent a joint submission to the Committee responsible for the review supporting the inclusion of Azithromycin (for use in FSW populations) and Cefixime in the EDL. This was unsuccessful.

A7.2.5 Gaps in our knowledge of STI in Tanah Papua

There are a number of important gaps in what we know about STIs in Tanah Papua including:

- Lack of data on STIs among MSM and waria
- Lack of data on STIs among regular partners of FSWs (boyfriends and husbands)
- Lack of data on STIs among general population
- Lack of data on other STIs including chancroid, donovanosis, herpes and HPV

A7.3 Strategic approach and key activities

Objective: To reduce STI prevalence in high prevalence populations in Tanah Papua

Overarching Outcome: STI prevalence reduced in high prevalence populations in Tanah Papua

Outcome 1: Gonorrhoea, chlamydia and syphilis prevalence reduced among sex workers

Outcome 2: STI prevalence reduced among HIV-positive sex workers

Outcome 3: Quality of STI diagnosis and treatment services improved at hospital and puskesmas level in Papua and West Papua

Outcome 4: Increased uptake of standardized STI services for MSM and waria in selected sites

How will we do it?

To reduce the prevalence of STIs in Tanah Papua we need to use a combination of strategies that rely on laboratory diagnosis and strategies that rely on presumptive diagnosis. We need to use most of the STI control strategies in the toolbox (see Box 1). Countries with good access to high quality laboratory diagnosis can afford to focus on improving access to services. Countries with weaker laboratory systems, including Tanah Papua, need to include strategies that rely on presumptive diagnosis.

Two broad strategic approaches are needed:

- Targeted STI interventions for high prevalence populations including PPT, enhanced syndromic management and syphilis screening (see 3.1)
- Improve the quality of STI diagnosis and treatment at district hospital and puskesmas level (see 3.2)

A7.3.1 Targeted STI interventions for high prevalence populations

Targeted STI interventions based on presumptive diagnosis are designed as transition strategies implemented over a period of time to achieve rapid reductions in STI prevalence in high prevalence populations that have poor uptake of services. The plan over the longer term is to shift from

strategies that rely on presumptive diagnosis to strategies that rely on laboratory diagnosis as prevalence drops and laboratory capacity improves.

The emphasis in targeted STI interventions is on the population rather than the individual. Similarly, the challenge is to achieve high (population) participation rates rather than (individual) demand for services. The interventions are not based on waiting for individuals to decide to go to a clinic for a check-up. Health staff can go out to a brothel with a supply of doxycycline and cefixime for PPT and condoms. NGO partners can map street sex work sites and work with health staff to provide PPT medications every three months.

The puskesmas and district hospitals , in partnership with local NGOs, will have a key role to play in the scale-up of standardized STI services for high prevalence populations including presumptive treatment on arrival, 3 monthly PPT, regular syphilis screening and PPT for sex workers' boyfriends and husbands. Specific attention will be given to providing STI diagnosis and treatment for HIV-positive FSWs. Table 17 lists the recommended key strategies for each high prevalence population. This section then gives additional background on four of the recommended strategies – PPT (3.1.1), syphilis screening (3.2.2), enhanced syndromic management (3.1.3) and use of surveillance activities for STI control (3.1.4).

Table 17: Key strategies for targeted STI interventions for seven populations

	Population	Key strategies	Indicative sites
1	Brothel-based sex workers	- PPT on arrival - PPT at 3 monthly intervals 100% condom use program - PPT for boyfriends of sex workers - Syphilis screening - Trial syphilis register – client record of serial TPHA, RPR results and treatment - Standard use of Penicillin injections (not doxycycline) for treatment of syphilis - Use surveillance for STI control: linked testing and treatment for gonorrhoea, chlamydia and syphilis during IBBS	- Jayapura (Tanjung Elmo) - Manokwari - Sorong
2	HIV-positive sex workers	- Early initiation ART 100% condom use - PPT 3 monthly 3 monthly syphilis testing - Use surveillance for STI control	- Jayapura (Tanjung Elmo) - Manokwari - Sorong - Wamena
3	Street sex workers	- PPT at 3 monthly intervals 100% condom use program - PPT for boyfriends of sex workers - Syphilis screening - Trial syphilis register – client record of serial TPHA, RPR results and treatment - Standard use of Penicillin injections - Use surveillance for STI control	- Jayapura - Wamena
4	Bar and massage parlours based sex workers	- Work with bar owners to implement an 'On arrival STI minimum package of services (MPS)' including presumptive treatment for gonorrhoea and chlamydia, syphilis testing and treatment, HIV RDT and reinforcement of 100% condom use. - Follow-up with 3 monthly PPT - Trial sex worker-held STI treatment record at selected clinic implementing presumptive treatment and syphilis screening with sex workers in bars and massage parlours (e.g., Kalvari Clinic in Wamena)	

5	Regular partners of sex workers	• Trial PPT for boyfriends of sex workers based in brothels (Tanjung Elmo)	• Jayapura (Tanjung Elmo) • Wamena
		• Use surveillance for STI control	
6	MSM	• Develop/adapt standardized algorithms for STI diagnosis and treatment for MSM • Support two puskesmas to act as demonstration sites delivering a minimum package of services for MSM	• Fak Fak • Jayapura
7	Waria	• Develop/adapt standardized algorithms for STI diagnosis and treatment for waria in Papua • Support two puskesmas to act as demonstration sites delivering a minimum package of services for waria in Papua	• Fak Fak • Jayapura

A7.3.1.1   Periodic presumptive treatment

There is considerable experience in Indonesia and in Tanah Papua specifically, in the use of periodic presumptive treatment (PPT) for chlamydia and gonorrhoea with 1 g azithromycin and 400 mg cefixime.[57] The Global Fund program supported three rounds of PPT amongst sex workers in selected sites in Tanah Papua in 2011.[58] This recent experience in using PPT with brothel-based sex workers in Papua and West Papua is a definite plus. Unfortunately PPT has not been implemented in a way that will maximize impact. Faced with small unsustained reductions in STI prevalence health staff has started to question the usefulness of PPT. We need PPT to control STIs among FSWs in Tanah Papua. To improve the effectiveness of PPT, as measured by a reduction in the prevalence of STIs, we need to understand that PPT works best with:

- Well-defined populations
- High prevalence of STIs[59]
- Low population mobility and turn-over
- High coverage of PPT
- High rates of condom use (ideally in conjunction with 100% condom use program)

PPT cannot work if FSWs have low condom use rates with clients and do not use condoms at all with their boyfriends. PPT can't work if the boyfriends of FSWs are not treated as well. Otherwise, after taking the PPT drugs the FSW will just be re-infected. PPT needs to be high coverage, linked to condom use programs, and combined with PPT for boyfriends of FSWs.

A7.3.1.2   Syphilis screening

Indonesia has documented evidence of the effectiveness of syphilis screening in high prevalence populations. In 2003 the AusAID-supported IHPCP commissioned a pilot syphilis control and behaviour change program amongst waria in Bali involving Yayasan Kerti Praja and Yayasan Gaya Dewata. The baseline syphilis screen documented a prevalence of 26 per cent (35/132). The quality of case management was higher than is usual in Indonesia with high treatment coverage (97%), standard use of Penicillin injections, and short interval to treatment (9.7 days). The second syphilis screen in July-August 2003 documented a significant reduction in prevalence to 12 per cent (16/133).

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[57] Majid N, Bollen L, Morineau G et al. Syphilis among female sex workers in Indonesia: need and opportunity for intervention. Sex Transm Infect. 2010 Oct; 86(5): 377-83.

[58] http://www.cenderawasihpos.com/index.php?mib=berita.detail&id=119

[59] Steen R, Chersich M, de Vlas SJ. Periodic presumptive treatment of curable sexually transmitted infections among sex workers: recent experience with implementation. Curr Opin Infect Dis. 2012 Feb;25(1):100-6.

The keys to effective syphilis screening include

- Screening programs with high population coverage (participation rates)
- Clear standardized case definitions for infectious syphilis, active infection and past infection
- Rapid treatment with prioritization of high-titre cases
- Standard use of Penicillin injections
- Individual records of serial titres and treatment

A7.3.1.3   Targeted screening using enhanced syndromic management

Enhanced syndromic management (syndromic management plus simple laboratory tests) is an important STI control strategy in low resource settings but has its limitations. Even in high prevalence populations its accuracy can be limited. In 1999, AusAID supported an evaluation of syndromic management algorithms[60] in Indonesia that showed that among FSWs syndromic management of cervical infections (gonorrhoea and chlamydia), with a Positive Predictive Value of 48 per cent, did not perform much better than random treatment.

Enhanced syndromic management has been used for targeted periodic screening in FSW populations in Indonesia over the past ten years with varying results. As with PPT, there are a number of factors that can undermine the effectiveness of enhanced syndromic management:

- Availability of effective drugs for treatment
- Lack of effective STI programs amongst boyfriends and male clients
- Positive Predictive Value of the algorithms used in enhanced syndromic management
- Frequency of the screening
- Coverage amongst the FSW populations
- Mobility in the FSW populations

The potential impact of the STI control strategy amongst FSWs will depend on a number of factors:

- Mobility of the population
- Coverage in the FSW population
- Frequency of intervention
- Syndromic management algorithms used and the quality of their application
- Treatment coverage
- Effectiveness of the STI drugs

A7.3.1.4   Use of surveillance activities for STI control

The largest scale and highest quality STI testing conducted in Indonesia, using sophisticated laboratory equipment and reagents (e.g., PCR for gonorrhoea and chlamydia), has been through the national surveillance system. The costs of sample collection, laboratory reagents and testing are centrally funded. Standard practice is that individuals who test positive, in accordance with unlinked anonymous testing methodology, are not treated. This is a wasted opportunity.

Prior to 2006, the IBBS protocol in Indonesia included STI syndromic diagnosis and management for all FSWs participating in the surveillance activity. This was a heavy workload demand and implementation was variable. In 2006 FHI introduced confidential linked testing with PCR for gonorrhoea and chlamydia and serological testing for syphilis for FSWs participating in the surveillance, with client-initiated return for treatment. This is an exciting initiative that hopefully will be scaled-up in Tanah Papua and implemented more broadly in Indonesia.

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[60] Miller P, Otto B. Prevalence of sexually transmitted infections in selected populations in Indonesia. Indonesia HIV/AIDS and STI Prevention and Care Project. June 2001

A7.3.2 Improve the quality of STI diagnosis and treatment at district hospitals and puskesmas level in Papua and West Papua

There are four reasons why it is important to improve the quality of STI diagnosis and treatment at the level of the puskesmas and district hospital:

- The targeted STI interventions for high prevalence populations depend on the quality of STI diagnosis and treatment at puskesmas level. It will be puskesmas staff who provide the PPT drugs. The syphilis blood samples taken in a syphilis screening program for FSWs will be tested in a puskesmas or district hospital laboratory. Registers of syphilis tests results and treatment details (to improve the accuracy of diagnosis and reduce overtreatment) will be maintained by clinic staff.
- This is a long term investment in improving the quality of, and demand for, STI services. A vision for the future is all individuals with STIs, including FSWs and MSM, attending STI clinics at the local puskesmas.
- STI treatment during surveillance activities will rely on the quality of STI diagnosis and treatment at puskesmas and district hospitals

Activities:

- Improve the supply and availability of a standardized list of STI laboratory reagents and supplies in puskesmas and district hospital laboratories
- Work at the national level with to review the National EDL to ensure inclusion of key STI drugs including cefixime, azithromycin and metronidazole in the EDL. In the interim, work with the District Legislative Assemblies[61] to approve procurement of STI drugs under the District health budgets[62]

Table 18: Standardized STI reagents and drugs by health facility

	Puskesmas	CoE and other district hospitals	Provincial health laboratory
STI reagents	• Gram stain • Methylene Blue • TPHA RDT • RPR • Wet mount	• Gram stain • Methylene Blue • TPHA RDT • RPR	• Gonococcal culture • PCR • Genotyping • HIV EQAS • TB EQAS
STI drugs	• Benzathin Penicillin • Cefixime • Azithromycin • Metronidazole • Doxycycline	• Benzathin Penicillin • Cefixime • Azithromycin • Metronidazole • Doxycycline	none

- Improve the quality of syphilis diagnosis and treatment with attention to:
  o Early diagnosis of infectious cases
  o Standard use of Penicillin injections
  o Rapid treatment with prioritization of high-titre cases
  o Individual records of serial titres and treatment

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[61] Dewan Perwakilan Rakyat Daerah (DPRD)
[62] Anggaran Pendapatan dan Belanja Daerah (APBD)

- o Provide technical input to WHO Indonesia and the MoH AIDS Sub Directorate in the next revision of the National STI Guidelines with particular attention to:
  - ▪ Need for TPHA RDT to be used in conjunction with RPR for syphilis diagnosis
  - ▪ Clear case definition for active syphilis that uses both TPHA and RPR tests
  - ▪ Inclusion of a stand-alone section on serological diagnosis of syphilis
- o Ensure STI clinics and puskesmas perform serial RPR titres on all TPHA positive /RPR reactive samples
- o Establish registers of serial syphilis results and treatment details in clinics providing sexual health services to sex workers to reduce the likelihood of over-diagnosis and unnecessary repeat treatments.
- Scale-up routine syphilis screening of antenates at first visit
- Advocate for, and support, inclusion of sites in Tanah Papua in gonococcal antimicrobial sensitivity surveys conducted in Indonesia.
- Develop/adapt standardized algorithms for STI diagnosis and treatment for MSM and waria and support two puskesmas to act as demonstration sites delivering minimum package of services for MSM and waria
- Strengthen diagnosis and treatment for trichomonas at puskesmas and district hospitals and work with the MoH to ensure supply and availability of metronidazole
- Adapt (based on the Thai manual) and distribute a training manual for laboratory technicians on STI diagnosis
- Provide training in public health approaches to STI control.

Will it work?

The MoH looks to WHO for leadership on technical issues such as the case definition for syphilis, gonococcal antimicrobial sensitivity surveys, and unlinked anonymous surveillance methodology. We will need some level of WHO support to move ahead with these strategies.

How will we know?

The IBBS rounds will provide prevalence data for syphilis, gonorrhoea and chlamydia.

In terms of implementing these changes, the REACH monitoring system will record key information for each REACH-supported puskesmas. Examples include:

- percentage of sites that have consistently had key STI-related reagents and drugs in stock over previous six months
- percentage of pregnant women and neonates screened for syphilis
- percentage of syphilis tests which correctly distinguish between active and former infection

In terms of providing services to high risk groups, the regular monitoring system can use clinic and quality control records to report on:

- percentage of sex workers correctly diagnosed and treated according to protocols
- Change in STI prevalence between new arrivals and repeat clinic visits
- percentage of sex workers given PPT for their regular partners

Will the benefits last?

The benefits of changes to the national EDL and guidelines will last. Accurate syphilis diagnosis and effective treatment will require ongoing low cost support from the CoE post program. The best sustainability strategy for STI diagnosis and treatment for MSM and waria is increased demand from those communities for the services.

Annex 8: Community empowerment proposal

The Catholic Dioceses of Jayapura, Timika and Sorong-Manokwari and the protestant Christian Gospel Church of Tanah Papua in collaboration with UNOPS Indonesia have submitted a community empowerment funding proposal to USAID, called Community Empowerment of People Against Tuberculosis (CEPAT), which is designed to complement REACH. The proposal seeks to use the broad reach of the churches to mobilise communities to support better detection of HIV and TB and TB-HIV cases, promote treatment and to advocate for better services. A copy of the concept note submitted to USAID follows.

A8.1   Background

Papua and West Papua Provinces (Tanah Papua) comprise a vast, largely undeveloped and underserved area in Indonesia. While population densities are low, disease burden are among the highest in the country. HIV and TB are emerging as the greatest threats to public health and development given their impact on productive age groups. HIV at 2.4 per cent prevalence overall is nearly 30 times the national average. HIV, poor nutrition, poverty, crowded living conditions and limited health services have created a perfect TB storm with TB as the highest proportion of HIV-related opportunistic infections in Indonesia (49%)[63]. Results from the Basic Health Research 2010 referred to by Indonesia's National TB Control Program (NTP) show that both provinces have prevalence rates of TB higher than the national rate of 1.0 per cent; West Papua, with a prevalence of 2.5 per cent, has the highest TB prevalence in the country.

Development has been largely in the coastal cities. The native Papuan population, however, is widely dispersed in small villages that are often not connected by roads to these more developed areas where health and other services are available. This is particularly true in Papua Province where 60 per cent of the local population lives in the central highlands. Most Papuans live below the poverty level as subsistence farmers and have little disposable income to pay for transport to distant medical facilities. Insurance reimbursement schemes at treatment hospitals confuse and frustrate rural villagers. Many who make it to hospitals give up in frustration. Others may live in areas that have health centres (PUSKESMAS) but these facilities often lack staff, medicines, laboratory or equipment necessary to treat their illnesses.

Cultural issues also complicate service delivery for illnesses like TB and HIV. Historically tribal communities excluded individuals who appeared sick with illnesses. That behaviour has led to stigmatization of individuals with TB, HIV or both. Infected individuals often do not seek or stop treatments owing to the discrimination and embarrassment they experience. Moreover, the rural poor are unfamiliar with chronic illnesses that require long term treatments. Completing courses of medicines for asymptomatic illnesses is often very difficult. Patients often take their medicine if they feel sick, not when they are ostensibly well.

A8.2   Strategic cooperation

Addressing the shortfalls in health services as well as improving health seeking behaviour, decreasing stigma, and improving drug adherence for the many affected residents of the highlands and West Papua will require a combination of health system strengthening, community mobilization and lobbying.

Communities are formed around tribe and church in this largely Christian area. Christian churches, Catholic and Protestant, are growing in influence socially and politically. The Department of

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[63] National TB Control Program (NTP), TB-HIV National Action Plan 2011-2014

Religious Representatives estimates 4,121 Protestant places of worship and 1,427 Catholic churches in Papua Province.[64] They are able to reach even the most remote villages to support their members thereby taking on social mobilization issues.

The Protestant Gereja Kristen Injil (GKI or Christian Gospel Church) and the Catholic Dioceses of Timika, Jayapura and Sorong-Manokwari have partnered together to propose using their broad reach to mobilize the Papuan highland communities and West Papua to better detect TB cases and to complete TB treatment, and to press national, provincial and district governments to increase and improve services for TB and HIV. These faith-based organizations see healthy communities as vital goals of their mission to help low-resourced and underserved areas. This partnership will work in concert with the AusAID funded KEMKES-Provincial Health Office (DINKES)-Clinton Health Access Initiative (CHAI) effort to rapidly scale-up access to HIV and TB diagnosis and treatment. Given the program scale, the GKI-Diocese partnership has asked the United Nations Office for Project Services (UNOPS) to assist in program and financial management during the first two years of implementation.

The Bishop of Timika and Head of GKI Synod will be responsible for the overall program implementation which is expected to last four years. UNOPS will station an international Program Coordinator and national finance personnel in Papua to work with GKI and the Diocese to build their capacity to deliver. UNOPS personnel will report to the UNOPS Project Centre in Jakarta. The Diocese of Timika will coordinate with the Dioceses of Jayapura and Sorong-Manokwari. Program personnel will be co-located with the AusAID funded KEMKES-DINKES_CHAI Centers of Excellence (CoE). Parishes and churches will be selected for cadre training as PUSKESMAS are selected for medical care scale-up. Program personnel will be responsible for district advocacy activities and the UNOPS Program Coordinator, Bishops, and Synod Head will coordinate provincial advocacy work. Data from community mobilization efforts and from the health sector will be fed to religious advocates for discussions with MUSPIDA, DPR and BAPPEDA.

A8.3   Technical approach

The AusAID funded KEMKES-DINKES-CHAI program will focus on the 15 highlands districts of Papua and Manokwari, Sorong and Fak-Fak in West Papua. Centres of Excellence (CoE) for the management of HIV, TB and sexually transmitted illnesses will be established in referral hospitals and later extended to PUSKESMAS in the surrounding areas with a target of established decentralized HIV-TB management in 150 facilities in the highlands and 35 facilities in West Papua over a four-year period. The church-based community mobilization work within the CEPAT program will be implemented in tandem with the development of clinical services provided through the AusAID program. The CEPAT program is proposed for Jayawijaya, Jayapura Peg. Bintang, Nabire, Sorong, Mulia, Manokwari, Enarotali Fak Fak and Mimika.

Component 1: Community mobilization:
Community awareness, early case identification and drug adherence will be largely in the hands of cadres recruited at the parish and church level. Training materials will provide basic information about TB, TB-HIV; signs and symptoms of TB infection; importance of early diagnosis; referral mechanisms for patients to the nearest qualified medical centre; contact tracing and referral; medications; importance of drug adherence; their roles as adherence monitors; record keeping and reporting. All activities will be in line with the Advocacy, Communication and Social Mobilization (AKMS) component of the NTP 2011-2014. Activities will thus also include familiarization of cadres

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[64] Papua Dalam Angka (Papua in Numbers) 2010, BAPPEDA Papua Province and BPS – Statistics of Papua Province

with the Patient's Charter for Tuberculosis Care. Cadres will be trained during one week training sessions in the villages with practical training. Village TB Posts (Pos TB Desa) will be established as bases for the cadres to operate from using church or village health post facilities. Records, spare meds, and supplies will be kept there. Baseline data from each parish or church will be collected during the initial training. Cadres will record daily activities including new cases detected and referral for sputum examination; case contacts referred; adherence support through DOTS; patients lost to follow-up; and patients completing treatment successfully. This information will be collected monthly. Cadres will report in writing to program personnel concerning shortfalls in medical services. Simple brochures and posters in local languages will be developed that promote early diagnosis and drug adherence. Medical personnel from local health centres will make periodic support visits and contact cadres to discuss any problems or issues with patients, medication supplies, side-effects or challenges to their work. Training programs will also be developed for ministers, parish priests, nuns, teachers and other religious leaders. Religious leaders and school teachers will be encouraged to include information on TB, TB-HIV and early detection and treatment in their sermons and classroom curriculum. Brochures, stickers, banners and event support will be provided. All activities will be documented on a monthly and quarterly basis. Data on case detection will include numbers tested; number positive; adherence; drop outs; cases completing treatment. This data can be analysed from province down to the cadre level and will aim at complementing the indicators identified within the 2011-2014 NTP Strategy. Success stories will be documented and circulated locally and nationally.

Component 2: Advocate for increased resources, improved services and legal issues:
The Musyawarah Pimpinan Daerah (MUSPIDA - Regional Leadership Consultative Group), Dewan Perwakilan Daerah (Parliament), Badan Pengembangan Daerah (Regional Development Agency) and Provincial and District Health Officers determine how health programs are funded, staffing levels, and the legal framework under which they operate. The new Special Unit for the Accelerated Development of Papua and West Papua (UP4B) which reports directly to the President will serve as a coordinating office when obstacles to implementation are identified. Senior GKI ministers, Catholic pastors, nuns and bishops will be trained in the elements of the TB program and program personnel will provide district and provincial data and justifications for budgets and personnel resources based on local disease burdens, impacts, and short falls in service deliver. Church officials will hear directly the service needs from TB positive and TB negative HIV patients, and may bring them or their representatives/families along when church officials meet with MUSPIDA, DPR, BAPPEDA and health officials at district or provincial levels or with UP4B officials. The Catholic Church in Papua New Guinea has been particularly active and successful in mobilizing Catholic Church parishioners to participate in awareness, adherence support and advocacy activities. A group of Catholic and GKI leaders may visit PNG at program kick-off.

A8.4 Exit strategy

GKI and Catholic Dioceses will be responsible for program management and implementation. They will see the benefits among their members in terms of increased numbers of individuals on treatment, increased adherence to medication regimens, increased survival rates and improved health services as a result of the program. We hope that through the program advocacy efforts and demonstrable results revealed in the health statistics, budget and staff allocations will be made by DINKES, DPR and BAPPEDA to sustain and strengthen the program. UNOPS supporting role will be gradually phased out after the second year of the program.

A8.5 Expected results

Church stakeholders such as ministers, bishops, nuns and educational personnel will have access to information and materials on TB treatment and patient care. Materials will reach patients and their

families directly. Patient needs for seeking and continuing with treatment will be identified and met, vulnerable and marginalized populations will receive special attention (for example, women through posyandus). Health Seeking Behaviour of patients will be improved. Program supported lobbying for resources will be documented along with results of additional budget and personnel allocations. The churches will take the lead in monitoring public service provision and identifying shortcomings and opportunities for improvement. There were 6,287 pulmonary and extra pulmonary TB cases diagnosed in 2010 in Papua Province from 16,900 suspected cases. We expect to see substantial increases in suspect and diagnosed cases and a substantial drop in defaulters. We will have baseline data from each of the parishes and churches where cadres and Pos TB are established, on population and current number of cases under treatment. We will be able to monitor recruitment for testing; adherence rates; drop-out rates; and treatment completion rates. All program activities will be in line with and complement the Indonesia's NTP Strategy 2011-2014, especially the components of Advocacy, Communication and Social Mobilization (AKMS) and the TB-HIV National Action Plan.

A8.6   Management and administrative capabilities

Founded in October, 1956, GKI has 1,237 churches and around 650,000 members, including 14 isolated tribes, in Papua and West Papua. GKI pastors and members are found in all districts where the program will be implemented. With the support of USAID and UNOPS, the GKI structure will allow for ready socialization and recruitment of cadres at the individual church level. The Synod Office in Jayapura has been working with the United Evangelization Mission on smaller scale endeavors since 2009. GKI has established a drop-in centre in Sentani for HIV positive people, performed youth HIV awareness activities across the highlands, and provides support for HIV positive individuals. The Dioceses of Timika, Jayapura and Sorong-Manokwari similarly have wide membership of at least 391,000 according to statistics from BAPPEDA. Catholic parish cadres have been trained for a number of health and non-health activities but their most notable effort has been a 2010 shelter program for HIV positive people in Wamena. Like GKI, the Diocese organizational structure similarly allows for ready socialization and recruitment of cadres in the individual parishes.

UNOPS has more than 30 years experience in implementing complex management and operational support services in peace building, humanitarian and development environments. In 2010, UNOPS implemented US$1.27 billion worth of projects for its partners, providing implementation support and management services, procuring goods and services, managing human resources and providing financial oversight of projects in some of the world's most challenging environments. US$21 million was delivered for USAID in 2010. UNOPS is currently supporting the Faculty of Public Health at the University of Indonesia as part of a Global Fund TB grant. UNOPS is also monitoring and evaluating the progress of the UN Partnership for Development Framework (UNPDF) in connection to the Government of Indonesia's Medium Term Development Plan (RPJMN) which includes health indicators for Papua and West Papua.

The funding proposal to USAID totals approximately A$3.8 million for four years of funding.

Annex 9: Implementation plan

A9.1 Component 1: Care, support and treatment

The CST component is the main program area for REACH. CHAI will spend significant amount of time and resources to promote the program, build the Provincial Steering Committees, develop relationships with key stakeholders, and recruit and develop new staff and CoE sites. A monitoring framework will be developed in the first quarter and baseline data collected for all program indicators. Systems for collection of monitoring data will be collected.

The establishment of the seven new CoE will occur progressively over the first 18 months. Some sites will be started in clusters to optimise training and use of other resources. CHAI will also establish two new offices in Sorong and Nabire in addition to strengthening its two existing regional offices in Jayapura and Wamena. These will serve as hubs for the CHAI teams and their activities across districts. Hiring of new CHAI and CoE staff will happen progressively over 18 months. While there are significant staffing needs for this program, this rolling approach to recruitment will enable a manageable process.

Current sites

- The Jayapura CHAI and CoE teams will be increased to their full staff complement. The teams will provide technical assistance to puskesmas in Jayapura District. They will also develop an expansion plan to support Kerom and Sarmi districts and begin implementation. The teams will initiate support to Pegunungan Bintang to establish that CoE and establish an ART site at the district hospital. Finally, the CHAI and CoE teams will support the GoI's new 'test and treat'[65] policy in Jayapura through technical assistance at Abepura hospital and Dok II hospital.
- The Wamena CHAI and CoE teams will be increased to their full staff complement. The teams will work with puskesmas in Jayawijaya District. They will also develop an expansion plan to support Lanny Jaya, Tolikara, Membramo Tengah, Yalimo, Yahukimo and Nduga districts and begin implementation. They will also provide assistance to Mulia to establish the CoE and an ART site at Mulia hospital.

New sites

- New CoE will be established in the following order: Sorong, Nabire, Enarotali, Mulia, Pegunungan Bintang, Fak Fak, and Manokwari.
- Sorong and Nabire will have CHAI offices established in the first six months of the program. Sorong in West Papua will be prioritised since it is also one of MoH's 'test and treat' sites. Nabire has a large underserved HIV positive population.
- Other CoE expansion in the first year will include Enarotali and Mulia. In Enarotali there is strong political will to implement and it shares with Nabire a large underserved HIV positive population. While it is the centre of political unease in Papua, Mulia also has a highly motivated hospital team and Medecins du Monde staff that are willing to transition to CHAI and continue working there.
- The other CoE sites in Pegunungan Bintang, Fak Fak, and Manokwari will be established in the first 18 months of the program. However, REACH will monitor its progress and may alter its implementation pace through an adaptive management approach.

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[65] Treatment will be initiated in accordance with current MoH policy of <350 CD4 cells.

The phased establishment of CoE and hospital and puskesmas sites supported by REACH is set out in Table 19.

Table 19: Phased expansion of Centres of Excellence and REACH supported hospitals and puskesmas

Establishment of CoE and number of hospitals and puskesmas joining REACH	Year 1 Jul – Dec 2012	Year 1 Jan – Jun 2013	Year 2 Jul – Dec 2013	Year 2 Jan – Jun 2014	Year 3 Jul 2014 – Jun 2015	Year 4 Jul 2015 – June 2016
Centres of Excellence						
CoE Jayapura and CoE Jayawijaya	2					
CoE Sorong and CoE Nabire	2					
CoE Enarotali and CoE Mulia		2				
CoE Pegunungan Bintang, CoE Fak Fak and CoE Manokwari			3			
Hospitals and puskesmas						
Hospitals	4	4	4	5		
Puskesmas	10	15	20	21	32	22

Training, mentoring, and technical assistance

- Conduct extensive Train the Trainer courses on HIV, CST, TB-HIV, and STIs for CHAI and CoE staff in the first six months; train and establish 21 district training teams in the first 24 months.
- Mentor and conduct training on HIV, TB-HIV, and STIs for eight hospitals and up to 35 puskesmas in year one.
- Train up to seven hospitals as ARV referral hospitals and up to 35 puskesmas as ARV satellite sites in year one.
- Conduct training for up to ten hospitals on TB Hospital DOTS Linkage and TB-HIV, and develop TB-HIV recording and reporting systems in eight hospitals and ten puskesmas in year one.
- Train up to five puskesmas as STI referral clinics for high prevalence populations in year one (in Jayapura, Sorong, Manokwari, and Wamena, brothel and street-based sex workers will be referred into services; in Fak Fak, MSM will be prioritised for these services).
- Strengthen eight hospital laboratories to function as district referral laboratories in year one; train nine puskesmas labs to have functioning STI labs in this same period.

A9.2   Component 2: Supply chain management for HIV-related commodities

Start-up activities in the Papuan provinces include assessment of the current supply chains for TB and STI commodities and identification of potential bottlenecks and mitigation strategies.

- Develop a transition schedule with key milestones, in collaboration with AIDS Sub Directorate, the Global Fund, and AusAID in year one.
- Draft best practice tools and curriculum in year two.

Training, mentoring, and technical assistance

- Conduct assessment, plan, and implement coordination and harmonization activities for TB and STI supply chain systems with PHOs in the Papuan provinces in year one.
- Train up to ten treatment sites in the Papuan provinces in recording, reporting, and inventory management in year one; conduct ongoing mentoring with five sites in the Papuan provinces on onsite management.
- Decentralise ARV management to West Papua as well as two other provinces in year one.
- Nationally, increase timely and accurate reporting up to 75 per cent in year one.
- Nationally, introduce, disseminate and promote the reporting system for HIV rapid tests.
- Develop the road map for the One Gate policy in year one; pilot One Gate activities in the Papuan provinces in year two.

A9.3 Component 3: Policy

Start-up activities include recruiting staff and establishing the Policy Secretariat at AIDS Sub Directorate, forming the expert panel, and developing and disseminating the SOP for evidence-based policy development. CHAI will work with the Secretariat to start implementation of this process with at least one cycle of evidence-based review by the end of year one.

- Establish Secretariat in the first six months, including development of procedures.
- Initiate preparation work to develop panel skills (for example, circulate journal articles, studies, and local data analysis).
- Support the Secretariat to conduct one major policy review in the first year, and two in each subsequent years.
- Support the rollout and promotion of revised guidelines and policies, especially to partners in the Papuan provinces.
- Establish with the Secretariat in year one an 'alert and response' system that can identify policy issues that fall out of the scheduled policy review cycle and can be addressed through a timely, yet systematic approach.

A9.4 Component 4: Operational research and monitoring

The key priority in the first quarter of year one will be to develop the Monitoring Framework, recruit and orient the team, and collect baseline data. In the second quarter, priority will be given to development of the operational research agenda. The program will implement quarterly data collection and analysis activities as well as develop and institutionalise regular discussion for implementation adjustments and feedback mechanisms with key stakeholders.

- Establish monitoring team; develop tools and train team on their usage
- Collect baseline data in the first quarter of year one
- Work with CoE as they roll out to implement strong data collection, embedded within their activities
- Conduct regular, systematic monitoring activities (collect data, analyse, review with program teams and stakeholders)
- Work with programs and other stakeholders to develop indicative research agenda in the first six months
- Begin at least one operational research project in year one

Table 20: REACH Implementation Plan, years 1 – 2

Note: indicators are used whenever possible; process measures are used in some cases. Actual targets and indicators will be determined in the first quarter in collaboration with the AIDS Sub Directorate, PHOs, and AusAID.

Project Ref.	Key Activities	Key Indicators	Y1 Jul - Dec 2012	Y1 Jan - Jun 2013	Y2 Jul - Dec 2013	Y2 Jan - Jun 2014
Component 1	Care, Support & Treatment					
Component 1 objective	To increase the number of Government of Indonesia (GOI) supported health facilities that are well staffed and equipped and providing quality HIV-clinical services in Tanah Papua					
Output 1.1	**Antiretroviral Therapy**: To increase access to antiretroviral therapy (ART) at puskesmas and hospitals in Tanah Papua, and adherence to ART among patients treated.					
1.1.1	**BASELINE DATA:** Collect baseline data from hospitals and puskesmas	Baseline data collected	11 Hospitals + 25 puskesmas	5 Hospitals + 20 puskesmas	21 puskesmas	16 puskesmas
1.1.2	**TRAIN THE TRAINER CST:** TOT CST, IMAI training for CHAI, hospitals, puskesmas and CoE team	# of people trained or # of teams	170 people	32 people	21 districts training teams (5 people for each district)	
		# of districts (kab/kota) with trainer team in place	21		21	
1.1.3	**IN-HOUSE TRAINING:** CST in-house training for 20 hospital staff	# of hospitals trained	4	4	4	4
1.1.4	**MENTORING:** Mentoring and in-house training to puskesmas by CoE, CHAI, hospital and DHO	# of puskesmas that have become satellite for ARV implementation	15	20	21	16
1.1.5	**ARV REFERRAL HOSPITALS:** Help increase number of ARV referral hospitals	# of ARV referral hospitals	3	4	TBA	TBA
1.1.6	**SATELLITE PUSKESMAS:** Help increase number of satellite puskesmas for ARV treatment	# of puskesmas that have become satellite for ARV initiation or follow up	15	20	21	16

Project Ref.	Key Activities	Key Indicators	Y1 Jul - Dec 2012	Y1 Jan - Jun 2013	Y2 Jul - Dec 2013	Y2 Jan - Jun 2014
Output 1.2	**Tuberculosis**: To improve the quality of TB diagnosis and treatment in Tanah Papua					
1.2.1	**BASELINE DATA:** Collect baseline data from hospitals and puskesmas	Baseline data collected	11 Hospital	5 Hospital	21 puskesmas	16 puskesmas
1.2.2	**TRAIN THE TRAINER TB: T**OT for TB and TB/HIV for CHAI, CoE, hospitals team, puskesmas and DHO	# of people trained or # of teams	97 people	21 district teams	-	-
		# of districts (kab/kota) with TB and TB/HIV trainer team in place.		21		
1.2.3	**IN-HOUSE TRAINING:** TB and TB/HIV in-house training for 20 hospital staff	# of hospitals trained	4	4	4	4
1.2.4	**MENTORING:** Mentoring and in-house training to puskesmas by CoE, CHAI hospital and DHO	# of PKM trained	-	20	21	16
1.2.5	**HDL AND TB/HIV HOSPITALS**: Help increase number of HDL (Hospital DOTS Linkage) and TB/HIV hospital	# of HDL and TB/HIV hospital	5	5	-	-
1.2.6	**TB DOT, TB/HIV PKM:** Help increase number of TB DOT and TB/HIV puskesmas	# of TB DOTS and TB/HIV PKM	-	10	21	16
1.2.7	**TB/HIV TESTING:** Implement TB and TB/HIV program in all puskesmas and hospital by offering HIV test to all TB patient and screen TB for all HIV patients and give prompt treatment to people with positive result	# of puskesmas and hospitals implemented TB and TB/HIV program	5 hospitals	5 hospitals/10 puskesmas	25	20
1.2.8	**RECORDING/REPORTING:** Implement TB and TB/HIV recording and reporting system	# of PKM and Hospital implement National TB and TB/HIV RR system	4	4/10 puskesmas	25	20

Project Ref.	Key Activities	Key Indicators	Y1 Jul - Dec 2012	Y1 Jan - Jun 2013	Y2 Jul - Dec 2013	Y2 Jan - Jun 2014
Output 1.3	**Sexually Transmitted Infections**: To reduce sexually transmitted infection (STI) prevalence in high prevalence populations in Tanah Papua					
1.3.1	**BASELINE DATA:** Collect baseline data from hospitals and puskesmas	Baseline data collected	11 Hospital + 5 PKM	5 Hospital + 4 PKM	-	-
1.3.2	**TRAIN THE TRAINER STI:** TOT STI for CHAI, CoE, hospitals team, puskesmas and DHO	# of people trained or # of teams	97	21 district teams	-	-
		# of districts (kab/kota) with STI trainer team in place.		21		
1.3.3	**IN-HOUSE TRAINING:** STI in-house training for 20 hospital staffs	# of hospital trained on STI	-	6	6	-
1.3.4	**MENTORING:** Mentoring and in-house training to puskesmas by CoE, CHAI hospital and DHO	# of PKM/clinic get STI training	-	10	15	15
1.3.5	**STI FOR AT RISK POPULATIONS:** Implement TA program for STI for brothel-based sex workers, street-based sex workers or MSM via puskesmas appointed by DHO/PHO	# of STI PKM / clinic	-	5	4	-
		# of sex workers that receive high quality STI management (including good data management)				
1.3.6	**STI FOR WIDER COMMUNITY:** Implement TA program for wider community by all puskesmas	# of puskesmas implementing program	-	8	5	5
1.3.7	**STI REFERRAL CENTRE:** Strengthen puskesmas/CoE capacity to become STI referral centre for FSW	# of STI referral PKM/clinic	-	5	4	-
1.3.8	**RECORDING/REPORTING:** Implement STI recording and reporting system	# of PKM and Hospital implement STI reporting system	-	8	5	5

Output 1.4	**Laboratories:** To strengthen laboratory capacity to provide HIV, TB and STI related diagnostic testing and monitoring					
1.4.1	**BASELINE DATA:** Collect baseline data from hospitals and puskesmas	Baseline data collected	11 hospitals + 25 puskesmas	5 hospitals + 20 puskesmas	21 puskesmas	16 puskesmas
1.4.2	**ASSESSMENT:** Assessment of lab capacity for HIV, TB, STI in hospitals by BLK	# of hospitals assessed	7	7	-	-
1.4.3	**HOSPITAL LABS:** Strengthen hospital lab to be district referral lab by Lab	# Hospitals with strong lab capacity in 9 COE	4	4	4	4
1.4.4	**PKM LABS:** Set up STI lab in puskesmas referral for STI	# of STI referral puskesmas/clinic	5	4	-	-
1.4.5	**QC PKM:** Conduct QC on puskesmas for STI and TB by hospitals	Error rate in all puskesmas implemented TB, STI is matched with national standard of error rate	implement in 10% of puskesmas		implement in 30% of puskesmas	
1.4.6	**QC HOSPITALS:** Conduct QC for hospitals on STI and TB by BLK	Error rate in hospital is following national error rate	-	5 hospitals	-	4 hospital
1.4.7	**EQAS:** Conduct QC for CD4, VL, EID, PCR CTNG	EQAS conducted for these tests	-	All EQAS completed at CHAI supported sites	-	All EQAS completed at CHAI supported sites
Output 1.5	**Infrastructure:** To strengthen health infrastructure at puskesmas level to support provision of primary health services including HIV-related care, support and treatment					
1.5.1	**ASSESSMENT:** Conduct infrastructure assessment	All COE and prioritized puskesmas assessed	9 COE, prioritized puskesmas sites	-	-	-
1.5.2	**PLAN AND IMPLEMENT:** Building accommodations, electricity, water supply based on assessment	All COE and prioritized PKM	-	5 COE, prioritized puskesmas sites	4 COE, prioritized puskesmas sites	prioritized puskesmas sites

Output 1.6	**Support for Effective Decentralised Systems**: To support policies that increase the efficiency, transparency and sustainability of service delivery in a decentralised health system					
1.6.1	**BASELINE DATA:** Collect baseline data	Baseline data collected	2 provinces/7 districts	6 districts	-	-
1.6.2	**CST PANEL:** Create CST Panel in each province	Papua & West Papua Province has CST Panel team	2	4	4	3
1.6.3	**CST WORKING GROUP:** Create and Support CST working group in provinces and districts	# of active CST Working group in each Province & District (kab/kota)	2 provinces	3 districts	3 districts	3 districts
1.6.4	**LOCAL POLICY ADVOCACY:** Review and provide advocacy on change/adjustment of HIV and HIV-related policy based on data supplied by data management team	Establish HIV and HIV-related policy in each province & district (at PHO, DHO as well as KPAP and KPAK level), such as RENSTRA or other implementing policies (PITC, PMTCT, STI, TB, TB/HIV)	2	4	4	3
1.6.5	**LOCAL POLICY CHANGE:** Policy adjustment based on data and recommendation	# of HIV & HIV-related policy (approved by the Local Government and resulted in PERDA HIV with IMS based on panel team recommendation)	2	4	4	3
1.6.6	**PROMOTION:** Socialization and implementation of the new policy to all districts	# of province and district socialize and implement the new policy	2	4	4	3
1.6.7	**ANALYSIS:** Analysis of the new implementation policy by the panel team	# of policy analysed by the panel team based on data	-	-	2	4

Output 1.7	**Medical Waste Management:** To strengthen safe management of infectious medical waste in Tanah Papua					
1.7.1	**ASSESSMENT:** Conduct medical waste management assessment in collaboration with infrastructure assessment (see 1.5)	All COE and prioritized PKM assessed	9 COE, prioritized puskesmas sites	-	-	-
1.7.2	**PLAN AND IMPLEMENT:** Develop medical waste plan based on assessment and implement in collaboration with infrastructure assessment (see 1.5)	All COE and prioritized PKM	-	5 COE, prioritized puskesmas sites	4 COE, prioritized puskesmas sites	prioritized puskesmas sites
Component 2	**Supply Chain Management For HIV Commodities**					
Component 2 objective	To decrease stock outs and increase efficiency of strengthened supply chain management of HIV-related commodities					
Output 2.1	**Provincial Level**: To strengthen supply chain management systems for HIV-related commodities in Tanah Papua					
2.1.1	**BASELINE DATA:** Collect baseline data	Baseline data collected	2 provinces	-	-	-
2.1.2	**PROVINCIAL ASSESSMENT:** Logistic need assessment for TB and STI supply chains	The logistic estimation	2 provinces	-	-	-
2.1.3	**COLLABORATE:** Work with PHO and DHO to improve coordination	% of hospitals sending accurate and on time HIV reporting	-	30%	40%	50%
		# of puskesmas and hospitals sending accurate and on time TB/STI reporting				
2.1.4	**TRAIN AND MENTOR:** Work with sites on quantification, storage, inventory management	% of treatment sites which have never experienced stock outs of STI meds and lab reagents	-	30%	40%	50%

		% of treatment site which have never experienced stock outs of TB meds and lab reagents				
		% of treatment site which have never experienced stock outs of HIV meds and lab reagents				
Output 2.2	**National Level:** To strengthen national and decentralised supply chain management systems for HIV-related commodities					
2.2.1	**Transition Planning**					
2.2.1.1	**DEVELOP SCHEDULE:** Create phased transition schedule in collaboration with MoH and GFATM	plan and schedule developed	x	-	-	-
2.2.1.2	**DOCUMENT MODELS:** Develop best practice tools and curriculum for SCM absorption into GoI	Drafts of best practice tools and curriculum	-	-	-	x
2.2.1.3	**GOI ABSORPTION:** Ongoing planning and trainings with GoI on the transitions by 2016	Quarterly meetings to plan transition and develop necessary trainings	x	x	x	x
2.2.2	**Decentralisation of ARV and management rapid test storage and distribution**					
2.2.2.1	**DECENTRALISATION ARV:** Implement the decentralized ARV system in new 12 Provinces	# of province implement decentralization of ARV	1	2	2	1
2.2.2.2	**DECENTRALISATION TESTS:** Implement the decentralized rapid test management in new 14 provinces	# of province implement rapid test management	2	2	2	2
2.2.3	**Decentralisation in Tanah Papua**					
2.2.3.1	**DECENTRALIZATION TANAH PAPUA:** Decentralization of SCM capacity building for HIV-related commodities in Tanah Papua	# of provinces	-	1 province (West Papua)	-	-

2.2.3.2	**PROVINCIAL ASSESSMENT:** Logistic need assessment for supply chain	Assessments completed	2 provinces	-	-	-
2.2.3.3	**DISTRICT ASSESSMENT:** Assessment and Gap Analysis at district level	# of assessment conducted and result available	2	2	3	3
2.2.3.4	**CURRICULUM DEVELOPMENT:** Adjustment & modification of SOP and develop training curricula.	Training curricula available	-	Yes	Yes	Yes
		SOP available	Yes	-	-	-
		SCM tools and standard forms available	-	Yes	-	-
2.2.3.5	**TRAINING:** SOP Training and Go Live Simulation	# of treatment site trained	-	10	15	15
2.2.3.6	**KPI:** Set up SCM KPI Measurement	KPI SCM measurement established	-	Yes	-	-
2.2.3.7	**MENTORING:** Supervise and mentoring of SCM implementation	# of treatment sites implement the SOP	-	5	10	10
		% of SCM KPI's being met	-	TBA	TBA	TBA
2.2.3.8	**FORECASTING:** Forecasting and quantification for HIV-Related commodities (ARV, Reagents, Rapid Test, CD4, IO dan IMS, TB)	# of provinces/districts trained in forecasting	2 provinces	5 district	5 district	5 district
2.2.3.9	**REPORTING TRAINING:** SCM Reporting System and Training for TB, STI, PMTCT	# of hospitals and puskesmas trained	-	9 hospitals/10 puskesmas	15 puskesmas	20 puskesmas
2.2.3.10	**REPORTING:** Timely & accuracy treatment site report for TB, STI, PMTCT	% of site submitting ARV report on time & accurately	-	TBA	TBA	TBA

2.2.4	**National Forecasting**					
2.2.4.1	**FORECASTING:** Forecasting and quantification for HIV-Related commodities (ARV, Reagen Rapid Test, CD4, IO dan IMS)	Established forecasting and quantification tool at national level for IO, IMS, Rapid Test and ARV	ongoing	ongoing	ongoing	ongoing
2.2.5	**National SCM Reporting System and Training**					
2.2.5.1	**REPORTS: T**imely & accuracy treatment site report for ARV	% of site submitting ARV report on time & accurately	0.7	0.75	0.8	0.9
		Patient coverage : % of patients who are treated by a site that reported on time and accurate	0.45	0.55	0.6	0.65
2.2.5.2	**PROMOTION:** Introduce and socialize reporting system for HIV rapid test, as well as STI and TB	% of site submitting quarterly report on Tool and Material on time & accurately	TBA	TBA	TBA	TBA
		# of decentralized provinces following national testing algorithm for reagents, rapid test consumption	TBA	TBA	TBA	TBA
2.2.5.3	**SATELLITE:** To establish satellite system (in order to make access to ARV drug closer to people)	Establish SOP for satellite management	x	-	-	-
		# of satellite for ARV treatment.	-	TBA	TBA	TBA
2.2.6	**National Inventory Order Management System**					
2.2.6.1	**IOMS**: To improve and utilize online inventory order management system	% of site using online reporting system	TBA	TBA	TBA	TBA

2.2.6.2	**SYNCHRONIZATION:** To synchronize inventory order management system with other reporting system and 3rd party system	Number of decentralized provinces using online order and inventory management system	TBA, but including both provinces in Tanah Papua	TBA	TBA	TBA
2.2.7	**ARV Inventory Management**					
	NATIONAL ARV MANAGEMENT: To support AIDS Sub Directorate to manage ARV supply at national warehouse	Value of expired ARV formulations as % of total value of HIV-related commodities in national warehouse	TBA	TBA	TBA	TBA
	TREATMENT SITE MANAGEMENT: To decrease stock outs at site levels	% of treatment site have experience ARV stock out	TBA	TBA	TBA	TBA
2.2.8	**SCM activities** and process quality management					
2.2.8.1	**KPI REVIEW PROCESS:** To support the AIDS Sub Directorate to implement a KPI review process to achieve supply chain targets	% of SCM KPI's being met and monitored by the AIDS Sub Directorate	TBA	TBA	TBA	TBA
2.2.8.2	**COMMUNICATION:** To reduce SCM communication disruption between national, province and treatment site for all stakeholders	Regular information disseminated re - stock of ARVs (both adult and paeds, IMS reagents and meds, and meds from national, province and district)	-	nationally distributed	nationally distributed	nationally distributed
		% of treatment sites following national HIV/STI guideline	-	30%	-	40%
Output 2.3	**One Gate**: To support the medium to long-term shift of incorporating supply chain management of HIV-related commodities within the national one gate policy					
2.3.1	**PTD:** Support policy and standard development of One Gate Policy and initiative People that Deliver (PtD) in national level	Policy and standard documented and socialized	-	-	Established Policy	-

2.3.2	**ONE GATE IN TANAH PAPUA:** Piloting One Gate Policy standard in Tanah Papua	Pilot initiated	-	-	-	Pilot initiated
2.3.3	**ONE GATE SOP:** Develop and implement SOP for SCM at provincial and district level in Papua	Established SOP standard for storage, order processing and distribution system at Provincial and District level	-	-	Established	-
		% of districts submitting SCM/logistics report on time & accurately	-	-	-	50%
2.3.4	**PHO AND DHO:** Develop and implement method for HIV-related commodities management in Papua	% of PHO and DHO have established standardized planning method for HIV-related commodities	-	-	-	50%
Component 3	**Policy**					
Component 3 objective	To implement an evidence based MoH national policy framework relevant to HIV-related care, support & treatment					
Output 3.1	**National Level Policy**: To strengthen the national policy framework relevant to HIV-related care, support and treatment					
3.1.1	**SECRETARIAT:** Establish Policy Secretariat at AIDS Sub Directorate; hire staff; develop processes	Secretariat established	x	-	-	-
3.1.2	**PRIORITIZE POLICIES:** Develop policy priorities with AIDS Sub Directorate	# of prioritized guidelines completed	x	x	-	-
3.1.3	**EVIDENCE BASED PANELS:** Conduct review panels through evidence based process	# of review meetings	-	x	x	x
3.1.4	**DISSEMINATION:** Work with Sub Directorate to plan and execute dissemination of approved policies and guidelines	# of policies disseminated	-	1	1	1

3.1.5	**CST POLICY ADVOCACY:** Provide evidence based advocacy on change or adjustment of the national policy from expert panel from provincial level to national level	# of revision on CST national policy	-	TBA	-	TBA
3.1.6	**PROVINCIAL ADVOCACY:** Help assure that national policy is able to respond to the provincial policy specific needs and conditions	# of provincial expert team becomes member of the national expert team	-	TBA	TBA	TBA
Component 4	**Operational Research**					
Component 4 objective	To generate and apply knowledge that contributes to achieving the program goal of increasing access to high quality HIV-related treatment in Tanah Papua					
Output 4.1	**Embedded Research**: To undertake embedded research that generates reliable knowledge with the potential to contributes to program goal					
4.1.1	**INDICATIVE RESEARCH AGENDA**: Develop research agenda with stakeholders	agenda developed	x	-	-	-
4.1.2	**SET UP:** Develop and prepare for launch of prioritized research area	Process and tools developed, staff trained	x	x	x	-
4.1.3	**LAUNCH:** Implement research	Research initiated		At least 1 research question	-	At least 1 research question
Output 4.2	**Local Engagement**: To increase use of operational research data to achieve program goals					
4.1.1	**DATA SYSTEM:** Create data collection system from puskesmas and hospitals	# site with established data collection system	Each CoE, puskesmas as they become established	Each CoE, puskesmas as they become established	all 9 CoE, prioritized puskesmas as they become established	puskesmas as they become established
4.1.2	**ANALYSIS:** Entry and analyse data at CoE level together with the DHO	Data collected and analysed, discussed with DHO	ongoing	ongoing	ongoing	ongoing
4.1.3	**CoE:** Monthly meeting at CoE level	Meetings conducted, minutes taken	6	6	6	6
4.1.4	**PROVINCE:** Quarterly provincial level meetings. Deeper data analysis at DHO or PHO level by data analyst and local panel expert	Meetings conducted, minutes taken	2	2	2	2

	TANAH PAPUA AND NATIONAL: Semi-annual Tanah Papua meetings; annual national meetings	Meetings conducted, minutes taken	1	1, 1	1	1, 1
4.1.5	**PROGRAM ADJUSTMENTS:** Provide recommendation for policy development and program adjustment	Quarterly adjusted work plans	2	2	2	2

113

Annex 10:   Budget

The four year total budget is A$24,990,417. The budget is presented in three tables below:

- Year one budget by line item (Table 21)
- Year one budget by program component (Table 22)
- Four year budget by line item (Table 23)

A10.1   Methodology

A two pronged approach was taken to development of the budget. Firstly, a review of program spending under CHAI Phase II from 2010 – 2012 was conducted. This included:

- Approved program budgets for 2010-2012
- Summary of accounts statements from 2011 detailing level of spending in major categories
- Review of program component spending with program managers.

Secondly, program managers provided costing on expected expenses related to program scale up and these were analysed and further refined.

Table 21: REACH year one budget

MASTER BUDGET	Year 1 July1'12-Jun30'13
Salary Employees	1,210,794
Payroll Tax	115,035
Health Insurance	112,133
Retirement	15,222
Subtotal: Salary and Benefits	**1,453,185**
Consultant	160,000
Lab & Diagnostic Supplies	-
Care Partner	1,063,778
Meeting & Training	2,283,229
Operational	
Insurance	8,000
IT Support	130,222
Office Equipment (Incl. Computers)	121,277
Office Furniture	114,500
Office Supplies	102,633
Telecommunications Expense	99,100
Rent/Lease Expense	68,667
Buildings Repairs & Maintenance	23,000
Security	49,500
Vehicle Repair and Maintenance	35,733
Capital Charges	202,778
Utilities	65,400
Staff Airfare/Extended Rail	372,000
Subtotal: Program & Operational cost	**4,899,818**
Rent/Lease Expense	34,000
Bank Charges	2,000
Printing	9,300
Postage/Courier	2,500
Staff Airfare/Extended Rail	60,000
Staff Lodging	20,000
Staff Meals	6,000
Car Service-Taxi-Local Transport-Fuel	62,630
Subtotal: Local Overhead	**196,430**
TOTAL CHAI INDONESIA PROGRAM	**6,549,433**
12% Global Allocation	785,932
Total Budget	**7,335,365**

Table 22: REACH year one budget by program component

MASTER BUDGET	CARE, SUPPORT & TREATMENT 72%	SUPPLY CHAIN MGMT 12%	POLICY 6%	OPERATIONAL RESEARCH & MONITORING 10%
Salary Employees	871,772	145,295	72,648	121,079
Payroll Tax	82,825	13,804	6,902	11,504
Health Insurance	80,736	13,456	6,728	11,213
SOS Insurance	-	-	-	-
Retirement	10,960	1,827	913	1,522
Subtotal: Salary and Benefits	**1,046,293**	**174,382**	**87,191**	**145,318**
Consultant	115,200	19,200	9,600	16,000
Lab & Diagnostic Supplies	-	-	-	-
Care Partner	1,063,778	-		-
Meeting & Training	1,643,925	273,988	136,994	228,323
Operational				
Insurance	5,760	960	480	800
IT Support	93,760	15,627	7,813	13,022
Office Equipment (Incl. Computers)	87,320	14,553	7,277	12,128
Office Furniture	82,440	13,740	6,870	11,450
Office Supplies	73,896	12,316	6,158	10,263
Telecommunications Expense	71,352	11,892	5,946	9,910
Rent/Lease Expense	49,440	8,240	4,120	6,867
Buildings Repairs & Maintenance	16,560	2,760	1,380	2,300
Security	35,640	5,940	2,970	4,950
Vehicle Repair and Maintenance	25,728	4,288	2,144	3,573
Capital Charges	146,000	24,333	12,167	20,278
Utilities	47,088	7,848	3,924	6,540
Staff Airfare/Extended Rail	267,840	44,640	22,320	37,200
Subtotal: Program & Operational Cost	**3,825,727**	**460,325**	**230,162**	**383,604**
Rent/Lease Expense	24,480	4,080	2,040	3,400
Bank Charges	1,440	240	120	200
Printing	6,696	1,116	558	930
Postage/Courier	1,800	300	150	250
Staff Airfare/Extended Rail	43,200	7,200	3,600	6,000
Staff Lodging	14,400	2,400	1,200	2,000
Staff Meals	4,320	720	360	600
Car Service-Taxi-Local Transport-Fuel	45,094	7,516	3,758	6,263
Subtotal: Local Overhead	**141,430**	**23,572**	**11,786**	**19,643**
TOTAL CHAI INDONESIA PROGRAM	5,013,449	658,279	329,139	548,565
12% Global Allocation	601,614	78,993	39,497	65,828
Total Budget	**5,615,063**	**737,272**	**368,636**	**614,393**
Grand Total Year 1 Budget:				**7,335,365**

115

Table 23: REACH budget July 2012 – June 2016

MASTER BUDGET	Year 1 July1'12-Jun30'13	Year 2 July1'13-Jun30'14	Year 3 July1'14-Jun30'15	Year 4 July1'15-Jun30'16	Average 2012-2016
Salary Employees	1,210,794	1,331,874	1,465,061	1,582,266	1,397,499
Payroll Tax	115,035	126,539	139,193	153,112	133,470
Health Insurance	112,133	123,347	135,681	149,249	130,103
Retirement	15,222	15,222	15,222	15,222	15,222
Subtotal: Salary and Benefits	**1,453,185**	**1,596,981**	**1,755,157**	**1,899,849**	**1,676,293**
Consultant	160,000	169,600	179,776	190,563	174,985
Lab & Diagnostic Supplies	-	-	-	-	-
Care Partner	1,063,778	1,063,778	1,063,778		1,063,778
Meeting & Training	2,283,229	1,435,545	1,635,545	1,483,545	1,709,466
Operational					
Insurance	8,000	8,480	8,989	9,528	8,749
IT Support	130,222	7,333	8,100	8,900	38,639
Office Equipment (Incl. Computers)	121,277	1,500	2,000	2,000	31,694
Office Furniture	114,500	-	-	-	28,625
Office Supplies	102,633	108,791	115,319	122,238	112,245
Telecommunications Expense	99,100	105,046	111,349	118,030	108,381
Rent/Lease Expense	68,667	72,787	77,154	81,783	75,098
Buildings Repairs & Maintenance	23,000	10,000	10,000	10,000	13,250
Security	49,500	25,400	25,400	25,400	31,425
Vehicle Repair and Maintenance	35,733	34,000	34,000	34,000	34,433
Capital Charges	202,778	-	-	-	50,694
Utilities	65,400	65,400	65,400	65,400	65,400
Staff Airfare/Extended Rail	372,000	394,320	417,979	443,058	406,839
Subtotal: Program & Operational cost	**4,899,818**	**3,501,980**	**3,754,788**	**2,594,444**	**3,687,758**
Rent/Lease Expense	34,000	36,040	38,202	40,495	37,184
Bank Charges	2,000	2,000	2,120	2,247	2,092
Printing	9,300	9,300	9,858	10,449	9,727
Postage/Courier	2,500	2,500	2,650	2,809	2,615
Staff Airfare/Extended Rail	60,000	63,600	67,416	71,461	65,619
Staff Lodging	20,000	21,200	22,472	23,820	21,873
Staff Meals	6,000	6,360	6,742	7,146	6,562
Car Service-Taxi-Local Transport-Fuel	62,630	66,388	70,371	74,593	68,496
Subtotal: Local Overhead	**196,430**	**207,388**	**219,831**	**233,021**	**214,167**
TOTAL CHAI INDONESIA PROGRAM	**6,549,433**	**5,306,349**	**5,729,776**	**4,727,314**	**5,578,218**
12% Global Allocation	785,932	636,762	687,573	567,278	669,386
Total Budget	**7,335,365**	**5,943,111**	**6,417,349**	**5,294,592**	**6,247,604**
Grand Total Four Year Budget:				**24,990,417**	

A10.2   Expansion of REACH in the Papuan provinces

The year one budget for REACH is A$7,335,364. This budget includes nearly A$1.3 million in expenses associated with program start up, including one-time staff training and capital purchases. Some examples of these costs are HIV, CST, IMAI, and TB-HIV trainings for new staff, vehicles for program implementation, and minor office renovations for the new sites. Budgets for subsequent years are lower. The average yearly budget for REACH is A$6,247,604.

This A$4.35 million increase in annual expenditure compared to CHAI Phase II (approximately A$1.9 million for the current year) reflects the major expansion of the program that has been requested by the GoI.

Additional funding is detailed below (these are average yearly costs):

- Operational costs of nine CoE: A$0.16 million
- Expansion of CST in Papua and West Papua Provinces through new care partnerships with the PHOs to fund 76 national staff for program implementation: A$1.06 million
- Training for staff at all sites and expanded program activities: A$1.17 million
- Salaries for seconded positions for the Policy Secretariat and for the PHOs: A$.85 million
- Salaries for new CHAI positions for program expansion: A$1 million.

Scale up of work has associated costs that will escalate over time. For example, more sites providing CD4 testing will require more training and mentoring of healthcare workers. Transportation and logistics are significant portions of the training line item and will increase as the program in subsequent years travels to farther, more remote districts to provide technical support and mentoring. Note that without an increase in the base award, program budgets must be lowered over time. For example, if six per cent of the budget needs to be spent to meet increased cost of salaries and operational expenses then that means a six per cent reduction in available funds for program activities.

Despite the increasingly high cost of operating in the eastern most provinces of Indonesia, the budget for REACH has managed to keep overhead costs to a minimum and to maximize available resources for programming. Figure 5 below illustrates how the REACH budget breaks down by expense categories, with 59 per cent of the funds allocated for programs expenditure. If salaries and benefits for staff working on CST programming were included, the proportion of funds going to programs would even be higher.

Figure 5: REACH four year budget by expense category
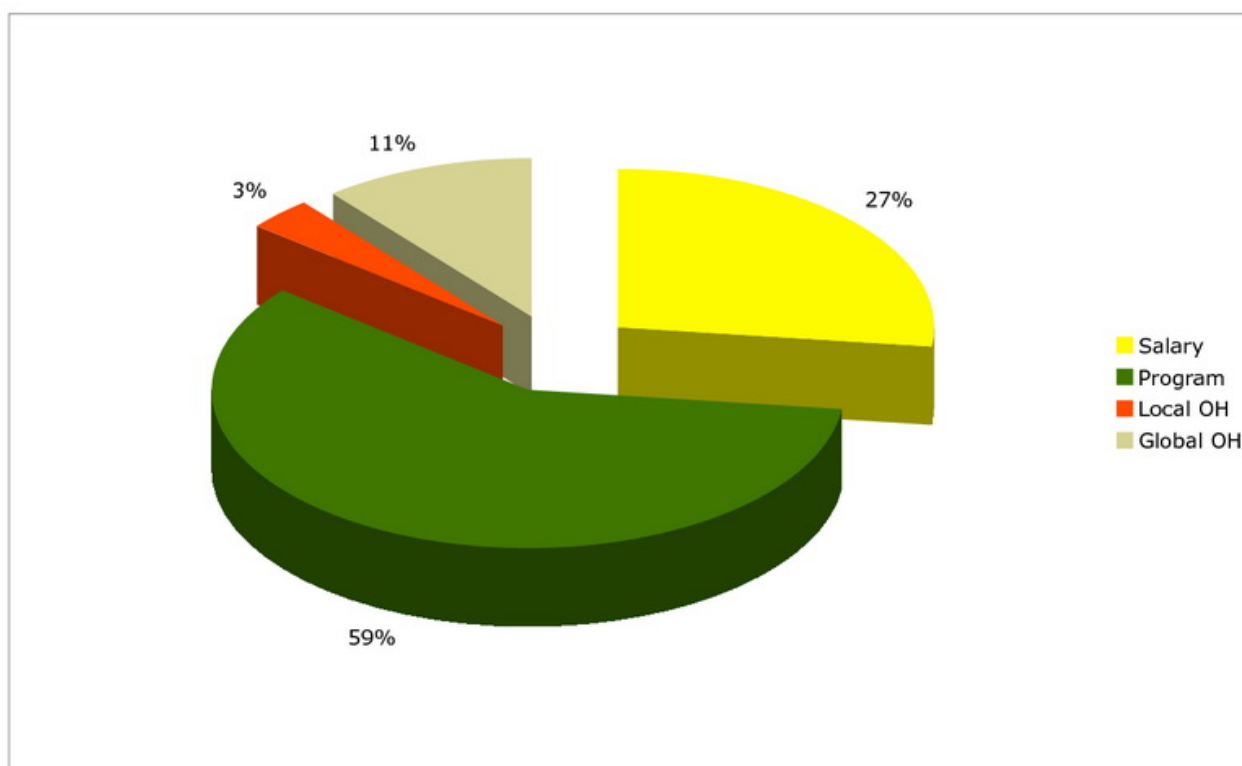
Figure 6 shows the proportion of the total program budget that is allocated to the four program components. CST in the Papuan provinces constitutes 78 per cent of the program budget. SCM is nine per cent, Operational Research & Monitoring is eight per cent, and Policy five per cent. Each of these program budgets will support CST work in the Papuan provinces as well as national-level activities.

Figure 6: REACH four year budget by program component
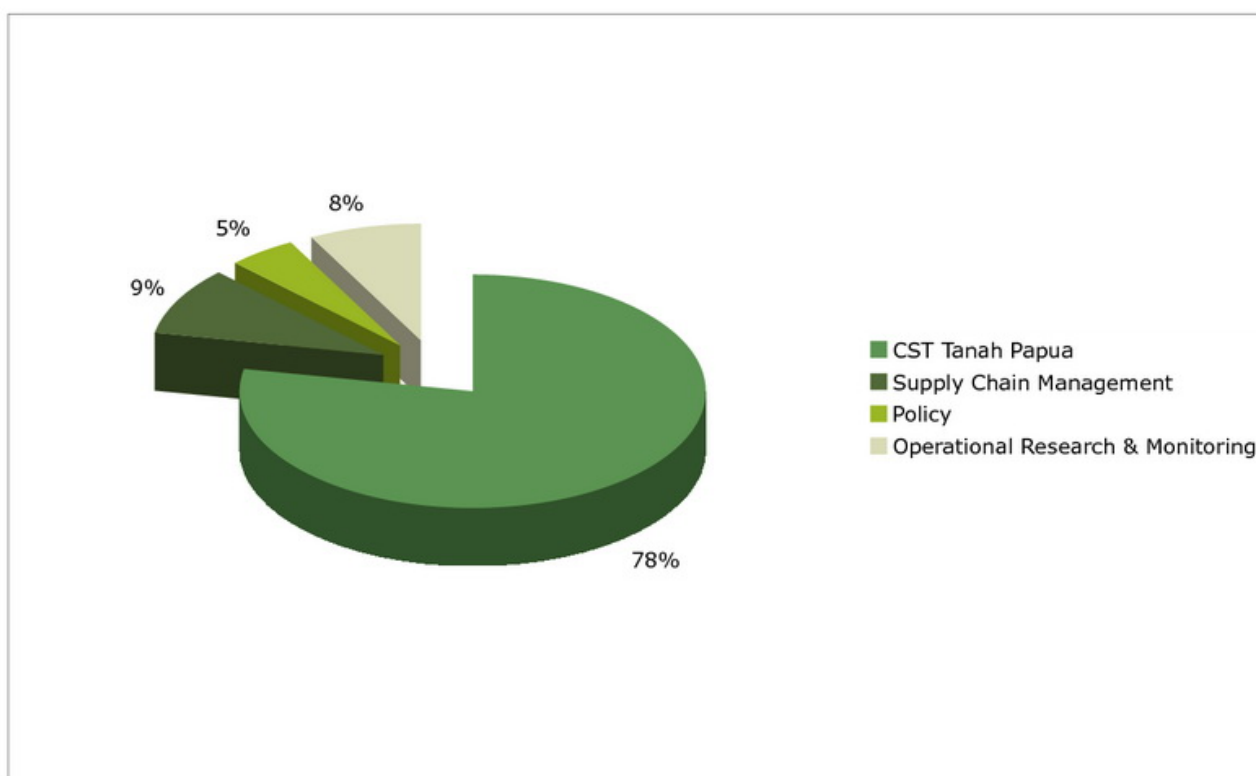
A10.3   Salaries and benefits

Salaries and benefits represent 27 per cent of the total budget. This provides funding for a team of two in-country expatriates, 55 national staff, and portions of regional staff salaries. Salaries for CoE staff are listed under Care Partners, (see *Care Partners* below).

Salaries for CHAI Indonesia staff (57 positions - 57 full-time equivalent) and to cover the cost of technical support from CHAI's regional office (4 positions - 1 full-time equivalent) average A$1.39 million per annum[66]. (See Annex 12 for a full outline of CHAI staffing for REACH).

All salaries and benefits are within standard CHAI's international and national salary ranges.

A10.4   Program

Program expenses (A$3.68 million) account for 59 per cent of the total budget. This is used to provide technical, programmatic, and operational support within:

Papua and West Papua provinces

- Six CoE in Papua Province, based in provincial and district hospitals
- Three CoE in West Papua Province, based in provincial and district hospitals

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[66] All amounts are average yearly costs for 2012-2016

- An additional 11 hospitals in Papua and West Papua
- Provincial and District Health offices
- Provincial and District AIDS Commissions
- West Papua Provincial Warehouse

National

- The MoH's AIDS Sub Directorate
- The MoH's Pharmaceutical Directorate
- Additional technical support to the National AIDS Commission as requested.

The program expenses budget will also pay for the implementation of a range of activities associated with district level scale up, quality assurance, trainings, meeting support, curriculum development and facilitation, on-site mentoring visits, and ongoing monitoring. Printing, postage, IT, program related travel and telecommunications costs are included. Significant expense line items (consultants, care partners, meetings & trainings, and operational) in this category are detailed below[67]:

Consultants

Short-term consultant costs totals A$0.17 million, which includes costs for legal and accounting services, tax filing, as well as visa and work permit filing for international staff, and consulting expenses for operational research, strategic planning, technologies for rural sites, and other CST technical support not available within CHAI's team.

Care partners

CHAI will be contracting with the PHOs as 'Care Partners' in Papua and West Papua to support 76 local staff positions for the nine CoE. These teams will include a range of clinical and technical expertise, including doctors, nurses, midwives, laboratory technicians, data clerks, communications officers, and administrative assistants.

Current civil servant salaries are inadequate to attract and keep potential candidates for these CoE positions. CHAI will work with the provinces to hire staff at GoI contract employee (PTT) rates which are above civil service salary rates. All of these local positions are budgeted within standard GoI salary ranges as defined within the government PTT employment guidelines. The agreements with provinces will only cover salary and benefits as well as administrative and human resource costs for the PHOs to manage these contracts. CoE-related meetings and trainings costs are captured in the meetings and training line item budget.

Care Partners totals are budgeted at A$1.63 million each year for years one to three. In year four, the provinces will be assuming responsibility for these care partner costs.

Meetings & trainings

This area covers all costs associated with programmatic meetings, trainings, ongoing mentoring and technical assistance activities, including travel, accommodation, travel allowances, training materials, and other related costs (A$1.71 million).

Meetings and trainings for CST include:

- Monthly clinical mentoring to health facilities - A$0.27 million
- Monthly data analysis meetings - A$0.08 million

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[67] There are no laboratory and diagnostic supplies in this budget. All these costs have been included in transition funding for the duration of the four year program. Procurement through the national supply chain system for additional laboratory commodities will be utilized as needed.

- Monthly CHAI/CoE/hospital/PHO working group meetings - A$0.17 million
- Laboratory quality control activities - A$0.09 million
- Laboratory capacity building at health facilities - A$0.19 million
- Quarterly and semi-annual planning meetings - A$0.21 million
- Annual ASHM training and short-course - A$0.09 million

Training costs for CST service decentralization will be shared between CHAI and the CoE hospitals. While most expenses have been captured, CoE hospitals will provide hospital staff time to mentor satellite health facility staff on an ongoing basis, as well as other programmatic in-kind donations.

Supply chain management activities include:

- Training and onsite support in the Papuan provinces - A$0.05 million
- Assessment of supply chain for other HIV-related commodities in the Papuan provinces - A$0.04 million
- Training in HIV rapid test and supply chain - A$0.05 million
- Training and setup of inventory management systems for other provinces - A$0.03 million
- Decentralization of ARV supply management training to provinces - A$0.01 million

For policy support to the MoH meetings and trainings include annual expert panel meetings for evidence-based guidelines review and meetings and trainings to disseminate policies. Operational research and monitoring activities include quarterly and semi-annual meetings with stakeholders to discuss data analysis and program progress.

Operational

Operational costs are captured under the program category as they directly support program implementation. Office equipment, office furniture, telecommunications, rent, capital charges, and staff airfares are some of the significant expense categories.

Office Equipment (including computers): This includes computers for new staff as well as netbooks for CoE staff. This also includes other equipment for the new CHAI offices and CoE offices. Most of these purchases will be in year 1 (A$0.12 million).

Office Furniture: Includes furniture for the nine CoE or CHAI offices. Most of these purchases will be in year 1 (A$114,500).

Telecommunications: Includes mobile phone costs for all CHAI staff, landlines and VSAT setup and monthly service CoE and CHAI offices. This also covers satellite phones for communications coverage in remote areas. Total telecommunications is A$0.11 million.

Rent: Total rent is A$0.08 million. Besides the Jakarta national office and the two regional offices in Jayapura and Sorong, CHAI will maintain only two other fully equipped offices (in Jayawijaya and Nabire). In the other five sites CHAI will be working out of the CoE sites or DHOs. CHAI will pay for some of the related costs (see office equipment, furniture, and supplies) but will not be paying for lease expenses.

Security: Security costs A$0.03 million.

Capital costs: A total of five utility vehicles and nine motorbikes will be purchased to support the ongoing clinical mentoring, technical assistance, and training activities by the CoE. Total capital charges are A$0.2 million.

Staff airfares: This amount of A$0.4 million includes travel for staff meetings, regional meetings, on boarding deployment and end-of-contract repatriation, annual leave and other travel not covered under meetings & trainings.

A10.9   CHAI local overhead

Key to CHAI's philosophy is keeping in-country overhead expenses to a minimum and to maximize allocation of resources to programming. The REACH budget has managed to keep in-country overhead relatively low: at three per cent (A$0.2 million). Office, staff travel and local transportation costs account for 80 per cent of this budget category. A majority of CHAI's offices in Tanah Papua are housed within government agencies and institutions at the provincial, district, or facility levels. This assist with maintaining low overhead costs and also reinforces CHAI's approach of serving in alignment with efforts of GoI. Significant expense line items in this category are detailed below:

Office: In Jakarta – the office is calculated per annum at A$0.03 million.

Staff airfares: This covers staff airfares for the two annual planning meetings.

Staff lodging: This covers staff lodging for the planning meetings.

Local transport: This covers a portion of staff local travel (30 per cent) in Jakarta and the Papuan provinces. Other local transport expenses are charged to programs.

A10.10   CHAI Global

Twelve per cent of the budget (A$0.66 million) will be allocated to CHAI's United States head office for administration, finance, accounting and human resources. This rate is standard across the countries were CHAI works and has been agreed to between AusAID and CHAI for the Phase II program. A portion of this amount helps support technical assistance by CHAI's Global Program through the Global Paediatrics Team, the Drug Access Program which works to lower ARV prices globally, the Procurement Program which handles international commodity purchase ordering and the Laboratory Services Program which provides technical assistance, particularly in the areas of early infant diagnosis, viral load, and point of care technologies and lowers diagnostic costs globally.

Annex 11: Roles and responsibilities and key relationship flowchart

Table 24: Key roles and responsibilities of AusAID, CHAI and partners by REACH program component

Organisation	Program component				
	CST	SCM	Policy support	Operational research	Cross-cutting
AusAID Health Unit					Co-convening of AIPH PCC and the AIPH PSCs. Program monitoring. Facilitating coordination with other AusAID programs and other donor programs. Policy interface with MoH.
AusAID Infrastructure Unit	Technical oversight of the infrastructure sub-design and contractor.				
CHAI	Assisting PHOs to establish CoE and ongoing technical support to CoE. Joint training and mentoring of health services with CoE staff. Advocacy and assistance to PHOs and DHOs with planning and budgeting. Reporting to AIPH Provincial Steering Committees and involvement with the Provincial Health Donor Implementing Agency Coordination Groups.	Technical support on SCM to the AIDS Sub Directorate, PHOs and DHOs. Development of a transition plan for exit of SCM technical assistance.	Establishment of the Policy Secretariat in the AIDS Sub Directorate. Technical support for the Policy Secretariat. Technical input to expert panels reviewing and developing policies. Development of a transition plan for handover of this work to the AIDS Sub Directorate.	Development of a research agenda with local stakeholders. Leverage of non-AusAID funds for research. Assist PHOs, DHOs and the Sub Directorate in the collection, analysis and dissemination of data and application for program improvement. Dialogue with AIDS Sub Directorate on national policy and program implications of operational research findings.	Reporting to AusAID and the AIPH PCC and PSCs. Program management. Assist PHOs, DHOs and the Sub Directorate in the collection, analysis of monitoring data and application of findings. Liaison and coordination with all partners

	Program component				
Organisation	CST	SCM	Policy support	Operational research	Cross-cutting
Ministry of Health	Setting overarching policy and programmatic directions. Program monitoring.	Management of national and decentralised SCM systems. Supply of STI reagents and drugs Coordination with the TB Sub Directorate on diagnostics and potential increased drug demand with REACH implementation	Management of the Policy Secretariat. Approval for national HIV CST clinical policies and guidelines.	Application of operational research findings to national policies and programs.	Program monitoring. Senior level participation in the AIPH PCC and PSCs. Coordination with National AIDS Commission and Provincial and District AIDS Commissions. Surveillance
National AIDS Commission				Consideration of the national implications of operational research findings	Co-Convenor of the AIPH PCC Coordination with the MoH and Provincial and District AIDS Commissions
Provincial Health Offices	Planning and funding of HIV CST services. Monitoring and supervision of DHOs. Convening & secretariat for Provincial Health Donor Implementing Agency Coordination Groups. Funding CoE from year 4.	Management of decentralised SCM systems.	Setting provincial policies. Implementation of national policies and guidelines.	Approval of operational research proposals. Participation in operational research. Application of findings.	Co-convening AIPH Provincial Steering Committees Program monitoring. Coordination with Provincial and District AIDS Commissions. STI surveillance for program management
District Health Offices	Planning and provision of HIV CST services, including adequate budget provision.	Management of decentralised SCM systems	Setting local policies. Implementation of national policies and guidelines.	Approval of operational research proposals. Participation in operational research. Application of findings.	Program monitoring. Coordination with Provincial and District AIDS Commissions.
Provincial and District AIDS Commissions (Papua and West Papua provinces)				Consideration of the implications of operational research findings	Co-convening of the AIPH Provincial Steering Committees (PSC) Membership of the Provincial Health Donor Implementing Agencies Coordinating Groups Coordination with MoH, PHOs and DHOs

	Program component				
Organisation	CST	SCM	Policy support	Operational research	Cross-cutting
Donor implementing agencies	Demand creation for HIV testing and treatment. One-to-one collaboration with CHAI. Participation in Provincial Health Donor Implementing Agency Coordination Groups.				Coordination with Provincial and District AIDS Commissions.
Civil society organisations	Demand creation for HIV testing and treatment. Collaboration with CHAI. Patient support. Community mobilisation.	Monitor stock outs			Coordination with Provincial and District AIDS Commissions.

Figure 7: Key relationships flowchart

REACH Tanah Papua will:

create **9 Centres of Excellence**

throughout **2 provinces** (Papua, West Papua)

in **21 districts** (out of 40 total districts)

training **120 puskesmas** (out of 443 total in Tanah Papua)

to provide care, support & treatment for people living with HIV/AIDS
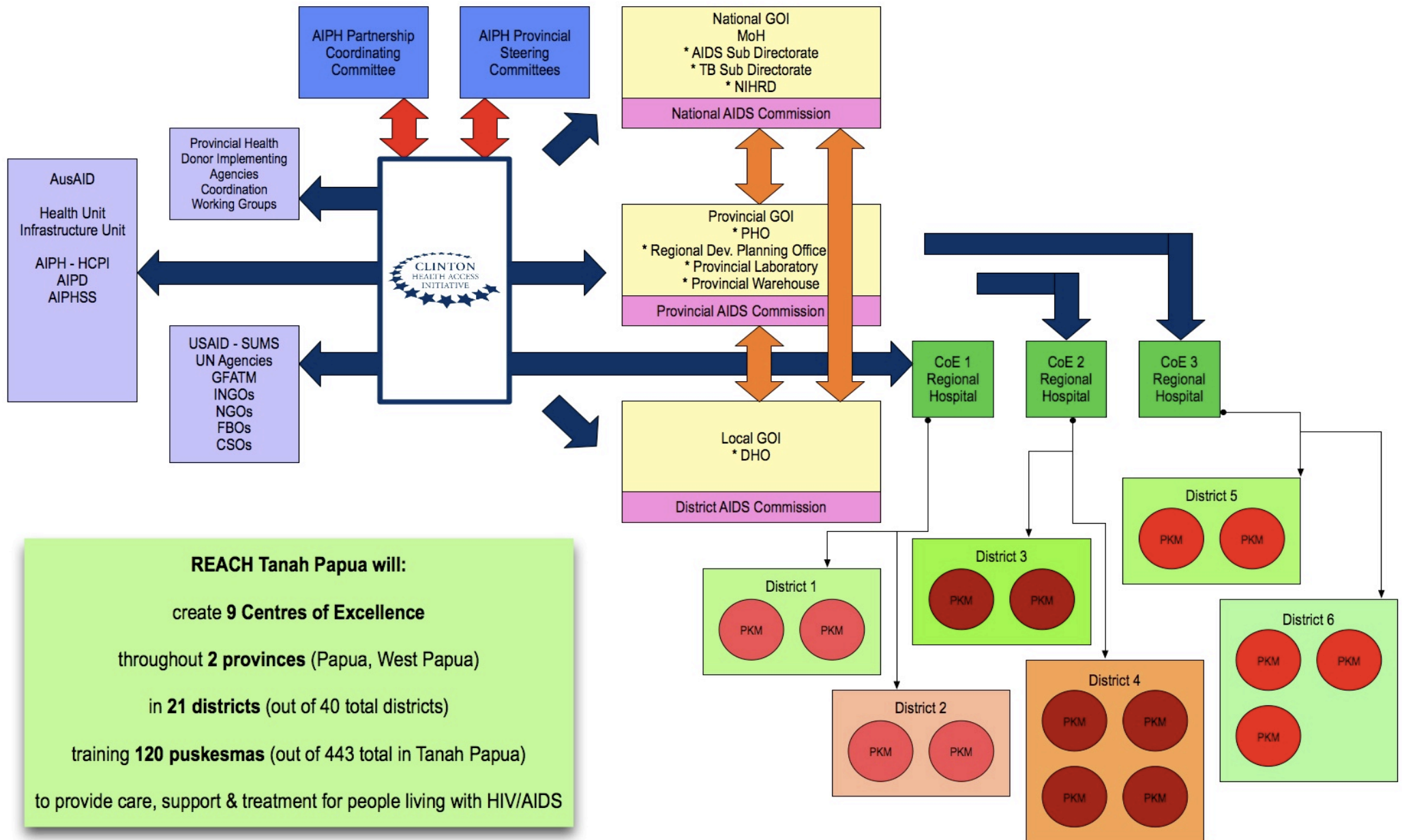
Annex 12: Program management

A12.1 Staffing

Care, support and treatment program component

Twenty-eight full-time staff in Papua and West Papua provinces will implement REACH's CST activities. The two Regional Program Managers, one in each province, will oversee the scale up of technical assistance. These managers will direct the programming and coordinate with the Program Managers in SCM, Policy, Operational Research and Monitoring, as well as with the Finance and Operation Managers. Two Deputy Regional Managers, one in each province, will support their work and directly manage the provincial CST Program Managers. The four site-based teams (in Jayapura, Jayawijaya, Nabire, and Sorong) will consist of Program Managers, Program and Technical Officers, Communications Officers, and other support staff. Each team will be responsible for providing technical assistance to CoE hospitals to integrate quality HIV-related services. In addition, 11 staff from Operational Research and Monitoring, SCM, Policy, Finance, and Administration will also support the CST efforts and will be embedded within the teams in the Papuan provinces. Finally, the Clinical Mentoring Team will consist of a rotating roster of Senior Clinical Mentors (up to three positions) with combined experiences in STI, TB-HIV, MCH, and laboratory management to supplement the CST component with on-the-job training, mentoring, and technical assistance. (The clinical mentors will support the work of the CoE. However, the bulk of clinical mentoring for hospitals and puskesmas will be provided by CoE staff.) Government Relations Officers in Papua and West Papua will work at the provincial level to coordinate with government offices, bilateral and multilateral donors, and facilitate the transition planning process for provincial assumption of CoE budgets and staffing in year 4.

Supply chain management program component

SCM will be staffed by one manager to oversee national and provincial SCM activities. One Jakarta-based supply chain analyst will work on decentralization to other provinces and support national-level forecasting, recording and reporting and data collection activities in conjunction with Global Fund-supported seconded staff. Two analysts will be based in the Papuan provinces to focus on site and provincial level supply chain issues.

Policy support to the Ministry of Health program component

Policy will be staffed by one manager to oversee the national policy development activities and support policy dissemination at the provincial level. The Policy Manager will work with the AusAID funded Policy Secretariat staff in the AIDS Sub Directorate to ensure the development and implementation of an evidence-based policy process.

Operations research and monitoring program component

One manager and several technical analyst positions will staff operational research and monitoring. A qualified monitoring and evaluation specialist will be hired as an advisor to design the monitoring framework and to periodically oversee monitoring and implementation over the life of the program. The Operational Research and Monitoring Manager will provide leadership and technical oversight across monitoring programs and operational research efforts. A Senior Data Analyst, along with Data Analysts and Data Mentors, will work with CoE data staff to monitor the program's progress towards intended outcome. The Senior Data Analyst will work closely with Regional Program Managers to assess and realign activities to reach these objectives. A Monitoring Specialist will work at national levels to ensure reporting happens upwards to GoI, AusAID, and other donors. Data Analysts in the field will work with other program staff to report key findings to

health facilities and other stakeholders. Finally, the Operational Research and Monitoring team has other analysts that will support all teams in applied analytics activities.

Finance & administration team

The Operations Managers, Finance Managers, Human Resource Administrator, Office Managers, and other support staff will ensure sound finance and administration policies are followed.

Management

A management team will support these program teams. The Country Director will provide overall oversight and management for REACH and ensuring coordination with government and partner organizations. Two Deputy Country Directors will be part of the senior management team. The Deputy Country Director for Programs will provide programmatic and clinical oversight. The Deputy Country Director for Finance and Operations will provide oversight to all human resource, administrative, and finance functions. Senior management will liaise with AusAID and be the main points of contact for reporting and compliance with AusAID policies.

Figure 8 (see below) shows the CHAI Indonesia organisational chart, detailing all CHAI staff positions for implementation of REACH. Figure 9 (see below) shows the staffing for the CoE. Note that the staffing for the CoE varies by sites and this is not reflected in Figure 9. The actual staffing for each CoE site is as follows:

- Jayapura: 12 positions (3 doctors, 3 nurses and midwives, 2 laboratory technicians, 2 data clerks, 1 communications officer, and 1 administration assistant)
- Pegunungan Bintang: 4 positions (4 doctors)
- Jayawijaya: 11 positions (2 doctors, 3 nurses and midwives, 2 laboratory technicians, 2 data clerks, 1 communications officer, and 1 administration assistant)
- Mulia: five positions (5 doctors)
- Enarotali: six positions (1 doctor, 1 nurse or midwife, 1 laboratory technician, 1 data clerk, 1 communications officer, and 1 administration assistant)
- Nabire: 12 positions (3 doctors, 3 nurses and midwives, 2 laboratory technicians, 2 data clerks, 1 communications officer, and 1 administration assistant)
- Sorong: 10 positions (2 doctors, 2 nurses and midwives, 2 laboratory technicians, 2 data clerks, 1 communications officer, and 1 administration assistant)
- Manokwari: eight positions (2 doctors, 1 nurse and midwife, 1 lab technician, 2 data clerks, 1 communications officer, and 1 administration assistant)
- Fak-Fak: eight positions (2 doctors, 1 nurse and midwife, 1 laboratory technician, 2 data clerks, 1 communications officer, and 1 administration assistant)

CHAI's South East Asia Regional Team

CHAI's South East Asia Regional Team will support the in country team's efforts through regular on- and off-site assistance. The Regional Director for South East Asia and the Deputy Regional Director will provide overall management and program guidance to the Country Director. The Deputy Regional Director will also ensure fiscal and administrative procedures follow CHAI headquarters' policies. The Director of Rural Program will assist the teams in program development and implementation, focusing on sustainable rural health service delivery models. The Operations Research and Monitoring Manager will support the development of appropriate systems and tools for that program component.

CHAI's Papua New Guinea program

CHAI's PNG team will also provide support and assistance to REACH. While there are differences between the PNG and Indonesian programs, both programs are assisting governments to increase access to HIV-related services and to scale up these interventions to the rural poor. CHAI PNG has

been established since 2006 and has extensive experiences with similar communities and environments that can inform the work in the Papuan provinces. Their expertise includes health systems strengthening through HIV service delivery; decentralising care services with centralized coordination; laboratory strengthening; and appropriate technologies for health (see Annex 4 for a list of lessons learned by CHAI PNG and their potential application to REACH).

CHAI global teams

CHAI Indonesia will also work with CHAI's global teams to implement the REACH program. This may include the Health Systems Strengthening Team to identify new solutions to address bottlenecks in the public finance system; the Clinical Services Team to provide clinical updates and assist in training and mentoring; the Drug Access Team to accelerate access to new drug products; and the Laboratory Support Team to strengthen in-country systems and introduce new diagnostic technologies. CHAI Indonesia will continue to report to CHAI's Headquarters office on all its operational functions, including budgeting, finance, reporting, human resources, and safety and security.

A10.2 Procurement arrangements

CHAI manages its expenditures through a decentralized control system with oversight from its Boston Headquarters office.

CHAI uses the following principles in making spending commitments:

Meet Patient Needs: Above all, the procurement of products or services should be conducted in the best interests of the patients and other individuals affected by HIV that CHAI is seeking to serve. This includes ensuring that the products or services provided are of high quality, are rapidly and effectively delivered, and suited to the specific needs or challenges identified.

Achieve Best Value for Money: In order to maximize the impact of the funds available, products or services should be purchased from sources that offer the best combination of quality and price.

Balance the need for efficiency with the requirement for strong financial oversight: Given the complexity of CHAI's work, the dynamic and complex nature of the health landscape in the Papuan provinces and elsewhere in Indonesia, and the core belief that every day that CHAI wastes, people die, it is important that country teams have the flexibility to make commitments to ensure the effective flow of work while observing all CHAI and AusAID financial management policies and guidelines.

CHAI Indonesia procurement procedures

All purchase requisitions require the approval of the Program Manager or budget holder and for items greater than IDR 10,000,000 the Country Director or Deputy Country Director. Any purchase exceeding IDR 20,000,000 requires two written quotations. A Procurement Committee consisting of the Operations Manager, Finance Manager and the person making the request must review the quotations. A recommendation is made which takes into account price and quality. A bid analysis form is completed documenting the reasons for the purchase decision and is signed by each person on the committee. The Country Director or Deputy Country Director must then approve the recommendation before purchase can proceed.

If a purchase exceeds IDR 20,000,000 but only one supplier is able to provide a quote on a product or service, a sole source justification must be provided.

All purchases greater than IDR 50,000,000 require a formal tender where advertisements are placed in the local newspaper with more stringent purchasing guidelines (for example, formation of a bid committee, preparation of a request for quotation, etcetera). A formal tender process for lesser purchases is encouraged if cost savings can be expected.

Figure 8: CHAI Indonesia organisational chart for REACH by location of staff
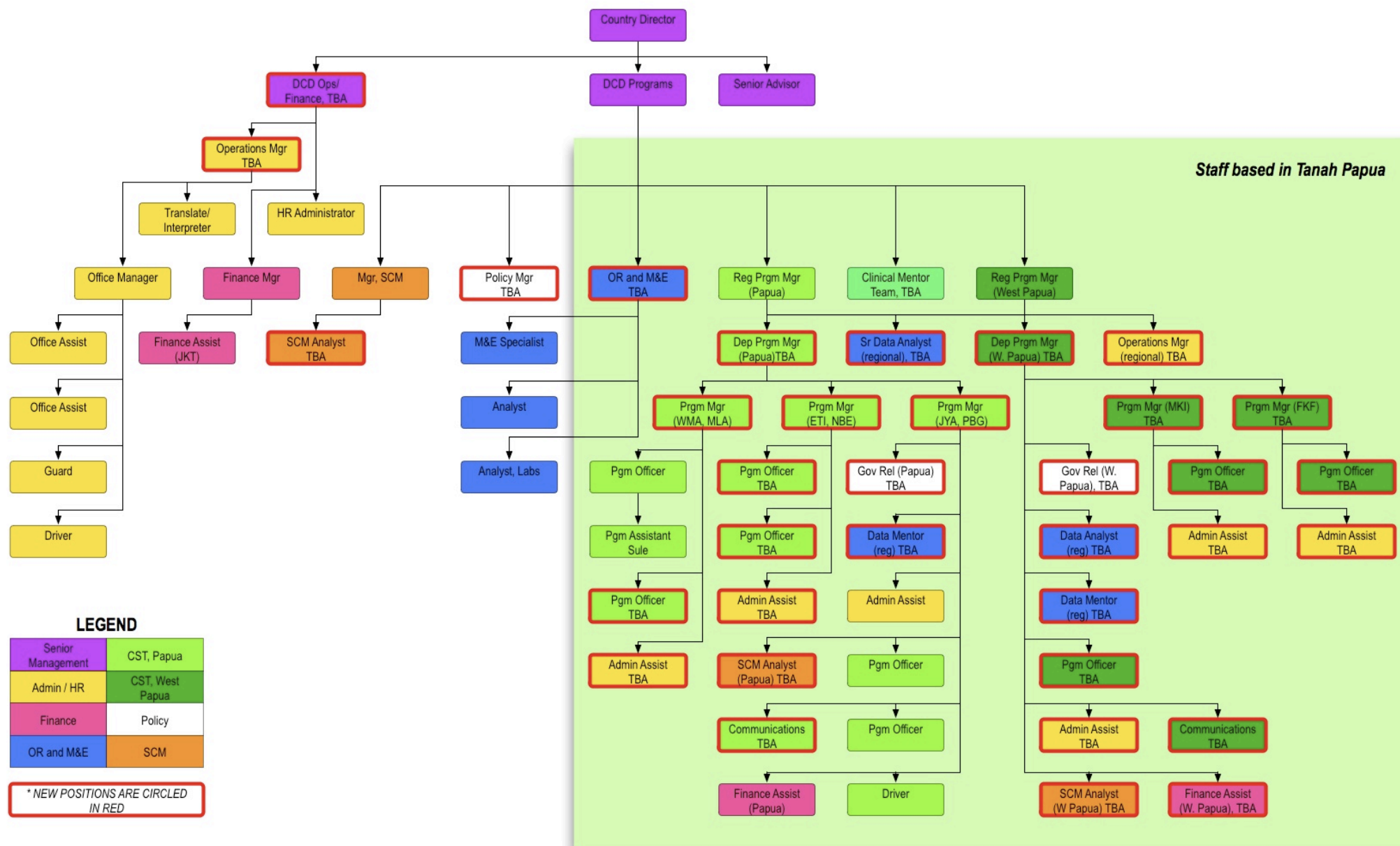
Figure 9: Staffing of Centres of Excellence by province

Staff based in Tanah Papua

Contracted CoE staff in West Papua (actual staffing plan will vary by site)

Contracted CoE staff in Papua (actual staffing plan will vary by site)

Sorong	Manokwari	Fak Fak	Jayapura	Pegununan Bintang	Wamena	Mulia	Enarotali	Nabire
CoE Doctor TBA	CoE Doctor TBA	CoE Doctor TBA	CoE Doctor TBA	CoE Doctor TBA	CoE Doctor TBA	CoE Doctor TBA	CoE Doctor TBA	CoE Doctor TBA
CoE Nurse TBA	CoE Nurse TBA	CoE Nurse TBA	CoE Nurse TBA	CoE Nurse TBA	CoE Nurse TBA	CoE Nurse TBA	CoE Nurse TBA	CoE Nurse TBA
CoE Midwife TBA	CoE Midwife TBA	CoE Midwife TBA	CoE Midwife TBA	CoE Midwife TBA	CoE Midwife TBA	CoE Midwife TBA	CoE Midwife TBA	CoE Midwife TBA
CoE Lab Tech TBA	CoE Lab Tech TBA	CoE Lab Tech TBA	CoE Lab Tech TBA	CoE Lab Tech TBA	CoE Lab Tech TBA	CoE Lab Tech TBA	CoE Lab Tech TBA	CoE Lab Tech TBA
CoE Data TBA	CoE Data TBA	CoE Data TBA	CoE Data TBA	CoE Data TBA	CoE Data TBA	CoE Data TBA	CoE Data TBA	CoE Data TBA
CoE Commun TBA	CoE Commun TBA	CoE Commun TBA	CoE Commun TBA	CoE Commun TBA	CoE Commun TBA	CoE Commun TBA	CoE Commun TBA	CoE Commun TBA
CoE Admin TBA	CoE Admin TBA	CoE Admin TBA	CoE Admin TBA	CoE Admin TBA	CoE Admin TBA	CoE Admin TBA	CoE Admin TBA	CoE Admin TBA

LEGEND

Admin / HR	CST, Papua
Policy	CST, West Papua
SCM	

* GFATM SECONDED POSITIONS ARE CIRCLED IN RED

Seconded staff in Jakarta

Secretariat Admin, TBA	Forecasting	Honoree
Secretariat Coordinator, TBA	Data	Honoree
	Reporting	Honoree

Annex 13: REACH monitoring structure and resourcing

Figure 10 is a simplified depiction of the REACH monitoring design.

Figure 10: Simplified depiction of REACH monitoring system
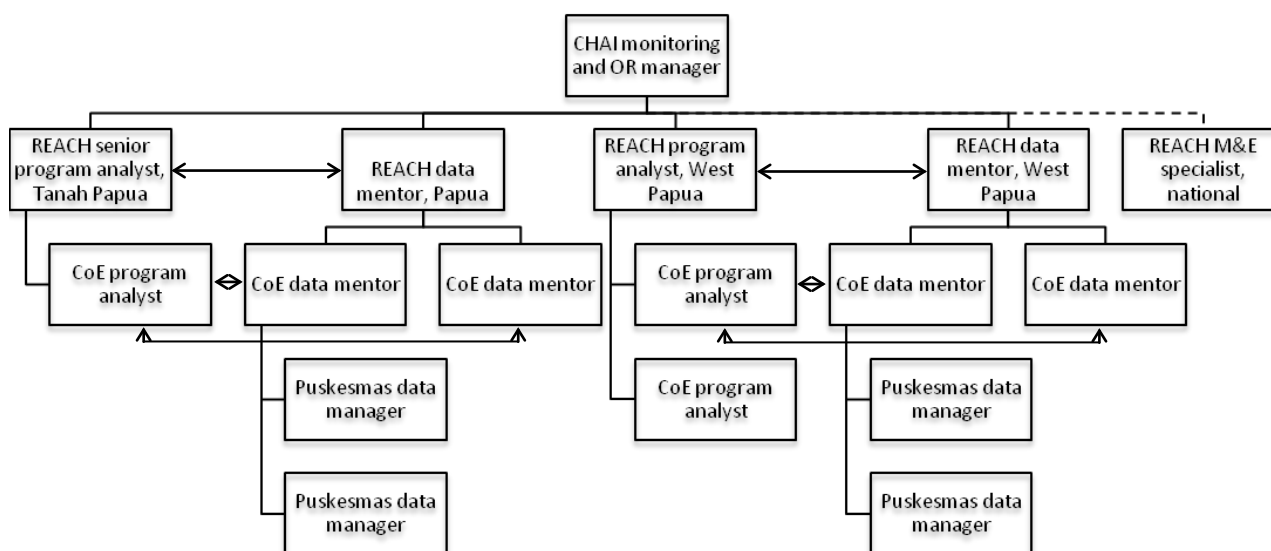
A13.1 Staffing for the monitoring system

The Monitoring system will be designed by a specialist Operational Research and Monitoring Advisor who will also be hired to oversee these functions over the life of the program. The Advisor, contracted to work with the program for regular, scheduled periods, will conduct analysis of program data on a biannual basis. The Operational Research and Monitoring Manager will provide day-to-day oversight. CHAI will appoint a program analyst and a data mentor in each province as well as an monitoring and evaluation (M&E) specialist in Jakarta. The program analyst in Papua is responsible for regional analysis for the two Papuan provinces. In addition, there will be program analysts and data mentors in every CoE. Much of the raw data will be provided by data managers at the puskesmas level[68].

The **M&E specialist in Jakarta** is responsible for:

- Collating training materials for REACH data management and data analysis staff

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[68] Note that data managers at puskesmas are outside the control of REACH. All the facilities visited for development of this proposal had active record-keepers, but that may not be the case in all potential REACH sites.

- Consulting with provincial staff, AusAID and the AIDS Sub Directorate to select external reporting indicators, prioritising standardised indicators used by existing partners where appropriate
- Analysis and feedback to program managers of data from the supply chain, policy and operational research components of REACH
- Reporting on all four program elements to REACH partners, including AusAID and GoI
- Overseeing training in the Papuan provinces

The **provincial data mentors** are responsible for:

- Training of CoE data mentors in data management
- Ongoing mentoring of CoE data mentors
- Collation and management of data from all CoE in their province, provision of these data to program analysts, PHOs and DHOs and other interested partners.

The **CoE data mentors** are responsible for:

- Training of puskesmas data managers in data management
- Ongoing mentoring of puskesmas data managers
- The recording, entry and management of data related to services provided at the CoE
- Collation and management of data from all puskesmas in the districts covered by the CoE, provision of these data to program analysts, CoE directors and other interested partners

The **puskesmas data managers** are responsible for:

- The recording, entry and management of data related to services provided at the puskesmas
- Simple analysis of service delivery at the puskesmas level

The **provincial program analysts** are responsible for:

- Training and ongoing mentoring of CoE data analysts in program relevant data analysis
- Ongoing analysis of REACH-supported service delivery and other program data for the province
- Feedback of analysis, including results of operational research, to PHOs and DHOs, CoE managers and other service providers, as well as to CHAI Jakarta
- Rigorous recording of results of analysis and feedback discussions, and subsequent monitoring of related programmatic changes

The **CoE program analysts** are responsible for:

- Ongoing analysis of REACH-supported service delivery and other program data in the CoE and its dependent puskesmas
- Feedback of analysis to CoE and puskesmas managers and data staff, as well as to provincial program analysts
- Support for puskesmas data managers in simple data analysis

A13.2 Resourcing the monitoring system

The major costs associated with the monitoring system are salaries (for upwards of two dozen data mentors/managers and analysts covering all the CoE and REACH program elements) and transport. CoE staff will have to travel to the puskesmas they mentor, and CHAI staff will have to travel to CoE. The important quarterly and six monthly live analysis sessions will also involve substantial travel costs, although these will frequently be shared across other areas of program implementation such as training.

External technical assistance will be required for initial training of CHAI and CoE monitoring staff. In the case of data mentors this expertise is available in Indonesia. For program analysis, international expertise may be needed.

In terms of hardware, REACH will provide puskesmas with laptops as necessary, along with the software they need to record and report data, as well as to analyse it for their own use. Routine site visits will verify that equipment is being used as intended.

Annex 14: Issues management register

Note: the 'flags' in the last column are indicators that the control may not be working. This will give rise to a re-examination of whether a different approach is needed to controlling the risk.

Existing controls are those being implemented by CHAI Phase II. If a control is being implemented by CHAI Phase II this is indicated in the control column by '*Existing*' at the end of the description of the control.

Specific risks	Impact		Inherent risk rating	Controls (existing & new)	Residual risk rating	Responsibility	When? Flags
	Consequence	Likelihood					
Program Management							
CHAI intends to scale up a successful demonstration program very rapidly. Management systems may become strained.	Moderate	Possible	High	The staffing structure of CHAI has been enhanced, with additional positions including new management, administrative and financial positions. Management procedures will be systematised and SoPs developed. Clear job descriptions and performance indicators will be developed for staff. *Existing*	Medium	CHAI management	2012 – 2013 Delays in filling new positions or development of systems
CHAI may be unable to find sufficient numbers of skilled staff to meet its staffing needs, especially (but not exclusively) in Tanah Papua.	Moderate	Possible	High	An active formal and word of mouth recruitment campaign will be conducted. The opening of new Centres of Excellence may need to be delayed. Less skilled staff may be recruited and trained. On-the-job training and intensive mentoring will be made available to develop staff skills rapidly. For CoE staff, CHAI will collaborate with local government to prioritize recruitment of local health care workers, former PTT clinicians, as well as staff finishing contract on other donor-funded programs. CHAI will also utilize its staff's extensive Indonesian network.	Medium	CHAI management	2012- 2013 Lack of suitable applicants
The AIPH Program Coordination Committee (PCC) will be the national level governance mechanism for REACH. At the provincial level there will be two Provincial Steering Committees (PSCs); one in each province. There may be differences in strategic directions between national and provincial level committees.	Moderate	Possible	High	The PSCs will meet shortly before PCC meetings and report to the PCC to promote alignment between the issues being considered by all three committees. Should there be differences in the strategic directions recommended by the PCC and PSC which cannot be resolved, the PCC and ultimately AusAID will be final arbiter.	Low	CHAI management and AusAID	Ongoing Differences in strategic directions
CHAI may be unable to retain staff in Tanah Papua due to the difficult conditions; highly trained and skilled staff also may seek better paying positions.	Moderate	Possible	High	CHAI will offer competitive salary and benefits package; trainings and other professional development opportunities for staff will always be prioritized as a means to train successors in the likely event that some staff will leave. CHAI will conduct rolling interviews to bring new staff onboard as needed in a standardized	Medium	CHAI management	2015-2016

Specific risks	Impact		Inherent risk rating	Controls (existing & new)	Residual risk rating	Responsibility	When? Flags
	Consequence	Likelihood					
				yet efficient pace. *Existing*			
Component 1: Care, Support and Treatment							
Overarching Objective: To increase the number of GoI supported health facilities that are well staffed and equipped and providing quality HIV-related clinical services in Tanah Papua							
Success breeds demands. CHAI is facing demands to increase coverage beyond the area envisioned in this funding proposal. A refusal to help may be politically unpalatable, and may hobble opportunities for collaboration in the future. Increasing coverage will, however, further strain capacity and threaten program quality.	Minor	Possible	Moderate	CHAI and AusAID have held extensive discussion with provincial and national partners, and have been clear about limiting the coverage of the program. MoUs will be developed at the provincial level defining districts to be covered by the program. Provincial Steering Committees will review all requests for expansion by non-REACH districts and work with CHAI management regarding inclusion of additional sites.	Low	CHAI management CHAI Tanah Papua staff	2012 – 2013 Additional demands for coverage
Centres of Excellence (CoE) staff will be required to work in remote areas, at pay scales equivalent to those of government health staff. CHAI may be unable to hire and retain adequate skilled staff to meet CoE needs.	Moderate	Likely	High	CHAI will take a proactive approach to hiring and/or retaining motivated, qualified staff, even if the hiring process does not fit exactly with implementation timing. CHAI will work with AusAID and MoH to explore incentive structures, including study and professional development opportunities, to attract and retain staff. Less skilled staff may be recruited and trained. On-the-job training, cross-placement in functioning centres and intensive mentoring will be made available to develop staff skills rapidly. CHAI will advocate with hospital directors (who are accountable to Bupati) to minimise staff rotation and to assign staff according to training and qualifications. AusAID sector manager to explore bridge financing possibilities. CHAI to develop mechanisms for rapid hiring. The opening of new Centres of Excellence may need to be delayed.	Medium	CHAI management CHAI Tanah Papua staff AusAID	2012 – 2013 Lack of suitable applicants High staff turnover
Health services are delivered by existing staff through existing government health services, largely at puskesmas level. Especially in the context of ongoing division of districts as regional autonomy expands, there is a risk that services will be understaffed, and that competent, trained staff will quickly rotate to jobs that do not deliver services in program areas.	Major	Likely	High	CHAI has worked with government to include staffing questions into the recent health facilities survey in Tanah Papua, and will use results to reassess this risk. Site selection criteria will prioritise adequately staffed sites with supportive management. CHAI will work with AIPD, Kinerja and other partners to advocate with District Health Offices (DHO) for adequate financing and staffing of health centres in the short and longer term. CHAI will support infrastructural development, including construction or upgrading of staff housing, to help the government attract and retain staff in remote locations. Scale down target for health centres actively supported and mentored.	Medium	CHAI management CHAI Tanah Papua staff	2012 – 2013 & ongoing Understaffed services High staff turnover
Objective 1.1 Antiretroviral therapy: To increase access to ART at puskesmas and hospitals in Tanah Papua, and adherence to ART among patients treated.							
People cannot access ARVs if they do not know their HIV status. Testing levels are currently low. CHAI will work on the supply side of testing, but relies on other partners,	Major	Possible	High	CHAI's program approach focuses on increasing routine HIV testing in health care settings and minimises the role of VCT. CHAI will appoint staff to	Low	CHAI management CHAI Tanah	Ongoing Numbers of HIV tests

Specific risks	Impact		Inherent risk rating	Controls (existing & new)	Residual risk rating	Responsibility	When? Flags
	Consequence	Likelihood					
including HCPI, to provide messaging to increase demand. There is a risk that organisations that have in the past focused on prevention messaging do not develop successful campaigns to support treatment initiation and adherence.				engage more actively with other partners, including HCPI, to provide quality messaging around HIV testing and treatment. AusAID staff will monitor progress of HCPI in treatment related messaging in Tanah Papua. Switch partners for treatment-related messaging if necessary.		Papua staff AusAID	Effectiveness of campaigns to promote HIV testing and treatment
The intention is to decentralise initiation of ARVs to puskesmas level. It is possible that this strategy will meet with resistance from health service gatekeepers. Concerns among service providers about poor adherence and loss to follow-up are known to be a barrier to initiation.	Major	Likely	High	Support for decentralised initiation of ARVs has been secured from the MoH. Component 3 (Policy) will work at the central level to support the development and dissemination of policies and protocols which encourage decentralised initiation of ARVs. CHAI will work with partners to develop community-based systems to support adherence. _Existing_	Medium	CHAI Tanah Papua staff	Ongoing Low levels of treatment initiation
If cultural as well as logistic barriers to adherence and continued follow-up are not addressed effectively, the program goal cannot be achieved.	Severe	Possible	High	The program is designed to minimise logistic barriers to adherence and follow-up by taking services closer to patients. CHAI will work with partners to develop community-based systems to support adherence, including working through the churches that have wide community reach in remote areas. This work is proposed under a separate funding partnership - if this funding is not available it will need to be secured within the AusAID program. Lessons from CHAI's work supporting adherence through cell-phones and other mechanisms in other countries will be applied where possible. The program will work to develop province-wide unique identifiers to allow for better control of follow-up between sites. CHAI will encourage partners including HCPI to develop effective messages to reduce cultural barriers to adherence. CHAI monitoring systems are designed to monitor adherence and follow-up on a monthly basis, and to take immediate action as necessary. Component 4 (Operational research) will explore the effectiveness of different models of adherence support, and scale up those proven most effective in the Papuan context. _Existing_	Medium	CHAI Tanah Papua staff CHAI management AusAID	Ongoing Moderate to low levels of adherence Moderate to high levels of loss to follow up Funding not available from other donors for community support Unique identifiers prove not feasible Ineffective messaging on adherence Lack of timely and quality operational research
Objective 1.2 Tuberculosis: To improve quality of TB diagnosis and treatment in Tanah Papua							
The TB and HIV programs are currently vertically funded and managed from different units of the Ministry of Health, and communication between programs is limited. Cross-referral of HIV and TB patients may be hampered in some sites.	Moderate	Possible	High	The CoE model focuses on integrating care for HIV, TB and STIs in hospital settings, and will extend this model to puskesmas settings.	Low	CHAI Tanah Papua staff	Ongoing Moderate to low levels of cross referral
Objective 1.3 Sexually transmitted infections: To reduce STI prevalence in high prevalence populations in Tanah Papua							
High population mobility and low consistent condom use among sex workers undermines the effectiveness of periodic presumptive treatment (PPT) as a STI control	Major	Likely	High	Work with Indonesia Planned Parenthood Federation clinic staff at Tanjung Elmo, Puskesmas Amben staff in Manokwari and Kalvari staff in Wamena to develop	Medium	CHAI Tanah Papua staff	2012 – 2013 STI prevalence

Specific risks	Impact		Inherent risk rating	Controls (existing & new)	Residual risk rating	Responsibility	When? Flags
	Consequence	Likelihood					
strategy in sex worker populations.				an 'on arrival' package of STI services for sex workers that includes PPT for gonorrhea and chlamydia, syphilis screening and 100% condom use			does not decrease
There are sometimes political obstacles to providing effective services for sex workers.	Major	Possible	High	CHAI liaison staff will work with HCPI, SUM, KPAP and other partners actively to lobby for service provision for sex workers and their partners.	Low	CHAI Tanah Papua staff	2012 – 2013 Sex workers not accessing services
STI control among sex workers is difficult to achieve unless their regular partners (with whom condom use is low) are also treated. There is limited experience with partner treatment programs in Indonesia; finding an effective model may take some time.	Moderate	Possible	High	The program intends to implement active referral and treatment of regular partners of sex workers, including providing positive presumptive treatment. Component 4 (Operational research) will explore the effectiveness of different models of partner referral and treatment	Low	CHAI Tanah Papua staff	2012 -2014 STI prevalence does not decrease Lack of timely and quality operational research
Gonorrhoea sensitivity to cefixime falls and treatment becomes less effective	Moderate	Possible	High	Support a Gonococcal Antimicrobial Sensitivity survey at the time of the next routine IBBS among sex workers in Tanah Papua.	Low	CHAI management	2014 IBBS conducted without survey
Diagnosis of syphilis requires TPHA and RPR tests done in conjunction. If health staff continue to use the TPHA rapid diagnostic test as a stand-alone syphilis diagnostic test they will not identify the high titre infectious cases that need priority in treatment and contact tracing. This will reduce the effectiveness of the syphilis control efforts.	Moderate	Possible	High	Provide technical input to MoH on revision of National STI Guidelines. Adapt the Australian Syphilis Diagnosis Training manual for use in Tanah Papua. *Existing*	Low	CHAI Tanah Papua staff	2013 and ongoing RPR not used
STIs are common; people often fail to recognise symptoms. When they do recognise symptoms they self-treat or seek treatment outside government health facilities. It may therefore be difficult to increase service provision for populations other than sex workers and their regular partners.	Moderate	Likely	High	CHAI liaison staff will work with HCPI, SUM, KPAP and other partners to strengthen messaging around STI symptom recognition and service availability. CHAI program staff will seek opportunities to provide mentoring and support through CoE to those who see STI patients outside the government health system.	Medium	CHAI Tanah Papua staff	2012- 2013 and ongoing Ineffective messaging No increase in STI clients in health services
Objective 1.4 Laboratories: To strengthen laboratory capacity to provide HIV, TB and STI related diagnostic testing and monitoring							
Some specimens are better examined centrally in provincial health laboratories for cost and quality reasons. Treatment center budgets do not allow for specimen shipment.	Moderate	Almost certain	High	REACH will work with provincial government to try to establish central specimen shipping contracts paid for by the province to facilitate shipments to central laboratories.	Medium	CHAI Tanah Papua staff	2012 – 2013 Provinces do not agree to cover this cost
Reagent costs are often centrally funded and budgets not allocated until mid-year. Unanticipated increases in supply needs may result in reagent stock-outs.	Major	Likely	High	SCM system will review monthly use and projections to better predict increase needs and work with the AIDS Sub Directorate, provinces and districts to address and pay for unanticipated needs.	Medium	CHAI Tanah Papua and SCM staff	2012 -2013 Low stock levels and stock outs
External quality control for hospitals and puskesmas can be provided by the Provincial Laboratories. Their external quality control will need to be arranged with commercial suppliers outside the country. These are unbudgeted costs that must be covered.	Moderate	Likely	High	REACH will cover costs for EQA program for the first two years while discussions are held with DHOs and PHOs and Bappeda to define ongoing funding mechanisms.	Low	CHAI Tanah Papua staff	2012 – 2013 Provinces do not agree to cover this cost

Specific risks	Impact		Inherent risk rating	Controls (existing & new)	Residual risk rating	Responsibility	When? Flags
	Consequence	Likelihood					
Objective 1.6 Infrastructure: To strengthen infrastructure at puskesmas level to support care, support and treatment services							
There may be significant delays in the release of data from the NIHRD survey of health facilities.	Major	Possible	High	AusAID and CHAI will negotiate with the MoH for access to the NIHRD data prior to its broader release. If access is denied it will be necessary for the infrastructure sub-design to undertake more comprehensive assessments when it visits sites. *Existing*	Low	AusAID and CHAI management Sub-design team	2012 Delay in release of data
Infrastructure needs for specific puskesmas will be identified by the sub-design. As REACH is rolled out over four years, puskesmas selection may change because of emerging factors.	Minor	Likely	Moderate	If different puskesmas are chosen for inclusion in REACH, their infrastructure needs are likely to be similar to those of puskesmas dropped from expansion plans, so this would not have a significant budget effect. Prior to any infrastructure work taking place in puskesmas not yet part of REACH, CHAI will update its assessment that inclusion of that facility in REACH remains viable.	Low	CHAI Tanah Papua staff	Ongoing Prior to contracting for new infrastructure work at puskesmas not yet part of REACH
Completion of even the early stages of infrastructure work will not occur until well after REACH has commenced implementation. If delays in infrastructure development take place this will exacerbate the situation.	Moderate	Certain	High	Puskesmas and hospitals will come on-line over 18 months and the first facilities to be involved will primarily be those in urban areas where there is a lesser need for infrastructure development. CHAI Phase II has demonstrated that it is feasible to decentralise HIV CST to puskesmas lacking in key areas of infrastructure, although this limits their capacity to provide some services such as those laboratory tests which require electricity. As the infrastructure work is completed, the range of services provided by puskesmas will be enhanced. Some puskesmas, particularly those in rural and remote areas, will only start to provide HIV CST services in years two to four which should allow sufficient time for infrastructure development.	Medium	Infrastructure sub-contractor	2012 – mid 2014 Delays in infrastructure development
Districts may not agree to cost share. The investment will be wasted if adequate maintenance is not provided. There is the danger of theft of infrastructure.	Moderate	Likely	High	Sustainability will be enhanced by the sub-design choosing infrastructure solutions with feasible maintenance requirements in rural and remote areas, the development of realistic maintenance plans, with a non-negotiable requirement for firm undertakings by DHOs for meeting operational and maintenance costs and monitoring of maintenance. CHAI and CoE staff will monitor maintenance and problems with maintenance will be addressed through technical advice and advocacy to DHOs. Anti-theft strategies will be incorporated into the infrastructure sub-design.	Medium	CHAI Tanah Papua and CoE staff AusAID Infrastructure Unit	2102 – 2013 Delays in provision of infrastructure Maintenance is not occurring
Objective 1.6 Support for effective decentralised systems: To support policies that increase the efficiency, transparency and sustainability of service delivery in a decentralised health system							
Governmental structures in Indonesia and Tanah Papua remain in flux. Division of responsibilities between levels of government is unclear. Vested interests between levels	Moderate	Likely	High	CHAI will appoint government relations staff to engage actively with government partners at both the provincial and the district level. These staff will also	Medium	CHAI Tanah Papua staff	2012 and ongoing Lack of effective

138

Specific risks	Impact		Inherent risk rating	Controls (existing & new)	Residual risk rating	Responsibility	When? Flags
	Consequence	Likelihood					
are sometimes not aligned, leading to obstacles in the development and implementation of effective funding mechanisms and policies. There is risk that policy improvements achieved at one level are not translated into policies or practice at other levels.				liaise proactively with other externally funded activities with a policy and programmatic focus, including AIPD. Component 3 (Policy) will try to ensure that central level policies provide an umbrella that covers Papua's special needs. Where national policies seem to obstruct the particular needs of the Papuan situation, AusAID's sector dialogue could become more actively devolved if necessary, with less focus on the central level and more on levels more likely to achieve program goals.		Policy Secretariat in MoH AusAID AIPD	funding mechanisms and policies
Further splitting of provinces and districts in Tanah Papua may undermine progress in achieving political support for program goals. Program development work may go back to square one in newly established provinces or districts.	Moderate	Almost certain	High	CHAI intends to support a regional program oversight mechanism which will include the people and institutions likely to be involved in any new provincial/ district governments in program areas.	Medium	CHAI Tanah Papua staff	Ongoing Creation of new provinces and/or districts
The intention is to transition funding and staffing support for CoE to PHOs by the end of the program. If division of responsibilities between province and district remain unclear, this may be difficult to achieve.	Major	Possible	High	CHAI will work with AIPD, Kinerja and other partners actively to advocate for PHOs to take over funding of CoE. Sectoral dialogue between AusAID and provincial level partners to reinforce the need to adequately fund the training, mentoring and QC roles of the PHOs. At AusAID's request, CHAI has included in the design a process to make recommendations to AusAID for post-program activity. AusAID could extend funding for CoE posts though CHAI or other mechanism beyond 2016.	Low	CHAI management and Tanah Papua staff AIPD AusAID	2015 – 2016 Reluctance by PHOs to take over CoE funding
Component 2: Supply chain management for HIV and related commodities							
Overarching Objective: To decrease stock outs and increase efficiency of strengthened supply chain management of HIV-related commodities							
Currently for ARV commodities, 70 per cent of the funding is from the Government of Indonesia and 30 per cent is from the Global Fund. With Global Fund phasing out in 2014, GoI needs to seek out other mechanisms to fund ARV purchases. If not, ARVs will not be available.	Major	Unlikely	Moderate	CHAI will advocate to the AIDS Sub Directorate and Tanah Papua PHO to provide funding in order to secure availability of ARV. *Existing*	Medium	CHAI SCM staff CHAI Tanah Papua staff	2013-2014 Stock outs of ARV
Objective 2.1 Provincial level: To strengthen supply chain management systems for HIV-related commodities in Tanah Papua							
Associated reagent of HIV/AIDS test are not available	Major	Likely	High	CHAI will advocate to the AIDS Sub Directorate and Tanah Papua PHOs to provide funding in order to secure availability of ARV. *Existing*	Medium	CHAI SCM staff CHAI Tanah Papua staff	Ongoing Stock outs of reagen rapid test Accuracy and timeliness of site reporting for commodities
Supply chain management of HIV-related commodities are not effective and inefficient in Tanah Papua (stock out, shortage stock, overstock and expired) due to decrease quality of coordination and monitoring among the	Major	Likely	High	CHAI will improve coordination between all stakeholders in Tanah Papua and also in national level through training and capacity building process of SCM Management. *Existing*	Medium	CHAI SCM staff CHAI Tanah	2013 stock out, shortage stock, overstocks

Specific risks	Impact		Inherent risk rating	Controls (existing & new)	Residual risk rating	Responsibility	When? Flags
	Consequence	Likelihood					
provinces, districs and treatment site as leadership change						Papua staff	and expired
Supply chain management in West Papua province is currently weak. Intensive efforts will be needed to improve systems in West Papua. Any further division of provinces will multiply this challenge to other areas.	Moderate	Possible	High	CHAI plans to support decentralisation of SCM for ARVs to West Papua Province. The head of the Papua Province Provincial Warehouse is willing to support this process and is a significant asset. If additional provinces are created decentralisation of SCM may need to occur for these provinces. Following approval of REACH a sub-design of SCM for other HIV-related commodities will be undertaken which will include strategies for strengthening SCM in West Papua. *Existing*	Low	CHAI Tanah Papua and SCM staff	2012 and ongoing Creation of additional provinces
With REACH, CHAI's SCM work will broaden to include supply chains for TB and STI treatment and related diagnostics in Tanah Papua. These involve different players, with different incentive structures. There is a possibility that turf wars could develop.	Moderate	Likely	High	CHAI will undertake a sub-design for these commodities. CHAI will conduct an initial assessment, including identification of key stakeholders, opportunities for collaborations and constraints. SCM, CST, and the Policy teams will focus its efforts to for address bottlenecks, not recreating parallel supply chain systems.	Medium	CHAI SCM, Tanah Papua, and Policy staff	2012-2014 Politically-motivated blockages in commodities
The supply chain for TB diagnostic tests and treatment differs from that of ARVs. These commodities may not be available at all treatment sites.	Moderate	Possible	High	SCM will extend its work to cover TB-related commodities. SCM will work with the CST and Policy teams to ease blockages and support, not recreate the existing TB supply chain system.	Medium	CHAI SCM staff	Ongoing Stock outs of TB commodities
The supply chain for STI diagnostic tests and treatment differs from those of ARVs and TB. These commodities may not be available at all treatment sites.	Moderate	Likely	High	SCM will extend its work to cover STI-related diagnostic tests and commodities. Component 3 (Policy) will work at the central level to support the development and dissemination of policies and protocols which improve STI control. Efforts will be made to include effective STI treatment drugs in the national essential drugs list. SCM will work with the CST and Policy teams to ease blockages and support, not recreate the existing STI supply chain system.	Medium	CHAI SCM staff and the Policy Secretariat in MoH	Ongoing Stock outs Inaccurate and late site reporting for commodities
Objective 2.2 National level: To strengthen national and decentralised supply chain management systems for HIV-related commodities							
The intention is to phase out AusAID support for SCM by the end of the program. The government currently has a moratorium on hiring staff; it is not clear how they will fill the posts currently filled by CHAI/GF-supported staff. In addition, experience suggests that staff are rarely assigned to replace donor-supported posts until funding has ended, leaving inadequate time for training and mentoring of replacement staff.	Major	Likely	High	Develop a clear transition strategy with timelines for a progressive shift of technical support for SCM so that the AIDS Sub Directorate is progressively able to take on functions currently undertaken by CHAI technical support, with a full exit of AusAID funded support by June 2016.	Medium	CHAI management and SCM staff	2012 and ongoing AIDS Sub Directorate is unable to devote staff to SCM functions
CHAI support for supply chain management currently relies extensively on funding from the Global Fund. The future of this funding is uncertain; if it is withdrawn, several	Major	Possible	High	Advocate for the MoH to take over funding of these funding positions. *Existing*	Medium	CHAI SCM staff	2013 Global Fund funding for SCM

140

Specific risks	Impact		Inherent risk rating	Controls (existing & new)	Residual risk rating	Responsibility	When? Flags
	Consequence	Likelihood					
SCM positions will be un-funded. The Phasing out of Global Fund and AusAID in SCM activities through CHAI in almost same time will have major impact in the quality of supply chain management of HIV-related commodities.							positions ceases
Transition of SCM activities to Subdit AIDS will not run well and impact the quality of supply chain management due to the lack of skills and/or lack of dedicated government staff to manage SCM activity successfully without technical assistance from CHAI or other donors	Major	Possible	High	CHAI will provide the AIDS Sub Directorate with the management methods and establish indicators to ensure the quality of work carried out by related stakeholders	Medium	CHAI SCM Staff and CHAI Management	2014 Subdit AIDS fails to manage the supply chain of HIV-related commodities independently
Objective 2.3 One Gate: To support the medium to long-term shift of incorporating supply chain management of HIV-related commodities within the national one gate policy							
In order to achieve the overall SCM objective, a pragmatic approach to supply chain management may be necessary. This may involve setting up or entrenching systems which undermine the longer-term interests of an effective national supply chain for all health-related commodities. Integration with the broader health system supply chain will be a complicated transition.	Major	Almost certain	Very high	Component 2.3 will work with national systems to support longer term solutions into which short-term fixes can be integrated. *Existing*	Medium	CHAI SCM staff	Ongoing Systems which entrench disease specific SCM systems
In order to meet the overall SCM objective, the activities of Components 2.1 and 2.2 are of necessity at odds with this sub-objective. CHAIs credibility in providing support to the Pharmaceutical Directorate, the principal partner for this sub-objective, may be compromised.	Moderate	Likely	High	CHAI has already established a good working relationship with the Pharmaceutical Directorate. Talks with the Directorate and partners currently controlling other parts of the supply chain have begun. All have expressed willingness to work towards a long-term solution. *Existing*	Medium	CHAI SCM staff	Ongoing Relations with the Pharmaceutical Directorate deteriorate
Component 3: Policy support to the Ministry of Health							
Overarching Objective: To implement an evidence- based Ministry of Health national policy framework relevant to HIV-related care, support and treatment							
Objective 3.1: National level policy: To strengthen the national policy framework relevant to HIV-related care, support and treatment.							
Previous attempts to provide similar support to the AIDS Sub Directorate have failed because it was not possible to arrive at a salary structure acceptable to the Sub Directorate and attractive to people with the requisite skills. This may be the case again.	Major	Possible	High	The current head of the AIDS Sub Directorate has expressed support for the proposed policy secretariat. Active recruitment may be needed. If a suitable candidate cannot be found a fallback option would be to recruit at above the government salary level, but this would need to be carefully considered as it would increase the risk that the position would be discontinued when AusAID funding ceases. Alternatively, REACH could focus its policy development work at the provincial and district levels in Papua, where CHAI supported services will be delivered. *Existing*	Medium	CHAI management	2012 and ongoing Recruitment difficulties for Policy Secretariat staff
In the past, decisions of the treatment working group have reflected the views of one or two long-serving group members. The secretariat aims to synthesise recent	Moderate	Likely	High	The work of the Secretariat aims to orient the policy working groups towards evidence based decisions rather than current practices of individual members. A	Medium	CHAI management and Policy	2012 – 2013 Policy decisions are not evidence

Specific risks	Impact		Inherent risk rating	Controls (existing & new)	Residual risk rating	Responsibility	When? Flags
	Consequence	Likelihood					
advances in research for group consideration, and to develop a systematic decision-making process which prioritises the weight of evidence rather than individual opinions. It is possible that important group members will resist this process.				blinded voting system is proposed to minimise the influence of individual clinicians. The Secretariat will need to invest time in stakeholder management.		Secretariat staff	based Slowness of policy development
The intention is for the policy secretariat to be an ongoing function of the AIDS Sub Directorate after AusAID funding ceases. While staff positions will initially be funded by AusAID, they will be seconded to the Sub Directorate. Office space shortage in the Sub Directorate may mean that this is not possible which would weaken the Sub Directorate's ownership	Moderate	Possible	High	If need be, policy secretariat staff can be located in the CHAI national office. This should be seen as a temporary measure and options for co-location with the Sub Directorate will be actively pursued till this is resolved	Medium	CHAI management	2012 and possibly ongoing Policy secretariat staff cannot be located in the Sub Directorate

Component 4: Operational research

Overarching Objective: To generate and apply knowledge that contributes to achieving the program goal of increasing access to high quality HIV-related treatment in Tanah Papua

Specific risks	Impact		Inherent risk rating	Controls (existing & new)	Residual risk rating	Responsibility	When? Flags
Operational research is an unglamorous field that is relatively new to Indonesia. In the CHAI program, it is very heavily integrated with routine monitoring activities. It may be difficult to recruit an experienced Indonesian to lead this program of work to success in Papua.	Moderate	Likely	High	Provide external support for the development of a program of operational research in the early phase of the program. Consider hiring people with experience in operational research not directly related to HIV or health service provision.	Medium	CHAI management	2012 Lack of suitable applicants
Decentralisation has led to an immense heterogeneity of policy and programming contexts, even within the program area supported by CHAI. This provides great opportunities to use simple comparative designs in operational research, but results may be hard to interpret.	Minor	Likely	Moderate	While the program intends to base its operational research on routine monitoring and limit the use of complex designs, Component 4.2 allows for more complex research questions to be addressed using external funding.	Low	Operational Research Manager	Ongoing External funding for more complex research is not available
The heterogeneity of the Papuan and the Indonesian contexts may limit the transferability of findings between different ethnic, cultural, geographic infrastructural and economic situations.	Minor	Likely	Moderate	The routine monitoring system will include relationship mapping and expenditure tracking, allowing differences in contexts to be described and their potential influence on produceability of results to be assessed.	Low	Operational Research Manager	Ongoing The routine monitoring system does not pick up contextual differences

Objective 4.1 Embedded research: Undertake embedded research that generates reliable knowledge with the potential to contribute to the program goal

Specific risks	Impact		Inherent risk rating	Controls (existing & new)	Residual risk rating	Responsibility	When? Flags
REACH will have access to populations in Tanah Papua about whom little is known. The intention is to maximise learning by working synergistically with other partners to develop joint research from funding sources external to the program. There is a risk that these research goals could hijack staff time and even service delivery, diverting REACH from the principle goal of increasing HIV treatment for Papuans in need of it.	Moderate	Possible	High	Risk assessments will be developed for any externally-funded research activities. The opportunity costs for CHAI and CoE staff time, the potential impacts on REACH program goals and community-related reputation risks will all be systematically considered. Any proposed externally-funded research will be referred to the appropriate governance bodies for consideration before agreement is reached.	Low	CHAI management, Operational Research Manager and Tanah Papua staff	Ongoing Research taking up too much staff time Research diverting health services from their core function

Objective 4.2 Local engagement: Increase the use of operational research data to achieve program goals

Specific risks	Impact		Inherent risk rating	Controls (existing & new)	Residual risk rating	Responsibility	When? Flags
Ideally, the principle users of the results of operational research are those responsible for program	Minor	Possible	Moderate	The REACH design includes a consultative phase during which potential end users will be asked to	Low	Operational Research	2013 – 2013 Operational

Specific risks	Impact		Inherent risk rating	Controls (existing & new)	Residual risk rating	Responsibility	When? Flags
	Consequence	Likelihood					
implementation locally. If the operational research component does not meet local information needs, the results are unlikely to be useful, or used.				identify knowledge gaps and information needs. These users will include AusAID and Indonesian government agencies at all levels, as well as service providers and users.		Manger	research results are not being applied
Operating environment							
Elections for Governor in Papua Province are more than a year overdue. Discussions and agreements around program design have been held with a Sub Directorate for AIDS whose leadership is very much in flux. Changes in key ministerial or Sub Directorate staff or the provincial government in Papua may lead to a change in priorities or otherwise undermine support for the program.	Moderate	Possible	Medium	CHAI will continue to maintain an open dialogue with Ministry of Health and other government staff; Papua province staff will engage with key figures in the provincial government and key political parties. *Existing*	Low	CHAID management CHAI Tanah Papua staff	2012 – 2013 As leadership positions change
Papua province and some program districts in Papua and West Papua will hold elections during the life of the program. Local elections have in the past triggered violence. This may restrict CHAI and government staff movement, and threaten mentoring and service delivery.	Moderate	Possible	High	Proactively hire indigenous staff wherever possible. Develop a staff safety plan including evacuation plans. Scale down or eliminate support in any conflict areas if needed. *Existing*	Medium	CHAID management CHAI Tanah Papua staff	Ongoing Local elections
Safety and security concerns will continue to be an issue throughout this four year program. This will affect staffing, implementation, and operations.	Major	Almost Certain	Very high	Security policies and protocols will be strengthened; implementation will be tested on a regular basis. Ongoing monitoring of safety and security situation through on-the-ground sources and regular communications. Prioritise hiring of indigenous staff wherever possible. Collaborate with UN security, AusAID security, CHAI HQ, and local police team to build early warning and alarm system for security. Developed and implement evacuation protocol if the event of extraordinary situations, including negotiating contract with local airlines as part of evacuation protocol and having cash reserve available for emergency charter flight. *Existing*	High	CHAI management, CHAI Tanah Papua staff	Ongoing Alerts of protests, tribal fights, and escalating violence

Annex 15: Compliance with AusAID policies

A15.1 Gender

The goal of REACH is equal access to CST for all that need it. Within this broad vision are substantive focal areas of work that at their core promote equity in HIV service provision.

One of the major challenges related to gender for REACH is reaching men. Apparently healthy men are far less likely to access health services than apparently healthy women; it is therefore more difficult to reach them with offers of HIV testing while they are still asymptomatic. REACH will work with the community outreach components of other donor programs and HIV testing services to develop strategies for reaching men. Partner counselling for women identified as HIV positive through antenatal care (ANC) or other routine testing will also be strengthened. An important part of these partner counselling services will be safeguarding the welfare of HIV-infected women whose partners are approached for testing and entry to care.

REACH will work proactively to provide early HIV treatment to the group of women in greatest need: street based sex workers, among whom prevalence is high and for whom service provision is virtually non-existent. Improved STI services will increase their ability to work safe from STI infection. Other sex workers, including those working in brothels and bars, will similarly benefit from access to early HIV treatment.

REACH will support the first services in the Papuan provinces providing specifically for the needs of transgenders. This is a small community, but one with particular vulnerabilities and a disproportionate effect on the spread of HIV. It has been entirely overlooked in the past. Similarly, gay men have had no services that meet their particular needs. REACH aims to rectify this in a program that provides access to people based on need.

REACH will identify the different impact of HIV diagnosis and treatment on men and women, and their differing care needs; we will integrate these issues into technical support, training and mentoring. REACH will also uniformly collect and disaggregate data by gender and other relevant variables to help monitor the program's efforts to reach its objectives, as well as to shape and direct future operational research questions and priorities.

A15.2 Greater involvement of people living with HIV

The greater involvement of PLHA (GIPA) has long been recognised as an important principle in the HIV response. The reality, however, is that application of the GIPA principle in Indonesia remains sub-optimal due to the limited capacity of PLHA and CSOs to fully participate in constructive ways.

The AIDS Sub Directorate has already initiated mechanisms to engage civil society organizations more inclusively. CHAI will continue to support these efforts through its Global Fund and REACH activities.

CHAI will continue to explore other meaningful ways to include PLHA groups in its work, including engaging PLHA expert patients to provide counselling and support to new ART patients, provide parent-to-parent counselling, and to assist with patient monitoring in the village. CHAI Indonesia will also work with its sister organization, CHAI PNG, to share culturally appropriate models and key programming lessons that can further the inclusion and participation of PLHA in REACH.

A15.3 Child protection

CHAI Indonesia will fully comply with Australia's child protection requirements, and report as required by AusAID. In addition, CHAI Indonesia is developing a child protection policy for all

staff who have contact with people under the age of 18. CHAI Indonesia's policy will meet AusAID's mandatory child protection compliance standards for contractors and NGOs. Note that as a technical assistance provider, CHAI does not provide direct clinical services to patients. Therefore staff will have limited contact with children and potential risks are minimised.

A15.4 Anti-corruption

CHAI Indonesia will fully comply with Australia's anti-corruption requirements and will be guided by AusAID Indonesia. The program will report as required.

A15.5 Environmental protection

The health sector is not generally considered an environmentally sensitive sector however CHAI considers that current MWM practices in Papua and West Papua health facilities have sufficient negative environmental impact to warrant intervention under REACH. To support AusAID in promoting ecologically sustainable development in accordance with the Environment Protection and Biodiversity Conservation Act[69], REACH will provide technical leadership in improving the safe management of infectious medical waste with introduction of non-incineration technology at CoE level. While there is no international convention that specifically covers MWM, the shift to non-incineration technology will be in compliance with Indonesia's environmental regulations, the Stockholm Convention on Persisting Organic Pollutants[70] (signed by both Indonesia and Australia) and the requirements of the WHO Guidelines for Disposal of Medical Waste[71]. The Program will identify indicators to support monitoring of the implementation of MWM practices.

A15.6 Branding

CHAI Indonesia will fully comply with AusAID's branding guidelines. CHAI Indonesia recognizes the Australian Government as the donor for REACH and will be transparent regarding where and how its funds are being used. This recognition will be applied throughout the program in all of its messaging and materials. In some circumstances where this may be politically or otherwise inappropriate, a common sense approach will be taken as outlined in the *Visibility and recognition*, *guidelines for managing contractors.* Such situations will be discussed with AusAID as they arise.

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[69] Environmental Management Guide for Australia's Aid Program
[70] Stockholm Convention on Persisting Organic Pollutants
[71] World Health Organization. Policy Paper. Safe health-care waste management.

Annex 16:   Key CHAI position descriptions

Currently, the only positions filled by international staff are the Country Director and the Senior Advisor. The new Operations Research and Monitoring Manager position may be filled by an international staffer. It is anticipated that all other positions will be filled by national staff.

Country Director (Jakarta)

Position Overview: The Country Director (CD) works with the Ministry of Health's political and administrative leadership to agree upon the role that the Clinton Health Access Initiative (CHAI) can play. The CD manages the overall country program, including planning, budgeting, managing relationships with government, donors, NGOs and UN agencies, implementation, monitoring/reporting, and expectation management. The CD also determines when specialized expertise needs to be made available within the country, and coordinates with the appropriate global staff of CHAI to ensure delivery. As the ambassador and program manager of CHAI in a country, the CD ensures that all actions of the country team are consistent with the organization's values, and continually strives to strengthen the mutual respect between the organization and government.

Responsibilities:

- Design CHAI's agenda and successfully execute it
- Maintain and strengthen the reputation of CHAI as a highly capable organization, whose agenda is primarily to partner with government and assist with its most pressing needs in the area of care and treatment
- Develop trust and strong relationships with all the key stakeholders in government, at both ministerial and administrative levels, as well as international agencies, NGOs, and donors
- Establish the appropriate processes and tools for planning, budgeting, program implementation, reporting, and monitoring progress
- Manage human resources and process for the country team and ensure appropriate staffing and administration
- Be knowledgeable of legal obligations and national laws and ensure CHAI compliance
- Maximize the use of program resources and participate in fundraising activities

Skills:

- Experienced in working with government, and demonstrated ability to favourably influence decision making processes in a diplomatic and collaborative manner
- Understands how to effectively build new relationships as well as nurture/strengthen existing ones at multiple levels in government
- Ability to navigate complex government processes with multiple influencers, and at negotiating and achieving consensus
- Result-oriented manager who can lead as well as execute
- Has demonstrated ability to work with the leadership of his/her organization on strategic, operational, and organizational issues, as a strong yet collaborative voice on the team
- An understanding of gender-related issues and the ability to integrate the principle of gender equality into program work
- Excellent written, presentation, and communication skills
- High level of proficiency in relevant computer applications particularly Excel, PowerPoint and Word

Pluses:

- 5-10 years experience in private or public centre enterprise, with increasing levels of responsibility and leadership; and a strong track record in achieving results; backgrounds in management in fast-paced, result-driven organizations normally provide good skill-sets.
- Has successfully served in a leadership role, with full operational and financial responsibility and accountability for a program, geographic region, business, or public initiative; experience conceiving, planning and executing programs or projects with documented results;
- Has demonstrated repeatedly that (s)he has brought in highly talented people into his/her organization; has built a band of loyal high-performers who will be willing to follow him/her to the next position

Education:

- Master's Degree in Business or Public Health preferred

Deputy Country Director (two positions: Programs in Jakarta/Papua and Finance & Operations in Jakarta)

Position description: The Deputy Country Director (DCD) will work with the Country Director and other internal partners to ensure the overall success of the country program. The DCD will help coordinate and support the Foundation's team on the ground to achieve the program's objectives, and forge stronger relations with government and other partners. A strong DCD will model a strong work ethic and mentor the development of younger employees. A flexible management style will allow a DCD to engage in details where needed, fill program management staffing gaps, and ensure projects are completed on time and on budget.

Responsibilities:

- Assist the Country Director develop CHAI's agenda in the country, in cooperation with the government;
- Help establish and achieve aggressive operational milestones;
- Provide administrative and managerial support to the Country Director in human resources, finance and general office administration
- Plan and execute specific programmatic initiatives, and support the team in doing so;
- Provide high-quality technical assistance to the government as needed/requested, often under a short timeframe;
- Coordinate efforts internally and with external partners to ensure resource maximization
- Advance a results driven culture focused upon the use of analytic, strategic and business skills
- Aids in resourceful decision making process that utilizes available resources and pursues the best outcome possible

Skills required:

- Responds quickly to needs of government, country staff and other CHAI colleagues
- Strong listening skills and a respect for local styles when engaging with government and other partners
- Ability to navigate complex government processes with multiple influencers, and negotiate and achieve consensus
- Works well independently and provides constructive, targeted feedback when program advancement stalls or problems arise
- Ability to dissect and structure a complex problem, drawing upon various sources and experiences
- Ability to work within budgetary constraints typical in a small foundation
- An understanding of gender-related issues and the ability to integrate the principle of gender equality into program work
- Excellent writing, presentation, and communication skills
- High level of proficiency in relevant computer applications particularly Excel, PowerPoint and Word

Pluses:

- A minimum of 5 years experience in private or public sector enterprise, with increasing levels of responsibility and leadership
- Knowledge of HIV/AIDS or public health is desired but not required
- Significant private sector experience beneficial

Education:

- Master's Degree (preferably in Business or Public Health) required

Senior Advisor (one position)

Background: The Clinton Health Access Initiative (CHAI) works with partner governments in more than sixty countries on five continents to help bring effective, high-quality HIV treatment and care to people living with HIV/AIDS worldwide. In Indonesia, CHAI supports the Government in achieving its goal of universal access to care, support and treatment for people living with HIV through support to national policy and guidelines development and implementation, strengthening the continuum of care at district and site level, and ensuring a reliable supply of treatment commodities. This approach requires clinical input at a national level as well as clinical mentorship and health systems strengthening at the district and site level.

Qualifications: CHAI is looking for a motivated, senior level health and development professional to provide strategic guidance, high level advocacy and technical support to national policy and program with a focus on Papua. This position

requires at least 10-15 years of experience in public health, and health systems strengthening; a clinical background is preferred.

The position also requires extensive experience in Indonesia including knowledge of GoI systems and the ability to navigate and advocate successfully at all levels. Bahasa Indonesia language skills are also a significant plus.

Responsibilities:

- Provide high level strategic and technical guidance to the CHAI Indonesia program with particular focus on Papua
- Conduct advocacy, coordination and support relationship building with government and non-governmental partners at all levels.
- Through regular trips to Papua, oversee progress towards activities and goals mutually agreed with GoI.
- Support the Papua based team by troubleshooting problems, building relationships, and providing technical oversight
- Provide technical direction and backstopping for clinical mentors and other field based positions as well as central level programs
- Represent CHAI to provide strategic and technical inputs at national level meetings and technical working groups
- Manage and support the Senior Clinical Mentor

Operational Research and Monitoring Manager (one position)

Position Description: The Operational Research and Monitoring (OR) Manager will work with a team to implement CHAI's operational research activities as well as lead the monitoring functions of the country's wider program. The OR Manager will be responsible for developing the program plan, identifying deadlines, budgeting and reporting and supervising the OR team. The OR Manager will be responsible for translating the research agenda into implementation. The manager will provide guidance on research design, coordinate protocol development, ensure approval by relevant ethics committees and monitor quality control during implementation. The manager will be responsible for appropriate dissemination of results.

Responsibilities include:

OPERATIONAL RESEARCH
- Work closely with the CHAI staff to identify research projects including impact assessments, rapid assessments, program evaluations and operational research studies and identify opportunities to utilize research results
- Lead OR team to develop indicative Operational Research Agenda and prioritise by projects and schedule
- Develop strong working relationships with key stakeholders in government, international partners, donors and NGOs, negotiate collaborative activities, and ensure maximum coordination of resources and effort
- Guide research design and protocols according to national and international standards
- Liaise closely with technical partners to support these operational research activities
- Establish workplan for each project and develop implementation schedule
- Conduct quality control measures on research activities
- Develop with team appropriate report back to the field and other stakeholders in timely manner

MONITORING
- Lead management of the monitoring efforts, with support from the Senior Data Analyst
- Coordinate regular meetings with other Program Managers to discuss monitoring data and adjustments to program implementation

- Create, manage and report on program budget
- Manage and coach teams and ensure everyone works towards the same objectives
- Represent CHAI at government meetings
- Work collaboratively with the CHAI global teams

Skills required:

- Demonstrated ability to manage complex workload and execute plans on time and on budget
- Highly entrepreneurial – creative thinking and high self-motivation
- Strong problem solving skills and analytical capabilities

- Strong interpersonal and relationship management skills
- Ability to navigate, complex government processes with multiple influencers; well poised with a high proficiency in negotiating and achieving consensus
- High level of proficiency in relevant computer applications particularly Excel, PowerPoint and Word; knowledge of statistical analysis software such as SAS, SPSS, or STATA
- Experience with qualitative software analysis such as MAXqda a plus
- An understanding of gender-related issues and the ability to integrate the principle of gender equality into program work
- Excellent writing, presentation and communications skills
- Fluency in English both written and oral; knowledge of *Bahasa Indonesia* helpful
- Willingness and ability to work in extremely resource-limited ways and areas

Pluses:

- Experience in working with HIV/AIDS or public health
- Experience in dealing with Government, Bi-lateral and multi-lateral organizations
- Experience working in resource-limited settings

Education:

- MPH, Master's degree, PhD or similar degree in public health or related health science or equivalent experience.
- 5+ years experience in HIV or other public health research in a development context

Regional Program Managers (two positions: Papua and West Papua)

Position Description: The Regional Program Manager will work with the Country Director, Deputy Country Director, and Senior Advisor to develop, plan, and implement the Care, Support & Treatment program in Tanah Papua. The Regional Program Manager will have oversight for the program and will work with senior management to achieve the program's objectives, and forge stronger relations with government and other partners. A strong Regional Program Manager will model a strong work ethic and mentor the development of younger employees. A flexible management style will allow a Regional Program Manager to engage in details where needed, fill program management staffing gaps, and ensure projects are completed on time and on budget.

Responsibilities:

- Help establish and achieve aggressive programmatic milestones;
- Plan and execute specific programmatic initiatives, and support the team in doing so;
- Provide high-quality technical assistance to the government as needed/requested, often under a short timeframe;
- Manage the budget and planning for the Care, Support & Treatment program;
- Coordinate efforts internally and with external partners to ensure resource maximization;
- Advance a results driven culture focused upon the use of analytic, strategic and business skills;
- Aids in resourceful decision making process that utilizes available resources and pursues the best outcome possible.

Skills required:

- Responds quickly to needs of government, country staff and other CHAI colleagues
- Strong listening skills and a respect for local styles when engaging with government and other partners
- Ability to navigate complex government processes with multiple influencers, and negotiate and achieve consensus
- Works well independently and provides constructive, targeted feedback when program advancement stalls or problems arise
- Ability to dissect and structure a complex problem, drawing upon various sources and experiences
- Ability to work within budgetary constraints typical in a small foundation
- An understanding of gender-related issues and the ability to integrate the principle of gender equality into program work
- Excellent writing, presentation, and communication skills
- High level of proficiency in relevant computer applications particularly Excel, PowerPoint and Word

Pluses:

- A minimum of 5 years experience in private or public sector enterprise, with increasing levels of responsibility and leadership
- Experience in working with HIV/AIDS or public health
- Experience in dealing with Government, Bi-lateral and multi-lateral organizations
- Experience working in resource-limited settings

Education:

- Master's Degree (preferably in Business or Public Health) or advanced degree in related field

Deputy Regional Program Managers (two positions: Papua and West Papua)

Position Description: The Deputy Regional Program Manager will work with the Regional Program Manager and other internal partners to ensure the overall success of the Care, Support & Treatment program. The Deputy Regional Program Manager will support the program and will work with the Regional Program Manager and their Program Managers to achieve the program's objectives, and forge stronger relations with government and other partners. A strong Deputy Regional Program Manager will model a strong work ethic and mentor the development of younger employees. A flexible management style will allow a Deputy Regional Program Manager to engage in details where needed, fill program management staffing gaps, and ensure projects are completed on time and on budget.

Responsibilities:

- Work with Regional Program Manager to establish and achieve aggressive programmatic milestones;
- Support programmatic initiatives and the team in doing so;
- Supervise managers that lead CST teams;
- Provide high-quality technical assistance to the government as needed/requested, often under a short timeframe;
- Assist the Regional Program Manager in budgeting and planning for the Care, Support & Treatment program;
- Advance a results driven culture focused upon the use of analytic, strategic and business skills;
- Aids in resourceful decision making process that utilizes available resources and pursues the best outcome possible.

Skills required:

- Responds quickly to needs of government, country staff and other CHAI colleagues
- Strong listening skills and a respect for local styles when engaging with government and other partners
- Ability to navigate complex government processes with multiple influencers, and negotiate and achieve consensus
- Ability to work within budgetary constraints typical in a small foundation
- An understanding of gender-related issues and the ability to integrate the principle of gender equality into program work
- Excellent writing, presentation, and communication skills
- High level of proficiency in relevant computer applications particularly Excel, PowerPoint and Word

Pluses:

- A minimum of 4 years experience in private or public sector enterprise, with increasing levels of responsibility and leadership
- Experience in working with HIV/AIDS or public health
- Experience in dealing with Government, Bi-lateral and multi-lateral organizations
- Experience working in resource-limited settings

Education:

- Master's Degree (preferably in Business or Public Health) or advanced degree in related field

Program Managers (eight positions: four in Papua, two in West Papua, two in Jakarta)

Positions include: Policy Manager, Supply Chain Manager, Operational Research and Monitoring Manager, Program Manager for Wamena and Mulia, Program Manager for Enarotali and Nabire, Program Manager for Jayapura and Pegunungan Bintang, Program Manager for Manokwari, and Program Manager for Fak Fak.

Position Description: The Program Manager will work alone or along with a team to manage a particular work stream within the country's wider program. Each Program Manager will be responsible for developing program plans, identifying deadlines, budgeting and reporting. As a Program Manager will be required to work with government officials and implementing partners, candidates must have excellent communications skills and a high degree of self-confidence. They must bring energy and enthusiasm as well as be able to function independently and have a strong commitment to excellence. We place great value on relevant personal qualities: resourcefulness, responsibility, tenacity, independence, energy, and work ethic. In country travel may be as great at 50 per cent.

Responsibilities include:

- Develop, monitor, adapt and manage several programs simultaneously
- Create, manage and report on program budget
- Manage and coach teams and ensure everyone works towards the same objectives
- Represent CHAI at government meetings
- Liaise closely with technical partners in government to monitor and evaluate interventions against objectives and targets, bringing in technical expertise when needed
- Develop strong working relationships with key stakeholders in government, international partners, donors and NGOs, and ensure maximum coordination of resources and effort
- Work collaboratively with the CHAI global teams

Skills required:

- Minimum of 5 years experience in private or public sector enterprise, with increasing levels of responsibility and leadership
- Demonstrated ability to manage complex workload and execute plans on time and on budget
- Highly entrepreneurial – creative thinking and high self-motivation
- Strong problem solving skills and analytical capabilities
- Excellent writing, presentation and communications skills
- Strong interpersonal and relationship management skills
- Willingness and ability to work in extremely resource-limited ways and areas
- An understanding of gender-related issues and the ability to integrate the principle of gender equality into program work
- High level of proficiency in relevant computer applications particularly Excel, PowerPoint and Word

Pluses:

- Experience in working with HIV/AIDS or public health
- Experience in dealing with Government, Bi-lateral and multi-lateral organizations
- Experience working in resource-limited settings

Education:

Minimum requirement: Undergraduate degree; post-graduate degree an advantage but not required.

Analyst (six positions: four in Jakarta, one in Papua, one in West Papua)

Positions include: Monitoring Specialist, Laboratory Analyst, Supply Chain Analyst, and Analyst

Position Description: Analysts typically enjoy working in fast-paced, environments either independently or with limited supervision; resourcefulness, tenacity, and flexibility are highly valued and are clearly demonstrated by successful candidates. Works tends to focus upon breaking down complex problems with qualitative and quantitative approaches as well as the application of business principles and cost/benefit analysis. Given the unpredictability of the work load, analysts must be results oriented and willing to work long hours. Analysts must collaborate with other CHAI teams as well as government or NGO partners.

Responsibilities include:

- Collect and analyse data, develop forecasts, and monitor results
- Develop models or other tools that can help structure problems or can be applied to derive analytic or strategic insight
- Draft and develop presentations
- Manage and execute upon multiple programs simultaneously
- Identify planning and execution risks and develop strategies for mitigation
- Communicate with internal and external stakeholders, identifying priorities, fulfilling requests, and building capacity

Skills required:

- Strong understanding of business principles and ability to apply them in daily work
- Ability to solve problems
- Strong attention to detail
- Excellent communications skills – both written and oral
- Ability to organize work efficiently and meet deadlines
- Strong interpersonal skills
- An understanding of gender-related issues and the ability to integrate the principle of gender equality into program work
- High level of proficiency in relevant computer applications particularly Excel, PowerPoint and Word

Pluses:

- 1 – 2 years experience working in the private sector
- Experience in HIV/AIDS or public health
- Experience in dealing with Government, Bi-lateral and multi-lateral organizations
- Experience working in developing countries

Education:

Minimum requirement: Undergraduate degree

Data Analyst (two positions: one in Papua, one in West Papua)

Position Description: Analysts typically enjoy working in fast-paced, environments either independently or with limited supervision; curiousity is their most important asset, and resourcefulness, tenacity, and flexibility are highly valued and are clearly demonstrated by successful candidates. Analysts must be able to see and explore the links between epidemiology and service provision, using clinical and other data to determine what needs are being met, and where the gaps are. Packaging of results for different users is an integral part of an analyst's work. Given the unpredictability of the work load, analysts must be results oriented and willing to work long hours. Analysts are a core part of provincial operational teams, and will work daily with program officers (and less frequently with government or NGO partners) to answer their questions and support their work. CHAI program analysts will also act as mentors to program analysts in CoE.

Responsibilities include:

- Training and ongoing mentoring of CoE data analysts in program relevant data analysis
- Ongoing analysis of REACH-supported service delivery and other program data for the province
- Responding to analysis requests and joint problem-solving with REACH staff and partners
- Packaging of results to meet the needs of different users
- Feedback of analysis to DinKes, CoE managers and other service providers, as well as to CHAI Jakarta
- Rigorous recording of results of analysis and feedback discussions, and subsequent monitoring of related programmatic changes

Skills required:

- Curiosity and a commitment to follow the data wherever it leads
- Strong understanding of HIV epidemiology and program logic

- Ability to work constructively to identify program strengths and weaknesses
- Strong attention to detail
- Excellent communications skills – both written and oral
- Ability to organize work efficiently and meet deadlines
- An understanding of gender-related issues and the ability to integrate the principle of gender equality into program work
- High level of proficiency in relevant computer applications particularly STATA/SAS/SPSS, Excel, PowerPoint and Word

Pluses:

- Experience in HIV/AIDS or public health program analysis
- Experience in operational/ implementation research
- Fluent Bahasa Indonesia (or a commitment to be functional within a year)

Education:

Minimum requirement: Undergraduate degree

Clinical Mentor (three positions in Tanah Papua)

Background: The Clinton Health Access Initiative supports the government of Indonesia in achieving its goal of universal access to care support and treatment for people living with HIV. One way CHAI assists Indonesia in achieving universal access is by supporting the development of technical capacity and health systems at a local level. This approach requires experienced clinicians to mentor their local colleagues in the identification of infected patients, the provision of comprehensive care including ART, and integration of HIV treatment into primary care. Assistance in the strategic thinking and management of resource-poor hospitals and clinics is also indispensable.

Qualifications: CHAI is looking for motivated physicians with at least 5 years of clinical experience as well as specific knowledge of HIV/AIDS treatment to serve as technical officers and clinical mentors in Papua and West Papua Provinces. We are looking for doctors with strong patient management skills, experience in both didactic and practical teaching, as well as experience treating HIV specifically. The candidate should have had direct experience with managing at least 100 HIV-infected patients in a longitudinal ambulatory setting, and with using all standard first and second line antiretroviral drugs, including side effect and toxicity approaches. Experience and skill in managing patients suffering with co-infections by tuberculosis, hepatitis B and C, pneumocystis, cryptococcal meningitis, diarrheal disease, and other complications is expected.

The candidate should have an understanding of gender-related issues and the ability to integrate the principle of gender equality into program work.

The ideal candidate should also have the strategic and programmatic skills necessary to identify bottlenecks to scaling up treatment and build the systems necessary to overcome those blockages. Experience in Papua or West Papua is strongly preferred. Experience with international organizations is a plus. Fluent Bahasa Indonesia required.

Responsibilities:

- With the Regional Program Manager and Deputy Country Director for Programs, engage service delivery networks and government partners at provincial and particularly district level to analyse the continuum of care and identify bottlenecks to care and treatment access;
- Following work plans designed with the Regional Program Manager, Deputy Country Director for Programs and local partners, implement activities and build systems to address those bottlenecks that are locally relevant, appropriate and agreed.
- Provide clinical guidance and information to build the capacity and confidence of service providers to identify, care for and treat patients with HIV.
- Serve as a resource for consultation regarding the management of ambulatory and hospitalized patients with all manifestations, both rare and common, of advanced HIV, as well as complications of HIV therapy
- Monitor and steward progress towards care and treatment targets set locally.
- Identify specific capacity building needs and facilitates implementation of capacity building. Bridge specialists who can act as short-term mentors with local service providers
- Support local level M&E by supporting data gathering, data analysis, as well as discussion and trouble shooting of issues identified.

Program Officers (13 positions: eight in Papua, five in West Papua)

Positions include: Program Officer, Communications Officer, and Government Relations Officer

Background: The Clinton Health Access Initiative (CHAI) works with partner governments in more than sixty countries on five continents to help bring effective, high-quality HIV treatment and care to people living with HIV/AIDS worldwide. In Indonesia, CHAI supports the Government in achieving its goal of universal access to care, support and treatment for people living with HIV through support to national policy and guidelines development and implementation, ensuring a reliable supply of treatment commodities and strengthening the continuum of care at district and site level in Papua. The latter will require program officers to conduct operational management, to provide inputs from a public health and development perspective, to facilitate communication with the variety of governmental and nongovernmental stakeholders and ensure the robust implementation of systems strengthening interventions agreed with technical advisors, mentors and treatment sites.

Responsibilities:

- Work with partner sites, local government and the CHAI team to plan implementation of an enhanced continuum of care for people living with HIV/AIDS
- Assist sites through regular meetings and communication in implementing plans and troubleshooting
- Facilitate short term and periodic technical assistance; ensure coordination internally among clinical mentoring team and staff for clarity and successful implementation of program activities and goals
- Work with the Operations Manager and Communications Coordinator as well as technical advisors to ensure communication and coordination with DinKes at the provincial level, KPA at district and provincial level, treatment sites and international and local partners
- Provide inputs from a public health, health systems strengthening and development perspective as needed
- Operationalize and implement recommendations and technical guidance as agreed with local partners.
- Facilitate monitoring, evaluation and analysis for continuous program adaptation and improvement
- Ensure the documentation of activities and outcomes in order to create replicable models and policy advocacy documents
- Perform basic finance and admin functions as needed under the guidance of the Director of Operations and in coordination with the Consultant for Papua

Qualifications

- Must be a citizen of Indonesia or possess a transferable stay permit with a Tanah Papua address
- Masters degree in a relevant field (public health, public policy, development etc.)
- Minimum 5 years professional experience as program manager preferably within an international organization at some point
- Experience with HIV/AIDS programs, health systems strengthening and managing organizational change strongly preferred
- Entrepreneurial ability to work quickly and effectively with minimal supervision
- Experience working with governments and governmental institutions; respect for the political processes and protocols involved in government programs
- Sensitivity to local political and cultural contexts; experience in Papua preferred
- Ability to absorb and synthesize a broad range of information
- Ability to handle multiple tasks simultaneously, set priorities, and meet deadlines
- Strong leadership and diplomacy skills,
- Strong problem solving and analytical skills
- An understanding of gender-related issues and the ability to integrate the principle of gender equality into program work
- Excellent communication (both written and oral) and interpersonal skills
- Excellent knowledge of spoken and written English and Bahasa Indonesia
- High level of proficiency with Microsoft office software, particularly Word, Excel and PowerPoint
- Understanding of basic finance

Finance Manager

Position Description: The Finance Administrator will report to the Deputy Country Director and will ensure compliance with Clinton Health Access Initiative and Government of Indonesia accounting and financial policies. He/she will also be responsible for administrative matters of the Indonesia CHAI office.

Responsibilities:

- In coordination with CHAI Indonesia's Deputy Country Director and US-based Finance Department, produce regular financial reporting including comparisons to budget, trends, and ratios with analyses and recommendations as needed
- Prepare monthly financial cash reports including bank reconciliations and review of final reports in coordination with HQ Offices
- Prepare bank and petty cash reconciliations. Implement control regimes over petty cash and bank accounts
- Maintain a system of internal controls, documentation and accounting that will ensure accurate reporting and recordkeeping in compliance with CHAI's policies and procedures
- Work with administrative staff to maintain accurate inventory of all assets, including supporting documentation as required by auditors
- Ensure compliance with Indonesian financial and taxation laws applicable to the Foundation including accurate and timely filing of tax returns and other filings as required by tax or other authorities
- Work with the US headquarters to prepare donor reports and contracts
- Manage multiple funding and accounts; manage transfers
- Work with administrative staff to manage vendor relationships, pay bills and invoices
- Maintain accurate records of cash on hand
- Manage payroll for local employees, including salary and taxes
- Review and analyse financial statements and supporting information related to Country Office and program expenditures
- Examine all payment vouchers and cheques made to ensure that they have been properly entered into the books and are consistent with CHAI requirements
- Preparation for potential audit with both internal and external agencies including Donors
- Manage Jamsostek insurance matters for the organization
- Coordinate with partner organizations within and beyond Indonesia on joint program accounting
- Manage Personnel and operational contracts administration
- Perform any other duties as assigned by the Deputy Country Director

Qualification and competency requirements

- Degree in accounting, finance or business administration.
- At least five years experience in accounting or book-keeping responsibilities.
- Practical knowledge of accounting software packages.
- Good interpersonal and team work skills.
- Excellent spoken and written English.
- Working knowledge with government institution desirable.
- Ability to work on Microsoft Office (Word, Excel, PowerPoint, etc.)

Finance Assistant (three positions: one in Papua, one in West Papua, one in Jakarta)

Role: The Bookkeeper will be responsible for ensuring compliance with Clinton Health Access Initiative accounting and financial policies for its Jayapura office, and possibly other locations in rural Papua province. A dynamic, entrepreneurial individual with expertise and knowledge of financial management and accounting practices and in-depth knowledge and command of financial administration of resources is desired.

Responsibilities:

- Implement an accounting software for a better and integrated management of multiple sites
- Prepare weekly financial reports, including bank reconciliations, and Cash Count
- Manage multiple bank accounts
- Examine all payment vouchers and checks made to ensure that they have been properly entered into the books and are consistent with CHAI
- Maintain an inventory of CHAI's assets
- Draft a budget for all program activities with input from responsible team members
- Develop and send "Surat Tugas" and other "Surat-Surat" for program activities
- Work with Administrative team to arrange flights/transportation and hotel for program team
- Collect quotations and deal with purchasing of materials for activities
- Work with Administrative team to make bookings for venues and meeting packages for events

- Follow up with vendor regarding training/meeting materials required
- Work with team to coordinate cash needs; conduct banking for cash withdrawals for petty cash/cash advance
- Distribute petty cash and collect expense reports from program team
- Manage vendor relationship, payment of bills and invoices
- Perform any other duties as required

Education

- Minimum requirement of 3 years of experience in Accounting/Finance and/or book-keeping responsibilities. Business, Accounting or Finance Degree is desirable. Exceptional experience will be considered in lieu of a degree.

Qualifications Required

- Entrepreneurial, detail-oriented individuals with strong managerial, interpersonal and teamwork skills are sought for this role. Fluency in English and Bahasa Indonesia is required. Candidates must be Microsoft Office savvy, particularly Excel.

Other skills and knowledge

- Practical knowledge of accounting software packages
- Previous private sector experience
- Experience with complex development settings
- Flexible enough to take on new tasks as they arise

Annex 17: Options for funding of the Centres of Excellence

The CoE are intended to be PHO facilities, located at the district level. AusAID funds will be used to pay for the CoE for the first three years, with the expectation that PHOs will take over the funding from the fourth year. CHAI considered options for funding mechanisms for the Coe. For non-salary operational costs it was decided that CHAI will directly pay for these costs, using AusAID funds, as this will avoid logistical obstacles that would slow program implementation.

For CoE staff salaries, the CHAI considered two options regarding how AusAID funds could be channelled to support the CoE:

1. CHAI sub-grants to the two PHOs for CoE staff salaries with CoE staff being employed directly by the PHOs; or
2. CHAI employs all CoE staff and pays for salaries directly from its AusAID funding.

There will be no difference in the level of salaries and benefits between the two options. If option one is adopted, it will be necessary to make a direct grant to the PHOs using CHAI's MoU with the MoH as the umbrella. It would not be feasible to channel the grant to PHOs through the Regional Development Planning Agencies (BAPPEDA) as this would require going through the annual strategic planning process for approval which would be too time consuming, especially as REACH will commence operations in July 2012.

A17.1 Direct granting to PHOs option

CHAI would transfer money annually to the PHOs to cover CoE salaries. Technical Arrangements would be developed between CHAI and the two PHOs. The agreements would be approved by the provincial governors and the provincial Regional Development Planning Agencies. Accountability for proper use of the funds would rest with the PHOs. Funding would cover salaries, health insurance, social insurance and tax.

Benefits with this system are:

- In addition to CoE staff being placed within the PHO structure they would be employees of the PHOs. This would reinforce PHO ownership of the CoE and may assist with realising the expectation that PHOs will take over CoE funding from year four.
- PHOs will develop improved skills in budget and human resource management.
- There would be no need to transfer employment of CoE staff from CHAI to the PHOs in year four. Any potential problems with such a transfer would be avoided.

Risks with this system are

- Misuse of funds.

To mitigate this risk a finance officer would be seconded from CHAI to help the PHOs with financial management, monitoring and reporting. Control mechanisms would be developed and followed as standard operating procedures. CHAI's Finance Manager together with the PHOs would develop a manual incorporating all control mechanisms before any money is released in the first quarter of year one. The manual will cover bank account arrangements, payments and funds transfers from the account, reporting, acquittals, invoicing, accounting policies and commitments, authorizations, roles and responsibilities, and conditions for ongoing support. A separate impress account would be used. Two signatures, one by CHAI and one by the PHOs, would be needed to transfer money.

The PHOs would regularly account for use of the funding to the Regional Development Planning Agency and the Ministry of Finance. CHAI would require the PHOs to submit financial reports every quarter.

A17.2 Direct employment by CHAI

CHAI would employ all CoE staff and place them in the CoE. The CoE would be PHO facilities, but the staff would be CHAI employees.

Benefits with this approach are:

- CHAI will have strong fiduciary control over the use of funds.
- Controls to mitigate against risks associated with using the government financial systems wold not be needed.
- Implementation could occur more quickly.

Risks with this approach are:

- The CoE staff may be viewed as CHAI project staff by other health facility staff. This could lead to unclear lines of authority and responsibility which could result in tension between health facility and CoE staff.
- If CoE staff are seen as CHAI staff, the overall perception may be that the CoE is a CHAI facility rather than a PHO facility.
- CoE staff may view themselves as CHAI staff, leading to different expectations and different affiliations and allegiances. This could make it difficult to absorb these staff into the PHOs in year four.
- The cost of the CoE staff would be less apparent to the PHOs. This may make it more difficult in the future for this aspect of the program to be absorbed into PHO budgets.

Overall, the benefits of direct sub-granting to the PHOs outweigh the risks, especially as the risks can be satisfactorily mitigated. CHAI will only directly employ the CoE staff if a grant cannot be made because of political, structural, or time constraints. A third option would for CHAI to employ all CoE staff in the first year, with a sub-grant being made to PHOs to cover salaries for years two and three.

Annex 18: Bibliography

AusAID, *An effective aid program for Australia: Making a real difference – Delivering real results.* Canberra, 2011.

AusAID, *AusAID Strategy for Assistance to Indonesia's Papuan Provinces.* Canberra, Undated.

AusAID, *Australia Indonesia Partnership Country Strategy 2008-2013*. Canberra, 2008.

AusAID, *Australia Indonesia Partnership for Decentralisation Delivery Strategy 2010-2015*. Jakarta, 2010.

AusAID, *Australia Indonesia Partnership for Health System Strengthening 2011-2016. Program Design Document*. Canberra, 2011.

AusAID, *Intensifying the response: Halting the spread of HIV. Australia's international development strategy for HIV*. Canberra, 2009.

AusAID, *Promoting practical sustainability*. Canberra, 2000.

AusAID, *Saving lives. Improving the health of the world's poor*. (AusAID's Health Strategy). Canberra, 2011.

Cohen, Myron S, Ying Q Chen, Marybeth McCauley, et al. 2011. *Prevention of HIV-1 infection with early antiretroviral therapy.* The New England Journal of Medicine 365 (6) (August 11): 493-505. doi:10.1056/NEJMoa1105243.

Elmslie, J., *West Papuan Demographic Transition and the 2010 Indonesian Census*. CPACS Working Paper 11/1. University of Sydney. 2010.

Government of Indonesia and its Development Partners, *Jakarta Commitment: Aid FOR Development Effectiveness. Indonesia's Road Map to 2014*. Jakarta, 2009.

Government of Indonesia, *Global Fund Proposal – Round 10. Cross-cutting health systems strengthening interventions.*

GRM, *Papua Assessment. USAID/Indonesia.* Jakarta, 2009.

Indonesian National AIDS Commission, *National HIV and AIDS Strategy and Action Plan 2010-2014*. Jakarta, 2010.

Kambodji, A., M. Linnan, and M. Kestari, *Adult sexual behaviour and other risk behaviours in East Java*. 1995, Yayasan Prospektiv: Surabaya.

Linnan, M., *AIDS in Indonesia: The Coming Storm*. 1992, USAID: Jakarta.

Miller P. *Donovanosis: control or eradication? A situation review of donovanosis in Aboriginal and Torres Strait Islander populations in Australia*. Office for Aboriginal and Torres Strait Islander Health, 2000.

Ministry of National Development Planning/National Development Planning Agency, *Summary of the Roadmap to Accelerate Achievement of the MDGs in Indonesia*. Jakarta, 2010.

Majid N, Bollen L, Morineau G, *et al.* Syphilis among female sex workers in Indonesia: need and opportunity for intervention. Sex Transm Infect. 2010 Oct; 86(5): 377-83.

Miller P, Otto B. *Prevalence of sexually transmitted infections in selected populations in Indonesia*. Indonesia HIV/AIDS and STI Prevention and Care Project. June 2001

Pontororing *et al*. *The burden and treatment of HIV in tuberculosis patients in Papua Province, Indonesia: a prospective observational study*, BMC Infectious Diseases 2010, 10:362

Provincial AIDS Commission, Papua and West Papua Provinces, *Communications Plan for HIV and AIDS Prevention and Management in Tanah Papua.* 2008.

Steen R, Chersich M, de Vlas SJ. Periodic presumptive treatment of curable sexually transmitted infections among sex workers: recent experience with implementation. Curr Opin Infect Dis. 2012 Feb;25(1):100-6.

Sutrisna A, Soebjakto O, Wignall FS, *et al, Increasing resistance to ciprofloxacin and other antibiotics in Neisseria gonorrhoeae from East Java and Papua, Indonesia, in 2004 – implications for treatment.* Int J STD AIDS. 2006 Dec;17(12):810-2.

Vogel IC, Richens J. *Donovanosis in Dutch South New Guinea: History, evaluation of the epidemic and control.* PNG Med J 1989: 32; 203-218.

World Bank, *Making the New Indonesia Work for the Poor (Overview),* Jakarta, 2006.

World Health Organisation, *World Health Statistics 2010.* Geneva, 2010.

Zachariah R, Ford N, Maher D, Bissell K, Van den Bergh R, van den Boogaard W, et al. *Is operational research delivering the goods? The journey to success in low-income countries.* The Lancet Infectious Diseases [Internet]. 2012 Feb [cited 2012 Apr 3];Available from: http://www.thelancet.com/journals/laninf/article/PIIS1473-3099(11)70309-7/fulltext

Zachariah R, Harries AD, Ishikawa N, Rieder HL, Bissell K, Laserson K, et al. *Operational research in low-income countries: what, why, and how?* The Lancet Infectious Diseases. 2009 Nov;9(11):711–7.