Independent Progress Report

Clinton HIV/AIDS Initiative in Indonesia

DRAFT FOR COMMENT

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Contents

Glossary of Acronyms and Terms

AIDS	Acquired Immunodeficiency Syndrome
ARVs	Antiretroviral drugs
ASHM	Australasian Society for HIV Medicine
CD4	Cells of the immune system that are destroyed by HIV
CHAI	Clinton HIV/AIDS Initiative
CST	Care, support and treatment
DepKes	Ministry of Health
DHO	District Health Office
DfID	United Kingdom Department for International Development
DMSS	DepKes Directorate of Medical Support Services
EID	Early Infant Diagnosis
EQAS	External quality assurance scheme
FDCs	Fixed dose combinations
FHI ASA	Family Health International Aksi Stop AIDS project
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
GoI	Government of Indonesia
HCPI	AusAID HIV Cooperation Program for Indonesia
HIV	Human Immunodeficiency Virus
IDI	Ikatan Dokter Indonesia, Indonesian Medical Association
IDAI	Indonesian National Paediatricians Association
IDUs	Injecting Drug Users
INGOs	International Non Government Organisations
IPR	Independent Progress Report
JOTHI	Jaringan Orang Terinefeksi HIV Indonesia (National Organisation of People Living with HIV)
KPA	National AIDS Commission
KPAP	Provincial AIDS Commission

KPAD	District AIDS Commission
M&E	Monitoring and evaluation
MNH	Maternal and Neonatal Health
NRL	National Serological Reference Laboratory (Australia)
OI	Opportunistic Infections
P2KTP	Tanah Papua Health Acceleration Program ('Save Papua')
Papua Barat	West Papua
Pendamping	Companion, term for peer support program
PEPFAR	US Government President's Emergency Fund for AIDS Relief
PHO	Provincial Health Office
PMTCT	Prevention of mother to child transmission
PNG	Papua New Guinea
PSM	Procurement and Supply Chain Management
Puskesmas	Community Health Centre
QASI	Quality Assessment and Standardization for Immunological Measures
RI	Rural Initiative
SCMS	Supply Chain Management Services
SOP	Standard Operating Procedures
STI	Sexually Transmitted Infection
TA	Technical Assistance
Tanah Papua	The land of Papua, comprising the Indonesian provinces of Papua and Papua Barat
TB	Tuberculosis
UNICEF	United Nations Children's Fund
UNAIDS	United Nations Joint Programme on AIDS
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

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Disclaimer

The views expressed in the Aide Memoire are those of the IPR Team only, and do not represent the views of Government of Indonesia or the Government of Australia.

Executive Summary

CHAI is making reasonable progress in its areas of focus, however there is considerable room for improvement in key areas. The assessment of progress against objectives has been constrained due to the lack of a comprehensive design document. Lack of a comprehensive design document with clear objectives is a substantial risk.

CHAI's primary strength is in procurement and supply chain management (PSM). CHAI has also demonstrated strengths in the care and treatment program area, with recent examples of high quality training and clinical mentoring in Papua. Partners in Papua support an ongoing presence in Jayapura and Wamena, and a focus on hospital systems, puskesmas strengthening and a broader community development approach to HIV care and support.

The work in paediatrics and laboratory strengthening is weak, and after completion of current activities could be wound down by mid-2011 or earlier. Technical support in paediatrics and laboratory strengthening after 2011 could be sustained by Indonesian systems, with Global Fund support.

Government of Indonesia (GoI) partners, including DepKes and the Papua Provincial Health Office, want CHAI to continue in Indonesia, but for the quality of CHAI's staffing, joint planning, coordination and communications to improve. The quality of relationships with GoI and other key players, including KPA, KPAP, UNAIDS, WHO, FHI and people living with HIV groups has been inconsistent. Strategic opportunities have been lost as a result. There is a lack of depth in forward-planning and inconsistency in the partnership approach with GoI at different levels in defining the priorities and planning in each of the focus areas of work. This is fundamental to sustainability. Opportunities for synergy with other Australian Indonesia Partnership activities including HCPI have been under-explored.

Given the size and complexity of Indonesia, CHAI's current work program is too ambitious. CHAI should focus its work in PSM, clinical mentoring and the Rural Initiative, guided by a clear design document, while phasing down other activities.

A more collaborative approach is required with joint work planning, led and owned by GoI. CHAI requires a more thorough M&E Plan and should provide more balanced reporting of progress, including identification of contentious issues and risks. Attention to gender equality issues could be significantly strengthened.

AusAID should be more proactive in monitoring CHAI relationships, sustainability and learning and in exploring opportunities for CHAI to complement other AusAID initiatives.

Key recommendations

Extension

A further 18 month phase is required to consolidate outcomes relating to PSM, clinical mentoring and the Rural Initiative, and to complete laboratory and paediatric initiative activities. It is recommended that:

i. CHAI be granted an extension from 1 January 2010 to 30 June 2011 (Phase II).

ii. CHAI lead a design process for Phase II, to be completed prior to 31 December 2009.

iii. The design to comply with AusAID requirements including: clear goal, objectives, outputs and outcomes; explanation of the development approach including how Jakarta Commitment aid effectiveness principles are applied, alignment with GoI policies and plans; an updated situation and needs analysis (including description of other donor and GoI HIV programs); risk analysis; implementation and sustainability arrangements; measures regarding gender equality, anti-corruption and child protection; M&E Plan; budget.

iv. Expertise on M&E and gender be provided by AusAID. M&E will be improved so as to monitor timely exit strategies, approaches to sustainability and the quality of interventions and relationships; and to include a schedule of data analysis and reporting to provide management information and accountability

v. The budget for Phase II be a maximum of AUD$2.25 million.

vi. The Phase II design be subject to an external peer review process to optimize harmonisation and alignment.

Phase II include:

i. An emphasis on PSM at national and provincial levels. Continued support to PSM for paediatric formulations and reagents. An exit strategy to phase-out CHAI support to other aspects of paediatrics and labs by 30 June 2011 or earlier.

ii. The work in Papua to continue, but not at an expanded level and with closer AusAID monitoring. No more than 70% of the budget should be used for Papua activities. A stronger community development approach in Wamena with increased engagement at puskesmas level and with local/district GoI partners.

iii. Clear and consistent objectives that can be effectively monitored, with a schedule of data analysis and reporting to provide management information and accountability. Attention to clarity regarding a coherent approach to planning and reporting of any PSM activity areas that are funded by both AusAID and Global Fund.

iv. A development approach that ensures GoI is fully consulted and leads work planning, and that GoI partners set the pace and determine entry points and priorities. CHAI can learn from capacity development approaches of HCPI and FHI e.g. in providing technical assistance (TA) in support of a programmatic approach and co-funding of activities with GoI.

v. Formalisation of the relationships with KPA, KPAP and KPAD.

vi. Ensure a stronger health systems strengthening approach including ensuring HIV/TB and STIs are addressed wherever practicable.

vii. Greater use of TA expertise based long-term in Indonesia and of Indonesian clinicians in training and clinical mentoring.

viii. A gender plan within the design to address not only whether activity is promoting equal participation but also equal benefits for females and males, equality of decision-making between women and men, promoting women's rights and developing capacity of partners to understand and promote gender equality within HIV responses.

ix. Increased AusAID engagement in design and monitoring of Phase II. Stronger engagement and oversight by AusAID to ensure quality and optimize synergies with HCPI and other AIPH activities (e.g. ASHM, NRL) and related Australia Indonesia Partnership for Development programs in the areas of decentralization and MNH.

New HIV Care, Support and Treatment (CST) Program 2011-2015

To ensure quality and effectiveness of AusAID support to 2015, an external design process is required, concurrent to CHAI's next phase. Through this process, the potential contribution of other providers and other forms of support to GoI can be fully assessed taking into account the new donor environment for CST. Timing of the design in 2010 is recommended to take into account: (i) PEPFAR and USAID's new program emphasis; (ii) Global Fund progress including CHAI's performance as the PSM sub-recipient; (iii) outcomes of a WHO/DepKes assessment of the health sector response to HIV; and (iv) the new AusAID Decentralization Program in Papua and Papua Barat and planning for new AusAID maternal and neonatal health activities in Papua and Papua Barat. It is recommended that:

i. AusAID fund a new HIV Care, Support and Treatment **(**CST) Program 2011-2015. The budget to be approximately AUD$6 million in total for the 4 year period.

ii. An independent design process for a new CST program be conducted in mid-2010. The CST Program to have a national systems and Papua/Papua Barat focus.

iii. The design to be informed by the principles of the Jakarta Commitment on Aid Effectiveness, particularly the need to strengthen country systems, and will consider all options e.g. managing contractor models, delegated aid, co-financing, budget support to GoI, donor harmonization including Indonesia Partnership Fund, partnerships with international NGOs, technical assistance, grant-making, output based aid.

iv. A tender process occur, if required, in early 2011 so that new program mobilises by July 2011 or soon thereafter.

v. The new program may include, but is not limited to, further support to GoI in focus areas of CHAI Phase II (i.e. PSM, clinical mentoring, rural needs), subject to an analysis of needs and gaps in the national and Papua/Papua Barat responses to HIV care, support and treatment.

1 Evaluation purpose and method

The Independent Progress Report (IPR) provides an evaluation of the Clinton HIV/AIDS Initiative (CHAI) in Indonesia for AusAID, GoI, the UN family and civil society stakeholders. The evaluation assessed CHAI's performance and lessons learned. The Team assessed CHAI against criteria of relevance, effectiveness, efficiency, sustainability, monitoring and evaluation, gender equality, and analysis and learning. The IPR provides guidance for improvements to programs and recommendations for further AusAID support.

The Team conducted meetings in Jakarta from 14-19 June 2009 and in Tanah Papua from 21-26 June 2009 (Appendix I), including with: DepKes and KPA; provincial, district and local government counterparts in Papua; the Provincial Health Office in Papua Barat; Community stakeholders including people living with and affected by HIV, national NGOs and local NGOs in Papua; multilateral agencies and donors (AusAID, USAID, UNAIDS, UNICEF, WHO) and other donor-funded projects (HCPI, FHI); and CHAI staff.

The Team reviewed project documents, technical reports and policies of GoI and AusAID (Appendix II). The Team also considered the data collected through CHAI's M&E systems.

2 Context

CHAI in Indonesia

AusAID has provided AUD$3.9 million to CHAI for a 21 month project from March 2008 to 31 December 2009. CHAI had a presence in Indonesia since early 2007 but was not registered as an NGO in Indonesia until April 2008. CHAI initially signed a Memorandum of Understanding (MoU) with DepKes on 27 July 2007. The MoU endorsed CHAI to work nationally and in the provinces of Papua and Papua Barat to provide access to high quality treatment for people living with HIV. The staff team was not in place until June 2008 in Jakarta, and until August 2008 in Papua. Implementation was impeded due to delays in agreeing a revised MoU with DepKes that conforms with updated regulations for foreign organizations, and the requirement that expatriate staff leave Papua for three months during national elections.

CHAI is an initiative of the William J. Clinton Foundation. In Indonesia, the Clinton Climate Initiative (CCI) also receives AusAID and Norwegian Government funding. AusAID and Global Fund are the only donors currently supporting CHAI in Indonesia. CHAI is funded as the Global Fund sub-recipient for HIV supply chain management (July 2009 - June 2014).

CHAI has a draft MoU with DepKes for the period July 2009-December 2011, which includes a 2009-2012 workplan. The workplan comprises six components: supply chain management; paediatric initiative; quality drug access; laboratory services strengthening; care and treatment; and targeted comprehensive service delivery in selected areas, currently covering Papua and Papua Barat.

Donor landscape

Funding for HIV care and treatment is insufficient to meet needs, especially in Papua. Global Fund Round 8 is the main source of funds for HIV treatment scale-up 2010-2015. With the exception of AusAID and Global Fund, other donor funding to HIV has been reducing since 2007 as a result of DFID withdrawal and a reduced USAID bilateral program.

Global Fund will be the dominant source of funds for the foreseeable future. The role of the USAID-funded FHI/ASA project in CST is reducing, and the USAID contract with FHI/ASA ends in March 2010. USAID will continue a bilateral HIV program with a focus on most at risk populations and an annual budget of approximately US$7 million. There is a possibility of some additional US Government funds (PEPFAR Partnership Framework) to be decided in 2010 for HIV-related health systems, national capacity building and Papua activities. AusAID's bilateral project (HIV Cooperation Program for Indonesia (HCPI)) addresses treatment services only in the context of injecting drug users and prisons, and has a HIV leadership and communication focus (HIV prevention and health promotion) in Papua. AusAID supports ASHM and NRL through the HIV Consortium for Partnerships in Asia and the Pacific, which has a modest budget for Indonesian capacity building partnerships to 2011.

GoI funds approximately 25% of the national response, which is a small proportion for a middle-income country. The GoI national HIV budget is not expected to increase significantly in the medium term. Funding at sub-national levels including Tanah Papua is increasing, but the amounts and duration remain unpredictable.

AusAID attention to health in Papua is increasing. AusAID is funding a new Decentralization Program with a focus at District level in Papua and Papua Barat 2010-2015. This new program will aim to strengthen GoI systems in health, education and other key sectors. HIV mainstreaming and gender equality are cross-cutting themes of the Decentralization Program. AusAID is also scoping possibilities for a new program of support to maternal and neonatal health in Papua in 2010.

Alignment with priorities of Government of Indonesia and Government of Australia

CHAI priorities are closely aligned with GoI, with the exception of paediatric treatment which is not regarded as a high priority by GoI respondents in Papua. Scaling-up access to treatment (including PMTCT) is a priority of GoI, within the context of the overall priorities of the KPA (National AIDS Commission) *2007-2010 HIV and AIDS Response Strategies* and *National HIV and AIDS Action Plan 2007-2010.* The GoI *Action Plan* requires a focus on higher prevalence provinces, most at risk populations, and the general population in Papua. Pediatric treatment is not an explicit national priority in KPA's *Action Plan.* CHAI workplans have been approved by DepKes. CHAI's program focus has been informed by a DepKes/WHO Review of the HIV response (2007), which identified paediatric ARV treatment as a gap.

CHAI's workplan received formal approval from the Provincial Health Offices of Papua and Papua Barat in January 2009.With the exception of paediatric treatment, CHAI priorities align with provincial priorities for HIV treatment that are established by *RENSTRA* (Provincial Strategies) for HIV and AIDS in Papua and Papua Barat. These include targets for scaling up ARVs, PMTCT, integrated care services and laboratory strengthening.

CHAI is a component of the Australia Indonesia Partnership for HIV (AIPH) 2008-2015. AIPH priorities are: a comprehensive HIV response in Papua; harm reduction in Java, Bali and prisons; and leadership including national systems. AIPH defines a programmatic approach and commits to progressively strengthen GoI to lead, plan, manage and increasingly fund the response. AIPH principles include to align with GoI plans and priorities, work at all levels in accordance with decentralization, and to increase the focus on high need populations including Papua.

Australia's new International HIV Strategy (*Intensifying the HIV Response* 2009) states the priority of optimising the role of health services within HIV responses including strengthening systems to overcome barriers to universal access to treatment. HIV is a priority of the AusAID Indonesia Country Strategy *Australia Indonesia Partnership Country Strategy 2008-2013*. The Country Strategy also promotes an orientation towards health systems strengthening**.** CHAI's systems orientation (e.g. PSM) is consistent with the AusAID International and Country Strategies.

3 Design issues

The IPR was required to assess CHAI's performance against the project's objectives and outputs. CHAI's objectives, intended outputs and outcomes, and implementation strategy are not clearly documented. There is no comprehensive design document. The evaluation assessed performance against program areas defined by the 2007 and 2009 MoUs with DepKes, the 2008-2009 Implementation Plan and the M&E Plan (Appendix IV p.42).

The focus of work plans and reports is 'areas of work', rather than clear objectives. There is no statement of program goal. The presentation by CHAI to the IPR Team referred to CHAI's global mission.[1] Areas of work are defined differently in different documents, but generally reflect the six program areas identified in the MoU with DepKes (PSM; access to quality drugs; laboratory services strengthening; paediatric initiative; Rural Initiative – pilot projects; and Care and Treatment incorporating training, clinical mentoring and national policy). These six focus areas are not mutually exclusive. Activities relating to "access to quality drugs" overlap significantly with PSM activities. The Rural Initiative overlaps with all other areas, as it largely comprises the application of the other focus areas (clinical mentoring, PSM, laboratory support) to a remote setting. Overlap is not necessarily a problem, but the rationale should be addressed in a document that explains the design logic to avoid confusion.

CHAI's 2008 Progress Report refers to the work plan as a 'living document'. This is borne out by the fluidity in program focus and loose project design. The lack of a clear design is a substantial risk. Planning documents do not provide evidence that the CHAI work focus is in response to consideration of activities that other programs are supporting (e.g. FHI, Global Fund, HCPI) rather than external factors, such as CHAI global priorities. Lack of a documented assessment of other HIV activities means that there may be a risk of duplication and poor coordination with other projects. With the commencement of CHAI activities funded by the Global Fund, there is a need for coordination of the planning and reporting of CHAI's Global Fund work with CHAI's AusAID-funded work.

4 Progress and lessons learned in key activity areas

4.1 Procurement and supply chain management (PSM), and access to quality drugs

CHAI is achieving good progress towards the intended outcome for this program area as identified in the M&E Plan i.e. Indonesia is accessing reduced prices for ARVs, introducing pediatric ARVs and is improving the timeliness and accuracy of forecasting and reporting.

[1] CHAI's mission is "to support the rapid expansion of access to high quality HIV/AIDS care and treatment for all who need it by improving the organization of commodity markets and enabling the effective and efficient management of health systems, thereby optimizing the use of available resources to save more lives".

There has been progress against all activity areas for PSM defined in the 2008-2009 workplan (listed in Appendix IV, p.42) and CHAI can demonstrate contribution to the intended outcomes, with the exception of distribution of paediatric ARVs and training of staff in Papua Barat. Distribution of pediatric ARVs has been postponed due to factors outside of CHAI's control but will occur in the second half of 2009.

CHAI has global expertise in PSM and has an excellent analysis of the challenges facing PSM at provincial and national levels. CHAI is the only active provider of technical assistance for all aspects of HIV-related PSM in Indonesia. UNICEF has procurement expertise but is no longer the GoI preferred procurement agent for ARVs. SCMS, another potential provider of TA, conducted initial assessments but is not working in-country. TA for HIV PSM is not a WHO priority.

At national level, CHAI has provided TA and logistical support to strengthen the forecasting, procurement, distribution planning, inventory management, and reporting capacity of DepKes. CHAI adapted an ARV forecasting tool for the Indonesian context, enabling site-level forecasting, and has trained DepKes on the tool. A Supply Chain Officer has worked with DepKes Sub-directorate AIDS to strengthen the national system. CHAI has advocated for procurement to reflect demand and supported emergency Global Fund purchases via UNICEF to avert stock outs. CHAI has assisted DepKes to access CHAI discount pricing for ARVs and diagnostics. Attention to building GoI sustainability in PSM is a central concern for both CHAI and DepKes, and CHAI is working towards handover of all roles in the medium term.

CHAI's work in developing Global Fund PSM Plans for Round 8 and Round 9 for treatment and prevention commodities is recognised by stakeholders including KPA as a significant contribution. CHAI worked with UNICEF to develop a procurement plan for HIV-related commodities for Indonesia's successful Global Fund Round 8 proposal. CHAI participated in the core proposal development team and PSM working group for the Round 9 proposal. CHAI's is supporting budgeting for supply of ARVs, drugs for TB and other opportunistic infections and prevention commodities such as syringes and condoms. In addition to improved reliability of ARV supply, broader systems strengthening outcomes are likely.

CHAI has advised DepKes on Voluntary Pooled Procurement (VPP), which is being taken up under Round 8. VPP has been welcomed by DepKes as a more cost-effective approach than previous systems. However VPP is not viewed as a long term option by DepKes, and ongoing TA in procurement will be important because a competitive bidding process may be the preferred procurement option in future years.

Working in partnership with DepKes with regular communication and use of skilled TA providers (including CHAI's Global PSM Adviser) has underpinned PSM success e.g. collaboration with DepKes and Kimia Farma has helped to initiate a system whereby Kimia Farma stores and distributes Global Fund ARVs.

DepKes has requested CHAI to be sub-recipient for supply chain management for Global Fund Round 8 (USD$1 million over five years). This indicates the confidence of DepKes in CHAI's comparative advantage in PSM. Enjoyment of the full benefits of the work funded by Global Fund hinge on AusAID maintaining its funding of a PSM component, which is significant factor weighing in favour of some ongoing AusAID support to CHAI in PSM.

PSM positions funded by Global Fund are to be placed in DepKes and will benefit from support by AusAID-funded CHAI staff. Planning for decentralization under the AusAID project, including an East Java pilot, is informing the approach to the work at provincial level in other parts of Indonesia. The Global Fund grant will enable CHAI to expand the decentralization work to all of East Java and other provinces.

CHAI is developing a PSM decentralization strategy in coordination with DepKes. As yet, CHAI's role in PSM at provincial level has been less robust than at central level, but its sub-national performance is likely to improve as it takes on the sub-recipient role for Global Fund. DepKes has sought CHAI's assistance in developing a decentralization strategy encompassing ARVs purchased by government and Global Fund. This will engage Kimia Farma, provincial authorities and hospitals in relation to data collection and analysis, ordering, storage, inventories and distribution. CHAI will support decentralization including for Papua, Papua Barat, Bali and Java. This geographic focus complements HCPI.

There has been some progress on PSM in Papua and initial scoping in Papua Barat. CHAI has assessed the status of facility reporting and stock management, and worked with the Papua district and provincial health offices to strengthen links to central agencies. CHAI has renovated space to store ARVs at Dok II Hospital Jayapura, which was reported by hospital staff to have been of immediate benefit. CHAI has conducted training in ten treatment sites in Papua on reporting and inventory management. Given the limited impact of training conducted in isolation, it is important that this be followed up.

A rapid test reagent supply chain system has been designed, but not yet implemented. Ownership of this new system by district and provincial counterparts is as yet unclear. Hospital and puskesmas reporting at some sites (e.g. Wamena) has improved as a result of initial CHAI visits. Follow up is required to ensure that improvements are integrated into the system, rather than reliant on individuals. Wamena and Papua Barat have requested support for training, working with hospitals on reporting, data analysis, and inventory management.

The '**Access to Quality Drugs'** program area is identified as a separate activity in CHAI plans, although could be considered a subset of PSM as the aim is to assist DepKes to secure competitive prices for quality-assured drug procurements. There is very slow progress towards the primary intended outcome i.e. WHO pre-qualification of Kimia Farma so as to increase Indonesia's access to quality products. The pre-qualification process has stalled after an initial WHO assessment. This appears to be due to lack of commercial incentive and political will, rather than CHAI's neglect. Another focus has been advice on international competitive bidding. However, VPP was chosen as the preferred interim approach rather than competitive bidding. Exploration of bidding as an option has reportedly provided useful lessons for DepKes to inform future policy on procurement.

Lessons learned and design implications

DepKes requests that PSM be a priority for a CHAI Phase II project. There is also demand for PSM support from provincial health offices in Papua and Papua Barat. A PSM focus can bring systemic benefits to both treatment and prevention. CHAI can expand the forecasting and procurement work to TB and other drugs for Opportunistic Infections (OIs), STI drugs, reagents and lab commodities.

Sustainability requires GoI ownership of systems (e.g. reagent supply system), a focus on improving recording and reporting tools that feed into the national system and integrated supply chain policies for a range of DepKes directorates.

CHAI currently provides significant support to DepKes for the forecasting and planning process, and this function can be progressively transferred to DepKes, with phase-out of assistance in the medium term and an increased provincial focus.

CHAI's role in capacity building for national procurement, including further work on competitive bidding, is required to prepare for a post-Global Fund environment.

4.2 Laboratory systems strengthening

Progress towards the three intended outcomes for this program area identified in the M&E Plan has been gradual and patchy ((i) Ministry of Health coordinates testing programs that provide patients with increased access to more affordable, high-quality CD4 tests, rapid tests, and early infant diagnosis (EID); (ii) patients in selected provinces have increased access to a network of high-quality HIV testing services pre- and post-ART initiation; (iii) selected provinces have improved and more efficient stock management of laboratory consumables at VCT testing sites and CD4 labs).

Issues of laboratory capacity and quality have meant that VCT and HIV treatment expansion has been delayed and constrained. There are two main areas of progress in laboratory strengthening supported by CHAI: CD4 reporting, referral and quality assurance; and HIV rapid testing and quality assurance. CHAI initiates and supports policy discussion, provides technical advice and logistical support, funds participation of laboratory staff in training on the conduct of HIV rapid tests, and provides stop-gap measures such as emergency procurement of reagents. In relation to EID, CHAI has worked with DepKes Directorate of Medical Support Services (DMSS) in planning EID pilots (see below).

Respondents reported that the assistance of CHAI in laboratory strengthening was appreciated as is not an area receiving support from other sources. Overall respondents report the role of CHAI as useful and there has been a significant increase in the number of sites able to conduct testing. However, there does not appear to be a comprehensive plan in place, including for the roll-out of training. This component would benefit from a greater role in ongoing support and mentoring to laboratory staff rather than an over reliance on one-off, off-site training, and could be better placed within a context of overall health system strengthening that places greater emphasis on increasing capacity for diagnosis of OIs (including tuberculosis) and STIs.

CHAI has assisted DMSS to establish a standardised reporting system for CD4 where laboratories report CD4 results on a monthly basis, thereby enabling central level monitoring of commodities, test statistics and an instrument maintenance checklist. While the number of laboratories reporting on a monthly basis is increasing, many still do not. Training was provided to two staff in each of the 24 CD4 laboratories by Becton Dickinson (manufacturers of CD4 machines) on a cost-sharing basis with CHAI. CHAI plans to assist DMSS to analyse results from reporting if requested. DMSS has not required assistance with analysis.

The ability of healthcare providers to accurately monitor patients' CD4 cell counts is critical for successfully initiating treatment and managing outcomes. The quality of CD4 testing in many facilities is reported to remain poor and unreliable. CHAI supported DMSS to implement a second national CD4 EQAS (external quality assurance scheme) for laboratories through Quality Assessment and Standardization for Immunological Measures (QASI) of Canada three times per year, with Dharmais Hospital laboratory as the national coordinating laboratory. CHAI's funding of a logistics officer in Dharmais Hospital laboratory to support the CD4 EQAS coordinator appears to be an essential resource to enable this process.

The QASI system is additional to the pre-existing CD4 EQAS in place since 2007, which continues to operate through the Thailand Centre of Excellence (COE) EQA program, in which laboratories participate 6 times per year. While one laboratory reported that there is no additional burden from running two simultaneous quality assurance programs, managing the two systems risks creating additional complexity. CHAI's rationale for promoting two EQA systems is that (i) participation in the QASI system provides an opportunity to compare results globally against a more robust data set; and (ii) the systems allow Indonesia to cross-check the results against one another. DMSS supports maintenance of the two schemes for these reasons. While there may well be added value for two systems, it is not clear that it is the best use of limited human and financial resources to maintain two systems.

The CD4 EQAS coordinator plays a key role in following up with laboratories displaying poor performance and providing advice. The IPR Team had access to minimal data on the outcomes of the EQAS, but it is reported that more laboratories are now participating in both EQAS systems and quality of CD4 results is improving. It does not appear that CHAI plays a direct role in this process. The role of the EQAS coordinator is being hampered by not yet undertaking training in Canada to enable certification and access to the QASI database, which would be expected to have already taken place.

CHAI has helped the Papua Public Health Laboratory to plan the CD4 referral network for the province. The network enables VCT centres to send specimens to one of five CD4 testing facilities. However, some report significant obstacles in implementing this system, including logistical constraints due to difficulties in transporting samples by air. CHAI is facilitating transport of specimens from Wamena to Jayapura for CD4 counts. There are questions around the sustainability of this process as it is yet to be integrated into local health systems.

In Papua, CHAI is arranging and funding training of laboratory staff from puskesmas and hospitals to attend HIV testing training. Some laboratories reported that despite receiving laboratory training from CHAI in OI diagnosis, they are unable to implement testing owing to a lack of equipment and reagents.

DMSS has conducted EQAS for HIV testing facilities for several years. CHAI is working with Australia's National Reference Laboratory (NRL) to establish four provincial health laboratories as HIV testing quality assurance hubs and to provide quality assurance for HIV testing for VCT centres nationally. The role of CHAI to date has largely been to funded participation of trainees. The future of this work is currently unclear, as CHAI has not committed to further financial support and NRL does not yet have funding to cover costs.

CHAI has played a significant role in advocating for EID, including through funding and organising a field trip to visit the national HIV referral laboratory in Botswana (involving

DepKes, Dharmais Hospital and the Papua Public Health Laboratory). A PCR machine for EID is being purchased through the Global Fund program. There is no clear plan for ensuring the elements are in place to provide a technically sound service (such as appropriate laboratory facilities) and to roll-out EID (including SOP and curriculum development, training for dried blood spot specimen collection, specimen transportation and training and support for laboratory staff). CHAI has a workplan that has been approved by DMSS which will address some of these issues, but the workplan has not been completely implemented. CHAI has assisted DMSS in creating a Technical Working Group, providing Draft SOPs, obtaining information on a DBS Kit Supplier and discussing the specifications for the PCR DNA Equipment.

Lessons learned and design implications

It is an important principle that the appropriate GoI stakeholder (DMSS in the case of laboratory strengthening) is fully involved in the recruitment of personnel. DMSS noted the need for CHAI personnel to be sensitive to the authority of DMSS and that CHAI is working to support them. In particular, DMSS is concerned that CHAI has not fully appreciated that DMSS has ownership of data arising from the CD4 EQAS process.

HIV laboratory strengthening needs to be more integrated within primary health care and a health systems strengthening approach. Training is just one component needed to improve laboratory capacity. CHAI needs to more fully consider the other issues needed to implement laboratory services such as reagents, equipment and ongoing mentoring. Particularly in Wamena and surrounding localities, an expanded role for CHAI in supporting the capacity of puskesmas to provide diagnostic testing for OIs, TB and STIs should be explored. CHAI should ensure that a clear plan is in place for laboratory strengthening, including a training and mentoring plan for facilities.

Serious limitations remain in access to timely and reliable CD4 services. The CD4 referral system and number and placement of CD4 machines should be revisited, taking into account new and simpler CD4 technologies being developed.

There needs to be careful consideration before expanding to new locations. Rather than expand work to new locations, CHAI should focus on existing locations to support sustainability of the work that has been commenced. Too rapid expansion places quality of services at risk in facilities that have already received training support. Mentoring and follow-up should be the immediate priority and ensuring facilities have the management capacity and resources to adequately implement services after training. Placement of a laboratory mentor in Wamena should be considered.

Increased collaboration with WHO is needed, noting that WHO has a mandate to work with DepKes in laboratory strengthening, and that funding for laboratory strengthening is included in Global Fund Round 8. Planning should incorporate a winding-down of involvement and an exit strategy for CHAI by June 2011 or earlier.

4.3 Paediatric Initiative

There is slow progress towards the intended outcome for this program area identified in the M&E Plan (i.e. that families have increased access to paediatric testing, care and treatment

services). Progress against the six activity areas of the 2008 work plan has mostly been in revision and distribution of national pediatric treatment guidelines, procurement of pediatric ARVs (yet to be distributed), and provision of didactic materials on pediatric treatment. There has been little progress in improving quality of HIV treatment and care for children in Papua and Papua Barat.

A small number of children and infants in Indonesia are currently receiving ART using adult formulations. DepKes and the Indonesian Association of Paediatricians (IDAI), with support from CHAI, are seeking to simplify treatment protocols and increase the number receiving treatment through early EID, introducing paediatric fixed dose combinations (FDCs) of ARVs, and by increasing access to PMTCT.

GoI national policy[2] identifies PMTCT as a priority: (i) among most at risk populations where there is a concentrated epidemic; or (ii) where there is a generalised epidemic such as in Tanah Papua. PMTCT is included as a priority within the Global Fund Round 8 grant and is situated within the context of maternal and child health in DepKes. However, paediatric HIV treatment has not been identified as priority in the *National Action Plan*, although several national-level respondents expressed support for it. Feedback in Papua was that paediatric treatment is not a priority at this stage, with higher order priorities needing to be addressed first. CHAI acknowledges that the concentrated nature of the HIV epidemic in Indonesia warrants a focused approach to paediatrics and that this is GoI's strategy. Nonetheless, there is concern that CHAI is setting up paediatrics as a new focus area, outside of GoI priorities.

It is planned that all VCT centres will implement PMTCT, and UNICEF has delivered some training, however many midwives have not yet received training. CHAI has played a role in supporting PMTCT in Jayapura through clinical mentoring.

Distribution of paediatric ARVs has been severely delayed by supply chain bottlenecks and is expected to commence in July 2009. CHAI has helped IDAI to prepare for roll-out by participating in development of an Action Plan for a 3 month trial, developing a paediatric dosing wheel, and printing and distributing the national paediatric treatment guidelines. The training curriculum is currently being developed with CHAI assistance, however a concern was raised about the appropriateness of CHAI's input (based on a Cambodian curriculum) for the Indonesian context. The IPR Team did not examine the curriculum and notes CHAI's explanation that the Cambodian document was provided at the request of Indonesian partners. CHAI plans to co-fund some training of paediatricians and has facilitated a lecture on paediatric FDC for paediatricians.

CHAI is expected to play a significant role in analysis of lessons learned through the pilot of ARV FDCs in four Jakarta hospitals for 30 patients (expected to be completed by September 2009). In supporting FDC roll-out, CHAI acknowledges that it will be necessary for DepKes and IDAI to ensure planning that addresses diagnostics, patient care, clinician training and supply of additional pediatric commodities. A comprehensive plan to roll-out paediatric treatment once the trial is complete is required, the need to incorporate lessons from the pilot notwithstanding. CHAI are advocating for a robust national strategy to roll out a package of

[2] *National HIV and AIDS Response Strategies* 2007-2010; *National HIV and AIDS Action Plan* (2007-2010)

paediatric services following the action plan. HIV treatment of children and infants is significantly more complicated than adults, hence there is a need for a plan for ongoing support and mentoring of paediatricians to cope with the increased demand expected following EID and FDC roll-out. IDAI reported that this will create additional burden on them that they do not currently have the resources to meet.

While there were initial attempts between UNICEF, FHI and CHAI to harmonise work on PMTCT and paediatric HIV treatment in Papua to ensure a unified approach, this has not come to fruition. UNICEF has a PMTCT project in Sorong (Papua Barat), and FHI has provided TA on PMTCT in Papua.

Lessons learned and design implications

Paediatric HIV treatment is not considered an immediate priority for Papua and there is a preference from stakeholders in Papua (shared by the IPR Team) for CHAI to focus their support on other higher priority issues.

Until the capacity for puskesmas to provide VCT services is increased, the model of PMTCT is difficult to apply in Papua where most women attend puskesmas for ANC. As most puskesmas do not have HIV testing or treatment capacity, women are referred to the hospital for those services. However, prohibitively high transport costs generally mean that women do not travel to the hospital for testing, or return for treatment follow-up.

In the rest of Indonesia, paediatric HIV treatment and PMTCT is considered to be a priority only in the context of populations at higher risk in areas of concentrated epidemic. In most cases this will mean the children of people who inject drugs. In such cases, it will be important to provide a holistic approach for the needs of the family with an emphasis on the particular needs of people who use drugs.

CHAI should have a minimal role in paediatric HIV treatment beyond PSM issues, analysis of the pilot of FDCs in Jakarta, and helping DepKes and IDAI to plan future work in support of further roll out of FDCs. Planning should incorporate a winding-down of involvement and an exit strategy for CHAI by June 2011 or earlier.

4.4 Care and treatment

This program area has included updating of national ART guidelines, training and clinical mentoring. As a result, there has been some progress towards the intended outcome stated in the M&E Plan that providers and stakeholders have access to up-to-date information on HIV epidemiology, care and treatment in Indonesia. CHAI has focused on addressing access to treatment information at the national level, Global Fund engagement and improving quality of services in Papua.

At the national level CHAI has collaborated with ASHM to provide funding to IDI for a position to form an Expert Panel for ART regimen approval and to revise national treatment guidelines. This position was filled in June 2009 with a commitment to 12 month's funding. This is a strategic contribution to the national treatment response. National respondents report that CHAI has been an active and valued partner in the Global Fund HIV Technical Working Group, grant proposal and implementation activities. CHAI was also represented on the core

proposal development team for Global Fund Round 9, which was also a role greatly appreciated by national stakeholders and are proposed sub-recipients for supply chain management in Round 9.

Proposed research activities on ART impact have not proceeded, due to funding constraints. CHAI funded the printing and distribution of the DepKes 2007 Integrated Bio-Behavioral Survey report.

CHAI's work in CST training and clinical mentoring has been focused in Papua. CHAI has faced difficulties recruiting mentors who are willing to relocate to Papua. Clinical mentors in Jayapura have worked in four hospitals and sixteen health centres, and CHAI supported Abepura Hospital to renovate its VCT clinic. The most significant outcomes from clinical mentoring have been in Wamena (discussed under Rural Initiative). Respondents were generally appreciative of the Jayapura-based mentors, however there was an expressed desire for a more proactive approach, more advance notice of activities and for clarity regarding the medium term plans so that efforts could be better coordinated. WHO in Jayapura indicated that two to three further years of intensive mentoring is required for clinicians in Papua.

CHAI's VCT and associated training has contributed to a substantial increase in VCT and ARV treatment in Tanah Papua. CHAI supported DepKes in conducting care and treatment training in Sentani for 16 doctors and 34 nurses from Papua and Papua Barat. The quality of this training was reported as high, but respondents were not clear regarding the process for refresher training and how supply of pharmaceuticals and patient adherence to ARV regimens, particularly in remote areas, could be ensured. This reflects concerns of respondents that the CHAI approach to increasing service provider capacity is not matched to health system capacity to meet increased need.

Lessons learned and design implications

Global Fund work is valuable and CHAI works well in the team setting. Apart from Global Fund engagement, CHAI has had little significant activity at national level under this program area. Given the timeframes and the overarching need to consolidate CHAI's focus, the proposed research work should not be a priority.

DepKes and WHO confirm that clinical mentoring is a national priority to improve workforce capacity to respond to HIV. CHAI can coordinate with DepKes and WHO on a national response to mentoring needs, while improving the Papua mentoring program through addressing recruitment, planning and coordination issues in partnership with provincial, district and local health services. Participation in a CST Pokja (national working group) would assist coordination.

The funding of the position to support national clinical guideline development is a good example of CHAI working effectively with professional associations and government. It is recommended that this be a 12 month full time equivalent position. CHAI and IDI should develop an exit strategy identifying alternative funding or other mechanisms to sustain the work after mid-2010.

Integrating a stronger focus on HIV/TB in Papua should be a priority. The integration of the VCT, STI and TB clinics at Wamena hospital is a positive outcome of CHAI's work.

Approaches could include extending HIV/TB services for Jayawijaya District beyond Wamena Hospital, and linking to the Jayapura-based HIV/TB Working Group and to KNCV (an INGO with TB expertise).

4.5 Rural Initiative (RI)

Intended outcomes for this program area, specified in the M&E Plan, are to: increase capacity of selected puskesmas to offer a broader range of HIV-related services; incorporate clinical mentoring in RI; strengthen pediatric care and treatment; and support PHO and DHO in exploring other HIV-related activities such as micro-financing, home-based care, and nutritional support. Of these outcome areas, the strongest progress has been in clinical mentoring and there has been some support at puskesmas level. The RI is yet to address paediatric care and treatment, or support to income-generating activities, sanitation, and nutrition.

After site assessment with GoI and FHI/ASA, the RI pilot commenced in September 2008. The pilot focuses on Wamena Hospital, Wamena city Puskesmas and Kalvari Clinic. Respondents reported that assistance under RI has been appreciated. There has been limited support from government, and some support from FHI/ASA, but generally the response is very under-resourced. Support from donors to the Wamena area has largely ceased. All respondents requested that RI in Wamena continue.

To date there has been little HIV care and treatment work focusing on remote rural communities in Indonesia. DHOs have not had staff for outreach work. Capacity and integration of HIV-related health systems in Jayawijaya District, where Wamena is located, is very poor, particularly beyond Wamena. Reasons for this include the impact of decentralization, regional autonomy, a legacy of weak administration and low funding, and the challenges of culture and terrain.

The P2KTP initiative (*Save Papua*) has been introduced by DepKes to reach remote communities with periodic visits from mobile clinics and addresses HIV, TB, malaria and child and maternal health. The contribution of P2KTP to HIV responses in remote areas is not yet clear. P2KTP is in early stages of implementation, is not yet well coordinated with local responses and has had no reported impact on HIV in Jayawijaya. Mobile clinics were not considered to have generated any significant rise in new HIV clients for health services in Wamena. It is not recommended that CHAI seek to link to P2KTP.

Achievements of RI have included clinical mentoring, care and treatment training, some short term logistics support and recent engagement with KPAD. However, the work has not met the expectations of respondents. The CHAI team have had a permanent presence for only around six months in Wamena. Expatriate and national staff have had little crossover. The full potential of RI has not been realized. The overall aim of the RI is not clear to respondents, some of whom felt it had been of limited value and fragmented. A lack of planning and coordination by CHAI across the full range of government and non-government agencies in the district was a shortfall.

Senior local health personnel met and jointly prepared a document of concerns for the IPR Team, which primarily related to issues regarding clarity of communication, planning and coordination. A mixed experience of CHAI training was reported, with training on universal

precautions and laboratory issues considered as poorly coordinated, whereas VCT training was well coordinated and more useful. Training was successful where the hospital took responsibility for coordination, logistics and certification.

There is also concern that not all CHAI staff have had appropriate experience and qualifications. Staff turnover is a problem i.e. the clinical mentors. Despite staff turnover, recent clinical mentoring at Wamena Hospital had been very successful and is highly regarded. Previous temporary mentors were reported to have over-estimated local capacity and there was concern that foreign clinical standards had been referenced rather than Indonesian guidelines. The engagement of skilled staff over an extended period of time appears to be essential. Understanding by mentors of Bahasa Indonesia and Indonesian systems was considered very important. Short visits by international experts was not supported and are perceived by some respondents as an attempt to raise facility activity levels driven by the need to meet external targets relating to provider initiated HIV testing and numbers of people on ART. There was concern that services would not be able to sustain increased service levels if the rise in demand was rapid and sufficient time had not been spent mentoring staff.

The current mentor has taken a health systems strengthening approach, building where possible on existing systems, using national and WHO guidelines, and thereby building institutional capacity as well as personal capacity. The integration of HIV, STI and TB services, and VCT training for staff across the hospital, is a sustainable outcome of this work. Support to Kalvari Clinic was highly valued including addressing reporting and supply chain issues and provision of infection control equipment.

There is a lack of consensus between GoI at national, provincial and district levels as to the preferred future focus for RI. The PHO requests CHAI to have a community development focus in Wamena with more attention to non-clinical needs. The DHO priorities are unclear and the Wamena Hospital is developing services with the aim of becoming a Centre of Excellence. Increased support to the puskesmas and Kalvari clinic was also requested. KPAD's priority is support to five puskesmas. Resolving PSM issues is a common priority, with unreliable air transport a difficulty. Some essential OI treatments (e.g fluconazole) are not available at Kalvari Clinic in Wamena.

CHAI clinical mentoring has contributed to clinical capacity and patient referral systems and HIV/TB/STI service linkage, but impact beyond the hospital appears as yet limited. Development by CHAI of a system to transport blood for CD4 testing to Jayapura has not been sustained in the absence of CHAI staff. Respondents were not aware of the CHAI SOPs for this work. Sustainable impact in this area is not possible without a well coordinated systems strengthening approach to the issues. Limited coordination across the range of health services in Wamena has not placed CHAI in a strong position to work at the systems level.

CHAI's recent engagement with the Jayawijaya KPAD including the initiative to strengthen five puskesmas in the Wamena area is positive and welcomed by the KPAD. CHAI assisted with recruitment of Head of HIV Administration in Jayawijaya based in KPAD. This position was occupied for 3 months in 2009 but is now vacant. As KPAD was already proceeding with recruitment, it is unclear if CHAI involvement was of strategic value.

CHAI has commenced work in the Jayawijaya District to develop patient support experts (*pendamping*). CHAI report they have supported the DHO to train 15 *pendamping* who have a current caseload of 70 patients. Health service staff could not describe added value from the CHAI *pendamping* program to patient support work already in place in Wamena. Respondents were not familiar with the CHAI guidelines for *pendamping* and it is unclear how the CHAI model has been adapted to local circumstances.

Lessons learned and design implications

In future CHAI /GoI documents, RI is to be referred to as *Integrated Pilot Projects to Strengthen Service Delivery in Selected Areas in accordance with MOH national programs and guidelines.* This may signal an intent of GoI that pilots are not necessarily to be defined by a Tanah Papua location.

Tension remains between health service staff in Wamena regarding RI. CHAI staff are aware of these tensions, but in planning and implementation CHAI need to be more informed and sensitive to the local and national context of the work. Where possible, CHAI should work within national and WHO guidelines and build on work to date rather than referencing foreign guidelines or introducing new approaches. CHAI should ensure that a clear RI plan is in place, linked to national and sub-national strategies and priorities. Considering the sensitive nature of Papua and extent of the epidemic, planning and implementation should formally engage KPA and Ministry of Health at national and sub-national levels.

Long term clinical mentoring using a systems strengthening approach by skilled, preferably Indonesian, doctors is preferred. Consideration should be given to linking with the joint DepKes WHO national clinical mentoring initiative funded under Global Fund Round 8. Output driven approaches should be avoided. A long term systems strengthening approach needs to value and learn from local knowledge, understand and respect local cultures, and invest in a gradual process of transfer of skills and knowledge.

There is little consensus on approaches to scaling-up HIV care, support and treatment in Jayawijaya. CHAI should work with district authorities to achieve this and to strengthen planning, but not take a lead role.

Under the MoU with DepKes, CHAI is not able to formally engage directly with community based organizations (CBOs). Any CHAI technical or financial support to CBOs is required to function through GoI institutions. Within these constraints, CHAI should consult with CBOs, liaise and share information and ideas as appropriate. Partnering with KPA in this area would be appropriate.

CHAI may be able to learn from community based groups how to support *pendamping* programs. The national HIV organisation Spiritia has developed a module for pendamping and report similar program activity in other areas of Indonesia. CHAI should work with Spiritia in developing the RI *pendamping* work.
CHAI should reconnect with FHI/ASA regarding rural work in East Java. FHI/ASA has a rural program in East Java. FHI/ASA report reasonable coordination with CHAI, although monthly meetings have stopped. FHI are interested in proceeding with collaboration.

5 Gender equality

The gender analysis and strategies to address gender-related issues in CHAI programming is either non-existent or very weak. This indicates a lack of appreciation of the integral importance of gender in HIV and health. CHAI's analysis is limited to presentation of the percentage of men and women employed or trained by CHAI and an expressed desire to not place an additional burden for health workers in collecting basic sex disaggregated data. CHAI reports that there is a module on women and HIV in *pendamping* training. CHAI needs to seek the support of a gender specialist for any further work to better understand the issues and implications for future work, and to better meet the needs of marginalised communities.

In addition to collecting sex disaggregated data, the work should consider the differences between men, women and people of diverse gender identities and sexualities related to:

- their different needs;
- implications of HIV status and treatment;
- constraints restricting participation and access to services; and
- trends, successes and lessons that relate to service provision.

Gender-related issues need to be mainstreamed into all training, programming and reporting including skills development around gender-sensitive issues and needs, including: violence protection; livelihoods and income security; testing and treatment issues specific to sex workers and their clients, drug users, men who have sex with men and waria; and understanding of the different impact of HIV diagnosis and treatment for men's and women's sexual and reproductive health needs.

CHAI could involve local community groups and NGOs to better understand and negotiate issues around gender. There may be potential for consulting with Women's Empowerment Bureaus who play a coordinating role with government line agencies and implementing organisations to promote women's issues.

6 Monitoring and Evaluation (M&E)

The M&E Plan is in the form of a matrix and is not contextualized. There is little connection between the data in the M&E matrix and the discussion and analysis in the narrative of progress reports provided to AusAID. It is unclear whether the existing M&E matrix of indicators is proving useful for management purposes to CHAI or AusAID. The M&E Plan has been in place for less than a year. It seems that little useful information has been generated against the M&E matrix to inform assessment of effectiveness, and although CHAI reports to the AIPH Program Coordination Committee there is no explicit link to the AIPH M&E Plan. Some of the indicators originally identified as key indicators, and included in the AIPH matrix, are no longer appearing in the CHAI M&E matrix.[3] For other indicators the AIPH requires sex disaggregation, but the CHAI data is not sex disaggregated.

[3] % HIV rapid test labs rated by EQAS coordinator as satisfactory/pass; % decrease in average price charged to patients for CD4 test in selected provinces; % increase in patients (boys/girls/men/women) in selected provinces receiving basic lab tests, including CD4; % increase in patients utilising VCT services in selected provinces and % patients tested that receive their results, # labs in selected provinces reporting CD4 & reagent stock outs

The matrix includes a description of the relationship of the activity to GoI objectives. A small number of CHAI indicators are partially aligned to GoI national indicators, but the alignment is sometimes unclear. For example, a CHAI indicator is "number adults tested for HIV" (in selected sites), whereas the national indicator is "percent women and men aged 15-49 who have been tested for HIV in last 12 months and have received their result". These indicators are linked, but not identical and the CHAI data is not sex disaggregated.

The Papua PHO reported a concern that reporting under CHAI's M&E system is not being shared with the PHO, indicating a need for closer alignment with provincial systems. In Wamena, there was a request for a joint annual evaluation in partnership with the local health agencies.

Reporting could be strengthened by consideration of the extent to which reported benefits and achievements are likely to be sustainable. Some benefits appear to be entirely reliant on CHAI inputs and initiatives. The M&E plan provides little basis for monitoring the likelihood of achieving sustainable benefits, and does not enable consideration of gender, anti-corruption, or coordination with other donors. The plan requires a greater emphasis on monitoring quality, sustainability and outcomes, in addition to selected quantitative outputs.

PSM is not included in the GoI national M&E system. CHAI should support GoI to improve monitoring of PSM within the national M&E System, as this is currently poorly addressed. This will assist progress towards a sustainable GoI PSM system.

CHAI should systematically collect, analyse and report sex disaggregated data. This would begin to demonstrate to Indonesian partners the value of disaggregation in understanding gender and HIV.

It is acknowledged that the existing M&E Plan was prepared by CHAI in response to AusAID's request and was considered a satisfactory first step to improving M&E. In future, the project requires a more thorough M&E Plan in the form of a narrative which links the data referred to in the matrix to reporting to GoI, CHAI, AusAID, Global Fund and other partners, provides a guide for the analysis of data, describes what analysis and reporting is done by whom and when, and addresses alignment issues including links to AIPH and GoI M&E. The plan should describe how lessons learned are fed back to inform project management and how the project M&E approach strengthens GoI M&E and implementation capacities. The plan should also acknowledge attribution as an issue, so that the extent that CHAI contributes to results as distinct from other causal factors can be assessed in reporting.

CHAI participated in a series of multi-stakeholder National M&E Workshops held in 2009 to coordinate the various M&E systems and indicators used in Indonesia, as well as to review and revise the national M&E guidelines and recording/reporting system.

7 Project management

Counterpart engagement

CHAI's technical counterpart is DepKes. CHAI is also situated within AIPH, for which AusAID's key counterpart is KPA. However KPA currently has minimal engagement in CHAI workplan development or oversight of strategy. In designing future work, attention needs to be given to the need for KPA/KPAP to be formally briefed on program directions

and to have the opportunity to provide input into decisions regarding focus and priorities. At the sub-national level, CHAI senior managers need to be more proactive in ensuring all key GoI partners (including PHO, DHO, KPAD and KPAP, Bupati etc) are fully informed.

Financial management

More information is required in financial reporting to aid in understanding of the rationale for expenses and the categorization of expenses e.g. by explaining what comes within expenses reported as 'TA and related costs', 'program management' and 'indirect costs'. It is not helpful for analysis that most expenses under each component are classified as 'indirect costs'. There is very little allocated for programming. This suggests that the vast majority of costs are for staffing, travel and administration. A program that primarily provides TA can be expected to have high staffing costs (salaries were 66% of allocations for first quarter 2009), however CHAI's programming costs appear to be very low by comparison and the rationale for this is not always clear. Most of the programming costs are for meetings and trainings, which is appropriate. There is a 12% on-cost for global support services. CHAI's Indonesia project has benefited from periodic support from its regional and global teams in the PSM, CST and laboratory program areas. A justification for the 12% on-cost could be provided by detailing the extent of support from the global and regional teams.

Other reporting

CHAI progress reports to AusAID could be more candid in reporting risks, risk mitigation measures, failures and challenges, as well as successes. The M&E Plan has been in place for less than a year and although some data has been generated, there is little evidence of analysis of data being conducted to inform reports and aid the assessment of effectiveness. It was not clear that the M&E Plan's many indicators have yet been useful for management purposes. As CHAI is now receiving funds from both Global Fund and AusAID, a coherent approach to managing, planning and reporting of co-funded activity is required.

Staffing

CHAI Indonesia has grown rapidly from one staff member in 2007, to a team of twelve in Jakarta and seven in Papua. This is a large staff team given the overall budget. Short term advisers and regional technical staff are also engaged by CHAI. International staff are paid at lower than market rates for comparable positions. Managing this rapid growth effectively is a significant challenge. The program is managed by the Deputy Country Director. There has been a changeover of Deputy Directors in the first year of the AusAID-funded program, and significant turnover of staff particularly in Papua. It is probable that consolidating the CHAI Papua and Jakarta teams and addressing turnover has diverted attention from establishing and maintaining some important external relationships. A number of key stakeholders in the HIV response reported irregular contact with CHAI staff, and consequently a lack of clarity regarding CHAI's plans and objectives. These communication issues may be due to inexperience of some CHAI staff or over-stretched management capacity.

GoI have expressed concerned that CHAI has had too many expatriate staff. CHAI is actively addressed this concern by ensuring a ratio of expatriate to Indonesian staff of 3:1 as requested by GoI. DepKes have requested that positions such as human resources manager and finance officer should be filled by national staff, as well as some technical positions where feasible. CHAI acknowledges the value of engaging local mentors, however CHAI reports that the pool of Indonesian clinicians with experience in HIV who are willing to relocate is small. There are however different opinions as to the feasibility of sourcing Indonesian clinicians

with a medium to long term commitment to Papua. Some informants were of the view that, with the right approach to recruitment and professional support, candidates could be found. CHAI could benefit from lessons from KNCV, FHI and HCPI on approaches to recruiting national staff. CHAI should also coordinate with the joint DepKes/WHO national HIV clinical mentoring program, which has identified over 50 Indonesian clinicians with potential to act as mentors. CHAI should avoid bringing in foreign experts unless there is a commitment to a long term relationship.

The development experience and technical qualifications of some staff was questioned by some stakeholders, particularly in relation to the work in Papua. There was concern from Papua partners about the qualifications of some CHAI staff to participate in laboratory work.

Given the critical importance and complexity of maintaining clear and regular communication with GoI at all levels, attention needs to be given to ensuring staff with government liaison roles are appropriately skilled and supported.

A review of the qualifications and experience of staff based in Papua to plan and implement a program in this complex and sensitive environment is required. It is recommended that at least one senior staff member in the Papua office be an Indonesian national.

Some GoI stakeholders expressed concern regarding the lack of involvement in CHAI recruitment processes. CHAI is actively working to address this issue.

The creation of seconded positions such as the CD4 Manager at Dharmais Hospital and the Global Fund PSM positions located in DepKes is a good capacity development approach, in that institutional capacity is more readily strengthened by locating positions within these services. Similarly, the clinical mentoring position in Wamena works primarily from the hospital.

8 Conclusions

CHAI Phase II, 1 January 2010-30 June 2011

Given the size and complexity of Indonesia and the funds available to CHAI, working both nationally and at provincial level across five activity areas is too ambitious. CHAI should focus its work on PSM, clinical mentoring and the Rural Initiative, guided by a clear and comprehensive design document, while phasing down other activities. Key counterparts including DepKes and PHO have requested the CHAI project to continue. A further 18 month phase is required to consolidate outcomes relating to PSM, clinical mentoring and the rural initiative, and to complete laboratory strengthening and pediatric treatment activities.

Design of the program for Phase II should be within the framework of the 2009 MoU with DepKes. The Program Direction and workplan attached to the MoU is subject to Annual Review. The CHAI design for Phase II should define objectives within the framework of the existing Program Direction and workplan, adjusted as necessary to address the phasing-out of activity and exit strategies for paediatrics and laboratory strengthening. There can be no expectation of ongoing funding from AusAID for these areas after June 2011, so planning should aim for sustainability in these areas by completion of Phase II.

During the design process, CHAI will need to assess whether to plan for ongoing work beyond July 2011in the areas clinical mentoring and rural pilots, and for those parts of the PSM program that are not funded by Global Fund. If CHAI's strategy is to seek funding for ongoing work in these areas, then a source of funds needs to be identified. This could be through competing for AusAID funds under a new CST program, if the design mission recommends a competitive tender. Alternatively CHAI could look to Global Fund or other donors. If CHAI decides not to seek further funding for this work, then the design will also need to include an exit strategy for these other areas of work.

The design should define the objectives and intended outcomes for activities that can be completed within the timeframe of Phase II e.g. analysis of the Jakarta FDC pilots to support the planning of the national roll out for FDC pediatric drugs, support to the CST Expert Panel and finalization and promotion of the updated national ARV guidelines, and further laboratory support in Wamena including a laboratory services mentor in Wamena Hospital.

The design should articulate a development approach that ensures collaborative working is strengthened in Phase II, with joint detailed work planning, led and owned by GoI. CHAI requires a communications strategy to inform the approach to and regularity of contact with all key players. This should be integrated into planning and include a more thorough and balanced reporting of progress, contentious issues, risks and risk mitigation measures. The relationships with KPA and Papua KPAP, and with other donor projects including FHI and HCPI need to be strengthened at formal and informal levels. Dialogue also needs to occur with community based organizations such as JOTHI and Spiritia. These groups reported a lack of information on CHAI's progress in improving access to and quality of HIV treatment and care, and had not had regular opportunities to provide their perspectives to CHAI.

The work in Wamena should be informed by a direct relationship with CHAI's PNG Rural Initiative, enabling regular sharing of lessons on capacity development and systems strengthening. The PNG Rural Initiative has been evaluated very positively by an IPR Team for AusAID.

Other options considered

The IPR Team considered recommending terminating AusAID support to CHAI in December 2009, or terminating AusAID support for all program areas except PSM in December 2009.

The option of terminating funding in December 2009 is not recommended because: (i) there is a clear request from DepKes and PHO that CHAI funding continue; (ii) the work that has recently commenced in PSM, clinical mentoring and the Rural Initiative requires a further 18 months to consolidate and realise sustainable outcomes; (iii) the PSM program is demonstrating good value for money and withdrawing AusAID funds would undermine the Global Fund PSM program; (iv) given the severity of the Papuan epidemic and extent of unmet treatment needs, AusAID should avoid creating a hiatus in its support to care and treatment in Papua of 18 months or more while a new program is designed.

For paediatrics and laboratory strengthening, although progress has been patchy the benefits to be realised in completing the work that has commenced are sufficient to warrant continuing activities to 2010-2011. Given the investment to date, it would be premature to terminate program areas in 2009. For paediatrics, analysis of outcomes of the Jakarta pilots for EID and FDCs and related support for planning for national roll-out of paediatric HIV

services will have been completed by the end of 2010 and activities such as support for planning of national roll out can wind down by June 2011 or earlier. For laboratories, gains can be made over an 18 month period by focusing on existing areas and supporting the Rural Initiative, rather than expanding into new activity areas or geographic sites. For care and treatment, the process for updating national guidelines and supporting the Expert Panel will run to mid-2010.

Independent design of a new HIV Care, Support and Treatment Program
To ensure quality and effectiveness of AusAID support to 2015, a thorough external design process for a new HIV care, support and treatment (CST) program is required, concurrent to CHAI's next phase. Through this process, the potential contribution of other providers of technical and capacity development assistance in CST, and other forms of CST support to GoI, can be fully assessed, taking into account the new donor environment for HIV CST.

The CST program should be situated within the AIPH framework and have a focus on Tanah Papua and strengthening national systems. The design process should consider the potential benefit of different approaches to supporting CST, including TA, capacity development through training and mentoring, grant-making and co-funding, and output-based aid.

Draft Terms of Reference for the design of this program are attached (Appendix V, p.44).

The AusAID contribution to CST under the new program could include any of the areas that CHAI currently works in (i.e. including PSM, laboratory strengthening, mentoring etc), or additional or alternative focus areas depending on need and GoI priorities. A full design and procurement process for a new program in CST may take 12 months or more prior to commencement.

Timing of the design process in mid-2010 is recommended to take into account: (i) PEPFAR and USAID's new program emphasis; (ii) Global Fund progress including CHAI's performance as the PSM sub-recipient; (iii) outcomes of a WHO/DepKes assessment of the health sector response to HIV; and (iv) the new AusAID Decentralization Program in Papua and Papua Barat and planning for new AusAID maternal and neonatal health activities in Papua and Papua Barat. The first phase of Global Fund Round 8 ends at 30 June 2011, so Global Fund performance data will be available by then for consideration by AusAID.

The design should be informed by the need to strengthen country systems, to be led by GoI priorities and to consider all options including (but not limited to) competitive tendering of the work to a managing contractor with expertise in TA and capacity development, co-financing of activities with other donors, and/or providing funds directly to UN or GoI agencies to lead the work. The design should also consider the benefits and risks associated with channelling AusAID funds through alternative mechanisms for CST work nationally and in Papua e.g. HCPI (through contract amendment), Indonesia Partnership Fund, KPA/KPAP, AusAID decentralization facility (at district level), HIV Consortium (ASHM, IDI and NRL).

The design process could consider continuing a partnership with CHAI in areas where it is demonstrating strong value for money. The design may consider, as an option, funding to CHAI for a phase III program of work in PSM and/or other activities if this is GoI's priority (rather than to consider another provider and/or another CST focus area), and CHAI has demonstrated effectiveness, and this option is assessed to represent value for money (as

compared to a tender process). Stakeholders including UNAIDS emphasised the need for AusAID to demonstrate flexibility in design of a future CST program, given the changing context. The design should be responsive to the dynamic context including changes in understanding of the HIV epidemic and associated needs nationally and in Tanah Papua.

9 Recommendations

9.1 Immediate priorities

The focus of the next four to six months should be working with AusAID on the Phase II design and immediately addressing concerns regarding quality of communications with key stakeholders. This process should be facilitated by easing of expatriate staff restrictions for Papua. A review of the qualifications and experience of staff based in Papua should occur without delay. Dialogue with Wamena health service partners should occur as soon as practicable regarding a way forward in response to the specific communication, coordination and planning concerns raised in the IPR evaluation process. Immediate steps can be taken to formalise the relationship between CHAI and KPA/ KPAP consistent with the MoU with DepKes and the AIPH program structure.

Particularly over the next four to six months, AusAID should devote more resources to its monitoring of and support to CHAI including agreeing reporting formats that include identification of risks and lessons and which specifically addresses progress in improving relationships with partners. CHAI should immediately increase dialogue with HCPI and FHI on strategic advice and opportunities for coordination and collaboration. CHAI should brief the national organization of people living with HIV (JOTHI) and other community based groups on CHAI achievements and plans, and ensure that community based organizations have an opportunity to provide their perspectives to CHAI.

9.2 Phase II: 18 month extension to CHAI

It is recommended that:

i. CHAI be granted an extension from 1 January 2010 to 30 June 2011 (Phase II).
ii. CHAI lead a design process for Phase II, to be completed prior to 31 December 2009.
iii. The design to comply with AusAID requirements including: clearly defined goal, objectives, outputs and outcomes; explanation of the development approach including how the Jakarta Commitment aid effectiveness principles are to be applied; alignment with GoI policies and plans; an updated situation and needs analysis (including description of other donor and GoI HIV programs); risk analysis; implementation and sustainability arrangements; measures regarding gender equality, anti-corruption and child protection; M&E Plan; budget.
iv. Expertise on M&E and gender be provided by AusAID. M&E will be improved so as to monitor timely exit strategies, approaches to sustainability and the quality of interventions and relationships. M&E needs to include a schedule of data analysis and reporting to provide management information and accountability.
v. The budget for Phase II be a maximum of AUD$2.25 million.
vi. The Phase II design be subject to an external peer review process to optimize harmonisation and alignment.

It is recommended that Phase II include:

i. An emphasis on PSM at national and provincial levels. Continued support to PSM for paediatric formulations and reagents. An exit strategy to phase-out CHAI support to other aspects of paediatrics and labs by 30 June 2011 or earlier.
ii. The work in Papua to continue, but not at an expanded level and with closer AusAID monitoring. No more than 70% of the budget should be used for Papua activities. A stronger community development approach in Wamena with increased engagement at puskesmas level and with local/district GoI partners.
iii. Clear and consistent objectives that can be effectively monitored, with a schedule of data analysis and reporting to provide management information and accountability. Attention to clarity regarding a coherent approach to planning and reporting of any PSM activity areas that are funded by both AusAID and Global Fund.
iv. A development approach that ensures GoI is fully consulted and leads work planning, and that GoI partners set the pace and determine entry points and priorities. CHAI can learn from capacity development approaches of HCPI and FHI e.g. in providing technical assistance (TA) in support of a programmatic approach and co-funding of activities with GoI.
v. Formalisation of the relationships with KPA, KPAP and KPAD.
vi. Ensure a stronger health systems strengthening approach including ensuring HIV/TB and STIs are addressed wherever practicable.
vii. Greater use of TA expertise based long-term in Indonesia and of Indonesian clinicians in training and clinical mentoring.
viii. A gender plan within the design to address not only whether activity is promoting equal participation but also equal benefits for females and males, equality of decision-making between women and men, promoting women's rights and developing capacity of partners to understand and promote gender equality within HIV responses.
ix. Increased AusAID engagement in design and monitoring of Phase II. Stronger engagement and oversight by AusAID to ensure quality and optimize synergies with HCPI and other AIPH activities (e.g. ASHM, NRL) and related Australia Indonesia Partnership for Development programs in the areas of decentralization and MNH.

9.3 New HIV Care, Support and Treatment (CST) Program 2011-2015

It is recommended that:

vi. AusAID fund a new HIV Care, Support and Treatment **(**CST) Program 2011-2015. The budget to be approximately AUD$6 million in total for the 4 year period.
vii. An independent design process for a new CST program be conducted in mid-2010. The CST Program to have a national systems and Papua/Papua Barat focus.
viii. The design to be informed by the principles of the Jakarta Declaration on Aid Effectiveness, particularly the need to strengthen country systems, and will consider all options e.g. managing contractor models, delegated aid, co-financing, budget support to GoI, donor harmonization including Indonesia Partnership Fund, partnerships with international NGOs, technical assistance, grant-making, output based aid.
ix. A tender process occur, if required, in early 2011 so that new program mobilises by July 2011 or soon thereafter.
x. The new program may include but is not limited to further support to GoI in focus areas of CHAI Phase II (i.e. PSM, clinical mentoring, rural needs), subject to an analysis of needs and gaps in the national and Papua/Papua Barat responses to HIV care, support and treatment.

10 Ratings against AusAID evaluation criteria

Criteria	/6	Explanation
Relevance	5	The CHAI program focus aligns well with the National HIV Strategy, Papua/PapuaBarat Provincial HIV Strategies, AusAID International HIV Strategy and Country Strategy, and AIPH priorities. The supply chain orientation to systems strengthening is supported by AusAID and DepKes policy. The emphasis on Papua is consistent with National Strategy and KPA priorities. The focus areas for labs and pediatrics reflect gaps identified by 2007 DepKes/WHO assessment. The pediatric work requires closer alignment to national and provincial plans - counterparts do not consistently identify paediatric treatment as a priority.
Effectiveness	4	Lack of clarity of objectives. Supply chain activities are achieving intended outcomes. Contributions to Global Fund planning has been highly strategic. Progress in labs and paediatrics is patchy and inconsistent. The Rural Initiative is in its infancy and gains (e.g. clinical mentoring) are fragile due to internal and external factors.
Efficiency	3	Expat salaries are low, however staff turnover has led to extra costs. It is unclear whether value for money has been a factor in CHAI's choice of partners (QASI, Roche, NRL). Insufficient budget information is provided by CHAI's reporting. The majority of budget allocation under each component were for administration, staffing and overhead costs, rather than for programming.
Sustainability	3	Inadequate joint GoI-CHAI forward planning to address transfer of skills and responsibilities to GoI partners. Requires more effective use of local staff in key roles. Sustainability will be stronger in PSM with Global Fund support for secondments than in other areas.
Gender Equality	2	Lack of analysis or planned response to gender inequalities relevant to testing, care and treatment, particularly the status of Papuan women. Technical monitoring data is not sex disaggregated.
Monitoring & Evaluation	4	The M&E matrix has been developed with support of an M&E adviser. The matrix needs to be complemented by a detailed plan that specifies how, when and by whom, data will be analysed and utilised. It should also address how CHAI M&E integrates with GoI M&E so as to build GoI M&E capacity in Papua and nationally.
Analysis & Learning	3.5	The Papua assessments were well conducted. Analysis of PSM is very good. Technical rigour in other areas has been questioned. Staff turnover has meant learning has been lost / slow. Ongoing analysis and learning needs to be a higher priority for staff. Lessons learned are captured (e.g. in the Program Brief) but could have a broader focus on relationships and planning rather than only operational issues. Lack of clear work-plans and established deliverables has limited the opportunity for critical analysis.

Satisfactory		Less than satisfactory	
6	Very high quality	3	Less than adequate quality
5	Good quality	2	Poor quality
4	Adequate quality	1	Very poor quality

Appendix I

Persons and organisations consulted

Government of Indonesia: Jakarta

Ibu Dyah Mustikawati, Head of Subdit AIDS and STIs, DepKes (Ministry of Health)

Ibu Martha, Director of Medical Support Services of Directorate of Medical Support Services Ministry of Health

Dr Puteri, Subdit AIDS Ministry of Health

Dr Diky, International Liaison, Planning Bureau, Ministry of Health

Dr Nafisiah Mboi, Secretary, KPA (National AIDS Commission)

Dr Naning, Head of Global Fund HIV Project Management Unit, Ministry of Health

Dr Agus Kosasih, Chief of Lab for Dharmais Hospital

Government of Indonesia: Papua and Papua Barat

Dr Bagus, Head of Papua Provincial Health Office

Dr Arnold, Head of Communicable Diseases Section, Papua Barat Provincial Health Office

Dr Beeri, Head of Communicable Diseases Section, Papua Provincial Health Office

Bapak Constant Karma, Provincial AIDS Commission

Dr Samual Bosa, Head of VCT, RSUD District Hospital Jayapura

Dr Nyoman, Head of VCT, RSUD Abepura

Dr Christian, Head of RSUD, Dian Harapan

Sister Siti, Head of Nursing, RSUD Dian Harapan

Dr Gusti, Head of VCT, RSUD Yowari

Ibu Lucy, Head of Provincial Warehouse, Jayapura

Ibu Sely, Head of Provincial Health Lab, Jayapura

Dr Juliawati, Head of CD4 referral lab at Dok II Jayapura

Dr Deri, Head of RSUD (District Hospital) Wamena

Pak Daulat Martua Raja, Coordinator, Jayawijaya District AIDS Commission

Dr Andreas, Internal Medicine Division, RSUD Wamena

Dr Marianna, member, TB/HIV working group, Jayapura

Dr Vivi, Coordinator HIV TB, RSUD Wamena

Ibu Sr Irna, Head Nurse, Puskesmas Wamena Kota

CHAI

Andrew Wardell, Country Director

Elizabeth Radin, Deputy Country Director

Charlotte Dolenz, Rural Initiative Program Officer

Dr Budi Arto, Rural Initiative Clinical Mentor, RSUD (District Hospital) Wamena

Asih Hartanti, Seconded CD4 Manager, Dharmais Hospital

Other CHAI staff responded to questions at CHAI's presentation to the IPR Team in Jakarta, 15 June 2009 including Maeve Magner, Global Director, Supply Chain and Ravi Menon, Papua Program Director.

NGOs, private providers and contractors

Ibu Dia Mukiarti, IDAI (National Paediatricians Association)

Tim McKay, HCPI Team Leader

Bob Magnani, Country Director, FHI

Jim Johnson, Deputy Country Director, FHI

Helena Picarima, FHI Jayapura

Chris Green , YYS Spiritia (Treatments Officer)

Mas Abdullah Denovan, Manager, JOTHI – Indonesia PLHIV Network

Mas Omar Syarif, Resourse Mobilisation , JOTHI

Mas Aris, Research and Programming , JOTHI

Bapak Robert Sihombing, Jayapura Support Group

Sr Siti, Jayapura Support Group, VCT counsellor Dok2 hospital Jayapura

Sr Feve RN, Head of nursing, Kalvari Clinic, Wamena

Ben Bogle RN, Kalvari Clinic, Wamena

Jamie Urig, consultant to DepKes for development of Global Fund R8 and R9 proposals and to DfID for Indonesia Partnership Fund annual assessment.

Multilateral organizations and donors

Nancy Fee, UNAIDS Country Coordinator

Lisa Baldwin, USAID Acting Director Office of Health and Senior HIV and AIDS Adviser

Ibu Ratna Kurniawati, USAID Senior HIV and AIDS Adviser

Dr. Subhash Hira HIV/AIDS-STI Team Leader, World Health Organization

Sharifah Tahir, Chief of HIV/AIDS Section, UNICEF

Dr Elsa Siahaan, WHO Papua

Manuel de Lara, Acting Chief of Field Office, UNICEF Papua

AusAID Indonesia Country Office

Cilla Ballard , Counsellor

Ibu Ria Arief, CHAI Activity Manager

Gerard Cheong, First Secretary AusAID Health Team

Appendix II

Document list

CHAI documents

Clinton Foundation Workplans for 2007 – 2009
Clinton Foundation activity reports (monthly and six monthly reports)
Clinton Foundation Annual Report (July 2007 – December 2008)
Clinton Foundation MoU with Ministry of Health
CHAI M&E Plan

General

Indonesia Program Brief, June 2009
LOA with MOH and PHO Papua and PHO Papua Barat 2008
Draft MOU 2009-2011 with MOH
2009 Workplan Approval Letter from MOH
CHAI Workplan 2009
Letter from PHO Papua regarding approval of Workplan 2009
Letter from PHO Papua Barat regarding approval of Workplan 2009

Financial Reports

Financial Progressive Report for Q1 2009
Progressive Expenditures Report
Expense Analysis 2007-2009
Annual Financal Report 2007-2008
Indonesia Budget 2007-2009

Progress Reports

CHAI Indonesia Progress Report January - May 2009
CHAI Indonesia Annual Report 2008
CHAI Indonesia Progress Report April - September 2008
CHAI Indonesia Monthly Program Status Reports (June 2008 through May 2009)

Monitoring and Evaluation

M&E Plan
M&E Matrix

Procurement and Supply Chain Management

Indonesia ARV Forecasting Tool
R8 PSM Plan 010509
R8 Quantification of PSM Commodities
MOH contract with Kimia Pharma and Annex (CF advisor role)
Proposal for National Decentralization Strategy

Global Fund Staff Secondment Plan
Terms of Reference for three Global Fund Seconded Staff
Reagent Usage Tool for Papua
Revised Hospital ARV Reporting Form in Papua
2010-2011 Projections of Patient ARV Cost for Government Budget
Analysis of Kimia Farma versus Global Fund Prices
UNICEF Emergency Order Request Letter
Draft of SOP's for Rapid test reagent system
Training Tool for Pelaporan (recording & reporting)
Timika SCM Assessment report Nov 08
Wamena SCM Assessment report Dec 08
Timika SCM TA trip report Dec 08
Timika Trip report Feb 09
Manokwari R&R training trip report Mar 09

Lab System Stengthening

Draft proposal for strengthening NEQAS programme for rapid tests.
CD4 Reporting Tool (Formilir Standard Pelaporan CD4)
Botswana Trip Report
Master Plan for rapid test National External Quality Assurance Scheme
Lab assessment tool for Indonesia EQAS
CD4 EQAS Schedule 2009
3 PHL's Assessment with Executive Summary
Lab Assessment PKM Kotaraja
Lab Assessment PKM Hamadi
Lab Assessment Amban Manokwari
Lab Assessment PKM Maripi Manokwari
Lab Assessment RS Dian Harapan
Lab Assessment RSUD Abepura
Lab Assessment RSUD Manokwari
Lab Assessment Yowari Hospital
Lab Trip Report Timika Jan 09
Lab Data RSUD Timika
Lab Training Report Manokwari
Lab Training Report Mimika
Reagent forcasting Tool
Report of CD4 EQAS Implementation
OI Training in Jayapura Report
Training Report CD4 Manual Gating
Technical Report of Traning on Reporting System and EQAS CD4
TQM Workshop Report
HIV TWG Meeting Report

C&T

Expert Panel Proposal (Draft)
Clinical Mentoring Implementation Plan
Jayapura Clinical Mentoring Report
Clinical Mentoring MOUs (3)
Mulia CST Training Report
Papua CST Training Report
Yowari Training Report
VCT process poster (draft)
PKM referral network poster (draft)

Pediatric C&T

Indonesia-specific pediatric dosing wheels
Didactic poster on pediatric HIV identification (draft)
Revised MOH Monthly ARV Report (including Pediatric information)

Papua General/Other

Papua Assessment Report
Papua PHO 2008 Structure
Jayapura Resource Map & Worksheet
Timika Resource Map & Worksheet
Manokwari Resource Map & Worksheet
Manokwari Trip report
Referral Network Summary – Manokwari

Rural Initiative

Rural Initiative Assessment Report
Rural Initiative Program Design
CD4 Referral Network Process Map
CD4 Referral Network Strategy
PIP Clinical Mentoring Implementation Plan
Pendamping Handbook (Bahasa Indonesia)
Pendamping Program Summary
Formulir Pendamping (Tool)

Other references

Jakarta Commitment: Aid for Development Effectiveness, Indonesia's Roadmap to 2014 (January 2009)
Government of Indonesia, *National HIV/AIDS Action Plan* (NAP) 2007 – 2010
Government of Indonesia, *UNGASS Report 2008*
National AIDS Commission, *2007 – 2010 HIV and AIDS Response Strategies*
Peta Estimasi Rawan Tertular HIV Tahun 2006 and *Respond Pelayanan Tahun 2007*
MOH quarterly report

Overall Drugs Management Situation Within The Public Sector In Indonesia DepKes 2004
Papua Provincial HIV Strategy
Papua Joint Communication Strategy
AusAID *Intensifying the response: halting the spread of HIV Australia's International development strategy for HIV* Canberra 2009
AusAID/Clinton Foundation Funding Agreement
Australia Indonesia Partnership for HIV (AIPH) M&E Plan
Supply Chain Management Services (SCMS) *Survey of HIV/AIDS Commodities Situation in Tanah Papua* 2008
Technical Assistance (TA) for Strengthening of HIV /AIDS Related Logistic Management in Indonesia, WHO 2007.
AusAID Gender Policy, 2007
Papua Assessment: USAID Indonesia, GRM, November 2008-January 2009.
Strategic Communication Plan for HIV and AIDS Prevention and Management in Tanah Papua, Papua Provincial AIDS Commission 2008.

Appendix III

Terms of Reference

Independent Progress Report June 2009

William J. Clinton Foundation HIV/AIDS Initiative (CHAI) in Indonesia

1. Purpose

The Independent Progress report will assess the overall performance of the William J. Clinton HIV Initiative in Indonesia including project management performance against the project component objectives and outputs; to provide a broader perspective on performance and achievement and adequately highlight the lessons learned; redirecting project for better performance and provide guidance on how to improve initiative performance for the remaining six months of the initiative; to assess progress toward achieving sustainability; and to assess the factors that are likely to enhance or inhibit progress towards sustainable outcomes. This report will also recommend if AusAID funding for the program should continue and if so propose the content of the program, the amount and duration of this funding, and options for ongoing contracting.

2. Background

The William J. Clinton Foundation (hereafter called The Clinton Foundation) is a charitable organisation established by President Clinton which works in four areas; Health Security, Economic Empowerment, Leadership Development and Citizen Service and Racial, Ethnic and Religious Reconciliation.

AusAID and The Clinton Foundation through CHAI signed a Memorandum of Understanding (MOU) in February 2006 to formally establish a partnership between the Australian Government and CHAI. Under the agreement, the Australian Government through AusAID is to provide funding up to AUD25 million over four years, complemented by funding from CHAI. The MOU was for CHAI to work together with public health authorities in various countries to scale-up treatment and care for people living with HIV.

As part of this commitment, AusAID Indonesia is providing AUD3.9 million to CHAI from 1 July 2007 to 31 December 2009.

CHAI signed a MOU with the Indonesian Ministry of Health (MOH) on 27 July 2007. The MOU endorses CHAI, in partnership with MoH to work nationally and in Papua and West Papua to provide access to high quality treatment for People Living with HIV (PLWH) in the following areas:

a. procurement and supply chain management;
b. laboratory system;
c. pediatric care, support and treatment;
d. the rural initiative (in Papua and West Papua);
e. drug access;

f. clinical mentoring support; and
g. program management and coordination.

The target audience for this Independent Progress Report is AusAID, Government of Indonesia (GOI) particularly MOH and KPA, other GOI departments, Papua and West Papua Provincial Governments and Papua and West Papua communities, multilateral agencies, NGOs, other donors and the community of professionals implementing the Australian aid program, all of whom need credible and independent advice on the results of past efforts and contractors.

2.1. Key issues

Key issues that this review will consider include the following:

a. AusAID Strategic Directions

Australia's new HIV/AIDS Strategy launched on 7 April 2009 was developed within the framework of the health Millennium Development Goals, commitments made at UN General Assembly and the Australian Government's increased emphasis on improving delivery of basic services and working in partnership with multilateral agencies globally and in the region. This context needs to be considered in determining any future support to CHAI in Indonesia, as well as the status of other Clinton Foundation projects in the region that currently receive Australian Government support.

The Australia Indonesia Partnership for HIV (AIPH) has a Monitoring and Evaluation (M&E) framework. AusAID has assisted CHAI to develop its own M&E logframe which is consistent with the AIPH M&E framework. This evaluation will assess the extent to which the M&E framework design is aligned with AIPH performance framework; the extent to which planned M&E activities have been implemented as designed; the extent to which the M&E system reports against indicators or evaluation questions indicated in the MEF is found in the progress reports; and comment on the accessibility of key information in progress reports to AusAID.

The AIPH Project Design Document was completed prior to CHAI commencing in Indonesia. This review could be used to find any linkages between CHAI outcomes and other AIPH components, the 2007 – 2010 National Action Plan (NAP) and National Strategy (STRANAS) and ways in which future work could be linked to the aims and targets of the NAP and STRANAS.

b. GOI ownership, capacity and sustainability

CHAI's collaboration with MOH is critical for the implementation and sustainability of CHAI outputs across all components of its program. The extent to which MOH is willing and able to continue the work after the completion of CHAI is fundamental to the success of this program. This review will/could consider the nature and extent of commitment required from MoH to continue CHAI activities in the long term.

At this stage, the extent of commitment from GOI to continue CHAI activities in the long term is not yet fully evident.

3. Objectives of the IPR Mission

The objectives of the IPR mission are:

- To independently assess the overall performance of CHAI in Indonesia against project components objectives, outputs and management;
- To identify lessons learned;
- To provide guidance to improve initiative performance; and
- If applicable, to provide recommendations for further support to CHAI in Indonesia.

The IPR will provide a broader perspective on performance and achievement and adequately highlight the lessons learned and to assess the ability and willingness of local stakeholders within the GOI to sustain CHAI outcomes once the project is completed.

4. Scope of IPR

The IPR will assess and rate the program's performance against the evaluation criteria of relevance, efficiency, effectiveness, impact (or potential impact), sustainability, monitoring and evaluation, gender equality and analysis and learning. The ratings will be based on the standard AusAID six-point scale, as outlined in the IPR template (see Attachment A). Standard evaluation questions to guide the evaluation team in forming these ratings are at Attachment B.

The evaluation team must be able to provide an assessment and rating of the evaluation criteria above and should give particular priority to examining the following questions:

4.1 Project achievements and effectiveness

a. Progress made towards achieving outputs and outcomes for the project to date;
b. How well CHAI is working to improve health service delivery and build capacity within existing Indonesia structures;
c. Assess whether CHAI works is likely to have significant impact on Health Systems Strengthening and links with other program associated with health such as TB and malaria;
d. Progress towards sustainability of initiative outcomes; identification of the key factors that will effect sustainability; and an assessment of the quality and effectiveness of interventions to move toward sustainability;
e. Recommend and assess changes (or impending changes) in the project external environment or strategic direction that could have implications for project implementation and/or achievement of project goal, purpose or objectives e.g.: any political or operational issues that could adversely affect the project outcomes or increasing synergy with relevant national and sub-national programs;

f. Appropriateness of Monitoring and Evaluation Schedules against the AusAID Indonesia Performance Assessment Framework (PAF), the extent to which the M&E framework design is aligned with AIPH performance framework, the extent to which planned M&E activities have been implemented as designed; the extent to which the M&E system reports against indicators and the extent to which targets have been achieved, including quality of reporting,

g. The level and quality of engagement of the GOI counterparts and other stakeholders;

h. The challenges of implementing HIV programs in Papua province including district and kabupaten kota level;

i. The extent to which the project fits into a broader strategic of Ministry of Health and National AIDS Commissions strategies to prevent and control the HIV epidemic;

j. Measurable contribution of CHAI in Indonesia to achievement of objectives under Indonesia HIV and AIDS National Strategy and 2009 – 2010 National Action Plan (STRANAS);

k. Assess the quality of key project outputs or deliverables such as reports and financial management;

l. Assess the timeliness of key deliverables against the annual plan and identify the causes of any significant delays;

m. The extent to which current design and approaches remain relevant and appropriate to meet the intended objectives;

4.2 A further objective of this review is to make the following recommendations and observations:

a. Changes in the project (strategic direction, design or approach) to strengthen implementation and increase sustainability if required including increasing synergy with relevant National and sub-national programs;

b. Identify and highlight lessons and achievements that may have wider implications and/or interest for the Ministry of Health and GOI;

c. Recommend whether this project should continue under implementation by CHAI or other implementing partner beyond December 2009 and describe any risks or implications if it is not continued; and

d. If the review recommends a further phase of work the IPR should include as an attachment, draft TORs for a design process for this next phase.

5. Evaluation Process

The evaluation will take around 4 weeks and is planned for mid June 2009. The exact date and timeline of the ICR is to be confirmed based on the evaluation plan that will be developed by the team leader.

In undertaking the IPR, the evaluation team will:

a. Conduct a desk study to assess relevant program documentation provided by AusAID and advice AusAID of any additional documents or information required prior to the in-country visit (2 days)

b. Develop an evaluation plan, which will include methodology and identifications of key respondents and further documentation as required. This methodology will indicate the roles and responsibilities of each team member for data collection, analysis and reporting (1 day)

c. Consultations with PNG review team regarding the outcomes of the review including major findings and lessons learned (1 day);

d. Participate in an AusAID briefing session in Jakarta at the start of the in-country field visit (1 day).

e. Conduct a consultation and field visit in Jakarta and Papua and West Papua (14 days including travel time).

f. Prepare an Aide Memoire for submission on the final day of the field review which outlines the major findings and preliminary recommendations of the IPR (1 day)

g. Participate in an AusAID debriefing session in Jakarta at the completion of the field visit and present initial findings of the IPR to AusAID Jakarta and Clinton Foundation and other relevant stakeholders (1 day)

h. Submit a draft IPR (7 days of writing for the team leader, 4 days writing for the team member)

i. Submit the final ICR (2 days of writing for the team leader)

6. Reporting Requirements

The IPR team shall provide AusAID with the following:

a. **Evaluation plan including methodology** – to be submitted one week prior to the in-country visit;

b. **Presentation of an Aide Memoire and discussion -** on the initial findings of the IPR to be presented to AusAID and **relevant stakeholders** at the completion of the in-country mission;

c. **Draft IPR** – to be submitted to AusAID within two (2) weeks of completing the field visit. AusAID may share the report with and seek feedback from GOI (including MOH and Provincial Health Office, the National AIDS Commission and the Provincial AIDS Commissions) and other key stakeholders, as appropriate. The report may also be subject to technical quality review and review by peers.

d. **Final IPR** – to be submitted within two weeks of receipt of AusAID comments on the draft IPR. The IPR Team shall determine whether any amendment to the draft is

warranted. The report should be a brief and clear summary of the IPR outcomes and focus on a balanced analysis of issues faced by the activity.

Both the draft and final reports should be no more than 25 pages each of text plus appendices. The Executive Summary, with a summary list of recommendations, should be no more than 2-3 pages.

7. Team Composition

The review team will comprise of an independent HIV specialist (Team Leader), a senior GOI HIV/AIDS expert (Team Member), AusAID Post HIV Adviser (Team Member), Papua Provincial Health Representative and AusAID Health and HIV Thematic Group HIV Adviser (Team Member). An additional team member (the M&E Adviser) will provide inputs from desk and will not need to join the team in Indonesia. The team will be assisted by the AusAID Health team at Post. The team collectively will have the following skills and qualifications:

- Expertise in one of the nominated specialties as stipulated under the review;
- Demonstrated knowledge of the health service delivery in Indonesia;
- Demonstrated knowledge of HIV/AIDS issues in Indonesia and globally;
- Demonstrated knowledge of health service delivery at the provincial level;
- Knowledge of AusAID policies and practices;
- Strong analytical skills, cross cultural communication and interpersonal skills and the ability to present information logically and concisely; and
- Expertise in the design, conduct and management of evaluations;

7.1 Team Leader

- Act as the Team Leader for the review mission and responsible for overall management of team inputs, liaison and production of an Aide Memoire, Review report in achieving mission objectives outlined above;
- Find any linkages between the PNG mid-term review and Indonesia mid-term review. Team leader is required to analyse the outcomes of PNG mid-term review and consult with PNG mid-term review team prior to this mission;
- Find any correlation of the outcomes of performance review with Joint Papua Communication Strategy and Save Papua document established by Ministry of Health.

Individual members of the team will provide advice and written inputs to the Team Leader, as instructed by the Team Leader, in order for the Purpose, Objectives and Reporting Requirements of the Review to be met. The responsibilities of each review team member are set out below.

7.2 GOI HIV Expert

- To provide an input to the Team Leader of the overall HIV/AIDS situation in Indonesia including update on new emerging issues in HIV/AIDS context;
- To liaise with other Indonesia stakeholders in the HIV/AIDS area in terms of providing information and perspectives relevant to the Review; and
- Any other tasks as directed by the Team Leader.

7.3 Papua Provincial Health Representative

- To provide an input to the Team Leader of the HIV and AIDS situation in Papua and West Papua issues; and
- Any other tasks as directed by the Team Leader.

7.4 AusAID Post HIV Adviser

- To provide inputs on the CHAI program in Indonesia in light of AusAID's new HIV Strategy;
- To provide inputs regarding challenges and achievements of CHAI Indonesia programs;
- To provide inputs to the Team Leader regarding changes in Indonesia environment; and
- Any other tasks as directed by the Team Leader.

7.5 M&E Adviser

- To assess whether the CHAI M&E framework including its indicators are useful and applicable;
- To find linkages between CHAI M&E framework and National M&E plan indicators and UNGASS;
- To review CHAI M&E indicators and find any links to AIPH M&E Plan; and
- Any other tasks as directed by the Team Leader.

7.6 AusAID Health and HIV Thematic Group HIV Adviser

- To act as the "bridge" between the CHAI Indonesia and Papua New Guinea review missions;
- To provide inputs on AusAID HIV policies and the broader HIV policy and program context; and
- Any other tasks as directed by the Team Leader. The team will be assisted by the AusAID Activity Manager to provide background information on the project implementation process, content and oversight to the review team through regular feedback during the review process.

Review Team	Duration in Australia	Duration in Indonesia	Duration in mission
Team Leader	1-12 June 2009 2 days prior coming to Indonesia for background reading	14 June – 2 July 2009 including: 16 days for in-country	11 days in Australia 19 days in-country

	1 day develop an evaluation plan, design the evaluation methodology, field research guide and instruments 1 day for consultation with PNG review team 5 days for writing and collating feedback and submitting draft report 2 days for writing and submitting the final report	missions for consultations and meeting with stakeholders 2 days participate in AusAID briefing sessions at the start and at the end of the in-country field visit 1 day for an Aide Memoire presentations and de-brief with AusAID Post	
Central GOI HIV Senior Officials		15 – 19 June in Jakarta	5 days in-missions
Papua Provincial Health Representatives		22 -26 June in Papua and West Papua	5 days in-missions
AusAID HIV Adviser		2 days reading 15 – 26 June for in-country missions including travel days to Papua	Two weeks in missions
AusAID HIV Thematic Group Adviser		2 days reading 15-26 June for in-country missions including travel days to Papua	19 days in-country
M&E Adviser	2 working days for background reading 5 working days for report writing	Up to 5 working days for discussions with IPR Review Team (via teleconference)	

APPENDIX IV

Project Intended Outcomes and Key Activity Areas

Activity areas (CHAI DepKes MoU)	Outcomes (M&E Plan)	Activity areas (2008-2009 Implementation Plan)
Procurement and supply chain management	Indonesia accesses reduced prices for specific ARVs, introduces pediatric ARVs, and improves the timeliness and accuracy of its inventory forecasting, management, and reporting	Support national bidding process for ARV procurement Assist in establishing a regional ARV distribution centre at the provincial level Strengthen the ARV forecasting and stock replenishment systems Assist in procurement and distribution of pediatric ARVs Provide Global Fund proposal assistance Support strengthening of PSM system in Tanah Papua Train partner staff in Jayapura, Merauke, Timika, Wamena, Sorong, and Manokwari
Paediatric care and treatment	Families have increased access to paediatric testing, care, and treatment services	Provide support in revision and distribution of national pediatric treatment guidelines Facilitate supply of pediatric formulation for children needing ART in Indonesia Support incorporation of pediatric care and treatment into HIV services at selected sites Provide didactic materials on pediatric treatment of HIV Develop training programs for pediatric C&T Improve quality of C&T for children with HIV (Papua, Papua Barat)
Access to Quality Drugs	Kimia Farma is progressing towards WHO pre-qualification to increase Indonesia's access to high-quality products	Improve MOH capacity to negotiate and access lower prices for ARV procurement Provide guidance and technical expertise in facilitating WHO prequalification for Kimia Farma (KF) Assist Kimia Farma to reduce its ARV costs
Laboratory systems strengthening	MOH coordinates testing programs that provide patients with increased access to more affordable, high-quality HIV testing (CD4 tests, rapid tests, and EID) Patients in selected provinces have increased access to a network of high-quality HIV testing services pre- and post-ART initiation Selected provinces have improved and	Improve MOH capacity to negotiate lower prices of CD4 machines, reagents and commodities Partner with DMSS and Canada's Quality Assessment and Standardization for Immunological Measures (QASI) to strengthen External Quality Assurance (EQA) schemes for national CD4 and with Australia National Serology Reference Laboratory (NRL) for rapid tests Assist in establishment of national infant diagnosis system Strengthen PHL at the province level and other laboratories at ART hospitals at district/city levels in Jayapura, Merauke, Timika, Wamena, Sorong, and Manokwari Support improved external quality monitoring system capacity on HIV-related laboratory tests Improve provincial distribution management for rapid test kits, CD4 reagents and other commodities Facilitate training and certification process for HIV testing for laboratory staff in ART hospitals and selected PKM in Tanah Papua

	more efficient stock management of laboratory consumables at VCT testing sites and CD4 labs	Facilitate the creation of a referral network for HIV-related laboratory exams
Care and treatment	Providers and stakeholders have access to up-to-date information on HIV epidemiology and care & treatment in Indonesia Families in selected sites in selected provinces have increased access to high-quality care and treatment services	1. Liaise between Subdirectorate AIDS and the Fogarty AIDS International Training and Research Program (AITRP) at Brown University in order to develop a nationwide ART impact study 2. Collaborate with MOH, Indonesian Medical Association (IDI,) and Australia Society for HIV Medicine (ASHM) to assemble an expert panel as the authority for ART regimen approval and to update national treatment guidelines 3. Support national surveillance efforts, including dissemination of results from 2007 Integrated Bio-Behavioral Survey (IBBS) and HIV Drug Resistance Surveillance (HDRS) activities Strengthen MOH capacity by increasing human resources Facilitate the establishment of a referral network within wards in the hospitals in Jayapura, Merauke, Timika, Wamena, Sorong, and Manokwari Assist in developing a referral network from referral hospital to PKM and vice versa in Jayapura, Merauke, Timika, Wamena, Sorong, and Manokwari Support establishment of clinical mentoring in selected hospitals and PKM for doctors, nurses, lab technicians & case managers Assist in development of clinical mentoring trainer of trainers program in Jayapura, Merauke, Timika, Wamena, Sorong, and Manokwari Support strengthening of ART patient monitoring systems in Jayapura, Merauke, Timika, Sorong, and Manokwari, in line with national system
Rural Initiative	Health facilities in Rural Initiative sites offer improved diagnosis, testing, care, and treatment services Families in Rural Initiative areas have increased awareness of HIV and C&T issues in the community	Increase capacity of selected PKM and sub-PKM to offer a broader range of HIV-related services Incorporate clinical mentoring in Rural Initiative Strengthen pediatric care and treatment (C&T) Support PHO and DHO in exploring other HIV-related activities such as microfinancing, home-based care, and nutritional support

APPENDIX V

Draft Terms of Reference for design of a new HIV CST program

1 Background

These Terms of Reference are for the design of a new HIV Care, Support and Treatment (CST) program in Indonesia, as a component of the Australia Indonesia Partnership for HIV 2008-2015. The program is to be conducted in partnership with Government of Indonesia. The program will have a particular focus on support to national systems and on the provinces of Papua and Papua Barat.

The Design is to be framed within the context of:

i. Australia Indonesia Partnership Indonesia Country Strategy 2008-2013;
ii. Indonesia National HIV and AIDS Strategy and Action Plan *(as at 2010)* ;
iii. Provincial HIV and AIDS policies and plans for Papua and Papua Barat;
iv. Australia's International HIV Strategy and the AusAID Health Policy (*revised as at 2010*);
v. Australia Indonesia Partnership programs including in relation to HIV, decentralization, health systems and maternal and neonatal health.

Since 2008, Australia has provided support to Indonesia's HIV CST response through:

i. Partnership with Clinton Foundation HIV and AIDS Initiative (CHAI) 2008-2011.
ii. HIV Cooperation Program for Indonesia, particularly in the context of CST needs of prisoners and injecting drug users.

The partnership with CHAI has focused on support to Government of Indonesia in the following areas:

i. Procurement and supply chain management
ii. Access to quality drugs
iii. Laboratory strengthening
iv. Pediatric Initiative
v. Care, support and treatment (with a policy, training and clinical mentoring focus)
vi. Rural Initiative (including a pilot in Wamena, Papua).

The other principal donor activities in HIV CST are:

i. Global Fund programs (particularly Round 8); and
ii. US Government-funded projects, including the Aksi Stop AIDS project implemented by FHI (*if still current*) and (*insert any new USAID and/or PEPFAR Partnership Framework CST activities funded in 2010*).

An Independent Progress Report of CHAI conducted in 2009 concluded that to ensure quality and effectiveness of AusAID support to 2015, a new program design is required so that the potential contribution of other providers and other forms of support to GoI can be fully assessed.

The design is required to take into account the new donor environment for CST including PEPFAR and USAID's new program emphasis, Global Fund progress including CHAI's performance as a Global Fund sub-recipient, the commencement of the AusAID

Decentralization Program in Papua and Papua Barat, and any planned AusAID maternal and neonatal health programs in Papua.

Objectives and scope of the design

The Objective is to prepare an Indonesia HIV CST program design for the Australia Indonesia Partnership that is feasible and sustainable**.**

The Indonesian and Australian Governments are signatories to the Paris Declaration, Accra Agenda for Action, Jakarta Commitment and Millennium Development Goals and, accordingly, the new program will adhere to the agreed principles of ownership, alignment, harmonisation, mutual accountability, sustainability and managing for results. It will also adhere to current AusAID policies and promote an inclusive approach to development in line with AusAID disability and gender policies. It will be sensitive to the application of the AusAID Child Protection Policy.

The scope of the design mission is:

i. Exploration of the extent of unmet HIV CST needs and development of a full rationale for an HIV CST program, based on GoI priorities, with a national systems and Tanah Papua focus;
ii. Confirmation of willingness and capacity of the Government of Indonesia, UN partners and other donors to commit financial and human resources to HIV CST;
iii. Consideration of all options and modalities, consistent with the aid effectiveness principles of the Paris Declaration and the Accra Agenda, including co-financing, budget support to Government of Indonesia, donor harmonisation through Indonesia Partnership Fund or other approaches, partnerships with international NGOs, managing contractor models, delegated aid including through partnerships with UN agencies, grant-making, and output based aid;
iv. Careful consideration of the links with HCPI (which concludes in 2013) , and links with CST activities of the HIV Consortium for Partnerships in Asia Pacific (ASHM and NRL), in order to ensure coherence with the program being designed;
v. Examination of viability of options in detail, including where possible the determination of cost-benefit, the recommendation on whether implementation is feasible and sustainable, and recommendation of a preferred option(s);
vi. Identification of gender equality issues relevant to HIV CST and the gender equality measures that should be addressed in program implementation, monitoring and evaluation;
vii. Development of the design to the point where it is costed and can, if necessary, be tendered and implemented. The design should meet AusAID's prevailing design requirements and include:
    a. a poverty analysis;
    b. a risk assessment;
    c. a sustainability analysis and strategy;
    d. a M&E framework including performance indicators;
    e. if appropriate, terms of reference for key personnel; and
    f. if appropriate, draft scope of services and basis of payment and suggested clauses for the memorandum of understanding against which the program can be implemented.

The design should be flexible and responsive to the dynamic context including changes in understanding of the HIV epidemic and associated needs nationally and in Tanah Papua.

The design should consider whether there should be ongoing AusAID support to procurement and supply chain management (PSM), based on an assessment of whether the funds available to GoI and CHAI for PSM from the Global Fund to Fight AIDS, Tuberculosis and Malaria are sufficient, and how much more work is required to build GoI capacity to sustain effective PSM systems nationally and in Tanah Papua.

The design should consider the benefits and risks involved in AusAID continuing to fund CHAI's PSM program. A further Phase of support will be relevant to the design if CHAI is performing well in PSM and GoI's preferred option is for AusAID to continue to support CHAI's PSM program rather than to consider another provider and/or another CST focus area.

The design should also consider the benefits and risks associated with channelling AusAID CST funds through other mechanisms including HCPI, Indonesia Partnership Fund, WHO, UNICEF, KPAP, AusAID's decentralization facility and the AusAID HIV Consortium (NRL and ASHM).

Duration and phasing

- Pre-mission briefing and desk study;
- Fieldwork: Jakarta, Papua, Papua Barat, other provinces if appropriate (minimum of 3 weeks);
- Jakarta debriefing with AusAID and Aide Memoire presentation to AusAID, GoI and sectoral stakeholders;
- Write-up of design and submission of Draft program design;
- Participation in Appraisal Peer Review process;
- Submission of finalized program Design; and
- Canberra AusAID debriefing.

Design team

The Team will comprise:

i. Team Leader with HIV and design experience.
ii. Design/ M&E expert.
iii. (Preferably two) Government of Indonesia representative/s (KPA and/or DepKes, national and provincial).
iv. An expert in Indonesia's HIV CST response.
v. AusAID HIV Adviser.

Reporting

i. Aide memoire prior to leaving Indonesia;
ii. Draft and Final Program Design Document;
iii. Suggestions for clauses in any memoranda of understanding.

Appendix VI

Aide Memoire

Independent Progress Report
Clinton HIV/AIDS Initiative in Indonesia

30 June 2009

Independent Progress Report Team

Acknowledgements

The Independent Progress Report (IPR) Team expresses its gratitude for the cooperation and support of: DepKes, KPA and other Government of Indonesia partners at provincial and district levels; the CHAI staff team; AusAID staff in particular Ria Arief (AusAID Program Manager); and Marcellinus Jerry Winata and Mia Badib (interpreters) who helped the IPR Team in our work.

Disclaimer

The views expressed in the Aide Memoire are those of the IPR Team only, and do not represent the views of Government of Indonesia or the Government of Australia.

CONTENTS

1 Evaluation purpose and method

The Independent Progress Report evaluates the Clinton HIV/AIDS Initiative (CHAI) for AusAID, Government of Indonesia (GoI) and civil society stakeholders. The evaluation assesses performance and lessons learned, and provides guidance for improvements and recommendations for further AusAID support. The Team conducted meetings in Jakarta from 14-19 June 2009 and in Papua Province from 21-26 June 2009, including with:

- DepKes and KPA;
- Provincial, district and local government counterparts in Papua;
- Community stakeholders including people living with and affected by HIV, national NGOs and local NGOs in Papua;
- Multilateral agencies and donors (AusAID, USAID, UNAIDS, UNICEF, WHO) and other donor projects (HCPI, FHI ASA);
- CHAI project staff and project partners at central and provincial levels.

The Team reviewed project documents, technical reports and policies of GoI and AusAID, and data collected through CHAI's M&E systems.

2 Context

CHAI in Indonesia
AusAID provided AUD$3.9 million to CHAI for a 21 month project from March 2008 to 31 December 2009. CHAI has had a presence in Indonesia since early 2007 but was not registered as an NGO until April 2008. The staff team was not in place until June 2008 in Jakarta, and in Papua until August 2008. Implementation has been impeded due to delays in agreeing a revised MoU with GoI, and the requirement that expatriate staff leave Papua for 3 months during national elections. Due to underspends, a no-cost extension is under consideration. CHAI has a draft MoU and workplan with DepKes for July 2009-June 2012. CHAI is an initiative of the William J Clinton Foundation, which also receives funds from AusAID and other donors for climate change projects in Indonesia. AusAID is the only donor currently supporting CHAI in Indonesia. However, CHAI will be funded to act as the Global Fund sub-recipient for HIV supply chain management for the period 2009-2014.

Donor landscape
Global Fund Round 8 is the main source of funds for treatment scale-up 2010-2015. With the exception of AusAID and Global Fund, other donor funding to HIV has been reducing since 2007 as a result of DfID withdrawal and a reduced USAID bilateral program. The FHI/ASA role in treatment is reducing. There is a possibility of some additional US Government (PEPFAR) funds to be decided in 2010 including for HIV-related health systems, but Global Fund will be the dominant source of funds for the foreseeable future. AusAID's bilateral project (HCPI) addresses treatment only in the context of IDUs and prisons, and has a prevention focus in Papua. GoI funds approximately 25% of the national response. The GoI HIV budget is not expected to increase significantly in the medium term.

AusAID attention to health in Papua is increasing. AusAID is funding a new Decentralization Program with a focus at district level in Papua and Papua Barat 2010-2015. This new program will aim to strengthen GoI systems in health, education and other key sectors. HIV

mainstreaming and gender equality are cross-cutting themes of the new Program. AusAID is commencing a new program on Maternal and Child Health (MCH) in Papua in 2010-2011.

Alignment with Indonesia and Australian priorities

CHAI is a component of the Australia Indonesia Partnership for HIV (AIPH) 2008-2015. AIPH priorities are: a comprehensive HIV response in Papua; harm reduction and prisons; and leadership including national systems. AIPH commits to progressively strengthen GoI to lead, plan, manage and fund the response. AIPH principles include to align with GoI plans and priorities, work at all levels in accordance with decentralization, and to increase the focus on Papua and high need populations. AIPH's objectives are to combine Australia's support for HIV into a coherent partnership that benefits from synergies between each element; and to strengthen GoI leadership and capacities to implement an effective, sustainable response. In addition to CHAI, AusAID funds HCPI and a Consortium of Australian HIV agencies, which includes ASHM and NRL.

A priority of Australia's new International HIV Strategy (*Intensifying the HIV Response* 2009) is to strengthen systems to overcome barriers to universal access to treatment. HIV support is a priority of the *Australia Indonesia Partnership Country Strategy 2008-2013*. The Country Strategy also promotes an orientation towards health systems strengthening**.** CHAI's systems orientation (e.g. supply chain) is consistent with the AusAID International and Country Strategies.

Scaling up access to treatment (including PMTCT) is a priority of GoI, within the context of the overall priorities of GoI's National Strategy and Action Plan on HIV, which require a focus on higher prevalence provinces, most at risk populations, and the general population in Papua. Paediatric treatment is not an explicit priority in GoI's National Action Plan on HIV. CHAI focus has been informed by a DepKes/WHO Review of the HIV response (2007), which identified paediatric treatment as a gap.

3 Overall progress

After delays in the establishment phase, CHAI is making reasonable progress despite significant external constraints. However there is considerable room for improvement in key areas. The project's strength is in procurement and supply chain management (PSM). Performance to date indicates CHAI can continue to play a catalytic role in relation to PSM and workforce capacity development. CHAI is seen by many GoI stakeholders as a source of fresh thinking for technical solutions and a provider of access to global expertise. This has been borne out in PSM, but less so in other areas where progress has been erratic and patchy.

There are some examples of success in clinical mentoring approaches and there is potential for this area to continue and strengthen. There is demand for CHAI to provide PSM support (nationally and in Papua) and for an improved program of clinical mentoring and training preferably from Indonesian mentors. The work in paediatrics and labs is relatively weak by comparison, and after completion of current activities could be wound down by mid-2011. Technical support in paediatrics and labs after 2011 could be sustained by Indonesian systems with Global Fund support. Partners in Papua support an ongoing presence in Jayapura and Wamena, and a focus on hospital systems, puskesmas strengthening and a broader community development approach to care, support and counselling.

DepKes and GOI counterparts want CHAI to continue, but for the quality of CHAI's staffing, joint planning, coordination and communications to improve. The quality of relationships and communications with GoI and other key players, including KPA, UNAIDS, WHO and FHI has been inconsistent. Strategic opportunities have been lost as a result. There is a lack of depth in forward planning in many areas. Having provided a catalytic function in focus areas, the longer term capacity development approach of CHAI is less clear and not well documented. A major concern is the lack of consistency of partnership approach with GoI at different levels in defining the priorities and planning in each of the focus areas of work. This is fundamental to sustainability, and suggests the approach to sustainability has not been systematic. Coordination with key implementing partners (e.g. IDAI, hospitals and clinics) is reported as erratic.

AusAID has adopted a 'hands off' approach. Active oversight of quality of relationships and of the development approach has not occurred until this evaluation. CHAI reports to the AIPH Program Coordination Committee but otherwise there has been little monitoring by AusAID of the quality, consistency or strategic implications of project reports. Opportunities for synergy with other AIPH activities (e.g. HCPI) have been under-explored.

The assessment of progress against objectives has been constrained due to the lack of a comprehensive design document or a clear statement of objectives. The focus of the workplan and reporting relates to activity areas, rather than clearly articulated objectives. There is insufficient clarity and consistency relating to objectives and the implementation strategy in 2007-2009 plans and reports. The focus is evolving within the broad parameters of activity areas. This has enabled flexibility for CHAI to adjust priorities and objectives relating to these areas as relationships have evolved. However, the lack of a clear design is also a substantial risk, and has contributed to confusion and lack of coordination. Without a consistent statement of objectives, the focus has often been on achieving targets and outputs rather than defined outcomes, and at times CHAI's desire to move quickly and deliver outputs has compromised relationships and longer term outcomes.

4 Progress and lessons learned in key activity areas

4.1 Procurement and supply chain management (PSM) and access to quality drugs

CHAI has global expertise in PSM and has an excellent analysis of the challenges facing PSM at provincial and national levels. DepKes requests that PSM be a priority for a CHAI Phase II project. CHAI is the only active technical assistance (TA) provider for all aspects of HIV related PSM in Indonesia. UNICEF has procurement expertise but is no longer the preferred procurement agent for ARVs. SCMS, another potential provider of TA, conducted initial assessments but is not working in-country. TA for HIV PSM is not a WHO priority.

There has been good progress on PSM at national level. CHAI adapted an ARV forecasting tool for the Indonesian context, enabling site-level forecasting, and has trained DepKes on the tool. CHAI has advocated for procurement to reflect demand and supported emergency Global Fund purchases via UNICEF to avert stock outs. CHAI's work in developing Global Fund PSM Plans for Round 8 and Round 9 for treatment and prevention commodities is recognised by stakeholders including KPA as a significant contribution.

CHAI has advised DepKes on Voluntary Pooled Procurement (VPP), which is being taken up under Round 8. This will lead to cost reductions and allows DepKes to purchase through an agent. VPP has been welcomed by DepKes as a more cost effective approach than previous systems. However VPP is not viewed as a long term option by DepKes, and ongoing TA in procurement will be important because a competitive bidding process may be the preferred procurement option in future years. Working in partnership with DepKes with regular communication and use of skilled TA providers (including CHAI's Global PSM Adviser) has underpinned PSM success e.g. collaboration to allow Kimia Farma to store and distribute Global Fund ARVs.

DepKes has requested CHAI to be sub-recipient for supply chain management for Global Fund Round 8 (USD$1 million over five years), which indicates the confidence of DepKes in CHAI's comparative advantage in PSM. The full benefits of the work funded by Global Fund hinge on AusAID maintaining its funding of a PSM component. PSM positions funded by Global Fund are to be placed in DepKes and will benefit from support of AusAID funded CHAI PSM staff. Planning for decentralization including an East Java pilot under the AusAID funded project will inform the approach to the work at provincial level funded by Global Fund.

CHAI is developing a PSM decentralization strategy in coordination with DepKes. As yet, CHAI's role in PSM at provincial level has been less robust than at central level, but its sub-national performance is likely to improve as it takes on the sub-recipient role for Global Fund. DepKes has sought CHAI's assistance in developing a decentralization strategy encompassing ARVs purchased by government and Global Fund. This will engage Kimia Farma, provincial authorities and hospitals in relation to data collection and analysis, ordering, storage, inventories and distribution. CHAI will support decentralization including for Papua, Papua Barat, Bali and Java. This geographic focus complements HCPI.

There has been some progress on PSM in Papua and initial scoping in Papua Barat. CHAI has conducted training in ten treatment sites in Papua on reporting and inventory management. A rapid test reagent supply chain system has been designed but not yet implemented. Ownership of this new system by district and provincial counterparts is as yet unclear. Hospital and puskesmas reporting at some sites (e.g. Wamena) has improved as a result of initial CHAI visits. Follow up is required to ensure that improvements are integrated into the system, rather than reliant on individuals. Wamena and Papua Barat have requested support for training, working with hospitals on reporting, data analysis, and inventory management.

CHAI's is supporting budgeting for supply of ARVs, drugs for TB and other opportunistic infections and prevention commodities such as syringes and condoms. In addition to improved reliability of ARV supply, broader systems strengthening outcomes are likely.

'Access to Quality Drugs' activities relate to assisting DepKes in securing competitive prices for drugs. The focus has been advice on international competitive bidding and steps required for Kimia Farma prequalification as a quality assured provider. This prequalification process has stalled after an initial WHO assessment. This appears to be due to lack of commercial incentive and political will, rather than CHAI's neglect. Exploration of bidding has provided lessons for DepKes to inform future procurement approaches. VPP was chosen as the preferred interim approach rather than competitive bidding.

Lessons learned and design implications

A PSM focus can bring benefits to both treatment and prevention. CHAI can expand the forecasting and procurement work to TB and other OI drugs, STI drugs, reagents and lab commodities.

Sustainability requires: GoI ownership of systems (e.g. reagent supply system); a focus on existing recording and reporting tools that feed into the national system; integrated supply chain policies for a range of DepKes directorates.

CHAI currently provides significant support to DepKes for the forecasting and planning process, and this function can be progressively transferred to DepKes, with phase out of assistance in the medium term and an increased provincial focus.

CHAI's role in capacity building for national procurement including further work on competitive bidding is required to prepare for a post-Global Fund environment.

4.2 Laboratory systems

There are two main areas of progress in lab strengthening supported by CHAI: (i) CD4 reporting, referral and quality assurance; and (ii) expansion of HIV rapid testing and quality assurance. CHAI has initiated policy discussions, provided technical advice and logistical support, funded participation of lab staff in training to conduct HIV rapid tests, and provided stop-gap measures such as emergency procurement of reagents.

Respondents reported that the assistance of CHAI in lab strengthening was appreciated as it is not an area receiving support from other sources. Respondents report the role of CHAI as useful and there has been a significant increase in the number of sites able to conduct testing. However there does not appear to be a comprehensive plan in place, including for the roll-out of training. This component would benefit from an emphasis on support and mentoring to lab staff rather than reliance on one-off, off-site training, and could be better placed within a context of overall health system strengthening that places greater emphasis on increasing capacity for diagnosis of OIs and STIs. There was concern from some partners about the appropriateness of qualifications of some CHAI staff to participate in lab work.

CHAI has assisted DMSS to establish a standard reporting system for CD4, enabling central level monitoring of commodities, test statistics and an instrument maintenance checklist. While the number of labs reporting is increasing, many still do not. Training was provided to 2 staff in each of the 24 CD4 labs by Becton Dickinson on a cost sharing basis with CHAI. CHAI plans to assist DMSS to analyse reporting. It appears that this is not yet happening. It is unclear whether CHAI is assisting DMSS to respond to issues arising from analysis.

As HIV treatment rolls-out, the ability of healthcare providers to accurately monitor patients' CD4 cell count is critical for successful treatment outcomes. The team heard reports that quality of CD4 testing in many facilities remains poor and unreliable. CHAI initiated and supported DMSS to establish and implement a second national CD4 EQAS (external quality assurance scheme) for CD4 labs through QASI of Canada, with Dharmais Hospital laboratory as the national coordinating laboratory. CHAI's funding of a logistics officer in Dharmais Hospital to support the CD4 EQAS coordinator appears to be an essential resource to enable

this process. The QASI system is additional to the pre-existing CD4 EQAS in place since 2003, which continues to operate through the Thailand Centre of Excellence EQA program. While one participating lab reported that there is no additional burden to participating labs from running two quality assurance programs, the Dharmais lab reported that managing the two systems created an additional burden and complexity for no discernable gain. There does not seem to be sufficient justification for this parallel system and effort could have been better placed in supporting the existing CD4 EQAS system.

The CD4 EQAS Coordinator follows up labs displaying poor performance and provides trouble-shooting advice and TA. More labs are now participating in both EQAS systems and quality of CD4 results is improving. It does not appear that CHAI plays a direct role in this process. The EQAS Coordinator has not yet been trained to enable certification and access to the QASI database.

CHAI has helped the Papua Public Health Laboratory plan a CD4 referral network where VCT centres send specimens to one of five CD4 testing facilities. However, some report significant obstacles in implementing this system, including logistical constraints creating difficulties in transporting samples between facilities. CHAI is also facilitating transportation of specimens from Wamena to Jayapura for CD4 counts. There are questions around the sustainability of this system.

In Papua, CHAI is arranging and funding training of lab staff from puskesmas and hospitals to attend HIV testing training. Some labs report that despite receiving training from CHAI in diagnosis of opportunistic infections, they are unable to implement testing due to a lack of equipment and reagents.

DMSS has conducted EQAS for HIV testing facilities for several years. CHAI is working with NRL to implement a program to establish four provincial health laboratories as HIV testing quality assurance hubs and to establish networks with VCT centres to provide quality assurance for HIV testing. The role of CHAI to date has largely been to fund participation of trainees. The future of this work is unclear, with CHAI not committing to further financial support and NRL not having alternative funding sources to cover costs.

CHAI has played a significant role in advocating for early infant diagnosis (EID), including through funding a visit to the HIV referral lab in Botswana. There appears to be an absence of a clear plan for ensuring the elements are in place to provide a technically sound EID service (such as appropriate lab facilities) and no clear plan regarding its roll-out including SOP and curriculum development, training for dried blood spot specimen collection, specimen transportation and training and support for laboratory staff. CHAI recognises these issues, but as yet has been unable to address them with DepKes personnel.

Lessons learned and design implications

It is an important principle that GoI (DMSS in the case of laboratory strengthening) is fully involved in the recruitment of personnel. Tensions remain within DMSS about the approach of CHAI in relation to the need for CHAI personnel to be sensitive to the authority of DMSS and that CHAI is working to support them. DMSS is concerned that CHAI fully appreciate DMSS ownership of data arising from the CD4 EQAS process.

HIV lab strengthening needs to be more integrated within primary health care and a health systems strengthening approach. Training is one component needed to improve capacity and CHAI needs to fully consider the other factors needed to implement lab services such as reagents, equipment and mentoring. CHAI should ensure that a clear plan is in place for lab strengthening including a training and mentoring plan for facilities.

Dialogue with DMSS should be opened about moving to a single CD4 EQAS system. Limitations remain in access to timely and reliable CD4 services. The CD4 referral system and number and placement of CD4 machines should be revisited, taking into account new and simpler CD4 technologies.

There needs to be careful consideration before expanding to new locations. Too rapid expansion places quality of services at risk in facilities that have already received training support. Priority should be given to mentoring, follow-up and ensuring facilities have the management capacity and resources to implement services. Placement of a lab mentor in Wamena should be considered.

Increased collaboration with WHO is needed. WHO has a mandate to work with DepKes in lab strengthening, and funding for lab strengthening is included in Global Fund Round 8.

An expanded role for CHAI in supporting the capacity of puskesmas to provide diagnostic testing for OI, TB and STIs should be explored.

4.3 Paediatric treatment

A small number of children are currently receiving ART using adult formulations. DepKes and IDAI, with support from CHAI, are seeking to simplify treatment protocols and increase the number receiving treatment through introducing EID and fixed dose combinations (FDCs) of paediatric ARVs, and by increasing access to PMTCT.

Paediatric HIV treatment has not been identified as a national priority although several national-level respondents expressed support for it. Feedback in Papua is that paediatric treatment is not a priority at this stage, with higher order priorities needing to be addressed first. There is concern about CHAI being seen to be setting up a new focus area rather than supporting existing programs and priorities.

GoI plans that all VCT centres will implement PMTCT, and UNICEF has delivered some training, however many midwives have not yet received training. CHAI has played a role in supporting PMTCT in Jayapura through clinical mentoring.

Paediatric FDCs will be introduced to Indonesia in July 2009. CHAI has helped IDAI to prepare for roll-out by participating in development of an Action Plan for a 3 month trial, developing a paediatric dosing wheel, and printing and distributing national paediatric treatment guidelines. The training curriculum is being developed with CHAI assistance, however there is concern about the appropriateness of CHAI's input (based on a Cambodian curriculum) for the Indonesian context. CHAI plans to co-fund some training of paediatricians and facilitated a lecture on paediatric FDC for paediatricians.

CHAI is expected to play a significant role in analysis of lessons learned through the pilot of FDC roll-out in four Jakarta hospitals for 30 patients not already on treatment.

A comprehensive plan to roll-out paediatric treatment once the trial is complete is lacking, the need to incorporate lessons from the pilot notwithstanding. Paediatric HIV treatment is significantly more complicated than for adults and yet there appears to be no plan for ongoing support and mentoring of paediatricians to cope with the increased demand expected following EID and FDC roll-out. IDAI report that this will create additional burden on them that they do not currently have the resources to meet.

While there were initial attempts between UNICEF, FHI and CHAI to harmonise work on PMTCT and paediatric HIV treatment in Papua to ensure a unified approach, this has not come to fruition.

Lessons learned and design implications

Paediatric HIV treatment is not an immediate priority for Papua and there is a preference for CHAI to focus on other issues.

Until capacity for puskesmas to provide VCT services increases, the model of PMTCT is difficult to apply in Papua where most women attend puskesmas for antenatal care. Most puskesmas have no HIV testing or treatment capacity. Transport costs mean that many women do not travel for hospital testing or HIV treatment follow-up.

In the rest of Indonesia, paediatric HIV treatment and PMTCT is considered to be a priority only in the context of populations at higher risk in areas of concentrated epidemic. In most cases this will mean the children of people who inject drugs. In such cases, it will be important to provide a holistic approach for the needs of the family with an emphasis on the particular needs of people who use drugs.

CHAI should have a minimal role in paediatric HIV treatment beyond analysis of pilot and helping DepKes and IDAI to plan any future work.

4.4 Care, support and treatment (CST)

At the national level CHAI has collaborated with ASHM to provide funding to IDI for a position to form an expert panel for ART regimen approval and revise national treatment guidelines. This position was filled in June 2009 with a commitment to 12 months funding.

Proposed research activities on ART impact have not proceeded due to funding constraints.

Respondents report that CHAI has been an active and valued partner in the Global Fund HIV Technical Working Group, grant proposal and implementation activities. As implementation of Round 8 progresses, GoI will mobilise resources from in-country donors and international development partners to support implementation.

CHAI's work in CST training and clinical mentoring has been focused in Papua and is discussed in 4.5.

Lessons learned and design implications

Global Fund work is valuable as CHAI has clear expertise in the SCM area and works well in the team setting. Apart from Global Fund, CHAI has little CST activity at national level

CHAI should ensure that a plan is in place for the IDI work, which addresses justification and options for ongoing funding of the position.

A clear plan regarding the relationship between the AusAID funded and Global Fund funded CHAI work is needed. The potential for additional work as requested by GoI should be acknowledged in CHAI work plans.

4.5 Rural Initiative

After site assessment with GoI and FHI/ASA, the Rural Initiative commenced in Papua in September 2008. The pilot focuses on Wamena Hospital, Wamena city Puskesmas, Kalvari Clinic and local NGOs. To date there has been little work of this nature in Indonesia. The Ministry of Health at national and sub-national levels has not had staff for outreach work and has not contributed substantially in this area. The DepKes *Save Papua* initiative is an exception, but its contribution to HIV responses in remote areas of Papua is not yet clear.

Respondents reported that assistance under the Rural Initiative had been appreciated. There has been limited support from government. Support from donors to the Wamena area has largely ceased. All respondents requested that the rural initiative in Wamena continue.

Apart from clinical mentoring, CST training, some short term logistics support and recent engagement with KPAD, the work has not met the expectations of respondents. The overall aim is not clear to respondents, many of whom felt it had been of limited value. A lack of planning and coordination by CHAI across the full range of government and non-government agencies in the district was a serious shortfall. Senior local health personnel met and jointly prepared a document of concerns. There is concern that not all CHAI staff have had appropriate experience and qualifications. Staff turnover is a problem.

The CHAI team have only had a permanent presence for around 6 months in Wamena and expat and national staff have had little crossover so the full potential of the initiative, including to address the problems raised, has not been realized.

Clinical mentoring at Wamena Hospital had been very successful and is highly regarded. The engagement of skilled staff over an extended period of time appears to be essential. Understanding by mentors of Bahasa Indonesia and Indonesian systems was considered very important. Short visits by international experts was not supported and was perceived by some respondents as an attempt to raise facility activity levels to meet external targets. The current mentor has taken a systems strengthening approach, building where possible on existing systems, using national and WHO guidelines - building institutional capacity as well as personal capacity. The integration of HIV, STI and TB services, and VCT training for staff across the hospital is another sustainable outcome of this work.

The Provincial Health Office (PHO) requests CHAI to have a community development focus in Wamena. Increased support to the Puskesmas and Kalvari clinic was also requested.

Capacity and integration of the HIV health system in Jayawijaya District is very poor. Reasons for this include the impact of decentralization, regional autonomy, a legacy of weak administration and low funding, and the challenges of culture and terrain.

CHAI clinical mentoring has contributed to clinical capacity and patient referral systems and HIV/TB/STI service linkage but impact beyond the hospital appears limited. Development by CHAI of a system to transport blood for CD4 testing to Jayapura, has not been sustained in the absence of CHAI staff. Respondents were not aware of the CHAI SOPs for this work. The quality of CST training in Sentani / Jayapura was reported as high but respondents were not clear regarding the process for refresher training and how supply of pharmaceuticals could be ensured. This reflects concerns of respondents that the CHAI approach to increasing service provider capacity is not matched to health system capacity to meet increased need.

It is questionable that sustainable impact in this area is possible without a well coordinated systems approach to the issues. Limited coordination across the range of health services in Wamena has not placed CHAI in a strong strategic position to work at the systems level.

CHAI recent engagement with the Jayawijaya KPAD including the initiative to strengthen 5 puskesmas in the Wamena area is positive and welcomed by the KPAD.

FHI/ASA has a rural program in East Java and is ready to start work with CHAI there. They report reasonable coordination with CHAI, although monthly meetings have stopped and they are now uncertain as to whether this collaboration will proceed.

CHAI has commenced work in the Jayawijaya District to develop patient support experts (*pendamping*). CHAI report they have supported the DHO to train 15 *pendamping* who have a current caseload of 70 patients. Health service staff could not describe added value from the CHAI *pendamping* program to patient support work already in place in Wamena. Respondents were not familiar with the CHAI guidelines for *pendamping* and it is unclear how the model will be adapted to local circumstances.

CST in the Rural Initiative, apart from clinical mentoring, has mainly involved training. CHAI assisted with recruitment of Head of HIV Administration in Jayawijaya based in KPAD. This position was occupied for 3 months in 2009 but is now vacant. As KPAD was already proceeding with recruitment it is unclear if CHAI involvement was of strategic value.

Lessons learned and design implications

In future CHAI /GoI documents, the Rural Initiative is to be referred to as *Integrated Pilot Projects to Strengthen Service Delivery in Selected Areas in accordance with MOH national programs and guidelines.*

Tension remains between health service staff in Wamena regarding the Rural Initiative. CHAI staff are aware of these tensions, but in planning and implementation CHAI need to be more informed and sensitive to the local and national context of the work. Where possible, CHAI should work within national and WHO guidelines and build on work to date rather than introducing new approaches. CHAI should ensure that a clear plan is in place for the Rural Initiative, linked to national and sub-national strategies and priorities. Considering the

sensitive nature of Papua and extent of the epidemic, planning and implementation should formally engage KPA and Ministry of Health at national and sub-national levels.

Long term clinical mentoring using a systems approach by skilled, preferably Indonesian, doctors is preferred. Consider linking with WHO's national clinical mentoring initiative.

Explore extending HIV/TB links beyond Wamena Hospital. This should include links to the Jayapura-based HIV/TB Working Group and to KNCV (an INGO).

There is little consensus on approaches to CST and HIV in Jayawijaya. CHAI should work with district authorities to achieve this and to strengthen planning, but not take a lead role.

Review of qualifications and experience of staff based in Papua to plan and implement a program in this complex sensitive environment is required.

CHAI should reconnect with FHI/ASA regarding rural work in East Java.

5 Gender equality

The gender analysis and strategies to address gender-related issues in CHAI programming is either non-existent or very weak. This indicates a lack of appreciation of the integral importance of gender in HIV and health. CHAI's analysis is limited to presentation of the percentage of men and women employed or trained by CHAI and an expressed desire to not place an additional burden for health workers in collecting basic sex disaggregated data. CHAI reports that there is a module on women and HIV in *pendamping* training. CHAI needs to seek the support of a gender specialist for any further work to better understand the issues and implications for future work, and to better meet the needs of marginalised communities.

In addition to collecting disaggregated data, the work should consider the differences between men, women and people of diverse gender identities and sexualities related to:

- their different needs;
- implications of HIV status and treatment;
- constraints restricting participation and access to services; and
- trends, successes and lessons that relate to service provision.

Gender-related issues need to be mainstreamed into all training, programming and reporting including skills development around gender-sensitive issues and needs, including violence.

CHAI could involve local community groups and NGOs to better understand and negotiate issues around gender. There may be potential for consulting with Women's Empowerment Bureaus who play a coordinating role with government line agencies and implementing organisations to promote women's issues.

6 Monitoring and Evaluation (M&E)

The M&E plan is in the form of a matrix and is not contextualized. There is little connection between the data in the M&E matrix and the discussion and analysis in the narrative of

progress reports provided to AusAID. It is unclear whether the existing M&E matrix of indicators is proving useful for management purposes to CHAI or AusAID.

A small number of CHAI indicators are partially aligned to GoI national indicators, but the alignment is sometimes unclear. For example, a CHAI indicator is "number adults tested for HIV" (in selected sites), whereas the national indicator is "percent women and men aged 15-49 who have been tested for HIV in last 12 months and have received their result". These indicators are linked, but not identical and the CHAI data is not sex disaggregated.

Reporting could be further strengthened by consideration of the extent to which reported benefits and achievements are likely to be sustainable. Some benefits appear to be entirely reliant on CHAI inputs and initiatives. The M&E plan provides little basis for monitoring the likelihood of achieving sustainable benefits, and does not enable consideration of gender, anti-corruption, or coordination with other donors. The plan requires a greater emphasis on monitoring quality, sustainability and outcomes, in addition to selected quantitative outputs.

PSM is not included in the GoI national M&E system. CHAI should support GoI to improve monitoring of PSM within the national M&E System, as this is currently poorly addressed. This will assist progress towards a sustainable GoI PSM system.

CHAI should systematically collect, analyse and report sex disaggregated data. This will demonstrate to partners the value of disaggregation in understanding gender and HIV.

It is acknowledged that the existing M&E plan was prepared by CHAI in response to AusAID's request and was considered a satisfactory step to improving M&E. In future, the project requires a more thorough M&E plan in the form of a narrative which links the data referred to in the matrix to reporting to GoI, CHAI, AusAID, Global Fund and other partners, provides a guide for the analysis of data, describes what analysis and reporting is done by whom and when, and addresses alignment issues including links to AIPH and GoI M&E. The plan should describe how lessons learned are fed back to inform project management and how the project M&E approach strengthens GoI M&E and implementation capacities.

7 Conclusions

Given the size and complexity of Indonesia and the funds available to CHAI, working both nationally and at provincial level across five activity areas is too ambitious. CHAI should focus its work in PSM, clinical mentoring and the rural initiative guided by a clear and comprehensive design document, while phasing down other activities.

A more collaborative approach is required with joint work planning, led and owned by GoI. CHAI's way of working needs to fit with the AIPH concept of phasing in an increasingly programmatic response. This could be achieved for example through cofunding with GoI, or providing direct targeted small grants to GoI e.g. to KPAP, KPAD, hospitals and clinics for capacity building activities.

CHAI requires a communications strategy to inform the approach to and regularity of contact with all key players. This should be integrated into planning and include more thorough and balanced reporting of progress, contentious issues, risks and risk mitigation measures. The

relationships to KPA and Papua KPAP in particular need to be strengthened, and other donor projects including FHI and HCPI. This needs to occur at formal and informal levels.

The work in Wamena should be informed by a direct formalised relationship with the PNG Rural Initiative, enabling sharing of lessons on capacity development and systems strengthening approaches.

Indonesian nationals have been under represented in the CHAI staff team, including in finance and human resource positions. Staff turnover has been a recurring problem. Implementation would be strengthened by long term in-country presence of technical expertise, and greater use of Indonesian nationals for clinical mentoring.

The relationship between AusAID and CHAI needs to be reconceptualised. There is a need for stronger monitoring by AusAID in relation to issues of sustainability, learning and complementarity with other AIPH activities and new AusAID health initiatives in Papua.

All key counterparts including DepKes and Papua Provincial Health Office have requested the CHAI project to continue consistent with the draft MoU with DepKes. A further 18 month phase is required to consolidate outcomes relating to PSM, clinical mentoring and the Rural Initiative, and to complete lab and paediatric initiative activities.

To ensure quality and effectiveness of AusAID support to 2015, a thorough external design process is required, concurrent to CHAI's next phase. A full design process for a new program in CST may take 12 months prior to commencement. A new program design is required so that the potential contribution of other providers and other forms of support to GoI can be fully assessed. A design process in 2010 will be able to take into account the new donor environment for CST which will be in place by 2010. Timing of the design in mid-2010 is recommended to take into account PEPFAR and USAID's new program emphasis, Global Fund progress including CHAI's performance as the PSM sub-recipient, and the commencement of AusAID Decentralization Program and MCH activities in Papua and Papua Barat. A design process in 2010 will allow a new program to commence by mid-2011.

8 Recommendations

8.1 Phase II: 18 month extension to CHAI

It is recommended that:

- CHAI be granted an 18 month extension from January 2010 to July 2011 (Phase II). This will have given CHAI a 3 year term to deliver on its AusAID/DepKes program.
- CHAI lead a design process for Phase II prior to December 2009.This design will be informed by the three year workplan attached to the July 2009 MoU with DepKes.
- AusAID provide guidance to CHAI on design requirements relating to clarity of objectives, M&E, risk analysis and risk mitigation, anti-corruption and gender. The design to include an updated analysis of needs and description of other donor and GOI HIV programs so that conflicts and duplication can be avoided. Expertise on M&E and

gender to be provided by AusAID. M&E to be owned by counterparts and to monitor timely exit strategies, sustainability approaches and the quality of interventions and relationships. Increased AusAID engagement in monitoring. Content of reports to be specified and monitored as part of a more comprehensive approach to M&E.

- The draft Phase II design be subject to an external peer review process to optimize harmonisation and alignment.

It is recommended that Phase II include:

- An emphasis on PSM at national and provincial levels. Continued support to PSM for paediatric formulations and reagents. An exit strategy to phase out CHAI support to other aspects of paediatrics and labs by June 2011 or earlier.

- The work in Papua to continue, but not at an expanded level. Currently between 60% and 70% of the budget is for Papua activities. This proportion should not increase. A stronger community development approach in Wamena with increased engagement at puskesmas level and with community leaders and local/district GoI partners. Closer AusAID monitoring of the work in Papua.

- Clear and consistent objectives that can be effectively monitored and reported, with a schedule of data analysis and reporting to provide management information and accountability. Attention to clarity regarding a coherent approach to planning and reporting of any PSM activity areas that are funded by both AusAID and Global Fund.

- A development approach that ensures GoI is fully consulted and leads work planning, and that GoI and local partners set the pace and determine entry points and priorities. Phasing in an increasingly programmatic response e.g. consider co-funding of activities with GoI and/or provision of grants to GoI partners, learning from HCPI. Formalisation of the relationships with KPA, KPAP and KPAD.

- Ensure a stronger health systems strengthening approach including ensuring HIV/TB and STIs are addressed wherever practicable.

- Greater use of TA expertise based long-term in Indonesia and of Indonesian clinicians in training and clinical mentoring.

- A gender plan within the design to address not only whether activity is promoting equal participation but also equal benefits for females and males, equality of decision-making between women and men, promoting women's rights and developing capacity of partners to understand and promote gender equality within HIV responses.

- Increased AusAID engagement in design and regular monitoring of Phase II. Stronger engagement and oversight by AusAID to ensure quality and optimize synergies with HCPI and other AIPH activities (e.g. ASHM, NRL) and related Australia Indonesia Partnership for Development programs in the areas of decentralization and MCH.

8.2 New HIV Care, Support and Treatment Program 2011-2015

It is recommended that:

- AusAID fund a new HIV CST Program 2011-2015. The budget to be approximately AUD$6 million in total for the 4 year period.
- An independent design process for a new CST Program July 2011-2015 be conducted. The CST Program to include a national systems and Papua/Papua Barat focus.
- The design to be conducted in mid-2010, recognising that at least 12 months is required from design to commencement if tendering is required.
- The design to be informed by the need to strengthen country systems and to consider all options e.g. INGO partnerships, managing contractor models, delegated aid, co-financing, budget support to GoI, Indonesia Partnership Fund, grant-making, output based aid.
- A tender process occur, if required, in early 2011 so that new program mobilises by July 2011 or soon thereafter. If a managing contractor model is preferred, CHAI can compete against other INGOs, private sector contenders and UN implementers.

9 Next steps

The evaluation Team's Final Report will be provided to AusAID by 20 July 2009. The Report will then be subject to a peer review process within AusAID. After the peer review, a decision on whether to accept the recommendations will be made and communicated to stakeholders.