

**THE GLOBAL FUND  
To Fight AIDS, Tuberculosis and Malaria  
Interim Secretariat**

Geneva, 31 January 2002

GFATM/B1/6 Annex

GUIDELINES FOR PROPOSALS

**PROPOSAL FORM**

*Guidelines for Proposals* set out detailed conditions of support and criteria for review of proposals. Reference is made in this form to relevant sections of the Guidelines.

<p><b><i>For the use of the Global Fund Secretariat:</i></b>  <i>Date Received:</i>  <i>ID No:</i></p>
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This form is divided into 3 sections:

**SECTION A** seeks summary information on the overall proposal, total funding sought and information related to general eligibility criteria, including details of the Country Coordinating Mechanism;

**SECTION B** seeks further detail on the overall proposal, its objectives, how it will be monitored and demonstration of additionality;

**SECTION C** seeks detail, including budgetary information, separately on each component of the proposal.

For additional pages, please mark clearly whether SECTION A, B or C.

**SECTION A: OVERVIEW INFORMATION**

<p><b>A.1. Country (or region):</b></p> <p style="text-align: center;"><b>INDONESIA</b></p>
<p><b>A.2. Proposal Title:</b></p> <p><b>Prevention and alleviation of the impact of HIV in Indonesia</b></p>
<p><b>A.3. Spell out which of the three health problems or combination of them this proposal aims to address (HIV/AIDS, TB and/or malaria) (<i>Guidelines para.4</i>) :</b></p> <p><b>HIV /AIDS</b></p>
<p><b>A.4 What are the additional outcomes expected from this proposal? (<i>Guidelines, para. 8 and Annex 1, II 3</i>).</b></p> <ul style="list-style-type: none"> <li>- Critical opportunity to prevent further increases in prevalence and incidence among youths injecting drugs and practicing unsafe sex</li> <li>- A massive and concerted effort to prevent further epidemic through strengthened public – private partnerships</li> <li>- Scaled - up best practices from the region such as 100% condom use and harm reduction</li> <li>- Improved access to health care for PLWHAs</li> </ul>
<p><b>A.4. Total Amount Requested from the Global Fund: (in US\$, by year)</b></p>

<b>Components (described in Section C)</b>	Year 1	Year 2	Year 3	Year 4	Year 5
	<b>(Budget)</b>	<b>(Estimated</b>	<b>.....)</b>		

**Component 1 ( IEC )**

**Component 2 ( Targeted Interventions )**

**Component 3 ( Care, Support & Treatment )**

**Component ( Program Management )**

**TOTAL (outlined in Section B)**

**A.5. Disease burden** (Refer to official documentation or sources of epidemiological data on the prevalence and magnitude of HIV/AIDS, TB and/or malaria in the country/region/area) **or potential disease burden** (indicators such as incidence of new infections etc) *(Guidelines para.6)*

Fourth largest population in the world after China, India, and America, consisting of 13,000 islands and 250 ethnic groups each with its own dialect /language and customs.

The economic crisis, that crippled Indonesia since 1997, has strong impact on the health status of the people, particularly the poor. Poverty increased from 11% to 24% (1998) and malnutrition is currently on the rise. The political unrest in Maluku, NTT, Aceh and other parts of Indonesia has virtually halted all public health services in those areas, including control for diseases of poverty : HIV, TB and Malaria. In many other provinces, cutbacks in health budget have disrupted the continuity of services, in particular at the primary health care level.

Indonesia is considered at risk of HIV epidemic due to many favorable conditions for the spread of HIV, including high-risk sexual behavior, poverty, prevalence of sexually transmitted infection, increasing migration and urbanization, widespread injecting drug use (IDUs), and proximity to areas with advanced epidemic.

**Sexual transmission of HIV-infection has increased since 1998 in many parts of the country. The Ministry of Health official estimation of HIV-cases (2001) calculated a range of 80,000 – 120,000 people living with HIV.** The majority of infections reported have been sexual (77.1%). However, in the last 2 years prevalence rates among injecting drug users have escalated sharply (21%). **Young people in the 20s are most affected to date, indicating that people are becoming infected with HIV in their late teens or early 20s.**

The occupation of the reported AIDS cases shows people from all walks of life : business people, students, laborers, fishermen, sailors, housewives, and commercial sex workers (male and female) are the groups more represented so far.

There are concentrated areas of the HIV/ AIDS epidemic as follows :

Jakarta: HIV prevalence was identified as high as 47% among IDUs ( 2002 )

22.0% among prison inmates in 2001; CSWs 1.5 % ( 2001 )

Papua: HIV prevalence was identified as high as 26.5% among CSWs ( 2000 )

Riau: HIV prevalence was identified as high as 8% among CSWs ( 2000 )

Bali: HIV prevalence was identified as high as 53% among IDUs ( 2000 )

**Even though the prevalence rate of HIV among blood donors is as low as 0.0148% (national data), there is almost 5 fold increase by 2000. The reason for this increase may be due to samples received from high risk groups.**

**The prevalence rate of HIV among pregnant mother s in Jakarta through VCT is 1. 5 % ( 1999 ) . In Papua and Riau through unlinked anonymous testing was 0.25% -0.35% . (1998 – 1999) .**

**The Behavior Surveillance Surveys conducted among Female Sex Workers in 8 big cities in Indonesia shows a low rate of condom use (0-9.4% ) ( since 1996 – 2000 ). The prevalence of HIV in transvestites in Riau ( 1998 ) was 6.5% , and in Jakarta (1997) was 6 % and in 1999, it increased to 7.1 % .**

**Married Men Buying Sex ( 1996 – 2000) average between 50.8 – 54.9%, while rate of unmarried men was lower at 43.5 – 48.2 %. Male Condom Use at last commercial sex was only 9.6 – 23.7 %.**

Senior High School male students who reported ever having sex was Jakarta 8.8% ( 1997), increasing to 22.9 % ( 1999 ) and in Surabaya 8% ( 1997) to 11.4 % ( 1999 )

STI reporting systems are far from complete in Indonesia, but a number of prevalence studies in four cities (Kupang, Jakarta, Surabaya, Manado) revealed the prevalence of Gonorrhoea between 19.6% - 30.9%, Chlamydia between 22.2% - 39.6%.

**A.6. Economic situation:** (Refer to official indicators such as GNP per capita, HDI or other information on resource availability) (*Guidelines para.6*)

At year 1980, the normal value of GNP, based on the concurrent price was US\$ 295, and it increased to US\$ 434 in 1998. The estimated number of poor people is 47.9 million at year 2002.

The Human Development Index for Indonesia was 67.7 in 1996 and decreased to 64.3 in 1999. ( Human Development Report ( 2001 ) )

The severe political and economic crisis that occurred in the country since the last four years has affected health sector financing severely. The allocations for health before the crisis were already quite low (2.5% of total government budget or US \$ 5/capita/year) and have been further reduced. From 1997-1998-2001 more than Rp.9 trillion was allocated for Health. This was only 0.9 – 1.3 % of the National Budget. In general, the total budget allocated for the health sector in 1999/2000 increased by 39.69% in comparison to the previous annual budget, from 3.81 to 5.74 billions rupiahs.

The expenditure for health is mainly from the donors (70%) with lesser government contribution (30%). Budget for programs in the Directorate General of Communicable Disease Control and Environmental health (CDC&EH) currently depends on loans, foreign support or grant-in-aid. The increasing caseload of the disease and the declining strength of the Indonesian economy will further increase the economic burden of HIV/AIDS in Indonesia.

**A.7 Political commitment:** (government contribution to the financing of the proposal or public spending on health or existence of supportive national policies or presence of a national counterpart in the proposal, or other indicator) (*Guidelines para. 6*).

HIV/AIDS control is the only one disease covered by a Presidential Decree No.36 /1994 that formally establish the National AIDS Commission ( NAC ) to address inter-sectoral implementation of the National AIDS Strategy. National AIDS Commission ( NAC ) members include partners from all sectors as well as NGOs. While President Megawati was the Vice President, she took the leadership of the NAP to accelerate its activities, and the NAC works under the Vice President's supervision. NAC has identified National Program priorities for the prevention and control of AIDS. Provincial and District level AIDS Commission have also been established. **The government has already prepared the 5 Year National Strategic Plan (2002 – 2006).**

Total budget for HIV/AIDS programme was Rp. 165.5 billion ( **year 2001** ), amounting to only 1.4 to 2.4 percent of the overall health budget. Of this total budget for HIV/AIDS programme, allocation from the government was around 48.5 billion rupiah (29.3% ), and the remaining was from donor agencies.

The Government of Indonesia has a strong commitment to the UNGASS declaration ( June 2001), the Asia – Pacific Ministerial meeting in Melbourne ( October 2001) , as well as the ASEAN HIV/AIDS Declaration adopted at the HOG Summit in Brunei Darussalam ( November 2001).

**A special session on HIV/AIDS for the Cabinet is being convened in mid March, 2002. Anticipated outcomes are a stronger leadership role by the President, commitment of a multi-sectoral ministry response, and increased budget allocation**

**This proposal is a joint proposal from multi-sectoral partners, NGOs and civil societies.**

**A.8 Links with existing activities:** (What links are there between this proposal and other current activities supported, for example, through, national health strategies, Poverty Reduction Strategies and Sector-Wide Approaches? Provide copies of these as supporting documentation, noting them in Attachment 1)

## **I. PREVENTION**

### **I. 1. Information, Education and Communication ( IEC )**

Many IEC activities have been conducted utilizing available grant and loan fund from the government. These activities have been conducted in various parts of the countries by all sectors including Non-Government Organizations (NGOs). The IEC activities include development of IEC materials, information dissemination, and peer education. World AIDS Days are commemorated every year in Indonesia and many sectors and NGOs are involved in various activities. The Ministry of Education implemented policy on prevention education to all levels of education set-up and also published materials on AIDS prevention and control to be used in junior, senior high schools, and universities. This is based on the Ministerial Instruction of 1997.

Because of lack of sufficient funding of sectoral ministries, and huge geographic nature and various ethnic groups, targeted IEC could not be implemented on the massive scale that is needed in Indonesia.

### **I. 2. Blood Safety Programme**

Blood donations screening against HIV has been done since 1992. At present 95% blood donations can be screened throughout the country, however 5% blood donations are utilized without proper screening because transfusion is done in remote areas where blood-screening facilities are not available. Moreover, since 1997, the economic crisis had made procurement of screening reagents a burden for the Ministry of Health.

### **I. 3. Condom promotion**

In the past, condom promotion has been promoted only as a contraceptive device. Presently the Family Planning Board has broadened its usage for double protection, that is prevention of pregnancy and STIs including HIV infection. The National Workshop of Ulemas (Islamic Religion Scholars) on HIV/AIDS Prevention and Control (1997) recommended that prevention of HIV be encouraged to avoid endangering self or others.

## **II. TARGETED INTERVENTION**

### **II. 1. Condom Use 100% in Entertainment Establishment**

In 1996, the Ministry of Health (Director General of CDC and EH) issued a circular to all Chiefs of Provincial Health Office in Indonesia to promote 100% condom use among high- risk groups. However, consistent condom use is still below 10%. 100% condom use project in entertainment establishment is being initiated in as a pilot project in Merauke municipality, Merauke district, which has the highest prevalence of HIV, with technical support from UNAIDS/WHO. Following international best experiences Indonesia will scale up the 100% condom use in 4 priority provinces.

### **II. 2. Prevention activities among IDUs (Harm reduction)**

HIV/AIDS Prevention activities among IDUs by the Government to date consist of a few pilot harm reduction activities have been initiated in Jakarta and Bali. A few non-government organizations have started some sporadic and limited activities. The new 5 year National Strategic Plan will expand Harm Reduction projects in 10 districts of Indonesia.

## **III. CARE, SUPPORT & TREATMENT**

### **III. 1. STI management**

STI management is being done through syndromic treatment as well as condom promotion. This innovative syndromic approach is being done in few provinces. It will be expanded and strengthened in the near future which will lead to a reduction in the risk of HIV transmission.

### **III. 2. Testing and Counseling**

Testing and counseling facilities are still very limited in Indonesia, both at Provincial Health Laboratories as well as blood banks for voluntary testing. Scaling up of voluntary testing services is a high priority for Indonesia.

### **III. 3. Implementation of Mother to Child Transmission Prevention**

MTCT in Jakarta has been initiated by The Torch of Science Foundation (Yayasan Pelita Ilmu). Recently, it has been initiated in Merauke District, Papua with the guidance of WHO.

### **III. 4. Continuum of Care**

A limited number of hospitals have trained their staff in HIV/AIDS care in Indonesia. Capacity in HIV / AIDS care

in Indonesia is limited. Some NGOs have been engaged in providing care for AIDS cases. Some guidelines on AIDS case management have been developed which include tuberculosis with HIV infection case management and community-based AIDS care. NGOs have set up shelters for people living with HIV/ AIDS in some areas, but there are limited home care projects.

**Because of limited budget, diagnostic services and the drugs for all STI cases, opportunistic infection and HAART (Highly Active Anti Retroviral Therapy) are in limited supply. Though some projects for HIV/AIDS care are being supported by donors, some bilateral donors do not allow purchase of drugs and consumables.**

**Without adequate drugs, the comprehensive efforts for prevention and alleviation from the impact of HIV infection cannot be possible. Support from the GFATM will allow to scale up the existing programmes.**

#### **IV. PROGRAM MANAGEMENT**

##### **IV. 1. Surveillance**

Epidemiological surveillance of AIDS is an ongoing activity of the National Strategic Plan and the National Programme for the Prevention and Control of AIDS. Epidemiological surveillance in Indonesia consists of HIV sentinel/ad hoc surveillance, behavior surveillance, and anti-microbiological resistance studies for STIs.

However, continuous efforts will be made to strengthen this program in the future.

##### **IV.2. National Capacity Building**

Capacity building on HIV/AIDS has been provided for technical professionals through in-country training as well as outside the country. Efforts are on way to improve the capacity of non-professionals on management skills, eg. Local AIDS commissions and others involved in the program.

##### **IV.3 Monitoring and Evaluation**

Activities on monitoring and evaluation have been conducted not only by the government, but also by the donor agencies with some good progress. External and internal evaluations have been carried out periodically. Biological and behavior indicators have been used for monitoring and evaluation.

##### **IV. 4 International Cooperation**

Indonesia has developed international cooperation at both global and regional levels. Through this cooperation, Indonesia has not only received technical and financial assistance, but also exchange views, lesson learned, experiences, and established various networking.

**A.9 Profile of the Country Coordinating Mechanism (CCM) – If not submitted by a CCM, please move directly to A.12. (Guidelines para. 9-14)**

*Various agencies and partners (including NGOs and Research Institutions) that are supporting this proposal are co-ordinated and organised through a country coordinating mechanism which is referred to in this document as CCM.*

1. Name of the CCM: **Komite Pengkoordinasian Pemanfaatan GFATM Indonesia ( Indonesian Country Coordination Committee for GFATM )**
2. Date of constitution of the current CCM: **21 February 2002**
3. Organizational structure (e.g., secretariat, sub-committee, stand-alone):  
The interim CCM was established through a consensus process with stake holders on the 15 February 2002 and formally approved by the Ministerial decision from the Minister of Health on 21 February 2002.  
  
The CCM is a stand alone committee that is service by the secretariat provided by the Ministry of Health. The CCM has also established 3 technical review panels for HIV/AIDS, TB and Malaria to review proposals and make recommendations to the CCM.
4. Frequency of meetings (e.g. monthly, quarterly):  
The CCM has met 3 times during the process of submission of proposals and will meet at least monthly when funds are received.
5. Major functions and responsibilities of the CCM:
  - To manage the activities related to the GFATM in Indonesia
  - To develop and encourage strong private – public partnership
  - To encourage/support the development of proposals for submission to the CCM
  - To oversee the monitoring and evaluation of proposals funded by the global fund
  - To report to the GFATM on progress made by the proposals funded
6. Major strategies to enhance CCM’s role and functions in the next 12 months:
  - Develop a workplan for the CCM for consideration at the March meeting that operationalizes the roles and responsibilities of the CCM
  - Prepare a communication plan to inform the community about the activities of the CCM in relation to GFATM
  - Building partnerships for a multisectoral approach through regular information sharing and participation in proposal development workshops
  - Build partnerships with civil societies, PLWHAs, and the private sector through regular information sharing and participation in proposal development workshops
  - Proposal development activities will consist of workshops led by CCM to be funded by UNAIDS Poject Acceleration Funds involving the NAC, multi Ministries, PLWHAs, civil society and private sector activities

**A.10. Please provide the total number and composition of members of CCM:**

People living with HIV/TB/malaria	1
NGOs/Community-based organisation	4
Private Sector	2
Religious/Faith groups	2
Academic/Educational Sector	1
Government Sector	9
Other (explain)	3
<b>TOTAL</b>	<b>22</b>

**A.10. Signatures:**

Members of the Country Coordinating Mechanism (CCM – see following page) sign below to endorse this proposal. Endorsement of this proposal does not imply any financial (or legal) commitment on the part of the partner agency or individual:

**Signature,**

**Chair of Country Coordination Mechanism:** \_\_\_\_\_

**Chair Name and Contact Information:** \_\_\_\_\_

**CCM Member Signatures**

Agency/Organization	Name/Title	Date	Signature
Director General CDC& EH	Prof. Dr. Umar F. Acyadi, MPH, PhD		
Secretary General MOH	Dr. Dadi S. Argadireja, MPH		
Muhammadiyah Foundation	Dr. Roenizar Roesin, MPH		
IDU Committee of Indonesia	Dr. Brotowasisto, MPH		
Director DTDC, CDC & EH, MOH	Dr. Haikin Rachmat, MSc		
Bangun Indonesia Foundation	Sumengen Sutomo, MPH, PhD		
Head of Medical Doctor Foundation	Dr. Suriadi Gunawan, DPH		
Gerdunas-TB	Dr. Tjandra Yoga Adhitama, SpP, MARS		
Director of Vector Borne Diseases	Dr. Thomas Suroso, MPH		
Country Program Adviser UNAIDS	Dr. Jane Wilson, Ph.D		
WHO Representative To Indonesia	Dr. Georg Petersen		
Secretary Dit.Gen CDC & EH, MOH	Dr. Sjafii Ahmad, MPH		
Senior Staff of the MOH	Dr. I. Nyoman Kandun, MPH		
Bureau of National Development and Planning	Drs. Arum Atmawikarta, MPH		
FK LOPA/ NGO	Suzanna Murni		
PPTI/ NGO	Dr. Yudanarso Dawoed		
Indonesian Health Association	Dr. Doddy Partomihardjo		
Faculty of Public Health-UI	DR. Adang Bachtiar, MPH		
Pharmaceutical association of Indonesia	Anthony Ch Sunarjo, MBA		
Head of Planning Bureau, MOH	Dr. H. Setiawan Soeparan, MPH		
Indonesia Christian Association	Dr. A.A. Tombokan Neloe, MHA		
Finance Department	Drs. Edi Kasanto, MA		

**A.11.** In case the Global Fund Secretariat has queries on this submission, please contact:

Name: Dr Haikin Rachmat ( Secretary CCM )

Title/Address: Director, Directly Transmitted Disease Control, CDC & EH, Ministry of Health

Tel.No.: 62 21 4240538 ( direct ) ; 4247608 ext 129

Fax No.: 62 21 4240538

E-mail: [haikin@ppmplp.depkes.go.id](mailto:haikin@ppmplp.depkes.go.id); [fonnyjs@centrin.net.id](mailto:fonnyjs@centrin.net.id) ; [c\\_basri@yahoo.com](mailto:c_basri@yahoo.com)  
[Jwilson.unaids@undp.org](mailto:Jwilson.unaids@undp.org); [laihat@centrin.net.id](mailto:laihat@centrin.net.id);

**A.12.** If submitting not under a CCM, but as an individual or a partnership of non-governmental organizations (NGOs) or from private sector, please explain clearly the circumstances, conditions and/or reasons why not applying under a CCM.

## SECTION B: OVERALL PROPOSAL

**B.1 Summary of overall proposal:** (Synopsis of proposal, describing overall objectives, who will be involved, the beneficiaries, listing the major health components and the synergies between the different components. [More detail on separate components is sought in section C).

### **Background**

The Government of Indonesia has formulated a Strategic Planning for HIV/AIDS Prevention and Control Program for the period of 2002-2006.

The Program for prevention and control of HIV/AIDS has always involved various sectors within MOH, other ministries, community organizations, the private sector, donor agencies/ international organizations, People Living With HIV and AIDs ( PLWHAs ) and the civil society. Therefore, representatives of all these sectors were involved from the beginning of the formulation of planning process including situation analysis of HIV/AIDS in Indonesia.

Indonesia is considered at risk of HIV epidemic due to many favorable conditions for the spread of HIV, including high-risk sexual behavior, poverty, high prevalence of sexually transmitted infection, increasing migration and urbanization, widespread injecting drug users (IDUs), and proximity to areas with advanced epidemic. The four most affected provinces are, Jakarta, Papua, Riau, and Bali province out of the 30 provinces of the country.

The National AIDS Strategy is based on the premise that HIV / AIDS is not merely a technical challenge, but also a fundamental development issue. Behavior change will not occur without significant change in social and political environment in the wider society. While information is critical to behavior change, there is substantial evidence to show that information alone is ineffective in changing behaviors.

Integrated approaches involving advocacy, education, voluntary counseling and testing, provision of condoms, harm reduction measures for IDUs, STI services, and care and support mechanisms are needed urgently.

Due to the above indications on the rapid increase of HIV during the last 2 – 3 years, Indonesia needs urgently to :

1. Inform and educate the public, opinion leaders of society, vulnerable and at risk populations (IEC),
2. Scale up the existing best practice programs with community-based interventions among populations with a high-risk behavior, (Targeted Interventions) and
3. Establishing integrated prevention, care and support programs in the four provinces of coverage. (Care, Support & Treatment)

**The GFATM support will be utilize to scale up the above components.**

### **Main Objective:**

**To prevent HIV infection and spread, and minimizing the suffering and socio-economic impact of HIV in Indonesia**

### **Description**

No	Program Component	Aims	Involvement	Beneficiaries
<b>1.</b>	<b>PREVENTION</b>			
1.1	Information, Education & Communication (IEC)	- Inform and educate the public; - Enhance political commitment; - Promote and support appropriate changes in behavior especially among vulnerable (youth) and populations with high-risk behavior	- Inter-sector Mins. - Local gov. ; - NGOs; - Private Sectors & - Int'l Agencies	Public Opinion Leaders, Policy Makers; Programmers; All Target Groups such as Youths, CSWs , Drug Users, and communities

<b>2. TARGETED INTERVENTIONS</b>				
2.1	Condom Promotion & 100% Condom Use	- Increased prevention - Increased empowerment of women	Sectoral ministries, NGOs, local gov, community, peers, and stake holders	Programmers; Target Populations such as CSWs & clients, partners of clients, families and communities
2.2	Harm Reduction amongst injecting drug users	- Increased service coverage and identification of IDUs - Decreased transfusion transmissible infections ( HIV, HBV & HBC etc) among IDUs	Sectoral ministries such as MoH, Law and Justice, Prison authorities, NGOs, local gov, community, peers, civil societies and stake holders	Programmers; Target Populations of IDUs , partners of IDUs, families and communities
2.3	Prevention of Mother to Child Transmission (PMTCT)	- Reduced HIV infection in newborns	MOH, local gov. NGOs & Private Hospitals & Clinics	Programmers; Target Populations needing services, families and communities
<b>3. CARE, SUPPORT &amp; TREATMENT</b>				
3.1	Improving STI services ( Syndromic approach )	- Prompt treatment of Sexually Transmitted Infections - Reduce STI prevalence and therefore HIV prevalence	MOH, local gov. NGOs & Private Hospitals & Clinics	Programmers; Target Populations needing services, families and communities
3.2	Voluntary Counselling & Testing	- Increased prevention among vulnerable and those at risk of HIV infection - Increased coverage of identification of high risk individuals for access to health education - Increased coverage of identification of HIV + people for access to health care	MOH, NGOs, community, civil societies	Programmers; Target Populations needing services, families and communities
3.3	Improved Access to Care, Treatment & Support with emphasis on continuum of care	- Increased secondary prevention - Increased quality of life of PLWHAs, affected families - Decreased number of children being orphaned - Sustained national productivity	sectoral ministries, civil societies, NGOs, private sectors and local government	Programmers, PLWHAs, families and communities
<b>4. PROGRAM MANAGEMENT</b>				
4.1	Monitoring & Evaluation	- Evidence Based Planning - Surveillance will serve as early warning system for population epidemic	CCM, NAP & partner implementing agencies within their activities and independent agencies	Programmers, Policy Makers, Population and communities
4.2	Capacity Building	-increased in program quality -assured sustainability of NAP	Gov, NGOs, private sectors, civil societies, PLWHAs	Programmers, Policy Makers, Population and communities

**Synergies with TB/Malaria programmes** will be pursued with specific components including :

- 1) strengthening and quality assurance of diagnostic services
- 2) availability of good quality reagents / drugs supported by legislation
- 3) improved capacity of surveillance of diseases
- 4) strengthened blood safety programmes, and
- 5) training in programme management

<b>Population to be covered</b>	<b>Indonesia</b>	<b>Jakarta</b>	<b>Papua</b>	<b>Bali</b>	<b>Riau</b>
General Pop. (Total)	210,438,700	10,054,800	2,284,600	3,006,200	4,614,500
Youth					
▪ 10 – 14 years	21,195,300	838,600	287,200	247,600	505,400
▪ 15 – 19 years	23,039,800	935,000	259,900	285,900	514,100
▪ 20 – 24 years	20,046,800	1,043,500	220,100	299,700	480,400
<b>Youths (in school)</b>	<b>12,379,018</b>	<b>840,979</b>	<b>129,729</b>	<b>231,401</b>	<b>259,148</b>
Junior Secondary ( 12 – 15 yrs )	7,600,093	400,871	79,300	131,183	159,778
Senior Secondary ( 16 – 18 yrs )	4,778,925	440,108	50,429	100,218	99,370
Youths (socially disabled )	6,700,000				
Sex Workers (data 1995)	150,000	7,666	1,426	1,532	4,846
Transvestites & Gay (data 1995)		4,338	74	123	-
IDUs		150,000			
<b>Partner exchange rate / yr</b>	<b>23,400,000</b>	<b>1,195,816</b>	<b>222,456</b>	<b>238,992</b>	<b>755,976</b>
Pregnant Women with HIV	3,000				
People Living With HIV/AIDS	80,000 – 120,000				

\* National Census: Indonesia Population Projection 2000

**B.2 Programmatic monitoring and evaluation:** (*Guidelines Para. 34-37*) (The proposal needs to include an outline of the monitoring and evaluation process that will be followed in relation to the overall proposal, including timelines, and baseline data, responsibility for collection, proposed/anticipated use of the information to be collected and involvement of target population with monitoring and evaluation. [Section C requests monitoring and evaluation information on major components])

All participating agencies have own internal monitoring and evaluation plans. Surveillance and reporting of HIV & AIDS is the requirement of the Government of Indonesia. The indicators identified in the overall plan will act as a monitoring tool for program follow up. At the same time, partners are required to fulfill the indicators as identified in their plan of action.

Process, output and outcome indicators have been defined.

**Reporting:**

Submission of Quarterly progress and financial reports to the CCM will be a requirement from participating partner/agency.

**Reviews:**

The project will be reviewed on a quarterly basis by the CCM. At the end of the project, the final report will be compiled and submitted from the CCM to the GFATM.

**Evaluation:**

An external evaluation will be conducted with international and national partners. The final report will be submitted from the CCM to the GFATM. External Evaluation from the GFATM board will be welcomed.

**Audit:**

The audit system will follow the regulation of the government and as defined by the GFATM board. External audit from the GFATM board will be welcomed.

**B.3. Financial management** (*Guidelines para. 19-22, 38-40*) (Describe arrangements in place for financial management, including suggested disbursement mechanisms and plans)

The CCM will arrange the financial management and disbursement mechanisms. This will follow the regulations of the country. The CCM will establish and maintain a project management unit ( PMU ) by placing an experienced project administrative person/s. Each participating agency/organization will develop a 3 monthly plan of action based on the submitted proposal, and will also submit 3 monthly progress and financial reports as well as for the next disbursement.

The PMU will be responsible for:

- Review and timely process activity proposals that are submitted to the CCM
- Timely submit statements of expenditures/ financial reports and forward technical progress report to the CCM
- Assure overall coordination in implementation of project activities by setting up and maintaining an Activity Monitoring System (AMS)
- Attending regular monthly meetings of the CCM
- Provide relevant and transparent budgetary information to all parties concerned at all levels

**B.4 Statement of Budget Requirements, Financial Commitments and Unmet Needs**

**2002** (*Guidelines para. 8, Annex III.2*) (*Demonstrate the additionality of the proposal*)

(US\$)

**Requested GFATM funding will be complimentary to the existing funding and will by no means replace the existing funding sources.**

1 USD = Rp 10,000

B.4 Statement of Budget Requirements, Financial Commitments and Unmet Needs  
2002 (*Guidelines para. 8, Annex III.2*) (*Demonstrate the additionality of the proposal*)

(US\$)

Budget Categories (please fill in according to plan)	Human Resources		Logistics & Supplies		Training & Supervision		Outreach Services		Commodities or Products*		Data & Information Systems		Other (explain)		TOTAL
<b>A) Budget Requirements</b>	286,157	2,044,423	1,259,355	1,927,240	3,811,189	111,780	1,647,330	11,087,474							
Government ( Total )	82,152	1,239,513	892,153	715,018	3,067,223	68,000	1,130,674	7,007,733							
Civil Society	5,250	255,910	66,510	74,020	37,500	9,680	12,367	461,237							
Private sector	45,000	549,000	103,000	395,000	21,400	34,100	28,320	1,175,820							
Donors ( FH - USAID )	153,755	-	197,692	743,202	685,066	-	475,969	2,255,684							
<b>FINANCIAL COMMITMENTS</b>															
by Source															
Government(MOH)	55,152	990,853	654,364	270,000	2,327,835	7,000	798,779	5,654,116							
Civil Society	5,250	1,600	30,000	-	5,000	5,000	3,000	49,850							
Private sector	45,000	549,000	49,000	390,500	1,400	34,100	28,320	1,097,320							
Donors	153,755	-	197,692	743,202	685,066	-	475,969	2,255,684							
<i>Others</i>															
<b>B) TOTAL COMMITMENTS</b>	<b>259,157</b>	<b>1,541,453</b>	<b>931,056</b>	<b>1,403,702</b>	<b>3,019,301</b>	<b>46,100</b>	<b>1,306,068</b>	<b>8,506,837</b>							
<b>C) UNMET NEEDS</b>	<b>27,000</b>	<b>502,970</b>	<b>328,299</b>	<b>523,538</b>	<b>791,888</b>	<b>65,680</b>	<b>341,262</b>	<b>2,580,637</b>							

\*Including drugs

**B.3 Duration** (provide an estimate):

Beginning and end dates:

From: April 2002 To: May 2006

Period to be covered by this request for financing:

From: Apr 2002 To: May 2003

## SECTION C: MAJOR COMPONENTS

(separate Section C pages should be prepared for each major component of the proposal i.e. make more copies if needed.)

**PROPOSAL COMPONENT ----** (Number separate components 1 of 4)

**C.1 Description:** (Describe this component of the proposal (e.g. disease-specific intervention), what it seeks to accomplish, who are the beneficiaries, who will be the implementing partners and strategies for implementation).

Describe this component of the proposal (e.g. disease-specific intervention)

### **I. Information Education & Communication (IEC) including BCC**

Information, Education and communication (IEC) is the most essential part of an HIV/ AIDS prevention programme. A concerted effort through a well-planned and effectively implemented IEC strategy, will create the necessary conditions for bringing about favorable behavioural changes especially among populations with high-risk behaviours.

Many IEC activities have been conducted utilizing available grant and loan funds from the Government. These activities have been conducted in various parts of the countries by all sectors including Non-Government Organizations (NGOs). The IEC activities include development of IEC materials, information dissemination, and peer education. World AIDS Days are commemorated every year in Indonesia and many sectors and NGOs are involved in a range of activities. In 1997, the Ministry of Education established a policy on prevention education for all levels of education set-up and also published materials on AIDS prevention and control to be used in junior, senior high schools, and universities. Implementation has been carried out in some provinces.

While Indonesia has been ready with political leadership, commitment and the multi-sectoral approach, accelerated efforts are much needed to build on, heighten and sustain the national response to the HIV/AIDS epidemic and to bring about the necessary changes required in policy and in practice, without stigma or discrimination. IEC will be an integrated part of every component of the programme such as quality of STD services, VCT and MTCT

Considerable efforts have been made by the Government and donors in limited scale efforts in designing and developing mass media messages to shift behaviour in Indonesia and address existing HIV/AIDS myths and issues. The main issues addressed in these campaigns are :

- Myths surrounding H/A transmission
- Use of antibiotics in prevention of HIV transmission
- De-stigmatization of condoms

Mass media and IEC materials production tailored to specific target groups needs to be scaled up to cover large sections of the population in provinces of highest prevalence, especially teachers, health and health related workers., local leaders and communities. Such an approach will promote community acceptance of people living with HIV/AIDS. The strategies used will be reprinting of sufficient copies of IEC materials and distribution of these materials through workshops, print media and community outreach, for example through entertainment sites.

Many NGOs have demonstrated capacity to undertake IEC in high risk areas (approximately 100) and several of these NGOs will intensify their activities with the most vulnerable populations with support from the GFATM.

IEC will be implemented in involvement and collaboration with Inter-sector Ministries, Local Government, NGOs, Private Sector & Int'l Agencies. The beneficiaries of this activity will be Public Opinion Leaders, Policy Makers; Programmers; All Target Groups such as Youths, CSWs , Drug Users, and communities

**Table 1 . Matrix : Youth**

<b>Target Group</b>	<b>Desired Behavioural Change</b>	<b>Approach</b>	<b>Media Channel</b>	<b>Interpersonal Channel ( networks )</b>	<b>Support Services</b>
Youth in School	<ul style="list-style-type: none"> <li>▪ Responsible sexual behaviour</li> <li>▪ Decreased drug use ( injecting )</li> <li>▪ Condom use</li> <li>▪ Health care</li> </ul>	<ul style="list-style-type: none"> <li>▪ Mass Media</li> <li>▪ Peer education</li> <li>▪ Curriculum Development</li> <li>▪ Extra - curricular</li> </ul>	TV, radio, press, interpersonal	<ul style="list-style-type: none"> <li>▪ Schools</li> <li>▪ School organizations</li> <li>▪ Ministry of Education</li> <li>▪ Ministry of</li> </ul>	<ul style="list-style-type: none"> <li>▪ Counseling</li> <li>▪ Condoms</li> <li>▪ STD services</li> <li>▪ Drug use support</li> </ul>

	seeking behaviour	activities		Religious Affairs	services
Youth in college	<ul style="list-style-type: none"> <li>▪ Responsible sexual behaviour</li> <li>▪ Decreased drug use ( injecting )</li> <li>▪ Condom use</li> <li>▪ Health care seeking behaviour</li> </ul>	<ul style="list-style-type: none"> <li>▪ Workshops</li> </ul>	TV, radio, press, interpersonal	<ul style="list-style-type: none"> <li>▪ NGOs</li> <li>▪ Ministry of Education</li> <li>▪ Ministry of Religious Affairs</li> <li>▪ NGOs</li> <li>▪ Youth Organizations</li> </ul>	<ul style="list-style-type: none"> <li>▪ Counseling</li> <li>▪ Condoms</li> <li>▪ STD services</li> <li>▪ Drug use support services</li> </ul>
Youth out of School ( urban )	<ul style="list-style-type: none"> <li>▪ Responsible sexual behaviour</li> <li>▪ Decreased drug use ( injecting )</li> <li>▪ Condom use</li> <li>▪ Health care seeking behaviour</li> </ul>	<ul style="list-style-type: none"> <li>▪ Peer education outreach</li> <li>▪ Mass Media</li> <li>▪ Adolescent health programme</li> </ul>	TV, radio, interpersonal Street theatre	<ul style="list-style-type: none"> <li>▪ Ministry of Religious Affairs</li> <li>▪ Ministry of Social Affairs</li> <li>▪ Ministry of Health</li> <li>▪ NGOs</li> </ul>	<ul style="list-style-type: none"> <li>▪ Counseling</li> <li>▪ Condoms</li> <li>▪ STD services</li> <li>▪ Drug use support services</li> </ul>
Policy Makers	<ul style="list-style-type: none"> <li>▪ Increased in support to the AIDS prevention programme</li> <li>▪ Increased in understanding of communication needs</li> </ul>	<ul style="list-style-type: none"> <li>▪ Mass Media</li> <li>▪ Interpersonal</li> <li>▪ Seminars</li> <li>▪ Meetings</li> </ul>	TV, Radio, Press	<ul style="list-style-type: none"> <li>▪ Parliament sessions</li> <li>▪ Cabinet meetings</li> <li>▪ Intersectoral Ministries</li> </ul>	
General Population	<ul style="list-style-type: none"> <li>▪ Increased ability to discuss sex &amp; sexuality</li> <li>▪ Increased seeking of information on STDs &amp; AIDS</li> <li>▪ Increased empathy for HIV and people living with AIDS</li> <li>▪ Increased condom use</li> </ul>	<ul style="list-style-type: none"> <li>▪ Mass Media</li> </ul>	TV, radio, Press, Billboards, Exhibitions Audio visuals	<ul style="list-style-type: none"> <li>▪ Associations</li> <li>▪ Community organizations</li> <li>▪ Workplace settings</li> </ul>	<ul style="list-style-type: none"> <li>▪ Counseling</li> <li>▪ Condoms</li> <li>▪ STD services</li> <li>Information</li> <li>▪ Hotline services</li> </ul>

**Because of lack of sufficient funding of sectoral ministries, and huge geographic nature and various ethnic groups, targeted IEC could not be implemented on the massive scale that is needed in Indonesia.**

As identified in the above, IEC activities will be intensified nationally as well as for targeted interventions, through components identified above. The goal of this component will be to shift behavior to more healthy, non-risk behaviors. This component will focus both nationally and to the general public (through the mass media campaign), vulnerable populations of youths as well as to targeted groups in high-risk behavior areas.

National Mass media campaigns will be the responsibility of the Ministry of Education and the Health Promotion center of the Ministry of Health.

IEC for youths ( in school and out of school ) will be the major responsibility of the Ministry of Education, and the Ministry of Social Welfare in collaboration with local NGOs. Outreach IEC activities will be coordinated with support from local NGOs ( Bersama, World Vision Indonesia, and DKT Indonesia ). Secondary implementing partners will be a range of community based organizations, NGOs, and government institutions that will make use of IEC materials and the NGO Support Fund.

**C.2 Objectives and indicators** (Provide information on objectives for this component.)

- **Main objective** (Describe the expected end situation)  
**Prevent HIV infection and spread, and minimizing the suffering and socio-economic impact of HIV in Asia**

- **Specific objectives:** (Related to indicators, including baseline data, current situation and annual targets)  
*(Guidelines para. 34-37)*

		INDICATOR	Baseline	Targets				
			2001	2002	2003	2004	2005	2006
	Output Indicators	Outcome Indicators						
Youth in School	<ul style="list-style-type: none"> <li>▪ # Workshops</li> <li>▪ # of posters</li> <li>▪ % of training</li> <li>▪ % of Peer Educators</li> <li>▪ % of teachers trained</li> </ul>	% Knowledge of HIV prevention	40%	65%	70%	80%	85%	90%
		% Knowledge of HIV prevention among IDUs	20%	40%	50%	60%	75%	90%
Youth in college	<ul style="list-style-type: none"> <li>▪ # of workshops</li> <li>▪ # of posters</li> <li>▪ % of training</li> <li>▪ % of Peer Education</li> <li>▪ % of teachers trained</li> </ul>	% Knowledge of HIV prevention	40%	65%	70%	80%	85%	90%
		% Knowledge of HIV prevention among IDUs	20%	40%	50%	60%	75%	90%
Youth out of School (urban)	<ul style="list-style-type: none"> <li>▪ # of workshops</li> <li>▪ # of posters</li> <li>▪ % of training</li> <li>▪ % of Peer Education</li> <li>▪ % of teachers trained</li> <li>▪ Adolescent health programme</li> </ul>	% Knowledge of HIV prevention	20%	40%	50%	60%	75%	80%
		% Knowledge of HIV prevention among IDUs	20%	40%	50%	60%	75%	80%
Policy Makers	# Advocacy, Seminars, Meetings	% Increased in support to the AIDS programme	50%	60%	65%	75%	80%	90%
		% Increased in community facilities	20%	40%	50%	60%	75%	90%
General Population	# TV, radio spots Press, Billboards, Exhibitions, Audio visuals	# Increased seeking of information on STDs & AIDS	60%	70%	75%	80%	85%	90%
		% Increased empathy for HIV and people living with AIDS	10%	30%	45%	55%	65%	80%

**C.3 Programmatic monitoring and evaluation plans:** (An outline of the monitoring and evaluation process that will be followed for this component.) (*Guidelines para. 34-37*)

Monitoring will be an ongoing process through the sectoral ministries and other support systems of the CCM. It will involve request for routine reports submitted on a regular basis by all partner agencies in the project. These reports will be reviewed and compiled for annual submission to the GFATM board.

Monitoring activities will include collecting reports from NGOs & teachers working with youths in school; NGOs working with youths out of school; collecting data on the distribution of IEC materials, airing of radio and TV spots aimed at youth ; along with listeners' surveys. Existing Baseline data will be reviewed and further data may be collected on knowledge and practices. Key indicators of the desired behaviour change will be measured through repeat surveys included in the proposals.

Reviews and Evaluation will also be an integrated component of each partner agency. The CCM will facilitate a mid year review where team members from the country national and international organizations will be requested as resource persons. A Final review and evaluation will be done through an external review team and should follow the criteria as set by the Global Fund.

**C.4 Duration:** (provide an estimate)

Beginning and end dates:

From: May 2002                      To: April 2006

Period to be covered by this request for financing:

From: May 2002                      To: April 2003

## SECTION C: MAJOR COMPONENTS

(separate Section C pages should be prepared for each major component of the proposal i.e. make more copies if needed.)

**PROPOSAL COMPONENT ----** (Number separate components 2 of 4 )

**C.1 Description:** (Describe this component of the proposal (e.g. disease-specific intervention), what it seeks to accomplish, who are the beneficiaries, who will be the implementing partners and strategies for implementation).

### II. Targeted Interventions

Targeted Interventions will aim at commercial sex workers, men having sex with men (MSM), transvestites, Injection Drug Users (IDUs), Prisoners, pregnant women with HIV, and Youths (15 – 24 years old) in school and out of school.

#### II. 1. Scaled up Condom Promotion & 100% Condom Use will cover districts in the 4 provinces of highest prevalence.

Limited scale efforts have been carried out in six donor-supported provinces. This needs to be scaled up in at least 4 provinces of highest prevalence. Availability of quality health education materials, women's empowerment strategies and the provision of providing user friendly services for high risk groups and condom availability will be the strategies for the programme.

The Ministry of Health (Director General of CDC and EH) has issued a circular in 1996, to all Chiefs of Provincial Health Office in Indonesia to promote 100% condom use among high- risk groups. However, consistent condom use is still below 10%. 100% condom use project in entertainment establishment is being initiated in as a pilot project in Merauke municipality, Merauke district, which has the highest prevalence of HIV, with technical support from UNAIDS/WHO.

Following the same international best experiences Indonesia will scale up the 100% condom use in entertainment establishments in selective districts within the 4 priority provinces.

This will massively increase prevention as well as increase empowerment of women especially the sex workers in protection themselves from infection with the virus. At the same time, mobilized increase responsibility from all persons with high-risk behaviour in prevention further transmission of sexually transmitted infections.

It will be implemented in collaboration among Sectoral ministries, NGOs, local government, community, peers, and stakeholders. The beneficiaries will be Programmers; Target Populations such as CSWs & clients, partners of clients, families and communities.

**II. 2. Scaling up Harm Reduction amongst injecting drug users** is an urgent priority of the country in view of alarming increase prevalence of HIV transmission among IDUs in recent years, 22% in 2001 and 47% in 2002. Activities have been very limited and there is an urgent need to scale up this programme. Advocacy efforts with Government leaders have been very successful and the Government supports the implementation of harm reduction pilots.

A few pilot harm reduction activities have been initiated in Jakarta and Bali. This consists of a pilot needle exchange by an NGO, through the PHC approach in Jakarta with support from FHI – USAID and outreach program in Bali, by a local NGO with support from AUSAID. A pilot project on pharmaco-substitution is being implemented by the MoH with support from WHO – UNAIDS. This is in 2 government drug dependency hospitals in Jakarta and Bali with an estimated coverage for 800 IDUs. Scaling up of efforts in intervention strategies are urgently needed.

The strategies needed are:

- Preparation of specific target IEC materials
- Provision of VCT of IDUs
- Provision of basic health care for socially disabled (poor) IDUs
- Harm reduction strategies.

The Ministry of Health will scale up Harm Reduction projects in 10 districts of Indonesia using international best practices for Harm Reduction and socio-culturally acceptable approaches suitable for the drug use community.

The program will follow the identified approaches and strategies in collaboration among sectoral ministries such as Ministry of Health, Law and Justice, Prison authorities, NGOs, local governments, community, peers, civil societies and stakeholders. The beneficiaries will be programme planners, the target population of IDUs, partners of IDUs, families and communities.

### **II.3. Expanding the coverage capacity for the Prevention of Mother to Child Transmission (PMTCT)**

The number of women and children infected by HIV in Indonesia is on the increase. In one pilot activity with 574 pregnant women 2.86% were positive for HIV. However, limited data is available to know the gravity of the situation. In view of the limited studies it is very urgent to give pregnant women counseling in high-risk provinces. Indonesian women have less opportunity to get VCT and testing services since the facilities are very limited and expensive. Only a few NGOs have undertaken PMTCT activities.

MTCT is a high political priority for Indonesia. Expanding the services will mean that more pregnant mothers can be identified, counseled, and offered ARVs and supportive services. It will also reduce HIV infection in newborns.

There is urgent need to :

- increase women's basic knowledge of HIV/AIDS and increase their awareness of HIV transmission from mother to child
- make access for pregnant women to get pre-test and post-test counseling regarding their HIV status
- make access for HIV positive pregnant women & their babies to get support in reducing the risk of HIV transmission from mother to child.

Jakarta and Merauke provinces are bearing the highest burden of HIV/AIDS and from present experience, have also found HIV positive cases among pregnant women. There is urgent need for the program to be continued in these 2 districts and scaled up to other districts and regions.

The strategies will be information dissemination through IEC materials focused on safe motherhood, VCT, care and support services for the mothers and babies, baby feeding counselling for HIV positive mothers, and family planning support.

In view of the fact that there is limited budget to scale up these activities that need to be carried out at least in 10 districts in 4 high risk provinces, the Global Fund support will be the much needed.

This will be a coordinated approach among the Ministry of Health, the local government, NGOs, the Private Hospitals & Clinics. The beneficiaries will be Programmers, Target Population of pregnant mothers needing services, families and communities that they live in.

**Table 2 . Matrix : Focus/Target Interventions**

<b>TargetGroup</b>	<b>Desired Behavioural Change</b>	<b>Approach</b>	<b>Media Channel</b>	<b>Interpersonal Channel ( networks )</b>	<b>Support Services</b>
Injecting Drug Users	<ul style="list-style-type: none"> <li>▪ Cleaning needles</li> <li>▪ Condom use</li> <li>▪ Appropriate treatment of STDs</li> </ul>	<ul style="list-style-type: none"> <li>▪ Outreach</li> <li>▪ Peer education</li> </ul>	Targeted print Audio-visuals	<ul style="list-style-type: none"> <li>▪ NGOs</li> <li>▪ De-addiction programmes</li> <li>▪ Prisons</li> </ul>	<ul style="list-style-type: none"> <li>▪ Counseling</li> <li>▪ Condoms</li> <li>▪ STD services</li> <li>▪ Drug use support services</li> </ul>
Brothel based Sex Workers	<ul style="list-style-type: none"> <li>▪ 100% Condom usage</li> <li>▪ Seeking treatment for STDs</li> </ul>	<ul style="list-style-type: none"> <li>▪ Outreach</li> <li>▪ Peer education</li> </ul>	Target messages, Prints Audio-visuals Drama, Street theatre	<ul style="list-style-type: none"> <li>▪ NGOs</li> <li>▪ Health Workers</li> <li>▪ Local GPs</li> <li>▪ Social workers</li> </ul>	<ul style="list-style-type: none"> <li>▪ Condoms</li> <li>▪ STD services</li> <li>▪ Counselling</li> </ul>
Street Sex Workers	<ul style="list-style-type: none"> <li>▪ Condom usage</li> <li>▪ Seeking treatment for STDs</li> </ul>	<ul style="list-style-type: none"> <li>▪ Outreach</li> </ul>	Target messages, Prints Audio-visuals Drama, Street theatre	<ul style="list-style-type: none"> <li>▪ NGOs</li> <li>▪ Health Workers</li> <li>▪ Local GPs</li> <li>▪ Social workers</li> </ul>	<ul style="list-style-type: none"> <li>▪ Condoms</li> <li>▪ STD services</li> <li>▪ Counselling</li> </ul>
Men who have sex with men & Transvestites	<ul style="list-style-type: none"> <li>▪ Condom usage</li> <li>▪ Appropriate treatment of STDs</li> </ul>	<ul style="list-style-type: none"> <li>▪ Outreach</li> <li>▪ Peer education</li> </ul>	Target messages, Prints Audio-visuals	<ul style="list-style-type: none"> <li>▪ NGOs,</li> <li>▪ Peers,</li> <li>▪ Health Workers</li> </ul>	<ul style="list-style-type: none"> <li>▪ Counseling</li> <li>▪ Condoms</li> <li>▪ STD services</li> </ul>

**C.2 Objectives and indicators** (Provide information on objectives for this component.)

- **Main objective** (Describe the expected end situation)

**Reduce HIV transmission among high risk and vulnerable populations**

- **Specific objectives:** (Related to indicators, including baseline data, current situation and annual targets) (Guidelines para. 34-37)

**Table 2 . Matrix : Focus/Target Interventions**

		INDICATOR	Baseline	Targets				
			2001	2002	2003	2004	2005	2006
	<b>Output Indicators</b>	<b>Outcome Indicators</b>						
Injecting Drug Users	# of Outreach services; Peer education; Targeted print Audio-visuals; # Distributed needles & syringe; Peer Counseling # condoms distributed	% IDUs sharing equipment	70%	55 %	45%	35%	25%	15%
		% Condom use at last sex	10%	30%	40%	50%	60%	75%
Brothel based Sex Workers	# of Outreach services; Peer education; Targeted print Audio-visuals Drama, Street theatre	% 100% Condom usage	10%	40%	50%	65%	75%	90%
		% Seeking treatment for STDs	30%	50%	60%	70%	80%	90%
Street Sex Workers	# of Outreach services; Audio-visuals Drama, Street theatre	% 100% Condom usage	10%	20%	30%	40%	50%	50%
		% Seeking treatment for STDs	10%	30%	40%	50%	60%	70%
Pregnant women with HIV	# IEC # counseling sessions # of ANC clinic offering & referring for MTCT	# of pregnant women counseled and tested	10%	30%	40%	50%	60%	70%
		# of mothers & babies given ARV	5%	25%	35%	45%	55%	65%
Men who have sex with men & Transvestites	# Target messages, Prints, Audio-visuals ;	% 100% Condom usage	5%	15%	25%	40%	50%	60%
		% Seeking treatment for STDs	30%	40%	50%	60%	70%	80%

**C.3 Programmatic monitoring and evaluation plans:** (An outline of the monitoring and evaluation process that will be followed for this component.) (*Guidelines para. 34-37*)

Monitoring will be an ongoing process through the sectoral ministries and other support systems of the CCM. It will involve request for routine reports submitted on a regular basis by all partner agencies in the project. These reports will be reviewed, compile for annual submission to the GFATM board.

Monitoring activities will include collecting reports from partners as identified in this project. Existing Baseline data will be reviewed and further data will be collected on knowledge and practices. Key indicators of the desired behaviour change will be measured through repeat surveys included in the proposals.

Reviews and Evaluation will also be an integrated component of each partner agency. The CCM will facilitate a mid year review where team members from the country national and international organizations will be requested as resource persons. A Final review and evaluation will be done through an external review team and should follow the criteria as set by the Global Fund.

**C.4 Duration:** (provide an estimate)

Beginning and end dates:

From: May 2002                      To: April 2006

Period to be covered by this request for financing:

From: May 2002                      To: April 2003

## SECTION C: MAJOR COMPONENTS

(separate Section C pages should be prepared for each major component of the proposal i.e. make more copies if needed.)

PROPOSAL COMPONENT ---- (Number separate components 3 of 4 )

**C.1 Description:** (Describe this component of the proposal (e.g. disease-specific intervention), what it seeks to accomplish, who are the beneficiaries, who will be the implementing partners and strategies for implementation).

### III. CARE, SUPPORT & TREATMENT

IEC alone will not have a significant impact on the spread of HIV infection, unless it is complemented by making health and other services available which address the factors contributing to vulnerability to STD and HIV infection. Adequate provision of health services such as availability of diagnostics, drugs, condoms, bleaches or needles, and also services such as counseling are needed.

#### III.1 Improving STI services ( Syndromic approach )

Studies conducted in different parts of the country have revealed the prevalence of GO between 19.6% - 30.9% and CT between 22.2% and 39.6%. However because of the limited budget to support the programme especially for drugs/ counselling services/antibiotic sensitivity, there is a need to scale up these activities in order to reduce the burden of STI which in turn will reduce the infection of HIV. Various strategies to support this programme will be identification of high risk individuals through VCT, provision of counselling services, drugs for those infected, and condom promotion.

STI management is being done through syndromic treatment as well as condom promotion. Special attention has been given to STI management of groups at high risk (sex workers & persons coming to the STD clinics ). The innovative syndromic approach is being done in few provinces, Riau and Bali. (50 % of health oprofessionals have been trained in syndromic approach.) However, services could not be implemented smoothly due to limited availability of commodities and supplies especially drugs for STIs.

These activities will be implemented in collaboration among Ministry of Health, local government, NGOs, private hospitals and clinics. The beneficiaries will be Programmers; Target Populations such as CSWs & clients, partners of clients, families and communities.

#### III.2 Voluntary Counselling & Testing

Despite considerable efforts to train counsellors over the last five years, there are still very limited numbers of effective counsellors available in Indonesia. Some of the reasons include different perceptions about confidentiality, a lack of time for counselling by medical practitioners, lack of involvement by social workers and psychologists, a need for ongoing supervision for counsellors, burn out and unmet ongoing support needs of counselors.

The Ministry of Health wishes to establish a minimum of 10 – 12 VCT centers in 4 provinces over one year as a critical component in HIV/AIDS prevention and care synergy.

VCT services will be implemented in collaboration among Ministry of Health, local government, NGOs, private hospitals, community, and civil societies. The beneficiaries will be Programmers; Target Populations such as CSWs & clients, partners of clients, families and communities.

#### III.3 Improved Access to Care, Treatment & Support with emphasis on continuum of care

Presently, due to limited budget, STI and AIDS cases are not being provided with the necessary drugs which is increasing the burden of disease in an exponential manner.

With increasing prevalence and case load, there is need to scale up this component through different strategies – avail of counselling services for those who are infected with HIV and STIs, availability of affordable drugs, follow up of family and social support, drugs for OI/AIDS/TB and diagnostic services.

At December 2001, the number of cumulative HIV & AIDS case reported are 2575. ( national surveillance data )

**Through the Global Fund it will be possible to provide support services along with care of HIV/STI infections through various clinics running these programmes. The strategies will consist of VCT, use of drugs for those infected and follow up of these cases.**

It will be implemented in collaboration among Ministry of Health, local government, NGOs, private hospitals, community, and civil societies. The beneficiaries will be Programmers; Target Populations of positive people, their families and communities.

**C.2 Objectives and indicators** (Provide information on objectives for this component.)

- **Main objective** (Describe the expected end situation)

**Prevent HIV infection and spread, and minimizing the suffering and socio-economic impact of HIV in Asia**

- **Specific objectives:** (Related to indicators, including baseline data, current situation and annual targets) (Guidelines para. 34-37)

**III. CARE, SUPPORT & TREATMENT**

		<b>INDICATOR</b>	<b>Baseline</b>	<b>Targets</b>				
	<b>Output Indicators</b>	<b>Outcome Indicators</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>	<b>2006</b>
Improving STI services ( Syndromic approach )	# training; guidelines; amount of drugs & condoms # of clinics giving syndromic approach	% Appropriate diagnosis & treatment of STI	<b>20%</b>	<b>50%</b>	<b>75%</b>	<b>85%</b>	<b>90%</b>	<b>100%</b>
		% Treatment Seeking for STIs	<b>20%</b>	<b>50%</b>	<b>65%</b>	<b>70%</b>	<b>80%</b>	<b>90%</b>
Voluntary Counselling & Testing	# of districts with VCT services # of guidelines & modules # of trained counselors	% of people request & received results		<b>10%</b>	<b>20%</b>	<b>30%</b>	<b>40%</b>	<b>50%</b>
Improved Access to Care, Treatment & Support with emphasis on continuum of care	# medical personnel trained # health facility with capacity for care # community support organizations	# of PLWHAs being cared by trained personnel						
		# cared by family members						
		# of PLWHAs receiving treatment for OI	<b>100</b>	<b>200</b>	<b>300</b>	<b>500</b>	<b>500</b>	<b>500</b>
		# of PLWHAs recd ARV	<b>20</b>	<b>100</b>	<b>100</b>	<b>100</b>	<b>125</b>	<b>150</b>

**C.3 Programmatic monitoring and evaluation plans:** (An outline of the monitoring and evaluation process that will be followed for this component.) (*Guidelines para. 34-37*)

Monitoring will be an ongoing process through the sectoral ministries and other support systems of the CCM. It will involve request for routine reports submitted on a regular basis by all partner agencies in the project. These reports will be reviewed, compile for annual submission to the GFATM board.

Monitoring activities will include collecting reports from NGOs & partners with identified target groups, and collecting data on input, process and output indicators. Existing Baseline data will be reviewed and further data may be collected on practices. Monitoring will focus on adequacy of supplies, appropriateness of training, performance of services providers etc. Key indicators of the desired behaviour change will be measured through repeat surveys included in the proposals.

Reviews and Evaluation will also be an integrated component of each partner agency. The CCM will facilitate a mid year review where team members from the country national and international organizations will be requested as resource persons. A Final review and evaluation will be done through an external review team and should follow the criteria as set by the Global Fund.

**C.4 Duration:** (provide an estimate)

Beginning and end dates:

From: May 2002                      To: April 2006

Period to be covered by this request for financing:

From: May 2002                      To: April 2003

## SECTION C: MAJOR COMPONENTS

(separate Section C pages should be prepared for each major component of the proposal i.e. make more copies if needed.)

PROPOSAL COMPONENT ---- (Number separate components 4 of 4)

**C.1 Description:** (Describe this component of the proposal (e.g. disease-specific intervention), what it seeks to accomplish, who are the beneficiaries, who will be the implementing partners and strategies for implementation).

### IV. PROGRAMME MANAGEMENT

Program management will be done in conjunction with secretariat of NAC, whose functions will be overseeing the implementation process. This will be conducted through periodic meetings of CCM, and monthly reports including meetings of CCM. Experts in relevant field may be invited to provide the necessary inputs. Site visits will also be conducted by CCM to review the quality of services rendered by different partners.

This component will also strengthen the communication system from central to the provincial center sites through computerized data - base. And will serve as a monitor and evaluation tool for the programme.

Flow of funds and this proper utilization will be done through in built mechanism already existing in the ministry of health, and will be further strengthened for efficient flow of funds. The capacity building for program manager will be strengthened through management training as needed.

The programme will take opportunity of existing and potential cost sharing mechanisms with UNAIDS, other donors in country.

**C.2 Objectives and indicators** (Provide information on objectives for this component.)

- **Main objective** (Describe the expected end situation)  
**To ensure quality support through increased programme management capacity**
- **Specific objectives:** (Related to indicators, including baseline data, current situation and annual targets)  
(Guidelines para. 34-37)

**IV. PROGRAMME MANAGEMENT**

		INDICATOR	Baseline	Targets				
			2001	2002	2003	2004	2005	2006
	<b>Output Indicators</b>	<b>Outcome Indicators</b>						
PROGRAMME MANAGEMENT	Regular training of staff at various levels	Proportion of facilities providing validated monthly reports	30%	50%	60%	70%	80%	90%
	Quarterly supervision visits to all facilities	Proportion of visits to these facilities	30%	50%	60%	70%	80%	90%
	Management Training for all programme managers	Proportion of managers trained	40%	60%	70%	80%	90%	95%
	Availability of computers at all sites	% facilities with computerized data base	20%	50%	60%	70%	80%	90%

**Budget Needs ( 12 months )**

	Activity	USD	
<b>Support to CCM</b>	<b>Regular Meetings CCM</b>	1,200	
	<b>Meetings of Technical Review Panels x 3 groups x 3 times</b>	500	
	<b>Meetings of M &amp; E working groups</b>	500	
	<b>Site visits for Supervision &amp; support x qtrly</b>	2000	
	<b>Meetings of Technical Review Panels x 3 groups x 3 times</b>	500	
	<b>Meetings of M &amp; E working groups</b>	500	
	<b>Preparation of Reports for CCM ; for GFATM</b>	500	
	<b>Secretariat costs x 12 months</b>	600	
	<b>Workshops for Proposal Development x 3 times ( funded by UNAIDS )</b>	0	
	<b>Lessons Learnt workshops and reviews of projects x 1 time</b>	10,000	
		0	
	<b>Programme support</b>	<b>Project Start up visit to project areas for strengthening private – public collaboration x 4 areas</b>	1,000
		<b>Programme Management training for participating partners</b>	5,000
<b>Set up Information Management System x 5 sites ( central &amp; 4 provinces</b>		20,000	
<b>Mid term Review (internal)</b>		5,000	
<b>Evaluation at end 12 months</b>		5,000	
	<b>52,300</b>		

**C.3 Programmatic monitoring and evaluation plans:** (An outline of the monitoring and evaluation process that will be followed for this component.) (*Guidelines para. 34-37*)

Monitoring will be an ongoing process through the sectoral ministries and other support systems of the CCM. It will involve request for routine reports submitted on a regular basis by all partner agencies in the project. These reports will be reviewed, compile for annual submission to the GFATM board.

Monitoring activities will include collecting reports from NGOs & teachers working with youths in school; NGOs working with youths out of school; collecting data on the distribution of IEC materials, airing of radio and TV spots aimed at youth ; along with listeners' surveys. Existing Baseline data will be reviewed and further data may be collected on knowledge and practices. Key indicators of the desired behaviour change will be measured through repeat surveys included in the proposals.

Reviews and Evaluation will also be an integrated component of each partner agency. The CCM will facilitate a mid year review where team members from the country national and international organizations will be requested as resource persons. A Final review and evaluation will be done through an external review team and should follow the criteria as set by the Global Fund.

**C.4 Duration:** (provide an estimate)

Beginning and end dates:

From: May 2002                      To: April 2006

Period to be covered by this request for financing:

From: May 2002                      To: April 2003

**C.5 Implementation Plans including resource allocations to partners (*Guidelines para. 40*)**

(US\$)

<b>Implementing Partner</b>	<b>Budget Categories (please fill in according to your plan)</b>							<b>TOTAL</b>
	<i>Human Resources</i>	<i>Logistics and supplies</i>	<i>Training &amp; Supervision</i>	<i>Outreach Services</i>	<i>Commodities or Products*</i>	<i>Data &amp; information systems</i>	<i>Other (explain)</i>	
Government	27,000	248,660	237,789	445,018	739,388	61,000	331,895	2,090,750
Civil Society	0	254,310	36,510	74,020	32,500	4,680	9,367	411,387
Private sector	0	0	54,000	4,500	20,000	0	0	78,500
Donors	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0
<b>TOTAL</b>	27,000	502,970	328,299	523,538	791,888	65,680	34,1262	2,580,637
<i>*Including drugs</i>								

**Attachment 1: List of Supporting Documents**

*Please note which documents are being included with your proposal by indicating a document number*

<p><b>General documentation:</b></p> <ol style="list-style-type: none"> <li>1. Poverty Reduction Strategy Paper (PRSP)</li> <li>2. Medium Term Expenditure Framework</li> <li>3. Sector strategic plans</li> <li>4. Any reports on performance</li> </ol>	<p><b>Attachment #</b></p> <p>—</p> <p>—</p> <p>—</p> <p>—</p>
<p><b>HIV/AIDS specific documentation:</b></p> <ol style="list-style-type: none"> <li>5. Situation analysis</li> <li>6. Baseline data for tracking progress<sup>1</sup></li> <li>7. National strategic plan for HIV/AIDS, with budget estimates</li> <li>8. Results-oriented plan, with budget and resource gap indication (where available)</li> </ol>	<p><b>Attachment #</b></p> <p>—</p> <p>—</p> <p>—</p>
<p><b>TB specific documentation:</b></p> <ol style="list-style-type: none"> <li>9. Multi-year DOTS expansion plan and budget to meet the global targets for TB control</li> <li>10. Documentation of technical and operational policies for the national TB programme, in the form of national manuals or similar documents</li> <li>11. Most recent annual report on the status of DOTS implementation, expansion, and financial planning (routine annual WHO TB Data [and Finance] Collection Form)</li> <li>12. Most recent independent assessment/review of national TB control activities</li> </ol>	<p><b>Attachment #</b></p> <p>—</p> <p>—</p> <p>—</p> <p>—</p>
<p><b>Malaria specific documentation:</b></p> <ol style="list-style-type: none"> <li>13. Situation analysis</li> <li>14. Baseline data for the tracking of progress</li> <li>15. Country strategic plan to Roll Back Malaria, with budget estimates</li> <li>16. Result oriented plan, with budget and resource gap indication (where available)</li> </ol>	<p><b>Attachment #</b></p> <p>—</p> <p>—</p> <p>—</p> <p>—</p>
<p><b>Crosscutting documents/activities</b></p>	<p><b>Attachment #</b></p>

<sup>1</sup> Where baselines are not available, plans to establish baselines should be included in the proposal.