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PROJECT PERFORMANCE ASSESSMENT REPORT

INDONESIA

INDONESIA HIV/AIDS AND STDS PREVENTION AND MANAGEMENT PROJECT

(LOAN NO. 3981)

June 13, 2005

Sector, Thematic, and Global Evaluation Group
Operations Evaluation Department

Currency Equivalents (annual averages)

Currency Unit = Indonesia Rupiah (Rp)
(Exchange Rate Effective as of April 2000)
Rp. 1 million = US$ 125.87
US$ 1 = Rp. 7,945

Abbreviations and Acronyms

AEM	Asian epidemic model
AIDS	Acquired Immunodeficiency Syndrome
ARV	Anti-retroviral
ASA	Aksi Stop AIDS (FHI-executed project of USAID)
ASEAN	Association of South-East Asian Nations
AusAID	Australian Agency for International Development
Bappenas	Ministry of Planning
BKKBN	National Family Planning Coordinating Board
BNN	National narcotics board
BPS	Central Bureau of Statistics
BSS	Behavioral Surveillance Survey
CAS	Country assistance strategy
CDC	Centers for Disease Prevention and Control (US)
CSW	Commercial sex worker
DepKes	Ministry of Health
DfID	Department for International Development (UK)
DIP	Investment budget item/allocation
DKT	Condom Social Marketing Agency
EAP	East Asia and Pacific Region (World Bank)
FHI	Family Health International
GDP	Gross domestic product
GFATM	Global Fund to fight AIDS, TB, and Malaria
GOI	Government of Indonesia
GPA	Global Program on AIDS (WHO)
HAPP	HIV/AIDS Prevention Project (USAID)
HC	Health center
HD	Human development
HDI	Human development index (UNDP)
HIV	Human immunodeficiency virus
HNP	Health, nutrition and population
HRG	High-risk group
HSPMP	HIV/AIDS and STDs Prevention and Management Project
IBRD	International Bank for Reconstruction and Development
ICR	Implementation Completion Report
IDU	Intravenous drug user
IEC	Information, education, and communication
IHPCP	Indonesia HIV/AIDS and STD Prevention and Care Project (AusAID)
IMF	International Monetary Fund
iwgAIDS	Inter-agency working group AIDS (epidemic model)
KPA	National AIDS Commission
KSAR	Provincial AIDS Commission
M&E	Monitoring and evaluation
MCH	Maternal and child health
MOF	Ministry of Finance
MOH	Ministry of Health
MSM	Men who have sex with men
MTR	Mid-term review (during project execution)
NAC	National AIDS Committee
NGO	Non-governmental organization
OED	Operations Evaluation Department
PDO	Project development objectives (for project status report)
PKBI	Planned Parenthood Association, Indonesia
PLWA	People living with HIV/AIDS

PMU	Program Management Unit (for HIV/AIDS and STDs, in MOH)
PSR	Project status report
Pukesmas	Publicly owned local health care facility
Rp	Rupiah
RSI	Resident staff in Indonesia – the World Bank country office
SAR	Staff appraisal report
SOP	Standard operating procedure
STD	Sexually transmitted disease
STI	Sexually transmitted infection
STP	Short term plan
TB	Tuberculosis
UN	United Nations
UNAIDS	United Nations Joint Program on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session (on AIDS)
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WB	World Bank
WHO	World Health Organization
YPI	Yayasan Pelita Ilmu, an Indonesian NGO

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About this Report

The Operations Evaluation Department assesses the programs and activities of the World Bank for two purposes: first, to ensure the integrity of the Bank's self-evaluation process and to verify that the Bank's work is producing the expected results, and second, to help develop improved directions, policies, and procedures through the dissemination of lessons drawn from experience. As part of this work, OED annually assesses about 25 percent of the Bank's lending operations. In selecting operations for assessment, preference is given to those that are innovative, large, or complex; those that are relevant to upcoming studies or country evaluations; those for which Executive Directors or Bank management have requested assessments; and those that are likely to generate important lessons. The projects, topics, and analytical approaches selected for assessment support larger evaluation studies.

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Relevance of Objectives: The extent to which the project's objectives are consistent with the country's current development priorities and with current Bank country and sectoral assistance strategies and corporate goals (expressed in Poverty Reduction Strategy Papers, Country Assistance Strategies, Sector Strategy Papers, Operational Policies). *Possible ratings:* High, Substantial, Modest, Negligible.

Efficacy: The extent to which the project's objectives were achieved, or expected to be achieved, taking into account their relative importance. *Possible ratings:* High, Substantial, Modest, Negligible.

Efficiency: The extent to which the project achieved, or is expected to achieve, a return higher than the opportunity cost of capital and benefits at least cost compared to alternatives. *Possible ratings:* High, Substantial, Modest, Negligible. This rating is not generally applied to adjustment operations.

Sustainability: The resilience to risk of net benefits flows over time. *Possible ratings:* Highly Likely, Likely, Unlikely, Highly Unlikely, Not Evaluable.

Institutional Development Impact: The extent to which a project improves the ability of a country or region to make more efficient, equitable and sustainable use of its human, financial, and natural resources through: (a) better definition, stability, transparency, enforceability, and predictability of institutional arrangements and/or (b) better alignment of the mission and capacity of an organization with its mandate, which derives from these institutional arrangements. Institutional Development Impact includes both intended and unintended effects of a project. *Possible ratings:* High, Substantial, Modest, Negligible.

Outcome: The extent to which the project's major relevant objectives were achieved, or are expected to be achieved, efficiently. *Possible ratings:* Highly Satisfactory, Satisfactory, Moderately Satisfactory, Moderately Unsatisfactory, Unsatisfactory, Highly Unsatisfactory.

Bank Performance: The extent to which services provided by the Bank ensured quality at entry and supported implementation through appropriate supervision (including ensuring adequate transition arrangements for regular operation of the project). *Possible ratings:* Highly Satisfactory, Satisfactory, Unsatisfactory, Highly Unsatisfactory.

Borrower Performance: The extent to which the borrower assumed ownership and responsibility to ensure quality of preparation and implementation, and complied with covenants and agreements, towards the achievement of development objectives and sustainability. Possible ratings: Highly Satisfactory, Satisfactory, Unsatisfactory, Highly Unsatisfactory.

Contents

This report was prepared by A. Edward Elmendorf, consultant, who assessed the project in January 2004, and peer reviewed by Martha Ainsworth, task manager. The report was edited by Bill Hurlbut, and Pilar Barquero provided administrative support.

Boxes

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Principal Ratings

	*ICR**	*PPAR*
Outcome	Unsatisfactory	Unsatisfactory
Sustainability	Unlikely	Unlikely
Institutional Development Impact	Negligible	Negligible
Bank Performance	Unsatisfactory	Unsatisfactory
Borrower Performance	Unsatisfactory	Unsatisfactory

* The Implementation Completion Report (ICR) is a self-evaluation by the responsible operational division of the Bank.

Key Staff Responsible

Project	*Task Manager/Leader*	*Division Chief/ Sector Director*	*Country Director*
Appraisal	Samuel S. Lieberman	Imelda Martinez	Marianne Haug
Completion	Puti Marzoeki	Alan Ruby	Mark Baird

Preface

This is a Project Performance Assessment Report (PPAR) for the Indonesia HIV/AIDS and STDs Prevention and Management Project (Ln. 3981-IND). The Loan was approved on March 27, 1996, and became effective on May 15, 1996. It provided financing for institutional development for HIV/AIDS and STD prevention, and for pilot interventions to reduce transmission of HIV/AIDS and STDs in Jakarta and Riau Provinces, along with complementary support to centrally provided Ministry of Health (MOH) services. The $35.2 million total Project cost was to be financed by an IBRD loan of $24.8 million, and $10.4 million in financing by the Government of Indonesia. Following major Project management problems and in the wake of the Indonesian financial, social and political crises that erupted beginning in mid-1997, $19.8 million of the loan – 80 percent - was cancelled in 1998. The remainder of the loan continued to disburse until the original closing date of September 30, 1999. Total disbursements amounted to $4.5 million.

The findings of the PPAR are based on: an OED mission to Jakarta in January 2004;[1] review of project documents and files in Washington and Jakarta, including the Staff Appraisal Report, the Implementation Completion Report, and Project Status Reports; and interviews with Indonesian government officials in the planning agency (Bappenas) and the Ministry of Health, health researchers in Jakarta, World Bank staff in Jakarta and Washington, development partners, in Jakarta, Geneva (by telephone), Atlanta (by telephone) and Washington, and non-governmental organizations (NGOs) in Jakarta. A list of people met is in Annex B. Annex C provides a timeline of key events with respect to the project and Indonesia's AIDS response. Annex E – an overview of HIV/AIDS epidemiology in Indonesia – is an abbreviated version of a paper by Elisabeth Pisani included in the Indonesia country case study prepared for OED's evaluation of Bank assistance for HIV/AIDS control. Appreciation is expressed to all concerned for their cooperation and assistance in connection with the PPAR.

Following standard OED procedures, copies of the draft PPAR were sent to government officials for their review and comments, but none were received.

1. The mission was conducted in connection with a case study of the effectiveness of the Bank's HIV/AIDS assistance to Indonesia (Elmendorf, Jensen and Pisani 2004), one of four country case studies for OED's evaluation of the Bank's assistance for HIV/AIDS control. This PPAR provides greater detail on the performance of the HIV/AIDS and STDs Prevention and Management Project, one element of that case study. The PPAR has been prepared by one member of the case study team (A. Edward Elmendorf), and takes into account findings from the case study, to which team members Eric Jensen and Elisabeth Pisani provided significant contributions.

Summary

The HIV/AIDS and STDs Prevention and Management Project (HSPMP) aimed to use intensive pilot efforts to achieve two objectives: (a) develop HIV/AIDS and STD institutional mechanisms at the national and provincial levels; and (b) develop interventions capable of reducing transmission of HIV and STDs. The total Project cost of $35.2 million was to be financed with an IBRD loan of $24.8 million and government counterpart funding for the remaining $10.4 million.

The HSPMP represented an effort to address the world-wide AIDS pandemic in Indonesia in the pre-epidemic stage of the disease. Prior to project preparation, in the early-mid 1990s, attention of policy makers in Indonesia and the Bank was gained for early intervention with commercial sex workers through epidemiological projections showing that, with no change in preventive efforts, Indonesia would have 500,000 sexually transmitted HIV infections within four years. These scenarios turned out to be quite inaccurate. Sexually transmitted HIV remains even today at a low level in Indonesia, while HIV transmission associated with drug use has grown rapidly.

Despite the weakness of the analytic foundation for an emergency response to HIV in Indonesia, the conceptual design of the HSPMP was sound, and based on accepted practices of the time. Project preparation took about one year, for an activity that was entirely new for the Bank in the country. The Project emphasized behavior change interventions with high-risk groups (HRG), public goods such as disease surveillance, and participatory engagement of affected populations. Involvement of non-governmental organizations (NGOs) in execution was a defining feature of the Project. The Project was expected to be an initial three-year phase of a longer Bank involvement. A Program Management Unit (PMU) was established in the Ministry of Health, with responsibility for coordination of all HIV- and STD-related activities of the Ministry, as well as for relevant donor-supported interventions, including the HIV/AIDS and STDs Prevention and Management Project.

The HSPMP was negotiated and approved early in 1996 and the Bank loan became effective in May. Project start-up was slow, due in part to delays in release of Indonesian government counterpart financing provided through the public investment budget. Managerial weaknesses appeared quickly. Procedures to facilitate NGO involvement agreed during negotiations were not communicated to provincial financial authorities, and it was only late in 1998 that a Ministry of Finance (MOF)-Bappenas circular on the subject was finalized. About 15 months after effectiveness, in July 1997, the East Asia financial crisis hit Indonesia, and the energy and attention of policy makers was necessarily focused on issues other than the managerial problems of the HSPMP. Political commitment to the Project weakened as the anticipated explosion of HIV transmitted by commercial sex workers that had provided a rationale for early intervention with marginalized and dis-empowered social groups did not occur. In 1998, eighty percent of the IBRD loan was cancelled, in connection with the restructuring of the Bank's Indonesia portfolio that took place in the wake of the East Asia crisis. Very little Project implementation took place after the crisis.

While the development of institutions to reduce STD and HIV transmission remains highly relevant and the need to pilot interventions substantially relevant, Project efficacy and efficiency were low. Project outcome is rated unsatisfactory. While some progress was made on improving the environment for NGO engagement, sustainability of Project achievements is rated unlikely. Bank performance is rated unsatisfactory. Despite the achievement of placing HIV on the agenda for GOI-Bank cooperation at an early stage in the epidemic, insufficient attention was paid during Project preparation to the breadth and depth of commitment to the Project, to institutional analysis, and to NGO capacity building requirements. As explained in the ICR, Bank supervisory support tended to focus on current issues rather than underlying problems of political commitment and the resolution of institutional rivalries within the MOH. Finally, borrower performance is also rated unsatisfactory. During Project preparation, attention concentrated on technical issues; the failure to address institutional roles and responsibilities within the MOH contributed to conflicts that impeded Project execution. Macro factors affected execution in strongly negative ways, and the implementing agency showed little commitment.

Despite its failure to achieve satisfactory development outcomes, the HSPMP offers valuable lessons, including confirmation of experience in other countries:

- Amplifying HIV/AIDS messages in the face of uncertainty risks undermining subsequent commitment to activities that require continuous nurturing of political and institutional support if the focus on HRG and public goods is to be maintained.
- Failure to assess institutional options and responsibilities prior to the launch of the project and to develop local ownership can result in unworkable institutional arrangements within the agency leading the AIDS response.
- Development of AIDS-related institutions and services requires long-term engagement of the Bank and its clients, and cannot be expected through a three-year pilot operation.
- More donor funds may be available in some environments, particularly in the pre-epidemic stages of HIV, than recipient countries are able to absorb, particularly for direct HIV/AIDS services provided through NGOs.
- Physical proximity of the Bank task manager in the Bank's country office does not necessarily strengthen Bank supervisory support to project implementation.

Ajay Chhibber
Acting Director-General
Operations Evaluation

1. Introduction and Background

THE EARLY SPREAD OF HIV/AIDS IN INDONESIA

1.1 The first case of HIV in Indonesia was identified in a foreign homosexual tourist in Bali in 1987. Systematic sentinel HIV surveillance of sex workers in Jakarta and Surabaya began in 1988, when no HIV-positive cases were found. As of December 31, 1993, the Ministry of Health (MOH) reported 193 HIV infections, of which 49 were AIDS cases (Jalal and others 1994). About half of the infections were spread through heterosexual activity, and only 3 were attributed to intravenous drug use. In 1993/1994 the first HIV-positive blood samples were identified among blood donors – only 8 out of 533,865. In the same period sentinel surveillance reported the first HIV-positive cases among sex workers – 3 were HIV-positive out of 52,870 tested.[2] Even as late as 1997, HIV prevalence was still sufficiently low that MOH statistics refer to a small number of cases in Irian Jaya as 'Thai fishermen, who have since left the country'.[3]

THE INITIAL INDONESIAN POLICY RESPONSE

1.2 As early as 1985, an unofficial working group of Indonesians was discussing HIV/AIDS in Indonesia. While only a few AIDS cases had been observed, public health researchers had the exploding Thai epidemic as a geographically, though not culturally, proximate example of the possible course of an Indonesian epidemic. A National AIDS Committee (NAC) was formed in 1987. AIDS became a notifiable disease in 1988. Starting in 1988, short and medium term plans for AIDS control were implemented with WHO Global Program on AIDS (GPA) assistance in four provinces thought to be at high risk -- Jakarta, Bali, Jogjakarta, and East Java. Sentinel HIV surveillance expanded to include nine provinces by the early 1990s, and screening of the blood supply grew rapidly (Jalal and others 1994). A National AIDS Prevention and Coordination Commission, including 14 Ministers, was created in 1994, but it did not meet. An AIDS strategy was adopted in 1994, modeled on the work of Indonesia's successful population and family planning board, BKKBN. It espoused broad principles rather than specific programs, and did not include focus on high-risk groups. The work of the National AIDS Commission and implementation of its strategy was supported by AusAID and UNDP projects, but national resources for strategy implementation were limited, particularly after the financial crisis starting in 1997.

1.3 Projections of the possible course of the HIV/AIDS epidemic were generated by expatriate consultants and researchers.[4] They were largely based on the African and Thai experiences of the late 1980s and early 1990s, and showed the potential for an explosive acceleration of the epidemic.

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2. National surveillance records, MOH, and U.S. Census Bureau HIV database.

3. Republic of Indonesia, MOH tables contained in a January 1997 Bank memorandum.

4. Linnan 1992.

WORLD BANK INVOLVEMENT IN HEALTH IN INDONESIA

1.4 The World Bank has had a long, active, and largely successful engagement in health in Indonesia. Starting with a population project in 1972, the Bank financed 13 health, nutrition and population (HNP) projects by 1996, with total financial commitments amounting to $638 million.[5] Completion reports on these projects show a very positive record. The outcome of one of the projects was rated highly satisfactory; the outcomes of ten were rated satisfactory and one marginally satisfactory.

1.5 The Bank's health sector strategy in Indonesia has evolved considerably over time, as health and other conditions in the country changed. When the HIV/AIDS and STDs Prevention and Management Project (HSPMP) was initially proposed, in late 1994, the Initial Executive Project Summary set out a two-pronged Bank health sector strategy in Indonesia: to foster facility-level service delivery through province-based projects; and to fund complementary operations which build central capacity to perform policy formulation, analytic, and technical assistance functions. HNP lending in Indonesia concentrated on financing and provision of services by the public sector, and gave little attention to private provision of health services in the country. The HSPMP fit within this strategic framework.

1.6 Discussions on HIV/AIDS by Bank HNP staff with the Indonesian authorities started in 1992. Based on the high prevalence of sexually transmitted diseases (STD) among high-risk groups, like sex workers, and the experience of the explosive HIV/AIDS epidemic in Thailand, Indonesia was perceived to have the potential for a major HIV epidemic. Although sentinel HIV surveillance in sex workers detected only a handful of HIV positive cases, one researcher estimated that, after adjusting for under-reporting, there were 40,000 to 50,000 infections by the end of 1993[6]. Assuming this to be correct, with no change in preventive efforts, it was projected that Indonesia would have half a million infections within 4 years.[7] Such thinking was widespread in the donor community in Jakarta at the time, and was stimulated by dialogue among World Bank and USAID staff and their Indonesian counterparts.

1.7 Within the Bank, the 1993 country economic report included a box suggesting that the epidemic had entered its "exponential growth phase, with doubling time for reported cases of less than a year and threatening to fall." The economic report found that policy makers "have responded quickly", with strategies including surveillance, clinical management, and prevention of blood transmission. Resources allocated to HIVAIDS were said to be inadequate, with insufficient recognition that preventing further spread of the virus would require "extensive behavioral change in the population, involving strong and visible leadership, intensive social marketing and training activities, and vigorous cooperation with the private sector, including NGOs." A successful strategy, according to the box, would involve promoting safe sex, STD prevention and control, campaigns targeted at "actual or potential high risk groups", and "identification of high priority

5. Water supply and sanitation in low-income communities is also included in the health portfolio.

6. Jalal and others 1994.

7. Jalal and others 1994.

initiatives".[8] In retrospect, the epidemiological data in the box were inaccurate, but the proposed responses were sound.

1.8 The project rationale and strategy set out in the SAR followed the approach of the Bank economic report, with heavy emphasis on STDs, HIV surveillance and HIV behavior change, and experience in Thailand. Regional dimensions within Indonesia were outlined, and set the stage for pilot interventions proposed in the HSPMP SAR for two provinces. The projections summarized above buttressed the argument for an emergency response and were the basis for calculating project benefits, but the conceptual design was driven more by internationally accepted practices at the time, with emphasis on high risk groups (HRG), public goods and services, and participatory engagement. During the internal review process the projections were not challenged (Annex E). Thus, it appears that a combination of awareness of the situation in other countries, availability of deeply worrisome projections and promotion of an alarming though highly uncertain scenario by resident expatriates, Bank staff, and some key Indonesian personnel put the issue of HIV/AIDS on the agenda for operational collaboration between the Indonesian government and the Bank at a very early stage in the epidemic in the country**.** The fact that the projections were inaccurate should not detract from the importance of the accomplishment of successfully inserting HIV into the GOI-Bank work program, in a country with only a nascent epidemic.

PROJECT PREPARATION

1.9 The HSPMP was prepared in an emergency mindset. An identification mission visited the country in October 1994, and preparation and appraisal missions took place in January-February, July, and October 1995. A grant by Japan for project preparation was mobilized, and the Bank managed the grant at the request of the authorities, to permit rapid processing. The speed of project preparation was not significantly different from other operations in Indonesia. Identification and preparation took place over one year. Yet the operation represented an entirely new activity for the Bank in the country and involved highly controversial areas of deeply personal behavior. According to the Staff Appraisal Report (SAR), no prior sector work was undertaken.

1.10 Within the Indonesian government, a number of agencies held responsibilities touching on HIV/AIDS issues, which had a bearing on project preparation. Beyond the inactive NAC and subsequent Commission, the Ministry of Planning (Bappenas) took a strong lead on public investment and donor relations. A key Bappenas official worked closely with researchers concerned by HIV in Indonesia, and was a champion promoting involvement. The Bappenas counterpart in the MOH planning bureau orchestrated the technical aspects of project preparation. Within the Ministry of Health, there was no overall institutional locus of responsibility for HIV/AIDS and STDs. Different aspects of HIV and STDs were covered by separate units responsible for specific diseases and for epidemiology.

1.11 To assist on project preparation, specialists on IEC and behavior change programs were recruited, along with experts on STD programs and public health

8. World Bank 1994.

laboratories, largely from the U.S. Centers for Disease Control and Prevention (CDC). One person was to assume responsibility for monitoring and evaluation, among other tasks. The absence of specialized expertise in institutional analysis and NGO partnerships stands out, in light of the fact that institutional development was to become a major objective of the project.[9]

2. Project Objectives and Design

2.1 The HSPMP was intended to help operationalize and implement the AIDS strategy presented in the Government's 1994 decrees, which aimed to lower STD and HIV incidence and deaths from AIDS in Indonesia. The specific objectives of the Project were to use intensive pilot efforts to develop (a) institutional mechanisms and (b) interventions capable of reducing transmission of STDs and HIV in Indonesia, as the first phase for longer run support for Indonesia's AIDS response. The project's three components included a core program for STD and HIV prevention interventions in each of two pilot provinces, to be designed and implemented in partnership with local NGOs, and a component to finance complementary activities at the central level (Box 1). Extensive monitoring and evaluation were to identify which trial interventions were promising and worth continuing. The Project was planned as a brief, three-year intervention, with subsequent operations to follow. The total cost of the project at appraisal was $35.2 million, financed by an IBRD loan of $24.8 million and a counterpart contribution from the Indonesian government of $10.4 million.

Box 1. Project Components

The HSPMP consisted of provincial-level pilots in Jakarta and Riau provinces and support to central activities of the MOH:

Jakarta ($8.8 million): The Project was to support behavior change, STD service delivery, STD and HIV surveillance, laboratory strengthening, NGO capacity building, and monitoring and evaluation. NGOs were to be contracted to play a key role in designing and carrying out behavior change interventions. Training and IEC material preparation and use were central to the Jakarta component.

Riau ($7.3 million): The Project was to finance activities comparable to those in Jakarta, including behavioral and service delivery initiatives (training, guidelines, and laboratory support) and surveillance, monitoring, and evaluation. Behavioral interventions were directed at health care personnel, commercial sex workers, and others at risk, and comparable efforts were to be made with secondary audiences. As in Jakarta, NGOs were expected to play a central role.

Central activities ($15.0 million): The project was to support coordination, technical assistance, media development, monitoring and evaluation and research, and other activities of central MOH units. Development and testing of procedures for syndromic management of STDs, including training, equipment, and supplies, were included. Surveillance support was initially to focus on Jakarta and Riau, and subsequently in other districts, including guidelines, training, and purchase of equipment and supplies. Centers of excellence for laboratory services were to be established in several areas, to serve as anchors for quality assurance. Provincial laboratories throughout the country were to be given increased capacity to handle HIV and STDs. To support behavior change activities at the provincial level, development of prototypes for needs assessments, preparation, and pre-testing of IEC materials, training of trainers, technical assistance, and research were anticipated at the central MOH level. Finally, the project provided funds for research on a range of topics related to HIV and STDs.

9. The Japanese grant provided for financing of an institutional specialist, but the individual was not hired.

2.2 The SAR recognized that progress towards the HIV transmission reduction goal might not be discernable in the three-year duration of project execution. At least initially, the SAR expected the reported number of STD and HIV cases to rise, as an indication that a strengthened surveillance system was functioning. For these reasons, the HSPMP was designed to attain a number of proximate objectives. Designated performance indicators covered four objectives: (a) improved awareness and behavior change in key groups; (b) improved knowledge and skills of health workers; (c) establishment of effective surveillance mechanisms; and (d) enhanced capabilities of the health laboratory system.

2.3 A defining feature of the Bank-financed Project was to be the role of NGOs in different aspects of implementation. They were to be actively involved in the Provincial AIDS Commissions. Individual NGOs were to be contracted for various behavior change, service delivery, training and monitoring and evaluation activities. For specified tasks, NGOs with known expertise were to be asked to submit proposals, and for other tasks NGOs would be able to submit unsolicited proposals to carry out STD and HIV/AIDS related activities. The loan was also to finance capacity building measures directed at smaller NGOs, some with strong ties to particular groups of interest to the Project.

2.4 The objectives of the Project were somewhat ambiguous in their follow-through in project design. The intention to develop institutional mechanisms and to pilot interventions was clear. These objectives needed to be more closely linked to the individual components, and to the monitoring and evaluation program. The indicators set out in the SAR covered only the activities to be carried out under various project components, without linkage to the project development objectives (PDO). A statement was needed on how monitoring and evaluation of the two fundamental objectives would be carried out. The project description in the Loan Agreement stated the objectives in geographic terms: to develop (a) institutional mechanisms and pilot interventions "in the provinces of Jakarta and Riau," and (b) "activities at the center" to reduce STD and HIV transmission and prepare for extension of the pilot interventions to other provinces.[10] The project status reports (PSR) PDO statements accurately follow the SAR and then discuss the project components without linkage to the pilot nature of the interventions or the monitoring of institutional development with reference to central or provincial AIDS program delivery capacity or NGO development.

2.5 The objectives of the Project were epidemiologically relevant (focusing on development of institutions for STDs/HIV/AIDS, and piloting interventions), but institutionally and politically premature, relative to the level of political commitment and existing institutional capacity that would have been necessary to implement and sustain them effectively in the environment of a nascent epidemic. An alternative health project to expand public health services of interest to HIV *and* other diseases could have been considered, particularly bearing in mind the limited knowledge of HIV and STDs then available in Indonesia. This might have been more responsive to the Bank's comparative

10. As with most other Bank-financed projects, the presentation of the project development objectives in the Loan Agreement was the only statement of objectives explicitly agreed between the borrower and the Bank.

advantages in dealing with large, national, structural issues, and fit more closely into the Bank's health sector strategy. Such an operation could have focused on institution-building, broadening and deepening political commitment to address controversial health issues, and providing public goods (like epidemiological and behavioral surveillance and improved laboratory capacity). It might have been able to introduce pilots for behavior change intervention after a mid-term review. This would have allowed more time to nurture commitment and build capacity before undertaking an aggressive push for targeted high-risk interventions for which there was little support at the time of the HSPMP.

3. Project Implementation

3.1 The Project was led by the Director General of Communicable Disease Control and Environmental Health in the Ministry of Health (DG-CDC/EH). An advisory Steering Committee was chaired by the Secretary-General of the MOH. The Bank loan supported the creation of a special HIV/AIDS and STDs Program Management Unit (PMU) reporting directly to the DG-CDC/EH. The Unit was to be responsible for planning, coordinating, monitoring, and evaluating all HIV/AIDS and STD-related work within the MOH. It was to provide technical assistance to local health agencies and to facilitate links with the National AIDS Commission. Beyond the Bank-financed Project, the PMU was to be responsible for coordination of all other donor assisted activities in the MOH related to STDs and HIV/AIDS. These broad responsibilities justified the name 'Program Management Unit', as distinct from a 'Project Management Unit.' However, while an MOH DG CDC-EH implementation decree of December 1996 gave the PMU responsibility for coordination of all donor-assisted projects, it described the PMU as a Project Unit without a permanent structural position within the Indonesian public administration. It thus appeared to undermine the institutional development objective of strengthening MOH structures to address HIV/AIDS.[11] As with other investment projects, Bappenas retained overall responsibility but was not engaged on a daily basis.

3.2 The Project was approved in February 1996, and the Bank loan became effective in May of that year. Project completion was expected by the end of March 1999. The Project faced difficulties from the beginning of execution. A one-day project launch workshop was held, but only at the end of July 1996 and apparently without participation of the task manager or other Washington-based Bank staff. The initial supervision mission, in September 1996, reported that a delay in availability of project funds apparently attributable to inadequate budget planning within the GOI was delaying central and provincial execution. The terms of recruitment of the Project Manager were unclear, and there was considerable lack of clarity regarding the planned work with NGOs. Responsibility for baseline surveys was being debated among the units tasked with carrying out different components of the Project. Overall, the initial supervision

11. The ICR treats the PMU as a project unit, and reflects the continuing confusion on this issue that persisted during HSPMP implementation. Since closure of the Bank loan, the PMU appears to have disappeared, in practice if not in form.

mission found the Project to be 'starting in a disappointing fashion.' Looking back, these are signs of limited readiness for implementation.

3.3 The second supervision mission, in February 1997, also reported significant delays, and the PMU was thought not to be in a position to manage the Project effectively. The PSR rated implementation progress and development objectives as satisfactory, while project management was unsatisfactory. Shortly thereafter, only about 15 months after loan effectiveness, the East Asia financial crisis hit Indonesia, and the attention of policy makers in both and GOI and the Bank was understandably devoted to issues more urgent than the HSPMP. The September 1997 supervision mission rated the Project unsatisfactory on implementation, though still satisfactory on development objectives because of progress on some components. The Bank's follow-up letter stated that, if in a further six months the rating remained unsatisfactory, the Bank would seek to discuss possible restructuring or, if necessary, closure of the Project.

3.4 Because of inadequate management, limited support within the MOH, and lack of evidence to demonstrate that HIV was actually spreading in the Indonesian population, the HSPMP was in a very weak position when the financial crisis hit Indonesia in July 1997. Other donor-financed health projects, including other Bank-financed projects for provincial health services, iodine deficiency control and safe motherhood, weathered the storm without major cancellations. Collapse of the whole health system was a real possibility at the time, while the number of HIV/AIDS cases was very low. Very little work occurred on the Project, post-crisis. A supervision mission in June-July 1998 reported that the MOH and Bappenas had decided to cancel approximately 80 percent of the loan. This was formally confirmed at the time of the initial restructuring of the entire Bank portfolio, in August, 1998, in the wake of the financial crisis. Of the $5.0 million remaining in the loan, over $3 million had already been disbursed. The cancellation took place following months of effort by the staff to turn around the poor performance of the Project.

3.5 While no aspect of the Bank's portfolio escaped critical scrutiny, the HSPMP was cut much more dramatically than other projects. Had the Project shown reasonable prospects for achieving its objectives, the HNP staff would have endeavored to protect it. According to decision-makers in the Bank, the effort required to restructure and redesign the Project to the new circumstances of HIV and of Indonesia's rapidly decentralizing health system, combined with the risks of failure and the work required to ensure a management system and staff that would effectively function, appeared to outweigh the potential benefits. In retrospect, the decision to close almost all activities must be seen as a reasonable response by both the GOI and the Bank, since the Project, as designed, seemed to have lost its priority and relevance in dramatically changed social, political and economic conditions, and had clearly had lost its constituency among key Indonesian stakeholders. [12]

3.6 The management problems affecting the HSPMP touched procurement and financial management. Twice – in January 1998 and January 1999 - the Bank advised the

12.. Some other donor-financed HIV/AIDS projects also suffered from the financial crisis and the changing context for HIV/AIDS work in Indonesia. A UNDP project was particularly affected (Janssen and Purwaningsih 2003)

PMU that unless audited financial statements were received by the end of March, the Bank would not extend the closing date of the loan and would delay Board presentation of new loans benefiting the MOH. In February 1999 the Bank informed the Ministry of Finance (MOF) that auditors were unable to audit certain HSPMP expenditures because of lack of documentation. The Bank therefore required that the government deposit funds into the Special Account for the Project equivalent to the amounts for undocumented project expenditures. The auditors also found problems in procurement, excessive payment for travel, weakness in programming training activities, and distribution of IEC materials.

3.7 The underlying and unresolved managerial problems that affected the HSPMP appear to be related largely to role conflicts between the PMU and the main line agencies of the MOH concerned with the Project – the Directorates for Directly Transmitted Diseases[13] and for Epidemiology and Immunization, and the Centers for Health Education and for Health Laboratories. Furthermore, there were conflicts between MOH agencies themselves, such as between the directorates responsible for specific diseases and for epidemiology, on HIV surveillance. By being staffed with technical specialists as well as administrators, the PMU duplicated functions of the line agencies.

3.8 The fundamental notion to strengthen the position of HIV and AIDS within the MOH, both technically and in its institutional position within the hierarchy, was sound, and responded directly to the institutional development objective of the Project. Unfortunately, there was insufficient role clarification and consultation prior to agreement on the arrangements during negotiations on the Bank Loan and insufficient time during implementation to resolve problems. The Indonesian Project Manager was a health researcher with no experience of Bank-financed projects, while an administrator with deep knowledge of Bank operational policies and procedures but not from the health sector would probably have had fewer conflicts with other MOH units and been more successful in facilitating execution of the various Project components, though not necessarily in gaining greater institutional prominence for HIV/AIDS and STDs within the MOH hierarchy. In sum, the establishment of appropriate institutional mechanisms to address HIV and AIDS within the MOH seems to have been given insufficient attention as a design issue.

3.9 At Bank request, a dossier of policies and procedures relating to use of Project funds to support NGOs was prepared for review during negotiations on the loan. An annex based on these materials was included in the Loan Agreement, and details were recorded in the agreed minutes of the negotiations. However, these arrangements were not converted into appropriate internal instructions within the GOI, nor were they communicated to provincial financial authorities, who continued to operate for NGO contracting under pre-existing rigid MOF rules. It was only late in 1998 – near the end of the execution of most Project activities - that a Bappenas-MOF circular was issued that resolved outstanding issues.

13 .The term ‘Directly Transmitted Diseases’ is used in the Indonesian English translation of decrees and other working documents.

3.10 The Indonesian financial and political crises of 1997 and 1998 highlighted two weaknesses in the design of the HSPMP – short duration and weak monitoring and evaluation. As an effort to develop new institutional mechanisms for STD and HIV prevention and management, the Project would probably have required longer than the three years initially planned. Had a normal five-year implementation period been envisaged, a full mid-term review (MTR) could have been built into the Project, with substantial mid-course correction. The Project was labeled a pilot. A true pilot would have included an evaluation design, establishment of control populations, and baseline surveys before initiation of project prevention activities. While large numbers of performance indicators were established during Project preparation and appraisal (Annex D), 'baseline' surveys were executed only in the third year of the Project when it was already near closure.

3.11 The flexibility reported as an important strategic element in the SAR was a positive design feature but did not work out in Project implementation. Bank resources were conceived to be used as a complement to other donor funding. The notion of complementarity was reflected in the assignment of responsibility for coordination of all donor-financed HIV/AIDS projects to the PMU, but was not adequately reflected in the specific management arrangements within the MOH. The assignment of responsibility for donor coordination to the PMU was never realized in practice, and was largely unknown in the donor community. The flexibility underscored in the SAR could have made the Project into an evolving tool for GOI response to a changing, poorly understood disease that was potentially threatening but only in ways that were not fully understood at the time of Project design. No MTR, with the possibility for correction and changing course, was foreseen in the SAR or in the Loan Agreement. There was no provision for annual reprogramming and updating of work programs, aside from consultant services, fellowships and training, or for a project implementation manual. Management advised the task team prior to negotiations that, given the pilot nature of the Project, it was important to build in the possibility of change after initial experience. The decision not to draw upon instruments widely used in other Bank-financed operations, such as a project implementation manual, an MTR, and annual work programming, seems to have been driven by the short duration of the Project as designed.

3.12 The early discussions within the Bank and with the Indonesian authorities concentrated on high-risk populations, but the project as appraised diluted this to an emphasis on behavior change through (i) increased knowledge of HIV risks while reinforcing traditional values and norms 'within the population'; (ii) enhanced skills in risk reduction for those engaged in high-risk behavior; and (iii) promotion of the use of STD services. Further dilution occurred during implementation.

4. Outputs and Outcomes, by Objective

DEVELOP INSTITUTIONS FOR REDUCING STD AND HIV TRANSMISSION

4.1 Despite the limited portion of the Bank loan that was used, the Project produced some outputs important to the strengthening of a number of institutions critical to STD and HIV prevention.

4.2 *Health care provider skills*: More than 2,000 health care providers were trained on the syndromic approach to managing STDs, largely at the provincial level in Jakarta and Riau. However, as the implementation completion report (ICR) observes, the training took place in single sessions without follow-up through refresher training or continuous supervision. No evaluation of health providers' knowledge and skill was conducted after the training. Surveillance training was provided to 2,500 health workers in eight provinces. Supervisory visits were not carried out, however.

4.3 *Surveillance of HIV and STDs*: The Project produced eight Standard Operating Procedures (SOPs) for surveillance. Two were disseminated to the provinces, three were cancelled, and three needed improvement. Institutional rivalries between the MOH Directorate for Epidemiology and Immunization (with a sub-directorate for surveillance), and the sub-directorates for specific diseases (with their own surveillance activities) contributed to the poor quality of the guidelines and procedures for HIV surveillance. Studies carried out under the Project on infection control, microbiological resistance, STDs among pregnant women, and STD management using the syndromic approach are thought to have provided valuable inputs, not so much for the project as for future policies and programs. The OED mission was told that work on SOPs sponsored by the Project duplicated similar work under other donor-financed projects, such as the USAID HIV and AIDS Project (HAPP). This is evidence of the need for the Program Management concept in the SAR that was not realized in practice.

4.4 *Public health laboratories*: The laboratory component was relatively more successful in implementation than the others, with training of staff in centers of excellence in four cities, and provision of equipment. Planning, however, was weak. Not all intended equipment was procured because procurement problems led to the cancellation of one round of ICB.[14] Five million dollars worth of reagents were not purchased because national needs were found already to have been met by the government budget. This reflected inadequate coordination between the Center for Health Laboratories and the DG CDC-EH. A longer execution period might have led to reallocation of the funds rather than cancellation. Laboratory quality assurance for HIV antibody testing functioned well, and the Center for Health Laboratories made good use of technical assistance.

14. The Bank responded to a non-objection request for a procurement award with an estimate that the recommended bidder's prices were 50 percent to 350 percent higher than international market prices. According to the ICR, the letter found that collusive practices between bidders and authorized medical equipment suppliers appear artificially to raise equipment prices, and recommended that supplies be procured through the UN.

4.5 *NGO engagement*: While the SAR did not specify it as an explicit Project objective, the HSPMP strived to ensure the design, introduction, and effective use of arrangements for the flow of public funds to NGOs for the provision of health services to hard-to-reach populations. Important progress towards this objective was achieved. An MOF-Bappenas circular was issued that clarified arrangements, and made it easier for NGOs to be able to contract for use of public funds, by simplifying the application of national procurement rules to them. The ICR reports that contracts were concluded with 64 NGOs – an important accomplishment bearing in mind the rigidities of MOF procedures before the late 1998 circular. Because at appraisal there were few NGOs available to the Project (in part because of stiff demand for those already operating by other donors), effectively the Project relied on creating large numbers of NGOs. For the NGOs to operate effectively, they required training, both in financial accounting and in their substantial tasks. The former was accomplished under the Project, but it is not clear that systematic training regarding counseling, condom distribution, or other substantial HIV-related tasks ever was planned or undertaken. Several respondents raised the issue of the absorptive capacity of the MOH and the NGO sector for this activity. The concurrent USAID HAPP project routed $3 million through the MOH, and the Ministry was able to disburse only $1 million by the end of the project. A two-year UNDP project for strengthening NGO capacity and partnerships for HIV/AIDS program implementation was extended to six years but still only implemented about 50 percent of planned activities despite the fact that 97 NGOs and CBOs received training and 17 CSOs received funds for small-scale interventions.[15]

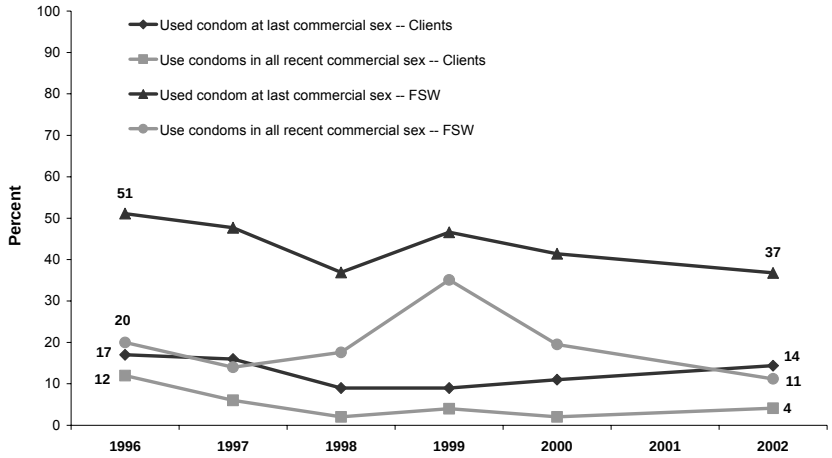
PILOT INTERVENTIONS FOR REDUCING STD AND HIV TRANSMISSION

4.6 The interventions for reducing STD and HIV transmission piloted under the HSPMP were conceived to address behavior change in high risk groups of commercial sex workers. Injecting drug users (IDU) were not targeted, presumably because the importance of this group to HIV transmission was not widely understood at preparation and there was little time to modify target groups during execution. IEC materials (posters, leaflets, T-shirts, handbooks, stickers, calendars, booklets, flipcharts, billboards, and banners) were produced. Media time (radio spots, TV filler, 16 mm films) also supported behavior change. NGOs were deeply involved in delivering IEC to target populations. The ICR reports that no data were documented on the numbers of people in target populations who received training or participated in awareness-raising sessions. The dispute between the PMU and the Center for Health Education, which was responsible for the IEC materials but wished an untargeted campaign, was never resolved. As Figure 1 shows, both sex workers and clients in Jakarta (one of the two project areas) report consistently low levels of condom use for the duration of the Project, despite both Bank and USAID-funded projects that focused on changing this behavior.[16]

15. Jansen and Purwaningsih 2003.

16. The spike in condom use reported by sex workers but not clients in 1999 may be related to the economic crisis, which reduced demand for commercial sex among Indonesian men. The women working in the north Jakarta port area covered by this surveillance are likely to have had proportionately more foreign clients in 1999 than in other years, and BSS data show that foreign clients are more likely to use condoms than Indonesian clients.

Figure 1. Flat or declining condom use in Jakarta



Source: Behavioral Surveillance Surveys (BSS, see Annex E)

5. Ratings

OUTCOME

5.1 ***Relevance***. The initial overall design was, and remains, *substantially relevant*, despite the dilution of the targeting during appraisal and execution, in the context of Indonesia's priorities and the Bank's country and sectoral strategies. Current high-risk target populations would focus somewhat more on IDU than CSW. The Bank's 2003 Country Assistance Strategy (CAS)[17] establishes, as a key pillar of strategy, making service delivery responsive to the needs of the poor, with particular reference to health services. The HSPMP concept fits well into this. Similarly, the Project objectives are consistent with the 2004 East Asia and Pacific regional AIDS strategy.[18]

5.2 The first objective, of strengthening institutions needed for the prevention and management of HIV/AIDS and STDs, is *highly relevant* in Indonesia today. With dramatic decentralization of public services since the financial and other crises of the late 1990s, provincial-level services have assumed increasing importance. Strengthening epidemiological and behavioral surveillance continues to be important in Indonesia. In particular, while the HSPMP did not address this problem, dealing with issues in the financing of surveillance is a high public priority, as Indonesia's health system is increasingly decentralized. Similarly, enhancing the capabilities of Indonesia's public health laboratories continues to be important to the country's priorities and the Bank's

17. World Bank 2003b.

18. World Bank 2004.

global and sectoral strategies. Finally, the effective establishment and operation of policies and procedures for improving the flow of public funds to NGOs for health services, and of making NGOs an active partner in the provision of services to hard-to-reach populations continues to be *highly relevant* today, particularly under a country strategy that emphasizes making service delivery responsive to the needs of the poor.

5.3 The second objective, of piloting interventions to reduce transmission of STDs and HIV, continues to be *substantially relevant* in Indonesia. The key problem concerns moving beyond disparate, discrete donor interventions, often associated with high quality technical support, into large national programs. This is an issue of both intervention design and institutional support.

5.4 ***Efficacy.*** Since most of the Bank loan was cancelled and only a fifth of the resources were actually disbursed, efficacy – the extent to which the Project objectives were achieved, or expected to be achieved - of the HSPMP is rated *negligible*, overall.

5.5 The efficacy of the project with respect to the first objective, of strengthening of AIDS institutions, is rated *modest.* As indicated above, the most significant achievements were in the areas of public health laboratories (see Annex D) and establishment of mechanisms for the flow of government funds to NGOs for public health action. The latter occurred near the end of the Project's limited period of execution, so they were only put partly into practice. Their apparent lack of use since then, and the rapid intervening change in the organization of the Indonesian health system, risk requiring future review and revision of the policies and procedures established during execution of the HSPMP.

5.6 The efficacy of the project with respect to the second objective, piloting of interventions, is rated *negligible,* despite the involvement of a considerable number of NGOs. The weaknesses in M&E made it impossible to build on project experience and ensure the learning that is an essential element of a successful pilot operation.

5.7 ***Efficiency***. Overall efficiency is rated *negligible*. Utilizing the iwgAIDS projection model that assumed a rapid escalation of the epidemic in Indonesia, with parameters similar to an African epidemic, the SAR estimated rates of return on Project investments, ranging from 13 to 41 percent. No economic analysis was prepared for the Implementation Completion Report. Available evidence on Project execution did not justify or permit estimating economic rates of return for this report. While the AIDS literature suggests that the interventions planned to be piloted under the HSPMP are normally cost-effective, particularly in environments of high STD prevalence, no estimates are available of the cost-effectiveness in Indonesia of the specific interventions piloted under the HSPMP. With respect to the first objective, on institutional development, efficiency is rated *modest* on the grounds that the limited achievements on public health laboratories and NGO engagement likely improved the cost-effectiveness of the AIDS program. With respect to the second objective, despite the sound theoretical underpinnings of the planned pilot interventions, their efficiency as executed is rated *negligible,* since little was implemented and there was substantial dilution of the emphasis on HRG in implementation.

5.8 Overall, despite the substantial relevance of its design, the HSPMP outcome is rated *unsatisfactory*, due to its negligible efficacy and efficiency. This flows largely from the failure of the authorities to execute nearly four-fifths of the HSPNP in the wake of management problems and the Indonesian financial crisis. The assessment of relevance, efficacy, and efficiency by project objective is summarized in Table 1.

Table 1. Summary of Project Outcome Ratings by Objective

	Relevance	*Efficiency*	*Efficacy*	*Outcome*
Objective 1: Develop Institutions to reduce STD and HIV Transmission	High	Modest	Modest	Moderately unsatisfactory
Objective 2: Pilot Interventions to reduce STD and HIV Transmission	Substantial	Negligible	Negligible	Unsatisfactory
Overall Project	Substantial	Negligible	Negligible	Unsatisfactory

INSTITUTIONAL DEVELOPMENT IMPACT

5.9 Overall, institutional development impact is rated *negligible*. The HSPMP had a *modest* impact on the enabling environment by facilitating and requiring the adoption of policies and procedures for use of public funds for provision by NGOs of health services deemed to be in the public interest. Other impacts on the enabling environment were negligible. Aside from its favorable impact on health laboratories, the Project had a *negligible* impact on building AIDS institutions within the MOH and provinces. The ICR reports that the number of NGOs working on HIV/AIDS increased dramatically during project implementation, despite the rigidity of MOF contracting procedures. However, only the NGOs already active prior to the Project could maintain their activities after the HSPMP ended.

SUSTAINABILITY

5.10 Sustainability is rated *unlikely*. First, despite indications to the contrary from core agency personnel during preparation and appraisal, there was very little ownership of the Project among the many agencies and personnel concerned. Key champions in Bappenas changed jobs early in execution. Second, only a small part of the Project was actually executed, and only 20 percent of the loan was disbursed. Third, there were few measurable outcomes associated with those HSPMP activities that were executed. Only the public health laboratories component may have some modest sustainability. If future use is made of the procedures for government financing of NGO services, the arrangements made in connection with the Project could be sustainable, but no GOI, Bank or other donor program or project is known currently to be using them. Fourth, the Project was conceived as a pilot, but had essentially no effective monitoring or evaluation. In these circumstances, sustainability could not be expected.

BANK PERFORMANCE

5.11 Bank performance was *unsatisfactory* on both quality at entry and supervision. The concept of early intervention with high-risk groups and support to public goods was,

and remains, fully consistent with Bank corporate and country strategy. Nonetheless, the pressure to advance rapidly led the Bank's preparation support and project appraisal to focus on specific technical dimensions of the proposed project and to pay insufficient attention to breadth and depth of ownership, institutional analysis and NGOs. The absence of sound sector work prior to identification and preparation, the complexity of the Project, and the limited period planned for its execution magnified these problems. These weaknesses meant that project approval was premature, and contributed to subsequent, managerial problems during project execution that were never resolved.

5.12 As observed in the ICR, the Bank's supervisory support tended to focus on current issues rather than the underlying fundamental problems of ambitious expectations and disagreements on target populations. While the staff paid attention to the Project's development objectives and demonstrated concern for M&E, the solutions proposed did not lead to meaningful action by the MOH or the core agencies of government. The tone of Bank communications was occasionally inappropriate and led to tensions with local stakeholders. The ICR points out that when supervision responsibilities were transferred from Washington to the World Bank Jakarta office, supervision missions became rare. Closeness of the task manager to day-to-day Project activities did not strengthen supervision in this case, but appeared to make the conduct of regular supervision missions seem unimportant.

BORROWER PERFORMANCE

5.13 Overall, borrower performance was *unsatisfactory*. During project preparation, leadership was taken by the central planning agency Bappenas. This is not surprising, in light of the then prevailing patterns of government action in Indonesia. However, the MOH implementing agencies, such as the Center for Health Education, and provincial level staff had a relatively passive role. Preparatory activities concentrated on technical aspects of the project, such as health laboratories and their requirements, and gave insufficient attention to definition of the respective roles and responsibilities of the many parties to be engaged in Project execution. Readiness for implementation was weak at the time of Loan signature. During implementation, macro factors – delays in receiving government counterpart funds under investment budget allocations, delays in ensuring adoption of an MOF circular to facilitate NGO participation, and the Indonesian financial crisis – had a strongly negative impact on the Project. Similarly, implementing agency performance factors were also negative, including conflicts between MOH units, unresolved role ambiguities between the PMU and the line departments of the MOH, reluctance to make use of technical assistance, and low levels of commitment to the Project. Monitoring was all but non-existent. While detailed indicators were set out in the SAR, target values were not fixed and baseline data were only collected late in Project execution (Annex D). There was no evaluation of the Project. While a high quality external review of Indonesia's HIV and AIDS programs was carried out near the end of the Project, discussions with stakeholders suggest that it had little impact. There were modest levels of compliance with requirements of the Loan Agreement, as indicated by the problems of delays in release of counterpart funds, PMU role confusion, and procurement performance.

6. Lessons

6.1 *There are risks of amplifying HIV/AIDS messages in the face of the inherent uncertainty in a nascent epidemic.* Political commitment was too closely tied to the expectation that HIV/AIDS would imminently explode under CSW-driven transmission, in the absence of early action. As the Project entered into execution, MOH staff could see that the alarming scenarios that established a rationale for emergency intervention were not being realized, undermining political commitment for the Project. The attention of policymakers inevitably turned to other subjects in the wake of the financial crisis. Yet, there were still good grounds, in the experience of other countries, for the GOI to devote attention and policy energy to HIV.

6.2 *A strategic focus on HRG and public goods is not enough to ensure results in a nascent epidemic.* Investments in institutional development and mobilization of political support among relevant decision-makers and implementers are even more important. Close supervision of interventions for HRG is critical to ensure that the focus is not lost in implementation. The pressures to broaden services beyond HRG were evident in Indonesia and the focus on HRG was diluted in implementation. Investments in a low-level epidemic that call for reaching out to dis-empowered and marginalized populations, such as commercial sex workers and IDU, need to include continuing activities to nurture and expand political support.

6.3 *More donor funds may be available than can be absorbed in direct HIV/AIDS services in a nascent epidemic.* Discussions with donors in Indonesia suggest that this was the case with NGOs. Policy development and institutional preparedness may initially be more important than widespread service delivery

6.4 *Closeness of the task manager to day-to-day Project activities does not necessarily strengthen supervision.* In the HSPMP it appeared to make the conduct of regular supervision missions seem unimportant. It is not just proximity to the client that is important, but the right kind of proximity.

6.5 *It is unrealistic in three years to expect to build capacity, institutions, and political commitment among the many stakeholders inside and outside government for controversial activities in highly contested areas like CSW and IDU. T*he HSPMP SAR appropriately foresaw the Project as the first phase of a long-term engagement, but the GOI and the Bank expected to accomplish too much in the limited period of a three-year operation.

6.6 *The Indonesia HSPMP experience underscores the country specificity of decisions on institutional roles and responsibilities and the need for analysis of institutional options*. In Indonesia, the Bank staff chose to focus their work on strengthening HIV/AIDS institutions in the health sector by creation of an MOH Program Management Unit, rather than a more simple Project Implementation Unit. Given the growing importance of sexually transmitted diseases (STDs) in the country and their importance as a vehicle for addressing HIV issues, the choice of focus on the MOH was appropriate. The National AIDS Commission was too weak, institutionally and politically, to be lead interlocutor. However, the institutional arrangements within the

MOH promoted by the project did not anticipate the duplication of roles and conflicts among units within the MOH, due in large part to weak institutional analysis at the time of project design.

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Annex A. Basic Data Sheet

INDONESIA HIV/AIDS AND STDS PREVENTION AND MANAGEMENT PROJECT (LOAN 3981)

Key Project Data *(amounts in US$ million)*

	Appraisal estimate	*Actual or current estimate*	*Actual as % of appraisal estimate*
Original commitment	24.8	4.51	18.1
Total cancellation		19.80	
Total project cost	35.20	5.54	15.7

Project Dates

	Original	*Actual*
Appraisal		08/15/95
Board approval		02/27/96
Signing		03/29/96
Effectiveness	05/15/96	05/15/96
Closing date	09/30/99	09/30/99

Staff Inputs (staff weeks)

	Actual/Latest Estimate	
	N° Staff weeks	*USUS('000)*
Identification/Preparation	24.2	113.5
Appraisal/Negotiation	17	57.3
Supervision	54	150.3
ICR	8.4	13.5
Total	103.6	334.6

Mission Data

	Date (month/year)	No. of persons	Specializations represented	Performance rating	
				Implementation progress	Development objective
Identification/ Preparation	October 1994	4	1 Population & Health Specialist, 3 consultants, HIV/AIDS and STDs	S	S
	February 1995	4	1 Economist, 1 Population & Health Specialist, 2 consultants, HIV/AIDS and STD	S	S
Appraisal/Negotiation	July 1995	2	1 Economist, 1 Population & Health Specialist	S	S
	October 1995	4	1 Economist, 1 Population & Health Specialist, 1 Public Health Specialist, 1 FMS	S	S
	January 1996	5	1 Economist, 1 Population & Health Specialist, 1 Operations Analyst, 1 Senior Counsel, Legal Department, 1 Disbursement Officer	S	S
Supervision	September 1996	2	1 Economist, 1 Population & Health Specialist	S	S
	January 1997	2	1 Economist, 1 Population & Health Specialist	S	S
	September 1997	2	1 Economist, 1 Population & Health Specialist	U	S
	June and July 1998 (no site visit)	3	1 Economist, 2 Population & Health Specialists	U	U
ICR	April 2000	3	2 Public Health Specialists, 1 Project Management Consultant	U	U

Annex B: List of People Met

Adiotomo, Dr. Sri Moertiningsih	Special Advisor, Coordinating Minister for People's Welfare
Aditya, Ms. Baby Jim	AIDS Activist, Partisan Club, Jakarta
Ahmadi, Dr. Umar Fahmi	Director General, Communicable Disease Control and Environmental Health, Ministry of Health, Jakarta
Argadiredja, Dr. Dadi S.	Secretary General, Ministry of Health, Jakarta
Atmawikarta, Dr. Arum	Bureau Chief for Health and Community Nutrition, National Development Planning Agency (BAPPENAS), Jakarta
Bahaudin, Dra. Nasirah	Chief, Division for International Cooperation, Bureau of Planning, Ministry of Health, Jakarta
Borowitz, Dr. Michael	Sr. Health Specialist, East Asia and Pacific Region, World Bank, Washington
Bottini, Mr. J. Victor	Community Development Specialist, Social Development Office, World Bank, Jakarta
Dasgupta, Mr. Aniruddha	Sector Coordinator, Infrastructure, World Bank Country Office, Jakarta
De Tray, Mr. Dennis	Country Director for Tajikistan, and former Country Director for Indonesia, World Bank Country Office, Jakarta
Dharmaputra, Dr. Nick	Center for Health Research, University of Indonesia
Djoerban, Prof. Zubairi	Medical oncologist and medical director, Yayasan Pelita Ilmu, an NGO that benefited from IBRD AIDS Project and other donor support
Gingerich, Ms. Molly	Director, Office of Health, Population, and Nutrition, USAID, Jakarta
Go, Dr. Harry K-D	Team Leader, Sr. Implementation and Procurement Specialist, Procurement Review Unit, Second Provincial Health Project, Departement Keschaftan RI, Jakarta
Hofman, Mr. Bert	Lead Economist, Indonesia Country Office, World Bank, Jakarta
Hohnen, Ms. Janet I.	Sector Coordinator, Human Development, Indonesia Country Office, World Bank, Jakarta
Holzschneider, Ms. Silvia	Consultant, Human Development Unit, World Bank Country Office, Jakarta
Jalil, Mr. Fasli	Director-General, Ministry of Education (formerly Chief of Social Welfare, Nutrition, and Health Bureau, National Development Planning Office BAPPENAS), Jakarta
Kartowistro, Dr. E. Iswandi	Population and Health Consultant, Insetra Consultama, Jakarta
Koek, Ms. Irene M.	Chief, Infectious Disease and Environmental Health Division, Bureau for Global Health, USAID Washington (formerly of USAID Jakarta Mission)
Komala, Ms. Leila Retna	Deputy Chairman for Human Resources and Cultural Affairs, National Development Planning Agency (BAPPENAS), Jakarta
Kuntari, Ms. Sri	Social Development Specialist, Social Development Office, World Bank, Jakarta
Kurniawati, Ms. Ratna	HIV/AIDS Team Leader, USAID/HPN, Jakarta
Lazzari, Dr. Stefano	Epidemiologist, WHO Headquarters, Geneva; formerly Advisor, World Bank-financed HIV/AIDS Project, Jakarta
Lieberman, Mr. Samuel	Lead Health Specialist, East Asia and Pacific Region, World Bank Country Office, Hanoi (formerly Task Manager, World Bank-financed HIV and STDs Management Project in Indonesia)
Linnan, Dr.Michael	Epidemiologist, Centers for Disease Prevention and Control, United States (formerly USAID-financed advisor in Indonesia)
Lubis, Dr. Imran	Project Management Specialist, Office of Health, Population, and Nutrition, US Agency for International Development (USAID), Jakarta (and formerly Manager, World Bank-financed HIVAIDS Project, Ministry of Health)
Mackay, Dr. Timothy	Director of AusAID Project, Jakarta (contractor comparable to FHI for

	USAID)
Mamahit, Dr. Endang R. Sedyaningsih	Researcher, National Institute of Health Research and Development, Communicable Disease Center, Ministry of Health, Jakarta
Marzoeki, Ms. Puti	Health Specialist, Indonesia Country Office, World Bank, Jakarta
Maw-Naing, Dr. Amaya	WHO Medical Officer STD/HIV/AIDS, World Health Organization Country Office, Jakarta
Mboi, Dr. Nafsiah	Consultant to National AIDS Commission (under Aksi Stop AIDS Project of USAID), former Member of Parliament, former Chair, UN Committee on Implementation of Convention on Rights of the Child
Onishi, Ms. Junko	Consultant, Kecamatan Development Project (KDP) Office, World Bank, Jakarta
Petersen, Dr. Georg	World Health Organization Country Representative, Jakarta (and former WHO/GPA Regional Advisor on AIDS in East Asia)
Pick, Mr. Billy	HIV/AIDS Advisor, Bureau for Asia and the Near East, USAID, Washington
Porter, Dr. Michael	Consultant, formerly head of the AIDS Unit, Asia Regions, World Bank
Riona, Mr. Pandu	Technical Surveillance, ASA Project, Ministry of Health
Saadah, Ms. Fadia	Sector Manager, Human Development Unit, East Asia and Pacific Region, World Bank, Washington
Siltanus, Ms. Fonny	STD/AIDS Subdirectorate, Communicable Diseases Control, Ministry of Health
Soekirman, Prof.	Professor of Nutrition and Chair, Board of Advisors, Koalisi Fortifikasi Indonesia (and Deputy Director for Human Development, BAPPENAS, at the time the IBRD-financed HIV/AIDS Project was prepared)
Soraya, Mr. George	Senor Municipal Engineer, World Bank Country Office, Jakarta
Steer, Mr. Andrew	Country Director, Indonesia Country Office, World Bank, Jakarta
Stout, Ms. Susan	Lead Monitoring and Evaluation Specialist, Global AIDS Unit, World Bank, Washington
Suharno, Mr. Djoko	Deputy Asst. for HIV/AIDS and Drug Abuse Prevention and Control, Coordinating Ministry for People's Welfare and National AIDS Commission, Jakarta
Sujudi, H.E. Dr. A.	Minister of Health, Jakarta
Usep, Mr.	Administrative manager, Yayasan Pilita Ilmu, an NGO that benefited from IBRD AIDS Project and other donor support
Utomo, Mr. Budi	Researcher, Population Council, Jakarta
Wibisono, Dr. Bing	National Professional Officer, HIV/AIDS/STI, World Health Organization Country Office, Jakarta (and MOH DG CDC officer when the IBRD project was prepared)
Wignall, Dr. F. Stephen	Country Director, Family Health International and Director, USAID Aksi Stop AIDS Project, Jakarta
Wilson, Ms. Jane	Country Coordinator, UNAIDS, Jakarta

Annex C: Timeline of Events for the HIV/AIDS and STDs Prevention and Management Project

Year	Events in Indonesia	World Bank Events
1985	AIDS study group formed by University of Indonesia and National Institute for Health Research (MOH).	
1987	First AIDS case identified, in foreign homosexual in Bali.	
1987	National AIDS Committee established by MOH, chaired by Director General of Communicable Disease Control and Environmental Health (DG CDC-EH).	
1988	▪ AIDS becomes a notifiable disease under MOH guidelines. MOH appoints Working Group on HIV/AIDS prevention, reorganized and expanded in 1989 by bringing in multisectoral and NGO representatives. ▪ HIV sentinel surveillance begins among sex workers in Jakarta and Surabaya. No HIV-positive cases found in either site.	
1989	The first AIDS Service Organization—the NGO Yayasan Pelita Ilmu — is established.	
1992	Mandatory HIV testing for transfused blood is introduced. By 1998, about 95 percent of transfused blood is screened for HIV. CDC Epidemiologist Dr.Michael Linnan, resident in Indoneisa, is lead author on the paper "HIV/AIDS in Indonesia: The Coming Storm." The paper states that all HIV epidemics inevitably follow the same course; it concludes that the Indonesian epidemic will follow the course of the HIV epidemic in Thailand.	AIDS enters WB policy dialogue with GOI authorities (SAR, pg. 91)
1992/ 1993	First HIV positive blood samples identified among blood donors. 8/533,865 blood bags HIV positive (0.0015 percent).	
1993		Box in a WB country economic study on Indonesia suggests that Indonesia has entered the AIDS epidemic's exponential growth phase, with the doubling time for the case load reaching less than one year and threatening to fall further.
1993/ 94	First HIV positive sample reported in sentinel surveillance; 3/52,870 sex workers tested positive for HIV (0.0057 percent).	
1994	▪ Presidential decree creates a National AIDS Prevention and Coordination Commission (NAC), including 14 Ministers, chaired by	

Year	Events in Indonesia	World Bank Events
	the Coordinating Minister for People's Welfare (May. The Commission does not meet)	
	▪ Comprehensive, multisectoral national AIDS strategy adopted, modeled on Indonesia's successful population control program BKKBN. The strategy espouses broad principles rather than specific programs, does not include focus on high risk groups among its basic principles, and is not financed (July) ▪ Bappenas and US CDC staff publish a paper (in a supplement – Vol. 8 - to the journal AIDS) predicting a "most likely" scenario of half a million HIV infections in Indonesia within 4 years. The paper states, based on personal communications with US CDC and WHO staff, that there were up to 50,000 HIV infections in Indonesia at end-1993 (July)	▪ WB project identification mission; 3 staff from US CDC participate (October). ▪ Initial Executive Project Summary (IEPS) for WB HIV/AIDS Prevention and Management Project. IEPS states that the number of HIV cases is projected to rise steeply to roughly 500,000 in 2000 and 700,000 in 2005, assuming effective prevention efforts are launched in the mid-1990s; if prevention programs are less successful in reducing infection risk, the IEPS projects a far steeper rise to 700,000 in 2000 and 1.2 million in 2005. Benefits of an early start on prevention cited in the IEPS include 200,000 fewer HIV cases by 2000 and 500,000 fewer AIDS cases by 2005. IEPS reports that "during the past few years, the Bank has drawn attention in discussions with planning and finance officials, to the adverse development impacts of an AIDS epidemic, and recommended decisive action." Project risks cited in IEPS are (a) spread of HIV so rapidly that public and private response mechanisms prove inadequate; (b) HIV initiatives will overwhelm GOI policies towards other health problems; and (c) possible difficulties in persuading different audiences to modify private behavior (December).
1995	Yayasan Spirita, an organization of people living with HIV, is formed.	▪ Project preparation mission on a "first, trial phase of a continuing program." Bank staff report "ownership of the project is very strong within the MOH," with "unequivocal endorsement" of the project concept and processing schedule (January). ▪ Appraisal of HIV/AIDS and STDs Management Project (October)
1996	▪ Behavioral surveillance among female sex workers, male and female factory workers and high-risk male groups (sailors and truck drivers) initiated in Jakarta, Surabaya and Manado. Factory workers are dropped from surveillance because reported risk behavior is so low, but surveillance among high-risk groups is repeated annually. ▪ Over 300 NGOs working or interested in the area of AIDS form an NGO Communication Forum (FKLOPA), chaired by Dr. Adhyatma, a former Minister of Health. ▪ Director General of CDC-EH issues a circular to provincial health Departments to promote 100 percent condom use in all prostitution localization areas.	▪ Approval of IBRD project (February). ▪ Effectiveness of IBRD loan for HIV and STDs Prevention and Management Project (May). ▪ Initial WB supervision mission finds the project to be "starting in a disappointing fashion" (September)
1997		▪ Second supervision mission reports PMU not in a position effectively to manage the project (January).
	▪ Financial crisis in Thailand spills over into Indonesia (July)	▪ PSR rates implementation progress and development objectives as satisfactory, project management as unsatisfactory (February). ▪ 3rd supervision mission rates project satisfactory on development objectives because of progress on some components. PMU still not staffed with specialists on surveillance, STDs, IEC and M&E. Follow-up letter sees failure to establish a functional PMU as main reason for unsatisfactory performance. If in a further six months rating remains satisfactory, Bank will seek to discuss possible restructuring or, if necessary, closure of the project (September).

Year	Events in Indonesia	World Bank Events
	▪ Indonesia seeks IMF assistance to confront financial crisis (October).	
1997/ 1998	Survey of HIV among 13,656 military recruits in 5 provinces. No HIV-positive cases found.	
1998	▪ Resignation of President Suharto (May)	▪ Meeting among USAID-financed HAPP Project staff, IBRD project staff and RSI staff on HIV/AIDS coordination. Meeting recognized a large number of areas of overlap, seemingly for the first time in a donor coordination meeting, and recommended follow-up actions (March). ▪ Supervision mission finds performance on action plan agreed in September 1997 to have been late and partial. Economic crisis has required decision makers to focus on the drug emergency and other immediate matters. Project still has no effective management structure and implementation arrangements. Staff concludes that BAPPENAS/MOH have decided to cancel $19.8 million from the HIV project and another $60 million or so from other Bank-funded health projects. PMU written comments on the draft of the mission's *aide memoire* state findings reflect a discontinuity and inconsistency on prior understandings. Comments continue that coordination with other donors is rejected, leaving PMU to manage only WB project and coordinate with HAPP project in N. Jakarta. Basic burden seen by PMU is short project life, planning assumption of an epidemic that does not happen, and contracts involving poor skill and management capacity of small NGOs (June-July). ▪ PSR concludes that the project's development objectives will not be achieved, and GOI and Bank have agreed on the cancellation of all or nearly all undisbursed funds. MOU between GOI and IBRD on portfolio restructuring in the face of economic crisis and tripling of problem projects from October 1997 CPPR to July 1 1998. Total cancellations of undisbursed loans amount to $1 billion, or 23 percent of loans outstanding and undisbursed. Of HNP operations, cancellations (including AIDS/STD loan) amount to $78.9 M, or 8 percent of total cancellations. Two of 8 projects in the sector were problem projects — Safe Motherhood (subsequently upgraded) and HIV/AIDS (August).
1999	▪ HIV prevalence in IDU sentinel site (Jakarta drug treatment center) is 16 percent, up from 0 percent in 1996 and 1997. ▪ MOH publishes *Healthy Indonesia 2010* perspective study with national health goals. The study is based on four pillars: (a) a "healthy paradigm" with emphasis on health promotion; (b) "professionalism," with emphasis on development of the country's health human resources; (c) a community managed health care program (JPKM); and (d) decentralization, with definition of boundaries, management guidelines and associated human resource policies.	▪ Closing of IBRD loan and cancellation subsequently of undisbursed balance (September). ▪ Completion of "External HIV/AIDS Assessment" by John Kaldor and Indonesian colleagues, financed under WB loan and published with USAID support in 2000. Assessment reported to be a valuable overview, with little, if any, impact (November).
1999/ 2000	Government budget for HIV set at approximately US$3.6 million.	
2000/ 2001	Government budgets for HIV/AIDS decreased to US$1.7 million for fiscal year 2000/2001.	
2000	▪ HIV sentinel surveillance among IDU records rise in HIV prevalence to 41 percent, from 16 percent a year earlier. Sentinel sites in Jakarta	* ▪ ICR review mission aide-memoire (draft) reports absence of comprehensive baseline data and final data collection makes objective evaluation of project outcome hard.. On project

Year	Events in Indonesia	World Bank Events
	prisons record HIV prevalence of between 12 and 18 percent, up from zero a year earlier.	management, AM concludes PMU duplicated STD directorate and this was source of "endless conflicts" throughout the project life (April). ▪ Local consultant report on project mgt as input to ICR points out that during project prep Bank had noted possible conflicts in PMU roles. PMU did not have power to provide leadership to other donor projects. Steering Committee proved ineffective in giving leadership. Report finds project deserves credit for securing regulatory support for NGOs in the future but that the institutional mechanism of GOI-NGO collaboration has yet to be proven over time. Little coordination with other donor project indicated by parallel work on syndromic approach. M&E consultant to PMU did not produce workable outputs. Day-to-day mgt marked by "sporadic and reactive impulses rather than systematic programming." Project did not fully utilize TA expertise. For most domestic consultants, participating units could not state whether products were satisfactory. Unclear consultant outputs reflected unclear scopes of work and lack of quality control by users. Bank supervision programming failed to follow appraisal schedule. Bank focused on superficial symptoms rather than fundamental problems of ambitious expectations, unrealistic targeting, incompetent mgt, and lack of LT mgt Advisor for PMU. Tense communication between Bank and PMU could have been lessened by understanding of "bureaucratic culture preferring collective and participatory approaches other than instructive methods." Bank involvement in technical matters such as SOPs developed with international support was considered inappropriate by MOH without demonstrating that it had comparable technical expertise available (May). * ▪ Implementation Completion Report (ICR) on HIV.AIDS and STDs Prevention and Management Project prepared by WB EAP staff finds project outcome unsatisfactory, quality at entry into the Bank's portfolio at the time of approval in 1996 satisfactory (June).
2002	▪ President Megawati calls first cabinet meeting on HIV/AIDS, followed by a second one in December 2003. She is out of the country at the time of this cabinet meeting (March). ▪ MOH leads national estimation process, in which estimates are made of the size of at-risk population and of HIV infection at the provincial level, with input from many sectors and NGOs. It is estimated that there are between 90,000 and 130,000 people living with HIV in Indonesia, around a third of the IDU. The estimates process is declared an international best practice by UNAIDS/WHO (October).	

Annex D. Key Project Performance Indicators

Outcome/Impact indicators

Indicator[19]	*Expected Reporting Frequency, as stated in SAR*[20]	*ICR Estimate*[21]
I. Goal: Improved Awareness and Behavioral change in Key Groups		
- Percent of CSWs seen by providers for STDs who: - can describe correct use of a condom according to standard guidelines, - can explain where and how they most recently obtained condoms - have a positive attitude toward consistent correct condom use	Quarterly	Data not available. Interview with a few CSWs during the ICR mission found good knowledge on where and how to obtain condoms, and positive attitude toward consistent condom use but actual use of condoms was highly dependent on the preference of clients.
- Percent of CS Ws in "lokalisasi" reached by project who report ever use of condom and use in last sexual act.	Yearly	In an assessment of syndromic approach training (1998) in district Kepri by NGOs at three "lokalisasi", one massage parlor and MCH clinic reported 50% ever use of condoms. From a Behavioral Surveillance Survey (BSS) conducted in two lokalisasis in Riau, on average 22% of CSWs reported 'always use' condoms, and 67% 'sometimes use' condoms, 54% reported use of condom in the last sexual act.
- Percent of persons by target group leaving group education sessions who: - can cite at least 2 means of STD prevention - state that HIV is a special type of STD; - state that a person can remain healthy for several years but still transmit the virus; - - express the importance of positive family attitudes toward a member with AIDS	Quarterly	Means of AIDS prevention (results from the same BSS): use sterile *needle* (65%), be faithful (62%), always use condom (77%).
- Percent of STD patients reportedly seeking care within 24 hours of noting symptoms	One day per month	Data not available.

19. Source: World Bank 1996 (SAR); no baseline or target values were given.

20. Source: World Bank 1996, Annex 4.

21. Source: World Bank 2000b (ICR).

Indicator[19]	*Expected Reporting Frequency, as stated in SAR*[20]	*ICR Estimate*[21]
II. Goal: Improved Knowledge and Skills of Health Providers		
- Percent of health workers trained in syndromic approach who, 6 months after training, can: - demonstrate appropriate use of flow chart - demonstrate how to use a condom - explain the importance of treating STDs as a way preventing AIDS	Every six months, beginning six months after first training workshops	Data not available.
III. Goal: Establish Effective Surveillance Mechanisms		
- Reported condom use with non-regular sex partners - Number of people aged 15-49 who reported condom use in most recent act of sex intercourse with a non-regular partner - Number of people aged 15-49 reporting sexual intercourse with a non-regular sex partner in the past month	Twice yearly	Data not available.
- Reported STD incidence (men) (reported episodes of syphilis in men aged 15-49 – past month) (men aged 15-19, surveyed)	Monthly	Data not available.
- Reported STD incidence (women) (reported women aged 15-24, positive for syphilis) (pregnant women aged 15-24)	Monthly	Data not available.
IV. Goal: Enhance Capabilities and Proficiency of Health Laboratory System		
-. Performance on bi-annual proficiency panel (competency report).	Every six months	30 out of 33 health and hospital laboratories covered by the Project conducted proficiency panel evaluation, regularly twice a year. 75% achieved maximum score.

Output indicators

Indicator[22]	*Expected Reporting Frequency, as stated in SAR*[23]	*Actual/Latest Estimate*[24]
IEC – BEHAVIORAL CHANGE		
- Number of group education sessions (packages) conducted by each province	Monthly	Data not available.
- Number of peer group education session conducted by each province	Monthly	18 batches in DKI and 223 batches in Riau. Monthly data on sessions were not recorded.
- Percent of health providers having received basic training in AIDS awareness and infection control by province	Monthly	Not included in ICR
- Number of educational materials printed and distributed by province by target.	Quarterly	Various media for general community, specific/closed community, adolescents/ students, high risk groups, health workers, religious group etc., consisting of 54,300 posters, 183,300 leaflets, 2,500 T-shirts, 5,000 modules, 75,000 handouts, 35,000 manuals, 100 fillers and 22 films, 38,000 stickers, 11,500 calendars, 12,500 booklets, 2,500 flipcharts
- Percent of factories/companies who have participated in educational programs (CEOs, managers, supervisors) who develop formal policies related to HIV/AIDS in the workplace	Yearly	There were occasions reported in Batam and Kepri districts, but not well recorded
- Percent of registered CSWs who have participated in at least one peer group education session within the past 3 months	Annual	Data not available
- Number of NGOs involved in implementing IEC activities.	Annual	64 NGOs
- Percent of schools reached by project that have organized peer group programs	Annual	Activities were reported, but data was not collected annually. No data recorded.
- Number of condoms distributed by each project management unit to NGOs providing IEC services	Annual	Distribution of condoms was reported but actual records were non-existent.
- Number of implementing agencies that have conducted focus group discussions or other activities to solicit feedback from those served by the NGOs	Annual	Number of agencies was around 23 from both provinces. Annual reports were not done
- Percent of implementing agencies who report at least 1 supervisory visit by PMU staff during past 6 months	Bi-annual	No report is available
BIOMEDICAL SERVICES		
- Number of syndromic approach training workshops conducted by province	Monthly	In Riau: 11 batches involving 330 health workers. In DKI: 30 batches involving 2,254 health providers

22. Source : World Bank 1996.

23. Source : World Bank 1996, Annex 4.

24. Source: World Bank 2000b.

- Number of condoms distributed by central province health department	Monthly	Not included in ICR
- Number of condoms distributed by health centers/clinics as a numerator (*sic*!, presumably percent) of number received	Quarterly	Survey was not done
SURVEILLANCE		
- Number of health workers trained in new surveillance methods	Monthly	2,520 persons in eight provinces.
- Number of supervisory visits made by central and provincial level [surveillance] staff	Monthly	No specific supervisory visits were executed.
HEALTH LABORATORIES		
Equipping Individual Facilities		
- Completion of Materials Checklist by each laboratory.	First year	22 provincial health laboratories and hospital laboratories completed the checklist.
- Completion of Readiness Report by each laboratory	First year	22 provincial and hospital laboratories provided reports, but only in the second year.
Assessment of Testing Capabilities		
- Completion of Knowledge Assessment (written).	First year	Some laboratories completed the assessment in the second year.
- Performance on Proficiency Panel of sera: a) ability to determine CD3/4/8 levels by flow cytometry b) ability to determine p24 levels c) ability to perform Cylymadia	Twice yearly	Carried out by laboratory of RSCM hospital, once a year. - Carried out by laboratory of RSCM hospital. - Carried out by 27 provincial health laboratories.
Final assessment of Preparedness		
- Visitation and completion of the Inspection Report.	Every year	Done every year.
Monitoring		
- Second year visitation and Inspection report	Second year	Done in the second year.

Annex E. An Overview of HIV/AIDS Epidemiology in Indonesia[25]

INTRODUCTION

This epidemiological overview focuses first on what was known about HIV, STI, and risk behavior in Indonesia in the mid-1990s. The overview then looks at how the situation has changed since that time, and looks for the impact of any interventions in Jakarta, an area in which several donors, including the Bank, intended to be active.

HIV AND STI IN INDONESIA IN 1995

Heterosexual Networking and STI Prevalence

The SAR describes high STI prevalence in the general population and in commercial sex settings, based largely on evidence from the port city of Surabaya. STI prevalence among nearly 1,900 sex workers surveyed in 1992-93 was 30 percent overall, with substantial differences between sex workers of different classes.[26]

Among women in the general population STI rates were far lower. A study of antenatal clinic attenders in a low-income areas of Surabaya and Jakarta conducted by the same team in 1992-93 found that 8.2 percent of women in Surabaya were infected with chlamydia, 4-5 percent in both cities had trichomonas infection, and under 1 percent in both cities were infected with either syphilis or gonorrhoea.[27] Several studies in other parts of Indonesia had similar findings.[28] Truckers, sailors and laborers in Indonesia were also tested. Prevalence ranged from 2.1 percent for syphilis to 8 percent for trichomonas.[29]

The SAR describes these truckers, sailors, and laborers as being "drawn from and arguably representative of the general population not only in Surabaya but elsewhere in urban Java." However, general population studies by the same authors recorded very much lower levels of sexual activity. For example, 77 percent of the sailors in the study population reported recent visits to sex workers, 10 times the highest rate reported by any sub-population in the population-based survey.[30] In a more recent household survey only

25. This annex is based on analyses by Elizabeth Pisani for the OED case study of the Bank's HIV/AIDS assistance to Indonesia (Elmendorf, Jensen, and Pisani 2004).

26. Joesoef and others 1997.

27. Joesoef and others 1996.

28. For a comprehensive summary of study findings, see ROI/MOH and WHO 2000.

29. Linnan 1995.

30. Kambodji and others 1995. 4.7 percent of urban males reported ever having bought sex; that percentage fell to 2.5 percent for periurban men and less than 1 percent for rural men.

2.5 percent of the male population in West Java reported having sex with a sex worker in the last year.[31]

A population-based survey in East Java also found that non-commercial sexual networking was extremely low in the general population. Some 85 percent of single people in urban areas of East Java were not sexually active, and monogamy was the norm for sexually active men and women in both rural and urban areas. Just 16 percent of sexually active men (and 10 percent of all men) in urban areas reported having sex with more than one woman in their lifetime. That fell to 4.3 percent for sexually active men in peri-urban areas. Some 7 percent of urban women reported sex with more than one man in their lifetime, and in rural areas only 3 out of 692 women reported anything but abstinence or lifetime monogamy.[32] Close to 60 percent of the adult population in East Java and 55 percent nationally was classified as rural in the 2000 census. In the East Java city of Malang, a quarter of young men and one in 10 young women who were university students said they had ever had sex. The students' definition of "having sex" included masturbation and kissing and hugging.[33]

Given these findings, the assumptions about STI infection and sexual networking in the general population in the SAR appear high. This is important because a large part of the project benefits in the economic analysis centered on improving the treatment of STI as a means of reducing the transmission of HIV, and at least some of the service provision was focused on services reaching the general public, in particular women seen at MCH services. An overestimate of STI in the general population would lead to an overestimate of the likely spread of HIV, and also of the benefits of a program focusing on STI services.

Male-Male Sex

In the early 1990s, very little was known about men who have sex with men (MSM) in Indonesia. There was virtually no open gay scene, even in Jakarta, although foreign tourists created a demand for male sexual services in Bali.

The exception was among *waria*, transgendered males who frequently sell sex to heterosexually identified men throughout Indonesia. *Waria* sell both anal and oral sex; in anal sex they are frequently the receptive partner, but they also report selling insertive anal sex. Indonesian and foreign researchers had been studying risk behavior and HIV infection among waria in Jakarta since the early 1990s. Unprotected anal sex with multiple partners was the norm in this group; HIV infection rose from 0 in 1993 to 0.8 percent in 1995,[34] putting it higher than prevalence among female sex workers.

31. Riono 2001.

32. Kambodji and others 1995.

33. Kambodji and Linnan 1995a.

34. Lubis and others 1997.

Injecting Drug Users

Equally little was known about injecting drug users in Indonesia. A 1994 study in Surabaya estimated that there were at least 2,500 IDU in the city at that time.[35] Of 100 drug users surveyed, 41 were IDU, almost all male. Forty percent of them reported knowing more than 10 other IDU, and 63 percent reported sharing needles. Actual levels of sharing were probably higher because the question as asked did not encompass all types of previously used needles. All of the IDU reported multiple sex partners; one in five said they had used a condom sometime in their lives, but none used a condom at last sex. HIV prevalence was zero, and hepatitis B was 12 percent. In a paper published in 1994, Jalal and colleagues report evidence of drug injection in sex workers and others, concluding that "injecting drug use may be greatly underestimated." By the mid-1990s, Jakarta's only drug treatment hospital, Rumah Sakit Ketergantungan Obat (RSKO), was seeing 2,000 outpatients a year, and the proportion who were injectors was rising (RSKO, personal communication). The experience of several other countries, including Thailand, had shown that HIV prevalence among IDU can rise extremely quickly and can contribute to developing a critical mass of infection that can seed a wider heterosexual epidemic. However neither the Indonesian authorities nor their development partners expressed concern at the time over these early warning signs of growing drug injection. The projections used in the economic analysis of the SAR did not take drug injection into account, and no pilot prevention activities were planned for injectors.

HIV Surveillance Data

In Indonesia as in every developing country, HIV case reporting greatly understates the true magnitude of the epidemic. For this reason that the WHO and UNAIDS recommend sentinel surveillance for HIV — the anonymous testing of specimens collected from groups at risk during routine service provision. The material below summarizes the main findings from the national sero-surveillance system in the early 1990s.

Table E2.HIV prevalence data from national surveillance, 1990-1994/5

Year	*Population*	*Number tested*	*Number positive*	*HIV Prevalence (percent)*
1990	Female sex workers	4,420	0	0
1991/92	Female sex workers	20,293	0	0
1992/93	Female sex workers	38,444	0	0
1993/94	Female sex workers	52,870	3	0.006
1994/5	Female sex workers	39,790	12	0.03
1993/94	Pregnant women	572	0	0
1994/5	Pregnant women	4,750	0	0
1992/93	Blood donors	533,865	8	0.002
1993/94	Blood donors	705,345	5	0.001
1994/5	Blood donors	748,813	17	0.002

35. Kambodji and Linnan 1995b.

In short, data from very active surveillance even in the high-risk groups found that HIV infection was extremely rare in Indonesia in the early to mid-1990s. Data from a very large number of blood donations suggest that, nationwide, a maximum of three Indonesian adults out of every 100,000 were infected with HIV. In the mid-1990s the Indonesian Red Cross, which conducts the screening, had no deferral criteria for high-risk individuals, and all positive blood samples were confirmed using Western Blot tests. In the five years from the start of surveillance in 1990 until 1995, HIV prevalence had not risen above 1 percent in any population in Indonesia. By comparison, HIV prevalence among sex workers in Thailand rose from 4 percent in 1989 to 30 percent by 1993.

THE EVOLUTION OF THE HIV EPIDEMIC IN INDONESIA SINCE THE BANK LOAN PROJECT

Data collection systems in Indonesia have improved greatly since the mid-1990s, when the Bank loan was prepared and appraised. This has increased our ability to understand the course of the HIV epidemic and the behaviors that drive it. HIV sentinel surveillance was expanded to include other sentinel groups such as IDU. Behavioral surveillance surveys (BSS) among high-risk sub-populations began in three cities in 1996. A further three cities were added in 1998, and the system was expanded to cover 16 cities in 13 provinces in 2002. One of the two areas in which the HSPMP and other donor projects were working, Jakarta, has been covered by this system since its inception.

Heterosexual Risk Behavior Continues Unchanged

The efforts of the government and its development partners to increase condom use in commercial sex and to improve the treatment of sexually transmitted infections appear to have had very little effect throughout the late 1990s. BSS data show that the proportion of sailors buying sex in Jakarta dipped during the economic crisis of 1998/99 but otherwise changed little, showing a slight but statistically significant downward trend from 57 percent in 1996 to 43 percent in 2002. Condom use among sex workers and their clients in Jakarta was constant or declined during this period (see Figure 1 of the main text) and STI prevalence actually rose among sex workers (Figure E1).

Box E1. Projections of HIV Infection in Indonesia

Modeling HIV epidemics is notoriously difficult, especially in the early days of an epidemic and where reliable data on the behavioral parameters that drive an epidemic are not available. However, projections are needed to demonstrate potential infections averted, if a classic cost/benefit analysis of an investment in HIV prevention is to be made.

In the early 1990s, two models were used to project the HIV epidemic in Indonesia — EpiModel and iwgAIDS. EpiModel is a curve-fitting program which was designed not to make forward projections, but rather to compute, using information about the natural history of HIV infection, the likely number of cumulative HIV infections, AIDS cases and deaths implied by a given level of current prevalence. In the opinion of leading epidemiologists: "Models that use epidemic curves, such as EpiModel, should not be used in situations where extensive spread of HIV has not been documented." [a]

EpiModel was used in Indonesia in 1994 to make projections described in Jalal and others (1994). The paper predicted that "it is most likely that Indonesia will have half a million infections within 4 years (on the basis of WHO/CDC EpiModel projections)." The parameters of the model are not given, but one of the data points through which the curve was drawn was an estimate of current HIV infections nationwide of between 40,000 and 50,000 (attributed to a personal communication from G. Loth and M. Linnan). This is 10 times the number of infections used by UNAIDS in their Indonesian models, and 233 times the reported HIV infections. It is over 3,400 times the number of infections found in HIV surveillance among 40,000 sex workers in that year; the sex workers tested represent around a seventh of all those estimated to be working in Indonesia at the time. Even using this data point, the epidemic would have had to grow twice as fast in Indonesia as it had in any other country to produce the numbers infected predicted by Jalal, and others.

The other model used in making projections for Indonesia was iwgAIDS. Developed by Stephen Seitz at the University of Illinois, it models demographic processes, sexual mixing dynamics, and the force of infection. This complex model was structured on African epidemics, and requires very detailed behavioral and biological inputs. In the opinion of a number of modeling experts, it is ill suited to Asian epidemics, which are concentrated in high-risk sub-populations, including injection drug users and MSM.[a] Attempts to use the model in the data-rich environment of Thailand were abandoned in the mid-1990s.

The use of the iwgAIDS model in the Indonesian context appears to have been based on a belief that the HIV epidemic would follow the same course in all countries.[b] In addition, the Indonesian model appears to have been parameterized on Thai data.[36] In Thailand, HIV infection in direct sex workers escalated from 4 percent to 30 percent in just four years, while in Indonesia it remained consistently below 1 percent even in the epidemiological "hot spots" of Jakarta and Batam over the same period. Survey data available in the mid-1990s give some clue as to why. Consumption of commercial sex is around 10 times more common in Thailand, while Thai direct sex workers serve 4 times as many clients as their Indonesian colleagues. This strongly suggests that the use of Thai parameters would yield unreliable projections in the Indonesian context.

The model results in the economic analysis of the SAR predicted that in the absence of the project, 17,500 people in Jakarta would be living with AIDS and 105,500 would have died of AIDS by 2010, while 140,000 would be living with HIV. The 3,000 cumulative AIDS cases the model predicts for Jakarta in 1995 compares to fewer than 40 cases ever reported in the city at that time. Some 8,500 people were projected to be living with HIV in 1995 — 0.15 percent of the adult population. This compares with HIV prevalence in close to 150,000 blood donors recruited without deferral in Jakarta of 0.001 percent. By 2010, it was projected that HIV prevalence would escalate to 2.5 percent of the projected adult population.

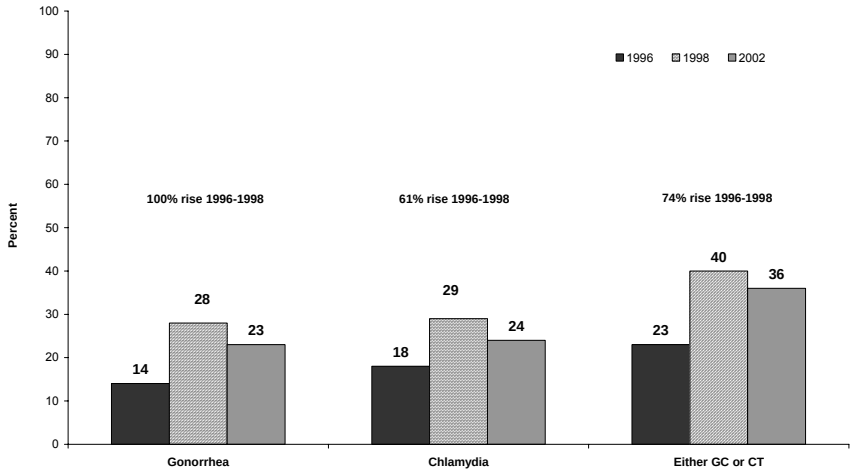
The internal consistency of the model results is poor. In the absence of war or other cataclysmic events which greatly increase adult mortality, the difference between cumulative HIV infections and current HIV infections would be expected to be roughly equal to the number of AIDS deaths. In the models published in the project appraisal, there are as many non-AIDS deaths among young HIV-infected adults as there are AIDS deaths. Such dramatic internal inconsistencies are a strong signal that the model outputs are unstable.

Because EpiModel, iwgAIDS and other existing packages fail adequately to describe concentrated epidemics with a variety of sub-populations at risk as they have developed in Asia, the UNAIDS reference group on HIV estimates and projections recommended the development of a more appropriate model. The Asian Epidemic Model (AEM), developed by Wiwat Peerapatanapokin and Tim Brown of the East West Center, is a curve-fitting model with a significant number of behavioral parameters, which builds a picture of the national epidemic from sub-epidemics in specific sub-populations. It has been parameterized for Jakarta using data available to the end of 2003, and is used in generating some of the projections in this Annex.

a. MAP 1997. b. Linnan 1992.

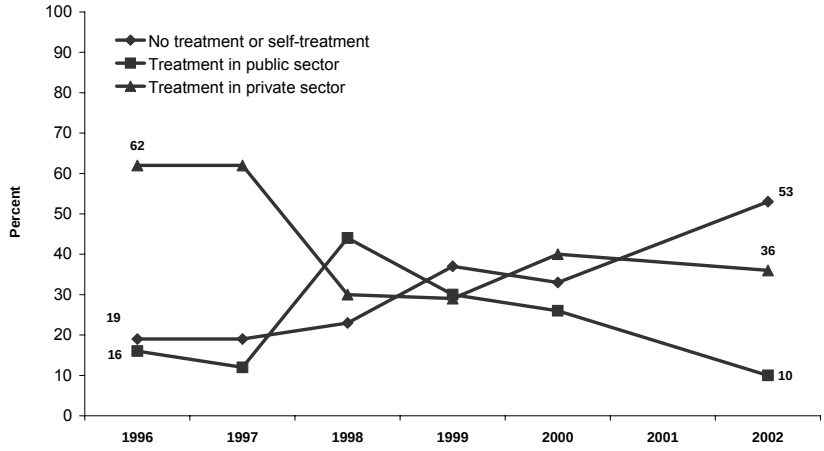
36. The parameters have not been published and repeated requests to the authors of the models for information about input parameters have gone unanswered. Two epidemiologists who were asked to contribute data recall that most of the input parameters used derived from Thai data.

Figure E1: Significant Increase in STI Prevalence Among Sex Workers in Jakarta



Source: Pisani and others 2004; Sedyangingsih-Mamahit, E. and S. Gunawan. 2000.

Figure E2: Only One in Ten Jakarta Sex Workers Seeks STD Treatment at Public Sector Facilities



Source: BSS data

More than half of sex workers with an STD self-treat or seek no treatment. There was a spike in use of public sector services during the crisis years of the late 1990s, probably because these services were more affordable than the private doctors who had been the norm until then (Figure E3). More recently, only 1 in 10 of those reporting STD symptoms reported that they went to a public sector clinic for care in 2002, similar to levels of public service consultation before the East Asian crisis. Those using public services tend to choose hospitals — the proportion using MCH or Puskesmas services was consistently low in all years. Similarly, around half of the men reporting STD

symptoms self-treat or seek no treatment, while the share using public services has fluctuated under 25 percent in all years, dropping to just 13 percent in 2002.

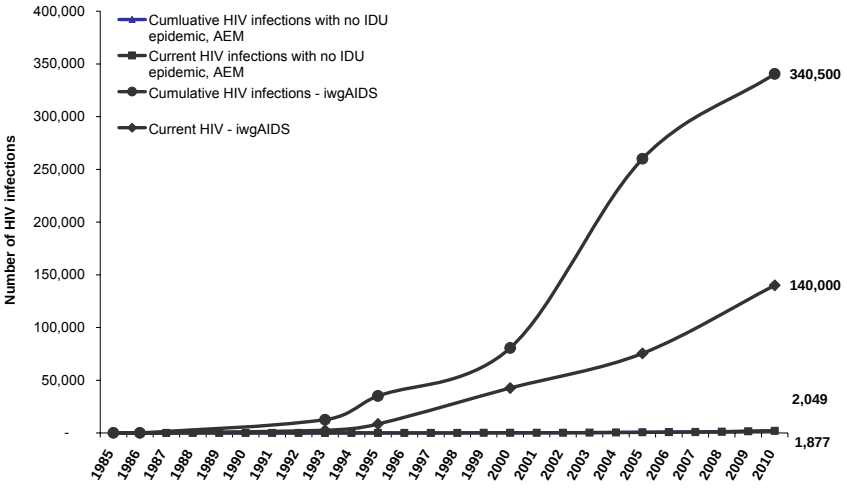
These data come from those who report symptoms. In the 1998 STI survey among sex workers, only 28 percent of those who tested positive for either chlamydia or gonorrhoea reported having experienced any recent STI symptoms. This means that the proportion of those infected who are not receiving medical attention is higher still.

These data suggest that STI strategies that focus on improving services in public sector facilities to which infected people are expected to self-refer have not been successful in Jakarta.

HIV Prevalence Among Sex Workers in Indonesia

Despite the failure of prevention programs to reduce risk behavior, HIV prevalence remained consistently low among sex workers in most areas of Indonesia throughout the 1990s. Because the supply of female sex workers is large, the turnover of women is high, and the frequency of commercial sex among clients is low, Indonesian sex workers have few partners in their commercial lives relative to their colleagues in, for example, Thailand. In addition, circumcision among men is almost universal. These factors combine greatly to limit the likelihood of a rapid rise in HIV infection among sex workers in the absence of any other "seed" factor. It is not possible to recalibrate the iwgAIDS model used for projections in the early 1990s with the data on sexual behavior now available, but the Asian Epidemic Model (AEM) can be used to make comparative projections. If one assumes, as the projections prepared for the SAR did, that injecting drug use will not assume a major role in the epidemic, uses parameters on sexual networking in the general population drawn from studies in East Java in the early 1990s, and adds parameters from the sex industry that only became available in behavioral surveillance from 1996, one can look at the expected development of the HIV epidemic in Jakarta.

Figure E3: The iwgAIDS Model in the Early 1990s Overestimated HIV Spread by Commercial Sex, in the Absence of an IDU Epidemic



Source: iwgAIDS and AEM models.

That seed factor was provided by the HIV epidemic among IDU, discussed below. The interaction between drug users and sex workers was the probable cause of the rise in HIV infection among sex workers that began in around 2000 — the year HIV prevalence first exceeded 5 percent among sex workers in any site. By 2003, HIV prevalence among sex workers exceeded 5 percent in a number of sites around Indonesia, but sites with no infections also remained common, sometimes in the same city. In Jakarta, HIV prevalence among sex workers ranged from 1.2 percent to 6.8 percent in different sites in 2003 surveillance.

Male-Male Sexual Risk Expands as Society Liberalizes

Surveillance among waria in Jakarta stopped in 1997, although the 6 percent prevalence recorded that year made this the most affected group in the country at that time. It was resumed in 2002. Condom use at last anal sex with a client rose slightly over that period, but consistent condom use remained low. The consequence was a rapid rise in HIV infection among waria, to 22 percent in 2002.[37]

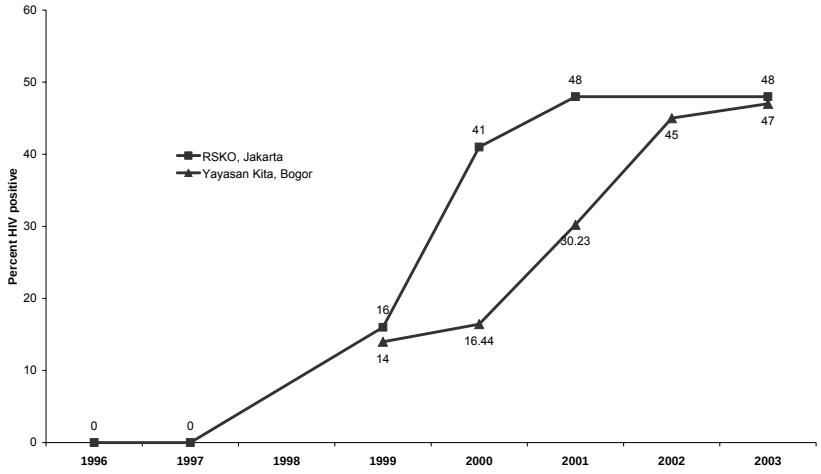
The social liberalization that occurred in urban areas in the late 1990s saw the emergence of an increasingly active gay scene. A number of cities opened bars and nightclubs where men gather to meet other men, often potential sex partners. In addition, a male sex industry (distinct from the transgender sex industry) developed in many cities. In Jakarta in 2002, men provided sex services to male clients in around 70 massage parlors, and freelance sex workers also worked in a number of cruising areas. Behavioral surveillance among male sex workers and other men who have sex with men in Jakarta, Batam (Riau), and Surabaya recorded very high levels of unprotected anal sex, despite quite high levels of awareness about HIV. HIV surveillance was conducted only in Jakarta — some 3 percent of male-identified sex workers and other MSM were infected with HIV.

HIV Explodes among IDU

The most significant development in the HIV epidemic in Indonesia has been the explosive growth of HIV among injecting drug users. This group has been included in sentinel surveillance in Jakarta since 1996, but HIV was first found in 1999, by which time 16 percent of injectors were infected. Just two years later, close to half of injectors tested positive, and similar rates were recorded at treatment centers in West Java, as Figure E4 shows.

37. Pisani and others 2004.

Figure E4: HIV Prevalence Rose Very Rapidly Among IDU in Java



Until 1998, less than 1 percent of AIDS cases seen at Jakarta's Rumah Sakit Cipto Mangunkusomo, the reference hospital for HIV treatment, were IDU. In 1999 that shot to 9 percent and has continued to rise since.[38]

Indonesia's Prisons — Possible Breeding Grounds for HIV

The prison system has emerged as a special concern in Indonesia's HIV epidemic. HIV surveillance in prisons has shown very rapid rises in prevalence in prison populations — more than one prisoner in four is now infected with HIV in more than one province. An early assumption was that rising prevalence among prisoners merely reflected rising prevalence among IDU, since drug offenders make up a significant and growing proportion of the prison population. But recently the surveillance system has picked up evidence of transmission within prison. This is probably related to ongoing injection in prison, as well as anal sex between inmates. Since prison terms are typically short, with around a quarter of prisoners incarcerated for just three months, infection in jail carries the extra danger that a prisoner will be released while in a stage of high viraemia. If he resumes sexual activity or injecting on release, the likelihood of onward transmission is high.

Putting it Together: The Actual Course of the Epidemic

With the benefit of hindsight, greatly improved data sources, and more appropriate modeling software, it is possible to recreate with some accuracy the path of the epidemic in Jakarta, and to project it forward with greater confidence. The evidence of the surveillance system together with the results of this exercise show that HIV prevalence began to escalate significantly in the early 2000s, driven very largely by a new epidemic in IDU. The take-off point for the epidemic was about five years later than that predicted

38. Sedyangingshih-Mahamit and Gunawan 2000.

by iwgAIDS, which predicted an early and rapid rise despite the fact that it included only limited transmission among drug injectors.

Figure E5. The Actual Course of HIV in Jakarta with an IDU Epidemic Was Delayed, With Fewer Infections Than Earlier Projections Based on Spread by Commercial Sex

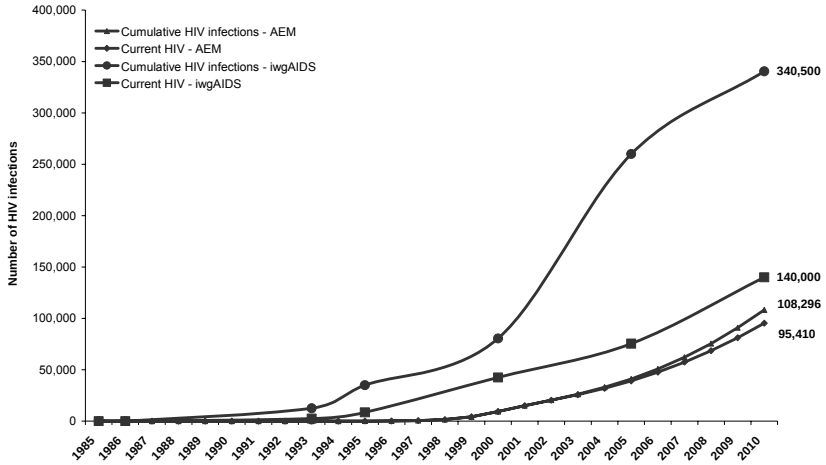


Figure E5 compares the outputs of iwgAIDS projections made in 1995 and AEM projections fitted to prevalence recorded in all sub-populations at risk and in the general population until mid-2003. By 2010, current HIV prevalence was 50 percent lower than predicted by iwgAIDS and cumulative infections were one-third predicted levels. The similar levels of current HIV infection predicted by AEM by 2010 cannot be understood as a validation of the iwgAIDS projections, since that model did not foresee the contribution of injecting drug use to the sexual as well as the non-sexual epidemic. Because IDU in Jakarta are overwhelmingly young men and injection is a recent phenomenon, rates of sexual activity are high. A quarter of male IDU reported in behavioral surveillance in 2002 that they had had sex with a female sex worker in the last year. The sexual interaction between IDU and other high-risk groups has provided a "booster" effect that has created a critical mass of infection in the commercial sex sector and thus had a major impact on the unfolding epidemic. While only around one-third of infections projected by AEM for 2010 will be in IDU, most of the other two-thirds are sexual infections that originated at some stage with an infection transmitted by needle-sharing. As Figure E3 showed, had there been no HIV epidemic among drug injectors in Jakarta, a sexual epidemic would not have developed by the end of the first decade of this century.

Leaving aside models, there is little evidence from surveillance, case reporting, or special studies that HIV is spreading widely among people who do not engage in definable risk behaviors and their primary sex partners. The exception to this rule is the country's easternmost province of Papua, where estimates made at the district level at the end of 2003 suggest that HIV already exceeds 1 percent in the general population.

In late 2002, the MOH led an estimation process that began by estimating the size of each at-risk population in each province, estimating prevalence within each of those

populations, and then aggregating into a national total. This process, validated by WHO and UNAIDS, estimated that 90,000-130,000 Indonesians were living with HIV at the end of 2002.[39] The process was repeated in early 2004, but at that time estimates for around a third of the epidemiologically more important provinces were made at the provincial level, using data collected at the district level. The resulting estimate was in the same range as the 2002 estimate, but the composition of populations was rather different. With improved data sources it was found that the number of clients of sex workers had previously been overestimated while infection rates in men who have sex with men were also too high. Infection rose among IDU and their sex partners.

39. Republic of Indonesia 2003.