



**Evaluation of the World Bank's
Assistance in Responding to the AIDS
Epidemic:
Indonesia Case Study**

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Acknowledgments

The authors acknowledge the support and assistance of a large number of people, including the many interviewees listed in Annex A, and the staff of the World Bank Country Office in Jakarta. Comments on the first draft from other members of the OED evaluation team (Martha Ainsworth, Judith Hahn, Joan Nelson, Richard Skolnik, Judy Twigg, Denise Vaillancourt, Heinz Vergin) and editorial assistance provided by William Hurlbut are gratefully acknowledged. Responsibility for the report, however, lies with the authors.

Abbreviations and Acronyms

AAA	Analytic and advisory activities
ADB	Asian Development Bank
AEM	Asian epidemic model
AIDS	Acquired Immunodeficiency Syndrome
AM	<i>Aide-memoire</i>
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
BPOM	Food and Drug Control Agency
BPS	Central Bureau of Statistics
BSS	Behavioral Surveillance Survey
Bupati	District Chief
CAS	Country assistance strategy
CB	Capacity-building
CBO	Community-based organization
CDC	Centers for Disease Prevention and Control (US)
CDD	Community-driven development
CGI	Consultative Group on Indonesia
CPPR	Country portfolio performance review
CSO	Civil society organization
CSW	Commercial sex worker
DepKes	Ministry of Health
DfID	Department for International Development (UK)
DHS	Demographic and Health Surveys (USAID)
DIP	Investment budget item/allocation
DKT	Condom Social Marketing Agency
EAP	East Asia and Pacific Region (World Bank)
FDA	Food and Drug Control Agency
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)
HFA	Health-for-all
HIV	Human immunodeficiency virus
HNP	Health, nutrition and population
HRG	High-risk group
IBRD	International Bank for Reconstruction and Development
ICR	Implementation Completion Report
IDA	International Development Association
IDU	Intravenous drug user
IEC	Information, education, and communication
IHPCP	Indonesia HIV/AIDS and STD Prevention and Care Project (AusAID)
IMF	International Monetary Fund
IMR	Infant mortality rate

iwgAIDS	Inter-agency working group AIDS (epidemic model)
JSDF	Japan Social Development Fund (at World Bank)
KfW	German Development Agency
KPA	National AIDS Commission
KPAD	Provincial AIDS Commission
M&E	Monitoring and evaluation
Menko Kesra	Coordinating Ministry of People's Welfare
MOF	Ministry of Finance
MOH	Ministry of Health
MOU	Memorandum of understanding
MSM	Men who have sex with men
MTP	Medium term plan
NAC	National AIDS Commission
NAMRU	Naval research laboratory in Jakarta (US)
NGO	Non-governmental organization
OED	Operations Evaluation Department
PAD	Project Appraisal Document
PCR	Project Completion Report
PKBI	Planned Parenthood Association, Indonesia
PLWA	People living with HIV/AIDS
PSR	Project status report (IBRD)
PMU	Project management unit
Pukesmas	Publicly owned local health care facility
Repelita	Five-year development plan
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
TA	Technical assistance
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
WBI	World Bank Institute
WHO	World Health Organization
YPI	Yayasan Pelita Ilmu, an Indonesian NGO

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Executive Summary

This case study assesses the impact of the World Bank's assistance on Indonesia's national response to HIV/AIDS, and derives lessons from that experience, as one of four case studies for the larger OED evaluation of the Bank's HIV/AIDS assistance. It reflects events through early 2004, at the time of the team's field mission to Indonesia.

The HIV/AIDS epidemic, until recently, was at very low levels in Indonesia. The first case of HIV was identified in a foreign homosexual tourist in Bali in 1987. Systematic sentinel surveillance of sex workers in Jakarta and Surabaya began in 1988. In 1993/1994, sentinel surveillance reported the first positive sample among sex workers and the first positive blood samples were identified among blood donors. Prevalence was still sufficiently low in 1997 that Ministry of Health (MOH) statistics refer specifically to a small number of cases in Irian Jaya as "Thai fishermen, who have since left the country," and this relatively small adjustment accounted for a significant share of all AIDS cases in the country at the time.

Projections of the possible course of the HIV/AIDS epidemic were generated by expatriate consultants and researchers beginning in the early 1990s. They did not take existing surveillance data as their starting point, were largely based on the sub-Saharan African and Thai experiences of the late 1980s and early 1990s, and showed rapid acceleration of the epidemic. In hindsight, the projection models were ill suited to the purpose to which they were put in Indonesia. Apparently based on these projections, the Bank staff reported that HIV appeared to be spreading at an increasing rate, and that HIV cases were projected to rise to roughly 500,000 in 2000 and to 700,000 in 2005, assuming that effective prevention efforts were launched during the mid-1990s. If prevention efforts were less successful, the model used by the Bank predicted that the number of cases would increase to an estimated 700,000 in 2000 and 1.2 million in 2005. This turned out to be dramatically wrong, as HIV prevalence barely increased through most of the 1990s. Since 1999, the HIV epidemic has emerged concurrently with an epidemic of intravenous drug use (IDU). IDU was rare prior to 1997, and has made a significant contribution to the HIV/AIDS epidemic. Without its contribution, more current projection models show virtually no epidemic taking place in Indonesia.

Prior to the AIDS epidemic and since its advent, 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 projects previous to its engagement on HIV/AIDS in the country in 1996. Nonetheless, much remains to be done to improve health services and outcomes. Compared to neighboring countries, Indonesia shows high infant and maternal mortality levels throughout the 1990s (including the period prior to the financial crisis), and UNDP data suggest that health indicators in Indonesia improved at a slower rate than would be consistent with Indonesia's per capita economic growth.

A \$24.8 million IBRD loan for the Bank-financed HIV/AIDS and STDs Prevention and Management Project was negotiated in January 1996. The project was designed to support behavioral interventions and to finance laboratory and testing support. Some of this was accomplished — more HIV screening among sex workers is one example. However, project execution was problematic from the outset. The Project Appraisal Document (PAD) sometimes budgeted substantial funds for expenditures that were unnecessary for Indonesia's situation. Clients at antenatal clinics were counseled about HIV/AIDS, even though HIV prevalence among married women was (and remains) virtually zero. Labs were equipped to speed processing, under the faulty assumption that supply bottlenecks were the cause of testing delays. Roughly 20 percent of the loan was programmed for test kits already in the possession of the government at appraisal. Many of the problems stemmed from a weak project management unit. Many also sprang from inappropriate project design, but these issues could have been handled by a more effective project management unit through reprogramming of the use of Bank funds. The projections should have been subjected to more searching scrutiny by specialists on HIV modeling. The failure of dire outcomes to materialize may have hurt political commitment as the project unfolded. The weaknesses in design and especially in project management led the project to be designated a problem project in the Bank's Indonesia portfolio only two years into its three-year planned execution. At the time of the East Asia financial crisis in 1997 and 1998, when the Bank's portfolio was restructured, 80 percent of the loan was cancelled. The HIV/AIDS project failed to achieve its development objectives, and was correctly judged by the EAP staff unsatisfactory at the implementation completion report stage.

The behavioral interventions of the Bank-financed project were to be implemented largely by NGOs. This required granting them tax-free status, and the collapse of an agreement with the Ministry of Finance (MOF) to facilitate NGO involvement in turn made this a lengthy process. Eventually, some NGOs did work on the project, but we found little evidence that NGOs new to HIV/AIDS work before working with the project have continued to work in this area. To a number of observers, the only meaningful contribution of the project was finally to gain acceptance of the idea and practice of government funding of NGOs for the provision of health services. The project may have helped to raise HIV/AIDS awareness at an early stage of the epidemic. However, it did so in alarmist fashion, and there appears to have been a period of complacency, perhaps backlash, during project implementation.

Except for the cancelled loan, there has been little HIV/AIDS-specific activity by the World Bank in Indonesia. Since 1999, the epidemic within intravenous drug users (spreading to their sexual partners) has helped fuel a growing sense of urgency regarding HIV/AIDS. Little if any of this increase can be attributed to Bank activities, as until very recently the Bank has hardly been involved in AIDS-related dialogue or programs since the close of the HIV/AIDS loan.

On net, the impact of the Bank on the progress of the HIV/AIDS epidemic in Indonesia has been minimal. The most direct intervention, the HIV/AIDS and STDs Prevention and

Management Project, accomplished little before most of the loan was cancelled. Outside of that loan, there have been some very informal high-level contacts between Bank staff and government officials that may have helped to raise awareness. However, given the nature of the epidemic at that time, the lack of information about its course, and the demonstrated lack of response by the government, it is difficult to attribute any impact to the Bank on this score. The funding mechanisms for NGOs are in place, and one lasting result may be the relative ease of incorporating civil society in future Bank-funded health and AIDS work in Indonesia.

The Indonesian case underscores the essential tension between early (and cost-effective) intervention and intensity of commitment. This tension was heightened by the unwillingness of the Government of Indonesia to focus resources on the social periphery, at appraisal, during the early stages of project implementation, and especially as health resources were stretched to the breaking point by the financial crisis. Commitment also may have been diminished by the nature of the project relative to needs perceived by stakeholders. In a context where little is known about the extent of the epidemic and the behaviors that spread HIV, as was the case in Indonesia in the early to mid-1990s, more appropriate interventions would have aimed at increasing public health monitoring and surveillance capabilities and behavioral studies. As understanding of the nature of the epidemic and the behaviors that spread it increased, this information could have been used for evidence-based advocacy and policy dialogue to create an environment that would support effective work with groups at risk for HIV.

1. Introduction

EVALUATION OBJECTIVES AND CONCEPTUAL FRAMEWORK

1.1 The objective of this case study is to evaluate the impact of the World Bank's assistance on Indonesia's national response to HIV/AIDS, and to derive lessons from that experience, as one of four case studies for the larger OED evaluation of the Bank's HIV/AIDS assistance presented in an OED Design Paper.¹ For present purposes, the Bank's assistance includes policy dialogue, analytic work, and lending. Indonesia was the recipient of a World Bank loan for HIV/AIDS and STD prevention and control (1996-99), and much of this case study addresses the impact of this project on measurable HIV/AIDS outcomes. However, we also address more broadly the impact of the totality of World Bank assistance, including the Bank's country assistance strategy (such as its response to the East Asian crisis) and the overall lending portfolio and dialogue, on the GOI response to the epidemic.

1.2 A key concern is the development effectiveness of Bank work in Indonesia in relation to HIV/AIDS. Consistent with OED evaluation criteria, "development effectiveness" is defined in terms of relevance, efficacy, efficiency, and institutional development impact:

- **Relevance:** Did the Bank "do the right thing" in its HIV/AIDS-related assistance to Indonesia? Was the Bank's strategy appropriate to the epidemiological situation? Was it well thought-out and documented? Did it take into account local political and institutional constraints? Did it take into account current Bank country and sectoral strategies? Did it take into account the work of other agencies and its own comparative advantages?
- **Efficacy and Efficiency:** Did the Bank "do things right"? Was the Bank's assistance to Indonesia effectively and efficiently implemented for achievement of the objectives agreed between the GOI and the Bank? Why or why not?
- **Institutional Development Impact:** This is the extent to which the Bank's HIV/AIDS assistance has enabled the country 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.

1.3 A second set of more narrowly defined questions relates to seven key evaluation issues elaborated in the Design Paper concerning: government commitment; strategic choices; the relation between HIV/AIDS policy and the health system; multi-sectoral responses; the use of NGOs; monitoring and evaluation; and impact on behavioral and epidemiological indicators.

1. World Bank/OED (2003).

METHODS

1.4 We have adhered to the analytic framework and methodology set out in the Design Paper. The sources of data (both quantitative and qualitative) included:

- **A literature and document review** (that incorporated research, policy studies, previous evaluations, government documents, World Bank documents and files, and documents of other donors) on the HIV/AIDS epidemic in Indonesia, the Indonesian government's response, and the response of the Bank and other key actors with respect to the Indonesian AIDS epidemic.
- **Assembly and analysis of available data** (epidemiological and behavioral data, surveys, government and donor expenditure — including the Global Fund, service delivery data, data on NGO activities).
- **Interviews with key stakeholders** (Bank staff, government officials, other donors, UN agencies, NGOs and CBOs, civil society). Most interviews took place in the office of the interviewee, with two members of the study team, in Washington or in Jakarta, during the field visit of the team in January 2004. A few were held by phone or videoconference as travel or timing constraints required.

1.5 We briefly describe the epidemiological, cultural, political and institutional context of the HIV/AIDS epidemic in Indonesia, since this has had an important bearing on the government response. We also describe the context of Bank activity in Indonesia, and construct an inventory of World Bank assistance, government policies and programs, and activities of others as a basis for understanding the Bank's inputs in relation to those of others. Based on this inventory, we construct a timeline of key events shaping the Indonesian response to AIDS. Finally, we combine this information (and interviews with key informants) to compare the current situation with the counterfactual of no Bank activity in Indonesia, in order to assess the difference between Indonesia's actual response to HIV/AIDS and what might have occurred in the absence of World Bank involvement. The limited scope of Bank work on HIV/AIDS in Indonesia coupled with the nascent stage of the epidemic at the time that the Bank was actively involved in HIV/AIDS interventions severely constrain the possible contrast to be drawn between actual and counterfactual scenarios.

1.6 Two key empirical strategies are identified in the Design Paper for establishing the counterfactual — (i) use of the sequencing of events in the timeline to establish “plausible causality” and (ii) comparison of inputs, outputs and outcomes across sub-national units. It was not possible to make sub-national comparisons in the case of the Bank-financed HIV/AIDS project in Indonesia because of (a) lack of data; (b) limited implementation of the Bank-financed-project; and (c) engagement of the Bank and one other donor, USAID, in one of the only two provinces where implementation of Bank-financed activities occurred. A third strategy for establishing the counterfactual is to obtain the views of key informants as to what might have occurred and how events might have been different in the absence of the Bank's involvement. This strategy was critical in the present study.

2. Country Background and the Beginnings of the AIDS Epidemic

POLITICAL, SOCIAL, ECONOMIC, AND INSTITUTIONAL CONTEXT OF HEALTH IN INDONESIA

2.1 Under the New Order of President Suharto, Indonesia had a strongly centralized, military-dominated government. Economic growth averaged 7 percent per annum from 1979 to 1996. In 1970 per capita income in Indonesia was only two-thirds that of India and Nigeria. By 1996 it had become four and a half times that of Nigeria and almost three times that of India. The share of the population living below the official poverty line declined from 60 percent in 1970 to 11 percent in 1996. However, aggregate reductions in poverty masked variations within and across regions. Corruption has long been a problem in the country. Then and now, and with the possible exception of the environment, the country has lacked oversight mechanisms, and stakeholders have had limited rights to speak out.²

2.2 The Demographic and Health Survey (DHS) showed an infant mortality rate (IMR) of 67 in Indonesia in 1987. The Indonesian IMR declined to 46 in the 1997 DHS and 35 in 2002. While this represented a quite substantial decline, mortality still remained high compared to similar countries in the region. UNDP data suggest that health indicators in Indonesia improved at a slower rate than would be consistent with Indonesia's per capita economic growth. The UNDP Human Development Report for 1993 ranked Indonesia at 88 on real GDP per capita but 102 on its Human Development Index. Similarly, the maternal mortality ratio in Indonesia was 390 in the 1990s, whereas neighboring Philippines and Vietnam showed ratios of 208 and 105. The fundamental healthcare delivery unit is the publicly owned health center or *Puskesmas*. The *Puskesmas* are numerous (over 7,100 by the mid-1990s³) and widely distributed throughout the country. Ideally each *Puskesmas* is staffed by a physician, one or more nurses, a midwife, and perhaps a public health officer to handle vaccinations, and serves a population of about 30,000. Low utilization of publicly provided health care in Indonesia is explained in part by low levels of government funding and correspondingly low quality of care. With per capita annual public and private spending each of about \$7, Indonesia allocated less than 1.5 percent of GDP to health in the early and mid-1990s. This was less than China (3.8 percent, public spending \$9) or the Philippines (2.4 percent, public spending \$10).⁴

THE EARLY SPREAD OF HIV/AIDS IN INDONESIA

2.3 The first case of HIV was identified in a foreign homosexual tourist in Bali in 1987. Systematic sentinel surveillance of sex workers in Jakarta and Surabaya began in 1988. The first HIV-positive donated blood appeared in 1992. As of 31 December 1993, the Ministry of Health (MOH) had reported 193 HIV infections, of which 49 were AIDS cases (Jalal *et al.* 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 positive blood samples were identified among blood

2. World Bank (1999).

3. World Bank/EAP (2000a).

4. World Bank/EAP (2000a).

donors — 8 cases among 533,865 persons tested. In the same period sentinel surveillance reported the first positive sample among sex workers — 3 cases among 52,870 tested.⁵ HIV prevalence — the percent of the population infected with HIV — was still sufficiently low in 1997 that MOH statistics refer to a small number of cases in Irian Jaya as “Thai fishermen, who have since left the country,” and this relatively small adjustment accounted for a significant share of all AIDS cases in the country at the time.⁶

THE INITIAL INDONESIAN POLICY RESPONSE

2.4 As early as 1985, an unofficial working group of Indonesians were discussing HIV/AIDS in Indonesia. A small number of AIDS cases had been observed through the national reporting system, many of them foreigners, and public health researchers were also aware of the expansion of HIV in Africa. A National AIDS Committee (NAC) was formed in 1987. AIDS became a notifiable disease in 1988, and the MOH instituted unlinked, anonymous sentinel sero-surveillance the same year. A short-term plan for AIDS control was implemented with WHO Global Program on AIDS (GPA) assistance in four provinces seen as high risk (Jakarta, Bali, Jogjakarta and East Java), providing training to clinical and laboratory staff. Sentinel surveillance expanded to include nine provinces by the early 1990s, and screening of the blood supply expanded rapidly (Jalal *et al.* 1994).

2.5 A National AIDS Prevention and Coordination Commission, including 14 Ministers, was created in 1994, but it did not meet. An AIDS strategy modeled on Indonesia’s successful population and family planning program BKKBN was adopted. It espoused broad principles rather than specific programs, and did not include focus on high-risk groups whose behaviors put them at greatest risk of contracting HIV and spreading it to others. Its implementation was hardly financed, aside from two AusAID and UNDP projects.

2.6 Within the MOH HIV/AIDS was, and continues to be, the responsibility of the Directorate-General for Communicable Disease Control and Environmental Health (DG CDC-EH). Among its various services, DG CDC-EH has a Directorate for Directly Transmitted Diseases, including a Sub-Directorate responsible for HIV/AIDS, STI, and leprosy, and a Directorate of Epidemiology and Immunization. These Directorates have mainly policy formulation, standard-setting, and training and technical support responsibilities, with services provided increasingly on a decentralized basis through provinces and districts, since the political, economic, social, and institutional changes of the late 1990s. A separate Directorate-General for Medical Services and Public Health was responsible until recently for the administration of Indonesia’s publicly owned general hospitals and health centers. This brief organizational overview shows that, consistent with the low prevalence recorded in sentinel surveillance among high-risk groups until the early 2000s, HIV/AIDS and STDs have not received the organizational priority of a major epidemic or central public policy concern.

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

6. Republic of Indonesia, Ministry of Health tables contained in a January 1997 Bank memorandum.

2.7 For all its limitations, the sentinel surveillance system — focusing as was appropriate on groups at high risk and achieving relatively good geographic coverage with sample sizes large enough to provide robust results — compares well with surveillance in most countries (including many industrialized countries) at that time. While the quality of laboratory testing was called into question, studies conducted by foreign research institutions using foreign laboratories or the U.S. Navy-run laboratory in Jakarta (NAMRU) found results no different from those registered by the national surveillance system.

2.8 Projections of the possible course of the HIV/AIDS epidemic were generated by expatriate consultants and researchers (e.g., Linnan 1992). They did not take existing behavioral or surveillance data as their point of departure, assuming patterns of sexual mixing, STI prevalence and base HIV prevalence far higher than could reasonably have been extrapolated from data — including sentinel surveillance among high-risk groups — available at the time. The models were largely based on the African and Thai experiences of the late 1980s and early 1990s, and showed rapid acceleration of the epidemic. In hindsight, as is explained below and in Annex B, the projection models were ill suited to the advocacy purpose to which they were put in Indonesia.

CONTEXTUAL FACTORS AT THE TIME OF THE WORLD BANK LOAN

2.9 In 1994, a Presidential Instruction directed the formation of a multisectoral National AIDS Council (KPA) as well as Regional AIDS Councils (KPAD). These bodies were constituted largely on paper. They were not supported by budget allocations or secretariat staff, and many have never met to this day. Even Jakarta, which has a relatively active KPAD supported by the activities of a number of donors (including the World Bank), had allocated only 300 million rupiah (around US\$30,000) to fund the KPAD and its activities by 2002, 0.003 percent of the city's development budget. By comparison, the city spends around 4,300 times that much on the sex industry in a year, and 1,700 times that much on heroin (Author's estimates based on BSS data and 2002 street prices).

3. Timeline of World Bank Actions and Indonesia's National Response to HIV/AIDS

WORLD BANK INPUTS THROUGH 1995

The Involvement of the World Bank in Indonesian Health Prior to the AIDS Epidemic

3.1 Prior to the AIDS epidemic and since its advent, the World Bank has had a long, active, and largely successful engagement in health in Indonesia. Starting with a population project in 1972, by 1996 the Bank had financed 13 health, nutrition and population (HNP) projects, including water supply and sanitation in low income communities (see Annex C). Total financial commitments by the Bank for these projects amounted to \$638 million. Completion reports on these projects show a very positive record. The outcome of one of the projects was rated highly satisfactory, 10 were rated satisfactory, and only one marginally satisfactory. In addition to lending, the Bank has supported Indonesian health services with a substantial body of sector work. Five formal sector studies were completed prior to initiation of the Bank's involvement in HIV/AIDS lending. They addressed population and family planning issues, health planning and budgeting, and health workforce issues, but did not make HIV/AIDS or other communicable diseases a major theme (see Annex D).

3.2 The Bank's health sector strategy in Indonesia has evolved considerably over time, as health and other conditions in the country changed. As documented in the annexes, starting with an initial and extended focus on population projects, the work program gradually expanded to encompass nutrition and health services. When the HIV/AIDS and STDs Prevention and Management Project was initially proposed, in late 1994, the Bank had a two-pronged health sector strategy, to foster facility-level service delivery components through a series of province-based projects, and to fund complementary operations which build central capacity to perform rational policy setting, analytic, and technical assistance functions.⁷ Virtually all Bank HNP lending has concentrated on financing and provision of services by the public sector.⁸

Rationale, Objectives, and Strategy of the Bank on AIDS and Health in Indonesia: Early Policy Dialogue and Analytic Work

3.3 Discussions on HIV/AIDS by Bank staff with the Indonesian authorities started in 1992. The initial discussions occurred at a time when epidemiologists were focusing not just on the risk behaviors that spread HIV, but also on predictors of "vulnerability" — contextual factors such as poverty and migration thought to heighten the potential for an HIV epidemic. By these measures,

7. IEPS, December 22, 1994, para 10.

8. One of the Bank briefing notes in preparation for the new government to take office in the course of 2004 finds that the Health for All (HFA) strategy pursued by Indonesia is no longer effective in addressing the health needs of the country, and proposes to encourage the government to rethink strategy away from direct public provision to public purchasing. (World Bank Indonesia Country Team, Briefing for the Incoming Government, Concept Note (draft), nd.)

Indonesia was perceived to have the potential for a major HIV epidemic. Researchers from the U.S. Centers for Disease Control and Prevention (CDC) and a U.S. Naval Medical Research Laboratory (NAMRU) in Jakarta also played roles. Although sentinel surveillance in around 40,000 sex workers a year recorded only a handful of HIV positive samples, one article by key CDC personnel estimated that there were 40,000 to 50,000 infections at the end of 1993, after adjusting for under-reporting. At then current levels of infection, with no change in preventive efforts, it was predicted that “Indonesia will have half a million infections within 4 years.”⁹ Such thinking was widespread in the National Planning Agency (Bappenas) and the donor community in Jakarta at the time.

3.4 Within the Bank, the early discussions led to inclusion of a box on HIV/AIDS in the Bank’s 1993 country economic report,¹⁰ which gave 1991 and 1992 data on HIV and AIDS cases and stated that “reported HIV figures suggest that the country has entered the epidemic’s exponential growth phase, with doubling time for the case load reaching less than a year and threatening to fall further.” The report found that policymakers “have responded quickly,” with strategies including surveillance, clinical management, and prevention of blood transmission. Resources allocated to HIV/AIDS 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 on “actual or potential high risk groups,” and “identification of high priority initiatives.”¹¹ In retrospect, the epidemiological projections in the box were inaccurate, but the proposed responses were sound.

3.5 On the basis of work by researchers from the U.S. CDC, Bank staff reported internally that, despite the relatively small number of “HIV patients,” the epidemic “necessitates an urgent and carefully designed policy response.” They explained that HIV appears to be spreading at an increasing rate, and reported, without further detail, that HIV cases were projected to rise to roughly 500,000 in 2000 and to 700,000 in 2005, assuming that effective prevention efforts are launched during the mid-1990s. If prevention efforts were less successful, staff stated that the number of cases would increase to an estimated 700,000 in 2000 and 1.2 million in 2005. HIV in Indonesia was reported to be spread almost exclusively through sexual contact.

3.6 A comparative advantage clearly enjoyed by the Bank in many undertakings is the quality of its analysis. In this instance, the CDC projections used by the Bank were incorrect. Some of our interlocutors doubted the Bank staff’s expertise on HIV/AIDS, a perception that may have been fueled by the internal inconsistencies and apparently extreme nature of the projections used to justify the project.

9. Jalal et al (1994).

10. See Box 4.2: “AIDS in Indonesia: Trends and Options.” The PAD (pg. 91) refers also to use of “informal notes to sustain a dialogue with the GOI about AIDS” in this period. No such notes have been found in the Washington or Jakarta files of the Bank on the HIV/AIDS project, but they may exist in other files on general health dialogue.

11. Report 11737, 5/25/1993.

THE HIV/AIDS AND STD PREVENTION AND MANAGEMENT PROJECT: IMPLEMENTATION AND RESULTS (1996-99)

Design, Preparation, and Appraisal of the HIV/AIDS and STDs Prevention and Management Project

3.7 Once the issue of HIV/AIDS was put on the agenda for operational collaboration between Indonesia and the Bank, the Bank staff moved swiftly. No sectoral analysis was done. 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 staff suggested to the authorities that the Bank manage the grant to permit rapid processing of the work.¹² The Implementation Completion Report (ICR) reported that NGOs and local provinces were involved in project design;¹³ however, to our knowledge only one NGO active in the behavioral change component of the project existed prior to appraisal. Appraisal was initially planned for June 1995 — about typical for health sector projects, but less than nine months after identification of an entirely new activity, and with components to be undertaken in a new way, through NGOs that did not exist at the time of appraisal.

3.8 To assist on project preparation, specialists on IEC and behavior change programs were recruited, along with experts on STD programs and public health laboratories, largely from the U.S. CDC. One person was to assume special responsibility for monitoring and evaluation. The absence of specialized expertise in institutional analysis and NGO partnerships stands out. The Japan grant provided for financing of an institutional specialist, but there is no indication that the individual was hired. It is striking that the Bank's task team responsible for project preparation support and appraisal of the project for Bank financing did not draw upon the expertise available through the AIDS Unit of the Asia Regions of the Bank, either from Bank staff or from trust funds available to the AIDS Unit. Within the Bank two well-regarded peer reviewers commented favorably on the project, while encouraging greater emphasis on monitoring and evaluation.

3.9 In some countries, existing institutions dealing with reproductive health issues have been adapted to help meet the challenges posed by the HIV epidemic. Reproductive health already deals with sexuality, and the step to becoming a provider to clients at risk of contracting HIV (especially condom provision) is in some senses a relatively small one, compared to agents working in other areas. The Bank had two decades of experience in working with the national family planning coordinating board (BKKBN), which had engineered a dramatic fertility decline and had a substantial personnel presence and distribution network throughout the archipelago. Several of our sources commented on the disinterest of the Ministry of Population, under which BKKBN functioned, in addressing HIV/AIDS. In simplest terms, the issue was that BKKBN built its power in part on being an agency that serves "good citizens" (married couples limiting their fertility), and the populations in which the epidemic was emerging (sex workers, their

12. Letter of Feb. 21, 1995 from H. Martinez to Secretary General of the MOH.

13. World Bank/EAP (2000b), pp. 12-13.

clients, and to a small extent in the mid-1990s, intravenous drug users) were anything but that. In particular, condoms, distributed as a means of fertility limitation through BKKBN, were only provided to married individuals.

3.10 Discussions on a possible HIV/AIDS project started with Bappenas, and the project was eventually based in the Communicable Disease Control and Environment Health Directorate (DG CDC-EH) of the MOH. This was a sound decision, although it seems to have been taken more at Bank initiative and at the behest of Bappenas than as a result of intensive discussions with DG CDC-EH. The Bank already had successful experience with the Directorate-General in connection with water supply and sanitation. Autonomous Centers for Health Education and for Health Laboratories were also involved in implementing the Bank-financed HIV/AIDS and STDs project.

3.11 The design of the Bank-financed HIV/AIDS project under the leadership of Bappenas and the planning directorate of the MOH followed the customary arrangements in Indonesia, but at a time when the authority of Bappenas was on the wane. The implementing agency, DG CDC-EH, should have been more closely involved at the design stage, and the Bank staff should perhaps have played a less central role than is indicated by the frequency of the preparation missions and Bank execution of the Japan Social Development Fund (JSDF) grant for preparation. The pilot character of the project, its relatively small size and short duration (3 years), its entry onto politically and socially controversial terrain, its financing of newly-created NGOs, and its efforts to reach marginalized populations all differentiated the HIV/AIDS project from other HNP operations financed by the Bank in Indonesia. By themselves, these differences might have called for a slow pace of project preparation, appraisal, and especially implementation. Yet, as indicated above, the Bank moved rapidly. In sum, the HIV/AIDS project was sound in concept (see Box 1) but its design, preparation, and appraisal failed adequately to reflect the lessons of World Bank operational policy and experience.

Box 1. The HIV/AIDS and STDs Prevention and Management Project

As set out in the Bank's appraisal report, the HIV/AIDS and STDs Prevention and Management Project financed by the Bank in Indonesia in 1996 was intended to operationalize and assist the government in implementing its Government's 1994 AIDS strategy and policy statements. They aimed at achieving lowering STD and HIV incidence and fewer AIDS deaths in the country. The project was to be a "first phase" activity using intensive pilots in two provinces to develop institutional mechanisms and interventions capable of reducing transmission of STDs and HIV in Indonesia. The total cost of the project at appraisal was \$35.2 million, financed by an IBRD loan of \$24.8 million and the Indonesian government for the remaining \$10.4 million.

Over its three-year execution implementation period, the project was expected to achieve certain proximate objectives towards the broader goal of reducing STD and HIV transmission, including: enhancing awareness about HIV and STD transmission and prevention strategies in specific groups; promoting behavior change among those participating in risky sexual activities; increasing the knowledge and skills of health care providers who deal with STDs and HIV; improving the capabilities of the health laboratory system as regards STDs and HIV; and establishing effective surveillance mechanisms for STDs and HIV and monitoring and evaluation systems to gauge the impact of various interventions.

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

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

Riau (\$7.3 million): The project financed activities comparable to those in Jakarta, including behavioral and service delivery initiatives (training, guidelines, and laboratory support) and associated 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 concerned. 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, at the central MOH prototypes for needs assessments, preparation, and pre-testing of IEC materials, training of trainers, technical assistance, and research were anticipated. Finally, the project provided funds for research on a range of topics related to HIV and STDs.

A Project Management Unit (PMU) was established within the Directorate-General for Communicable Disease Control and Environmental Health (DG CDC-EH) of the MOH. NGO involvement in project implementation was to be a defining feature of the project, and an NGO grant fund was included in the Jakarta component. Close MOH-NGO cooperation was expected. Funds were channeled through development budget allocations at the central, provincial and district levels.

3.12 The PAD underscored the importance of making the best use of donor assistance, and contained an annex with a matrix on donor funding of HIV/AIDS activities. Donors were said to concentrate on specific geographical areas, and none was reported to contribute to what was seen as the Bank's role, namely to provide a "broad approach or framework through which to prioritize and coordinate various grant-funded trials and demonstration efforts." The arrangements agreed with the Indonesia authorities gave the PMU for the Bank-financed project authority to coordinate all HIV-related donor activities. Reports of other major externally funded projects, including those working in the same geographical areas, make no mention of the coordinating role of the government through the PMU, and it is not clear that the planners or implementers of such projects were ever aware of this role.

3.13 The extent of Bank engagement at the time with other donors is not documented beyond the matrix information in the PAD annex. UNDP and AusAID projects were being formulated at the time of preparation and appraisal of the Bank-financed project,¹⁴ and no stakeholder seized the opportunities for fully coordinated design. Staff from the U.S. CDC played a key role in project preparation. During preparation and appraisal the interaction between Bank staff and CDC seems to have been collaborative and intense.

Implementation Issues (Including Policy Reforms) Prior to the East Asian Crisis

3.14 The HIV/AIDS Project faced difficulties from the beginning of implementation. Overall, the initial supervision mission found the project to be "starting in a disappointing fashion." The second supervision mission in February 1997 also reported significant delays, and the PMU was thought not to be in a position effectively to manage the project. Nonetheless, the internal Project Status Report (PSR) rated implementation progress and development objectives as satisfactory, while project management was unsatisfactory. The Bank suggested changes in the management structure in its follow-up letter. In July 1997 the Steering Committee set up under the Loan Agreement met for the first time, and a new decree was adopted setting out the PMU structure. This did not solve the management problems, and the September 1997 supervision mission reported the project unsatisfactory on implementation, though still satisfactory on development objectives because of progress on some components. However, the Bank indicated that, if in a further six months the rating remained unsatisfactory, it would seek to discuss possible restructuring or, if necessary, closure of the project. By that time, Indonesia was deeply into the East Asian financial crisis.¹⁵

3.15 The principal institutional and policy innovation of the Bank-financed project concerned use of government funds obtained through the Bank loan for grants to NGOs. At the Bank's request, a dossier of policies and procedures for this was prepared for review during negotiations on the loan, and a schedule on this subject based on these materials was included in the Loan Agreement. However, no NGO manual was prepared, and these arrangements turned out to be insufficient. It was only late in 1998 that a Bappenas-MOF circular was issued that resolved

14. Janssen et al (2003); AusAID (undated).

15. Assistance from the IMF was requested in October 1997.

outstanding issues. The roles and responsibilities of the PMU were not clear to the MOH sub-directorates involved in STI/HIV work and surveillance, or to other donors in the field of HIV.

3.16 The technical assistance components of the project faced difficulties from the outset. The lack of clarity on the relative roles and responsibilities of the PMU and the Bank and the Bank's approval requirements led to tensions and delays. Opportunities to draw effectively on the TA resources of other donors were missed.

The Impact of the East Asian Financial Crisis on the Project

3.17 Approximately one year into project implementation, the Indonesian financial crisis hit. As a stand-alone project with inadequate management, with limited support within the MOH, and with new information suggesting that the alarming projections underlying the project would not be realized, the HIV-AIDS project was in a weak position. Other donor-financed health projects, including at least two Bank-financed projects, weathered the storm. Collapse of the whole health system was a real possibility at the time, while the number of HIV/AIDS cases was very low.

3.18 The East Asian financial crisis of 1997 and OED's 1999 Country Assistance Note¹⁶ led to major changes in the Bank's Country Assistance Strategy and its portfolio of loans to Indonesia. An Interim Country Assistance Strategy was discussed by the Bank's Board in March 1999, focusing on ensuring short-term stabilization, building the institutional foundations for sustainable growth, and reinforcing the social safety net. In the wake of the crisis, adjustment lending moved rapidly to center stage, including a US\$1 billion policy reform support loan in July 1998 and thereafter a social safety net adjustment loan of \$600 million.¹⁷ The OED Country Assistance Note draws attention to the focus on the crisis, and does not even mention Bank involvement in the Indonesian health sector.

3.19 Approximately 80 percent of the loan for the HIV/AIDS project was cancelled at the time of the initial, August 1998 portfolio restructuring in the wake of the financial crisis, leaving a total of US\$5.54 million. The cancellation took place following months of effort by the staff to turn around the poor performance of the project. While the data make clear that no aspect of the Bank's portfolio escaped critical scrutiny at the time of the portfolio restructuring, the HIV/AIDS loan was cut much more dramatically than others. Weak project management and limited support from other Indonesia stakeholders led to cancellation of nearly all of the uncommitted balance of the IBRD loan.

Outputs and Outcomes of the Project

3.20 Much of the behavioral change and counseling portion of the HIV/AIDS project was to be performed by NGOs. With support from the Bank loan, IEC materials were produced and media time was used to support behavior change. In project design, these materials were intended to be targeted at high-risk sub-populations. However, a dispute between the PMU and the Center for

16. World Bank/OED (1999).

17. Data from President's memo P7307 on the social safety net adjustment loan.

Health Education, the government agency charged with implementing that part of the project, was never resolved. The Center for Health Education did not support the strategy of focus on high-risk groups, preferring “awareness raising” in the general population. This illustrates the downside of designating implementation partners who were not fully involved in designing the project and lacked ownership of it. For the most part, the NGOs that were expected to carry out the bulk of the behavior change activity did not exist at appraisal, but were to come into existence as part of the project. The limited absorptive capacity of the MOH and the NGO sector for this activity was a major issue during project implementation, and remains so today (see Box 2).

Box 2. Pitfalls and Limited Progress with NGOs

The Operations Evaluation Department (OED) assessment of Bank involvement with NGOs (Gibbs et al. 1999) describes 37 lending operations involving NGOs or community-based organizations (CBOs). Nineteen of these were rated “unsatisfactory,” but the authors noted that there appeared to be some learning, as more recent projects were more likely to be better rated than earlier projects. Three factors were considered necessary to satisfactory outcomes: (a) a supportive environment for NGOs, (b) effective working relationships with NGOs, and (c) sufficient NGO capacity. Arguably, none of these was present in Indonesia at the time of preparation and appraisal of the HIV/AIDS and STDs Prevention and Management Project. NGOs financed from public funds were not welcomed by many stakeholders. While it seems to have been recognized that the work to be done could not be accomplished by the MOH and its subordinate agencies, several of our respondents mentioned the mixed feelings that channeling money outside of the Ministry seemed to elicit in some MOH staff. Because many NGOs were new, working relationships, administrative capacities and professional skills were not well developed.

The argument was made by several respondents that a beginning must be made in developing policies, procedures, and practices for government financing of NGOs for key public purposes, and that the project provided a useful way to accomplish this.¹⁸ There may well be some merit to this argument. We note, however, that Gibbs et al. also point out that Bank involvement may harm NGOs when the NGOs cannot handle accompanying funding or timing constraints. Both of these constraints apparently were severe, and were made more so by MOF refusal to grant the necessary tax-free status to newly created NGOs for most of the first year of the project. On net, of 18 NGOs not previously working on HIV/AIDS involved with the project, we understand that only one remains working on HIV/AIDS in Jakarta. This NGO, known as YKB, had operated for years previous to the loan in family planning, but began work on HIV/AIDS through the Bank-supported project. Some of the NGOs employed with loan funds still exist in their pre-project forms as, for example, general health outreach clinics associated with hospitals. The situation is similar in Riau, where three pre-existing NGOs and 38 startups were involved with the project, and one of the newcomers survives (although it apparently is not doing HIV/AIDS work). We heard the new NGOs referred to as “red plate specials” — an allusion to connections with government officials, who drive vehicles with red license plates. While we did not see evidence of harm to NGOs from their association with the Bank-financed project (after Gibbs et al.), it is clear that the NGO component did not receive the careful nurturing from the Bank that was needed from preparation through appraisal and implementation.¹⁹ On the other hand, several respondents reported an improved legal framework for government-financed NGOs attributable to this project.

18. Other Bank-financed projects are reported also to have contributed to this achievement.

19. To be specific, the Bank inputs in the ICR show no mission of the Bank with an NGO specialist, and there is no evidence that the preparation team of consultants financed by a Japanese grant included an NGO specialist.

3.21 In the absence of information demonstrating that the project was implemented as envisaged and actually reached people likely to be exposed to HIV with interventions likely to support safer behavior, it is difficult to attribute any change in outcomes to the project. This is in part because in Jakarta, the only Bank-funded area for which behavioral trend data are available (collected with support from USAID), other donor activities were also present. Teasing out the Bank contribution in the absence of strong project implementation data would therefore be impossible. The point is rendered moot because behavioral surveillance in Jakarta recorded no significant change in risk behavior (specifically in condom use in commercial sex) over the duration of the Bank-financed project and beyond, as documented in Annex B.

3.22 Additional outputs of the project included equipping laboratories to support HIV surveillance and supplying them with reagents, preparation of guidelines for STD management, and studies. While the laboratory component was relatively successful compared to others, it was poorly planned; a more flexible project management would have been able to reallocate funds planned at appraisal for laboratory support for other project purposes.

Box 3. Indonesia's HIV surveillance system in search of an early epidemic

One of the major aims of the Bank-funded project was the improvement of active surveillance for HIV in Indonesia. The national surveillance system was far from perfect in the mid-1990s. International guidelines were inappropriately adapted and standard operating procedures were left largely to the whim of local implementers.

Systematic sero-surveillance among sex workers began in Jakarta and East Java as early as 1988. The following year, Bali and Yogyakarta were added, and in 1990 Riau and North Sumatra provided data for the first time. In 1991, surveillance was also conducted in West Java, Central Java, and West Nusa Tenggara. By 1994, 15 sentinel sites operated around the country. All the sites focused on female sex workers, but "ad hoc" sero-surveys among other groups were also common.

There appears to have been a distrust of the quality of data generated by the national sentinel surveillance system. "They kept saying to us that if we weren't finding HIV it was because our surveillance was so bad," said one government health researcher. This perhaps explains the ever-larger samples of high-risk populations included in surveillance. "There was a sense of desperation," commented an international adviser. "If we weren't finding positive samples we weren't trying hard enough." Another adviser commented that procurement of test kits was a source of revenue for some individuals within the MOH, increasing the incentives for high volumes of testing. Throughout the early 1990s, tens of thousands of test kits were procured for surveillance annually, using routine government budgets.

Collaboration with Donors

3.23 One characteristic of successful Bank interventions in many environments where a number of external financiers are present is close cooperation and coordination with other donors. In Brazil, for example, USAID provided "strategic inputs," such as training, to complement the Bank-financed projects (Brazil case study). In Indonesia, both the USAID HIV/AIDS Prevention Project (HAPP) and the Bank-financed project were operating in Jakarta on some of the same client populations. It was not until March 1998 that a meeting involving Bank staff was held to coordinate efforts between the HAPP and Bank-financed HIV/AIDS projects, and there is no indication that such contacts occurred previously without Bank

intervention. The outcome was more a statement of principle on how coordination should proceed than an actual division of labor. There were donors active in Indonesia, most notably USAID and AusAID, which had at their disposal experts to perform tasks in that were needed in the HIV/AIDS project, such as training NGOs. The fault is unlikely to lie only with the Bank, but it is clear that there was a failure to exploit potential complementarity and synergies within the design and implementation of the HIV/AIDS and STDs Prevention and Management Project under what could have been global donor support to the GOI HIV/AIDS program.

The Level and Content of Bank Engagement (1999-2003)

3.24 Due largely to the unforeseen emergence of an HIV epidemic among sexually active IDU, HIV prevalence began to rise markedly in several risk groups in Indonesia around 2000. With increasing awareness of the concentrated epidemic among the staff, HIV has begun to gain new attention in the work of the Bank. The latest, October 2003 Country Assistance Strategy (CAS), contains the first explicit mention of HIV/AIDS in a CAS on Indonesia submitted to the Bank's Executive Directors. It states that the Bank will help elevate the policy dialogue and awareness on HIV/AIDS, addressing analytical and funding gaps as required. Working within an emerging World Bank HIV/AIDS Strategy for the East Asia and Pacific Region,²⁰ the EAP staff have prepared an extensive program of analytic and advisory activities (AAA). Under the rubric of strategic information gathering and analysis to support policy dialogue and program planning, the resources required for an effective response to HIV/AIDS would be estimated. This would complete work initiated previously on micro-costing of prevention and estimating the cost of scaling up activities. Policy and socio-economic impact studies would cover barriers to political and leadership support for HIV/AIDS prevention, review of legal and institutional barriers to providing preventive interventions in high-risk groups, effects of HIV/AIDS on poverty, on households, on the health care system, and on the labor market. Finally, options to increase engagement of other sectors such as transport, education, and the private sector would be explored.²¹

20. World Bank/EAP (2003a).

21. World Bank/EAP (2003b).

4. The Impact of the Bank's HIV/AIDS Assistance

EVOLUTION OF INDONESIAN HIV/AIDS POLICY AND SPENDING

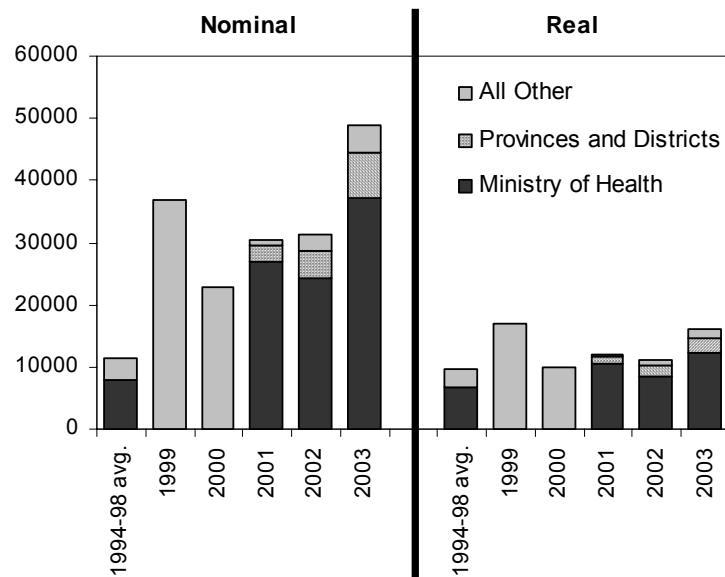
4.1 Figure 1 shows nominal and real GOI HIV/AIDS budgets for the 1994-2003 period. The 1994-1998 figures are five-year averages, and come from the sixth five-year development plan, *Repelita VI*. Because the disastrous effects of the 1997 crisis on the rupiah would dominate the diagram if this were graphed in dollars, budgets are shown in billions of rupiah. Budgeted spending in 1999 was much higher than annual average budgets during the 1994-1998 period, apparently because reported budgets for that year included donor spending, while other years did not.²² Actual government spending in that year is reported by MOH CDC staff to have been around 20 billion rupiah. Fiscal 2000 was only nine months long, in order to synchronize fiscal and calendar years. Even after inflating the actual budget by one-third to annualize the 2000 budget, HIV/AIDS budgets fell markedly, in both real and nominal terms. By 2003, the real budget had returned to 1999 levels, and the nominal budget surpassed its 1999 level in the same year.

4.2 Beginning in 2001, accelerated decentralization occurred, and the composition of HIV/AIDS spending changed as well. Comparing the *Repelita VI* period of 1994-1998 with 2001 and subsequent years shows that central government budgets through the MOH remain the dominant channel for HIV/AIDS funds. However, in the post-decentralization period, funds budgeted by provinces and districts (out of block grants) account for a significant and growing share of budgeted HIV/AIDS expenditures. The province and district portion of each bar, non-existent in the pre-decentralization era, grows to 19 percent of MOH expenditures by 2003. Locality budgets understate the true spending by these entities as there is not, to our knowledge, a central tabulation of locality budgets. There are currently 32 provinces and 469 districts (*kabupatens*), each of which may allocate some share of a block grant to HIV/AIDS activities. The figures we have represent data collected by the monitoring and evaluation unit of the USAID Aksi Stop AIDS (ASA) project for the provinces and districts in which they are operating. ASA is operating in roughly one-third of all provinces, so the figures we have omit local expenditures. In some instances, ASA is not operating there because prevalence is low, so local HIV/AIDS budgets are likely to be low as well. However, in some instances, these are high-prevalence areas where other donors have taken the lead role. The most notable of these is probably Bali, where AusAID has a large project. Therefore, estimated budgets for 2001 and subsequently, and particularly the sub-national share of these budgets, must be considered underestimates of true HIV/AIDS budgets.

22. Information from ..[name omitted].

4.3 During the period under examination, we attempted to calculate government budgets designated for HIV/AIDS activities as a share of all health expenditures. In summaries of development budgets (e.g., EAP PERII²³), the closest proxy for health is “social welfare, health, role of women, children and adolescents.” Unfortunately, we were unable to find these data for the post-decentralization period, perhaps because a significant share of direct health expenditures devolved to sub-national units. We do know that the increase in HIV/AIDS budgets for 1999 was also an increase in the share of HIV/AIDS expenditures, which averaged 0.8 percent in the most recent five-year plan, increased to 1.3 percent in 1999, and declined back to 0.8 percent in 2000.

Figure 1. HIV/AIDS Budgets, 1994-2003



Sources: 1994-2000; Phase 2 HIV/AIDS Prevention and Care Project. AusAID, 2002. 2001-2003: Country Report on Follow-up to the Declaration of Commitment on HIV/AIDS (UNGASS). Republic of Indonesia National AIDS Commission, May 2003 (converted to Rupiah at annual average exchange rates).

4.4 According to data collected for an internal World Bank strategy note on HIV/AIDS in Indonesia,²⁴ the overall “budget” available for HIV/AIDS in Indonesia in 2003 was around \$20.4 million. One-fourth (26 percent) of the funding (\$4.3 million) was provided by the GOI, and seventy-four percent (\$16.1 million) by donors. As this report is written, the Bank is finalizing plans to assist the GOI to set up a system for tracking public expenditures for HIV/AIDS within a framework of national health accounts at the national and sub-national levels.²⁵ In this work it will be worth also taking into account work included in a Bank study on decentralization in 2000.²⁶

4.5 The Bank appears to have had no impact on GOI budgets or spending related to HIV/AIDS, beyond the expenditures directly associated with the Bank-financed STDs and AIDS Prevention and Management Project.

23. World Bank/EAP (1999).

24. Holzschneider (2003).

25. World Bank/EAP (2003b).

26. World Bank/EAP (2000a).

EVOLUTION OF THE EPIDEMIC

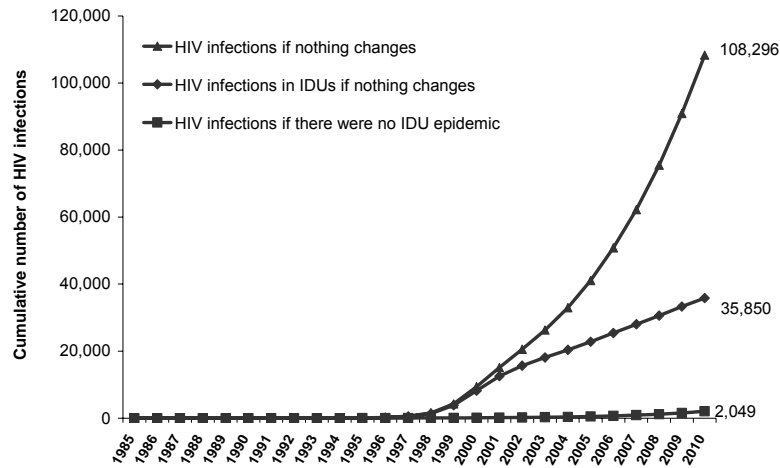
4.6 In 1997, epidemiologist James Chin (the author of EpiModel) was invited to review existing data and make a new estimate of the number of people living with HIV in Indonesia. He concluded that the country had between 20,000 and 50,000 people living with HIV in Indonesia at that time. Using data available to mid-1999, UNAIDS epidemiologists in Geneva estimated that 55,000 Indonesians were infected with HIV at the turn of the century. An external assessment, including a review of all existing data was carried out in November 1999, and was followed by a consensus workshop in 2000. This eventually contributed to an estimate made in March 2001 of 100,000 people living with HIV. In late 2002, the MOH led an estimation process that began by estimating the size of each at-risk population at a provincial level, estimating prevalence within each of those populations in each province, and then aggregating to a national total. This more rigorous process arrived at an estimate that was not greatly different from the previous one — HIV infections in Indonesia at the end of 2002 were estimated at between 90,000 and 130,000. The Indonesian estimation process has since been adopted by UNAIDS/WHO as the gold standard for estimation of current HIV prevalence in countries with concentrated epidemics.

4.7 Behavioral research in East and West Java conducted in the mid-1990s showed that a maximum of 8 percent of men in urban areas had ever paid for sex; in rural areas the rate was as low as 1 percent and the proportion who were active clients of sex workers was lower still.²⁷ 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 appear to have combined to greatly limit the rapidity of the rise in HIV infection among sex workers in the absence of any other “seed” factor. Unfortunately, with the breakdown of central authority at the end of the 1990s, an epidemic of injecting drug use has taken hold in many urban areas. HIV prevalence rose from zero to 40 percent in IDU in Jakarta between 1997 and 2000. 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 had a major impact on the unfolding epidemic.

4.8 Figure 2 shows the results of projections using the Asian Epidemic Model. Unless behaviors change, it is expected that some 108,000 people in Jakarta will have become infected with HIV by 2010. Roughly a third of them are drug injectors. However, had there been no IDU epidemic at all, around 106,000 infections would have been avoided. This is because IDU infect their sexual partners, providing a “boost” to prevalence in the heterosexual population, including among high-risk groups where HIV prevalence would otherwise have been expected to remain low through 2010. Preventing an epidemic among IDU is therefore absolutely critical to preventing an epidemic in a wider population.

27. Kambodji et al (1995) and Riono (2001).

Figure 2. The HIV epidemic in Jakarta with and without injection drug use



Source: Asian Epidemic Model calibrated by E. Pisani for Jakarta using sentinel data 1992-2003 and behavioral data 1996-2003

4.9 By 2002 HIV prevalence had risen to 22 percent among transvestite sex workers in the capital, and very high rates of active syphilis among the HIV positive indicate that those who are infected are still having unprotected sex with numerous partners. A growing body of behavioral evidence suggests that those who do engage in risk very often have multiple risks, so that HIV travels very easily from one risk group to another. From the very low rates recorded in the mid-1990s, HIV has begun a steady climb among female sex workers across the country. While condom use has risen marginally in a number of sites, unprotected sex with clients remains the norm among sex workers. This is confirmed by consistently high levels of STI measured in a recent survey in eight cities.²⁸ There is little evidence 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. Estimates made there at the district level at the end of 2003 suggest that HIV already exceeds one percent in the general population.

IMPACT OF BANK ASSISTANCE

Political Commitment

4.10 The Bank's early engagement on HIV in the country appears initially to have had a marginally beneficial impact on the commitment of Indonesian decision makers outside the health sector to address issues associated with HIV, partly through the legitimizing effect of Bank involvement. However, this commitment level was not sustained as a consequence of multiple factors — the failure of the epidemiological projections that justified the Bank-financed project to be realized, the inevitable loss of attention to long-term issues under the stress of financial crisis, and the lack of inclusion in the project of activities to nurture and grow

28. MOH and ASA program: Multi-city survey of STI among sex workers, unpublished data.

commitment. Within the MOH, there was little, if any, commitment by the staff to addressing HIV-related issues as a major policy problem calling for new types of intervention, and the Bank's impact there was negligible or — in the short-term — negative.

Public Goods

4.11 The Bank-financed project appears to have had some impact on one public good, HIV surveillance, and a less clear impact on another, laboratory support. The final report by the PMU states that 10,660 screening tests in high-risk groups took place during the period of just over two years of active project execution. This compares with an average of 4,000 tests a year among sex workers in Jakarta every year since 1991. The government's final project report stated that most of the laboratory testing was done with already available reagents, which implies that this activity was a continuation of routine surveillance rather than any expansion due to the project. Laboratory bottlenecks were presumed to exist in project design, but we found no evidence that was the case, and heard evidence to the contrary.

4.12 The final report by the PMU states that training in HIV/AIDS surveillance was provided in Jakarta (no numbers given) and Riau (a total of 180 people). This is a surprising number given the relatively technical nature of surveillance work, and leads us to question whether training was being provided to people who needed it or would use it. No evaluation is available, but at a recent gathering of operational surveillance staff from all of Jakarta's five districts, it was found that none had previously received any specific training on HIV surveillance.

4.13 The Bank-financed project sponsored the development of guidelines and procedures in several areas of surveillance, and two out of eight planned modules were adopted. The procedure for HIV sentinel surveillance was published in 1998. By 2001, the sentinel surveillance guidelines were no longer appropriate to the changing nature of the Indonesian epidemic, or to the administrative context. They were revised in 2002.

Prevention and Treatment of HIV

4.14 The HIV/AIDS and STDs Prevention and Management Project had no direct, measurable impact on prevention of HIV or STI prevalence, nor, as discussed in Box 4, on the behaviors that spread them. The Bank's Policy Research Report, *Confronting AIDS*,²⁹ however, contributed to establishment of an intellectual environment that encouraged attention to prevention among some donors. Treatment of PLWA is only now becoming an issue in Indonesia. The previous work supported by the Bank did not address treatment issues. The government's new strategy and Indonesia's Third Round application to the Global Fund raise treatment issues, which are not included in the work program to be supported by the Bank's JSDF grant, or under the DfID grant. The cost and financial aspects of treatment may become an issue to be addressed as part of the work on the cost of HIV and HIV services to be sponsored under the DfID grant.

29. World Bank (1997).

Box 4. Accounting for the Failure to Effect Behavior Change

One potential reason that behaviors did not change even in “target” populations in “target” provinces is that behavior change interventions did not actually reach the vast majority of those at risk, either because they were not implemented at all, or because they were implemented on far too small a scale.

In a low-prevalence epidemic, small levels of behavior change among a high proportion of the population at risk has a greater impact than high levels of behavior change in a small proportion of the population. To put it more bluntly, quantity is more important than quality. Achieving “quality” (high levels of behavior change) generally takes repeated exposure to a multi-faceted intervention delivered at an individual level. This is especially difficult to achieve where there is high turnover in the population — certainly the case in the sex industries in Jakarta and Riau. BSS data show that between 55 and 60 percent of sex workers in Jakarta and Riau had worked in their current location for a year or less.

Estimates made by the Ministry of Health in late 2002 suggest that Jakarta has, at any one time, between 27,000 and 37,000 sex workers, serving up to 1.3 million clients a year³⁰. Early BSS questionnaires do not ask directly about interventions, but they do ask about sources of knowledge about AIDS. In the five years between 1996 and 2000, only 7 out of 1,799 male respondents reported getting information from NGOs or health staff. Among sex workers, between 4 and 5 percent of 1,400 sex workers in Jakarta reported discussing HIV or getting information about HIV from NGOs or health staff every year, with the exception of a blip in 1999 when the proportion reached a high of 11 percent. By 2002, 8 percent of sex workers and 2 percent of high-risk men were being reached by NGOs or health personnel in Jakarta.

These data point to the difficulty of working through NGOs to provide services on a large scale in a short period. This was especially true in Indonesia in the mid-1990s, since the NGO sector was not well developed, and established NGOs working with high-risk populations were few and far between.

Institutional Development (Government and NGO)

4.15 At the level of national policy and procedure concerning government contracting of NGOs for the provision of services of public interest, the Bank has had a positive impact. As discussed above, the issue proved to be much less tractable than anticipated by the Bank’s task team during preparation and appraisal of the HIV/AIDS project, but two years of debate within the public service and continuing prodding by the Bank led to acceptance and implementation of the idea through a Bappenas-MOF circular of late 1998. Since the essence of the problem lay in the use of public funds of the GOI for activities implemented by NGOs, this was not an action that could have been sponsored by donors making direct grants to NGOs. The risk of back-sliding is real, and it will be important for the Bank and other partners of the GOI to encourage continuing use of this new instrument until it has become a matter of routine. At the level of the NGOs themselves, the Bank’s impact, thus far, has been disappointingly small, and all but negligible. Continuing, intensive effort over many years is likely to be required.

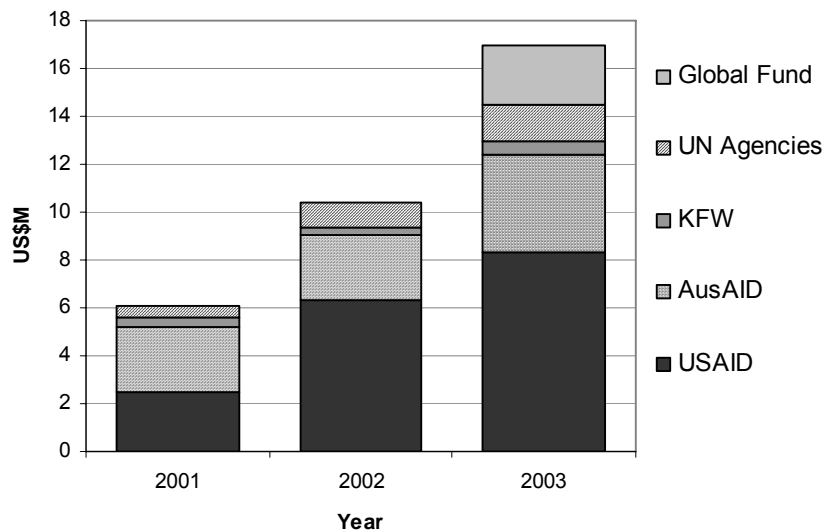
30. Joesoef et al (1997).

Activities of Other Donors and Interactions with the Bank

4.16 The main current donors for HIV/AIDS are USAID, AusAID, and the GFATM. Figure 3 below summarizes donor funding in recent years. The Global Fund is likely to become increasingly important in the future. Based on detailed estimates of the size of populations at risk for HIV and the numbers currently infected, the DG CDC-EH has begun to develop estimates of the amount of funding needed to provide adequate HIV prevention and care services throughout the country. However, no results from the work are available. A costing exercise also is included in the Bank's planned analytic and advisory activities.

4.17 Our interviews and the available documentation suggest that the Bank's direct impact, if any, on the activities and levels of financial flows (see above) of donors has been marginal. Consultative, coordinating activities essentially did not take place in connection with the Bank-financed project. Nonetheless, *Confronting AIDS* was influential with donors and HIV program planners outside the World Bank, because it validated the need to target prevention programs at those with the highest risk behaviors in countries with low prevalence and concentrated HIV epidemics. Both USAID and its implementing partner FHI were able to draw on *Confronting AIDS* in order to support programs focused at reducing risk behavior in those most likely to become exposed to HIV. Similarly, while it was designed before *Confronting AIDS* was published, the concept of the Bank-financed project espoused the principle of targeting, though this principle was compromised in implementation.

Figure 3. Donor Funding for HIV/AIDS Activities



Source: *HIV/AIDS in Indonesia: Short Strategy Note (Draft 12/17/2003)*.

5. Lessons on the Key Evaluation Issues

POLITICAL COMMITMENT

5.1 While the argument in Bank studies such as *Confronting AIDS* and by Bank staff on the cost-effectiveness of early intervention is well taken, Indonesia illustrates an essential tension between early response and a low level of political commitment. In a climate of uncertainty, the effects of intervening must be weighed against the downside risk of not acting — inaction is politically less controversial but risky because of a potentially more severe epidemic than would have been the case with early intervention. Uncertainty is itself costly in this sense, and a logical way to have proceeded in Indonesia would have been first to reduce the uncertainty surrounding decisions, where possible. The clear sources of uncertainty at appraisal were a lack of country-specific knowledge of the extent of infection and of behaviors that would hasten its spread. In this context, the establishment of monitoring and surveillance systems is of paramount importance. Behavior change and the easing of supply bottlenecks, in the absence of fundamental information about the extent of the epidemic and the behaviors that spread it, should be secondary concerns, unless, as in the case of sex workers, there are clear indications of a need for behavior change

5.2 In retrospect, senior Indonesian decision-makers did not take HIV seriously in the mid-1990s, and the work supported by the Bank did not increase their concern about the epidemic. One result of proceeding with a relatively superficial project that counseled married women in antenatal clinics about HIV was that the government avoided the need to take a hard look at deeper social issues. This issue was not addressed directly during preparation and appraisal of the Bank-financed project.

5.3 If the government is not sufficiently committed to following through on politically difficult actions foreseen by the project design, there is little that can be done in the absence — as in the Indonesia case — of measures built into the project itself that are expected to increase commitment. This is especially the case in an emerging area of development where little local expertise exists and where the arrangements made by the borrower and the Bank for project implementation do not provide for long-term, intensive technical support for the Bank project, whether this expertise is financed from the Bank loan or furnished by another donor. The dilution of an initial focus on high-risk groups of the HIV/AIDS project highlights the need for high levels of government commitment, especially among those responsible for overseeing and managing project implementation, in order for this work to move in the desired direction after appraisal.

5.4 The justification for the Bank-financed project was infections averted. Since HIV can only be spread when an infected individual shares a risk behavior with an uninfected individual, infections can, in low prevalence epidemics, only be averted by working with populations most likely to be infected — sex workers and their clients, men who have sex with men, and IDU. If commitment to providing services for these populations is insufficient within the body actually chosen to implement the project (in this case, the MOH), as seems to have been the case in Indonesia, then the project is unlikely to deliver the projected benefits in terms of infections averted and costs saved.

5.5 Key Bank staff, perhaps influenced by projections of catastrophe if no action were taken, apparently felt strongly that the institution should be involved in visible activity on HIV in Indonesia. At an early stage of its work on HIV in the country, the Bank made its most important choice, namely to move forward on the basis of questionable projections, without careful consideration of the alternatives. Had the Bank decided at that stage to proceed more cautiously, it would have been appropriate to commission a sector study and to organize an external review of the results by experts on AIDS modeling and other aspects of the epidemic. No sector study was undertaken, and there was no external review of the assumptions regarding STI and HIV prevalence and patterns of sexual behavior that appeared in the PAD and were used to justify and design the project. The political constraints to maintaining a focus on marginalized populations received little attention. Alternative paths — including integrating HIV prevention into other sectoral activities or preceding any eventual loan with extended policy dialogue intended to lay the foundation for effective targeted interventions — were apparently not considered. Apparently, the pressure felt by key Bank staff and their Indonesian counterparts to act and to be seen to be acting led this possibility not even to be considered. The project represented a radically new set of activities for the Indonesians and had an inappropriate management structure. It was large in relation to the financial engagement of other donors on HIV/AIDS³¹ and, especially in relation to the absorptive capacities of the handful of actors who were engaged on HIV/AIDS and already coping with funding from other donors. Thus it is hardly surprising that the project failed to meet its objectives, and that the Bank staff most immediately concerned in the EAP Region made this finding in the ICR.

AIDS AND THE HEALTH SECTOR

5.6 The Bank staff chose consciously, according to the evidence in the PAD, to focus their work on HIV/AIDS within the health sector, and this choice appears to have been appropriate. Given the growing importance of sexually transmitted diseases (STDs) in the country, and their importance as a vehicle for addressing HIV issues, choosing to focus on the MOH was appropriate. The National AIDS Commission was too weak, institutionally and politically, to be lead interlocutor and BKKBN was not interested. The failure of the Bank-financed HIV/AIDS project in Indonesia should not be seen as an indictment of the health sector playing a central role in the fight against HIV/AIDS. Its lack of implementation resulted from inadequate engagement of the MOH at the design stage, from widespread reluctance among senior decision-makers to focus attention on the high risk groups requiring targeting during a concentrated epidemic, from the diversion of policy-makers' focus from HIV during the financial crisis, and especially from an ill-conceived and inappropriately staffed management structure. The Indonesian HIV/AIDS project serves to underscore the country specificity of decisions on AIDS and the health sector institutionally as well as epidemiologically and particularly the need for analysis of institutional options.

31. See data on donors' recent financing of HIV/AIDS in Indonesia in Figure 3.

Box 5. Recent Growth in Commitment to Addressing HIV/AIDS in Indonesia

In recent years, commitment to dealing with HIV has risen dramatically within the MOH. The Director of Communicable Disease Control regularly addresses the issue in national and international forums and consistently reports estimated cases rather than the far lower numbers of reported cases. HIV has been discussed at the Cabinet level on two occasions. The Minister of Health recently raised the possibility of invoking the law on contagious diseases to allow funds and activities to be mobilized against HIV more readily. This proposal was not adopted for practical and ethical reasons, but it demonstrates a growing sense of urgency within the MOH.

The very rapid rise in HIV infection among IDU has brought the police, the National Narcotics Board (BNN), and the Ministry of Justice and Human Rights (which runs the prison system) into the dialogue in recent months, and all have been involved in a move toward supporting harm reduction efforts.

The national parliamentary commission on health and welfare has held regular hearings on HIV over the past two years, and commission members have visited provincial and district parliaments in an effort to broaden commitment. The National Parliament and three provincial parliaments have also hosted a high-profile photo exhibition focusing on (and attended by) Indonesians living with HIV.

While the Bank has not been involved, concerted advocacy on the part of external development partners and programs they support appear to have contributed to these improvements through materials presented in cabinet meetings and in parliament and support for the data sources on which they are based. The programs have worked closely with the press and other constituencies to increase public attention to HIV. Coverage of MOH advocacy efforts within the government has been significant. They have lobbied both publicly and in private for legislative changes that are a prerequisite for successful prevention. For example, in April 2003 the BNN declared that all harm reduction efforts were illegal (including extremely limited needle exchange and methadone substitution programs implemented by NGOs in Bali). The MOH, with the strong support of bilateral and multilateral donors, reacted swiftly, approaching BNN, the police and security forces, parliamentarians, and other decision-makers to argue for a more constructive approach. Study tours to countries with successful harm reduction policies were organized. As a result, a Memorandum of Understanding supporting harm-reduction interventions nationwide was signed between BNN and KPA in December 2003, in the presence of the President.

The advocacy efforts arose in part from a realization that small “boutique” interventions implemented by NGOs could never have an impact on the national epidemic in a country the size of Indonesia. Structural interventions are needed and cannot be achieved without the active engagement of senior policymakers. UNAIDS has made strategic use of international commitments, particularly Indonesia’s involvement in the ASEAN regional strategy on HIV and the United Nations General Assembly Special Session on AIDS, to prod the government into a more active response.

Open and positive discussion of HIV-related issues in the press is also an indication of an improved environment for addressing AIDS. In 2003, the average monthly number of articles on HIV in benchmark publications more than tripled to 43, compared with 13 in 2001 before the intensive lobbying efforts began.

5.7 Caution is needed against the risk that AIDS-related services might squeeze out other priority health services, in terms of financial or political support with governments and – because of the tendency to follow development assistance fashions and global priorities - especially with donors. Some MOH officials’ time was diverted from other health issues to AIDS by the project. The Indonesia case also makes clear that there is a risk that more donor funds may be available for HIV-related services than the country is able to absorb.

5.8 Public health surveillance for HIV is an activity that risks losing attention during periods of crisis and particularly under the decentralization of health services. The existence of positive externalities suggests the importance of continuing subsidization of HIV surveillance by the national health authorities. National guidelines and oversight are needed. Since the Bank has facilitated decentralization with support to provincial health projects in Indonesia, it also has a responsibility to contribute to the determination of which services should be decentralized and how public goods and other services with a common, societal interest will be financed and provided in the new environment.

MULTISECTORAL RESPONSE

5.9 The behaviors that spread the HIV virus have their roots in social and cultural practices, and a wide variety of sectors have a role to play in supporting people to reduce their risk, and in minimizing the impact of infection on individuals and communities. The Indonesian experience illustrates one of the potential pitfalls of the multisectoral approach: By making HIV everybody's business, it became nobody's business. Indonesia sought to establish a multisectoral response to HIV by presidential decree early on, with the support of the multisectoral planning agency Bappenas. Indeed this was cited in the PAD as evidence of strong political commitment to HIV. It happened before any single ministry, including the MOH, had developed a strong response to the virus in its own sector. The 14 Ministers who by decree made up the National AIDS Commission (NAC) can be forgiven for not meeting — it is likely that none of them considered HIV a sectoral priority. This was a problem in the early stages of Bank involvement in HIV in Indonesia, and remains a problem today. A joint consultant report sponsored by several donors in 2002 found the current mechanisms for supporting a national response to HIV/AIDS do not deliver benefits or tangible effects, and that there is a great sense of frustration with waiting for improvements.³²

5.10 Until very recently, the Bank has been silent on multisectoral dimensions of HIV/AIDS in Indonesia. The NAC has been and remains politically and organizationally weak and it already has one key external partner in Australia. Beyond the development of health services, the Bank has been involved in adolescent reproductive health through the Safe Motherhood Project approved in 1997. Under the JSDF grant and the DfID grant, the Bank will begin substantially to expand its concerns to multisectoral dimensions of HIV. Plans are being laid to provide resident TA support to the NAC from the DfID grant. Beyond this the Bank has not required or strongly encouraged an HIV component in any of its other activities in Indonesia. In other countries, such as Laos, Bank-funded infrastructure projects that lead to temporary or permanent concentrations of male workers or displacement of populations (to mention but two of many circumstances where intervention outside the health sector may be appropriate) have included a mandatory component for HIV prevention. Senior Indonesian figures such as the Vice-Governor of Papua, the province worst affected by HIV, have suggested that all foreign investment contracts should include HIV prevention programs in the workforce. This represents an important potential opening for Bank engagement on HIV outside the health sector in Indonesia. Additional opportunities are in early stages of exploration in connection with a Bank-financed highways

32. Reis et al (2002).

project. Bank education staff in Indonesia are planning work on HIV/AIDS and the school curriculum in collaboration with the Dutch authorities.

5.11 The Indonesia experience suggests the importance of country-specificity in determining the nature and extent of multisectoral response. Now that the HIV epidemiology is becoming clearer, high priority needs to be given to IDU. A wide variety of public agencies are concerned, including agencies with which the Bank has had relatively little contact in the past, such as the Ministry of Justice. Multisectoral coordination takes on a specific meaning in this case in the fight against drug abuse. However, the Bank risks spreading itself too thin, if it engages directly on drug abuse issues, and may do well to limit itself to encouraging and – where necessary – facilitating a concerted multisectoral donor response that gives particular attention to drug abuse issues.

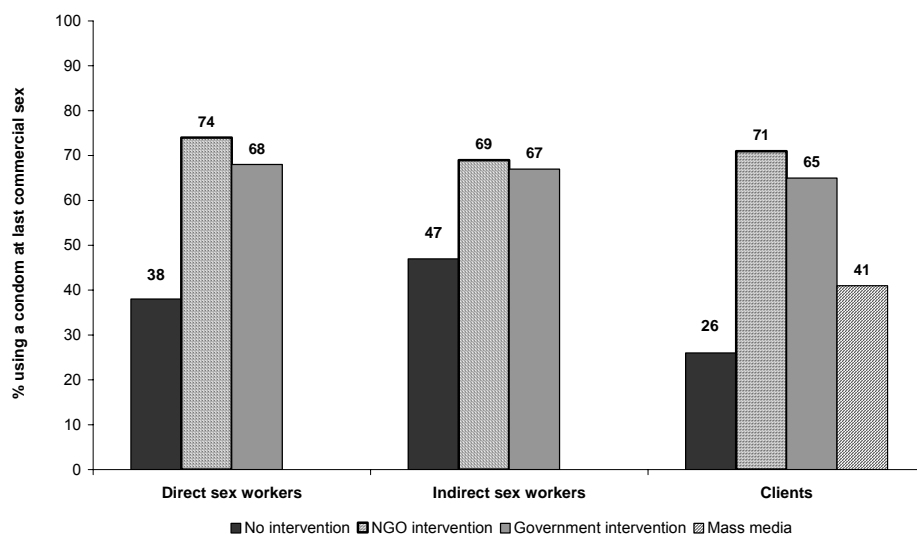
NGOs

5.12 The Indonesia case provides little evidence regarding the importance of NGOs to an effective response to HIV, but it does underscore, once again, the importance of country specificity in determining where, how, and to what extent NGOs should be engaged. The lack of NGO capacity and unwillingness of public agencies to relinquish fiduciary responsibilities were clear constraints in Indonesia. The two years of work required to establish apparently suitable government policies and procedures in Indonesia — while not anticipated during preparation, appraisal, and negotiation of the IBRD loan — were well invested.³³ Unfortunately, the closure of the Bank loan in 1999 raises the possibility that the debate will have to be renewed when the issue arises again in the future.

5.13 The assumption that NGOs are better placed to work with high-risk groups than is the Government needs to be tested at the country level, and may not be well founded in Indonesia. Several Indonesian public agencies have wide reach in such groups. The departments responsible for health, social affairs, and tourism, for example, all have regular contact with female and transvestite sex workers. As Figure 4 shows, behavior change among those reporting being reached by government and NGO prevention programs is virtually identical. It may be easier to change the attitudes and ways of doing business of agencies that already have national reach than to rely exclusively on NGOs to cover the vast and diverse needs of a country the size of Indonesia. If this is to be attempted, however, intensive technical support will be needed for a significant transitional period.

33. Indonesia's other experience with contracting along the lines of the NGO component was limited to publicly funded and executed community driven development programs. Consideration is being given in connection with the JSDP grant, to using a large umbrella NGO as a channel for small grants to individual NGOs; the umbrella NGO was a beneficiary under the HIV/AIDS project.

Figure 4. The Impact of Prevention Programs on Condom Use



Source: National surveillance system, 2002/3

5.14 The Indonesia NGO experience underscores the risk that more donor funding for NGO services may be available than the NGOs in the country are able to absorb. This was and remains the case with NGOs in Indonesia, and it calls for a major long-term and continuing collaborative effort by Indonesia's development partners to strengthen NGO capacity to implement and manage HIV-related programs. The JSDF grant proposal expected soon to enter into execution includes a component to build knowledge, skills, and capacity of local NGOs and civil society networks in HIV/AIDS. Much more than this single activity is likely to be needed. Links with the Bank-financed Urban Poverty Project are an integral part of the JSDF proposal and could, over time, be established with the Bank-supported rural CDD platform. Intensive local supervisory support will be imperative.

MONITORING AND EVALUATION

5.15 The lesson of the Indonesia experience on monitoring and evaluation (M&E) seems to be that it should be established as an independently identified, carefully prepared, and highly visible part of project management integrated by practice into regular decision-making. The indicators in the PAD prepared by an external consultant were insufficient. In the implementation phase, despite repeated reminders by Bank supervision missions, it appears that little or no effort was made to systematize program monitoring so that at least the "plausible contribution" model could be used to evaluate program impact. It should be noted that the "plausible contribution" model is in any case inadequate to address issues of attribution. As a described pilot project, hoping to demonstrate what works and what does not so that successful elements could be replicated, an evaluation design with a control group would have been necessary from the outset. This is especially the case in Jakarta, where another donor-funded project was actively carrying out many of the same activities in many of the same target populations. As suggested in the ICR,

monitoring should remain a responsibility of project management, but evaluation can and should be contracted out to a third party. If such a contract is concluded before the beginning of project execution, with appropriate incentive structures, the likelihood that M&E will succeed increases.

IMPACT ON BEHAVIORAL AND EPIDEMIOLOGICAL INDICATORS

5.16 Globally since 1996, the Bank has been a partner in discussions of improved monitoring and evaluation of national responses to HIV. In those discussions, which led to the publication of the Guide to the Monitoring and Evaluation of National AIDS Programs (UNAIDS, 1999), donors and lenders agreed that they would not require countries or program implementers to measure behavioral or disease outcomes in ways that could distinguish between the contribution of different funders or discreet activities. They agreed, rather, jointly to support behavioral and biological surveillance systems that would measure such outcomes at the national level, using standardized indicators appropriate to the epidemic type. Individual program monitoring data were to be used to establish the “plausible contribution” of various program elements to the changes measured. In the Bank’s work in Indonesia these arrangements were not taken into account.

5.17 In Indonesia, the HIV/AIDS project did not generate any sustained impact on either behavioral or epidemiological monitoring. Work by MOH, BPS, and donor agencies has in recent years led to the development of one of the developing world’s best behavioral surveillance systems. The contribution of the Bank of this effort appears to have been small, at best.

6. Conclusion: The Development Effectiveness of the Bank's HIV/AIDS Assistance

DEVELOPMENT EFFECTIVENESS

6.1 We summarize our assessment of the development effectiveness of the Bank's assistance to Indonesia in relation to HIV/AIDS under OED's three central criteria:

- Relevance:** A project design that focused on high-risk groups, on surveillance and monitoring, and policy and institutional development, with provision of support services as needed, would have been appropriate for the stage of the epidemic in Indonesia at the time the Bank-financed project was being designed. The early discussions within the Bank and with the Indonesian authorities seem to have concentrated on high-risk populations. However, the project as appraised and, even more so, as implemented, diluted this focus by including activities to increase knowledge of HIV risks while reinforcing traditional values and norms and promoting use of STD services among the general population. The loan funded unnecessary reagents and laboratory equipment and interventions with very low-risk populations that were unnecessary for Indonesia's situation. These funds could have been reprogrammed for higher priority activities if the assumptions about sexual mixing and STI prevalence had been realized and the project had been successfully managed with the flexibility foreseen in the PAD. The faulty epidemiological projections should have been subjected to more searching scrutiny by specialists on HIV modeling, since they provided the underlying rationale for what became inappropriate interventions. Thus, as executed, the project was politically and institutionally premature in Indonesia. The East Asian financial crisis understandably swept away attention from HIV/AIDS in the government and in the Bank. A project providing services designed into the Bank-financed project would be highly relevant today, although many of the obstacles that led in practice to the diminished emphasis on high-risk groups persist today. As the HIV epidemic has more clearly emerged as one focused on IDU, the Bank has begun to re-engage on the issue in the country, with preparation of a relevant study program. It needs also to explore and exploit opportunities for introduction of HIV-related services in projects outside the health sector, with particular attention to the IDU issue.
- Efficacy and efficiency:** The pressure to advance rapidly with approval of an IBRD loan led the Bank's preparation and appraisal to focus on specific technical dimensions of the proposed project and to pay insufficient attention to building political commitment, institutional analysis, and NGO capacity. This contributed to subsequent managerial problems during project execution, which were never resolved. The Bank and its partners failed to exploit adequately the potential for complementarity in donor support to Indonesia's struggle to deal with HIV/AIDS. However, the climate among donors working in HIV/AIDS in Indonesia is now one that enthusiastically supports cooperation, providing the Bank with good opportunities to increase interaction and complementarity.

- **Institutional development impact:** The institutional development impact of the Bank in relation to HIV/AIDS has undoubtedly been greatest through its support to strengthening of Indonesia's health services and systems with 21 loans and credits over 30 years. The total cost of these projects was \$2.8 billion, with total Bank financial commitments of \$1.2 billion. With the single exception of the Safe Motherhood Project, the Bank has not financed HIV/AIDS-specific services under other operations. At the level of more specific HIV/AIDS services, the institutional development impact of the Bank has been negligible. Some impact is perceptible on policies and procedures for use of government funds to contract NGOs for the provision of services deemed to be in the public interest, although the long-term sustainability of the changes is unclear. There is little evidence of impact on the NGOs themselves.

6.2 Overall, we find that the Bank's assistance to Indonesia in relation to HIV/AIDS has been ineffective. However, this conclusion needs to be qualified by pointing out that the available evaluations and especially our interviews suggest that other donors also have been less than uniformly successful.³⁴ Bank-supported activities were not fully implemented, had limited or no success in reducing risky behaviors or prevalence of STI in high-risk populations, and therefore little immediate impact on the course of the HIV epidemic throughout the late 1990s. Furthermore, we conclude that it is extremely difficult for donor assistance oriented towards the provision of condoms and STI treatment for sex workers and their clients, clean needles for drug users, and counseling, testing and care for those at highest risk of HIV to be effective in the pre-epidemic stage of the disease. Donors face a risk of "throwing money" at the problem when policy and institutional change and information gathering are more important than widespread service delivery.

IMPROVING THE EFFECTIVENESS OF FUTURE HIV/AIDS ASSISTANCE TO INDONESIA

6.3 The Bank needs to focus its efforts on areas of comparative advantage, and avoid engagement in other areas. As we see the Bank's work in Indonesia and beyond, it appears that its comparative advantages on HIV in the country are:

- **Facilitating the financing and provision of public goods and services, and goods and services with positive externalities.** This necessitates identification of which goods and services that meet these standards are highest priority in Indonesia, and which have a largely private character and can and should be left to the market, except for the poor. In the context of decentralization, health information generally and public health and HIV surveillance in particular, stand out as public policy priorities. This does not necessarily imply Bank financial commitments for these purposes. Through analytic work and policy dialogue, the Bank can help to secure the finance and financing mechanisms for these things in the long term, and to develop mechanisms by which the central government can work with decentralized health authorities with financial resources and other incentives to ensure execution of programs of public health benefit. Despite the availability of trust

34. Projects of other donors have experienced delays, had problems resulting from inflexible design and implementation arrangements, and have had varied impact. See especially Jansen and Purwaningsih (2003).

funds, at least some support for the analytic work and policy dialogue from the Bank's administrative budget is essential.

- **Policy dialogue, convening power, and access.** These capabilities need to be used but strategically and selectively, given the competition for “air time” with high-level government officials by the Bank's Country Team. Strategic and selective use of these capabilities for HIV/AIDS will have the advantage that when the Bank speaks, stakeholders will listen. The opportunity to raise the profile of attention to HIV through the Consultative Group of donors supporting Indonesia's development led by the Bank should not be missed.
- **Advocacy for the integration of HIV prevention activities into other sectoral activities,** particularly other health sector projects and large infrastructure projects that may increase the opportunities for modifying risk behavior, for example, through displacement of people, increase of mobility, or the creation of concentrated single-sex workforces.
- **Mobilization of large financial resources for service delivery, when they are needed and when the people and institutions are ready for them.** This time may come on HIV in Indonesia, but it is not the case today. For institutional and policy change, the smaller amounts of financial resources likely to be required are frequently available as grants from other donors. Where grant funds are available to begin interventions for emerging problems with relatively low perceived priority, extremely strong reasons are needed to justify loan financing. This situation poses challenges to the Bank in its determination to make HIV/AIDS a corporate priority and simultaneously to respect its policy of being lender of last resort.
- **Capacity to design and, where necessary, undertake economic and institutional analysis.** The Bank's capacities in this area were neglected in early stages of the work on HIV/AIDS in Indonesia, but the Country Team is now moving forward with a large program of work. Focusing on priorities in this work is essential, as the burden of financing, planning and executing the program is considerable. In the course of these analyses, maximum use should be made of the rich data generated by the national surveillance system and other existing data collection efforts.
- **Access of Indonesian policymakers to global knowledge sharing.** The AIDS Leadership Program of the World Bank Institute can be successfully engaged to help in gaining commitment by facilitating exchange of experience and increasing knowledge among countries experiencing IDU-driven epidemics.
- **The policies and procedures for delivery of Bank-financed technical assistance occasionally inhibit its delivery and effectiveness.** Partners, such as USAID and AusAID, have strong capabilities in this area. Wherever possible, individual TA specialist assignments of concern to the Bank should be financed and mobilized by the Bank's partners. Bank involvement in the design of assignments and review of products

would, however, remain essential. Reducing loan financing of technical assistance would also have the advantage of increasing the acceptability of IBRD terms among some Indonesian stakeholders. IDA grants could help to overcome this problem, but the cumbersome character of execution of Bank-financed TA would remain.

6.4 An increased communication effort is needed if the Bank's past and future AIDS-related analytic products are to have significant impact in Indonesia. Beyond the general impact on donors of the Bank's *Confronting AIDS* study, largely through percolation of ideas from headquarters staff, in our interviews the only paper specifically mentioned for its utility, even within the donor community, was the brief "AIDS-at-a-Glance" summary included among the Bank's public health fact sheets on its external website. No Bank documents or studies were cited by our Indonesian interlocutors. Lengthy, often scholarly English language publications of the kind usually written by and for the Bank require not only translation into Bahasa Indonesia but also adaptation and specially designed dissemination programs if they are to have broad readership and impact in the country. USAID has devoted substantially more resources than the Bank to this kind of activity, with correspondingly greater success. The series of Briefing Notes for the Incoming Government being prepared by the Bank Country Team, including one on HIV/AIDS, with their associated communications activities, represent a promising opportunity.

6.5 The Bank needs to distinguish carefully its programmatic support on HIV/AIDS from its financing. The two were too closely linked in the HIV/AIDS project of the mid-1990s. The Bank's emerging AAA work program shows promise for engaging government officials increasingly in HIV/AIDS policy and program issues. The corporate priority of the Bank on HIV/AIDS should not necessarily imply an IBRD lending posture in countries such as Indonesia with a concentrated epidemic and relatively easy availability of donor grants. Where and how IBRD, IDA credit, or IDA grant resources are deployed should be a secondary issue.

6.6 The sustainability of interventions in countries at early stages of the HIV epidemic and relatively low levels of government commitment merits particular attention. Very long-term engagement should be the rule, with the nature of the intervention evolving to suit prevailing conditions. The country's HIV program and its financing should be separated. The Bank should support and facilitate coordination of the entire program through non-lending activities, and focus its financial support on the continuing development of health care services and public goods without necessarily funding AIDS-specific service delivery. The Bank should have every reason to commit to a decade-long involvement in the program to fight HIV in concentrated epidemic countries while really operating as financier of last resort and doing whatever it can to facilitate grant financing for the Bank-supported program.

6.7 Finally, where client governments are reluctant to work with high-risk groups, as is hardly surprising in the early stages of the HIV/AIDS epidemic, grant financing by other donors channeled directly to civil society may be seen as a pathway to more immediate behavioral change.³⁵ However, this strategy has subtle costs and risks that may not be evident during the life

35. The experience of the Multi-Country AIDS Projects in Africa may produce useful lessons with respect to channeling Bank financial resources as directly as possible to beneficiaries while still respecting the requirement to provide funds to governments.

of the project: (a) less institutional and policy impact within the government, and less generation of political commitment, because the government is to some extent being circumvented; and (b) low NGO sustainability. Moreover, the Indonesian experience has shown that governments may be unwilling to allow a significant civil society component to operate. The availability of grants from the Global Fund to Fight AIDS, TB, and Malaria (GFATM) is likely to exacerbate rather than resolve this problem, since they are also channeled through the government and the Global Fund has even less field presence than the Bank. Indeed, there is a danger that the GFATM may repeat structural and political errors similar to those that undermined the Bank-financed project in Indonesia nearly a decade ago. If the donor community is unable to ensure and successfully manage sustained, long-term grant funding channeled outside the government, the Indonesian case suggests that the prospects for impact on countries in pre-epidemic stages of HIV are low.

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Annex A: 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 HIV/AIDS 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 Subdirector, 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	Senior 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

* Interviewee for purposes of the case study report

Annex B: An Overview of HIV/AIDS Epidemiology in Indonesia

INTRODUCTION

This epidemiological overview focuses first on what was known about HIV, STI, and risk behavior in Indonesia in the mid-1990s, as the World Bank was considering a loan to the country and then designing a program. 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 World Bank, intended to be active.

HIV AND STI IN INDONESIA IN 1995 — WHAT WAS KNOWN?

Heterosexual Networking and STI Prevalence

The situational analysis underpinning the World Bank's involvement in the HIV/AIDS sector in Indonesia 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. [1]

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. [2] Several studies in other parts of Indonesia had similar findings (for a comprehensive summary of study findings, see [3].) Truckers, sailors and laborers in Indonesia were also tested. Prevalence ranged from 2.1 percent for syphilis to 8 percent for trichomonas. ([4])

The project appraisal document 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.” (p. 2) 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.³⁶ [5] In a more recent household survey only 2.5 percent of the male population in West Java reported having sex with a sex worker in the last year.[6]

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

36. 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.

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. [5] 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. [7]

Given these findings, the assumptions about STI infection and sexual networking in the general population used in the project appraisal document appear high. This is of importance because a large part of the project design 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. Any overestimate of STI in the general population would lead to a significant overestimate of the likely spread of HIV, and also of the impact 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, some of whom went on to work on the HIV/AIDS and STDs Prevention and Management Project, 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, [8] putting it higher than prevalence among female sex workers.

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.[9] 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.”[10] 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).

By the mid-1990s, 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 over the early warning signs of growing drug injection. None of the projections prepared in the mid-1990s took drug injection into account in any serious way, 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. It is 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. Table B1 below summarizes the main findings from the national sero-surveillance system in the early 1990s. Details by population and geographic site are given at the end of this annex.

Table B1: HIV prevalence data from national surveillance, 1990-1994/5

<i>Year</i>	<i>Population</i>	<i>Number tested</i>	<i>Number positive</i>	<i>HIV Prevalence (percent)</i>
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

In short, data from very active surveillance even in the high-risk groups — which are not mentioned in the World Bank project appraisal — 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.

Box B1. 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.” [11]

EpiModel was used in Indonesia in 1994 to make projections described in Jalal et al. (1994) [10] 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 produced the numbers infected predicted by Jalal, Linnan and colleagues.

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. [11] 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 be based on a belief that the HIV epidemic would follow the same course in all countries.[12] In addition, the Indonesian model appears to have been parameterized on Thai data.³⁷ 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.

37. 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.

Box B.1 (continued)

The model results in the World Bank project appraisal document 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 case study report.

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

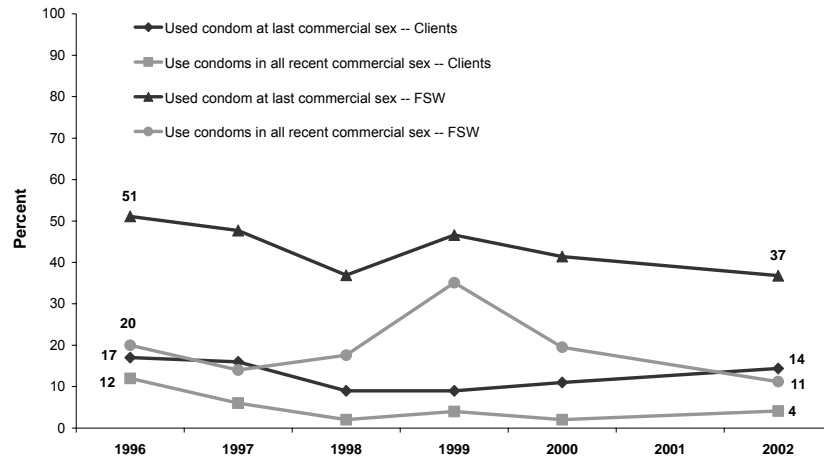
Data collection systems in Indonesia have improved greatly since the mid-1990s, and this has increased our ability to understand the course of the HIV epidemic and the behaviors that drive it. HIV sentinel surveillance was expanded to include other sentinel groups such as IDU. Behavioral surveillance 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 World Bank and other donors 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 otherwise changed little, showing a slight but statistically significant downward trend from 57 percent in 1996 to 43 percent in 2002. As Figure 5 shows, both sex workers and clients in Jakarta report consistently low levels of condom use for the seven years for which data

are available, despite the fact that both World Bank and USAID-funded projects focused their efforts to change this behavior on the city.³⁸

Figure 5: Flat or Declining Condom Use in Commercial Sex in Jakarta



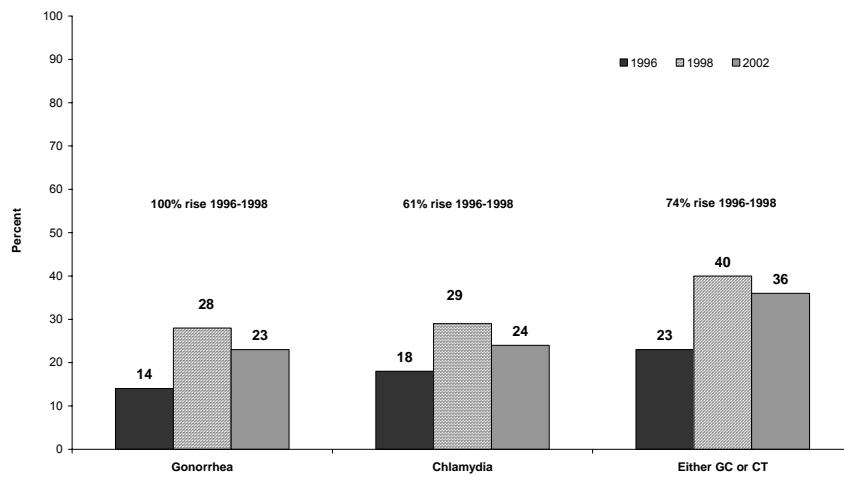
Source: BSS data

No change in condom use means no change in STI transmission, unless efforts to improve screening and treatment for those at risk succeed in diminishing the overall prevalence of STI. Figure 6 suggests that this has not been the case.³⁹

38. 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.

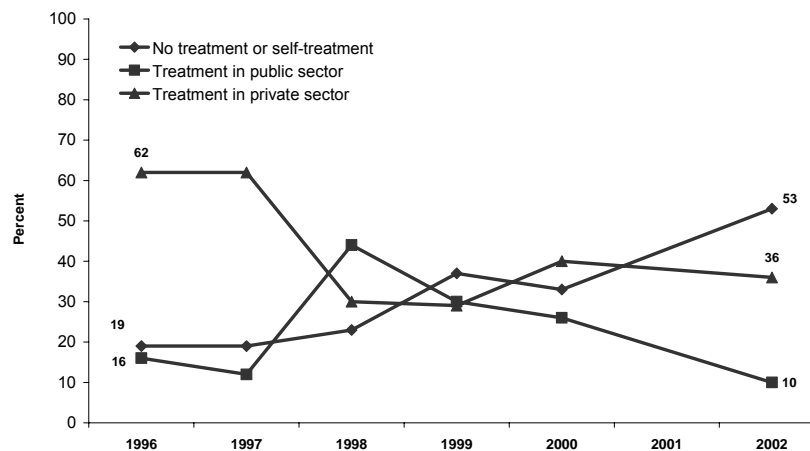
39. The difference in STI prevalence between 1996 and 1998 is statistically significant. The sample frame for the 2002 survey was slightly different, so it is not possible to draw statistical inferences about the change.

Figure 6: Significant Increase in STI Prevalence Among Sex Workers in Jakarta



Source: [14,15]

Figure 7: 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 (Figure 7). 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. 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 (data not shown). 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.

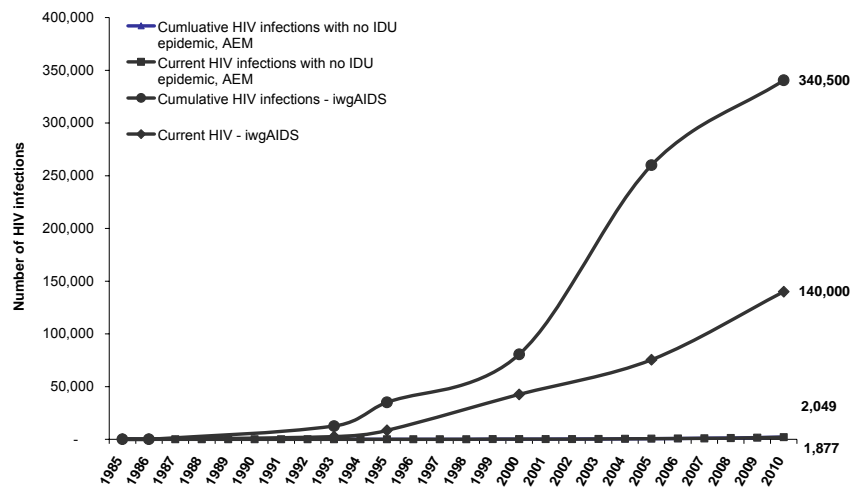
These data come from those who report symptoms. But in the 1998 STI survey among sex workers, only 28 percent of those who tested positive for either chlamydia or gonorrhoea reported having experienced any recent STI symptoms. This means that the proportion of those infected who are not receiving medical 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 to greatly 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 World Bank project appraisal 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 8: 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

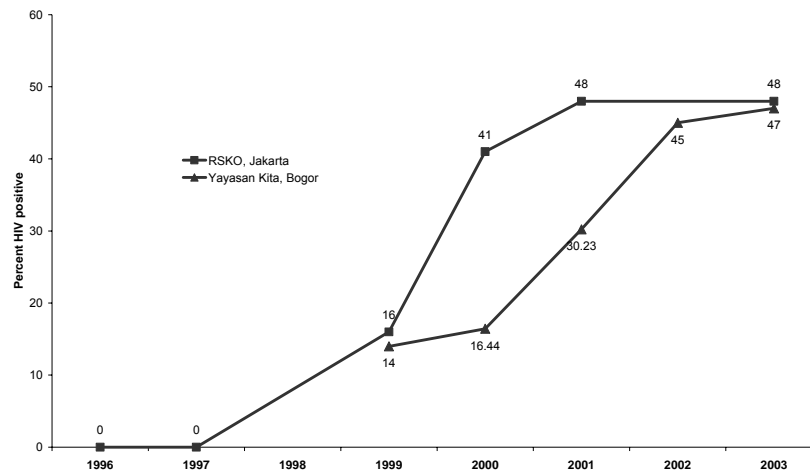
Surveillance among waria in Jakarta stopped in 1997, although the 6 percent prevalence recorded that year made this the most affected group in the country at that time. It was resumed in 2002. Condom use at last anal sex with a client rose slightly over that period, but consistent condom use remained low. The consequence was a rapid rise in HIV infection among waria, to 22 percent in 2002 [14].

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 9 shows.

Figure 9: 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 Mangunkusumo, the reference hospital for HIV treatment, were IDU. In 1999 that shot to 9 percent and has continued to rise since.[15]

Indonesia's Prisons — 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 now 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 did, in fact begin 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 by iwgAIDS, which predicted an early and rapid rise despite the fact that it included only limited transmission among drug injectors.

Figure 10. 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

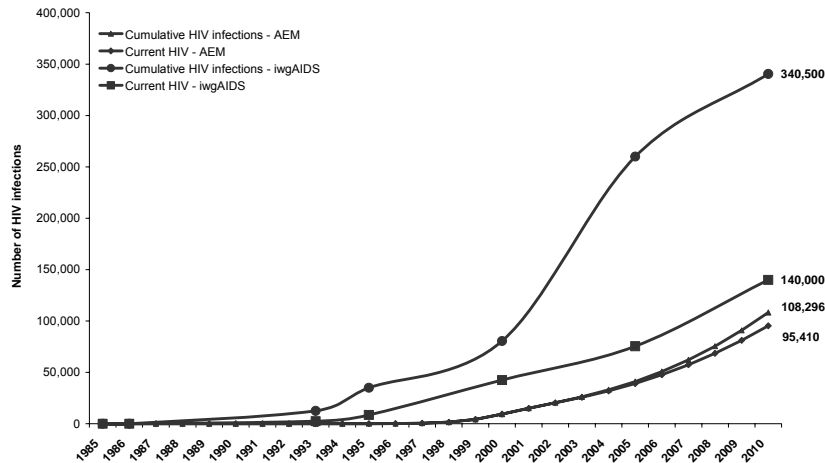


Figure 10 compares the outputs of iwgAIDS projections made in 1995 and AEM projections fitted to prevalence recorded in all sub-populations at risk and in the general population until mid-2003. By 2010, current HIV prevalence was 50 percent lower than predicted by iwgAIDS and cumulative infections were one-third predicted levels. The similar levels of current HIV infection predicted by AEM by 2010 cannot in any way 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 8 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. [13]

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.

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APPENDIX TO ANNEX B

HIV prevalence by year and province, female sex workers, 1990-95
(Data are from national surveillance unless stated)

Date	Location	Number tested	Number positive	HIV Prevalence (percent)
1990	North Sumatra	1,048	0	0
1991/92	North Sumatra	994	0	0
1992/93	North Sumatra	1,808	0	0
1993/94	North Sumatra	1,387	0	0
1994/5	North Sumatra	1,549	0	0
1990/91	Batam, Riau	112	0	0
1991/92	Batam, Riau	259	0	0
1992/93	Batam, Riau	172	0	0
1993/94	Batam, Riau	211	2	0.9
1994/5	Riau	2,710	6	0.2
1993/94	Bengkulu	521	0	0
1994/5	Bengkulu	541	0	0
1991/92	Jambi	578	0	0
1992/93	Jambi	401	0	0
1993/94	Jambi	459	0	0
1994/5	Jambi	599	0	0
1991/92	Lampung	248	0	0
1992/93	Lampung	235	0	0
1993/94	Lampung	597	0	0
1994/5	Lampung	419	0	0
1992/93	West Sumatra	25	0	0
1993/94	West Sumatra	29	0	0
1994/5	West Sumatra	70	0	0
1990	South Sumatra	599	0	0
1991/92	South Sumatra	351	0	0
1992/93	South Sumatra	511	0	0
1993/94	South Sumatra	1730	0	0
1994/5	South Sumatra	2,717	1	0.04
1990	West Java	1,013	0	0
1990/91	West Java	704	0	0
1991/92	West Java	2,229	0	0
1992/93	West Java	5,779	0	0
1993/94	West Java	5,258	0	0
1994/5	West Java	343	0	0
1995	Bandung, West Java[16]	342	0	0
1990/91	Jakarta	1,002	0	0

Date	Location	Number tested	Number positive	HIV Prevalence (percent)
1991/92	Jakarta	4,407	0	0
1992/93	Jakarta	3,375	0	0
1993/94	Jakarta	4,816	1	0.02
1994/5	Jakarta	3,375	3	0.09
1990	Jogjakarta	884	0	0
1992/93	Jogjakarta	266	0	0
1993/94	Jogjakarta	255	0	0
1994/5	Jogjakarta	367	0	0
1990/91	Central Java	8,399	0	0
1991/92	Central Java	2,556	0	0
1992/93	Central Java	9,088	0	0
1993/94	Central Java	13,936	0	0
1994/5	Central Java	4,569	1	0.02
1992/3	Surabaya[1]	1,873	0	0
1995	Surabaya	614	0	0
1990/91	East Java	2,955	0	0
1991/92	East Java	5,945	0	0
1992/93	East Java	12,263	0	0
1993/94	East Java	13,828	0	0
1994/5	East Java	5,987	0	0
1994/5	East Java	230	0	0
1990/91	Bali	500	0	0
1991/92	Bali	759	0	0
1992/93	Bali	837	0	0
1993/94	Bali	677	0	0
1994/5	East Kalimantan	4,970	0	0
1992/93	Central Kalimantan	258	0	0
1993/94	Central Kalimantan	356	0	0
1994/5	Central Kalimantan	971	0	0
1990	West Kalimantan	647	0	0
1990/91	West Kalimantan	784	0	0
1991/92	West Kalimantan	635	0	0
1992/93	West Kalimantan	546	0	0
1993/94	West Kalimantan	1,392	0	0
1994/5	West Kalimantan	2,392	0	0
1992/93	South Kalimantan	220	0	0
1993/94	South Kalimantan	514	0	0
1994/5	South Kalimantan	697	0	0
1990	North Sulawesi	229	0	0
1991/92	North Sulawesi	318	0	0

Date	Location	Number tested	Number positive	HIV Prevalence (percent)
1992/93	North Sulawesi	110	0	0
1993/94	North Sulawesi	530	0	0
1994/5	North Sulawesi	126	0	0
1990/91	Central Sulawesi	510	0	0
1991/92	Central Sulawesi	314	0	0
1992/93	Central Sulawesi	625	0	0
1993/94	Central Sulawesi	736	0	0
1994/5	Central Sulawesi	553	0	0
1994/5	Southeast Sulawesi	281	1	0.35
1994/5	South Sulawesi	6,324	0	0
1993/94	NTB	57	0	0
1994/95	NTB	102	0	0
1990/91	NTT	101	0	0
1992/93	NTT	450	0	0
1993/94	NTT	386	0	0
1994/95	NTT	214	0	0
1990/91	Maluku	789	0	0
1991/92	Maluku	700	0	0
1992/93	Maluku	1,070	0	0
1993/94	Maluku	3,486	0	0
1994/95	Maluku	1,531	0	0
1992/93	Irian Jaya (Papua)	405	0	0
1993/94	Irian Jaya (Papua)	1,709	0	0

**HIV prevalence by year and province, other high risk populations, 1990-95
(Data are from national surveillance unless stated)**

Date	Population	Location	Number tested	Number positive	HIV Prevalence (percent)
1990	Prisoners	North Sumatra	231	0	0
1994	STD patients	Medan, N Sumatra	191	0	0
1990	Prisoners	South Sumatra	557	0	0
1994/5	Prisoners	South Sumatra	1,206	4	0.3
1990	Prisoners	West Java	720	0	0
1990	Prisoners	Jakarta	935	0	0
1991/2	Transvestsites [17]	Jakarta	602	0	0
1993	Transvestsites[18]	Jakarta	228	1	0.4
1995	Transvestites [18]	Jakarta	253	2	0.8
1990	Prisoners	Central Java	317	0	0
1990	Prisoners	East Java	426	0	0

Date	Population	Location	Number tested	Number positive	HIV Prevalence (percent)
1990	Transvestites	East Java	154	1	0.7
1990	Prisoners	Bali	226	0	0
1990	Prisoners	West Kalimantan	131	0	0
1990	Prisoners	North Sulawesi	214	0	0
1991	STD patients	Bali	236	3	1.3
1989/92	Drug users	13 provinces	296	0	0

HIV prevalence by year and province, other high risk populations, 1990-95
(Data are from national surveillance unless stated)

Date	Population	Location	Number tested	Number positive	HIV Prevalence (percent)
1994/5	Pregnant women	Jakarta	76	0	0
1995/6	Pregnant women	Jakarta	64	0	0
1994/5	Pregnant women	Jogjakarta	406	0	0
1995/6	Pregnant women	Jogjakarta	275	0	0
1992/3	Pregnant women	Surabaya [2]	599	0	0
1994/5	Pregnant women	Bali	410	0	0
1995	Pregnant women	Various urban areas	1900	0	0
1992/3	Blood donors	Jakarta	154,313	5	0.0032
1993/4	Blood donors	Jakarta	161,986	0	0
1994/5	Blood donors	Jakarta	149,335	2	0.001
1993	Blood donors	Bali	1,262	0	0
1993/4	Blood donors (hospital)	Merauke	381	1	0.3
1994/5	Blood donors (hospital)	Merauke	389	0	0
1992/3	Blood donors	National ex Jakarta	379,552	3	0.0008
1993/4	Blood donors	National ex Jakarta	543,359	5	0.0009
1994/5	Blood donors	National ex Jakarta	599,478	15	0.003

Annex C: World Bank Health, Nutrition and Population Operations in Indonesia

Approval Year	Project Name	Total Cost (appraisal, \$ million)	Total Cost (actual, \$ million)	Loan/Credit Amount Committed (\$ million)	Loan/Credit Amount Disbursed (\$ million)	ICR/PCR number (date)* ⁴⁰	ICR/PCR Rating ⁴¹
2003	Health Workforce and Services Project	429.4	NA	105.6	NA	25294* (5/19/2003)	S
2001	2 nd Provincial Health Project	895.8	NA	102.6	NA	22051* (5/25/2001)	S
2000	1 st Provincial Health Project	79.1	NA	38.0	NA	20423* (5/10/2000)	S
2000	2 nd Water and Sanitation for Low Income Communities Project	106.7	NA	77.4	NA	20132* (5/16/2000)	S
1998	5 th Health Project — Improving the Equity and Efficiency of Provincial Health Services	56.2	NA	44.7	NA	17357* (6/16/1998)	S
1997	Safe Motherhood Project ⁴²	61.9	NA	42.5	NA	16624* (6/3/1997)	S
1996	Intensified Iodine Deficiency Control Project	45.3	NA	28.5	NA	15639* (11/18/1999)	S
1996	HIV/AIDS and STDs Prevention and Management Project	35.2	5.5	24.8	4.5	20566 (6/16/2000)	U
1995	4 th Health Project — Improving Equity and Quality of Care	134.3	49.0	88.0	39.0	25727 (9/28/2001)	S

NA = not applicable

* Project appraisal report or project appraisal document.

40. Where no ICR/PCR is available, because the project is in execution, the PAD number is given.

41. The latest PSR rating on Development Objectives is given where no ICR is yet available.

42. This project sponsored small group information sessions on reproductive health for adolescents covering – among other matters - sexual behavior, STDs, and drug and alcohol abuse; see Terence H. Hull, “Evaluating Peer Educator Initiatives (PS/KS) in Indonesian Adolescent Reproductive Health Projects,” Australian National University, August 29, 2003.

Approval Year	Project Name	Total Cost (appraisal, \$ million)	Total Cost (actual, \$ million)	Loan/Credit Amount Committed (\$ million)	Loan/Credit Amount Disbursed (\$ million)	ICR/PCR number (date) ⁴⁰	ICR/PCR Rating ⁴¹
1992	Water Supply and Sanitation for Low Income Communities Project	80.0	80.0	80.0	45.1	20420 (6/16/2000)	S
1992	3 rd Community Health and Nutrition Project ⁴³	164.1	100.3	93.5	72.2	22959 (12/24/2001)	S
1991	5 th Population Project	148.4	134.0	104.0	99.9	16801 (6/26/1997)	S
1989	3 rd Health Project	103.5	133.3	43.5	42.9	16055 (10/1/1996)	HS
1985	2 nd (Manpower Development) Health Project	65.8	54.5	39.0	37.2	12745 (12/2/1994)	MS
1985	4 th Population Project	94.4	44.8	46.0	32.5	12310 (9/14/1993)	S
1985	2 nd Community Nutrition and Health Project	56.2	52.9	33.4	31.8	11997 (6/16/1993)	S
1983	Provincial Health Project	64.8	43.1	27.0	24.4	9133 (11/16/1990)	S
1980	3 rd Population Project	72.6	29.1	35.0	24.2	7564 (12/23/1988)	S
1977	1 st Nutrition Development Project	26.0	22.0	13.0	12.7	5757 (6/28/1988)	HS
1977	2 nd Population Project	60.0	94.5	24.5	19.8	1534b* (5/31/1977)	S ⁴⁴

43. The ICR reports that social anthropologists were hired to carry out field assignments in Irian Jaya on topics of concern, including cultural practices on behavior facilitating spread of HIV.

44. Inferred from appraisal report on 3rd Population Project, from the PCR attached to the Project Performance Audit Report (Report 6276, June 23, 1986), and OED Report on the World Bank and Indonesia's Population Program (Report 9379, Feb. 13, 1991)

Approval Year	Project Name	Total Cost (appraisal, \$ million)	Total Cost (actual, \$ million)	Loan/Credit Amount Committed (\$ million)	Loan/Credit Amount Disbursed (\$ million)	ICR/PCR number (date) ⁴⁰	ICR/PCR Rating ⁴¹
1972	Population Project	33.0	32.4	13.2	12.9	PP8* (2/29/1972) ⁴⁵	S ⁴⁶
TOTAL		2,812.7	NA	1,204.7	NA	NA	HS- 2 S-17 MS-1 U-1

45. Appraisal report

46. Inferred from appraisal report on 2nd Population Project, from the PCR attached to the Project Performance Audit Report (Report 5675, May 28, 1985) and OED Report on the World Bank and Indonesia's Population Program (Report 9370, Feb. 13, 1991).

Annex D: HIV/AIDS in Indonesia and World Bank Economic and Global Sector Studies, 1993-2003

Year	Title	Report Number and Responsible Unit	Author(s)	Comments
1993	World Development Report 1993 — Investing in Health	DEC	Jamison et al.	Boxes 1.2 (The economic impact of AIDS), 4.9 (Coping with AIDS in Uganda), and 4.10 (HIV in Thailand: from disaster toward containment)
1993	Indonesia — Sustaining Development — country economic report	11737 (5/25/1993) EAP	Shilling et al.	Box 4.2: AIDS in Indonesia: Trends and Options. Gives 1991 and 1992 data on HIV and AIDS cases and states “reported HIV figures suggest that the country has entered the epidemic’s exponential growth phase, with doubling time for the case load reaching less than a year and threatening to fall further.” Under-reporting means “actual number of cases may fall in the 15,000 — 20,000 range.” Box states policy makers “have responded quickly,” with strategy including surveillance, clinical management, and prevention of blood transmission. Resources allocated are said to be inadequate, and what is reported lacking is sufficient recognition that lowing the epidemic will 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, as proposed in the box would involve promoting safe sex, STD prevention and control, campaigns targeted on “actual or potential HRGs,” and “identification of high priority initiatives..”
1997	Health, Nutrition and Population — (World Bank Sector Strategy)	HDNHE	Preker	Notable for lack of coverage of HIV/AIDS in Indonesia or elsewhere; HIV only is mentioned with one indicator in the statistical appendix.
1997 and 1999	Confronting AIDS — Public Priorities in a Global Epidemic (World Bank Policy Research Study)	DEC	Ainsworth and Over	Box 6.1 projects the impact of behavioral interventions in three countries, including Indonesia. Increased condom use among sex workers, to 20 percent, and others with many partners to 20 percent, shows dramatic impact, compared to baseline and compared to increased condom use among women in stable relationships.
2003	Indonesia Country Assistance Strategy	Report 27108 (10/29/2003) EAP	Arulpragasam and Poppele	Under the general objective of improving health outcomes, the 2003 Indonesia CAS for the first time mentions HIV/AIDS. It states that the Bank “will help elevate the policy dialogue and awareness on HIV/AIDS, addressing analytical and funding gaps as required to do so.” ⁴⁷

47. A very substantial body of analytic work has been planned in response to this commitment.

Annex E: World Bank Health Sector Work on Indonesia

Year	Title	Report Number	Comments
1979	Indonesia — Health Sector Overview	2379	Formal sector study
1980	Indonesia — Regional aspects of family planning and fertility behavior	2922	Formal sector study
1989	Indonesia — Issues in health planning and budgeting	7291	Formal sector study
1990	Indonesia — Family planning perspectives in the 1990s	7760	Formal sector study
1991	The World Bank and Indonesia's population program	9370	OED study
1994	Indonesia's health workforce — issues and options	12835	Formal sector study
1996	Redesigning Government's Role in Health: Lessons for Indonesia from Neighboring Countries	Indonesia Discussion Papers Series No. 1	This paper (S. Lieberman) was the first in a series on Indonesia but the only one on health issues. It called for de-concentrating to the provincial level of most major health responsibilities; taking steps to convert the MOH into an agency that performs tasks such as technical support, program review, policy analysis and advocacy; using a range of instruments to guide and encourage private provision of health services; and securing the increased public funding needed to bring about rapid health gains.
1996-1999	Watching Briefs on nutrition issues in Indonesia	24786, 24788	Short briefs on under-nutrition in young children, facing the challenge to reduce maternal mortality, and the proportion of child mortality association with malnutrition.
1998	What do Doctors Want? Developing Incentives for Doctors to Serve in Indonesia's Rural and Remote Areas	WPS 1888	Policy Research Working Paper (Kenneth M. Chomitz et al of the research department - DEC) suggesting increasing representation of outer islands students in medical schools as one action to increase willingness to serve there; establishment of training programs is also proposed in the outer islands for public health graduates to serve as facility managers in lieu of doctors.

Year	Title	Report Number	Comments
2000	Indonesia — Health strategy in a post-crisis decentralizing Indonesia	21318	Formal sector study. Paper calls decentralization the entry point for reform, sees enhancing district level capacity to formulate and implement health policy locally as important step, finds the proposed Health Council a good cross-district mechanism to bring together district-level representatives, NGOs, the private sector and the health professions. Study recommends MOH manage a poverty and health fund focusing on the poorest areas, and writes of formation in 1999 of a “Partners for Health” alliance of WB, ADB, WHO and UNICEF. Annex Tables 1 and 2 juxtapose levels and shares of current health spending by program with “ideal” spending levels. STD spending would rise from 0.25 percent to 1.49 percent and from 417,887 Rp per health center (HC) to 12,918,517 per HC (increase 30 times) as part of proposed overall growth from 165 m to 865 m per HC (increase 5 times) .
2003	Decentralization in Indonesia’s Health Sector — an Update — Essential Public Health Functions: Prevention, Control and Surveillance of Infectious Diseases	NA	Informal report (Daniel Miller, US CDC secondee to HDNHE, the health sector “anchor”). Draws attention to serious negative consequences for public health functions of decentralization as practiced in Indonesia, and points to de facto re-centralization of some activities, including HIV services, by external funding; report also calls for laboratory support, quality control, and quality assurance for surveillance to be strengthened, with enhancement of central authority and oversight over laboratories.

Annex F: Indonesia: Timeline of Events related to HIV/AIDS

Year	Events in Indonesia	World Bank Events	Development Partner 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	<ul style="list-style-type: none"> ▪ 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. Prevalence zero in both sites. 		WHO-GPA supports MOH National AIDS Committee in developing Short Term Plan on AIDS and Medium Term Plan on AIDS (1988/89-1991).
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.	AIDS enters WB policy dialogue with GOI authorities (PAD, pg. 91)	CDC Epidemiologist Michael Linnan 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.
1992/93	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.	UNDP sponsors a project to develop HIV responses in non-health ministries.

Year	Events in Indonesia	World Bank Events	Development Partner Events
1993/94	First HIV positive sample reported in sentinel surveillance; 3/52,870 sex workers tested positive for HIV (0.0057 percent).		
1994	<ul style="list-style-type: none"> ▪ Presidential decree creates a National AIDS Prevention and Coordination Commission (NAC), including 14 Ministers, chaired by 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) 	<ul style="list-style-type: none"> ▪ 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). 	<ul style="list-style-type: none"> ▪ 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)
1995	Yayasan Spiritu, an organization of people living	<ul style="list-style-type: none"> ▪ Project preparation mission on a "first, trial phase of a 	

Year	Events in Indonesia	World Bank Events	Development Partner Events
	with HIV, is formed.	<p>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).</p> <ul style="list-style-type: none"> ▪ Award of \$14,000 grant from WB Small Grants Committee to Yayasan Kusuma Buana (YKB) for production of IEC materials on HIV/AIDS/STDs and their distribution at STD service outlets and public health facilities and to NGOs, in Bali, Java and Riau (August). ▪ 6 Indonesians — largely but not exclusively military — participate in WB Economic Development Institute regional workshop on AIDS in the military in South and Southeast Asia held in Thailand (September). <p>▪ Appraisal of HIV/AIDS and STDs Management Project (October)</p>	<ul style="list-style-type: none"> ▪ Implementation of the AU\$ 19 million Indonesian HIV/AIDS and STD Prevention and Care Project Phase 1 begins in three provinces (Bali, NTT and South Sulawesi, September). It continues until June 2001.
1996	<ul style="list-style-type: none"> ▪ 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. 	<ul style="list-style-type: none"> ▪ 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) 	<ul style="list-style-type: none"> ▪ USAID provides support in HIV prevention under the international AIDSCAP agreement, implemented by FHI. ▪ WHO Update on AIDS in Indonesia (Dr. Stefano Lazzari) shows, of a total of 119 AIDS cases, homo-bisexual behavior as risk factor in 51, heterosexual behavior as risk factor in 47, and IDU as risk factor in 3 (December)
1997	<ul style="list-style-type: none"> ▪ Financial crisis in Thailand spills over into Indonesia (July) 	<ul style="list-style-type: none"> ▪ Second supervision mission reports PMU not in a position effectively to manage the project (January). ▪ PSR rates implementation progress and development objectives as satisfactory, project management as unsatisfactory (February). 	<ul style="list-style-type: none"> ▪ USAID-funded AIDSCAP project is re-launched as the HIV/AIDS Prevention Project (HAPP), implemented by Family

Year	Events in Indonesia	World Bank Events	Development Partner Events
		<ul style="list-style-type: none"> ▪ 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). 	<p>Health International in collaboration with MOH DG CDC-EH (July).</p> <ul style="list-style-type: none"> ▪ Indonesia seeks IMF assistance to confront financial crisis (October).
1997-1998	Survey of HIV among 13,656 military recruits in 5 provinces. HIV prevalence 0.		
1998	<ul style="list-style-type: none"> ▪ Resignation of President Suharto (May) 	<ul style="list-style-type: none"> ▪ 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, 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 <i>aide memoire</i> 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 	

Year	Events in Indonesia	World Bank Events	Development Partner Events
		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 (since upgraded) and HIV/AIDS (August).	
1999	<ul style="list-style-type: none"> ▪ HIV prevalence in IDU sentinel site (Jakarta drug treatment center) is 16 percent, up from 0 percent in 1996 and 1997. ▪ MOH publishes <i>Healthy Indonesia 2010</i> 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. 	<ul style="list-style-type: none"> ▪ 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	<ul style="list-style-type: none"> ▪ HIV sentinel surveillance among IDU records rise in HIV prevalence to 41 percent, from 16 percent a year earlier. Sentinel sites in Jakarta prisons record HIV prevalence of between 12 and 18 percent, up from zero a year earlier. 	<ul style="list-style-type: none"> * ▪ 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 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 	

Year	Events in Indonesia	World Bank Events	Development Partner Events
	<ul style="list-style-type: none"> ▪ President opens national HIV/AIDS conference held in Jakarta (July) ▪ President Abdurachman Wahid drops the post of Coordinating Minister of People's Welfare, and the Chair of the NAC passes to the Office of the Vice President, Megawati Soekarnoputri (August). 	<p>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).</p> <p>* ▪ 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).</p>	<ul style="list-style-type: none"> ▪ Implementation of the US\$ 14 million USAID-funded ASA project begins, implemented by Family Health International in conjunction with MOH in 10 provinces (October).
2001			<ul style="list-style-type: none"> ▪ WHO sponsors estimation workshop; consultant James Chin estimates there are 80,000 — 120,000 people with HIV in

Year	Events in Indonesia	World Bank Events	Development Partner Events
	<ul style="list-style-type: none"> ▪ Radical decentralization of government functions becomes effective. Under Law No 22/1999 public health surveillance remains the authority of the central government, but no budget is secured. Other health and welfare programs become the responsibility of over 350 districts (May) ▪ The Coordinating Ministry for People's Welfare (Meko Kesra) is reinstated in August 2001, by the incoming President, Megawati Soekarnoputri. NAC returns to Meko Kesra (August). ▪ National AIDS Committee/MOH publishes first National Report on HIV, intended for a wide audience and launched at the Asia-Pacific AIDS conference in Melbourne (November). 		<p>Indonesia (March).</p> <ul style="list-style-type: none"> ▪ UN General Assembly Special Session on HIV/AIDS (UNGASS) (June).
2002	<ul style="list-style-type: none"> ▪ 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). ▪ Central Bureau of Statistics (BPS) is invited by MOH to collaborate on behavioral surveillance. BPS expands behavioral surveillance among high risk groups to 13 provinces (May). ▪ Campaign to promote condom use among high risk men (sponsored by ASA and MOH) runs in mass media. Within weeks, a radical Islamic group threatens to burn down TV stations. Campaign is cancelled. MOH does not intervene despite lobbying from health and moderate religious community (June). ▪ Population based survey among transgender sex workers in Jakarta records 22 percent HIV prevalence, up from 6 percent in 1997 (September). ▪ 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 		

Year	Events in Indonesia	World Bank Events	Development Partner Events
	<p>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).</p> <ul style="list-style-type: none"> ▪ MOH publishes sectoral plan for HIV/AIDS prevention and care 2003-2007. The plan estimates funding needs at 1.2 trillion rupiah, and states that these needs should be met mostly through national funding. If foreign funding is needed, the plan states that grant rather than loan financing should be sought (December). 		
2003	<ul style="list-style-type: none"> ▪ National Narcotics Board declares harm reduction activities among IDU illegal (April). ▪ Office of the Coordinating Minister for People's Welfare/National AIDS Commission publishes updated National HIV/AIDS Strategy, 2003-2007, prepared by a team including donor project staff. Funding reported to be a major constraint, to be overcome by promoting multisectoral coordination. Importance of political will at highest levels is underscored, supported by government agencies, NGOs and the private sector. Strategy reports "drastic increase" in number of new cases of HIV and covers Indonesia's participation in meeting international commitments of UNGASS and ASEAN in 2001. Amendment of prior strategy justified by changes in epidemic, development of methods to control HIV/AIDS (ARVs, IEC, 100 percent condom use, harm reduction for IDU are mentioned), government decentralization, and "internationally binding resolutions." Advent of GFATM reported informally also to be a consideration. Strategy states "foreign aid best given in the form of grants or soft loans." Foreign assistance expected to be used "proportionally to meet the needs of both the government and NGOs." (mid-year) 	<ul style="list-style-type: none"> ▪ Under the general objective of improving health 	<ul style="list-style-type: none"> ▪ First Round Indonesian proposal to GFATM is signed; HIV-related component supports DOTS for TB in 4 provinces with high HIV seropositivity; two year HIV approved funding level \$6.9 million (June); Round Two and Three proposals are rejected . ▪ WHO promotes "3X5" initiative for

Year	Events in Indonesia	World Bank Events	Development Partner Events
	<ul style="list-style-type: none"> ▪ MOU between National Narcotics Board and NAC signed in the presence of President Megawati. In indirect language, the MOU supports harm-reducing interventions among IDU (December). ▪ MOH announces that private pharmaceutical company in Indonesia will be licensed to produce ARVs (December). 	<p>outcomes, the WB 2003 Indonesia CAS for the first time mentions HIV/AIDS. It states that the Bank “will help elevate the policy dialogue and awareness on HIV/AIDS, addressing analytical and funding gaps as required to do so.” A substantial body of analytic work is planned in response to this commitment (October)</p> <ul style="list-style-type: none"> ▪ WB HIV/AIDS Strategy for the East Asia and Pacific Region (draft) draws lesson from Indonesia of need to maintain political commitment to prevention at the low-level stage of the epidemic. Lending expected to focus on surveillance, prevention and service delivery, with a broad set of instruments and options for client countries. Analytic work expected to concentrate on 5 key challenges: (a) political commitment and multisectoral support; (b) public health surveillance and M&E; (c) prevention; (d) care, treatment and support; and (e) health services delivery (November). ▪ WB Japan Social Development Fund (JSDF) proposal proposes testing and developing innovative mechanism for establishing “HIV/AIDS competent” communities in Java cities where HIV/AIDS threat is significant. Grant request of \$1.6 m, in association with Bank-financed first Indonesian Urban Poverty Project. Implementing agency would be Yayasan Pelita Ilmu. DfID-financed proposal for AIDS-related sectoral studies readied for execution by WB staff (December). ▪ WB prepares for forthcoming CPPR. No HNP operations are shown as problem projects. Mainstreaming of project readiness criteria — a problem that was evident in the HIV/AIDS and STD Management Project — is a concern throughout entire portfolio, as are weak M&E systems, exacerbated by absence of baseline data. CPPR action to strengthen HNP operation M&E is proposed (December). 	<p>treatment of people living with AIDS (PLWA) (Fall).</p> <ul style="list-style-type: none"> ▪ UNAIDS Jakarta office completes unified workplan and budget 2004-5. Plan foresees WB support of National AIDS Commission (NAC) with implementation and dissemination of social and economic analytic studies. WB budget support (from DfID grant) also foreseen for a TA position on multisectoral dimensions of AIDS in NAC secretariat (December)
2004			End of IMF-supported program in Indonesia (January).