

## **Asia Pacific CSAT Report YEAR 01: January – March 2008**

### **START UP JANUARY 2008**

#### **CHALLENGES**

**Asia Pacific GFTAM Grants:** As of January 2008 there were 128 Global Fund grants in the Asia Pacific region spread over the 20 countries and the Western Pacific. 30 were up to 3 months behind, 21 behind by 3-6 months and 26 that were over 6 months behind. There were an additional 30 that had yet to be scored. Indonesia had been identified as a key troubled area by their UNAIDS Civil Society Partnership Officer (CSPO), in December 2007 at a meeting convened by UNAIDS Regional Support Team (RST) of CSPOs from the Asia Pacific (AP), who also reported that AusAID was pouring 2 Million to address some of the issues. 7 Sister/APN+ have good Indonesia contacts in CS and in the various UN country offices but there are a number of issues within country that would need to be navigated.

**Language:** There are over 250 languages and dialects spoken in Asia. To find a Regional Coordinator with the experience and skill that CSAT requires plus the language was identified as a challenge. Prioritizing a language would also pose a challenge. Bahasa was identified as a language that could serve a number of countries in the region.

**Geography:** There are 20 countries that make up Asia Pacific (East Asia & the Pacific, South Asia) The 21<sup>st</sup> is Western Pacific which is a multi-country grant and not easily accessed by internet and even post. There are also a time differences to contend with, in addition to language and culture. A solution would be to open a 2<sup>nd</sup> CSAT office possibly in the Pacific. The needs there are quite different from Asia.

#### **Asia Context Outside of Technical Issues<sup>1</sup>**

The following characteristics have been identified as unique to the Asian environment that contribute to the continuing challenges of CS successfully working together and create barriers for appropriate funding levels and commitment to the HIV/AIDS response in the region.

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<sup>1</sup> The Regional 2008 UNGASS Review – Civil Society Preparation meeting was called by HDN following an informal meeting held at ICAAP in Colombo, Sri Lanka, August 2007. At this initial meeting there was shared interest in further discussing overall increased civil society participation in UNGASS and Universal Access related processes. There was no funding for this meeting and all participants funded their own participation. This allowed freedom for focused and honest discussion around UNGASS, Universal Access and the civil society regional response to HIV/AIDS. Representatives from AFAO, AHRN, APCASO, APN+, HDN and ITPC attended this meeting held in Chiang Mai 21 Sept. 2007

- Diversity (cultural issues, repressive governments, ethnic, language)
- Low HIV/AIDS prevalence, coverage and treatment
- High population density
- Low profile, off radar, in the shadow of Africa
- Migration
- Drug use patterns
- Epidemiology, uniform prevalence among concentrated populations
- More resources, higher literacy, relative political stability, good infrastructure
- Small CS voice, CS not confrontational/vocal – a lot of stigma
- Rapid change due to economic growth
- Rich/poor gap is large
- Cultural taboos discourage talk about sex, HIV etc.
- Weak leadership

**Capacity of CSO:** In addition to the above list there are many issues that CSOs face in the AP region. Many lack the capacity to be PRs, SRs or even SSRs. This and the general lack of knowledge on the GFTAM create many challenges for meeting the CSAT mandate.

### **REQUESTS FOR SUPPORT**

**APCOM:** The Asia Pacific Coalition of Men's Sexual Health (APCOM) approached CSAT for assistance in December 2007 to submit a proposal as well and to also look at the MSM proposal from Nepal from Round 7 to see about the possibility of resubmitting for Round 8. APCOM convened several meetings of its affiliates to discuss GFTAM to which CSAT was always invited to attend but scheduling did not permit. CSAT worked with APCOM to access TSF of AP, connected them with the CSPO in Sri Lanka who is working with the MSM group there, met with their Consultant who is based in Bangkok and provided some other background info. APCOM mobilized some resources and have come up with a plan for Round 8. CSAT AP met with APCOM representatives in Bangkok in late March and the plan was to link APCOM members from South Asia with CSAT to broker TS for them for Round 8 submissions. This failed to materialize, most likely due to some political situations within these countries that warranted APCOM to send a representative for face-to-face meetings within these countries. APCOM has quite a few focal points through out the Asia Pacific region and while the CSAT AP Host is working with them through APCOM, the proposals that come from out of the APCOM affiliates will really be from individual countries such as India, Nepal and some others. This relationship warrants further exploration and after the experience of Round 8 should warrant more productive results in Round 9.

**China:** Since October 2007, Linda Liang of the Global Fund Developing

Countries Delegation has approached 7 Sisters/APN+ and then CSAT when the AP Regional Host was announced to work together to promote CS involvement in GFTAM activities. This has been on-going, she did approach CSAT for funding to support the TS needed for China but that is not CSAT's role. Current plans call for a Reference Group to be formed with CSAT staff and other members from the 7 Sisters networks who have also been approached. CSAT will continue to work with Linda and see what can be accomplished in China.

**Malaysia:** CSAT shared information regarding Round 8 with CS representatives in Malaysia at the workshop to implement the 7S tool "Minimum Standards for Civil Society Participation in the Universal Access Initiative" (MSCVSP). This was the first time Malaysia qualified for GFTAM funds in quite awhile and their seemed to be little interest by MAC (Malaysian AIDS Council) who was hosting the workshop to follow up. CSAT had a conversation with the person who headed Malaysia's previous GFTAM submission and it seemed unlikely that this would move forward. After the workshop, CSAT sent printed information on Round 8 to participants from the PT Foundation. CSAT has since learned that a small group has convened and are working on a GFTAM proposal. No further requests for assistance have been received and no other information is known but CSAT AP will follow up on this. As there is no CCM in Malaysia it questionable as to what the process has been or whether this proposal will make it for consideration to Round 8 however it is possible that whatever is developed could be submitted in Round 9 with additional work

### **OTHER**

**Vietnam & Cambodia:** CSAT AP has learned that CS proposals or submissions to country proposals for CS systems strengthening have been in development in Vietnam and Cambodia. These are being done through (Health Development Network) HDN's Country Platform Partnerships. Current plans call for CSAT to strengthen ties to HDN's work within these countries and move the working relationship beyond information sharing. We are currently looking at implementing MSCVSP in these countries and conducting the workshops by October 2008, CSAT can build on those efforts.

**Purple Sky Network:** At the 16<sup>th</sup> GF Board Meeting in Kunming there was a commitment by the GF and the private foundations to "champion" proposals related to gender and sexual minorities for Round 9. CSAT AP approached the Greater Mekong MSM Network (The Purple Sky Network) about submitting for Round 9 and USAID is interested in possibly supporting this. These conversations are on-going.

**UNAIDS:** Conversations have been on-going with UNAIDS regarding CSAT. CSAT was introduced to over 20 AP CSPOs at a meeting held in December 2007

in Bangkok by UNAIDS RST. Of those in attendance Indonesia has responded most enthusiastically and the CSPO has facilitated introduction of CSAT to CS representatives on the CCM, staff and coordinator of the CCM, the National AIDS Commission (NAC) and CS representatives from 12 Provinces involved with HIV submissions for Round 8. Unfortunately, Indonesia has proven to be the exception but given that the UCCs and CSPOs in the AP face many challenges including no funding and lack of human resources perhaps it is understandable.

**TSF:** TSF was also attending the meeting convened by UNAIDS RST in December 2007 and a short meeting occurred between CSAT AP and a TSF staff person after the initial introduction. CSAT AP requested a formalized meeting with TSF for the following month to discuss CSAT activities as well as TSF's plans for the USD 5 Million they had received to support TS for GFTAM activities. These requests were not responded to. Since then, CSAT' information and a draft of the work plan for AP has been shared with TSF staff. Apparently, it has been reported, that the TSF in AP is experiencing many difficulties at this time and so perhaps that is limiting their effectiveness. Could also be a lack of clarity on CSAT's role which could be causing some of the perceived resistance but at this time this is not clear.

### **WORK PLAN**

At the CSAT meeting held in March 2008 in Morocco, CSAT AP decided to focus on Indonesia for Year 1 for many of the reasons already stated. From 17-21 March, CSAT Regional Host AP (7 Sisters/APN+) met with the UNAIDS CSPO, CS representatives from the CCM, CS representatives from 12 provinces convened for Round 8 submissions, staff of the National AIDS Commission, staff of the CCM, other UN offices in Jakarta, AusAID and government officials to discuss and negotiate CSAT AP's role. Given the many challenges and language constraints, a plan to hire and place CSAT staff inside the National AIDS Commission to work side by side with the CCM was developed and greeted enthusiastically by all involved. From 21-31 March a TOR and Work Plan was developed using existing CSAT materials. These were approved and a call for candidates was issued. Interviews were scheduled for 14-15 of April and an interview team was compiled. The results will be in the next report.

Attached to this report (pages 5-7) is some background information on GFTAM in Indonesia and notes compiled from the early meetings of the CSAT AP Regional Host and the UNAIDS CSPO who is in charge of coordinating the Round 8 submission for Indonesia.

## **INDONESIA RECEIVED TWO GRANTS FOR AIDS IN R1 AND R4.**

1) **R1** was approved at US\$ 7.8million. To date, US\$ 5.7million has been disbursed.

The **principal recipient** for R1 is Directorate of Directly Transmitted Disease Control, **Department of Health**.

The grant covers 4 provinces: **Jakarta; Bali; Papua and Riau**. (plus 1 additional province West Papua)

The program targeted vulnerable groups: youth (in and out of school); commercial sex workers; intravenous drug users; pregnant women and people living with HIV. Strategies include expanding HIV information and education and improving access to care, support and treatment services. Peer education, VCT, laboratory work and treatment referral are priority focus areas of the program.

This grant did not receive high performance rating throughout the whole duration. At its phase 2 review, the GF gave this grant a Conditional Go with a number of recommendations for changes to the workplan priorities and other interventions to increase funds absorption and disbursement to reach set target (this includes increasing training for programme implementation and M&E). This grant is expected to end in 2008 and it has not succeeded in qualifying for the Rolling Continuing Channel mechanism.

2) **R4** was approved at US\$ 54.8million. To date, US\$ 22million has been disbursed.

The **principal recipient** for R4 is Directorate of Directly Transmitted Disease Control, **Department of Health**.

The grant covers 17 provinces: DKI Jakarta West Java East Java Central Java South Sumatra North Sumatra DI Yogyakarta West Kalimantan East Kalimantan Banten South Sulawesi West Nusa Tenggara East Nusa Tenggara West Irian Jaya Papua - Timika

The program also targeted vulnerable groups: youth (in and out of school); commercial sex workers; intravenous drug users; pregnant women and people living with HIV. Strategies were focused on prevention, care, support and treatment.

This grant also did not receive high performance rating in the first few quarters but its performance did improve at the end of Phase 1. Prior to submitting the Phase 2 proposal, the CCM for the first time recommended that a second Principal Recipient be added to assist in the implementation of this grant. A civil society organization PKBI was short-listed and selected to become the second PR. While this was considered to be a good development, many difficult issues arose and

required a lot of consultation and technical assistance.

Unfortunately in January 2007 due to problems identified by the Global Fund Office of Inspector General regarding mismanagement of funds and cases of conflict of interest in Indonesia between the Principal Recipient of TB grant and AIDS grant and certain sub-recipients, the Global Fund imposed funding restrictions on all grants to Indonesia for more than 9 months. Up until now, Phase 2 of the R4 AIDS grant has not yet been signed. R4 has lost 9 months in programme implementation and its performance in the remaining Phase 2 will face difficult challenges as a result of the funding restriction and temporary pause of implementation. This restriction period that occurred in 2007 also had impact on the designation of the second PR in Round 4... focus was placed on the lifting of restriction and there was not enough technical assistance provided to PKBI. In the end, PKBI withdrew their interest to be second PR for Round 4 because they could not reach agreement on the grant budget and the management costs.

### Other applications

3) In 2007 Indonesia also submitted a proposal for Round 7 AIDS (to achieve national Universal Access targets through comprehensive approach in 7 provinces) but the proposal was not approved due to many weaknesses identified by the TRP. It was proposed that the National AIDS Commission be the sole PR for Round 7. The main weakness was lack of details and inadequate linkages between goals, targets and workplans and budget. We did not map out details of implementation model at province and district level.

4) We are now focused on succeeding in Round 8. Situation is severe as the funds for AIDS in Indonesia will start to run out in 2009. CCM has already agreed that there should be more than 1 PR and that non-government entities should be encouraged to apply to be PR. For Round 8 AIDS, the proposal will cover 12 provinces.

<b>12 recommended provinces for Round 8 AIDS component</b>			
<b>DKI Jakarta</b>	<b>Jawa Timur</b>	<b>Riau</b>	<b>Sulawesi Selatan</b>
<b>Jawa Barat</b>	<b>Bali</b>	<b>Kep.Riau</b>	<b>Papua</b>
<b>Jawa Tengah</b>	<b>Sumatera Utara</b>	<b>Lampung</b>	<b>Papua Barat</b>

Different from past proposal development processes, a regional consultation (12 provinces) will be held in Jakarta on 17-18 March to seek inputs from province and local representatives in order to obtain work plan, activities, technical and financial resource estimates from each province. This will be the basis of the Indonesia R8 AIDS proposal to be submitted in July 2008.

A Call for Interest to be PR for R8 will be announced asap (before end of

February) and interested entities will be asked to apply. It is expected that the CCM will designate a team to review the candidates and select suitable PRs.

For civil society sector, if they want to become PR, there is still a lot of support that needs to be provided in order to ensure that an Indonesian civil society entity will meet the 4 minimum requirements set out by the Global Fund for PRs.

Language is a major challenge as competency in English is a requirement for PRs as they have to communicate with Global Fund Secretariat and the LFA in English.