FAMILY HEALTH INTERNATIONAL

AKSI STOP AIDS PROGRAM

Year Three Workplan

October 1, 2007 – September 30, 2008

Approved: December 31, 2007

A Joint Program for HIV/AIDS Prevention, Care, Support, and Treatment
funded by
The United States Agency for International Development and
The Indonesian Partnership Fund for HIV/AIDS
in collaboration with
The Indonesian National AIDS Commission
and
The Indonesian Ministry of Health

USAID Cooperative Agreement No. 497-A-00-05-00045-00
UNDP Contract No. 035/2005

0Table of Contents

ABBREVIATIONS USED IN THE WORKPLAN

ADPEL	Port Administration Authority
APD	Asia Pacific Division
APINDO	The Indonesian Employers' Association
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASA Program	Aksi Stop AIDS Program
BCC	Behavior Change Communications
BKKBN	National Family Planning Board
BNN	National Narcotics Board
BPS	Indonesian Bureau of Statistics
BSS	Behavioral Surveillance Survey
CBO	Community-based Organization
CDC	Center for Communicable Disease Control (P2M)
COC	Continuum of Care
CST	Care, Support and Treatment
FBO	Faith-based Organization
FHI	Family Health International
GFATM	Global Fund to Fight AIDS, Tuberculosis, and Malaria
GOI	Government of Indonesia
HIV	Human Immunodeficiency Virus
IA	Implementing Agency
IBBS	Integrated Biological and Behavioral Survey
IDU	Injecting Drug User/Injection Drug Use
IEC	Information, Education and Communication
IHPCP	Indonesia HIV/AIDS Prevention and Care Project Phase 2 (AusAID)
ILO	International Labor Organization of the United Nations
IMAAI	Integrated Management of Adult/Adolescent Illnesses
KfW	German Development Bank
KPI	Indonesian Women's Coalition
MARGs	Most-at-risk Groups
MOH	Ministry of Health
MOL&HR	Ministry of Law and Human Rights
MOM&T	Ministry of Manpower and Transmigration
MSM	Men who have Sex with Men
MUI	Indonesian Council of Ulemas
NAC	National AIDS Commission
NGO	Non-Governmental Organization
OGAC	Office of the U.S. Global AIDS Coordinator
OI	Opportunistic Infections
Pepfar	President's Emergency Plan for AIDS Relief
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
RA	Result Area
RTI	Reproduction Track Infections
SA	Sub-agreement
SMS	Short text message service
SMS	Short Message Services (text message)
STI	Sexually Transmissible Infection

TA	technical assistance
TOT	Training of Trainers
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNODC	United Nations Office of Drug Control
UP	Universal Precautions
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
Waria	Male transvestite/transsexual
WHO	World Health Organization

I. INTRODUCTION

Family Health International (FHI) has assumed the challenging task of managing the **Aksi Stop AIDS Program** (ASA), beginning on October 1, 2005, with the combined resources of:

- The United States Agency for International Development (USAID); and
- The Indonesian Partnership Fund for HIV/AIDS.

This document outlines the comprehensive activities planned for the Year Three of the joint program, October 1, 2007 to September 30, 2008. This will be the last year of the program as currently planned. Due to the necessity of a three-month close-out period at the end of the program, the implementation of all program activities, therefore, will end on June 30, 2008.

The ASA Program represents a truly unique example of donor harmonization and collaboration, designed specially to assist the National AIDS Commission and the Ministry of Health to respond the expanding HIV/AIDS epidemic in Indonesia in the most appropriate and effective ways possible.

USAID has awarded a three-year Cooperative Agreement to FHI with the goal of containing the STI/HIV/AIDS epidemic through (1) reduced incidence of STI/HIV/AIDS in most-at-risk groups (MARGs) thereby helping to prevent a generalize epidemic and (2) reduced incidence of STI/HIV/AIDS within the general population of Papua. Expected results include:

- Increased coverage of most-at-risk groups with tailored interventions and improved uses of risk reduction behaviors, practices, and access to and use of services; and

- Increased ability of implementing agencies to regularly monitor, evaluate and improve program performance, thus achieving expanded coverage.

An amendment to the Cooperative Agreement was signed in July 2006 to add an additional component to the program for second generation STI/HIV/AIDS surveillance including both biological and behavioral assessments of MARGS, as well as – for the first time – the general population in Papua.

During the third year, all USAID funded activities will come under the policies and procedures of the President's Emergency Plan for AIDS Relief (PEPFAR) managed through the Office of the U.S. Global AIDS Coordinator (OGAC), including comprehensive reporting requirements.

The Indonesian Partnership Fund has also contracted with FHI through its financial manager, UNDP, to implement comprehensive prevention, care, support, and treatment activities which compliment and expand on the USAID funded activities, with the specific goals of:

- Individual risk of sexual transmission of HIV reduced:

- Individual risk of HIV transmission among injecting drug users and sexual transmission to their partners reduced;

- Awareness of general population, particularly young people, to reduce their vulnerability to HIV/AIDS infection and discrimination behaviors towards People Living with HIV/AIDS (PLWHA);

- Access and quality of care, treatment and support for PLWHA improved with a focus on increasing VCT, treatment of OIs, and community-based care and support;

- Capacity to prioritize and allocate resources for HIV/AIDS strengthened through operationalization of the "Three Ones" framework at national, province, and district levels.

By combining these goals, FHI has designed a joint program with one workplan, one management system, and one monitoring and evaluation mechanism that contributes significantly to the National Response to HIV/AIDS, while fulfilling the expectations and specific objectives of each donor agency. The jointly funded ASA Program has been designed to achieve the following major results:

Result Area 1: Increased Intervention Coverage and Use of Risk Reduction Behaviors, Practices, and Services; which will address the issues related to HIV/AIDS transmission through commercial sex, injecting drug use and men having sex with men, as well as special activities for the general population in Papua.

Result Area 2: Improving IAs Ability to Self Assess and Enhance Programs: which will focus on improving the coverage and quality of all program activities through strengthened monitoring and analysis of activities in the field, and aggregated reporting and evaluation upward through the entire program management structure.

Result Area 3: Strengthening the Institutional Response; which will include assistance to the local AIDS commissions, the Ministry of Health and the health service network, the national prison system, and the uniformed services in order to strengthen their institutional responses to HIV/AIDS as well as to create a more conducive environment for expanded comprehensive programming in the field.

Result Area 4: Implementing Second Generation Biological and Behavior STI/HIV/AIDS Surveillance among the most-at-risk groups in the seven target provinces and within the general population of Papua, as well as facilitating the analysis of results and their use in advocacy and evidence-based decision making.

All strategies and activities outlined within this workplan are based on the current Government of Indonesia HIV/AIDS National Strategy; The USAID Indonesia HIV/AIDS Expanded Response Strategy 2002 – 2007; The National Action Framework 2005 – 2007 of January 2005 by the National AIDS Commission; the recommendations of the UN Global Task Team, and FHI's lessons learned and best practices compiled through years of experience as an international leader in managing comprehensive, effective responses to HIV/AIDS.

II. THE HIV/AIDS EPIDEMIC IN INDONESIA

During the last year, the number of people living with HIV/AIDS has continued to increase despite the combined efforts of the government, civil society, the private sector, international donors and implementing organizations such as FHI. According to the official 2006 estimations of population size of most-at-risk groups, between 170,000 and 217,000 Indonesians are currently infected with the HIV virus, and over 6,500,000 engage in high risk behaviors. The situation in Tanah Papua (consisting of the two provinces of Papua and West Papua) is even direr, with 2.4% of the general population already infected (IBBS, 2007).

Injecting drug use remains the major contributor to the dramatic expansion of the epidemic outside of Papua, especially when it interfaces with commercial sex or recreational sex with multiple partners, each of which are major at-risk behaviors in their own right. With the increasing efforts by the police force to address the growing national drug problem through coercive methods, the prison system has become a major incubator for infection with HIV, TB and STI, while also presenting an opportunity to respond to the epidemic within the IDU population through a structured, institutional framework.

The commercial sex industry across Indonesia remains active, with high mobility among both prostitutes and their clients, while condom use remains stubbornly low. Commercial sex and unprotected sex with multiple partners within the gay community also remain major avenues of infection. Waria, which intersect with both of these categories, continue to show alarming levels of both STI and HIV infection. Partners of female and male prostitutes, their clients, and injecting drug users are also developing into a significant most-at-risk group; and small, yet ever increasing numbers of HIV positive pregnant women indicate a relentless, expanding epidemic.

The epidemic is evolving differently in Papua. Commercial and transactional sex are major contributing factors in most urban areas. High mobility of the population, frequent unprotected premarital and intergenerational sex, multiple concurrent sexual relationships and alcohol abuse, combined with very low levels of circumcision, are causing infection rates to soar in the general population.

III. PROGRAM FRAMEWORK

As determined at the beginning of the ASA Program, the primary focus of the program remains on dramatically increasing intervention coverage in order to reach over 60% of all most-at-risk groups in the seven target provinces and at least 40% of the general population in Papua with two effective interventions. This increase in coverage must be accompanied by improvements in the quality of all interventions and services, as well as in the management of coordinated responses at all levels. Building capacity of all partner organizations including local NGOs; government sectors; and the national, provincial and district level AIDS commission will continue to be crucial in achieving these goals.

The combined objectives of the program to reduce risk behaviors among MARGs and the general population in Papua will be accomplished through a comprehensive and coordinated approach to delivering STI/HIV/AIDS preventions, care, support, and treatment services through key partnerships with a mix of proven technical interventions, all adapted to the specific needs of each target group in each target area. Overall program activities will focus on raising demand for prevention services and supplies; delivery of accurate and comprehensive information concerning the epidemic; increasing the quality and coverage of outreach and peer education activities; increasing the availably and utilization of testing, screening, care, treatment and support services; and reducing barriers to accessing all of these services.

FHI and its partners will also help build institutional capacity to design and implement comprehensive programs for HIV/AIDS within the national prison system and the uniformed services, two institutions that have a critical role in play in reducing transmission of the virus, both internally among their constituents as well as in the general population through both direct prevention efforts, as well as through the normative influence these groups have.

FHI will continue to assist the National AIDS Commission in developing the capacity of provincial and district level AIDS commissions, an activity which will complement and significantly facilitate implementation of comprehensive and sustainable STI/HIV/AIDS activities at the local level. Strengthened local AIDS commissions will be able to: collect, analyze, and use all relevant data, including IBBS, estimates, and coverage; develop and manage a comprehensive and sustainable local responses based on empirical evidence; coordinate all HIV/AIDS programming in the district or province; provide technical leadership; and monitor and evaluate results. As timely and accurate data tracking the course of the HIV/AIDS epidemics among key population subgroups are essential for performing many of these functions, FHI will also continue its long-standing support to the development of an effective and efficient second generation HIV/AIDS surveillance system in Indonesia.

Target Populations and Areas

Following strong epidemiologically-based logic, FHI has focused its activities on specific MARGs where transmission risk is highest; including injecting drug users, male and female prostitutes and their clients, men who have sex with men, and partners of all of these groups. In Papua, the focus also includes the general population (15 to 45 years), especially ethnic Papuans including youth, women of reproductive age, and ports of border region populations.

Based on careful and detailed analysis of the recent 2006 estimations of most-at-risk population size and their locations at the provincial and district levels, FHI will continue to focus its activities in a total of 79 districts within eight provinces where significant “hotspots” of high risk behavior have been identified. By focusing on these areas, FHI in collaboration with other stakeholders will be able to reach an estimated 60 – 80% of the most-at-risk groups in these provinces, and thereby make a significant impact on slowing and containing the epidemic. The program target areas are:

Target Districts

Papua	East Java	West Java
1 Jayapura District	1 Surabaya City	1 Bandung City
2 Jayapura City	2 Sidoarjo District	2 Bandung District
3 Keerom District	3 Malang City	3 Cimahi City
4 Peg. Bintang District	4 Malang District	4 Bogor City
5 Sorong District	5 Banyuwangi District	5 Bogor District
6 Sorong City	6 Jember District	6 Cianjur District
7 Nabire District	7 Kediri City	7 Cirebon City
8 Jayawijaya District	8 Kediri District	8 Cirebon District
9 Puncak Jaya District	9 Pasuruan City	9 Sumedang District
10 Paniai District	10 Pasuruan District	10 Depok City
11 Mimika District	11 Tulungagung District	11 Bekasi District
12 Biak District	12 Nganjuk District	12 Bekasi City
13 Mappi District	13 Gresik District	13 Subang District
14 Asmat District	14 Madiun City	14 Karawang District
15 Manokwari District	15 Madiun District	15 Tasikmalaya City
16 Fakfak District	**DKI Jakarta**	16 Indramayu District
17 Kaimana District	1 West Jakarta	17 Sukabumi City
18 Merauke District	2 North Jakarta	**Central Java**
19 Kab. Teluk Bintuni	3 East Jakarta	1 Semarang City
North Sumatera	4 South Jakarta	2 Semarang District
1 Medan City	5 Central Jakarta	3 Surakarta City
2 Deli Serdang District	**Kep. Riau**	4 Banyumas District
3 Serdang Bedagai City	1 Tanjung Balai Karimun District	5 Tegal District
4 Toba Samosir District	2 Batam City	6 Batang District
5 Tanjung Balai District	3 Tanjung Pinang City	7 Pati District
6 Langkat District	4 Bintang District	8 Kendal District
7 Simalungun District		9 Salatiga City
8 Pematang Siantar City		10 Cilacap District

Key Principles

The implementation of the joint ASA Program will continue to be guided by the following key principles:

- **The "Three Ones"**

The ASA Program is itself a prime example of donor harmonization within the context of a national HIV/AIDS action framework, under one national coordinating authority, and contributing to a country-level monitoring and evaluation system. This emphasis will continue throughout the life of the program

- **Promote appropriate behavior change through the "ABC" approach**

In line with proven international best practices and the USG policy, the ASA Program will continue to promote the reduction and elimination of risk behaviors using the most appropriate combination of the "A,B,Cs" for each specific target group.

- **Implement a prevention–to–care continuum to increase access to all necessary services with appropriate referral among implementing organizations**

PLWHA and other at risk of HIV infection need access to an array of services provided by many different, and sometimes unconnected, organizations. Filling gaps in services, strengthening referral systems, and creating synergies between prevention and care services (including STI diagnosis and management, and VCT) to ensure that clients receive a continuum of services is an essential and central element of the program.

- **Employ evidence-based decision-making to guide program development and adaptation**

The ASA program has worked closely with the national, provincial and district AIDS commissions to determine estimations of population size of most-at-risk groups in each respective area, compile all relevant activity data, and analyze the latest surveillance data to inform program design and implementation. The emphasis on evidence-based decision-making will continue during Year Three, with the results of the next round of biological and behavior surveillance eagerly waited.

- **Work within existing structures to achieve scale**

FHI has already established close working relationships with the relevant government sectors, non-governmental organizations including FBOs, and private sector companies which have extensive reach across the target areas, and will continue to strengthen the combined capacity of these networks to provide better quality services and more effective program interventions to a greatly expanded target group.

- **Encourage greater involvement of target populations**

Realizing the crucial role each target population have in determining their own behaviors, FHI will increase its emphasis on peer led interventions and peer education during Year Three. This will help ensure that activities address the specific needs and aspirations of each individual target group, as well as help empower and clarify responsibility for personal action and establish safer social norms within these often marginalize groups.

- **Greater involvement of People Living with HIV/AIDS (PLWHA)**

Because only PLWHA can generate new infections, it is vital that they are actively engaged in prevention activities, and empowered to effectively promote comprehensive care, support, and treatment services for HIV/AIDS. Involvement of PLWHA, both as individuals and as peer organizations, will be encourage in all program activities, especially in strengthening prevention activities within care settings and creating peer support for "HIV Stops with ME' interventions.

- **Achieving scale within an urgent response**

The ASA Program has been designed, and will continue, to address the enormous need for HIV/AIDS prevention, care, support, and treatment on a massive scale throughout the eight target provinces, as well as the urgency of a rational, comprehensive response in order to limit the expansion of the epidemic and mitigate the impact that an uncontrolled HIV/AIDS pandemic would have on the future of Indonesia.

Major Progress To Date

During the first two years of the ASA program, October 2005 to September 2007, major progress was made in the following areas:

- Strengthened collaboration within the **Accelerated National Response to HIV/AIDS** managed by the National AIDS Commission, including active support to develop capacity of provincial and district level AIDS commissions and eager participation in all program and policy efforts at the national level.

- Through **Response Mapping Workshops and continuing coordination meetings** within each target province, higher quality program planning has been instituted

including better quality estimations of population size for each most-at-risk group, mapping the geographic spread of local "hot spots", review of current local program initiatives and their coverage, and identification of gaps in the local response; all combining to provide a strong evidence base for local decision making.

- **Subagreements** have been executed with all of the 133 local Implementing Agencies that have been selected in collaboration with the respective local AIDS commissions to implement the various components of the local response in each of the 78 targeted districts.

- **Technical strategies** for all program components are continually being reviewed, updated, and augmented to adjust to developments in the program and changes in the epidemic; each major **intervention** has been defined; and appropriate **indicators** for each technical area have been determined.

- All **program management systems** have been reviewed and up-graded with an emphasis on decentralization, development and utilization of a web-based M&E reporting system, as well as a Quality Assurance/Quality Improvement system, and efficient financial management.

- **Basic training and mentoring** continue to be provided to both old and new Implementing Agencies in HIV/AIDS programming, all relevant technical areas, and practical monitoring, reporting, and financial management skills.

- A new round of **biological and behavior surveillance for STI/HIV/AIDS** was instituted, beginning with a ground-breaking survey among the general population in Papua in 2006 and the latest round among most-at-risk groups which began in August 2007.

- **Substantial progress was made toward the achievement of program coverage targets**. "Outreach" targets for some MARG (female prostitutes and waria) have been or will be reached or exceeded by the end of Year Two, and program strategies have been recently revised to focus more effort on reaching the targets for high-risk men, MSM and IDU during Year Three, which will remain a challenge due to the scale and hidden nature of these groups. The basic network of clinical services is in place, and the agreements and frameworks have been established for rapidly scaling-up program efforts directed to National, Provincial and District AIDS Commissions, prison inmates and the uniformed services during Year Three.

Collaboration

Working within the framework of the National Response to HIV/AIDS, FHI will continue to actively support the National AIDS Commission, and the provincial and district/municipality-level AIDS commissions throughout the target areas. This collaboration will focus on policy development, administrative support, technical assistance, and capacity building. FHI will also assist these commissions in designing, managing and monitoring appropriate responses to the epidemic in collaboration with all stakeholders in their respective areas, including all relevant local government sectors, NGOs, religious institutions and community groups, the private sector, and all donor-sponsored programs.

Working through and with the National AIDS Commission, FHI will continue to support collaboration with several major line ministries and GOI agencies, including the Ministry of Health, Ministry of Social Welfare, the Coordinating Ministry for the People's Welfare, the Ministry of Defense and the Indonesian Armed Forces, the Ministry of Justice and Human Rights, the National Narcotics Board, the Ministry of Transportation, the Ministry of Manpower, and the National Police as they each develop their own policies and interventions to address the epidemic.

FHI will also continue to provide financial support and technical assistance to a large number of local non-governmental organizations, currently planned at over 133, to implement a full range of interventions in the field. FHI will not only provide funding for these organizations through formal sub-agreements, but is also committed to assisting in the development of their technical and management capacities, as well as encouraging their active participation within the coordinated response to the epidemic in their respective areas.

Collaboration between FHI and the Health Policy Initiatives Program (HPI) managed by Constella Futures which commenced work in Indonesia in September 2006 is expected to contribute significantly to strengthening policy support for HIV/AIDS programming. Initial work has focused on assessing current policy, analyzing operational barriers, developing appropriate strategies for advocacy for 100% condom use, and assisting the National AIDS Commission to develop a resource allocation model.

FHI will also continue its strong collaboration with the United Nations' family of organizations, particularly the UNAIDS Secretariat, WHO, UNICEF, UNFPA, ILO, UNODC, UNESCO, UNDP, again within the framework of one, coordinated national response to HIV/AIDS. Collaboration with the Global Fund to Fight AIDS, Tuberculosis, and Malaria will continue and be strengthened, focusing primarily on providing technical assistance especially for training and capacity building efforts, development of quality control systems, and monitoring of implementation in the field, and implementation of risk reduction activities for IDU.

The AusAID-funded *Indonesia HIV/AIDS Prevention and Care Project (IHPCP)* and *DKT* will continue as examples of outstanding cooperation and mutual support through all stages of program implementation.

FHI will also continue to work closely with several other USAID-supported programs, including *John Snow Incorporated* for basic and reproductive health services (PMTCT, VCT, and STI management); and *KNCV* on tuberculosis prevention, diagnosis and treatment for PLWHA.

Monitoring and Evaluation, and Key Indicators

FHI has established a comprehensive monitoring and evaluation system that provides the kinds of data needed to track performance and promote better quality interventions. This system provides essential and regular data for effective program management and accurately measure the effectiveness of interventions. This information will be shared with the National AIDS Commission, the Ministry of Health, and respective donors on a regular basis through a series of quarterly implementation reports, which will include the results of process and performance indicators as appropriate. All project data will also be routinely submitted for entry into the national database once the system has been established, and contribute to the

establishment and efficient functioning of one M&E system for the National HIV/AIDS Program.

Beginning in Year Three, all program activities will also be reported to USAID using the standard indicators mandated by PEPFAR on a semi-annual basis. These indicators and their respective targets may be found in Annex VIII.

Monitoring Program Implementation

FHI views "monitoring" as a process to ensure that program activities are being implemented as scheduled and at acceptable levels of quality. FHI provincial representatives and their staff will have the major responsibility to monitor all program activities in their respective provinces, with backup support and technical assistance from Jakarta staff. This monitoring will consist of compiling and analyzing monthly reports from each implementing agency including data on the achievement of mutually agreed-upon process indicators, and routine monthly site visits. The provincial staff will also be responsible for monitoring the implementation of district level coordination meetings during which each IA will report on achievements against targets and engage in joint problem solving. Results of both the monthly site visits and the routine coordination meetings, together with the monthly implementation reports from each IA, will be reported to Jakarta using a simple, user friendly reporting format. Additional monitoring will be provided by both the technical and program units in Jakarta on a semi-annual basis specifically focusing on Quality Assurance and Quality Improvement (QA/QI), as well as whenever an urgent need may arise. The Monitoring and Evaluation Unit will assist with the compilation and interpretation of data, and ensure that results are properly analyzed and documented. They will also be available to ensure that the entire monitoring system continues to function well.

Appropriate output and process indicators and suggested targets are found under each Result Area component below, as they are specific to the activities contained in each. Data on achievements of the indicators will be collected from monthly activity reports from implementing agencies and augmented by periodic assessments of program interventions to measure quality and effectiveness. The ability to sustain such monitoring activities beyond the project will be key to sustainability any efforts to involve local KPAs process.

Measuring Program Outcomes

In the absence of controlled experimental research, the HIV/STI repeated cross-sectional prevalence surveys for all most-at-risk groups, including both sentinel and integrated biological and behavioral surveillance (IBBS) surveys, are optimal for providing biological outcome indicators on the one hand and behavioral outcome indicators on the other. Although the results of such surveys cannot be causally linked to specific program interventions, they will nevertheless provide evidence that the combined effects of multiple interventions by FHI, GOI, and other programs are having the desired impact on HIV/AIDS/STI prevalence trends. FHI will assist the National AIDS Commission, the Ministry of Health, and the Indonesian Bureau of Statistics to design and implement these surveys with high scientific rigor to guarantee accurate results. Proposed outcome indicators with base line values and annual targets, as well as program coverage targets by province and year are provided in Annex I.

National Joint Data Base

FHI will also work closely with the M&E Unit of the National AIDS Commission, the UNAIDS Secretariat, the IHPCP, and all other major players in developing and maintaining a national Development Database for the Indonesian AIDS Response in line with the "Three Ones" principle. This data base will not only enable the National AIDS Commission and others to review and report on progress in achieving the required targets of 60% coverage of MARG and 40% coverage of the general population in Papua, but will also help strengthen collaboration and efficiency among the large number of organizations responding to the epidemic in Indonesia.

IV. PROGRAM INTERVENTIONS

Result Area I: Increased Intervention Coverage and Use of Risk Reduction Behaviors, Practices and Services

To address the need to increase coverage, improve quality, and more accurately target interventions to reduce risk behaviors among most-at-risk groups, FHI will continue to implement a menu of interventions across all key MARGs, as follows:

- Outreach: including peer outreach
- Individual Level Interventions: including individual risk assessments, and counseling
- Group Level Interventions: peer support groups and group risk assessments
- STI management and Voluntary HIV Counseling and Testing (VCT)
- Case Management: including positive prevention, treatment adherence and linkages to services
- Partner Notification, Counseling and Referral Services
- Health Communication and Public Information: including IEC and targeted behavior change communication (BCC) materials, interactive multimedia campaigns, edutainment and social marketing
- Risk reduction for IDU (using Partnership Funds)
- Community-Level Interventions: including community mobilization, local and central-level advocacy; and other "structural" interventions such as 100% condom use campaigns and policies

Though these interventions will be the focus of all program activities under Result Area I, the mix will vary as appropriate for each MARG. Other, more specific interventions will be added as necessary, for example for risk reduction programming for IDU.

1. Reducing STI/HIV Transmission in Commercial Sex

Focusing on female and male prostitutes and their clients and partners, in Year Three FHI will continue to support a range of interventions—as outlined above—to reduce STI and HIV transmission during commercial sex. The priority will continue to be on promoting **risk reduction behaviors**, including condom use, screening and appropriate treatment of STIs, use of lubricants, reducing the number of partners, and VCT.

A. Female Prostitutes

As in Year One and Year Two, the priority will be on empowering female prostitutes, through strengthening negotiating skills, raising awareness of their right to health, and facilitating access to clinical services, so that they can protect themselves against STIs and HIV infection. In support of this strategy, efforts to improve access to condoms and local regulations concerning their use the working environments will be intensified. Since each specific locale will require a unique adaptation of the overall strategy, FHI will provide each implementing partner with practical training in the knowledge and skills needed to implement effective interventions, including the analysis of the needs, perceptions and aspirations of the target group related to HIV/AIDS and sexual health, applied behavior change theory, management of interpersonal communications and how to develop appropriate messages to facilitate change. These skills and their effective translation into action in the field will be monitored and mentored through routine participatory quality assurance activities.

The key components of the strategy in Year Three are as follows:

- **Increased outreach coverage.** The network of FHI partner NGOs delivering outreach and peer-led interventions to female prostitutes will be maintained across all target provinces. Each organization has been tasked with ramping up coverage by implementing locally appropriate, interactive interventions that may include peer-led individual and group discussions, edutainment events, targeted communications through various media, support groups and structural interventions. FHI will continue to work with selected implementing partners to better assess the motivation and ability of female prostitutes to change their high-risk behaviors related to HIV/AIDS, and develop more effective communication strategies including clear, compelling messages to encourage and support appropriate change. Experience both internationally and in Indonesia has proven that interactive, interpersonal communications and peer education are the most effective methods to instigate change, and will continue to be aggressively applied throughout the program. Emphasis will be placed on increasing the quality and effectiveness of these activities by, for example, encouraging female prostitutes to look to the future and protect/prepare themselves for the next phase in their lives and through constant reinforcement of a handful of carefully chosen messages across all activities.

  The success of these activities is dependent on creating an environment conducive to reducing risk of sexual transmission of HIV/AIDS, and to this end FHI and its implementing agencies will continue to work closely with the relevant government agencies at the district level to develop local policies and commitments, including:

  - The local health services, to promote STI screening and treatment and VCT, and to discourage self-treatment with antibiotics;

  - The local social welfare services, to enhance skills building and alternative work programs for brothel-based and street-based prostitutes; and

- Local "gatekeepers", to promote condom use through a better appreciation of the benefits to all involved, as well as the development and implementation of effective local condom use policies based on the results of collaboration with HPI in pilot activities in East Java. (See Increased Condom Use section below.)

- **Increased STI screening and VCT.** Routine STI screening for all prostitutes will ensure lower levels of STIs and a lower risk of HIV infection. FHI will therefore continue to expand and improve the quality of a network of STI clinics providing routine STI screening (at least four times a year) and treatment services to female prostitutes in the target areas. FHI will also actively promote a new drug regiment for the treatment of STIs which should have a dramatic effect on STI rates across the program area. VCT has been integrated into these services on an "opt-out" basis throughout the STI clinic network, using the three rapid tests recommended by the government to provide a one-day service wherever possible. Case management will also be provided on a similar basis, and case managers will provide links to home and community based care activities for PLWHA. Delivery of these services will continue to be integrated within the promotion of appropriate behavior change as well as a PMTCT component, by including counseling about the possibility of getting pregnant, STI-HIV transmission risks and prevention measures and contraceptives where appropriate. A number of STI clinics that are deemed ready will also be equipped to extend services to PLWHA in the target group, ranging from "initial health assessments" to care and treatment.

  The clinic network will include NGO clinics as well as an increasing number of government-supported public health centers and private health service providers that are frequently used by the various target groups. Where necessary, combined STI/VCT services will be provided through mobile clinics, which will include simple lab facilities in order to provide a one-day service.

  FHI will maintain the current network of partner clinics throughout the target areas, but will also actively collaborate with the MOH and the GFATM at all levels to ensure that appropriate clinical services are available to the target groups in each "hotspot" in each of the seven priority provinces, and that overlap and competition among clinics is kept to a minimum. FHI will continue to provide technical assistance to all clinical services training organized by the MOH regardless of funding source, and will continue to focus support on the development of one harmonized, effective, well-managed clinical network under the auspices of the MOH. (Please see Result Area Three: Section 2: Strengthening STI/HIV/AIDS Clinical Services for a more detailed description of these activities.)

- **Increased condom use.** To develop environments that are conducive to consistent condom use, FHI will continue to collaborate with The Health Policy Initiative (HPI) to promote and institute insightful public policy on 100% condom use at all levels. FHI will also continue to work with DKT, local governments, and the network of NGOs to develop more effective approaches to engage sex industry gatekeepers in institutionalizing the 4As: increasing the availability, accessibility, affordability and acceptability of condoms. One brothel complex will be selected in each province to pilot efforts to execute and intensively promote a local policy for condom use using the model developed in collaboration with HPI. Strategies will include:

- Holding business meetings with owners and managers of entertainment establishments to introduce basic HIV/AIDS issues and the commercial benefits of 100% condom use.

- Education and condom promotion, including events and contests facilitated by local stakeholders and distribution of targeted IEC materials and safer sex packages.

- Establishment of sustainable, local sources for procuring condoms in collaboration with DKT, which will provide revolving funds to set up each specific local vendor as well as training and oversight in entrepreneurial skills.

- FHI will also continue to support the efforts of the National AIDS Commission to promote the use of female condoms to better empower female prostitutes to take charge of their own sexual health, beginning with pilot activities in Tanah Papua.

- Periodic and extensive screening for STI's throughout each pilot site in collaboration with the local community health center, as well as treatment of all STIs using a more effective drug regiment.

- **Working through existing networks.** FHI will also continue work with the Indonesian Women's Coalition (KPI) on a range of activities aimed at reducing STI infection and promoting consistent condom use. Working through its extensive network, KPI is working on empowering female prostitutes with regard to their right to health, stressing the importance of routine STI screening and their responsibility to prevent infection, and building condom negotiation skills. KPI will also advocate and raise awareness among sex industry gatekeepers and stakeholders in local government, assisting the latter to issue and enforce a position statement on the HIV/AIDS and STI prevention program. KPI will organize local workshops for peer educators to increase their knowledge on a range of issues including gender, health rights, and advocacy, with the goal of empowering female prostitutes. Trainings will also be organized for decision makers from the local AIDS commissions, health services, and government sectors to increase their awareness of the rights of female prostitutes and the responsibility of local governments to affirm them. This will also service as a strong advocacy tool to promote appropriate policy change at the local level. These activities will initially be piloted in Jakarta and Central Java.

- **Ports and highways communication campaign.** This will be needs-focused, designed to reach both female prostitutes and high-risk men in six provinces concentrated on commercial ports, fishing ports, and along highways; and in associated localized sex industry areas. Priority areas include Medan, Batam, Jakarta, Semarang, Surabaya, Malang, and Cirebon. Using the services of a professional advertising agency, Matari, FHI will collaborate with the relevant government sectors and partner NGOs in each location on a range of promotion and edutainment activities that will cover prevention education, reinforcement of key messages, distribution of condoms and lubricants, and placement of posters and signboards, and other targeted promotional events. Matari has already organized extensive focus group work with the target audience in each of the

priority areas, and used the results to develop the overall concept and design of appropriate supporting materials. These in turn have been validated and pre-tested, again, directly with the target group, with final results presented to the MOH, NAC and other stakeholders in Jakarta for approval. The launch of the campaign is scheduled for mid-December 2007 in Subang, West Java, after which the results will be evaluated and the overall concept adjusted accordingly before expansion throughout ASA's eight target provinces. Technical assistance from Matari and ASA's communications consultants will be provided to each province to assist them in designing the most cost-effect and realistic campaign possible based on the local situation and available resources. Supporting materials will be produced by Matari and disseminated to all partner NGOs to support both routine outreach activities as well as the specific local campaign events.

- **Comprehensive community interventions (pilot).** FHI will continue to provide comprehensive community-based interventions for female prostitutes in specific villages which continually provide a significant number of young females to the commercial sex industry. One such area may be Indramayu in West Java. The package of interventions covers advocacy and awareness raising to local community leaders, religious organizations and schools; improving knowledge of HIV/AIDS and women's rights; increasing prevention efforts, as well as providing STI, VCT, and CST services, including strengthening of support groups and access to ARV.

Support activities

- FHI will continue to implement a comprehensive training program for all IAs on behavior change skills including how to analyze behaviors, opportunities for change and knowledge level of individual target groups; outreach methodologies; management of peer education; and how to assess and improve program effectiveness. FHI is working with a team of training experts to develop a comprehensive curriculum and training modules covering all aspects of behavior change. The first two modules focusing on HIV/AIDS information, behavior change theory and practice, as well as the standard operating procedures for all program behavior change interventions has been completed; and work is continuing on the third module which will focus on the supporting skills required to implement effective behavior change interventions. Parallel to this FHI has contracted with a local organization, Inspirit, to improve the facilitation skills of a group of master trainers consisting of national and provincial level FHI staff, selected professionals from partner implementing agencies and local government sectors, with the goal of establishing a team of trainers in each of the seven target provinces. The provincial training teams will then be assisted to organize and implement the series of trainings for all partner NGOs in each province. The training package consists of series of both classroom and mentored field work activities, focusing on developing the practical skills needed to change the high-risk behaviors within each specific target groups.

- FHI will organize a small study tour to India to observe the successful intervention model for female prostitutes being implemented by FHI and other partners under the Gates Foundation funded Avahan Program. A key element of the program success seems to be the organization of sex workers into community-based solidarity/support groups. Participants will include representatives from the GOI, partner NGOs, and FHI staff.

- In collaboration with the National AIDS Commission, FHI will also organize a national workshop focusing on the integration of gender issues within the promotion of HIV/AIDS/STI prevention activities in order to raise awareness of these important issues and begin the process of policy change within the relevant government sectors.

B. Clients and High-Risk Men

Men who buy sex are the key bridge between most-at-risk groups and the general population, and as such play an important role in driving the HIV epidemic. As in previous years, FHI's strategy in the third year will be to target certain groups of men who buy sex with interventions aimed at encouraging them to adopt less risky behavior, including partner reduction and consistent condom use, and so prevent the further transmission of the virus. The main identifiable groups are truckers, seamen, salesmen, construction and plantation workers, and soldiers, who buy sex primarily from direct female prostitutes; as well as businessmen and civil servants, who are the principal clientele of indirect prostitutes.

Activities in Year Three will be developed under two principal strategies: outreach and a targeted media campaign, augmented by delivery and/or facilitation of STI and VCT services in hotspot areas and selected workplaces. FHI will continue to support its network of local NGOs providing behavior change interventions to clients in brothel and entertainment settings, as well as to high risk men in workplace settings, including those associated with highways, ports, and transportation hubs, as well as the construction and extraction industries. To further scale up coverage, FHI will work closely with strategic ministries including the Ministry of Transportation, Ministry of Health (particularly port health offices), Ministry of Mines and Energy, Office of State-Owned Enterprises, and the Ministry of Industry and Trade. Planning workshops have been held at the provincial level in each of the targeted provinces to:

- Develop practical work plans to scale up coverage of programs for high-risk men in both the formal and informal sectors, with priority given to ports and highways and large scale resource and transportation companies;

- Produce ministerial policies to define the responsibilities of departments at all levels to facilitate prevention and care efforts for high-risk men;

- Ensure cooperation between local NGOs, health care providers, and government officials and other HIV/AIDS programs in port areas, along transportation routes and in large scale business in resource and transportation sectors;

- Ensure commitment to and participation in targeted BCC campaigns.

Activities under the two key strategies are outlined below:

- **Increased outreach coverage.** Having identified in Years One and Two key subgroups of clients and potential clients, as well as the kinds of approaches that would likely be most effective, FHI's network of partner NGOs will continue to deliver a range of interventions as outlined at the beginning of this section. Emphasis this year will be placed on improving targeting, quality, and coverage. More focused, interactive peer

education, aimed at engaging the clients more directly on their goals and current behaviors, will be a key component. Interventions will include:

- In companies and organizations where significant numbers of men with high-risk behavior work, the aim will be to achieve more significant coverage through **targeted workplace programs** using both individual and group approaches. In Year One and Year Two, FHI increased the number of NGOs contracted to carry out workplace interventions from four, has hired additional staff and consultants to focus on workplace activities, and conducted a comprehensive mapping of high-risk industries in all eight target provinces. The results will be the basis for Year Three action, which will focus on maintaining active, responsive workplace programs in the 70 companies currently collaborating with ASA, and adding an additional 50 new companies. A priority will be to expand and strengthen behavior change communications, with an emphasis on one-on-one interpersonal dialogues, as well as increasing referrals to VCT and STI clinical services either in-house or through local service providers. Supporting media and edutainment events will also continue to be organized within each participating company with assistance from ASA.

- An innovative approach will be piloted in North Sumatra where a working group consisting of representatives from the Provincial AIDS Commission, local universities, the provincial health services, and FHI, has been established to be responsible for managing **HIV/AIDS prevention in the workplace** across the province. An annual workplan has been developed which includes activities for raising awareness through dialogues with company officials and technical assistance for interventions to be implemented directly within and by the targeted companies. A total of 30 companies have been targeted during Year Three.

- In non-workplace settings, **direct outreach to truckers, seamen and other high-risk men**, particularly those in the transportation sector will also continue through the network of BCI implementing agencies. Interventions will continue to be implemented in previously mapped hotspots such as entertainment establishments, brothels, truck stops and bars, as well as through targeted edutainment events.

- **Implementation of local policies for condom use in selected pilot sites** combining technical assistance from HPI, DKT and the ASA Program. A pilot site will be identified in each of the eight target provinces and the local government will be helped to formulate and execute a local condom use policy. Implementation of the local policy will be augmented with the social marketing of condoms by DKT, the intensive screening of STI's by the local health services, and the extensive promotion of safer sexual behaviors by partner NGOs with the goal of having a significant, measurable impact on STI levels among FSW and actual condom use by their clients.

- **Integrated interventions along highways and in ports.** FHI will work with local stakeholders—including the Traffic and Highways Office (DLLJR), Pelindo (port authorities), shipping companies, stevedoring companies, port workers' and seamen's unions including API, and port health offices—to plan and coordinate an integrated local response that covers prevention, STI and VCT services, and support services for positive people. FHI will assess training needs and respond as necessary, for example with training on peer-led education for ship's captains and STI/VCT training for port health

officials. Implementation will be focused on key ports and highways from North Sumatra to East Java, and in Tanah Papua.

- **More intensive promotion of STI clinical services and VCT.** FHI will work with companies, industry associations and the local health services to promote STI and VCT services for high risk men to by strengthening referral systems and in particular by identifying a wider network of public and private health care providers (clinics and/or doctors) that are prepared to provide services to high-risk men. Such providers will be assessed and trained by FHI. In workplaces, in-house clinics (where they exist), or external clinics or private doctors that are commonly used by the target group population will be trained. To increase uptake, referral points (peer promoters) in each company will be trained to promote services through one-on-one outreach.

- **Targeted media campaigns.** FHI will launch a series of targeted campaigns for high-risk men in workplace and non-workplace settings, prioritizing large ports in Java and North Sumatra, key transport routes in Java and large transportation and natural resource companies. The purpose of the campaign will be to intensify ABC messaging, increase demand for appropriate STI services and communicate the benefits of VCT services. Messages will be linked to the aspirations of the target group, moving beyond provision of basic HIV information to effective promotion of safer behaviors.

  The campaign developed by Matari Advertising Agency will be very specifically targeted, using a variety of media including signboards in port areas, billboards along highways, and advertisements in truck stops, gas stations, urinals, toll booths and entertainment areas. A series of "edutainment" events will also be organized in major hotspots in collaboration with local authorities and partner implementing agencies with technical assistance by Matari to greatly increase exposure to the campaign in a very enjoyable manner. Tabloids, local newspapers and radio stations known to be popular among the target groups will also be used. Port authorities, port health officials, toll road operators, gas station attendants, restaurant managers and staff and sex work establishments will be enlisted to convey supporting messages and IEC materials to driver and sailors, while large-scale transport and natural resources companies will provide parallel and reinforcing messages through internal workplace programs. Additionally, IAs providing direct outreach in ports, highways and entertainment areas will deliver messages that are also in line with the phases of the campaign.

Support activities

- FHI will also continue to be actively involved in the Working Group for Workplace Programs under the National AIDS Commission, and will assist them to organize a series of one-day workshops (at national level) for the Ministries of Health, Transportation, Mines & Energy, State-Owned Enterprises, Ocean Resources & Fisheries, Manpower Development, and Construction and Engineering will be organized to focus on:

  (i) developing a written strategy for each ministry, outlining how they will support programs that target high-risk men, for example by developing supporting legislation, and

(ii) determining their role as co-participants in the targeted media campaign, and detailing their specific contributions to HIV/AIDS interventions.

- All partner NGOs implementing workplace programming will receive additional training in HIV/AIDS, STI, VCT, behavior change, and appropriate approaches specifically for private sector companies, in order to increase their skills and improve the quality of implementation in the field focusing in Jakarta, West Java and East Java. Emphasis will also be given to strengthening the coordination between workplace and hotspot interventions for high risk men.

Monitoring by Indicators

Indicators for each major component of the program are set within the subagreement of each Implementing Agency based on realistic expectations and the local response map and strategic plan. The targets detailed below represent the combined totals of all relevant subagreements. Each Implementing Agency will report on achievements against targets on a monthly basis. Results will be analyzed by relevant FHI staff, compiled by the M&E Unit, and reported within the quarterly implementation report.

Key indicators for this component include:

Result Area I: Increase Coverage and Use of Risk Reduction Behaviors, Practices and Services	Year 1 Achievement	Year 2 Achievement	Year 3 Target
Indicators			
A. Commercial Sex			
Outreach for Behavior Change			
- Female Prostitutes Reached	32,287	94,731	101,041
- High Risk Men Reached in Hotspots	169,762	655,944	708,971
- High Risk Men Reached Through Workplace Programs	91,168	174,937	472,648
- Pimps Educated	2,733	8,279	8,500
- Community Leaders Educated	1,403	11,261	11,500
- Average Active Peer Educators/Volunteers	580	3,612	3,700
- IEC/BCC Materials Distributed	330,402	1,031,383	1,300,000
STI Services			
- Female Prostitutes Screened for STI (First Screening)	11,136	27,027	38,487
- Female Prostitutes Screened for STI (Total Screening)	25,402	71,907	83,764
- Female Prostitutes Received STI Treatment (Total STI Treatment)	18,696	63,198	65,000
- Clients Received STI Treatment	667	3,533	5,160
VCT Services			
- Female Prostitutes Received Pre-Counseling Services	2,145	11,595	37,502
- Female Prostitutes Tested for HIV	1,863	10,102	33,752
- Female Prostitutes Received Post-Counseling Services	1,264	8,438	30,377
- High Risk Men Received Pre-Counseling Services	486	3,550	3,628
- High Risk Men Tested for HIV	464	3,381	3,465
- High Risk Men Received Post-Counseling Services	336	2,523	2,939
CST Services			
- Female Prostitutes Receiving Case Management Services	96	719	999
- High Risk Men Receiving Case Management Services	53	182	200

For complete information on program targets over the full three year program, please refer to Annex I.

Partner Organizations for Commercial Sex

I. Commercial Sex				
No	Institution	Location	Activities	Funding Source
Multiple Sites				
1	Indonesia Women Coalition (Komisi Perempuan Indonesia)	All sites	Support for Enabling Environment	Partnership Fund
2	Matari Advertising	All sites	MSM and High Risk Men Media	Partnership Fund
North Sumatera				
1	Pusat Pengkajian dan Pemberdayaan Masyarakat Nelayan (P3MN)	Medan	BCC for FSW and Clients in Hot Spot & Workplace	Partnership Fund
2	Solidaritas Perempuan Pekerja Seks (SP2S)	Deli Serdang and Serdang Bedagai	BCC for FSW and Clients in Hot Spot & Workplace, Transvestites, and Case Manager	Partnership Fund
3	KARANG	Tanjung Balai Asahan	BCC for FSW and Clients in Hot Spot & Worplace, MSM & Transvestites	Partnership Fund
4	PARAS	Langkat	BCC for FSW and Clients in Hot Spot & Workplace, MSM & Transvestites	USAID
5	Perhimpunan Buruh Independen	Simalungun and Pematang Siantar	BCC for FSW and Clients in Hot Spot	USAID
6	Bina Insani	Simalungun and Pematang Siantar	BCC for FSW and Client in Hot Spot and Workplace,Transvestites, and MSM	USAID
7	Yayasan Peduli Aids Deli Serdang	Deli Serdang and Serdang Bedagai	STI, VCT & CST Services	USAID
8	Komite AIDS Huria Kristen Batak Protestan (HKBP)	Toba Samosir	STI, VCT & CST Services	Partnership Fund
9	Puskesmas Padang Bulan	Medan	STI, VCT & CST Services	Partnership Fund
10	Puskesmas Kerasaan	Simalungun and Pematang Siantar	STI, VCT & CST Services	Partnership Fund
11	Puskesmas Stabat	Langkat	STI, VCT & CST Services	Partnership Fund
12	Puskesmas Datuk Bandar	Tanjung Balai Asahan	STI, VCT & CST Services	Partnership Fund
13	Puskesmas Bandar Baru	Deli Serdang	STI, VCT & CST Services	Partnership Fund
14	TBD	Dairi and Karo District	STI, VCT & CST Services	Partnership Fund
15	Pesada	Diare District	BCC for FSW and Clients Hot Spot	USAID
Riau Islands				
1	Yayasan Srimersing	Karimun	BCC for FSW and Clients	USAID
2	Yayasan Bentan Serumpun	Tanjung Pinang	BCC for FSW and Clients, VCT	USAID
3	Yayasan Batam Tourism Development Board	Batam	BCC for FSW and Clients; STI Services & VCT	Partnership Fund
4	Yayasan Hanz	Karimun	BCC for FSW and Clients; STI Services & VCT	USAID
5	Health Office Batam City	Batam	STI Services & VCT	Partnership Fund
6	Health Office District Kepulauan Riau	Kepulauan Riau District	STI Services & VCT	Partnership Fund
7	Health Office Tanjung Balai Karimun	Karimun	STI Services & VCT	Partnership Fund
8	Health Office Tanjung Pinang City	Tanjung Pinang, Kepulauan Riau District	STI Services & VCT	Partnership Fund

I. Commercial Sex				
DKI Jakarta				
1	Komite Kemanusiaan Indonesia (KKI)	Jakarta	BCC for Clients in Workplace	Partnership Fund
2	Yayasan Kusuma Buana	West, Central, & East Jakarta	BCC for FSW and Clients in Hot Spot and Worplace	Partnership Fund
3	Komunitas Aksi Kemanusiaan Indonesia (KAKI)	North Jakarta	BCC for FSW and Clients in Hot Spot	USAID
4	Bandungwangi	East Jakarta	BCC for FSW and Clients in Hot Spot	USAID
5	ICODESA	East Jakarta	BCC for FSW and Clients in Hot Spot	USAID
6	PKBI Jakarta	East Jakarta	BCC for FSW and Clients; STI Services & VCT	Partnership Fund
7	Yayasan Kapeta	Central and South Jakarta	BCC for FSW and Clients in Hot Spot	Partnership Fund
8	Sudinyankes Jakarta Barat	West Jakarta	STI Services & VCT	Partnership Fund
9	Tegak Tegar	West Jakarta	CM and Home Base Care	Partnership Fund
West Java				
1	Health Office District Indramayu	Indramayu	BCC and STI	Partnership Fund
2	Health Office District Karawang	Karawang	BCC and STI	Partnership Fund
3	Health Office District Subang	Subang	BCC for FSW and Clients	Partnership Fund
4	Yayasan Mitra Sehati	Bekasi	BCC for FSW and Clients	USAID
5	Yayasan Gerakan Penanggulangan Narkoba dan Aids (YGPNA)	Cianjur, Sukabumi	BCC for FSW and Clients	USAID
6	Yayasan Mutiara Hati	Bogor District, Bogor City	BCC for FSW and Clients.	Partnership Fund
7	Warga Siaga	Cirebon City and Cirebon District	BCC for FSW and Clients;	Partnership Fund
8	PKBI Jawa Barat	Bandung City	BCC for FSW and Clients; STI Services & VCT	Partnership Fund
9	Health Office District Bekasi	Bekasi	STI Services & VCT	Partnership Fund
10	Health Office District Bogor	Bogor District	STI Services & VCT	Partnership Fund
11	Dinkes Cirebon City	Cirebon City	STI Services & VCT (FSW)	Partnership Fund
12	Himpunan Konselor HIV/AIDS (HIKHA) West Java	Bandung City, Sumedang and Subang District	VCT	Partnership Fund
Central Java				
1	Fatayat NU	Tegal & Batang	BCC for FSW and Clients	Partnership Fund
2	Kalandara	Semarang City	BCC for FSW and Clients	USAID
3	LSM TEGAR	Salatiga City & Semarang District	BCC for FSW and Clients	Partnership Fund
4	Solidaritas Perempuan untuk Kemanusiaan dan Hak Asasi Manusia (SPEKHAM)	Surakarta City	BCC for FSW and Clients	USAID
5	LPPSLH	Banyumas City	BCC for FSW and Clients	USAID
6	Health Office District Kendal	Kendal District	BCC for FSW and Clients; STI Services	Partnership Fund
7	Health Office District Pati	Pati District	BCC for FSW and Clients; STI Services	Partnership Fund
8	PKBI Tegal	Tegal	BCC for FSW and Clients; STI Services & VCT	Partnership Fund
9	PKBI Semarang	Semarang City, Kendal	BCC for FSW and Clients; STI Services & VCT	USAID
10	Health Office District Cilacap	Cilacap District	BCC for FSW and Clients; STI Services & VCT	Partnership Fund
11	Health Office District Salatiga	Salatiga City	STI and VCT Services	Partnership Fund
12	Health Office District Batang	Batang District	STI and VCT Services	Partnership Fund
13	Health Office District Semarang	Semarang District	STI Services & VCT	Partnership Fund

I. Commercial Sex				
East Java				
1	Yayasan Media	Surabaya City, Gresik, Sidoarjo	BCC for Clients	USAID
2	Yayasan Mulia Abadi	Surabaya City, Sidoarjo, Pasuruan, Gresik, Kediri, Tulungagung, Nganjuk	BCC for Clients (Workplace Program)	USAID
3	Puskesmas Putat Jaya	Surabaya City	BCC for FSW & Clients; STI Services & VCT	Partnership Fund
4	Palang Merah Indonesia Banyuwangi	Banyuwangi	BCC for FSW and Clients	USAID
5	Yayasan Genta	Surabaya City, Sidoarjo, Gresik	BCC for FSW and Clients	USAID
6	Yayasan Bambu Nusantara	Madiun City & Madiun District, Nganjuk	BCC for FSW and Clients	USAID
7	SUAR NURANI	Kediri City and District	BCC for FSW and Clients	USAID
8	CHESMID	Tulungagung	BCC for FSW and Clients	USAID
9	Health Office District Banyuwangi	Banyuwangi	BCC for FSW and Clients; STI Services	Partnership Fund
10	Health Office Madiun City	Madiun City	BCC for FSW and Clients; STI Services & VCT	Partnership Fund
11	Health Office Kediri City	Kediri City	BCC for FSW and Clients; STI Services & VCT	Partnership Fund
12	Hotline Service	Surabaya Municipality	BCC for FSW, Clients & IDU; VCT, CST & Case Management	Partnership Fund
13	RS Dr. Sutomo Surabaya	East Java	CST Services	Partnership Fund
14	Health Office Surabaya City	Surabaya City	STI Services & VCT	Partnership Fund
15	Health Office Madiun District	Madiun District	STI Services & VCT	Partnership Fund
16	Health Office Nganjuk District	Nganjuk District	STI Services & VCT	Partnership Fund
17	Health Office Kediri District	Kediri District	STI Services & VCT	Partnership Fund
18	Health Office Sidoarjo District	Sidoarjo District	STI Services & VCT	Partnership Fund
19	Health Office Pasuruan District	Pasuruan District	STI Services & VCT	Partnership Fund
20	Health Office Jember District	Jember District	STI Services & VCT	Partnership Fund
21	Puskesmas Sumber Pucung	Malang City & Malang District	STI Services & VCT for FSW, Clients, Transvestites & Gay Men	Partnership Fund

2. Reducing HIV Transmission among MSM

The goal in Year Three will be to continue to expand and improve the quality of coverage to the key sub-target groups of waria, male prostitutes, and gay men. As in previous years, messages will be focused on encouraging a reduction in the numbers of sex partners and promoting a range of safer behaviors, including condom and lubricant use and increased uptake of STI and VCT services. The principal strategies for expanding coverage will be a targeted BCC campaign and scaled up outreach, using a range of interventions as indicated at the beginning of this section. Peer-led outreach will again be an important element, as will be structural interventions.

- Taking into account the large and dispersed nature of the gay community in Indonesia and the urgent need to intensify BCC activities and uptake of health services, FHI will implement an **integrated multi-channel communications campaign** targeting gay men.

The campaign will provide newly developed BCC messages that stress the benefits of safer sex practices and health services, including appropriate STI treatment and VCT/CST services. In addition to standard IEC media and safer sex packets, the campaign will utilize SMS messages, internet, email and hotline services, gay-specific publications as well as special events and outreach in bars and massage establishments. The campaign will be developed in cooperation with a professional advertising agency, Matari, and focus specifically on increasing coverage of discreet MSM though innovative approaches and channels which reflect the unique lifestyles of this very hard to reach population..

- In Year Three, FHI will **increase outreach coverage**, working through its network of NGO partners. Increasing emphasis will be placed on the use of peer-level educators, and basic outreach training will focus on training master trainers from each IA who will, in turn, train peer educators within the IA. Strategies for scaling up both the extent and the quality of coverage will include the following:

    - In selected IAs working with gay men and waria, training **community-based counselors** in positive prevention, partner notification, and psychosexual counseling. MSM hotlines will also be supported in selected implementing agencies which have the capacity to manage these intricate activities.

    - The scale-up of **SMS and internet outreach**. With the technical assistance of Satu Dunia, several selected MSM implementing agencies, including IGAMA, Abiasa, and Gessang, will develop innovative approaches to using SMS gateways and web-based communications to promote HIV/AIDS awareness and preventions, specifically targeting gay men who are notoriously hard to identify and reach through traditional outreach activities.

    - To promote increased use of water-based lubricants and condoms, FHI will again **distribute "safe sex" packets** in bars and massage establishments, as well as through peer led outreach activities.

- To ensure a more **conducive environment** for the sustainable implementation of these strategies, FHI will seek to strengthen structural interventions through collaboration with bar owners and other gatekeepers**.** Following on from meetings with bar owners, FHI will conduct intensive one-on-one advocacy with establishment owners and managers to strengthen BCC efforts, social marketing of condoms (working with DKT) and uptake of STI and VCT services, especially on site. An additional goal of these meetings will be to gain commitment to participate in the implementation of on-site targeted BCC campaigns. FHI is currently collaborating with the owners/managers of 49 male sex worker massage establishments in Jakarta in the provision of BCC and STI/VCT services. In Year Three, advocacy will be intensified to increase their participation in BCC efforts, marketing condoms and water-based lubricants and facilitating the uptake of health services. Owners/managers will be encouraged to take over the program and work directly with service providers and condom distributors to ensure sustainability.

- **STI and VCT service coverage** will also be expanded through **on-site STI and VCT services in "hotspot" areas,** as well as mobile services where needed. On-site labs will also be available to ensure one-day service. (Please see Result Area Three: Section 2: Strengthening STI/HIV/AIDS Clinical Services for more detail.)

Support activities

- Training for behavior change, with a component on peer education for all MSM IAs will be provided. (Please see previous section for more details.)

- A series of special events will also be organized at gay venues in the larger cities across the ASA target provinces, beginning in the Heaven Club and Starlight Disco in Jakarta. These events will emphasize safer sexual practices and HIV/AIDS awareness through messages and approaches appropriate for the gay community.

Monitoring by Indicators

Key indicators for this component include:

Result Area I: Increase Coverage and Use of Risk Reduction Behaviors, Practices and Services	Year 1 Achievement	Year 2 Achievement	Year 3 Target
Indicators			
B. MSM			
Outreach for Behavior Change			
- Transvestites Reached	7,635	14,807	15,038
- Gay Men Reached	14,481	43,374	302,803
- Active Peer Educators/Volunteers (End of Quarter)	121	909	851
- IEC/BCC Materials Distributed	59,239	211,303	263,834
STI Services			
- Transvestites Screened for STI (First Screening)	1,115	3,008	4,277
- Transvestites Screened for STI (Total Screenings)	2,499	7,148	8,554
- Transvestites Received STI Treatment	836	4,816	6,843
- Gay Men Screened for STI (First Screening)	104	605	1,451
- Gay Men Screened for STI (Total Screening)	234	2,411	2,902
- Gay Men Received STI Treatment (Total STI Treatment)	56	2,075	2,231
VCT Services			
- Transvestites Received Pre-Counseling Services	538	1,949	3,111
- Transvestites Tested for HIV	536	1,895	2,800
- Transvestites Received Post-Counseling Services	472	1,611	2,520
- Gay Men Received Pre-Counseling Services	440	2,194	3,079
- Gay Men Tested for HIV	427	2,042	2,771
- Gay Men Received Post-Counseling Services	370	1,727	2,494
CST Services			
- Transvestites Receiving Case Management Services	152	332	427
- Gay Men Receiving Case Management Services	3	106	142

Partner Organizations for MSM

II. MSM				
No	Institution	Location	Activities	Funding Source
Multiple Sites				
1	Satu Dunia	All sites	BCC Support	Partnership Fund
2	Matari Advertising	All sites	MSM and High Risk Men Media	Partnership Fund
North Sumatera				
1	Solidaritas Perempuan Pekerja Seks (SP2S)	Deli Serdang and Serdang Bedagai	BCC for FSW and Clients in Hot Spot & Workplace, Transvestites, and Case Manager	Partnership Fund
2	KARANG	Tanjung Balai Asahan	BCC for FSW and Clients in Hot Spot & Worplace, MSM & Transvestites	Partnership Fund
3	PARAS	Langkat	BCC for FSW and Clients in Hot Spot & Workplace, MSM & Transvestites	USAID
4	Bina Insani	Simalungun and Pematang Siantar	BCC for FSW and Client in Hot Spot and Workplace,Transvestites, and MSM	USAID
5	Jaringan Kesehatan Masyarakat (JKM)	Medan, Deli Serdang and Serdang Bedagai	BCC for Transvestites, MSM, Client in Workplace, Counselors and Case Manager	USAID
6	Yayasan Peduli Aids Deli Serdang	Deli Serdang and Serdang Bedagai	STI, VCT & CST Services	USAID
7	Puskesmas Kerasaan	Simalungun and Pematang Siantar	STI, VCT & CST Services	Partnership Fund
8	Puskesmas Datuk Bandar	Tanjung Balai Asahan	STI, VCT & CST Services	Partnership Fund
9	Puskesmas Stabat	Langkat	STI, VCT & CST Services	Partnership Fund
10	Puskesmas Padang Bulan	Medan	STI, VCT & CST Services	Partnership Fund
Riau Islands				
1	Yayasan Gaya Batam	Batam	BCC for Transvestites & Gay Men	Partnership Fund
2	Health Office Batam City	Batam	STI Services & VCT	Partnership Fund
DKI Jakarta				
1	PKBI Jakarta	East Jakarta	BCC for FSW and Clients; STI Services & VCT	Partnership Fund
2	Yayasan Pelangi Kasih Nusantara	Jakarta	BCC for Gay Men	USAID
3	Yayasan Srikandi Sejati	Jakarta	BCC for Transvestites & VCT	USAID
4	Lembaga Penduli AIDS Yayasan Karya Bakti	North and East Jakarta, Depok	BCC for Gay Men and MSW	USAID
West Java				
1	PKBI Jawa Barat	Bandung City	BCC for FSW and Clients; STI Services & VCT	Partnership Fund
2	Srikandi Pasundan	Bandung City, Bandung, Cimahi	BCC for Transvestites	Partnership Fund
3	Himpunan Abiasa	Bandung City, Bandung District, Cimahi City, Sumedang District, Cirebon City, Cirebon District, Indramayu District, Tasikmalaya City, Bekasi City, Bekasi District, Karawang District, Subang District	STI Services & VCT	Partnership Fund
4	Himpunan Konselor HIV/AIDS (HIKHA) West Java	Bandung City, Sumedang and Subang District	VCT	Partnership Fund

II. MSM				
Central Java				
1	Health Office District Kendal	Kendal District	BCC for FSW and Clients; STI Services	Partnership Fund
2	Health Office District Pati	Pati District	BCC for FSW and Clients; STI Services	Partnership Fund
3	PKBI Tegal	Tegal	BCC for FSW and Clients; STI Services & VCT	Partnership Fund
4	PKBI Semarang	Semarang City, Kendal	BCC for FSW and Clients; STI Services & VCT	USAID
5	Health Office District Cilacap	Cilacap District	BCC for FSW and Clients; STI Services & VCT	Partnership Fund
6	Lembaga Graha Mitra	Selected districts (10 cities & districts)	BCC for Transvestites & Clients	Partnership Fund
7	Yayasan Gerakan Sosial, Advocacy dan Hak Asasi Manusia untuk Gay Surakarta (GESSANG)	Surakarta City	BCC for Transvestites Sex Workers and Clients	Partnership Fund
8	Health Office District Salatiga	Salatiga City	STI and VCT Services	Partnership Fund
9	Health Office District Batang	Batang District	STI and VCT Services	Partnership Fund
10	Health Office District Semarang	Semarang District	STI Services & VCT	Partnership Fund
East Java				
1	Yayasan Gaya Nusantara	Surabaya, Sidoarjo, Jember, Banyuwangi	BCC for Gay Men	Partnership Fund
2	Ikatan Gaya Arema Malang (IGAMA)	Malang City	BCC for Gay Men & Partners	USAID
3	Persatuan Waria Kota Surabaya (Perwakos)	Surabaya City, Gresik, Sidoarjo, Jember, Madiun, Nganjuk	BCC for Transvestites & VCT	USAID
4	Health Office Sidoarjo District	Sidoarjo District	STI Services & VCT	Partnership Fund
5	Health Office Pasuruan District	Pasuruan District	STI Services & VCT	Partnership Fund
6	Health Office Jember District	Jember District	STI Services & VCT	Partnership Fund
7	Puskesmas Sumber Pucung	Malang City & Malang District	STI Services & VCT for FSW, Clients, Transvestites & Gay Men	Partnership Fund
8	Puskesmas Perak Timur	Surabaya City	STI Services & VCT for Transvestites, Gay Men & Clients	Partnership Fund

3. Reducing STI/HIV Transmission among IDU

The practice of injecting drugs using contaminated equipment or solutions continues to account for the highest number of new HIV infections in Indonesia. At the same time, there is growing concern about the extent of sexually transmitted HIV infections originating within the sexual networks of IDUs. It is increasingly clear that addressing these problems effectively calls for a comprehensive package of risk reduction activities and support, as well as a more in-depth understanding of contributing issues such as addiction.

In the first two years of the program, interventions focused on expanding coverage by adding to the number of IAs working with this sub-population. Current strategies are working, with over 25,000 IDUs reached by program activities to date. During Year Three a total of 24 IAs will be carrying out interventions in communities and/or in prisons, while one additional subagreement will be executed to support strengthening the network of NGOs working with IDU at the national level. This should translate into the continued dramatic expansion of program coverage during Year Three.

Strengthening capacity and improving effectiveness in the field will be given the highest priority, and will be achieved through the following strategies:

- **Scaling up coverage** by:
  - Expanding the number of outreach workers in each implementing agency and providing them with advanced training and mentoring to ensure that high levels of motivation are maintained, as well as expanding the catchment areas of several NGOs to reach as many local IDU hotspots as possible.
  - Improving the quality and quantity of program targets based on more realistic assessments of population size in each area, and providing technical assistance in tracking achievements against targets within each implementing agency.
  - Continuing implementation for the experimental coupon system by four implementing agencies, with possible expansion into one new area in Medan. Operational research of the coupon system completed in Year Two indicated that the approach was effective in expanding access and reach only in new areas where networks had yet to coalesce, and therefore will continue to be implemented on a limited basis only. Innovative adjustments, though, will be trialed, such as offering larger incentives for recruiting female IDU in order to expand access to this previously limited target group. Technical assistance on managing this system will continue to be provided by FHI as needed.
  - Experimenting with alternative models for "secondary" distribution of clean needles and syringes through networks of IDU.
  - Increasing coverage by adding non-injecting targets. The aim of these pilot activities which will be introduced first in Batam, Riau Islands, is to encourage drug users who are not yet injecting to avoid injecting drugs and to adopt safer sexual behaviors. Outreach workers will be trained to identify these nescient drug users and provide them with appropriate messages and motivation to raise their awareness of the risks of injecting before it is too late.
  - Expanding coverage to include partners of IDU following operational assessments to identify appropriate methods and messages to reach this often neglected group. The majority of partners will be reached through the expansion of counseling activities and group discussions focusing on issues relevant to this target group such as safer sexual practices and family planning.

- **Improving the standard of information in the field** with the continuing development of new, innovative IEC materials for outreach workers and their target groups on various relevant topics, including basic information on HIV/AIDS, drugs, and addiction, and more specific issues such as blood-borne viruses, available services, and sexual health and preventing sexual transmission of HIV. Formative research on a new series of materials was completed during Year Two and production of these innovative materials will be completed early in Year Three. All outreach workers will also receive advanced training in the use of IEC materials, as well as improved communication skills as part of the continuing capacity building efforts of the ASA Program.

- **Enhancing behavior change strategies** by:
  - Ensuring that IAs continue to profile target groups to assess changes in demographics and drug use patterns and to adjust strategies accordingly;
  - Reducing the risk of sexual transmission by engaging both IDUs and their sex partners through partner tracing/notification and referral, as well as couples

counseling, on sexual health and pregnancy risks. FHI has developed and begun a series of training for all IDU implementing agencies using a new comprehensive curriculum for risk reduction which includes strategies and training modules for IDU counselors as well as clinical service providers focusing on IDU sexual health.

Improving the effectiveness of STI, VCT and other clinical services and strengthening their integration with field activities will be achieved through the following strategies:

- **Integrating outreach with clinical services** to provide a continuum of care for IDU and their partners. This will include finalizing protocols, guidelines and training modules for comprehensive clinical services including PMTCT, TB, family planning, STIs and addiction withdrawal, followed by training of clinical personnel and the facilitation of stronger working relationships between outreach and clinical services. Selected public health centers will be prepared to provide comprehensive care to serve the special needs of IDU and their partners. Prophylaxis and treatment for opportunistic infections including TB will be provided to IDU and their partners who test positive for HIV. Connection with home and community based care activities will then be established through trained case managers.

- **Improving the take-up of services offered by IAs** including VCT, provision of risk reduction materials, substitution therapy, basic health care, case management, support groups and CST, and explore ways of scaling these up, as well as expanding into partner notification/referral and couples counseling. Given the high rate of sexual transmission of HIV between/from IDU, STI services will also be developed for this target group. Referral systems and networking will be improved at the local level, and the awareness and commitment of local service provides will be enhanced through training and coordination meetings on a regular basis. Every effort will be made to emphasize the importance of offering user-friendly services to this underserved and often misunderstood target group.

- **The roles and responsibilities of case management** specifically for IDU will be reviewed and revised to include an emphasis on palliative and home based care, as well as community support for HIV positive IDU.

Strengthening advocacy, political support, and a conducive environment will be achieved through the following strategies:

- FHI continue to work closely with the NAC's **Working Group for Risk Reduction among IDU**, together with the National Narcotics Board, UNODC, the MOH, and the National Police Force to establish political support and legislative assurance for comprehensive IDU programming in the field.

- FHI will also continue to support improved **collaboration at the local level** among our IAs, the provincial AIDS commissions, the local Narcotics boards, and the local police to ensure understanding of the local situation, mutual appreciation of need for IDU programming, clarity of roles and responsibilities, and the establishment of a practical, working relationship among all involved.

- In addition, FHI will identify a **national organization** to provide support and help coordinate an IDU NGO network, to advocate for a more conducive environment for the achievement of the targeted interventions, to expand the network where needed, and to increase the scope and quality of its capacity building efforts for local IDU NGOs.

Support activities

- Advanced training for all IAs to expand and reinforce technical skills for IDU interventions will be implemented in collaboration with the National AIDS Commission and national experts, and once finalized will become the basis for a national training curriculum for risk reduction among IDU. Follow-up mentoring in the field by local IDU trainers will also be included.

- FHI will organize a national level workshop on programming risk reduction interventions for injecting drug users to be facilitated by an international expert from the region in order to identify lessons learned from previous experience in Indonesia as well as to plot the course for future IDU activities in the country.

- FHI will also organize a national level workshop on IDU support group development for selected IAs and other relevant institutions to discuss how to stimulate and strengthen this crucial component of IDU work. The workshop will be facilitated by an international expert from the region.

Monitoring by Indicators

Key indicators for this component include:

Result Area I: Increase Coverage and Use of Risk Reduction Behaviors, Practices and Services	Year 1 Achievement	Year 2 Achievement	Year 3 Target
Indicators			
C. IDU			
Outreach for Behavior Change			
- IDU Reached	10,259	38,669	47,987
- IDU Sex Partner Reached	295	3,754	4,020
- IDU Participating in Support Group	1,337	5,950	7,799
- IDU Referred for Substitution Therapy	1,032	8,788	13,244
- Active Peer Educators/Volunteers (End of Quarter)	70	450	952
- Printed IEC Materials Distributed	77,183	267,614	386,696
- Needles Distributed (*Partnership Funds Only*)	74,053	665,574	1,109,215
- Other Materials Distributed	157,950	858,953	1,335,733
VCT Services			
- IDU Received Pre-Counseling Services	914	4,575	5,632
- IDU Tested for HIV	802	3,556	5,069
- IDU Received Post-Counseling Services	551	2,852	4,562
- IDU Sex Partner Received Pre-Counseling Services	87	547	693
- IDU Sex Partner Tested for HIV	66	457	624
- IDU Sex Partner Received Post-Counseling Services	54	417	561
CST Services			
- IDU Receiving Case Management Services	1,107	2,294	3,136
- IDU Sex Partner Receiving Case Management Services	69	284	509

Partner Organizations for IDU

III. IDU				
No	Institution	Location	Activities	Funding Source
Multiple Sites				
1	TBD (IDU Networking)	All sites	IDUs	Partnership Fund
North Sumatera				
1	Yayasan Galatea	Medan	BCC for IDUs and Partner, Counselor & CM	Partnership Fund
2	Medan Plus Support	Deli Serdang, Serdang Bedagai, Pematang Siantar & Simalungun	BCC for IDUs and Partner, Counselors & CM	Partnership Fund
3	Puskesmas Padang Bulan	Medan	STI, VCT & CST Services	Partnership Fund
4	Puskesmas Kerasaan	Simalungun and Pematang Siantar	STI, VCT & CST Services	Partnership Fund
Riau Islands				
1	Yayasan Batam Tourism Development Board	Batam	BCC for FSW and Clients; STI Services & VCT	Partnership Fund
DKI Jakarta				
1	Yayasan Rempah	North Jakarta	BCC for IDUs and Partner, Counselors and CM	Partnership Fund
2	CHR University of Indonesia	South Jakarta & Depok	BCC for IDUs, Counselors and CM	Partnership Fund
3	Yayasan Karisma	East Jakarta	BCC for IDUs & CM	Partnership Fund
4	Community Encourage of PLWHA (COMET)	Central Jakarta	BCC for IDUs, Counselors and CM	Partnership Fund
5	Atmajaya University	Central, West & North Jakarta	BCC for IDUs, Counselors and CM	Partnership Fund
6	Perkumpulan Pemberantasan Tuberkulosis Indonesia Jakarta (PPTI)	Jakarta	VCT and CST Services	USAID
7	Yayasan Layak	Jakarta	CST & Training	USAID
West Java				
1	Yayasan Bahtera	Bandung City, Bandung, Cimahi Bekasi, Bekasi City, Sumedang	BCC for IDUs, VCT & CST	Partnership Fund
2	Yayasan Permata Hati Kita (Yakita)	Bogor City & Bogor District	BCC for IDUs, VCT & CST	Partnership Fund
3	PANTURA PLUS	Karawang District	BCC for IDUs, VCT & CST	Partnership Fund
4	Lembaga Studi Paradigma Rakyat (LESPRA)	Bekasi City and Bekasi District	BCC for IDUs, VCT & CST	Partnership Fund
5	Yayasan Akes Indonesia (YAKIN)	Tasikmalaya	BCC for IDUs, VCT & CST	Partnership Fund
6	Yayasan Masyarakat Sehat	Bandung District and Subang District	BCC for IDUs, VCT & CST	Partnership Fund
7	Rumah Sakit Hasan Sadikin	Bandung City	CST	Partnership Fund
8	Himpunan Konselor HIV/AIDS (HIKHA) West Java	Bandung City, Sumedang and Subang District	VCT	Partnership Fund
9	Yayasan Insan Hamdani-Bandung Plus Support	Bandung District and Bandung City	VCT & Case Management Services	USAID
Central Java				
1	Yayasan Wahana Bakti Sejahtera	Semarang City, Semarang, Salatiga City	BCC for IDUs & VCT	Partnership Fund
2	Yayasan Mitra Alam	Surakarta & Salatiga Cities	BCC for IDUs & VCT	Partnership Fund
3	Yayasan PEDHAS	Banyumas & Cilacap Districts	BCC for IDUs & VCT	Partnership Fund

III. IDU				
East Java				
1	Yayasan Sadar Hati	Malang City & Malang District	BCC for IDUs & VCT	Partnership Fund
2	Yayasan Bina Hati	Sidoarjo District & Surabaya City	BCC for IDUs, VCT & Case Management	Partnership Fund
3	Lembaga Studi Pembelajaran untuk Pencerahan (LSP2)	Surabaya City & Gresik District	BCC for IDUs, VCT & Case Management	Partnership Fund
4	Kelompok Kerja Pelita Hati Husada (KKPHH)-Dinkes Banyuwangi	Banyuwangi District	BCC for IDUs, VCT & Case Management	Partnership Fund
5	Yayasan Bambu Nusantara	Madiun City & Madiun District, Nganjuk	BCC for IDUs, VCT & Case Management	Partnership Fund
6	Puskesmas Gondang Legi	Malang District	VCT, CST & Case Management for IDUs	Partnership Fund

4. Reducing STI/HIV Transmission among the General Population in Papua

The nature of the epidemic in Tanah Papua, the limited infrastructure and the physical challenges of working in the region mean that—more so than in any other target province—mobilizing others to take action and leveraging the efforts and resources of other organizations active in the fight against HIV/AIDS is critical to achieving the necessary program scale and quality. FHI will continue to coordinate closely with the Provincial AIDS Commission and provincial health offices in Papua and West Irian Jaya Provinces, the IHPCP and other local and international NGOs to scale-up and manage comprehensive responses that address the unique situation in Papua, targeting both people at high risk and the general population.

A. Most-at-risk Groups in Papua

The overall strategy for reducing HIV transmission among most-at-risk groups in Tanah Papua—which now comprises two provinces—remains basically the same as that for the other provinces, though approaches need to be adapted to the unique situation there. Because of the lack of experienced NGOs in many areas, program strategies have been adjusted to include more direct work with local governments and private sector companies, and a stronger reliance on public health centers to provide both outreach and clinical services to most-at-risk groups in their local areas.

B. General Population in Papua

Given the growing prevalence of HIV among the general population in Papua, HIV/AIDS program coverage urgently needs to be expanded. As in Year One and Year Two, FHI will focus on raising awareness among Papuans to the HIV/AIDS situation and mobilizing and empowering communities to take action, including satisfying existing demand for prevention, care, treatment, and support services, working with and through existing institutions and networks in the community, as outlined below.

While the number of people needing and seeking care and treatment services is increasing, **health services** infrastructure remains at a very basic level throughout most of Papua. STI, TB, VCT and CST services are available only in the larger cities and quality is low. Widespread stigma surrounding HIV/AIDS is another constraint on access to health services. An urgent priority in Year Three remains, therefore, to strengthen health care delivery systems and improve access across Tanah Papua.

FHI will collaborate with provincial health authorities on a **Basic Health Services Strengthening Initiative** designed to strengthen the capacity of public health centers to respond more effectively to the presence of the epidemic in the communities they serve. This is part of a broader government initiative to support these centers in the execution of their statutory roles and responsibilities vis-à-vis community health care. The Provincial Health Services have decided to pilot this new approach in six public health centers in Jayapura, and in one public health clinic in each of ten districts. A three-tier system will be established with experienced referral hospitals providing technical assistance and management support through district levels hospitals down to selected public health centers at the community level. Integration of prophylaxis and treatment of opportunistic infections including TB, ART, PMTCT, and pediatric ARV treatment in pilot facilities as well as pediatric AIDS care will be stressed. Linkages will also be made to home and community based care services. FHI will provide both technical and limited financial support to ensure the pilot is a success, before further expansion across the provinces. Preliminary activities will include:

- Development of methodologies, training modules and materials with the aim of integrating HIV/AIDS prevention, care, support, and treatment into all aspects of the public health center service. Emphasis will be placed on promoting early detection of STI and HIV, and providing appropriate services and cross referrals where necessary.
- Development and publication of a handbook for public health center staff containing simple guidelines for service delivery;
- Training of a cadre of provincial trainers in each of the program components, and facilitating the organization of training and intensive mentoring in all the associated skill areas needed by the staff of each center;
- Strengthening of management and logistical support systems from the provincial health services; and
- Piloting activities in TB, PMTCT and palliative care will also be supported.

In addition to strengthening the health system, ASA will build upon the awareness raising and mobilization efforts undertaken in Years One and Two to support a number of key partners and constituencies as they move from planning to action in Year Two.

Positive people in Papua still face considerable challenges, not just in terms of access to appropriate care, support, and treatment, but also in being accepted in the community. In Year Three, FHI will continue to collaborate closely with support groups for PLWHA, facilitating their participation in a range of training and networking opportunities. Such groups are playing a growing role in AIDS education in the community and promoting safer behavior among the positive community in particular ("AIDS stops with me") and FHI will continue to respond to requests for program support.

Workplaces offer considerable scope for reaching high-risk men in Tanah Papua. Many natural resource industries in various locations around the province employ large workforces of Papuan men from the Central Highlands, who often work for three to four months at a time away from their families before returning home to the upland areas. FHI will continue to collaborate with the Workplace Technical Working Group comprising the Provincial AIDS Commission, the regional Manpower Office and major companies to encourage and support the development of workplace HIV/AIDS programs, including direct technical assistance in developing appropriate workplace programming within strategic private sector firms, as well as piloting workplace activities for civil servants and seamen from Makassar who arrive in large numbers seasonally to fish the waters off FakFak district.

BP – Tangguh Community Health Initiative. Under a MOU agreement with USAID, FHI will continue to closely collaborate with the Tangguh Community Health Unit of BP to organize a comprehensive HIV/AIDS response for the Bird's Head region of Papua. Beginning in Teluk Bintuni District, FHI will assist BP to build the capacity of the local AIDS commission; promote community mobilization through the "Stepping Stones" approach with PCI; provide special outreach to MARGs and youth in the area; provide training in STI, VCT, and CST for BP's medical staff; and establishing an HIV/AIDS workplace program for the employees of the LNG plant in Teluk Bintuni.

Project Concern International. Using an adaptation of the "Stepping Stones' methodology, PCI will continue to deploy a cadre of village motivators throughout their target area of Nabire and Paniai to raise awareness and develop commitment to develop a local responses to HIV/AIDS in each village and expand their work into Sorong. They will also work closely with the local AIDS commissions, church groups, and tribal organizations in the area to elicit their support and collaboration.

World Vision. World Vision will continue to work primarily with youth (15–24-year-olds) in the Wamena area of Jayawijaya district. A broad range of activities, including sports activities and radio broadcasts, will be implemented with churches, youth groups, and other organizations, aimed at developing the capacity of local leaders to develop and manage a local response to the epidemic in their respective areas.

World Relief has been contracted to translate and adapt two training modules on peer leadership skills for youth and basic HIV/AIDS awareness for use by faith-based organizations in Tanah Papua. Once completed and pre-tested, World Relief will organize a workshop to introduced these modules to 75 participants from interested organizations that will use these materials to strengthen their community mobilization initiatives.

Local NGO partners. FHI will also continue to collaborate with several other NGOs that are working with both the general population and high-risk groups, such as KKW and PKBI.

Faith-based groups: FHI will continue to work with various Protestant, Catholic and Muslim groups as well as individual churches to facilitate the promotion of basic HIV/AIDS education, eliminate stigma and discrimination, encourage better health-seeking behavior and prepare communities for a more active response to HIV in the community, including home nursing and support for people widowed and orphaned by AIDS. Specific interventions are currently in place with the Geraja Protestant Indonesia in FakFak and Kamana and the Catholic Diocese in Jayapura, and will be expanded to other religious groups on request.

Tribal Councils. In Year Three FHI will continue to provide support for basic HIV/AIDS education, advocacy, and developing local responses for HIV/AIDS preventions and support in local communities with the Tribal Council of Tanah Papua.

Youth—both in and out of school—will continue to receive high priority in Year Three. World Vision will expand its existing interventions with children who drop out after completing elementary or junior high school (few children in the province continue to senior high school). Yayasan Binterbusi will continue to target Papuan students studying in Java. This is of key importance as many of these students will return to Papua to work in government and the private sector. Possibilities for coordinating these activities with local government programs in Papua will therefore be explored. FHI will also compliment

UNICEF's in-school program for youth by engaging out-of-school youth in peer-led programs aimed at increasing life skills and promoting responsible behavior.

The Indonesian Armed Forces. Aware of the urgent need for targeted HIV and STI services in their units, local military health officers are highly motivated and regularly participate in activities organized by the AIDS Commission and other organizations in Papua. In Year Three FHI will assist the three territorial units of the Indonesian military in Papua to expand peer leader training, develop appropriate local IEC materials, and find solutions to long standing issues with condom supply and demand in this difficult geographic area. Efforts will also be made to update existing clinical services to include STI and VCT whenever possible.

Support activities

- FHI will continue to organize training in community mobilization for local governments, community groups, and faith-based organizations to expand their crucial role in organizing local responses to HIV/AIDS prevention and care.
- FHI will also facilitate a province-wide meeting of stakeholders to discuss condom supplies and logistics for both male and female condoms, to overcome critical supply deficiencies in these important commodities across the two provinces.
- Workshops/training for hospital and public health center staff in the context of the health strengthening initiative will continue to be supported.

Monitoring by Indicators

Key indicators for this component include:

Result Area I: Increase Coverage and Use of Risk Reduction Behaviors, Practices and Services	Year 1 Achievement	Year 2 Achievement	Year 3 Target
Indicators			
D. General Population in Papua			
Outreach for Behavior Change			
- Male Age under 25 yr Reached	17,961	143,905	150,502
- Male Age more than 25 yr Reached	54,852	168,354	170,960
- Female Age under 25 yr Reached	9,054	92,295	92,505
- Female Age more than 25 yr Reached	15,974	156,537	156,777
Indivuals reached by mass media	17,194	126,104	134,410
- Local Organizations Involved in HIV/AIDS Programs	10	45	75
- Community and Religious Leaders Educated	1,160	2,650	2,700
- Individuals Trained in HIV/AIDS Community Mobilization for HIV/AIDS Prevention, Care and/or Treatment	252	1,546	2,000
- Active Peer Educators/Volunteers (End of Quarter)	60	583	2,000
- IEC/BCC Materials Distributed	23,507	146,282	369,399
STI Services			
- Male Received STI Treatment	116	283	900
- Female Received STI Treatment	78	236	650
VCT Services			
- Male Received Pre-Counseling Services	545	1,384	2,289
- Male Tested for HIV	518	1,294	2,060
- Male Received Post-Counseling Services	490	1,218	1,854
- Female Received Pre-Counseling Services	364	1,122	2,031
- Female Tested for HIV	345	1,017	1,828
- Female Received Post-Counseling Services	328	985	1,645
CST Services			
- Male Receiving Case Management Services	30	142	400
- Female Receiving Case Management Services	15	100	200
PMTCT Services			
# of Service Outlets Providing PMTCT Services According to National & International Standards	-	-	4
# of Pregnant Women who Received HIV Counseling & Testing for PMTCT and Received Their Test Results	-	-	500
# of Pregnant Women Provided with a Complete Course of ARV in PMTCT Setting	-	-	50
# of Health Workers Trained in the Provision of PMTCT Services According to National and International Standards	16	16	100

Partner Organizations for Papua

IV. Papua				
No	Institution	Location	Activities	Funding Source
Most at Risk Groups				
1	Primari	Nabire	BCC for FSW and Clients	USAID
2	PKBI Jayapura	Jayapura District	BCC for FSW and Clients; STI Services & VCT	Partnership Fund
3	Yayasan Harapan Ibu	Jayapura District	BCC for FSW, MSM, Clients and Gen Pop	Partnership Fund
4	Dinkes Papua (Health Services Strengthening)	Jayapura	STI Services	USAID
5	Dian Harapan Hospital	Jayapura City	STI Services	USAID
6	Pusat Kesehatan Reproduksi Merauke	Merauke	STI Services & VCT	USAID
7	PKM Samabusa-Nabire	Nabire	STI Services and VCT	USAID
8	Sele Be Solu Hospital	Sorong City & Sorong District	VCT & CST	USAID
General Population				
1	Yayasan Harapan Ibu	Jayapura District	BCC for FSW, MSM, Clients and Gen Pop	Partnership Fund
2	Yayasan Mitra Karya Mandiri (Yamikari)	Merauke	BCC for Gen Pop	USAID
3	Yayasan Sosial Agustinus Sorong	Sorong City & Sorong District	BCC for Gen Pop	Partnership Fund
4	Kelompok Kerja Wanita Papua (KKW)	Jayapura District	BCC for Gen Pop	Partnership Fund
5	World Vision International	Jayawijaya	BCC for Gen Pop	USAID
6	Yayasan Binterbusih	Central Java	BCC for Papuan Students	Partnership Fund
7	PCI	All targeted districts	General Population	USAID
8	PKM Samabusa-Nabire	Nabire	STI Services and VCT	USAID
9	Sele Be Solu Hospital	Sorong City & Sorong District	VCT & CST	USAID
10	World Relief	All Sites	Team Module Development	Partnership Fund
11	Gereja Protestan Indonesia	Kaimana & Fakfak	General Population	USAID

Result Area II: Improving Implementing Agencies' Ability to Self-Assess and Enhance their Programs

Involvement in program assessment and analysis at the local level is critical to improving program performance, planning and fine-tuning local strategies, ultimately leading to expanded coverage and improvements in quality of service.

To achieve the target of 95% of implementing agencies self-assessing and implementing performance-enhancing activities on a monthly basis, FHI will continue to support the development and implementation of a system for monitoring and reporting, built around self assessments and **routine coordination meetings** at the district level. The coordination meeting is a mechanism for ensuring that every IA will carry out **routine self-assessment**, by requiring them to bring the results to this forum. In addition, it provides an opportunity to discuss corrective action and promote stronger coordination among stakeholders in each district. Routine coordination meetings are currently being attended by the very large

majority of ASA supported implementing organizations in collaboration with their respective district AIDS commissions, with assistance from FHI provincial staff.

The self-assessment mechanism begins with:

- **Setting targets within each sub-agreement** document by the IA in consultation with local AIDS Commission and FHI provincial and technical staff. Targets for all subagreements have recently been renegotiated and revised to reflect changes in the official 2006 estimations of most-at-risk population sizes, the capacity of each organization, and their ability to contribute to the district level comprehensive response. IAs will continue to keep regular records in line with FHI's data recording and reporting mechanisms.

- Each month, **IAs will assess their activities** through: comparison of coverage against targets; appraisal of service quality, effectiveness and staffing issues; identification of bottlenecks in supply and demand; proposed resolution of identified problems; identification of successful initiatives; and plans for expansion.

- Practical **reporting forms and qualitative assessment tools** will help lead IAs through this process, and routine **data quality assessments** will be implemented.

- Provincial staff, supported by the M&E Unit from Jakarta, will provide **mentoring and guided practice**, as necessary, to assist IAs in data collection and analysis, as well as in the establishment of internal mechanisms to self-assess and manage change.

- During **routine district coordination meetings**, IAs will have the opportunity to discuss results of their self-assessment with other service providers and the district level AIDS Commission, share lessons learned and innovative practices, and seek solutions jointly. Provincial staff will actively support these meetings, and report results to the M&E Unit in Jakarta which will track issues identified in each meeting and provide any necessary **guidance or technical assistance** to ensure the successful, continuous implementation of these important meetings.

- Twice a year, program technical staff will conduct participatory **quality assurance assessments** (QA/QI) of each IA's program using newly revised standardized assessment tools and checklists. This will include site visits, observation of service transactions, and interviews with service uses, non-users, and people who influence the risk environment (e.g. gatekeepers). Surveys will be conducted according to protocols developed by FHI and involve the active participation of the IA staff in evaluating their own achievements. Provincial staff will then assist each IA to implement appropriate corrective action, and follow-up during the next round of self-assessment and problem-solving to ensure all issues are adequately addressed.

- FHI will also organize provincial level **workshops on data analysis** to strengthen the capacity of local implementing partners, local AIDS commissions, and FHI provincial staff to make maximum use of the wealth of program data being generated in order to improve program effectiveness.

Monitoring by Indicators

Key indicators for this component include:

Result Area II: Improving IA's Ability to Self Assess and Enhance Program	Year 1 Achievement	Year 2 Achievement	Year 3 Target
Indicators			
# of Partner Organizations Attending Regular Coordination Meeting	67	127	130
# of Implementing Agencies Provided with Technical Assistance for HIV Related Policy Development	54	108	130
# of Implementing Agencies Provided with Technical Assistance for HIV Related Capacity Building	85	132	135
# of Individuals Trained in HIV-Related Community Mobilization for Prevention, Care and/or Treatment	358	2,309	1,996
# of Implementing Agencies Provided with Technical Assistance for Strategic Information Activities	78	132	135
# of Individuals Trained in Strategic Information (Incl. M&E, Surveillance and/or MIS)	303	977	1,064

Results Area III: Strengthening Institutional Responses to the Epidemic

1. Managing Comprehensive Responses to HIV/AIDS through National, Provincial and District AIDS Commissions

The National AIDS Commission (NAC) continues to take an increasingly prominent role in shaping Indonesia's response to the epidemic. Similarly, provincial and district AIDS commissions are leading local responses, with local resources slowly becoming available as awareness of the scope of the problem builds at both national and local levels.

FHI has been a leading contributor in terms of both technical and financial support for the strengthening of the NAC and local AIDS commissions. During Year Three, FHI's role will change as the National AIDS Commission assumes greater responsibility for the development of the national, provincial and district AIDS commission network.

In Year Three, FHI will continue to work closely with the **NAC**—alongside HPI, IHPCP and UNAIDS — to strengthen the national program, focusing on the following key areas:

- Contributing to the development of annual workplans;

- Working with the NAC to provide support for increased commitment and coordinated planning with **strategic sectors** that can influence mobilization at the community level with regard to MARGs, for example with the Ministry of Transportation, Pelindo (port management); the Ministry of Manpower and Transmigration; the Ministry of Mining & Energy; the Ministry of Law and Human Rights, the Ministry of Defense, and the MoH.

- Facilitating **Working Groups** at the national level on sexual transmission, IDU risk reduction, ports and highways, HIV/AIDS prevention in the workplace, HIV/AIDS prevention in prisons, monitoring and evaluation, and national population estimates.

- Assist within efforts to **develop capacity in provincial and district AIDS commissions,** focusing on on-the-job training to improve management and technical capacities at the provincial and district level, including advocacy, information and communications, and leveraging more resources at the local level.

In collaboration with the NAC, FHI provincial staff will continue to work closely with the AIDS commissions in all eight provinces and 79 target districts to facilitate and mentor the improvement of technical and operational capability. Efforts will be focused on the following areas:

- Improving program management at the province and district levels, in particular through:

- Stimulating **greater coordination** among related sectors at the provincial level, for example between the prison system, the health system and district AIDS commissions;

- Facilitating the routine development of evidence-based **strategic plans and annual workplans**, with support for response mapping where necessary (if there are significant changes in the local risk populations);

- Building capacity for **institutional development, networking and community mobilization** among IAs and related technical sectors;

- Strengthening local **policy development** and increasing the role of local implementing partners;

- **Reducing stigma and discrimination** among civil society through public information campaigns, working through local Information & Communication Offices and local education authorities;

- Strengthening local **monitoring and evaluation**, among other means by improving the frequency and effectiveness of routine coordination meetings and consolidating utilization of specially designed software for the collection, analysis and application of district level data in operational activities.

Support activities

- FHI will continue to provide technical assistance in the provincial and district level training with joint funding from the government.

- Technical and limited financial assistance will also be provided to provincial and district AIDS commissions to support the development of strategic plans and annual workplans, and to facilitate the routine coordination meetings at the district level for all stakeholders in the local response to HIV/AIDS.

- A National Workshop for Journalists will be organized in collaboration with the NAC to increase the effectiveness of the print and electronic media in reducing stigma and discrimination of people living with HV/AIDS.

- An Exit Workshop will be organized in each province in collaboration with the respective provincial AIDS commission and other stakeholders to review past experience, identify lessons learned and determine how to continue a comprehensive response once donor funding is no longer available.

Monitoring by Indicators

Key indicators for this component include:

Result Area III: Strengthening the Institutional Response	Year 1 Achievement	Year 2 Achievement	Year 3 Target
Indicators			
A. National, Provincial, District AIDS Commision			
# of KPAD with a Strategic Plan			
-Provincial	3	7	8
-District	21	53	79
# of KPAD with Active Secretariat			
-Provincial	5	7	8
-District	48	57	79
# of KPAD with an Annual Work plan			
-Provincial	4	9	8
-District	22	49	79
# of KPAD Implementing Regular Coordination Meeting			
-Provincial	6	7	8
-District	34	44	79
# of KPAD whose Budget is Increased over the Previous Year Relative to Overall Development Spending			
-Provincial	5	6	6
-District	36	40	43
# of Individuals Trained in HIV-Related Policy Development	114	563	695
# of Individuals Trained in HIV-Related Institutional Capacity Building	143	971	1,131
# of Individuals Trained in HIV-Related Stigma and Discrimination Reduction	3	211	221
# of Individuals Trained in HIV/AIDS Community Mobilization for HIV/AIDS Prevention, Care and/or Treatment	543	826	830

Partner Organizations

VI. AIDS Commission				
No	Institution	Location	Activities	Funding Source
National				
1	National AIDS Commission	All sites	Policy & Institutional Development	USAID

2. Strengthening STI/HIV/AIDS Clinical Services

Support for clinical services will continue to be provided with the overall aim of containing the HIV/AIDS epidemic in Indonesia. Key objectives are to prevent new infections, provide the services needed by those at risk of transmitting HIV or at risk of being infected, and provide care, treatment and support for those already infected. In Year Three the program will place even greater emphasis on encouraging people at risk to take action to protect not just themselves but their partners and future children as well. In addition, FHI will continue to scale up efforts to improve access and quality, and encourage stronger integration between clinical services and outreach to ensure a continuum of care from prevention and diagnosis through to a full range of care, support and treatment services.

Strategies in Year Three will focus on the following:

A. Strengthening HIV-related health service networks:

- Assisting the MoH and local health services to build systems for basic health services for IDU and STI/HIV/AIDS-related clinical services that deliver a continuum of care, using appropriate public health approaches, with built-in quality control systems and good logistics management. This will include technical assistance and limited financial support for policy development; development of national guidelines, protocols, and standard operating procedures for each component of the continue of care; training throughout the health service network; establishment of quality assurance and reporting/recording systems; and monitoring and mentoring of implementation in the field, both within FHI supported activities, as well as within the overall health service provider network in collaboration with the MOH at all levels.

- Facilitating providers of STI and HIV/AIDS-related clinical services (including public health centers, private clinics, NGO clinics, FBO hospitals/clinics, government hospitals, professional associations, support groups, etc.) to provide accessible, user-friendly services that support risk reduction/behavior change, meet stipulated technical quality standards for services and management, and are integrated into a network of services providing a continuum of care. Clinical service providers will be assisted to establish networks with behavior change, VCT, and CST service providers (including PMTCT) to ensure optimal synergies, rational allocation of resources, and adequate coverage of all crucial target groups.

- Facilitating the development of standard recording and reporting systems throughout the health services at all levels, beginning with VCT and expanding into STIs and CST as quickly as possible, to ensure compatibility of data and the efficient tracking of services.

B. Support for the provision of HIV-related services:

STI screening and treatment services will continue to be scaled up by strengthening support for service delivery through public health centers and by identifying private service providers who already serve the target populations but are not part of the existing network of government and NGO clinics. FHI will provide appropriate training, mentoring, and monitoring of quality by FHI staff in collaboration with the MOH at all levels, as well as limited fungi for key clinical services in areas where other resources are not available. The key interventions are outline below:

- **Periodic STI screening, examination and treatment** for female prostitutes and waria (at least four times a year) and gay men (frequency depending on the extent of their sexual networks) aiming for 100% coverage of target populations with routine STI screening. STI services will also be provided for people with symptoms outside scheduled screening. Efforts will be made to devise reward schemes for those who attend regular screening, particularly for waria.

STIs covered by screening	Female prostitutes	Waria	Gay men
GO and non-GO (chlamydial) cervicitis	✓		
Syphilis	✓	✓	✓
Trichomonas vaginalis	✓		
Bacterial vaginosis	✓		
Candidal vaginitis	✓		
GO and non-GO (chlamydial) urethritis		✓	✓
Proctitis (anorectal)		✓	✓

- **Enhanced syndromic management of STI** for clients and IDU, with an automatic offer of VCT.

- **Voluntary Counseling and Testing (VCT)** services represent the key entry point into the full range of interventions that make up the continuum of care. VCT services will therefore be strongly linked to BCC and especially STI services in an effort to increase coverage. VCT clients who test negative will be counseled on staying free of infection and referred 'back' to appropriate BCC and/or STI services, while those who test positive will be counseled and referred onward to case management services. Pregnancy counseling will also be introduced as a standard protocol in all VCT. All VCT will meet the minimum counseling and laboratory standards developed by the MOH with the assistance of FHI and WHO. Again, FHI will provide technical assistance and limited funding for specific VCT service providers, as needed, in addition to collaborating closely with the MOH, the GFATM, and WHO to establish and support a national network of VCT clinical services, with a priority on the seven target provinces.

  In order to dramatically expand uptake of these important services in Year Three, special attention will be given to strengthening local referral systems through better coordination among local stakeholders under the auspices of the local AIDS commissions and health services whenever possible, as well as improving the quality of services through such initiatives as better patient flow, providing quicker results, and establishing a more user-friendly approach recognizing the unique perceptions and requirements of each target group. Links with CST and ARV services will also be improved in order to counter the feeling that VCT is a dead end. In addition, FHI will assist the MOH and local health services to develop a standard reporting and recording system for VCT which should significantly help to better track service uptake and solve implementation problems.

  Among the principal features of VCT services will be:
  - **One-roof service for VCT and STI**, with VCT provided on an opt-out basis as an integral part of the client flow. Clients who access VCT but have never accessed STI services will be screened for syphilis and referred to other STI clinical services.
  - **One-roof service for VCT and Basic Health Care** linked with community-based outreach for IDU. IDU reached will be assisted in accessing VCT as quickly as possible. IDU accessing Basic Health Care Services will be offered VCT on an "opt-out" basis.
  - **One-day service**, using a combination of the three rapid tests recommended by MoH.
  - **Mobile VCT and STI services** will be provided where needed. Mobile facilities will include a simple laboratory to ensure one-day service.

- **Integration of targeted PMTCT** (PMTCT Prong II) into other services. All STI, VCT, and case management services for female prostitutes, men who buy sex, IDU, and gay men (some male prostitutes have female partners) will include information and counseling on the possibility of the client or their partner getting pregnant, the risk of transmitting STI or HIV to the baby, and available prevention measures. Assistance will be given for accessing contraceptive measures if required. Both individual and couple counseling will be encouraged.

- **Pilot PMTCT with one-stop CoC service model (PMTCT Prong III):** Developed for IDUs and their partners, these services include targeted PMTCT and TB screening and treatment. The model will be implemented initially through Gondang Legi Public Health Centers in Malang, Gambir Public Health Center in Jakarta, and one public health center (TBD) in Bandung in collaboration with HSP/JSI, UNICEF, WHO and IHPCP. In Papua, one-stop CoC services for the general population will be piloted through six public health centers in Jayapura and one public health center in each of ten districts, as well as in two hospitals. These services will target HIV positive pregnant women, and will provide appropriate ARV treatment, safe delivery, medical follow-up of the new born, and counseling on breast feeding and informed choice.

- **Care, Support and Treatment,** consisting of ART, management of opportunistic infections (OIs), psychosocial support, and palliative care, will be expanded in particular by increasing the range of services offered by basic health care facilities either directly or via referral networks. All CST services will meet the minimum standards developed by the MoH with assistance from FHI, WHO, and IHPCP. Among the key features of CST will be:

    - **One-roof service** for case management and VCT as an integral part of the client flow.

    - **Support groups** will be facilitated by case management services and offered to all positive people.

    - Several STI clinics and Basic Health Services clinics for IDU will offer **Initial Health Assessments** for newly diagnosed PLWHA to determine the clinical stage of the disease. The results of the health assessments will provide service providers a basis for developing treatment and referral plans, including TB screening and treatment. Clinics that are not yet ready to provide this service will refer PLWHA to a local hospital for an initial health assessment.

    - **Strengthening CST services** at Dr Soetomo (Surabaya), Gatot Soebroto (Jakarta Army Hospital), Hasan Sadikin (Bandung), RS Selebesolu (Sorong), and RS Dian Harapan and Dok II (Jayapura) Hospitals, as well as another in Medan (TBD) as models for CST delivery elsewhere. Additional hospitals in Papua will be supported in connection with the “Basic Health Services Strengthening Initiative” as local commitment and funding increase. Financial and technical support will be provided for various capacity building events. Standard operating procedures for referral mechanisms and the delivery of services are being developed by these lead hospitals, and will become the basis for training and roll out to related district hospitals and public health centers in order to bring these services closer to the PLWHA in the field.

- **Care and Treatment services** for PLWHA will be available **through selected public health centers** operating as satellites of these designated referral hospitals. Services will be based on the IMAAI approach and consist of chronic, acute, and palliative care including OI prophylaxis, OI treatment, ART, PMTCT and TB screening and treatment.

- Pilot **Palliative** and **Home and Community Based Care** (HCBC) will be implemented in Jakarta and Papua, as a first step in developing long-term care services for PLWHA. Based on this experience, a model program will be defined and appropriate training curriculum and management systems will be developed for use in future expansion in East and West Java. Key components of the program will include proactive linkages among PLWHA, case managers, clinical service provides and HCBC facilities, and home visit teams to provide direct care and adherence support in the community.

- **Promotion of the Concept of Continuum of Care and Prevention** will be an integral part of all program activities, including strengthening access to both prevention and care services, improving quality of services, strengthening the coordination and integration of services, and reducing stigma and discrimination.

- **Basic Health Care Services and Addiction-Related Health Services for IDUs**: IDU IAs will work with a local public health center or hospital to provide services or referrals for care and treatment for health problems that are related to addiction or the use of contaminated needles (e.g. abscesses, hepatitis, HIV), and diagnosis and treatment for STI, as well as TB/HIV, PMTCT, addiction therapy, and family planning.

- **Strengthening Integration of HIV and TB services:** FHI will continue to work closely with the National TB Program and KNCV, using both TBCAP and ASA funding, to support the development of national TB/HIV policy, guidelines, and strategic planning, as well as assist in the development of a national TB/HIV curriculum and training modules. FHI will also provide technical assistance in the training of staff from ten hospitals to pilot the joint TB/HIV program in Tanah Papua, East Java and Jakarta; and provide operational support to satellite public health centers to bring coordinated TB DOTS, HIV VCT and ARV treatment to the community level as soon as is feasible, especially within Tanah Papua. Coordinated efforts between the National TB Program and the National HIV/AIDS Program within the prison system will also be encouraged.

- **Strengthening service quality** FHI will continue to exercise strict quality control through regular monitoring of medical records, lab results, and on-site implementation based on the new, streamlined QA/QI system. Priority focus will continue to include:

  - Quality Assurance for STI, VCT and case management sites. (Fifty records from each site will be checked each month and an on-site assessment made every 3-6 months.)

  - Quality Control for STI and HIV testing laboratories

- **Interventions for the general population in Papua** will be developed and implemented in collaboration with the provincial health services, Global Fund, WHO, and IHPCP. As outlined under Result Area 1, FHI will support the basic health services strengthening initiative and, in particular, the system's capacity to respond to the HIV/AIDS epidemic.

The priority will be to provide a continuum of care (CoC) from prevention to CST, under one roof. FHI will provide support for inputs including training, supplies, and technical assistance, as well as assist with establishing logistics management, quality assurance, reporting/recording and monitoring systems, and provide technical assistance directly to service providers as required. Emphasis will be placed on ensuring that services are delivered according to MoH protocols and meet the minimum quality standards.

- The **CoC/one-stop shopping** service model will be implemented in six public health centers and referral hospitals in Jayapura and ten target districts in cooperation with provincial and district health services, and selected public health centers. A full range of services will be provided including VCT, ARV, STI, TB, malaria, and family planning.

- **Provider-initiated testing and counseling**: The "Could it be HIV" approach will be used for all patients who come to the public health centers, regardless of the service sought, including those receiving TB treatment. If HIV is suspected, the patient will be referred to VCT, followed up with case management and CST for positive patients or STI screening and treatment for negative patients.

Support activities

- FHI will organize a **National Workshop to Share Experiences** among Doctors from the ASA supported clinical network as well as representatives from provincial health services and the MOH in order to consolidate lessons learned by each clinic, share experiences, stimulate closer networking, and motivate staff to improve quality.

- FHI will also continue to organize **training for the staff from all FHI supported clinical care providers** in each priority program area, including refresher training for older staff as well as introductory training for new staff, using the standard methodologies and curriculums developed previously. These include:

    - **IMAAI Training** through a series of three separate five-day trainings on acute, chronic, and palliative care for teams (1 doctor and 2 nurses) from collaborating hospitals in Jakarta, East Java, West Java, and Riau Islands.

    - **Expert Patient Training** to prepare selected PLWHA to assist in the IMAAI training as example patients.

- **Training of Trainers (TOT) in STI clinical management** to deepen the pool of experienced trainers in support of national scale-up.

- **Refresher Training for Master Trainers for VCT** to further strengthen and build capacity within this important cadre of trainers.

- **A study tour to Cambodia focusing on Home Based and Community Care** will be organized for a small group of five participants from the MOH and FHI to learn from the successful experience in the Battembang community with an emphasis on the practical organizational and referral issues needed to make HBCC work

- FHI will support the participation of one FHI staff member to attend the **STDs/AIDS Diploma Course** offered by the Consortium of Thai Training Institutes for STDs and SIDS (COTTISA) in Bangkok in late October 2007 in order to build further capacity in the management of STIs, remain up-to-date with recent advances in STI within the region, and encourage active networking among STI service providers within the region.

- In addition to those purchased with Partnership Funds, FHI will also use USAID funding to procure additional US FDA approved **HIV test kits and STI reagents** as required throughout the network of ASA support clinics and hospitals during Year Three.

Monitoring by Indicators

Key indicators for this component include:

Result Area III: Strengthening the Institutional Response	Year 1 Achievement	Year 2 Achievement	Year 3 Target
Indicators			
B. MoH Health Services Network			
- Number of District with Established "Continuum of Care"	36	40	40
- Number of STI Clinics	33	66	66
- Number of VCT Sites	39	91	95
- Number of Community & Home Based Care Sites	46	67	67
- Number of ARV Treatment Sites	-	-	6
- Number of Service Outlets Providing PMTCT Services According to National and International Standards	-	11	11
- Number of Women who Received HIV Conseling and Testing for PMTCT and Received Their Test Results	-	-	48
- Number of Women Provided with a Complete Course of ARV in PMTCT Setting	-	-	2
- Number of Workers Trained in the Provision of PMTCT Services According to National and International Standards	-	-	35
- Number of Individuals with Advanced HIV Infection Receiving Antiretroviral (ARV) Therapy	-	244	1,000
- Number of Individuals Reached by Community and Home Based Care Programs in the Past 12 Months	1,503	4,309	5,250
- Number of TB Patient Received VCT Services	1,536	5,094	5,500
- Number of HIV-Infected Clients Attending HIV Care/Treatment Services that are Receiving Treatment for TB Disease	-	6	336
- Number of Service Outlets Providing Clinical Prophylaxis and/or Treatment for TB to HIV Infected individuals	-	1	10
- Number of Individuals Trained to Provide Clinical Prophylaxis and/or Treatment for TB to HIV Infected Individuals	-	6	168
- Number of Staff Trained in STI Clinical Management	217	563	650
- Number of Individuals Trained in Counseling	175	405	468
- Number of Individuals Trained in Testing	71	220	230
- Number of Case Managers Trained	236	548	552

Partner Organizations for Health Service Network

VIII. MoH Health System				
No	Institution	Location	Activities	Funding Source
North Sumatera				
1	Yayasan Galatea	Medan	BCC for IDUs and Partner, Counselor & CM	Partnership Fund
2	Medan Plus Support	Deli Serdang, Serdang Bedagai, Pematang Siantar & Simalungun	BCC for IDUs and Partner, Counselors & CM	Partnership Fund
3	Yayasan Peduli Aids Deli Serdang	Deli Serdang and Serdang Bedagai	STI, VCT & CST Services	USAID
4	Komite AIDS Huria Kristen Batak Protestan (HKBP)	Toba Samosir	STI, VCT & CST Services	Partnership Fund
5	Puskesmas Padang Bulan	Medan	STI, VCT & CST Services	Partnership Fund
6	Puskesmas Kerasaan	Simalungun and Pematang Siantar	STI, VCT & CST Services	Partnership Fund
7	Puskesmas Stabat	Langkat	STI, VCT & CST Services	Partnership Fund
8	Puskesmas Datuk Bandar	Tanjung Balai Asahan	STI, VCT & CST Services	Partnership Fund
9	Puskesmas Bandar Baru	Deli Serdang	STI, VCT & CST Services	Partnership Fund
10	TBD	Dairi and Karo District	STI, VCT & CST Services	Partnership Fund
Riau Islands				
1	Yayasan Bentan Serumpun	Tanjung Pinang	BCC for FSW and Clients, VCT	USAID
2	Yayasan Hanz	Tanjung Balai Karimun	BCC for FSW and Clients; STI Services & VCT	USAID
3	Yayasan Batam Tourism Development Board	Batam	BCC for FSW and Clients; STI Services & VCT	Partnership Fund
4	Health Office Tanjung Balai Karimun	Tanjung Balai Karimun	STI Services & VCT	Partnership Fund
5	Health Office Batam City	Batam	STI Services & VCT	Partnership Fund
6	Health Office Tanjung Pinang City	Tanjung Pinang, Kepulauan Riau District	STI Services & VCT	Partnership Fund
7	Health Office District Kepulauan Riau	Kepulauan Riau District	STI Services & VCT	Partnership Fund
DKI Jakarta				
1	PKBI Jakarta	East Jakarta	BCC for FSW and Clients; STI Services & VCT	Partnership Fund
2	CHR University of Indonesia	South Jakarta & Depok	BCC for IDUs, Counselors and CM	Partnership Fund
3	Yayasan Karisma	East Jakarta	BCC for IDUs & CM	Partnership Fund
4	Community Encourage of PLWHA (COMET)	Central Jakarta	BCC for IDUs, Counselors and CM	Partnership Fund
5	Atmajaya University	Central, West & North Jakarta	BCC for IDUs, Counselors and CM	Partnership Fund
6	Yayasan Layak	Jakarta	CST & Training	USAID
7	Sudinyankes Jakarta Barat	West Jakarta	STI Services & VCT	Partnership Fund
8	Perkumpulan Pemberantasan Tuberkulosis Indonesia Jakarta (PPTI)	Jakarta	VCT and CST Services	USAID
9	Tegak Tegar	Jakarta	CM Services	Partnership Fund
West Java				
1	Health Office District Indramayu	Indramayu	BCC and STI	Partnership Fund
2	Health Office District Karawang	Karawang	BCC and STI	Partnership Fund
3	Health Office District Subang	Subang	BCC for FSW and Clients	Partnership Fund
4	PKBI Jawa Barat	Bandung City	BCC for FSW and Clients; STI Services & VCT	Partnership Fund
5	Yayasan Bahtera	Bandung City, Bandung, Cimahi Bekasi, Bekasi City, Sumedang	BCC for IDUs, VCT & CST	Partnership Fund

VIII. MoH Health System				
6	Yayasan Permata Hati Kita (Yakita)	Bogor City & Bogor District	BCC for IDUs, VCT & CST	Partnership Fund
7	PANTURA PLUS	Karawang District	BCC for IDUs, VCT & CST	Partnership Fund
8	Lembaga Studi Paradigma Rakyat (LESPRA)	Bekasi City and Bekasi District	BCC for IDUs, VCT & CST	Partnership Fund
9	Yayasan Akes Indonesia (YAKIN)	Tasikmalaya	BCC for IDUs, VCT & CST	Partnership Fund
10	Yayasan Masyarakat Sehat	Bandung District and Subang District	BCC for IDUs, VCT & CST	Partnership Fund
11	Rumah Sakit Hasan Sadikin	Bandung City	CST	Partnership Fund
12	Health Office District Bekasi	Bekasi	STI Services & VCT	Partnership Fund
13	Himpunan Abiasa	Bandung City, Bandung District, Cimahi City, Sumedang District, Cirebon City, Cirebon District, Indramayu District, Tasikmalaya City, Bekasi City, Bekasi District, Karawang District, Subang District	STI Services & VCT	Partnership Fund
14	Health Office District Bogor	Bogor District	STI Services & VCT	Partnership Fund
15	Dinkes Cirebon City	Cirebon City	STI Services & VCT (FSW)	Partnership Fund
16	Himpunan Konselor HIV/AIDS (HIKHA) West Java	Bandung City, Sumedang and Subang District	VCT	Partnership Fund
17	Yayasan Insan Hamdani-Bandung Plus Support	Bandung District and Bandung City	VCT & Case Management Services	USAID
Central Java				
1	Health Office District Kendal	Kendal District	BCC for FSW and Clients; STI Services	Partnership Fund
2	Health Office District Pati	Pati District	BCC for FSW and Clients; STI Services	Partnership Fund
3	PKBI Tegal	Tegal	BCC for FSW and Clients; STI Services & VCT	Partnership Fund
4	PKBI Semarang	Semarang City, Kendal	BCC for FSW and Clients; STI Services & VCT	USAID
5	Health Office District Cilacap	Cilacap District	BCC for FSW and Clients; STI Services & VCT	Partnership Fund
6	Yayasan Wahana Bakti Sejahtera	Semarang City, Semarang, Salatiga City	BCC for IDUs & VCT	Partnership Fund
7	Yayasan Mitra Alam	Surakarta & Salatiga Cities	BCC for IDUs & VCT	Partnership Fund
8	Yayasan PEDHAS	Banyumas & Cilacap Districts	BCC for IDUs & VCT	Partnership Fund
9	Health Office District Salatiga	Salatiga City	STI and VCT Services	Partnership Fund
10	Health Office District Batang	Batang District	STI and VCT Services	Partnership Fund
11	Health Office District Semarang	Semarang District	STI Services & VCT	Partnership Fund
12	Balai Pencegahan & Pengobatan Penyakit Paru (BP4) Semarang	Semarang City	VCT & Case Management Services	USAID
East Java				
1	Puskesmas Putat Jaya	Surabaya City	BCC for FSW & Clients; STI Services & VCT	Partnership Fund
2	Health Office District Banyuwangi	Banyuwangi	BCC for FSW and Clients; STI Services	Partnership Fund
3	Health Office Madiun City	Madiun City	BCC for FSW and Clients; STI Services & VCT	Partnership Fund
4	Health Office Kediri City	Kediri City	BCC for FSW and Clients; STI Services & VCT	Partnership Fund
5	Hotline Service	Surabaya Municipality	BCC for FSW, Clients & IDU; VCT, CST & Case Management	Partnership Fund

VIII. MoH Health System				
6	Yayasan Sadar Hati	Malang City & Malang District	BCC for IDUs & VCT	Partnership Fund
7	Lembaga Panca Indera	Madiun City & District	BCC for IDUs, VCT & Case Management	Partnership Fund
8	Yayasan Bina Hati	Sidoarjo District & Surabaya City	BCC for IDUs, VCT & Case Management	Partnership Fund
9	Lembaga Studi Pembelajaran untuk Pencerahan (LSP2)	Surabaya City & Gresik District	BCC for IDUs, VCT & Case Management	Partnership Fund
10	Kelompok Kerja Pelita Hati Husada (KKPHH)-Dinkes Banyuwangi	Banyuwangi District	BCC for IDUs, VCT & Case Management	Partnership Fund
11	Persatuan Waria Kota Surabaya (Perwakos)	Surabaya City, Gresik, Sidoarjo, Jember, Madiun, Nganjuk	BCC for Transvestites & VCT	USAID
12	RS Dr. Sutomo Surabaya	East Java	CST Services	Partnership Fund
13	Health Office Surabaya City	Surabaya City	STI Services & VCT	Partnership Fund
14	Health Office Madiun District	Madiun District	STI Services & VCT	Partnership Fund
15	Health Office Nganjuk District	Nganjuk District	STI Services & VCT	Partnership Fund
16	Health Office Kediri District	Kediri District	STI Services & VCT	Partnership Fund
17	Health Office Sidoarjo District	Sidoarjo District	STI Services & VCT	Partnership Fund
18	Health Office Pasuruan District	Pasuruan District	STI Services & VCT	Partnership Fund
19	Health Office Jember District	Jember District	STI Services & VCT	Partnership Fund
20	Puskesmas Sumber Pucung	Malang City & Malang District	STI Services & VCT for FSW, Clients, Transvestites & Gay Men	Partnership Fund
21	Puskesmas Perak Timur	Surabaya City	STI Services & VCT for Transvestites, Gay Men & Clients	Partnership Fund
22	Puskesmas Gondang Legi	Malang District	VCT, CST & Case Management for IDUs	Partnership Fund
Papua				
1	PKBI Jayapura	Jayapura District	BCC for FSW and Clients; STI Services & VCT	Partnership Fund
2	Dinkes Papua (Health Services Strengthening)	Jayapura	STI Services	USAID
3	Dian Harapan Hospital	Jayapura City	STI Services	USAID
4	Pusat Kesehatan Reproduksi Merauke	Merauke	STI Services & VCT	USAID
5	PKM Samabusa-Nabire	Nabire	STI Services and VCT	USAID
6	Sele Be Solu Hospital	Sorong City & Sorong District	VCT & CST	USAID

3. Establishing HIV/AIDS Interventions within the Prison System

Evidence of high HIV prevalence in prisons, alongside high rates of TB infection, and high risk behaviors including drug use, continue to indicate the urgent need for a comprehensive package of measures aimed at protecting the health not just of prison inmates and staff but of their families and communities as well. Such a package should include HIV/AIDS awareness raising; prevention, care, and treatment, including integrated treatment of HIV-TB co-infections; and drug rehab support.

In previous years, FHI assisted on the development of the National Strategy for HIV/AIDS Interventions in Prisons and the guidelines for its implementation. On this basis the government issued a recommendation for program implementation in 14 provinces, and dramatically increased the budget for health within the correctional system, including will support the implementation of the recommendations on HIV/AIDS. Also, the Minister of Health, Minister of Home Affairs and Minister of Law & Human Rights signed an MoU delineating the responsibilities of local governments to provide services both in prisons and

in the community following release. Testing, care and treatment will be referred to local health services, but guidelines are still needed for the provision of OI management and social services for PLWHA.

The ASA Program will also work closely with the TBCAP Program, KNCV, the National TP and HIV/AIDS Programs, and the Directorate General for Corrections to coordinate activities addressing the co-infections of HIV and TB within the prison setting. A major effort will be made to establish a strong coordination mechanism within the Working Group for TB/HIV under the Directorate General for Corrections to facilitate real collaboration among these various stakeholders and establish a workable policy for administering appropriate diagnosis and clinical management of these diseases beginning first in selected pilot prisons before expansion throughout the entire prison network.

In Year Three, a key strategy will be to provide targeted support to prisons identified as needing high priority for HIV/AIDS programs. A total of 50 prisons in six provinces have been identified through consultation and coordination with the related ministries. The principal activities to support this strategy will include:

- Continuing assistance in building the capacity of a **national response team** that will train trainers at the provincial level. The team will also provide assistance for the management of the prison program at national level, provide technical guidance and capacity building to prisons in all provinces, and monitor program implementation through regular visits to each target province (at least every 6 months).

- In the 50 high priority prisons, assist the provincial trainers to:

    - deliver **training for prison staff on HIV/AIDS, BCC, basic health care, case management and counseling**;

    - Facilitate the development of **annual workplans** for HIV/AIDS in each prison.

- Establish services for **STI, VCT and CST** in 28 priority prisons which have in-house clinics and support training of prison medical staff by national trainers (already trained), as well as help establish referral services to local providers for the other 22 prisons.

- Improve **access to prevention materials** (condoms and bleach) in the 28 priority prisons with in-house clinical services.

- Through partner IAs, continue to provide **outreach** and assist prison staff to implement prevention and risk reduction activities for prisoners. In particular they will work with prison staff to identify **inmate peer leaders**, who will be trained to work specifically on risk reduction for IDUs.

- Continue work with the national response team and the working group on prisons to develop **guidelines for services for inmates with dual infections of HIV and TB**. These guidelines will subsequently be incorporated into training for prison staff, and become the basis of pilot activities in selected prisons.

Support Activities

- FHI will continue support for the national response team, including an introduction to HIV/AIDS prevention, HIV/AIDS program management, the establishment of referral systems, and the management of clinical services.

- Continue training on STI, VCT, case management and CST for medical officers and prison staff in 28 priority prisons will also be facilitated by FHI in collaboration with the MoH. FHI will also support training efforts for other prisons as opportunities present themselves.

- Develop an appropriate M&E system for the national prison network and provide technical assistance in rolling out the system country wide, beginning with ASA supported institutions.

Monitoring by Indicators

Key indicators for this component include:

Result Area III: Strengthening the Institutional Response	Year 1 Achievement	Year 2 Achievement	Year 3 Target
Indicators			
C. Prison System			
# of Prisons with Established HIV/AIDS Prevention Program	19	42	64
# of Prisons Providing Referal to VCT	11	32	56
# of Prisons Providing Referal to STI Services	4	8	50
# of Prisons Providing Referal to CST Services	7	16	56
# of Prison's Staff Trained in HIV/AIDS	435	1,887	1,922
# of Prisoners Reached	4510	16,863	22,538
# of Prisons which Provide Access to Condoms	7	9	51

Partner Organizations for the Prison System

VIII. Prison System				
No	Institution	Location	Activities	Funding Source
National				
1	Ministry of Law & Human Rights	All sites	Policy & Institutional Development	Partnership Fund
North Sumatera				
1	Yayasan Galatea	Medan	BCC for IDUs and Partner, Counselor & CM	Partnership Fund
2	Medan Plus Support	Deli Serdang, Serdang Bedagai, Pematang Siantar & Simalungun	BCC for IDUs and Partner, Counselors & CM	Partnership Fund
Riau Islands				
1	Yayasan Batam Tourism Development Board	Batam	BCC for FSW and Clients; STI Services & VCT	Partnership Fund
DKI Jakarta				
1	Partisan	Jakarta and Tangerang	BCC for Prisoners	Partnership Fund
West Java				
1	Yayasan Bahtera	Bandung City, Bandung, Cimahi Bekasi, Bekasi City, Sumedang	BCC for IDUs, VCT & CST	Partnership Fund
2	Yayasan Permata Hati Kita (Yakita)	Bogor City & Bogor District	BCC for IDUs, VCT & CST	Partnership Fund
3	PANTURA PLUS	Karawang District	BCC for IDUs, VCT & CST	Partnership Fund
4	Lembaga Studi Paradigma Rakyat (LESPRA)	Bekasi City and Bekasi District	BCC for IDUs, VCT & CST	Partnership Fund
5	Yayasan Akes Indonesia (YAKIN)	Tasikmalaya	BCC for IDUs, VCT & CST	Partnership Fund
6	Yayasan Masyarakat Sehat	Bandung District and Subang District	BCC for IDUs, VCT & CST	Partnership Fund
Central Java				
1	Yayasan Wahana Bakti Sejahtera	Semarang City, Semarang, Salatiga City	BCC for IDUs & VCT	Partnership Fund
2	Yayasan Mitra Alam	Surakarta & Salatiga Cities	BCC for IDUs & VCT	Partnership Fund
3	Yayasan PEDHAS	Banyumas & Cilacap Districts	BCC for IDUs & VCT	Partnership Fund
East Java				
1	Yayasan Sadar Hati	Malang City & Malang District	BCC for IDUs & VCT	Partnership Fund
2	Yayasan Bina Hati	Sidoarjo District & Surabaya City	BCC for IDUs, VCT & Case Management	Partnership Fund
3	Lembaga Studi Pembelajaran untuk Pencerahan (LSP2)	Surabaya City & Gresik District	BCC for IDUs, VCT & Case Management	Partnership Fund
4	Kelompok Kerja Pelita Hati Husada (KKPHH)-Dinkes Banyuwangi	Banyuwangi District	BCC for IDUs, VCT & Case Management	Partnership Fund

4. HIV/AIDS Prevention and Treatment within the Uniformed Services

FHI has been instrumental in the preliminary development of a coordinated response to the HIV/AIDS epidemic within Indonesia's unformed services: the army, navy, air force and the police. Notable achievements to date include the establishment of an AIDS commission within the Ministry of Defense (MoD), a core team of national trainers and more than 860 trained peer educators, strong commitment to the HIV/AIDS program at the national level, and increasingly high levels of commitment at the provincial and corps levels as well.

In Year One, FHI supported the completion of a draft National Strategy for the MoD AIDS Commission (which has responsibility for the coordination of the HIV/AIDS response in the police as well as in all three branches of the military). Based on comprehensive response mapping, the National Strategy outlines the program for each branch. Also in Year One,

training models for outreach and peer-led education were revised and trialed; refresher training was conducted for national trainers, and peer leader training was delivered to more than 150 marines and naval officers.

In Year Two, FHI continued support the strengthening and expansion of the HIV/AIDS program by providing technical input to the MoD AIDS Commission and liaising with Armed Forces Headquarters; facilitating policy development, planning and training and providing limited financial resources in response to requests to assistance.

During Year Three the emphasis will be on the dramatic scale up of activities throughout the Uniformed Services including the following key strategies:

- **Leverage program support** from within the individual services as well as from other sources, such as the US Pacific Command (US PACOM) and the UN family.

- **Strengthen program management and technical capacity** through the following:

    - Training for national trainers on BCC, VCT, case management, UP, CST and M&E.

    - Peer leader training (facilitated by national trainers) for high-risk groups of military and police personnel.

    - Clinical services training for response teams in selected military hospitals based on standard operating procedures drafted in Year Two, beginning with a pilot at the Ramilan Military Hospital in East Java.

    - Assistance for the development of targeted IEC materials.

    - Technical assistance in the design and implementation of a integrated biological and behavior surveillance study within the Department of Defense and the military services.

- **Improve targeting of interventions**: Only identified high-risk military and police groups will be targeted with interventions. These include Marines and naval sailors; the Army's Strategic Reserves Command (Kostrad), Special Force (Kopassus) and Army Engineers; the Air Force's Special Force; and the Police Mobile Brigade and Criminal Investigation Department. In addition to these groups, FHI will also facilitate implementation for all uniformed services personnel in provinces where HIV prevalence is high, e.g. Papua and the Riau Islands.

- **Strengthen program and policy development**: FHI will assist the MoD and the four Military Headquarters to make final adjustments to the National Strategy and provide further assistance to each branch to translate this into more detailed strategies and plans. Operational strategies will be developed by the MoD and FHI with the participation of the chief health officers for each branch so they in turn can advocate to their commanders for commitment and support. FHI will provide specific technical assistance in the following areas:

- Developing annual workplans for eight identified priority units (six corps and two territorial units).
- Developing and using monitoring systems for each priority unit.
- Developing policy on and system for condom distribution.
- Integrating HIV/AIDS into education and training.
- Promoting HIV and STI surveillance within each service branch.

Monitoring by Indicators

Key indicators for this component include:

Result Area III: Strengthening the Institutional Response	Year 1 Achievement	Year 2 Achievement	Year 3 Target
Indicators			
D. Uniformed Services			
- # of Updated Strategic Planning Ministry of Defense/Police AIDS Comission	0	1	2
- # of Uniformed Services Units with Program Plan	1	1	3
- # of Uniformed Services Corps Trained for Peer Leader Education	1	7	8
- # of Uniformed Services Personnel Trained as Peer Leaders	0	565	1,200
- # of Uniformed Services Personnel Trained as BCC Trainer	9	9	76
- # of Uniformed Services Personnel Trained as CSU Trainer	0	30	64
- # of Uniformed Services Personnel Reached	NA	24,425	25,500
- # of Uniformed Services Corps Provided Access to Condom	0	-	8
- # of Uniformed Health Services Providing STI Services	0	7	8
- # of Uniformed Health Services Providing VCT Services	0	10	10
- # of Uniformed Health Services CST Services	1	6	6

Partner Organizations for Uniformed Services

IX. Uniformed Services				
No	Institution	Location	Activities	Funding Source
1	Ministry of Defense (Uniformed Services)	All sites	Policy & Institutional Development	Partnership Fund

Result Area IV: Strengthening HIV/AIDS and STI Surveillance

FHI will continue to collaborate closely with the Ministry of Health, the Technical Working Group on Surveillance, the National AIDS Commission, and the Indonesian Bureau of Statistics (BPS) to complete the latest round of second generation biological and behavioral surveillance targeting most-at-risk groups across all eight target provinces. The major objectives of these efforts include:

- To produce accurate estimates of relevant behavior and biological indicators in order to track changes in the epidemic;
- To strengthen the methodological and operational design of the national HIV sentinel surveillance system;

- To expand the national sentinel surveillance system to include "passive" monitoring of HIV and STI infection at selected VCT sites;

- To increase capacity at the national, provincial, and district levels to collect, analyze, and use surveillance data to target interventions and monitor population-level results; and

- To measure program achievements based on relevant behavioral and biological outcome indicators.

BPS has been contracted to design and implement the current round of STI/HIV/AIDS surveillance among MARGs in the eight target provinces. Data collection has been completed in September 2007 among female and male prostitutes, waria, injecting drug users, gay men, and high-risk men, including a sample of civil servants in Papua and East Java. Testing for HIV, gonorrhea, Chlamydia, and syphilis among all MARGs has been combined with behavior surveillance using the standard set of questions developed over the previous two rounds of behavior surveillance. Respondents have also been tested for HIV/AIDS. Following data entry, cleaning and analysis will precede formal dissemination of results through a serious of workshops is currently scheduled for late 2007.

V. PROGRAM MANAGEMENT AND STAFFING

In order to ensure strong management support to the multiple components of the comprehensive joint program, FHI has established an organizational structure that incorporates the principles of decentralization, with over 80% of technical and program staff placed in the provinces, and quality assurance through centralized, responsible financial, contracting, and reporting systems. A total of 112 staff is planned, as outlined the organizational structure found in Annex III.

In order to facilitate strong management and effective two-way communications within a decentralized system, FHI will organize a series of quarterly meetings with the Chief Representative from the target provinces during which program updates will be discussed, targets and achievements assessed, implementation reviewed, problems identified, and appropriate corrective action determined. FHI will also organize an annual all staff workshop during which the entire staff will come together to evaluate achievements to date and set the direction for the coming year's activities.

FHI will also continue to manage collaboration with each of the numerous and diverse implementing partners. FHI will continue to ensure the each partner implements effective, innovative interventions; achieves maximum results; and provides consistent reporting of achievements, while maintaining absolute compliance with both USAID and UNDP financial polices and regulations.

Implementation of all sub-agreements will be carefully monitored through monthly implementation and financial reports from the IAs (to be reviewed by the provincial office and relevant units in Jakarta), and augmented by monthly site visits by provincial program staff and semi-annual site visits by the relevant technical monitor from Jakarta. The routine district coordination meetings will also be important to ensure that targets are met, problems

solved, and designs adjusted to the changing reality of implementation in the field. Appropriate technical training and practical assistance will be provided whenever needed.

In order to stay abreast of international developments in HIV/AIDS programming, FHI will send a small delegation for FHI staff to the 2008 Pepfar HIV/AIDS Implementer's Meeting in Uganda.

FHI's Asia Pacific Regional Office (APRO) in Bangkok will continue to provide management support and technical assistance to the program in Indonesia. This will be accomplished through regular communications; site visits by selected APRO staff as requested; and through participation in several FHI regional and global strategic information meetings covering management, finance, M&E, behavior change, and other technical areas throughout the year. Experiences will also be exchanged on the international level through attendance at FHI's Global Management Meeting in Arlington by the Country Director.

VI. TECHNICAL ASSISTANCE

To augment the technical expertise of the FHI staff in Indonesia and the Asia Pacific Regional Office, as well as ensure strong program design, implementation and management, FHI proposed to utilize the services of the following local and international consultants:

- **Dr. Arwati Soepanto** will continue to assist FHI in liaising with the various sectors of the Government of Indonesia involved in HIV/AIDS programming, most significantly with the Ministry of Health.

- **Mitu Prie** will also continue to assist in the research, design, execution, and assessment of targeted communications to support all of FHI's behavior change initiatives, including Papua-specific media.

- **Stephanie Pirolo, Tetty Rachmawati,** and **Ronny Ronodridjo** will continue to provide technical assistance in the development and implementation of the comprehensive training on behavior change for all partner NGOs.

- **Made Efo Suarmiartha** and **Supriyanto Slamet** will also continue to provide assistance to the program by providing training and mentoring in behavior change theory and application to the large number of partner NGOs working in this area.

- **Agustinus Mandagi** will continue to provide assistance on the design and implementation of activities focusing on MSM.

- **Bambang Irawan** will continue to provide professional expertise in the research, design, and production of IEC materials to support all program components. He will be joined by **Arief Rachman** with experience in risk reduction for IDU to help develop appropriate IEC materials specifically for this important target group.

- **Dr. Irwanto** and **I Made Setiawan** will continue to provide technical assistance in the design and implementation of risk reduction interventions for IDU.

- An **International Expert on IDU support groups** will provide technical assistance to the program and facilitate a national workshop for partner NGOs working on support activities for HIV positive IDU.

- An **International Expert in IDU Risk Reduction** will be hired to help introduce international best practices and facilitate a national workshop focusing on this crucial component of the program.

- **Trio Mardjoko** will continue to provide assistance in data entry and data management for the ASA Program's M&E system.

- **Flora Tanujaya** will continue to assist the program by providing technical assistance on selected clinical services activities, health service strengthening in Tanah Papua, and TB/HIV interventions.

- **Asih Hartanti** will continue to provide technical expertise in the field of clinical laboratory testing quality control, and assist with training in laboratory testing on a limited basis.

- **Teresa Promboth,** an international expert in the continuum of care will also be hired to help facilitate senior level workshops for medical specialists to encourage their active involvement in HIV/AIDS treatment, as well as to introduce international best practices.

- **Astrid Sulitomo** will provide technical assistance in HIV/AIDS Counseling and Testing in order to more rapidly expand the cadre of professional counselors in Indonesia.

- **Marcel Latuihamallo** will continue to support the strengthening of HIV/AIDS counseling through operational research and training.

- **Sally Wellesley** will continue to provide excellent assistance in report writing and editing of all major program documents.

- **Emmy Sahertian** will be hired to provide technical assistance in and facilitate the mobilization of faith-based organizations (FBOs) in the fight against HIV/AIDS in Tanah Papua.

- **Claudia Surjadjaya** will continue to provide technical assistance in the design and implementation of workplace interventions throughout all target provinces, while **Helina** and **Lita** will provide assistance specifically to workplace programs in the province of North Sumatra.

- **Lisbeth Bollen** will continue her excellent work on streamlining the program wide QA/QI system, as well as assist with other operational research activities and report writing.

- **Gunawan Kusumo,** following his retirement from active service with FHI, will continue to support the program in Papua as a consultant to the local government as well as liaison with local community groups on HIV/AIDS.

- **Pandu Riono** will continue his relationship with the ASA Program as a part-time consultant focusing on the analysis and use of IBBS data, especially within advocacy and program design.

ANNEX I

Program Coverage Targets
and
Program Performance Indicators

Program Coverage Targets

Program Coverage Target

NORTH SUMATERA PROVINCE

Most at Risk Populations (MARPs)	# Estimated Population of provinces*	ASA Coverage (Actual)	ASA Coverage (Actual)	ASA Coverage (Target)	Other Coverage	Total Coverage	% Covered
		Year I	Year II	Year III			
IDU	**18,385**	933	3,233	9,774	-	**9,774**	53%
Female sex workers	**8,920**	2,553	7,051	8,149	-	**8,149**	91%
Waria Sex Worker	**1,430**	79	3,549	3,549	-	**3,549**	248%
High Risk Men	**189,955**	12,578	66,861	113,831	-	**113,831**	60%
MSM	**41,585**	-	2,146	25,042	-	**25,042**	60%
Total	**260,275**	**16,143**	**82,840**	**160,344**	**-**	**160,344**	**62%**

KEPULAUAN RIAU PROVINCE

Most at Risk Populations (MARPs)	# Estimated Population of provinces*	ASA Coverage (Actual)	ASA Coverage (Actual)	ASA Coverage (Target)	Other Coverage	Total Coverage	% Covered
		Year I	Year II	Year III			
IDU	**5,140**	159	415	2,081	-	**2,081**	40%
Female sex workers	**9,265**	5,673	12,696	13,517	-	**13,517**	146%
Waria Sex Worker	**365**	504	670	670	-	**670**	184%
High Risk Men	**97,360**	22,870	88,390	88,390	-	**88,390**	91%
MSM	**5,855**	1,079	1,601	3,513	-	**3,513**	60%
Total	**117,985**	**30,285**	**103,772**	**108,171**	**-**	**108,171**	**92%**

DKI JAKARTA PROVINCE

Most at Risk Populations (MARPs)	# Estimated Population of provinces*	ASA Coverage (Actual)	ASA Coverage (Actual)	ASA Coverage (Target)	Other Coverage	Total Coverage	% Covered
		Year I	Year II	Year III			
IDU	**33,615**	3,555	10,053	10,053	10,780	**20,833**	62%
Female sex workers	**31,520**	4,540	15,633	18,564	-	**18,564**	59%
Waria Sex Worker	**1,340**	1,760	2,704	2,704	-	**2,704**	202%
High Risk Men	**401,170**	104,695	268,964	335,309	-	**335,309**	84%
MSM	**45,630**	5,827	20,498	30,409	-	**30,409**	67%
Total	**513,275**	**120,377**	**317,852**	**397,039**	**10,780**	**407,819**	**79%**

TANAH PAPUA

Most at Risk Populations (MARPs)	# Estimated Population of provinces*	ASA Coverage (Actual)	ASA Coverage (Actual)	ASA Coverage (Target)	Other Coverage	Total Coverage	% Covered
		Year I	Year II	Year III			
IDU	**660**	-	-	-	-	**-**	0%
Female sex workers	**7,055**	2,144	4,650	4,650	700	**5,350**	76%
Waria Sex Worker	**545**	-	82	313	-	**313**	57%
High Risk Men	**71,960**	3,777	23,861	44,319	-	**44,319**	62%
MSM	**5,990**	17	92	3,594	-	**3,594**	60%
General Population	**1,417,260**	**97,841**	**561,091**	**570,744**	**-**	**570,744**	**40%**
Total	**1,503,470**	**103,779**	**589,776**	**623,620**	**700**	**624,320**	**42%**

WEST JAVA PROVINCE

Most at Risk Populations (MARPs)	# Estimated Population of provinces*	ASA Coverage (Actual)	ASA Coverage (Actual)	ASA Coverage (Target)	Other Coverage	Total Coverage	% Covered
		Year I	Year II	Year III			
IDU	**27,445**	2,635	10,457	10,457	10,000	**20,457**	75%
Female sex workers	**29,560**	5,594	18,175	18,602	-	**18,602**	63%
Waria Sex Worker	**3,420**	1,414	2,186	2,186	-	**2,186**	64%
High Risk Men	**380,795**	42,825	82,139	228,922	-	**228,922**	60%
MSM	**170,210**	1,528	7,511	101,916	-	**101,916**	60%
Total	**611,430**	**53,996**	**120,468**	**362,083**	**10,000**	**372,083**	**61%**

CENTRAL JAVA PROVINCE

Most at Risk Populations (MARPs)	# Estimated Population of provinces*	ASA Coverage (Actual)	ASA Coverage (Actual)	ASA Coverage (Target)	Other Coverage	Total Coverage	% Covered
		Year I	Year II	Year III			
IDU	**8,955**	1,019	5,819	5,819	-	**5,819**	65%
Female sex workers	**13,305**	7,519	17,847	18,317	-	**18,317**	138%
Waria Sex Worker	**1,560**	896	1,479	1,479	-	**1,479**	95%
High Risk Men	**205,070**	41,657	125,958	122,912	-	**122,912**	60%
MSM	**98,695**	977	3,513	59,290	-	**59,290**	60%
Total	**327,585**	**52,068**	**154,616**	**207,817**	**-**	**207,817**	**63%**

EAST JAVA PROVINCE

Most at Risk Populations (MARPs)	# Estimated Population of provinces*	ASA Coverage (Actual)	ASA Coverage (Actual)	ASA Coverage (Target)	Other Coverage	Total Coverage	% Covered
		Year I	Year II	Year III			
IDU	**26,390**	1,958	8,692	9,804	4,000	**13,804**	52%
Female sex workers	**22,535**	4,264	18,679	19,242	-	**19,242**	85%
Waria Sex Worker	**3,590**	2,982	4,137	4,137	-	**4,137**	115%
High Risk Men	**415,300**	74,185	174,708	247,936	-	**247,936**	60%
MSM	**132,010**	5,053	8,013	79,040	-	**79,040**	60%
Total	**599,825**	**88,442**	**214,229**	**360,159**	**4,000**	**364,159**	**61%**

Total 7 Provinces

Most at Risk Populations (MARPs)	# Estimated Population of provinces*	ASA Coverage (Actual)	ASA Coverage (Actual)	ASA Coverage (Target)	Other Coverage	Total Coverage	% Covered
		Year I	Year II	Year III			
IDU	**120,590**	10,259	38,669	47,987	24,780	**72,767**	60%
Female sex workers	**122,160**	32,287	94,731	101,041	700	**101,741**	83%
Waria Sex Worker	**12,250**	7,635	14,807	15,038	-	**15,038**	123%
High Risk Men	**1,761,610**	260,930	830,881	1,181,619	-	**1,181,619**	67%
MSM	**499,975**	14,481	43,374	302,803	-	**302,803**	61%
General Population	**1,417,260**	97,841	561,091	570,744		**570,744**	**40%**
Total	**3,933,845**	**423,433**	**1,583,553**	**2,219,232**	**25,480**	**2,244,712**	**57%**

Note: * Source of data: 2006 MoH and NAC Pops Estimation

Performance Indicators

No	Indicators	Baseline Value	Target			Source of Data
			Year 1	Year 2	Year 3	
I	**MARGS**					
A	**Female Sex Workers (FSWs)**					
1	% of FSWs working in establishments where condoms are available					BSS
	North Sumatra					
	Direct FSW	67%	70%	85%	95%	
	Indirect FSW	65%	70%	85%	95%	
	Kepulauan Riau					
	Direct FSW	82%	85%	90%	95%	
	Indirect FSW	78%	85%	90%	95%	
	DKI Jakarta					
	Direct FSW	72%	80%	85%	90%	
	Indirect FSW	20%	40%	60%	70%	
	West Java					
	Direct FSW	26%	40%	55%	70%	
	Indirect FSW	43%	55%	65%	80%	
	Central Java					
	Direct FSW	78%	80%	90%	90%	
	Indirect FSW	21%	40%	60%	70%	
	East Java					
	Direct FSW	58%	65%	75%	85%	
	Indirect FSW	41%	55%	65%	75%	
	Papua (3 sites)					
	Direct FSW	71%	75%	80%	90%	
	Indirect FSW	65%	75%	80%	90%	
2	% of FSWs reporting proposing condoms to all of their clients in the last week					BSS
	North Sumatra					
	Direct FSW	25%	35%	55%	70%	
	Indirect FSW	56%	65%	75%	85%	
	Kepulauan Riau					
	Direct FSW	59%	65%	75%	80%	
	Indirect FSW	57%	65%	75%	80%	
	DKI Jakarta					
	Direct FSW	26%	35%	50%	60%	
	Indirect FSW	26%	35%	50%	60%	
	West Java					
	Direct FSW	11%	20%	35%	45%	
	Indirect FSW	44%	60%	75%	85%	
	Central Java					
	Direct FSW	62%	70%	80%	85%	
	Indirect FSW	73%	80%	85%	90%	
	East Java					
	Direct FSW	32%	40%	50%	60%	
	Indirect FSW	30%	40%	55%	65%	
	Papua (3 sites)					
	Direct FSW	70%	80%	90%	90%	
	Indirect FSW	51%	60%	75%	85%	
3	% of FSWs reporting condom use during most recent sex act with client					BSS
	North Sumatra					
	Direct FSW	48%	55%	70%	80%	
	Indirect FSW	91%	91%	95%	95%	
	Kepulauan Riau					
	Direct FSW	64%	65%	70%	75%	
	Indirect FSW	76%	80%	85%	85%	
	DKI Jakarta					
	Direct FSW	41%	55%	65%	75%	
	Indirect FSW	45%	50%	60%	70%	
	West Java					
	Direct FSW	23%	30%	45%	60%	
	Indirect FSW	62%	70%	85%	85%	
	Central Java					
	Direct FSW	76%	80%	85%	85%	
	Indirect FSW	90%	90%	90%	90%	
	East Java					
	Direct FSW	41%	45%	55%	60%	
	Indirect FSW	42%	45%	55%	60%	
	Papua (3 sites)					
	Direct FSW	82%	85%	90%	90%	
	Indirect FSW	64%	70%	80%	90%	

No	Indicators	Baseline Value	Target			Source of Data
			Year 1	Year 2	Year 3	
I	**MARGS**					
A	**Female Sex Workers (FSWs)**					
4	% of FSWs reporting consistent condom use with clients in the last week.					BSS
	North Sumatra					
	Direct FSW	14%	20%	30%	40%	
	Indirect FSW	65%	70%	80%	85%	
	Kepulauan Riau					
	Direct FSW	32%	40%	50%	55%	
	Indirect FSW	43%	50%	60%	65%	
	DKI Jakarta					
	Direct FSW	15%	20%	35%	45%	
	Indirect FSW	26%	30%	40%	50%	
	West Java					
	Direct FSW	8%	15%	30%	40%	
	Indirect FSW	47%	55%	65%	75%	
	Central Java					
	Direct FSW	29%	30%	40%	50%	
	Indirect FSW	61%	65%	75%	80%	
	East Java					
	Direct FSW	17%	20%	35%	45%	
	Indirect FSW	28%	35%	50%	55%	
	Papua (3 sites)					
	Direct FSW	61%	65%	75%	80%	
	Indirect FSW	45%	50%	60%	65%	
	Note: The target will have FSWs exposed to any HIV interventions as the denominator					
5	% of FSWs screened for STI in the last month					BSS
	North Sumatra					
	Direct FSW	40%	50%	60%	75%	
	Indirect FSW	1%	10%	30%	55%	
	Kepulauan Riau					
	Direct FSW	43%	55%	60%	75%	
	Indirect FSW	39%	50%	65%	75%	
	DKI Jakarta					
	Direct FSW	5%	15%	30%	50%	
	Indirect FSW	6%	15%	30%	50%	
	West Java					
	Direct FSW	5%	15%	30%	50%	
	Indirect FSW	3%	15%	30%	50%	
	Central Java					
	Direct FSW	26%	35%	50%	60%	
	Indirect FSW	8%	15%	30%	50%	
	East Java					
	Direct FSW	8%	15%	30%	50%	
	Indirect FSW	3%	10%	20%	35%	
	Papua (3 sites)					
	Direct FSW	40%	55%	75%	80%	
	Indirect FSW	13%	20%	30%	40%	
6	% of FSWs had Sti symptoms in the last 1 year who self-treated					BSS
	North Sumatra	70%	60%	45%	35%	
	Kepulauan Riau	66%	50%	45%	35%	
	DKI Jakarta	88%	75%	60%	50%	
	West Java	82%	75%	60%	50%	
	Central Java	56%	40%	30%	25%	
	East Java	64%	50%	40%	35%	
	Papua (3 sites)	58%	40%	30%	25%	
B	**Potential Clients of FSWs**					
1	% of married Target Male Groups who have extramarital partner in the last year					BSS
	North Sumatra	51%	50%	45%	40%	
	Kepulauan Riau	29%	27%	23%	20%	
	DKI Jakarta	36%	35%	30%	28%	
	West Java	29%	26%	23%	20%	
	Central Java	61%	60%	55%	50%	
	East Java	38%	36%	30%	28%	
	Papua (3 sites)	27%	26%	23%	20%	

No	Indicators	Baseline Value	Target			Source of Data
			Year 1	Year 2	Year 3	
I	**MARGS**					
B	**Potential Clients of FSWs**					
2	% of Target Male Groups reporting commercial sex in the last year					BSS
	North Sumatra	63%	60%	55%	50%	
	Kepulauan Riau	65%	62%	57%	55%	
	DKI Jakarta	64%	60%	55%	50%	
	West Java	34%	32%	29%	27%	
	Central Java	72%	69%	65%	60%	
	East Java	63%	60%	55%	50%	
	Papua (3 sites)	42%	40%	35%	30%	
3	% of Clients using condom during most recent sex act with FSWs					BSS
	North Sumatra	16%	20%	35%	40%	
	Kepulauan Riau	38%	40%	50%	55%	
	DKI Jakarta	17%	20%	30%	40%	
	West Java	5%	15%	30%	40%	
	Central Java	30%	35%	45%	55%	
	East Java	43%	50%	55%	60%	
	Papua (3 sites)	46%	50%	55%	60%	
4	% of Clients reporting consistent condom use in commercial sex in the last year.					BSS
	North Sumatra	6%	10%	20%	25%	
	Kepulauan Riau	14%	20%	30%	35%	
	DKI Jakarta	8%	10%	15%	25%	
	West Java	1%	5%	15%	25%	
	Central Java	9%	15%	25%	35%	
	East Java	12%	15%	25%	35%	
	Papua (3 sites)	35%	40%	45%	50%	
5	% of men reporting STIs in the last year who self-treated					BSS
	North Sumatra	66%	62%	57%	55%	
	Kepulauan Riau	60%	55%	50%	50%	
	DKI Jakarta	68%	65%	60%	55%	
	West Java	70%	67%	63%	57%	
	Central Java	67%	65%	62%	58%	
	East Java	79%	75%	70%	65%	
	Papua (3 sites)	75%	70%	65%	60%	
C	**Transgender (Waria) Sex Worker**					
1	% of transvestite (*waria*) sex workers reporting proposing condoms to all of their clients in the last week					BSS
	DKI Jakarta	65%	70%	85%	90%	
	East Java	66%	75%	85%	90%	
	West Java	30%	50%	70%	80%	
2	% of *waria* sex workers using condom at last anal sex with client					BSS
	DKI Jakarta	81%	85%	90%	90%	
	East Java	71%	80%	85%	90%	
	West Java	63%	70%	80%	85%	
3	% of Waria reporting consistent condom use in anal sex with clients in the last week.					
	DKI Jakarta	56%	60%	70%	75%	
	East Java	49%	55%	65%	70%	
	West Java	17%	20%	30%	40%	
4	% of *waria* sex workers using condom with water-based lubricant with last anal client					BSS
	DKI Jakarta	43%	50%	60%	70%	
	East Java	22%	30%	40%	50%	
	West Java	18%	25%	35%	45%	
5	% of waria SW who had STI screening in the last three months					BSS
	DKI Jakarta	80%	85%	85%	85%	
	East Java	68%	75%	85%	85%	
	West Java	71%	75%	85%	85%	

No	Indicators	Baseline Value	Target			Source of Data
			Year 1	Year 2	Year 3	
I	**MARGS**					
D	**Male Sex Workers**					
1	% of establishment-based male sex workers working in establishments where condoms are available					BSS
	DKI Jakarta	95%	95%	95%	95%	
	East Java	97%	97%	97%	97%	
	West Java	97%	97%	97%	97%	
2	% of male sex workers reporting proposing condoms to all of their clients in the last week					BSS
	DKI Jakarta	55%	60%	75%	75%	
	East Java	41%	50%	65%	70%	
	West Java	36%	45%	60%	70%	
3	% of male sex workers using condom with the last anal client					BSS
	DKI Jakarta	84%	84%	85%	85%	
	East Java	47%	55%	65%	70%	
	West Java	78%	80%	85%	85%	
4	% of Male Sex reporting consistent condom use with anal Clients in the last week.					
	DKI Jakarta	53%	60%	70%	75%	
	East Java	29%	35%	45%	55%	
	West Java	50%	60%	70%	75%	
5	% of male sex workers using condom with water-based lubricant with last anal client					BSS
	DKI Jakarta	69%	75%	80%	85%	
	East Java	24%	35%	45%	50%	
	West Java	58%	65%	75%	80%	
6	% of male sex workers who had STI screening in the last month					BSS
	DKI Jakarta	27%	35%	40%	45%	
	East Java	22%	30%	35%	40%	
	West Java	9%	15%	25%	35%	
E	**Gay Men**					
1	% gay men using condom in the last anal sex					BSS
	DKI Jakarta	62%	70%	75%	80%	
	East Java	41%	45%	55%	60%	
	West Java	41%	45%	55%	60%	
2	% of gay men reporting consistent condom use with anal partners in the last month.					BSS
	DKI Jakarta	49%	55%	65%	70%	
	East Java	19%	25%	35%	40%	
	West Java	20%	25%	35%	40%	
3	% gay men using condom with water-based lubricant in the last anal sex					BSS
	DKI Jakarta	61%	70%	75%	80%	
	East Java	34%	45%	50%	55%	
	West Java	37%	45%	55%	60%	
4	Average number of male anal partners in the last month					BSS
	DKI Jakarta	2.2	2	1.8	1.8	
	East Java	1.9	1.7	1.5	1.5	
	West Java	2.1	2	1.8	1.8	
F	**IDUs & Prisoners**					
1	% of IDUs reporting condom use during most recent commercial sex act					BSS
	DKI Jakarta	31%	35%	45%	50%	
	East Java	25%	30%	40%	50%	
	West Java	44%	45%	55%	60%	
	North Sumatera	33%	40%	50%	55%	
2	% of IDU reporting consistent condom use with commercial sex in the last month.					BSS
	DKI Jakarta	10%	15%	25%	35%	
	East Java	13%	15%	25%	35%	
	West Java	29%	35%	45%	50%	
	North Sumatera	16%	20%	35%	40%	

No	Indicators	Baseline Value	Target			Source of Data
			Year 1	Year 2	Year 3	
I	**MARGS**					
F	**IDUs & Prisoners**					
3	% of IDU reporting consistent condom use with non commercial sex in the last year.					BSS
	DKI Jakarta	3%	10%	30%	50%	
	East Java	7%	15%	35%	50%	
	West Java	12%	25%	40%	55%	
	North Sumatera	5%	10%	20%	30%	
4	% of IDUs sharing water or injecting equipment (other than needle/ syringes) in the last week injection					BSS
	DKI Jakarta	77%	60%	45%	35%	
	East Java	99%	85%	65%	40%	
	West Java	56%	45%	35%	30%	
	North Sumatera	85%	70%	50%	40%	
5	% of IDUs who report sharing injecting needles in the last week					BSS
	DKI Jakarta	36%	35%	30%	20%	
	East Java	75%	70%	60%	50%	
	West Java	34%	30%	20%	20%	
	North Sumatera	52%	48%	35%	30%	
6	Average number of sex partners of IDUs in the last year					BSS
	DKI Jakarta	2.6	2	1.5	1.5	
	East Java	3.9	3.5	3	2	
	West Java	3.5	3	2	1.5	
	North Sumatera	1.9	1.5	1.5	1.5	
7	% IDUs who had unprotected commercial sex in the last year					BSS
	DKI Jakarta	90%	80%	60%	45%	
	East Java	87%	70%	55%	40%	
	West Java	71%	60%	50%	40%	
	North Sumatera	84%	70%	55%	40%	
8	% of IDUs who share needle and who clean with bleach					BSS
	DKI Jakarta	33%	38%	45%	50%	
	East Java	11%	16%	25%	30%	
	West Java	28%	33%	40%	45%	
	North Sumatera	23%	28%	35%	40%	
9	Number of IDUs presenting at support services who were referred by prison programs					Combined Program Data
	DKI Jakarta	0	400	750	1000	
	East Java	0	300	600	800	
	West Java	0	400	750	1000	
	North Sumatera	0	250	500	700	
10	% of prisons which provide access to condoms					Combined Program Data
	DKI Jakarta	0%	30%	60%	60%	
	East Java	0%	10%	20%	20%	
	West Java	0%	10%	20%	20%	
	North Sumatera	0%	10%	20%	20%	
11	% prisons who provide access to bleach					Combined Program Data
	DKI Jakarta	0%	0%	30%	30%	
	East Java	0%	3%	5%	10%	
	West Java	0%	3%	5%	10%	
	North Sumatera	0%	3%	5%	10%	
G	**Program/Interventions/Services**					
1	The number of target groups reached by outreach educators					Combined Program Data
	FSW	0	24,000	71,000	93,000	
	High risk Men	0	268,000	781,000	1,029,000	
	MSM	0	14,300	32,500	42,250	
	IDU	0	11,300	33,000	45,400	
2	Number of patients provided services at STI clinics					Combined Program Data
	Male patients	0	3,000	4,500	6,100	
	Female patiients	0	21,600	63,900	83,700	
	Total patients	0	24,600	68,400	89,800	
3	Number of patients seen at VCT centers					Combined Program Data
	Male patients	0	1,500	2,250	3,050	
	Female patiients	0	10,800	31,950	41,850	
	Total patients	0	12,300	34,200	44,900	

No	Indicators	Baseline Value	Target			Source of Data
			Year 1	Year 2	Year 3	
I	**MARGS**					
G	**Program/Interventions/Services**					
4	Number of individuals receiving community and home-based care programs					Combined Program Data
		0	35	50	65	
5	Number of individuals receiving case management services					Combined Program Data
		0	1000	2250	3050	
6	% of target group who have utilized VCT services					BSS
	North Sumatra					
	FSW	13%	20%	35%	50%	
	High risk Men	1%	3%	5%	5%	
	Kepulauan Riau					
	FSW	19%	25%	35%	50%	
	High risk Men	1%	3%	5%	5%	
	DKI Jakarta					
	IDU	9%	15%	25%	30%	
	FSW	8%	20%	35%	50%	
	High risk Men	1%	3%	5%	5%	
	MSW	21%	30%	35%	40%	
	Transvestites	43%	60%	70%	75%	
	West Java					
	FSW	6%	10%	25%	30%	
	High risk Men	1%	3%	5%	5%	
	Central Java					
	FSW	7%	15%	25%	30%	
	High risk Men	1%	3%	5%	5%	
	East Java					
	IDU	5%	10%	15%	20%	
	FSW	12%	20%	25%	30%	
	High risk Men	1%	3%	5%	5%	
	MSW	15%	20%	25%	30%	
	Transvestites	20%	40%	60%	70%	
	Papua (3 sites)					
	FSW	23%	40%	60%	70%	
	High risk Men	11%	12%	15%	20%	
7	% of HIV tested target group who have picked up the result					Combined Program Data
	North Sumatra	55%	65%	70%	80%	
	Kepulauan Riau	57%	65%	70%	80%	
	DKI Jakarta	65%	65%	70%	80%	
	West Java	49%	65%	70%	80%	
	Central Java	23%	65%	70%	80%	
	East Java	64%	65%	70%	80%	
	Papua (3 sites)	53%	65%	70%	80%	
8	% of target group receiving positive HIV results who are then referred to CST in the last year					Combined Program Data
		0%	40%	60%	70%	
9	Number of districts that have comprehensive "package approach"					Program Data
		0	16	39	62	

No	Performance Indicators	Baseline Value	Target			Source of Data
			Year 1	Year 2	Year 3	
Result Area II: Improving IA's Ability to Self Assess and Enhance Program						
1	# of partner organizations attending monthly coordination	NA	120	144	144	Combined Program Data
2	# of districts implementing monthly coordination meeting	NA	74	74	74	
3	# of local organizations provided with technical assistance for HIV related policy development	NA	120	144	144	
4	# of local organizations provided with technical assistance for HIV related capacity building	NA	120	144	144	
5	# of individuals trained in HIV-related community mobilization or prevention, care and/or treatment	NA	120	144	144	
6	# of local organizations provided with technical assistance for strategic information activities	NA	120	144	144	
7	# of individuals trained in strategic information (incl. M&E, surveillance and/or MIS)	NA	300	0	300	

No	Performance Indicators	Baseline Value	Target			Source of Data
			Year 1	Year 2	Year 3	
	Result Area III: Strengthening the Institutional Response					
A.	**National, Provincial, District AIDS Commision**					
1	# of KPAD with a Strategic Plan					Combined Program Data
	-Provincial	7	7	7	7	
	-District	0	16	39	62	
2	# of KPAD with active secretariat					
	-Provincial	7	7	7	7	
	-District	7	16	39	62	
3	# of KPAD with an Annual Work plan					
	-Provincial	6	7	7	7	
	-District	7	16	39	62	
4	# of KPAD implementing regular coordination meeting					
	-Provincial	0	7	7	7	
	-District	0	16	39	62	
5	of KPAD whose budget is increased over the previous year relative to overall development spending.					
	-Provincial	7	7	7	7	
	-District	15	16	39	62	
6	# of individuals trained in HIV-related policy development	NA	0	300	40	
7	# of individuals trained in HIV-related institutional capacity building	NA	0	300	40	
8	# of individuals trained in HIV-related stigma and discrimination reduction	NA	0	300	40	
9	# of individuals trained in HIV-related community mobilization or prevention, care and/or treatment	NA	38	300	40	
B.	**MoH Health Services Network**					
1	Number of district with established "continuum of care" in targeted district	7	16	39	48	Combined Program Data
2	Number of STI Clinics	22	30	48	48	
3	Number of VCT sites	20	60	74	74	
4	Number of staff trained in STI Clinical Management accorning to national & international standards	180	380	480	500	
5	Number of individuals trained in counseling according to national & international standards	75	275	375	400	
6	Number of individuals trained in testing according to national & international standards	50	210	350	400	
7	Number of Case Managers trained according to national & international standards	75	295	395	435	
C.	**Prison**					
1	# of prisons with established HIV/AIDS prevention program	5	8	28	50	Combined Program Data
2	# of prisons providing referal to VCT	0	1	8	20	
3	# of prisons providing referal to STI Services	0	1	8	20	
4	# of prisons providing referal to CST Services	0	1	4	12	
5	# of prisons with staff trained in HIV/AIDS	5	8	28	50	
6	# of prisons which provide access to condoms	0	0	10	28	
7	# of prisons which provide access to bleach	0	0	10	28	
D.	**Uniformed Services**					
1	# of updated strategic planning ministry of defense/Police AIDS comission	0	2	2	2	
2	# of uniformed services units with program plan	0	4	4	4	
3	#f of uniformed services corps trained for Peer Leader Education	1	2	12	12	
4	# of uniformed services personnel trained as BCC trainer	0	12	12	12	
5	# of uniformed services personel trained as CSU trainer	0	0	12	12	
6	# of uniformed services corps provided access to condom	NA	1	10	11	
7	# of uniformed health services providing STI services	NA	10	10	10	
8	# of uniformed health services providing VCT services	5	10	10	10	
9	# of uniformed health services CST services	3	6	6	6	

No	Indicators	Baseline Value	Target			Source of Data
			Year 1	Year 2	Year 3	
II	**General Population in Papua**					
1	Number of population exposed to community programs, including steppingstones					Combined Program Data
	Aged 15 - 24 yo		70,000	212,000	284,000	
	Aged more than 25 yo		80,000	243,000	323,000	
2	Number of population exposed to HIV awareness messages through mass media			750,000		PCI Survey/BSS (General Pop)
3	Number of facilities offering STI management services		10	14	14	Combined Program Data
4	Number of facilities offering VCT		10	14	14	Combined Program Data

No	Indicators	Baseline Value	Target			Source of Data
			Year 1	Year 2	Year 3	
II	**General Population in Papua**					
5	Number of facilities offreing HIV/AIDS-related CST services		10	14	14	Combined Program Data
6	Number of facilities offering PMTCT services		3	6	10	Combined Program Data
8	Number of population served by STI Services programs					Clinic data
	Aged 15 - 24 yo		500	750	1,000	
	Aged more than 25 yo		750	1,500	2,000	Clinic data
9	Number of population served by VCT programs					Clinic data
	Aged 15 - 24 yo		250	375	500	
	Aged more than 25 yo		375	750	1,000	Clinic data
10	Number of population receiving CST services					Clinic data
	Aged 15 - 24 yo		50	100	150	
	Aged more than 25 yo		150	300	400	Clinic data
11	Number of population receiving PMTCT services		500	1,000	1,250	Clinic data
12	% of people who report being reached by any HIV programs					PCI Survey/BSS (General Pop)
	Aged 15 - 24 yo		25%	40%	50%	
	Aged more than 25 yo		20%	30%	40%	
13	% of people citing at least two acceptable ways of protection from HIV infection					PCI Survey/BSS (General Pop)
	Aged 15 - 24 yo		25%	40%	50%	
	Aged more than 25 yo		20%	30%	40%	
14	% of people citing correct knowledge about HIV/AIDS transmission					PCI Survey/BSS (General Pop)
	Aged 15 - 24 yo		25%	40%	50%	
	Aged more than 25 yo		20%	30%	40%	
15	% of people reporting a willingness to acknowledge that someone in the family has HIVAIDS					PCI Survey/BSS (General Pop)
	Aged 15 - 24 yo		10%	25%	30%	
	Aged more than 25 yo		15%	30%	35%	
16	% of people reporting a willingness to care for a family member who has HIVAIDS		10%	25%	30%	PCI Survey/BSS (General Pop)
17	% of pregnant women attending antenatal clinics and had syphilis test with positive serology for syphilis		30%	15%	10%	Clinic data
18	Median age at first (penetrative) sex among young men and women aged 15-24 surveyed.					BSS
	Men	16	16	17	19	
	Women	14	14	15	17	
19	% youth (aged 15-24 surveyed) reported penetrative sex last year					BSS
	Men	36%	30%	30%	25%	
	Women	33%	30%	30%	25%	
20	% youth (aged 15-24 surveyed) reported ever had penetrative sex					BSS
	Men	38%	35%	30%	25%	
	Women	22%	25%	20%	17%	
21	% youth (aged 15-24 surveyed) reported bought sex with money or gifts last year					BSS
	Men	32%	30%	25%	20%	
	Women	17%	15%	10%	10%	
22	Percentage of youth (aged 15-24 surveyed) reporting the use of condom during the most recent act of sexual intercourse with a non-regular sex partner					BSS
	Men	15%	20%	30%	60%	
	Women	13%	20%	30%	60%	
23	Percentage of youth (aged 15-24 surveyed) reporting consistent condom use during sexual intercourse with a non-regular sex partner in the last year					BSS
	Men	16%	25%	30%	40%	
	Women	11%	20%	30%	40%	
24	Percentage of youth (aged 15-24 surveyed) reporting the use of condom during the most recent act of sexual intercourse with regular sex partner					BSS
	Men	5%	10%	25%	35%	
	Women	3%	10%	20%	40%	
25	Percentage of people (people aged 15-49 surveyed) who report having had at least one sex partner other than regular sex partner (s) in the last 12 months					BSS
	Men	36%	30%	25%	20%	
	Women		20%	17%	15%	
26	% of women aged 15-24 testing positive for HIV during routine sentinel surveillance at antenatal clinics	4%	5%	4%	3%	Clinic data

ANNEX II

Partner Organizations

FHI Partner Organizations

No	Institution	Location	Activities	Funding Source
Multiple Sites				
1	Ministry of Defense (Uniformed Services)	All sites	Policy & Institutional Development	Partnership Fund
2	Indonesia Women Coalition (Komisi Perempuan Indonesia)	All sites	Support for Enabling Environment	Partnership Fund
3	Matari Advertising	All sites	MSM + High Risk Men Media	Partnership Fund
4	TBD (IDU Network)	All sites	IDUs	Partnership Fund
6	BPS	All sites	IBBS	USAID
7	Satu Dunia	Jakarta, Semarang, Malang	BCC Support	Partnership Fund
North Sumatera				
1	Pusat Pengkajian dan Pemberdayaan Masyarakat Nelayan (P3MN)	Medan	BCC for FSW and Clients in Hot Spot & Workplace	Partnership Fund
2	Solidaritas Perempuan Pekerja Seks (SP2S)	Deli Serdang, Serdang Bedagai	BCC for FSW and Clients in Hot Spot & Workplace, Transvestites, and Case Manager	Partnership Fund
3	KARANG	Tanjung Balai Asahan	BCC for FSW and Clients in Hot Spot & Worplace, MSM & Transvestites	Partnership Fund
4	Yayasan Galatea	Medan	BCC for IDUs and Partner, Counselor & CM	Partnership Fund
5	PARAS	Langkat	BCC for FSW and Clients in Hot Spot & Workplace, MSM & Transvestites	USAID
6	Perhimpunan Buruh Independen	Simalungun, Pematang Siantar	BCC for FSW and Clients in Hot Spot	USAID
7	Yayasan Peduli Aids Deli Serdang	Deli Serdang, Serdang Bedagai	STI, VCT & CST Services	USAID
8	Jaringan Kesehatan Masyarakat (JKM)	Medan, Deli Serdang and Serdang Bedagai	BCC for Transvestites, MSM, Client in Workplace, Counselors and Case Manager	USAID
9	Medan Plus Support	Deli Serdang, Serdang Bedagai, Pematang Siantar & Simalungun	BCC for IDUs and Partner, Counselors & CM	Partnership Fund
10	Bina Insani	Simalungun, Pematang Siantar and Simalungun	BCC for FSW and Client in Hot Spot and Workplace,Transvestites, and MSM	USAID
11	Komite AIDS Huria Kristen Batak Protestan (HKBP)	Toba Samosir	STI, VCT & CST Services	Partnership Fund
12	Puskesmas Padang Bulan	Medan	STI, VCT & CST Services	Partnership Fund
13	Puskesmas Kerasaan	Simalungun, Pematang Siantar	STI, VCT & CST Services	Partnership Fund
14	Puskesmas Stabat	Langkat	STI, VCT & CST Services	Partnership Fund
15	Puskesmas Datuk Bandar	Tanjung Balai Asahan	STI, VCT & CST Services	Partnership Fund
16	Puskesmas Bandar Baru	Deli Serdang	STI, VCT & CST Services	Partnership Fund
17	Pesada	Diari District	BCC for FSW and Clients Hot Spot	USAID
18	TBD	Dairi and Karo District	STI, VCT & CST Services	Partnership Fund
Riau Islands				
1	Yayasan Srimersing	Tanjung Balai Karimun District	BCC for FSW and Clients	USAID
2	Yayasan Bentan Serumpun	Tanjung Pinang City, Kepulauan Riau District	BCC for FSW and Clients	USAID
3	Yayasan Hanz	Tanjung Balai Karimun District	BCC for FSW and Clients	USAID
4	Yayasan Batam Tourism Development Board	Batam City	BCC for FSW and Clients;IDU; Workplace	Partnership Fund
5	Yayasan Gaya Batam	Batam City	BCC for Transvestites & Gay Men; VCT & MK Services	Partnership Fund
6	Health Office Tanjung Balai Karimun	Tanjung Balai Karimun District	STI, VCT & MK Services	Partnership Fund
7	Health Office Batam City	Batam City	STI, VCT & MK Services	Partnership Fund
8	Health Office Tanjung Pinang City	Tanjung Pinang City, Kepulauan Riau District	STI, VCT & MK Services	Partnership Fund
9	Health Office District Kepulauan Riau	Kepulauan Riau District	STI, VCT & MK Services	Partnership Fund

No	Institution	Location	Activities	Funding Source
DKI Jakarta				
1	Komite Kemanusiaan Indonesia (KKI)	North and South Jakarta	BCC for Clients in Workplace	Partnership Fund
2	Yayasan Kusuma Buana	West, Central, & East Jakarta	BCC for FSW and Clients in Hot Spot and Workplace	Partnership Fund
3	Komunitas Aksi Kemanusiaan Indonesia (KAKI)	North Jakarta	BCC for FSW and Clients	USAID
4	Bandungwangi	East Jakarta	BCC for FSW and Clients	USAID
5	ICODESA	North Jakarta	BCC for FSW and Clients	USAID
6	PKBI Jakarta	East Jakarta	BCC for FSW and Clients; STI & VCT Services and CM	Partnership Fund
7	Yayasan Pelangi Kasih Nusantara	Central, West and South Jakarta	BCC for Gay Men and MSW	USAID
8	Lembaga Penduli AIDS Yayasan Karya Bakti	North and East Jakarta, Depok	BCC for Gay Men and MSW	USAID
9	Yayasan Rempah	North Jakarta	BCC for IDUs and Partner, Counselors and CM	Partnership Fund
10	CHR University of Indonesia	South Jakarta & Depok	BCC for IDUs, Counselors and CM	Partnership Fund
11	Yayasan Karisma	East Jakarta	BCC for IDUs & CM	Partnership Fund
12	Community Encourage of PLWHA (COMET)	Central Jakarta	BCC for IDUs, Counselors and CM	Partnership Fund
13	Atmajaya University	Central, West & North Jakarta	BCC for IDUs, Counselors and CM	Partnership Fund
14	Partisan	Jakarta and Tangerang	BCC for Prisoners	Partnership Fund
15	Yayasan Srikandi Sejati	Jakarta and Depok	BCC for Transvestites & CM	USAID
16	Yayasan Layak	Jakarta	CST & Training	USAID
17	Sudinyankes Jakarta Barat	West Jakarta	STI , VCT and CST Services	Partnership Fund
18	Perkumpulan Pemberantasan Tuberkulosis Indonesia Jakarta (PPTI)	Jakarta	VCT and CST Services	USAID
19	Yayasan Kapeta	Central and South Jakarta	BCC for FSW and Clients	Partnership Fund
20	Tegak Tegar	Jakarta	CM Services	Partnership Fund
West Java				
1	Health Office District Indramayu	Indramayu	BCC and STI	Partnership Fund
2	Health Office District Karawang	Karawang	BCC for FSW and Clients; STI, & VCT Services	Partnership Fund
3	Health Office District Subang	Subang	BCC for FSW and Clients;STI, VCT & MK Services	Partnership Fund
4	Yayasan Mitra Sehati	Bekasi	BCC for FSW and Clients; VCT & MK Services	USAID
5	Yayasan Gerakan Penanggulangan Narkoba dan Aids (YGPNA)	Cianjur District, Sukabumi City	BCC for FSW and Clients	USAID
6	Yayasan Mutiara Hati	Bogor District, Bogor City	BCC for FSW and Clients.	Partnership Fund
7	Warga Siaga	Cirebon City and Cirebon District	BCC for FSW and Clients;	Partnership Fund
8	PKBI Jawa Barat	Bandung City	BCC for FSW and Clients;STI, VCT & MK Services	Partnership Fund
9	Yayasan Bahtera	Bandung City, Bandung, Cimahi Bekasi, Bekasi City, Sumedang	BCC for IDUs, VCT & CST	Partnership Fund
10	Yayasan Permata Hati Kita (Yakita)	Bogor City & Bogor District	BCC for IDUs, VCT & CST	Partnership Fund
11	PANTURA PLUS	Karawang District	BCC for IDUs, VCT & CST	Partnership Fund
12	Lembaga Studi Paradigma Rakyat (LESPRA)	Bekasi City and Bekasi District	BCC for IDUs, VCT & CST	Partnership Fund
13	Yayasan Akes Indonesia (YAKIN)	Tasikmalaya	BCC for IDUs, VCT & CST	Partnership Fund
14	Yayasan Masyarakat Sehat	Bandung District and Subang District	BCC for IDUs, VCT & CST	Partnership Fund
15	Srikandi Pasundan	Bandung City, Bandung District, Cimahi City, Sumedang District, Cirebon City, Cirebon District, Indramayu District, Tasikmalaya City, Bekasi City, Bekasi District, Karawang District, Subang District, Bogor District, Bogor City, Cianjur District, Depok District	BCC for Transvestites; VCT & MK Services	Partnership Fund
16	Rumah Sakit Hasan Sadikin	Bandung City	VCT, CST & ART Services	Partnership Fund
17	Health Office District Bekasi	Bekasi	STI, VCT & MK Services	Partnership Fund

No	Institution	Location	Activities	Funding Source
West Java				
18	Himpunan Abiasa	Bandung City, Bandung District, Cimahi City, Sumedang District, Cirebon City, Cirebon District, Indramayu District, Tasikmalaya City, Bekasi City, Bekasi District, Karawang District, Subang District	BCC for Gay Men	Partnership Fund
19	Health Office District Bogor	Bogor District	STI, VCT & MK Services	Partnership Fund
20	Dinkes Cirebon City	Cirebon City	STI, VCT & MK Services	Partnership Fund
21	Himpunan Konselor HIV/AIDS (HIKHA) West Java	Bandung District, Bandung City, Sumedang District and Subang District	VCT	Partnership Fund
22	Yayasan Insan Hamdani-Bandung Plus Support	Bandung District, Bandung City, Kerawang District, Subang District, Sukabumi City, Tasikmalaya City, Cianjur District, Cimahi City	Case Management Services	USAID
Central Java				
1	Fatayat NU	Tegal & Batang	BCC for FSW and Clients	Partnership Fund
2	Kalandara	Semarang City, Karanganyar District, Sukoharjo District, Sragen District, Klaten District	BCC for FSW and Clients (Workplace Program)	USAID
3	LSM TEGAR	Salatiga City & Semarang District	BCC for FSW and Clients	Partnership Fund
4	Solidaritas Perempuan untuk Kemanusiaan dan Hak Asasi Manusia (SPEKHAM)	Surakarta City	BCC for FSW and Clients	USAID
5	LPPSLH	Banyumas District	BCC for FSW and Clients	USAID
6	Health Office District Kendal	Kendal District	BCC for FSW and Clients; STI Services	Partnership Fund
7	Health Office District Pati	Pati District	BCC for FSW and Clients; STI Services	Partnership Fund
8	PKBI Tegal	Tegal, Batang District	BCC for FSW and Clients; STI Services & VCT	Partnership Fund
9	PKBI Semarang	Semarang City, Kendal	BCC for FSW and Clients; STI Services & VCT	USAID
10	Health Office District Cilacap	Cilacap District	BCC for FSW and Clients; STI Services & VCT	Partnership Fund
11	Yayasan Wahana Bakti Sejahtera	Semarang City, Semarang, Salatiga City	BCC for IDUs & VCT	Partnership Fund
12	Yayasan Mitra Alam	Surakarta & Salatiga Cities	BCC for IDUs & VCT	Partnership Fund
13	Yayasan PEDHAS	Banyumas & Cilacap Districts	BCC for IDUs & VCT	Partnership Fund
14	Lembaga Graha Mitra	Selected districts (10 cities & districts), Tegal City, Pemalang District	BCC for Transvestites & Clients	Partnership Fund
15	Yayasan Gerakan Sosial, Advocacy dan Hak Asasi Manusia untuk Gay Surakarta (GESSANG)	Surakarta City	BCC for Transvestites Sex Workers and Clients	Partnership Fund
16	Health Office District Salatiga	Salatiga City	STI and VCT Services	Partnership Fund
17	Health Office District Batang	Batang District	STI and VCT Services	Partnership Fund
18	Health Office District Semarang	Semarang District	STI Services & VCT	Partnership Fund
19	Balai Pencegahan & Pengobatan Penyakit Paru (BP4) Semarang	Semarang City and 6 Cities / District	VCT & Case Management Services	USAID
East Java				
1	Yayasan Media	Surabaya City, Gresik, Sidoarjo	BCC for Clients	USAID
2	Yayasan Mulia Abadi	Surabaya City, Sidoarjo, Pasuruan, Gresik, Kediri, Tulungagung, Nganjuk	BCC for Clients (Workplace Program)	USAID
3	Puskesmas Putat Jaya	Surabaya City	BCC for FSW & Clients; STI Services & VCT	Partnership Fund
4	Palang Merah Indonesia Banyuwangi	Banyuwangi	BCC for FSW and Clients	USAID
5	Yayasan Genta	Surabaya City, Sidoarjo, Gresik	BCC for FSW and Clients	USAID
6	Yayasan Bambu Nusantara	Madiun City & Madiun District, Nganjuk	BCC for FSW and Clients, IDU	Partnership Fund & USAID
7	SUAR NURANI	Kediri City and District	BCC for FSW and Clients	USAID
8	CHESMID	Tulungagung	BCC for FSW and Clients	USAID
9	Health Office District Banyuwangi	Banyuwangi	BCC for FSW and Clients; STI Services	Partnership Fund
10	Health Office Madiun City	Madiun City	BCC for FSW and Clients; STI Services & VCT	Partnership Fund

No	Institution	Location	Activities	Funding Source
East Java				
11	Health Office Kediri City	Kediri City	BCC for FSW and Clients; STI Services & VCT	Partnership Fund
12	Hotline Service	Surabaya Municipality	BCC for FSW, Clients & IDU; VCT, CST & Case Management	Partnership Fund
13	Yayasan Gaya Nusantara	Surabaya, Sidoarjo, Jember, Banyuwangi	BCC for Gay Men	Partnership Fund
14	Ikatan Gaya Arema Malang (IGAMA)	Malang City	BCC for Gay Men & Partners	USAID
15	Yayasan Sadar Hati	Malang City & Malang District	BCC for IDUs & VCT	Partnership Fund
16	Yayasan Bina Hati	Sidoarjo District & Surabaya City	BCC for IDUs, VCT & Case Management	Partnership Fund
17	Lembaga Studi Pembelajaran untuk Pencerahan (LSP2)	Surabaya City & Gresik District	BCC for IDUs, VCT & Case Management	Partnership Fund
18	Kelompok Kerja Pelita Hati Husada (KKPHH)-Dinkes Banyuwangi	Banyuwangi District	BCC for IDUs, VCT & Case Management	Partnership Fund
19	Persatuan Waria Kota Surabaya (Perwakos)	Surabaya City, Gresik, Sidoarjo, Jember, Madiun, Nganjuk	BCC for Transvestites & VCT	USAID
20	RS Dr. Sutomo Surabaya	East Java	CST Services	Partnership Fund
21	Health Office Surabaya City	Surabaya City	STI Services & VCT	Partnership Fund
22	Health Office Madiun District	Madiun District	STI Services & VCT	Partnership Fund
23	Health Office Nganjuk District	Nganjuk District	STI Services & VCT	Partnership Fund
24	Health Office Kediri District	Kediri District	STI Services & VCT	Partnership Fund
25	Health Office Sidoarjo District	Sidoarjo District	STI Services & VCT	Partnership Fund
26	Health Office Pasuruan District	Pasuruan District	STI Services & VCT	Partnership Fund
27	Health Office Jember District	Jember District	STI Services & VCT	Partnership Fund
28	Puskesmas Sumber Pucung	Malang City & Malang District	STI Services & VCT for FSW, Clients, Transvestites & Gay Men	Partnership Fund
29	Puskesmas Perak Timur	Surabaya City	STI Services & VCT for Transvestites, Gay Men & Clients	Partnership Fund
30	Puskesmas Gondang Legi	Malang District	VCT, CST & Case Management for IDUs	Partnership Fund
Papua				
1	Primari	Nabire	BCC for FSW and Clients	USAID
2	PKBI Jayapura	Jayapura District	BCC for FSW and Clients, MSM; STI Services, Case Management & General Population	Partnership Fund
3	Yayasan Harapan Ibu	Jayapura City	BCC for FSW, Transvestites, Clients, Case Management and Genereral Population	Partnership Fund
4	Yayasan Mitra Karya Mandiri (Yamikari)	Merauke	BCC for FSW, HRM, General Population & Case Management	USAID
5	Yayasan Sosial Agustinus Sorong	Sorong City & Sorong District	General Population, VCT & Case Management	Partnership Fund
6	Kelompok Kerja Wanita Papua (KKW)	Keerom, Pegunungan Bintang	General Population	Partnership Fund
7	World Vision International	Jayawijaya	General Population	USAID
8	Yayasan Binterbusih	Central Java	BCC for Papuan Students	Partnership Fund
9	PCI	All targeted districts	General Population	USAID
10	Dinkes Papua (Health System Strengthening)	All targeted districts	STI Services & VCT	USAID
11	Dian Harapan Hospital	Jayapura City	STI Services, VCT & Case Management	USAID
12	Pusat Kesehatan Reproduksi Merauke	Merauke	STI Services	USAID
13	PKM Samabusa-Nabire	Nabire	STI Services & VCT	USAID
14	Sele Be Solu Hospital	Sorong City & Sorong District	VCT & CST	USAID
15	Gereja Protestan Indonesia	Kaimana & Fakfak	General Population	USAID
16	World Relief	All Papua	BCC Modules	Partnership Fund

ANNEX III

Program Budgets

TOTAL JOINT PROGRAM FUNDING BY PROVINCE - FY08

No.	Donors	Papua	East Java	Central Java	West Java	DKI	North Sumatra	Riau	Total
I.	USAID	3,923,364	1,206,932	977,244	615,798	1,369,250	1,004,288	790,212	9,887,087
II.	PARTNERSHIP/UNDP	1,061,940	1,661,075	1,165,597	1,573,357	1,760,917	817,118	699,066	8,739,069
	Total	4,985,303	2,868,007	2,142,841	2,189,155	3,130,167	1,821,406	1,489,277	18,626,156

FAMILY HEALTH INTERNATIONAL
USAID Funded FY08
BUDGET SUMMARY BY PROVINCES

Program Cost		Papua	East Java	Central Java	West Java	DKI	North Sumatra	Riau	Total
I.	Salaries	536,595	197,037	154,132	122,973	206,923	167,938	125,969	1,511,567
II.	Fringe Benefit	198,310	59,493	49,578	29,747	69,409	49,578	39,662	495,776
III.	Consultant	67,912	20,374	16,978	10,187	23,769	16,978	13,582	169,780
IV.	Travel and Transportation	911,986	273,596	227,997	136,798	319,195	227,997	182,397	2,279,965
V.	Non Capital Equipment/Facilities	11,000	3,300	2,750	1,650	3,850	2,750	2,200	27,500
VI.	Supplies	147,200	44,160	36,800	22,080	51,520	36,800	29,440	368,000
VII	Other Expenses	277,069	83,121	69,267	41,560	96,974	69,267	55,414	692,673
VIII	Subaward/Subagreement/Contracts	1,192,191	351,521	274,468	163,638	394,225	287,706	225,328	2,889,076
VII.	Indirect Cost	581,100	174,330	145,275	87,165	203,385	145,275	116,220	1,452,750
	Total	3,923,364	1,206,932	977,244	615,798	1,369,250	1,004,288	790,212	9,887,087

FAMILY HEALTH INTERNATIONAL
Partnership/UNDP Funded FY08
BUDGET SUMMARY BY PROVINCES

Program Cost		Papua	East Java	Central Java	West Java	DKI	North Sumatra	Riau	Total
I.	Salaries	146,390	175,033	124,410	158,768	168,255	96,585	72,215	941,657
II.	Fringe Benefit	19,573	35,588	23,132	32,029	37,367	16,015	14,235	177,939
III.	Consultnat	10,948	19,906	12,939	17,915	20,901	8,958	7,962	99,530
IV.	Travel and Transportation	105,254	191,370	124,391	172,233	200,939	86,117	76,548	956,852
V.	Non Capital Equipment/Facilities	-	-	-	-	-	-	-	-
VI.	Supplies	18,480	33,600	21,840	30,240	35,280	15,120	13,440	168,000
VII	Other Expenses	38,522	70,040	45,526	63,036	73,542	31,518	28,016	350,200
VIII	Subaward/Subagreement/Contracts	636,726	979,089	711,668	958,331	1,060,361	492,404	424,069	5,262,648
VII.	Indirect Cost	86,047	156,449	101,692	140,804	164,271	70,402	62,579	782,243
	Total	1,061,940	1,661,075	1,165,597	1,573,357	1,760,917	817,118	699,066	8,739,069

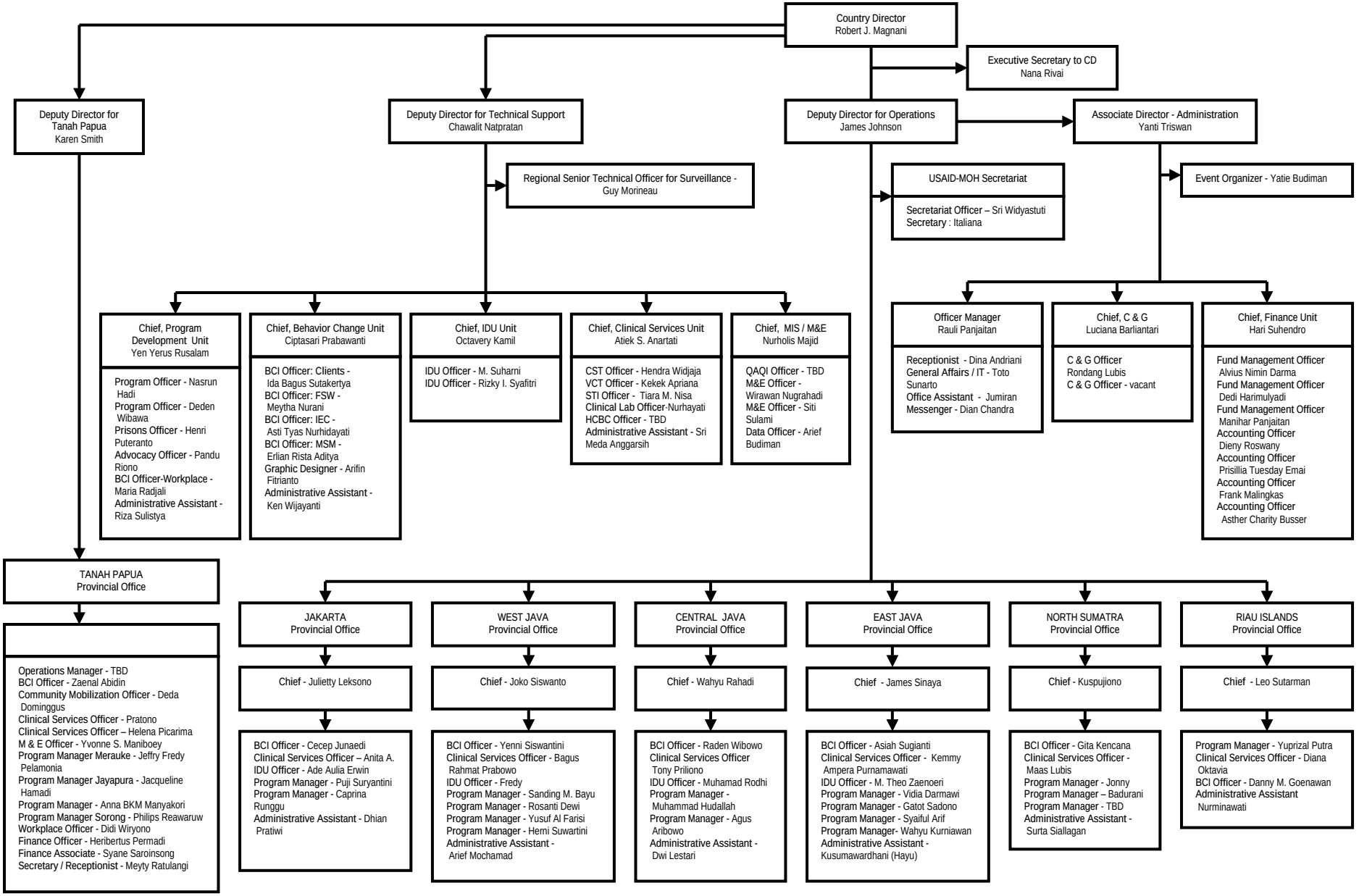
FAMILY HEALTH INTERNATIONAL
Partnership/UNDP Funded FY08
BUDGET SUMMARY BY COMPONENT

		Sexual Transmission	IDU	General Population	CST	"3 ones"	Total
I.	Salaries	489,662	235,414	169,498	28,250	18,833	941,657
II.	Fringe Benefit	92,528	44,485	32,029	5,338	3,559	177,939
III.	Consultant	51,756	24,883	17,915	2,986	1,991	99,530
IV.	Travel and Transportation	497,563	239,213	172,233	28,706	19,137	956,852
V.	Non Capital Equipment/Facilities	-	-	-	-	-	-
VI.	Supplies	87,360	42,000	30,240	5,040	3,360	168,000
VII.	Other Expenses	182,104	87,550	63,036	10,506	7,004	350,200
VIII.	Subaward/Subagreement/Contracts	2,736,577	1,315,662	947,277	157,879	105,253	5,262,648
IX.	Indirect Cost	406,766	195,561	140,804	23,467	15,645	782,243
	Total	4,544,316	2,184,767	1,573,032	262,172	174,781	8,739,069

ANNEX IV

Organizational Chart

FHI Indonesia Country Office Organization Structure
1 September 2007



ANNEX V

Consultant Schedule

Annex V Consultant Schedule

No.	Consultant Name/Title	Description	Funding Source	Total # Days	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	International Consultant															
	TBD	IDU Support Groups	UNDP	10					■							
	TBD	Risk Reduction for IDU	UNDP	10						■						
	Teresa Promboth	Continum of Care	USAID	10		■										
	Stephenie Pirola	BCI Training Development	USAID	80	■	■	■	■	■	■	■	■				
	Liesbeth Bollen	QA/QI	USAID	60	■	■	■	■	■	■	■	■	■			
	Sally Wellesley	Report Writing	USAID	20			■	■		■	■		■	■		■
			UNDP	20			■	■		■	■		■	■		■
	Local Consultants															
	Arwati Soeparto	GOI Liaison	USAID	40	■	■	■	■	■	■	■	■	■	■	■	■
	Mitu Prie	Communications	USAID	160	■	■	■	■	■	■	■	■	■			
	Made Efo Suarmartha	BCI Training and Mentoring	USAID	100	■	■	■	■	■	■	■					
	Supriyanto	BCI Training and Mentoring	USAID	100	■	■	■	■	■	■	■					
	Bambang Irawan	IEC for MSM	USAID	60	■	■	■	■	■	■	■	■				
	Arif Rahman	IEC for IDU	UNDP	40	■	■	■	■	■	■	■	■				
	Tetty Rachmawati	BCI Training	USAID	120	■	■	■	■	■	■	■	■				
	Ronny Ronodirdjo	BCI Training	USAID	60	■	■	■	■	■	■	■					
	Agustinus Mandagi	MSM	USAID	60	■	■	■	■	■	■	■					
	Irwanto	IDU Risk Reduction	UNDP	60	■	■	■	■	■	■	■	■				

No.	Consultant Name/Title	Description	Funding Source	Total # Days	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	I Made Setiawan	IDU Risk Reduction	UNDP	90	■	■	■	■	■	■	■					
	Flora Tanujaya	Clinical Services	USAID	60	■	■	■	■	■	■	■	■	■			
	Asih Hartini	Clinical Laboratory	USAID	90	■	■	■	■	■	■	■	■	■			
	Astrid. Sulitomo	VCT	USAID	60	■	■	■	■	■	■	■	■	■			
	Claudia Surjadjaja	Workplace	UNDP	120	■	■	■	■	■	■	■	■	■			
	Emmy Sahertian	Mobilization of FBOs/Papua	USAID	90	■	■	■	■	■	■	■	■	■			
	Herlina	Workplace – North Sumatra	USAID	120	■	■	■	■	■	■	■	■	■			
	Lita	Workplace – North Sumatra	USAID	120	■	■	■	■	■	■	■	■	■			
	Gunawan Kusumo	GOI Liaison - Papua	USAID	60	■	■	■	■	■	■	■	■	■			
	Trio Mardjoko	M&E Data Management	USAID	120	■	■	■	■	■	■	■	■	■			
	Marcel Latuihamallo	Counseling	USAID	60	■	■	■	■	■	■	■	■	■			
	Pandu Riono	Advocacy and Data Use	USAID	90	■	■	■	■	■	■	■	■	■			

ANNEX VI

International Travel Schedules
FHI Staff and Consultants

ANNEX VI International Travel: ASA Staff and Consultants														
	Activity/person	Sites/Days		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep
	FHI APD + HQ Support														
	TBD Senior Director	Bangkok – Jakarta	1 trip x 5 days				■								
	Deborah Murray (Regional Dir)	Bangkok – Jakarta	1 trip x 5 days				■								
	Celine Daly (Director Technical)	Bangkok – Jakarta	1 trip x 5 days						■						
	Graham Neilsen (Dir. TU)	Bangkok – Jakarta	1 trip x 5 days		■										
	Dimitri Prybylski (STI)	Bangkok – Jakarta	1 trip x 5 days									■			
	Penny Miller (STI - CST)	Bangkok – Jakarta	1 trip x 5 days						■						
	Kathleen Casey (VCT)	Bangkok – Jakarta	2 trips x 12 days		■			■							
	Kim Green	Bangkok – Jakarta	2 trips x 12 days			■			■						
	Philippe Girault (BCI)	Bangkok – Jakarta	3 trips x 19 days		■			■	■		■				
	TBD (M&E)	Bangkok – Jakarta	2 trips x 5 days				■			■					
	Nancy Jamison	Bangkok - Jakarta	4 trips x 12 days		■		■		■		■				
	Consultant														
	TBD (IDU Support Groups)	Bangkok – Jakarta	1 trip x 12 days				■								
	TBD (Risk Reduction IDU)	Bangkok – Jakarta	1 trip x 12 days						■						
	Teresa Promboth (COC)	Manila - Jakarta	1 trip x 12 days	■											
	Conferences / Workshops/ Trainings														
	Home & Comm. Care Study Tour														
	2 Staff	Jakarta–Phnom Penh	2 trips x 14 days					■							
	COTISSA (STI)														
	1 Staff	Jakarta - Bangkok	1 trip x 30 days		■										

ANNEX VI International Travel: ASA Staff and Consultants															
	Activity/person	**Sites/Days**		**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**June**	**July**	**Aug**	**Sep**
	FSW Study Tour														
	2 Staff	Jakarta - Delhi	2 trips x 14 days							■					
	Pepfar Meeting														
	5 Staff	Jakarta - Kampala	5 trips x 5 days									■			
	FHI Regional Meetings/Workshops														
	10 Staff	Jakarta - Bangkok	10 trips x 5 days		■			■	■		■				
	FHI Global Management Meeting														
	1 Staff	Jakarta – U.S.A.	1 trips x 7 days										■		
	Demobilization														
	Guy Morineau	Jakarta - Paris	3 trips												■
	Robert Magnani	Jakarta – U.S.A.	2 trips												■
	Karen Smith	Jakarta – U.S.A.	1 trip												■
	James Johnson	Jakarta – U.S.A.	1 trip												■
	Chawalit Natpratan	Jakarta – Bangkok	1 trip												■

ANNEX VII

International Travel Schedules
Participant Training

ANNEX VII International Travel: Participant Training														
	Activity/person	Sites/Days	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	Home + Comm. Care Study Tour													
	GOI - 1 NGO - 2	Jakarta – Phnom Penh 3 trips x 14 days					■							
	FSW Study Tour													
	GOI - 2 NGO - 2	Jakarta – Delhi 4 trips x 14 days							■					

ANNEX VIII

PEPFAR Indicators

Table 2.1 and Table 2.2 : USG Indonesia Targets for FY 2007 and FY 2008 (Supporting documents for target justification)						
Indicators	**FY 2007 (Oct 1, 2006 – Sept 30, 2007)**			**FY 2008 (Oct 1, 2007 – Sept 30, 2008)**		
	Downstream (Direct)	Upstream (Indirect)	**Total**	Downstream (Direct)	Upstream (Indirect)	**Total**
PREVENTION:						
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	2	3	**5**	2	19	**21**
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	48	72	**120**	54	414	**468**
COUNSELING AND TESTING						
Number of individuals who received counseling and testing for HIV and received their test results	**6,873**	**31,188**	**38,061**	**11,829**	**60,880**	**72,709**
CARE						
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease during the report period	96	240	**336**	168	480	**648**
Number of individuals provided with facility-based, community based and/or home-based HIV-related palliative care including those HIV-infected individuals who received clinical prophylaxis and/or treatment for tuberculosis (TB)	577	2,523	**3,100**	996	4,942	**5,938**
TREATMENT						
Number of individuals receiving antiretroviral therapy at the end of the reporting period	144	8,856	**9,000**	350	10,650	**11,000**

JUSTIFICATION FOR USG INDONESIA PEPFAR TARGETS

During the Mini-COP development process, target setting was initiated by the SI Advisor from USAID/RDMA, the Deputy Director of the Office of Health from USAID/Indonesia Mission, and the Department of Defense (DOD) Technical Officer. Meetings and discussions were held with USAID partners (FHI and HPI) to set downstream (direct) and upstream (indirect) targets for FY 2007 to FY 2008 based on their 2006 program results, their projected programmatic growth, and expected expansion. The FHI Monitoring and Evaluation Officer met with the National AIDS Commission Officers and with GFATM staff members to assess their health management information systems to better understand their operational plan and targets in order to use them to estimate USG Indonesia upstream (indirect) targets. Finally, proposed USG targets have been reviewed by National AIDS Commission (KPA) and Ministry of Public Health (MOH) in order to obtain an official concurrence.

Estimation of Downstream (Direct) Targets:

The downstream target estimates are provided by USAID partners and Department of Defense (DOD) for 2007 to 2008. These targets are expected future results for individuals receiving services at USG-supported points of service delivery. USG partner downstream target estimates are based on direct USAID support to the "Aksi Stop AIDS" (ASA) project, which implements HIV/AIDS activities within 78 priority districts within seven priority provinces, while DOD provides support the Indonesia Department of Defense Forces' developing HIV/AIDS program through building the military human resources capacity in prevention, treatment, and care, and improving the military medical laboratory infrastructure.

Estimation of Upstream (Indirect) Targets:

DFiD, through the Indonesia Partnership Fund managed by UNDP and Global Fund contributes significant resources to FHI to implement the ASA project. Therefore, the upstream (indirect) targets are estimated in accordance with the ASA strategic framework and work plan for prevention, counseling and testing, as well as palliative care which is partially supported by Indonesia Partnership Fund.

USG and partners have worked extensively with antiretroviral (ARV) treatment programs to develop national guidelines and comprehensive CST in collaboration with WHO and other donors to provide technical assistance for ART care and support, training curricula, and a patient monitoring system. In addition, USG assists with strengthening laboratory services including CD4 testing.

In setting targets for individuals receiving PMTCT, counseling and testing, palliative care, and ART, there is no overlap between downstream (direct) and upstream (indirect) targets because the nature of the USG Indonesia programs are implemented in different geographic areas and/or points of service delivery. In addition, a great deal of care was taken to minimize double counting between USG agencies.

Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting <u>and</u> number of pregnant women who received HIV counseling and testing for PMTCT and received their test results

Indicators	FY 2007 (Oct 1, 2006 – Sept 30, 2007)			FY 2008 (Oct 1, 2007 – Sept 30, 2008)		
	Downstream (Direct)	Upstream (Indirect)	**Total**	Downstream (Direct)	Upstream (Indirect)	**Total**
PREVENTION:						
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	48	72	**120**	54	414	**468**
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	2	3	**5**	2	19	**21**

The PMTCT activities are a small component of the USG PEPFAR program in Indonesia. Therefore, the USG will focus its efforts to prioritize and reach the most-at-risk populations and their partners who are getting pregnant; and general population pregnant women in Papua.

Explanation of Calculation for Downstream Targets:

The USG downstream support is designed to develop PMTCT models in 2 clinics in East Java and West Java in 2007 and will increase to 3 clinics in 2008. Based on 2006 program monitoring data, with an estimated 2 pregnant per month per clinic who received HIV counseling and testing for PMTCT and received their test results. In FY 2007, there is 12 months of its operation. But in FY 2008, it is only 9 months because FHI procurement mechanism will be ending in June 2008. It is estimated that .045 % of pregnant women in Papua and most-at-risk populations or partners who are pregnant tested HIV positive; with all of the positive pregnant women to be provided with a complete course of antiretroviral prophylaxis.

Downstream Target Calculation		
PMTCT indicator	**2007**	**2008**
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	= **48** (2 PMTCT clinics x 2 pregnant women who received HIV counseling and testing for PMTCT and received their test results x 12 months).	= **54** (3 PMTCT clinics x 2 pregnant women who received HIV counseling and testing for PMTCT and received their test results x 9 months).
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	= **2** (48 x .045)	= **~3** (54 x .045)

Explanation of Calculation for Upstream Targets:

USG will assist Government of Indonesia and GFATM round 4 by providing technical assistance on scaling up of the model, building capacity on Standard Operation of Practices (SOP) to clinical and project staff and strengthening monitoring and evaluation system

Government of Indonesia plans to implement PMTCT services in two hospitals in Jayapura and one hospital in Jakarta in 2007. Government of Indonesia also plans to add 20 new PMTCT clinics in Papua in 2008. The same scenario used to estimate the upstream targets for the number of pregnant received HIV counseling and testing for PMTCT and received their test results (2 pregnant women /month/clinic). HIV prevalence among pregnant is 0.045% and all of them will be provided with a complete course of antiretroviral therapy.

Upstream Target Calculation		
PMTCT indicator	**2007**	**2008**
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	= **72** (3 PMTCT clinics x 2 pregnant women who received HIV counseling and testing for PMTCT and received their test results x 12 months).	= **414** (23 PMTCT clinics x 2 pregnant women who received HIV counseling and testing for PMTCT and received their test results x 9 months).
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	= **3** (72 x 0.045, HIV prevalence rate =.045%)	= **19** (414 x 0.045, HIV prevalence rate =.045%)

Total USG Targets	
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	Total Target: FY 2007 Downstream = 48 Upstream = 72 **Total = 120 (48+72)** Total Target: FY 2008 Downstream = 54 Upstream = 414 **Total = 468** (54+414)
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	Total Target: FY 2008 Downstream = 2 Upstream = 3 **Total = 5 (2+3)** Total Target: FY 2008 Downstream = 2 Upstream = 19 **Total = 21 (2+19)**

Number of individuals who received counseling and testing for HIV and received their test results

Indicators	FY 2007 (Oct 1, 2006 – Sept 30, 2007)			FY 2008 (Oct 1, 2007 – Sept 30, 2008)		
	Downstream (Direct)	Upstream (Indirect)	**Total**	Downstream (Direct)	Upstream (Indirect)	**Total**
COUNSELING AND TESTING						
Number of individuals who received counseling and testing for HIV and received their test results*	**6,873**	**31,188**	**38,061**	**11,829**	**60,880**	**72,709**
- MARP	4,320	30,888	**35,208**	8,316	60,080	**68,396**
- General Population in Papua	2,304	0	**2,304**	3,326	0	**3,326**
- TB patients	249	300	**549**	187	800	**987**

* Downstream and upstream targets are further sub-divided by target population

Explanation of Calculation for Downstream Targets:

USG will expand direct support for counseling and testing services targeting MARPs and general population in Papua in FY 2007 and 2008. The targets are calculated based on clinic records of number of clients attending counseling and testing clinics and estimates an increase of uptake of counseling and testing in subsequent year.

- MARP: USG will support 15 counseling and testing clinics targeting MARPs in 2007 and will expand to 35 sites in 2008. It is estimated 40 clients per month will be tested per site. Likewise, the percentage of clients receiving their test results is expected to be at 60%. Estimated targets for 2008 will be only 9 months of its implementation but it expects a 10% increase in uptake of counseling and testing.
- General Population in Papua: USG will expand VCT sites to 8 sites in 2007 to 14 sites in 2008 with the same calculation as mentioned above.
- TB patients: 187 TB patients received counseling and testing for HIV and received their results in 9 months of its implementation. In 2007 and 2008, the same expected outputs are estimated, that is 249 (12 months) and 187 TB patients tested for HIV and received their test results respectively.

Downstream Target Calculation Number of individuals who received counseling and testing for HIV and received their test results		
Target Population	**2007**	**2008**
MARP	= 4,320 (40 clients x 12 months x 15 sites x 60% received their test results)	=8,316 (40 clients x 9 months x 35 sites x 60% received their test results) x 10% increase
General Population in Papua	= 2,304 (40 clients x 12 months x 8 sites x 60% received their test results)	= 3,326 (40 clients x 9 months x 14 sites x 60% received their test results) x 10% increase
TB patients	= 249 (187/9x 12 months)	= 187 (187/9x 9 months)
Total	**6,873**	**11,829**

Explanation of Calculation for Upstream Targets:

The upstream (indirect) target estimates are based on expected outputs from the Partnership Fund and GFATM.

- MARPs: The ASA project plans to expand its counseling and testing sites to 51 sites in 2007; and 54 sites in 2008 with support from the Partnership Fund including 4 military corps clinics and 1 hospital where FHI works in close collaboration with the Indonesian Defense Forces. DOD provides technical assistance on developing technical capacity of clinic personnel. It is estimated 40 clients per month per site with 60% of those tested receiving their test results. It is 9 months of implementation period in 2008. The same as above, it expects a 10% increase uptake of counseling and testing sites in 2008.

  USG through the ASA project has provided technical assistance on developing national counseling and testing guidelines, standard operation of practice manuals to support the ongoing accelerated scale up of counseling and testing services which is supported by GFATM. USG target estimates are based on GFATM performance and targets but they are adjusted with an estimated 30% of clients receiving their test results at national counseling and testing sites. It is estimated that 16,200 and 47,250 individuals received counseling and testing and receiving their test results in 2007 and 2008 respectively.

- TB patients: Through TBCAP funds, there are plans to integrate counseling and testing services in 10 TB clinics in 2007 and another new 10 sites in 2008. It is estimated 30 TB patients received a HIV test and their test results. Assuming an increase to 40 TB clients in 2008.

Upstream Target Calculation Number of individuals who received counseling and testing for HIV and received their test results		
Target Population	**2007**	**2008**
MARP	= 30,888 (PTF: 40 clients x 12 months x 51 sites x 60% received their test results) + GFATM=16,200	= 60,080 (PTF: 40 clients x 9 months x 54 sites x 60% received their test results) + 10% increase +GFATM=47,250
TB patients	= 300 (10 clinics x 30 TB patients)	= 800 (20 clinics x 40 TB patients)
Total	**31,188**	**60,880**

TOTAL USG TARGETS	
Number of individuals who received counseling and testing for HIV and received their test results	Total Target: FY 2007 Downstream = 6,873 Upstream = 31,188 **Total = 38,061 (6,873+31,188)** Total Target: FY 2008 Downstream = 11,829 Upstream = 60,880 **Total = 72,709 (11,829+60,880)**

Number of individuals provided with facility-based, community based and/or home-based HIV-related palliative care including those HIV-infected individuals who received clinical prophylaxis and/or treatment for tuberculosis (TB) <u>and</u> Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease during the report period

Indicators	FY 2007 (Oct 1, 2006 – Sept 30, 2007)			FY 2008 (Oct 1, 2007 – Sept 30, 2008)		
	Downstream (Direct)	Upstream (Indirect)	**Total**	Downstream (Direct)	Upstream (Indirect)	**Total**
CARE						
Number of individuals provided with facility-based, community based and/or home-based HIV-related palliative care including those HIV-infected individuals who received clinical prophylaxis and/or treatment for tuberculosis (TB)	577	2,523	**3,100**	996	4,942	**5,938**
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease during the report period	96	240	**336**	168	480	**648**

Explanation of Calculation for Downstream Targets:

USG will directly support health facilities providing clinic based care with a link to NGO/CBOs providing community and home-based care. Number of PLHA receiving palliative care is a result of strong linkages and referrals from counseling and testing clinics. Therefore, the targets are calculated based on a percentage of HIV positive individuals who received counseling and testing and received their test results and followed up with case management services.

In FY 2007, USG supports 31 sites for providing HIV related palliative care. It is estimated, 481 PLHA provided with palliative care based on 14% of 6,873 clients at counseling and testing clinics tested positive and an estimated 50% of those tested positive will receive case management services. USG will expand support to 58 sites to served 828 PLHA in 2008 using the same calculation based on 11,829 VCT clients.

In 2006, one TB clinic was established. In 2007, USG HIV funds will allow expansion to 3 new TB clinics (4 clinics in total). In 2008, USG will add another 3 new hospitals including 2 hospitals in Papua and one hospital in North Sumatra which is 7 clinics in total. It is estimated 24 patients who tested positive for HIV and received HIV care/treatment services per TB clinic. Therefore it is estimated 96 and 168 patients in 2007 and 2008 respectively.

Downstream Target Calculation		
Care Indicators	**2007**	**2008**
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	= 481 PLHA (6, 873 VCT clients x 14% tested positive and 50% received case management services).	= 828 PLHA (11,829 VCT clients x 14% tested positive and 50% received case management services).
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease during the report period	= 96 (4 TB clinics x 24 clients)	= 168 (7 TB clinics x 24 clients)
Number of individuals provided with facility-based, community based and/or home-based HIV-related palliative care including those HIV-infected individuals who received clinical prophylaxis and/or treatment for tuberculosis (TB)	**Total = 577(481+96)**	**Total = 996 (828 +168)**

Explanation of Calculation for Upstream Targets:

The upstream (indirect) target estimates are based on the number of HIV positive individuals who received counseling and testing clinics funded by the Partnership Fund. The same calculation method is applied for estimation of upstream targets.

In 2007, 152 sites will be provided care and support services funded by the Partnership Fund. It is estimated 2,183 PLHA provided with palliative case based on 14% of 31,188 clients at counseling and testing clinics tested HIV positive and an estimated 50% of those tested will receive case management services. In 2008, 208 sites will be supported using the Partnership Fund, with estimated 4,262 PLHA receiving palliative care. The calculation based on 14% of 60,880 VCT clients and those who tested positive will be provided with case management services.

In addition, DOD plans to support the training of 20 military medical personnel in treatment, care, and support. It is expected that each trained personnel will provide treatment and care to 5 patients in FY 2007 and 8 patients in FY 2008, therefore 100 patients in 2007 and 200 patients in 2008.

TB/HIV patients from TB clinics which are funded by the TBCAP project contribute to upstream targets. FHI expects to expand TBCAP to 10 clinics in 2007; and 20 sites in 2008 with an estimated 24 TB/HIV patients per clinic. So that is an estimated 240 HIV patients who received TB treatment in 2007 and 480 in 2008.

Upstream Target Calculation		
Care Indicators	**2007**	**2008**
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	= 2,283 PLHA (31,188 VCT clients x 14% tested positive and 50% received case management services) + 100 patients from DOD	= 4,462 PLHA (60,880 VCT clients x 14% tested positive and 50% received case management services) + 200 patients from DOD.
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease during the report period	= 240 (10 TB clinics x 24 clients)	= 480 (20 TB clinics x 24 clients)
Number of individuals provided with facility-based, community based and/or home-based HIV-related palliative care including those HIV-infected individuals who received clinical prophylaxis and/or treatment for tuberculosis (TB)	**Total = 2,523(2,283+240)**	**Total = 4,942 (4,462 +480)**

TOTAL USG TARGETS	
Number of individuals provided with facility-based, community based and/or home-based HIV-related palliative care including those HIV-infected individuals who received clinical prophylaxis and/or treatment for tuberculosis (TB)	Total Target: FY 2007 Downstream = 577 Upstream = 2,523 **Total = 3,100 (577+2,523)** Total Target: FY 2008 Downstream = 996 Upstream = 4,942 **Total = 5,938** (996+4,942)
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease during the report period	Total Target: FY 2007 Downstream = 96 Upstream = 240 **Total = 336 (96+240)** Total Target: FY 2008 Downstream = 168 Upstream = 480 **Total = 648 (168+480)**

Number of individuals receiving antiretroviral therapy at the end report period

Indicators	FY 2007 (Oct 1, 2006 – Sept 30, 2007)			FY 2008 (Oct 1, 2007 – Sept 30, 2008)		
	Downstream (Direct)	Upstream (Indirect)	**Total**	Downstream (Direct)	Upstream (Indirect)	**Total**
TREATMENT						
Number of individuals receiving antiretroviral therapy	144	8,856	**9,000**	350	10,650	**11,000**

Explanation of Calculation for Downstream Targets:

ARV medication and services are supported by Government of Indonesia and GFATM. In 2007 - 2008, USG will support an expansion of the coverage of the community-based ART adherence counseling and support through the NGO/CBO network as a part of case management services in 8 sites. NGO/CBO provides active referral system for PLHA to access ARV therapy and then follow up them in the community and home in order to provide health education and psychological support as well as facilitate ART patient to participate in self help groups. Even though USG does not provide ARV medication, USG Indonesia counts these numbers as direct targets since it is significant support services to ARV patients because without community-based adherence counseling and support, ARV patients will not receive a high quality of ARV treatment.

In 2007, it is estimated 25% of palliative care patients are on ART, resulting in 144 (25% of 577). In 2008, it is estimated 350 ART patients provided with a community –based support for ART adherence from USG, there are consisting of 249 (25% of 996) newly initiating ARV in 2008 and 101 ARV patients continue in the therapy from 2007 cohort, based on an estimation of 70% of 144 ARV patients.

Downstream Target Calculation		
Treatment Indicators	**2007**	**2008**
Number of individuals receiving antiretroviral therapy	= 144 (577*25%)	= 350 (996*25%) + (144x70%)

Explanation of Calculation for Upstream Targets:

In 2007-2008, USG provides indirect support to GOI and GFATM to scale up national ART services. USG Indonesia has worked extensively to provide technical assistance on developing national guidelines and comprehensive CST in collaboration with WHO and other donors, as well as provide technical assistance for ART care and support training curricula. In addition, DOD assists with strengthening laboratory services including CD4 testing. In 2008 USG will continue efforts to train clinical staff who serves as front-line trainers for the expansion of sites offering ART under the national plan, provide technical support on laboratory, as well as strengthening record-keeping to manage ART patients.

In June 2006, the number of individuals receiving antiretroviral therapy is 3,438 in 25 clinics throughout the country. GOI/MOH anticipates in 2007 and 2008 to have 75 government clinics that will provide ARV clinical services funded by GFATM and another 31 clinics will get support by the government.

GOI/MOH estimates that nationally 9,000 individuals will receive ART in 2007 and it will increase to 11,000 in 2008. The upstream target estimates of number of individuals receiving ART are based on national estimates minus direct USG targets, which is 8,856 (9,000 - 144) in 2007 and 10,650 (11,000 - 350) in 2008.

Upstream Target Calculation		
Treatment Indicators	**2007**	**2008**
Number of individuals receiving antiretroviral therapy	= 8,856 (9,000-144)	= 10,650 (11,000-350)

TOTAL USG TARGETS	
Number of individuals receiving antiretroviral therapy	Total Target: FY 2007 Downstream = 144 Upstream = 8,856 **Total of National estimates= 9,000 (144+8,856)** Total Target: FY 2008 Downstream = 350 Upstream = 10,751 **Total of National estimates = 11,000** (350+10,650)

Due to the nature of epidemic, there is not a great demand for OVC care related to HIV. Currently the need is supported by Department of State through Save the Children, US. Therefore, no targets for this Mini-COP FY 2007 funds have been proposed. As the epidemic emerges, and strategic focus and funding levels increase, targets for OVC services will be added to measure these strategic goals.

Additional core indicator proposed for Indonesia PEPFAR

Number of individuals that are reached through community outreach that promotes HIV/AIDS prevention through other behavioral change beyond abstinence and/or being faithful

Indicators	FY 2007 (Oct 1, 2006 – Sept 30, 2007)			FY 2008 (Oct 1, 2007 – Sept 30, 2008)		
	Downstream (Direct)	Upstream (Indirect)	**Total**	Downstream (Direct)	Upstream (Indirect)	**Total**
PREVENTION:						
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful*	**667,868**	**646,711**	**1,314,579**	**857,530**	**842,883**	**1,700,413**
- IDU	0	22,000	**22,000**	0	33,000	**33,000**
- FSW	29,295	29,295	**58,590**	36,326	36,326	**72,652**
- MSM/MSW	117,802	117,803	**235,605**	172,394	172,393	**344,787**
- High risk men	303,394	455,090	**758,484**	370,814	556,222	**927,036**
- Prisoners	16,800	3,000	**19,800**	30,000	9,000	**39,000**
- PLHA	577	2523	**3,100**	996	4,942	**5,938**
- Military	0	17,000	**17,000**	0	31,000	**31,000**
- General Population in Papua	200,000	0	**200,000**	247,000	0	**247,000**

Downstream and upstream targets are further sub-divided by target population as most USG support for community outreach activities is to MARPs in priority 7 provinces and general population in Papua**.**

Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful is proposed as a core indicator for Indonesia since prevention among most-at-risk populations and general population in Papua is the primarily focus of the USG Indonesia HIV/AIDS strategy.

Explanation of Calculation for Downstream Targets:

The downstream (direct) target estimates are provided by USG partners that provide direct support for prevention activities targeting most-at-risk populations including IDU, FSW, MSM/MSW, clients of sex workers reached through brothels and sex establishments, high-risk men such as truck drivers, fishermen, port workers, taxi motor drivers, and PLHA. Both MARPs and the general population are primary targets of efforts in Papua. The mini-COP targets are calculated based on estimating size of MARPs and general population in Papua and the percentage of target population that will be exposed to community outreach activities. Size estimation among most-at-risk populations has been conducted in 2006 in the 7 provinces by FHI and its partner through a participatory "response mapping methodology".

- FSW: There was an estimated 117,180 FSW in 7 focus provinces. Based upon this, it is estimated 50% of FSW would be reached by the end of 2007. The coverage of FSW will be increased to 62% in 2008. These figures takes into account the 50% of FHI partners that implement FSW received direct funds from USAID. Therefore FSW targets are 29,295 in 2007 and 36,326 in 2008.
- MSM/MSW: There was an estimated 574,646 MSM/MSW in focus provinces. It is estimated 41% of MSM/MSW would be reached through the ASA program. The coverage will be increased to 60% in 2008. These figures takes into account the 50% of FHI partners that implement MSM/MSW received direct funds from USAID. Therefore MSM/MSW targets are 117,802 in 2007 and 172,394 in 2008.
- High risk men: High risk men are included as clients of sex workers reached through brothels and sex establishments, high-risk men such as truck drivers, fishermen, port workers, taxi motor drivers as well as men at high risk at workplaces. There was an estimated 1,404,600 high-risk men in 7 focus provinces. The program aims to reach 54% among high-risk men with community outreach activities in 2007. The coverage will be increased to 66% in 2008. These figures take into account about 40% of FHI partners which implement programs targeting high-risk men that are funded by USAID. The results will be 303,394 and 370,814 high risk men will reached in 2007 and 2008 respectively.
- Prisoners: FHI and partners implement a prisoner program, which will expand its prisons to 28 sites in 2007; and 50 sites in 2008 with an estimated 600 inmates per prison. The expected outreach services will reach 16,800 inmates in 2007 and 30,000 in 2008.
- PLHA: PLHA is a critical target population for the prevention program component of the USG Indonesia strategy. USAID partners will integrate prevention messages and behavior change intervention that is tailored for positive people into the case management package. All PLHA who have accessed basic care and TB/HIV programs will also receive prevention activities which is 577 PLHA in 2007 and 996 in 2008 will be reached with prevention intervention.
- General Population in Papua: General population will be reached through workplace and community-based prevention programs in Papua. Project Concern International (PCI) will reach 100,000 individuals and workplace programs implemented by a

variety of private sector businesses and government ministries will cover another 100,000 employees in 2007
(200,000 people reached in total). The prevention program in Papua expects to expand its implementation sites with an estimated 230,000 individuals who will be reached through community-based programs and an additional 17,000 from the workplace program or 247,000 people reached in total in 2008.

Downstream Target Calculation **Number of *Number of individuals that are reached through community outreach that promotes HIV/AIDS prevention through other behavioral change beyond abstinence and/or being faithful***		
Target population	**2007**	**2008**
- FSW	= 29,295 (117,180 FSW size estimation x 50% coverage x 50% direct funded by USG)	= 36,326 (117,180 x 62% coverage x 50% direct funded by USG)
- MSM/MSW	= 117,802 (574,646 MSM/MSW size estimation x 41% coverage x 50% direct fund by USG)	= 172,394 (574,646 MSM/MSW size estimation x 60% coverage x 50% direct fund by USG)
- High-risk men	= 303,394 (1,404,600 high risk men size estimation x 54% coverage x 40% direct fund by USG)	= 370,814 (1,404,600 high risk men size estimation x 66% coverage x 40% direct fund by USG)
- Prisoners	= 16,800 (28 sites x 600 inmates)	= 30,000 (50 sites x 600 inmates)
- PLHA	= 577 (refer to care calculation)	= 996 (refer to care calculation)
- General Population in Papua	= 200,000 (100,000 x 2)	= 247,000 (230,000 from community outreach activities + 17,000 from workplace program)
Total	**667,868**	**857,530**

Explanation of Calculation for Upstream Targets:

The upstream target estimates are calculated by target population and based on USG level of support and leveraging of resources through The Partnership Fund and GFATM and National AIDS commission.

- IDU: All IDU programs are funded by the Partnership Fund and GFATM. It was estimated that there were 55,000 IDUs in 7 provinces (FHI, 2006). In 2007, FHI aims to reach 40% of IDUs, which is 22,000 IDUs. In 2008, it aims to reach 60% coverage or 33,000 IDUs.
- FSW, MSM/MSW, and High risk men: The same calculation that was used to estimate the downstream targets was applied to estimate the upstream (indirect) targets for FSW, MSM/MSW, and high-risk men. But the upstream targets for prevention also account for the expected outputs of activities which received monies from the Partnership Fund.
    - There are 50% of FHI partners which implement programs targeting FSW and MSM/MSW
    - There are 60% of CBOs and NGOs which implement programs targeting high-risk men.
- Prisoners: FHI provides technical assistance on the development of a master trainer curriculum. Implementation costs of the program are funded by National AIDS Commission. In 2007, 5 prisons will participate and estimates 600 inmates per prison. In 2008, program will expand to 15 prisons. There are 3,000 inmates who will be reached in 2007 and 9,000 in 2008.

- PLHA: All PLHA who have accessed basic care and TB/HIV programs will also receive prevention activities which is 2,523 PLHA in 2007 and 4,942 in 2008 will be reached with prevention intervention.
- Military: All military programs are also funded by the Partnership Fund. FHI works closely with DOD to provide technical assistance on developing a national strategic plan for HIV/AIDS prevention, care, and treatment in the military including, developing a master trainer curricula and a program monitoring system. As July 2006, 3,000 uniform workers were served. The expected outreach activities will reach 17,000 uniform workers in 5 corps and 1 regional command in 2007. FHI plans to expand its activities into 8 corps and 2 regional commands, with an estimated 31,000 uniform workers who will be reached in 2008. The proposed number of uniform workers reached is 8.6% and 15.8% of the total military personnel in 2007 and 2008 respectively.

The USG will provide the following support and products in 2008 through the Partnership Fund and GFATM;

- Establishing 1,500 targeted condom outlets in "hot spots" where there is a convergence of risk behavior and higher levels of HIV infection among most-at-risk populations.
- Training of 720 company staff to provide services and undertake workplace HIV/AIDS activities.

Upstream Target Calculation **Number of *Number of individuals that are reached through community outreach that promotes HIV/AIDS prevention through other behavioral change beyond abstinence and/or being faithful***		
Target population	**2007**	**2008**
- IDU	= 22,000 (55,000 IDU size estimation x 40 % coverage)	= 33,000 (55,000 IDU size estimation x 60 % coverage)
- FSW	= 29,295 (117,180 FSW size estimation x 50% coverage x 50% direct fund by USG)	= 36,326 (117,180 x 62% coverage x 50% direct fund by USG)
- MSM/MSW	= 117,803 (574,646 MSM/MSW size estimation x 41% coverage x 50% direct fund by USG)	= 172,393 (574,646 MSM/MSW size estimation x 60% coverage x 50% direct fund by USG)
- High-risk men	= 455,090 (1,404,600 high risk men size estimation x 54% coverage x 60% direct fund by USG)	= 556,222 (1,404,600 high risk men size estimation x 66% coverage x 60% direct fund by USG)
- Prisoners	= 3,000 (5 sites x 600 inmates)	= 9,000 (15 sites x 600 inmates)
- PLHA	= 2,523 (refer to care calculation)	= 4,942 (refer to care calculation)
- Military	= 17,000	= 31,000
Total	**646,711**	**842,883**

Total USG targets	
Number of Number of individuals that are reached through community outreach that promotes HIV/AIDS prevention through other behavioral change beyond abstinence and/or being faithful	Total Target: FY 2007 Downstream = 667,868 Upstream = 646,711 **Total = 1,314,579 (667,868+646,711)** Total Target: FY 2008 Downstream = 857,530 Upstream = 842,883 **Total = 1,700,413** (857,530+842,883)

PEPFAR Indicators

USG Targets in Collaboration with Partners for FY07 to FY08									Justification for estmating targets,	
Indicators	**Baseline FY06 (9 months)**		**FY07**			**FY08**			**Direct Justification**	**Indirect Justification**
	(Oct 1,2005-June 30, 2006)		**(Oct 1,2006-Sept 30, 2007)**			**(Oct 1, 2007-Sept 30, 2008)**				
	Direct	Indirect	Direct targets	Indirect targets	**Total**	Direct targets	Indirect targets	**Total**		
3.3.1 Prevention of Mother and Child Transmission (Only FHI)										
Number of service outlets providing the mininum package of PMTCT services according to national and international standards	0	0	2	3	**5**	3	23	**26**	Provide capacity building (dev training curriculum and train clinical staff) & TA (2 centers - Jakarta/East Java/West Java in year II and add 1 more in year III). .	Train clinical staff & TA (2 hospitals in Jayapura, 1 in Jakarta in year II and add 20 more in Papua in year III). Currently, FHI has no substantive involvement with PMTCT but will put effort for greater influence in year II and III. The centers and their activities will be supported by GFATM and govt
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	0	0	48	72	**120**	54	414	**468**	Estimated 2 pregnant women/month/center, source of estimation - clinic data recorded in FHI M&E system	Estimated 2 pregnant women/month/center for 9 months
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	0	0	2	3	**5**	2	19	**21**	Estimate 4% of pregnant women in Papua and 5% of pregnant MARPs women tested are HIV positive, source of estimation - VCT clinic data for MARPs/FHI - use the mid point 4.5%	Estimate 4% of pregnant women in Papua and 5% of pregnant MARPs women tested are HIV positive, source of estimation - VCT clinic data for MARPs/FHI - use the mid point 4.5%
Number of health workers trained in the provision of PMTCT services according to national and international standards	0	0	35		**35**	182		**182**	7 persons each from PMTCT sites will be trained	7 persons each from PMTCT siteswill be trained
3.3.2 Abstinence and Be Faithful (Only FHI)										
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	n/a	n/a	95,000	55,000	**150,000**	220,000	110,000	**330,000**	FHI is working with local churches, tribal organizations,community groups, local NGOs and 2 INGOs to provide AB prevention messages in papua. Year II and Year III targets based on cummulative targets from all FHI-Ias.	Indirect activites funded partnership fund.
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence (a subset of the total reached with AB)	n/a	n/a	19,000	11,000	**30,000**	44,000	22,000	**66,000**	20% of people served with AB will primary focus only A which includes school based programs and activities provided by FBOs; bible classes, relegious youth groups et al.	20% of people served with AB will primary focus only A which includes school based programs and activities provided by FBOs; bible classes, relegious youth groups et al.
Number of indivual trained to promote HIV/AIDS prevention through abstinence and/or being faithful	n/a	n/a	311	35	**345**	311	35	**345**		
3.3.3 Medical Transmission Blood Safety (No activity)										
Number of service outlets carrying out blood safety activities					**0**			**0**		
Number of individuals trained in blood saftety					**0**			**0**		
3.3.4 Medical Transmission Blood / Infection Safety (No activity)										
Number of individuals trained injection safety					**0**			**0**		
3.3.5 Condoms and Other Prevention (FHI and DOD)										
Number of targeted condom services outlets	-	747	-	1,500	**1,500**	-	1,500	**1500**		FHI faciliates meeting between distributors and establishment owners. In term of condom management and logistic provided by DKT which is not USAID funded. Baseline 676 outlets for FSW, clients of SW and IDU and 71 for waria. Year I, II doubled outlets from baseline.
Number of individual trained to promote HIV/AIDS prevention through other behavior change beyond abtinence and/or being faithful	1,640	-	2,786	600	**3,386**	2,843	720	**3,563**		

USG Targets in Collaboration with Partners for FY07 to FY08									Justification for estmating targets,	
Indicators	**Baseline FY06 (9 months)**		**FY07**			**FY08**			**Direct Justification**	**Indirect Justification**
	(Oct 1,2005-June 30, 2006)		**(Oct 1,2006-Sept 30, 2007)**			**(Oct 1, 2007-Sept 30, 2008)**				
	Direct	Indirect	Direct targets	Indirect targets	**Total**	Direct targets	Indirect targets	**Total**		
FHI	1,640	-	2,782	600	**3,382**	2,837	720	**3,557**	Baseline includes training for outreach worker , peer educator, STI service providers and community leader in papua, which is 1,640 total. In year II, average 10 people including program manager, field coordinator, outreach worker for 70 IAs and another 25 peer educators for 22 IAs funded by USAID provide services for FSW,MSM, waria and high risk men and year III just reflesher. STI, Year II, 43 clinics and 4 staff per clinic get train and Year III same number. Prison program, year II 25 master trainers and 4 staff per prison will be trained in 50 prisons total, for Year III no training among prison. For papua general population, 10 companies receive training, 10 people/company. PCI will train 635 peer educators, community leaders in the communities. In year II, 50 companies will participate in the program and 20 person trained per company. In year III, 60 new companies will participate in the program and 20 person trained per company. For year II and III, training for workplace program 40% funded by USAID.	In year II, 50 companies will participate in the program and 20 person trained per company. In year III, 60 new companies will participate in the program and 20 person trained per company. For year II and III, training for workplace program 60% funded by partnership fund.
DOD	-	-	4	-	**4**	6	-	**6**		
Number of individuals that are reached through community outreach with promote HIV/AIDS prevention through other prevention beyond abtinence and/or being faithful	**59,960**	**141,118**	**667,868**	**646,711**	**1,314,579**	**857,530**	**842,883**	**1,700,413**	HPI will contribute to this indicator indirectly since HPI addresses the operational policy issues and barriers that impede the implementation of the 100% CUP.	
-IDU	-	5,627	-	22,000	**22,000**	-	33,000	33,000	NO direct IDU program funded by USAID.	All IDU programs are funded by partnership fund and GFATM. Estimated IDU in 7 targted provinces is 55,000. In the year II, FHI aims to reached 40% coverage, which is 22,000. In year III aimed at 60% of coverage in targeted provinces, which is 33,000.
-FSW	11,980	16,097	29,295	29,295	**58,590**	36,326	36,326	72,652	117,180 estimated FSW in 7 focused provinces. In year II, FHI aims to reached 50% of FSW and in year III for 62%. These will take into account of 50% of IAs direct funded by USAID and another 50% funded by partnership fund.	117,180 estimated FSW in 7 focused provinces. In year II, FHI aims to reached 50% of FSW and in year III for 62%. These will take into account of 50% of IAs funded by partnership fund.
-MSM/MSW	6,458	6,547	117,802	117,802	**235,605**	172,394	172,394	**344,788**	13,968 MSW (waria) and 560,675 MSM estimated in 7 focused provinces. In year II, FHI aims to reached 41% and in year III for 60%. These will take into account of 50% of IAs direct funded by USAID.	13,968 MSW (waria) and 560,675 MSM estimated in 7 focused provinces. In year II, FHI aims to reached 41% and in year III for 60%. These will take into account of 50% of IAs direct funded by partnership fund.
-Clients of SW reached them through brothels and sex establishments -High rirk men at gathering points: truck drivers, fisherman, port workers, taxi -moter drivers and sailors -High risk men in formal sector: workplace	41,440	112,405	303,394	455,090	**758,484**	370,814	556,222	**927,036**	High risk men for Indonnesia including clients of SW which FHI reached at brothel and sex establishments, high risk men at gathering points; truck drivers, fishermen, port workers, taxi moter drivers, sailors and high risk men at workplaces. In year II, FHI will reach 54% high risk men and Year III for 66%. There is 40% of IAs funded by USAID.	High risk men for Indonnesia including clients of SW which FHI reached at brothel and sex establishments, truck drivers, fishermen, port workers, taxi moter drivers, sailors and high risk men at workplaces. In year II, FHI will reach 54% high risk men and Year III for 66%. There is 60% of IAs funded by partnership fund, .
- Prisoners	-	-	16,800	3,000	**19,800**	30,000	9,000	**39,000**	baseline, FHI started with policy and curriculum development, not yet implementation. Estimated 600 inmates per prison. FHI will work in 28 prisons in Year II. And additional 22 prisons in Year III.	FHI privide TA to master trainer and the use of training curriculum. In year II, 5 prisons will partcipate and estimated 600 inmates per prison funded by national AIDS commission. In Year III, additional 10 prisons will be included with same estimation of inmates per prison.
- PLHA	82	442	577	2523	3100	996	4942	5938	All PLHA reached with basic care will provide with prevention services as the part of case management module.	All PLHA reached with basic care will provide with prevention services as the part of case management module.
-Military				17,000	**17,000**		31,000	**31,000**	No USAID fund for uniform service programs.	All militatry programs funded by partnership fund. FHI provide TA on national strategic plan for HIV/AIDS prevention, care and treatemnt in militaty, develop training curriculum and master trainers, M&E system and mentoring. In July 2006, 3,000 uniform workers served. Year II, 17,000 will served in 5 corps and 1 reginal command and Year III, additional 14,000 workers will be reached in additional 3 corps and 1 additional regional command. It is estimated 196,000 military personnel in Indonesia. So it is estimated 8.6% and 15.8% reached in 2007 and 2008 respectively. In-direct estimates are results a collaboration of FHI and DOD.

USG Targets in Collaboration with Partners for FY07 to FY08									Justification for estmating targets,	
Indicators	Baseline FY06 (9 months)		FY07			FY08			Direct Justification	Indirect Justification
	(Oct 1,2005-June 30, 2006)		(Oct 1,2006-Sept 30, 2007)			(Oct 1, 2007-Sept 30, 2008)				
	Direct	Indirect	Direct targets	Indirect targets	Total	Direct targets	Indirect targets	Total		
-General population in papua	-		200,000	-	**200,000**	247,000	-	**247,000**	In year II, proect Concern International will reached 100,000 and workplace program will cover additional 100,000. In Year III, pci will epand to 230,000 by adding targeted areas and workplace program will cover another 17,000 by reaching more workplaces.	
3.3.6 Palliative Care: Basic Health Care and Support (FHI and DOD)										
Number of service outlets providing HIV related palliative care (excluding TB/HIV)	15	121	31	152	**183**	58	208	**266**	Case management is psycho-social support and faciliating accessibility to needed care including comprehensive care to PLHA. The case mgmt. provided by case manager for 6 months. After 6 months, case managers refer PLHA to support groups and help forming and facilitating the groups. Number of outlet here is defined as no. of clinics/ hospitals/ facilities/ institutions provided case management for PLHA and funded by USAID. From year II, the clinical care services will be incorporated in the package. In year II, will enhance quality of service delivery system in 2 hospitals and 6 PHC in Jayapura and 8 prisons that FHI provides training (introduce case mgmt. concept and dev. approprite definition + advocate the concepts + develop case mgmt. curriculum + TOT manual + TOT training) and TA. In year III, will add 1 hospital and 14 PHC in Papua and 12 prisons .	Same definition for outlet. Baseline includes 46 funded by Partnership Fund and 75 national ARV hospitals. Will add 22 new projects supported by partnership fund (year II), 1 military hospital and 2 corps clinics. Will add 53 PHC, 1 military hospital and 2 corps clinics in year III.
Number of individual trained to provide HIV related palliiative care (excluding TB/HIV)	**394**	**0**	**462**		**462**	**322**		**322**	Baseline includes 169 health care providers and 225 case managers. Year II includes refresher training and new training for palliative care (3 persons/new site).	Refresher for 50% of existing health care providers + training for new health care providers (3 persons (nurse, doctor, case manager) from each site)
FHI	394	-	442		**442**	302		**302**	Baseline includes 169 health care providers and 225 case managers. Year II includes refresher training and new training for palliative care (3 persons/new site).	Refresher for 50% of existing health care providers + training for new health care providers (3 persons (nurse, doctor, case manager) from each site)
DOD		-	20		**20**	20		**20**		
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	94	3491	481	2283	**2,764**	828	4462	**5,290**		
FHI	94	3491	481	2,183	**2664**	828	4262	**5090**	Baseline includes individulas reached by USAID funded projects. 14% of VCT clients tested positive (FHI records, year I). Expect to provide 50% case management services to PLHA for year II and III. (4,527 have HIV and 6,332 have AIDS.)	Baseline includes 3200 ARV recipients at ARV hospitals (source-GFATM) minus ART clients at FHI outlets + people reached through Partnership funded projects. 14% of VCT clients tested positive (FHI records, year I). Expect to provide 50% case management services to PLHA for year II and III.
DOD	0	0	0	100	**100**	0	200	**200**	DOD plans to support the training of at least 20 military medical personnel in treatment, care and support. It is expected that each trained personnel will be treat and care 5 patients in FY 2007 and 8 patients in FY 2008. So, FY 2007=100 and FY2008 = 200.	
3.3.7 Palliative Care: TB/HIV (FHI)										
Number of service outlets providing clinical prophylxis and/or treatment for TB to HIV infected individuals (diagnosis and persumed) according to national and international standards in palliative care setting	1	0	4	10	**14**	7	20	**27**	For baseline, FHI provides HIV test at 1 TB clinics. In year II, with HIV fund will expand 3 new TB clinics. Year III FHI will has 2 hospitals in papua and another 1 in north sumatara.	Indirect from TB-CAP funds, Year II support 10 clinics and another new 10 sites in year III.
Number of individual trained to provide clinical prophylxis and/or treatment for TB to HIV infected individuals (diagnosis and persumed) according to national and international standards	n/a	n/a	48	120	**168**	84	240	**324**	In each TB clinics will train 12 people: 2 doctor, 2 nurses,2 case manager, 3 counselors, 2 lab and 1 administor. Year II, 4 and 7 in Year III.	In each TB clinics will train 12 people: 2 doctor, 2 nurses,2 case manager, 3 counselors, 2 lab and 1 administor. Year I, 10 clinics and 20 clinics in Year III.
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease according to national and international standards	n/a	n/a	96	240	**336**	168	480	**648**	Year II, estimated 24 PLHA receive TB treatment per TB clinics based on 10% of TB clients who got positve for HIV from FHI monitoring report. Year II is the same.	Year II, estimated 24 PLHA receive TB treatment per TB clinics based on 10% of TB clients who got positve for HIV from FHI monitoring report. Year II is the same.

USG Targets in Collaboration with Partners for FY07 to FY08									Justification for estmating targets,	
Indicators	**Baseline FY06 (9 months)**		**FY07**			**FY08**			**Direct Justification**	**Indirect Justification**
	(Oct 1,2005-June 30, 2006)		**(Oct 1,2006-Sept 30, 2007)**			**(Oct 1, 2007-Sept 30, 2008)**				
	Direct	Indirect	Direct targets	Indirect targets	**Total**	Direct targets	Indirect targets	**Total**		
3.3.8 Palliative Care: OVC (no program)										
Number of providers/caretakers trained in caring for OVC					**0**			**0**		
Number of OVC served by OVC programs					**0**			**0**		
3.3.9 Counseling and Testing (FHI and DOD)										
Number of service outlets providing counseling and testing according to national and international standards	**8**	**20**	**23**	**51**	**76**	**49**	**54**	**106**	No. of outlet funded by USAID in year II. Year I, 8 outlets providing complete packages (pre-test, testing, post-test counselling) attached to STI clinics in the hot spots areas. 10 outlets provided pre-test and post-test counselling + blood drawing. Year 2, will add 6 PHC in Jayapura + 1 PHC in Nabire (complete VCT outlet) and 8 outlets in prisons (no testing). Year III, will add 14 PHC in Papua for complete VCT outlets + 12 outlets (no testing) in prisons.	Year I, 20 sites for IDUs providing pre-test and post-test counselling and blood drawing. Year II, will add 26 complete VCT outlets funded by partnership fund (NGO+PHC) and will add 5 complete VCT outlets in 4 military corps clinics and 1 hospital. Year III, will add additional 3 complete VCT outlets in 2 corps clinics and 1 hospital. Government has no money to support VCT operations.
FHI	8	20	23	51	**74**	49	54	**103**	No. of outlet funded by USAID in year II. Year I, 8 outlets providing complete packages (pre-test, testing, post-test counselling) attached to STI clinics in the hot spots areas. 10 outlets provided pre-test and post-test counselling + blood drawing. Year 2, will add 6 PHC in Jayapura + 1 PHC in Nabire (complete VCT outlet) and 8 outlets in prisons (no testing). Year III, will add 14 PHC in Papua for complete VCT outlets + 12 outlets (no testing) in prisons.	Year I, 20 sites for IDUs providing pre-test and post-test counselling and blood drawing. Year II, will add 26 complete VCT outlets funded by partnership fund (NGO+PHC) and will add 5 complete VCT outlets in 4 military corps clinics and 1 hospital. Year III, will add additional 3 complete VCT outlets in 2 corps clinics and 1 hospital. Government has no money to support VCT operations.
DOD			0	2	**2**	0	3	**3**		VCT clinic here are overlap with FHI.
Number of individual trained in counseling and testing according to national and international standards	419	0	567		**567**	633		**633**	At present, trained 368 counsellors + 51 lab staff. Will train 16 individuals from prisons and 88 counsellors & 44 lab staff in year II and refresher training. Year III, refresher training, and will train additional 24 staff from prisons and 42 staff from PHC in Papua.	
Number of individuals who received counseling and testing for HIV and received their test results	**515**	**1,610**	**6,873**	**31,188**	**38,061**	**11,829**	**60,880**	**72,710**		
Counseling and testing to MARPs	328	1,362	4,320	30,888	**35,208**	8,316	60,080	**68,396**	Baseline includes VCT clients received testing and post-test counselling funded by USAID. Estimate 2 persons/day X 20 days X 12 months X sites x 60% return for post test counselling in year II. Add 10% of 9 months in year III.	Estimate 2 persons/day X 20 days X 12 months X sites x 60% return for post test counselling + 30% of GFATM targets of 54,000, based on their FY06 performance. Add 10% of 9 months in year III + 5%of GFATM targets (94500 - unrealistic targets because no adequate TA and monitoring to ensure people will come back for results and post test counseling/GFATM may not get funding for phase II/round II) GFATM VCT sites are the same with national VCT sites.
General PoP in Papua			2,304		**2,304**	3,326		**3,326**	There are 8 sites in 2007 and 14 sites in 2008.	
TB patients	187	248	249	300	**549**	187	800	**987**	Year II and Year III maintains the same rates as year I.	
3.3.11 ART services (FHI)										
Number of service outlets providing ART according to national and/or international standards	0	106	8	128	136	8	128	136	ARV is implemented by gov. through GFATM. FHI through NGO network provide community based ARV adherence counseling 8 out of 15 sites direct support by USAID.	Baseline = no. of gov hospitals provided ARV funded by GFATM and government. In year II, 22 ARV clinics will expaneded. In year III same as year II.
Number of health workers (including peer eductors) trained to delivery ART services according to national and/or international standards	394		550		**550**	322		**322**	ARV training includes in care and support training, so same people with care and support training. The ARV training will provide for 4 people per ARV clinics. FHI help to TA develop training curriculum and monitoring.	ARV training includes in care and support training,so same people with care and support training.
Number of individuals newly initiating ART during the reporting period	n/a	n/a	144	1,000	1,144	249	2,000	2,249		
Number of individuals who receiving ART at the end of the reporting period	n/a	3,438	144	8,856	9,000	350	8,650	11,000	FHI provide community adherence counseling and support as the part of case manage services. The calculation based on 25% of PLHA who followed by case management services are on ART in 2007 and 2008, also will received direct support. We estimates 70% ART patient in 2007 will continue in the therapy 2008.	Ever received ART 5940, June 2006 and still on therapy 3,438 at only 25 clinics. In year II,III 75 ARV clinic supported by GFATM will provide ARV clinical services, 31 clinics implement ART services fully funded by government. Total of ARV patient estimates 9,000 in 2007 and 11,000 in 2008. Indirect support will be total - direct support.

USG Targets in Collaboration with Partners for FY07 to FY08									Justification for estmating targets,	
Indicators	**Baseline FY06 (9 months)**		**FY07**			**FY08**			**Direct Justification**	**Indirect Justification**
	(Oct 1,2005-June 30, 2006)		**(Oct 1,2006-Sept 30, 2007)**			**(Oct 1, 2007-Sept 30, 2008)**				
	Direct	Indirect	Direct targets	Indirect targets	**Total**	Direct targets	Indirect targets	**Total**		
3.3.12 Laboratory Infrastructure (DOD)										
Number of laboratories with capacity to perform 1) HIV test and 2) CD4 tests and/or lymphocyte tests			2		2	2		2		
Number of individuals trained in the provision of laboratory-related activities			6		6	6		6	Number of people trained on CD4 count instrument/Lab training. FY 07=6 and FY 08=6. Assumption --- at least two technicians training on one CD 4 count instrument and at least two technicians will attend the RTC technical lab training course in Bangkok --- the latter funded by the DOD DHAPP.	
Number of tests performed at USG-supported laboratories during the report period 1) HIV testing, 2) TB diagnosis 3) Syhilis testing, and 4) HIV disease moniting			17400		17,400	17400		17,400		
3.3.13 Strategic Information (FHI)										
Number of local organizations provided with technical assistance for strategic information activities	166		216		216	216		216	Baseline includes 80 IAs, 78 district KPA, 7 provincial KPA, 1 national KPA. Will expand to addition 50 IA in year II. Will provide TA to the same organizations in year III.	
Number of individual trained in strategic information (includes M&E, surveillance, HMIS, use of data)	273		263		263	263		263	Baseline includes no. of IA staff trained. Will train 2 persons each from 78 district KPA, 1 person each from 7 provincial KPA and 2 persons each for addition 50 IA. Will provide refresher training to all persons trained in year III.	
3.3.14 Other Policy and Systems Strengthening (FHI and HPI)										
Number of local organizations provided with technical assistance for HIV-related policy development	90	0	113	30	**143**	137	36	**173**	FHI and HPI provide TA to same organization to complement efforts. Count on FHI.	
-FHI	90	0	113	30	**143**	137	36	**173**	Year 1 includes 78 district KPA, 7 provincial KPA, 1 national KPA, 4 ministries (MOH, MOD, MOM, MOLHR). Will expand to 3 departments (Tourism, Transportation and Police) in year II. FHI maintain the same in Year III. FHI provides TA to 50 companies in Year II and 60 companies in Year III on developemnt HIV/AIDS workplace policy according to ILO code of practice. And 40% of implementationof workplace policy funded by USAID.	FHI provides TA to 50 companies in Year II and 60 companies in Year III on developemnt HIV/AIDS workplace policy according to ILO code of practice. And 60% of implementationof workplace policy funded by partnership fund.
-HPI			3		**3**	2		**2**	1) KPA, 2) KPAD in province #1, 3) KPAD in province #2	
Number of local organizations provided with technical assistance for HIV-related institutional capacity building	172	0	302	110	**412**	326	116	**442**	FHI and HPI provide TA to same organization to complement efforts. Count on FHI.	
- FHI	172	0	302	110	**412**	326	116	442	Baseline includes 80 IAs, 78 district KPA, 7 provincial KPA, 1 national KPA, 5 regional prison offices, and DOC. Will expand to additional 57 IAs, 3 regional prison offices and 50 prisons in year II. Will maiatain the capacity building in year III. FHI provides TA to 50 companies in Year II and 60 companies in Year III on developemnt HIV/AIDS workplace policy according to ILO code of practice. And 40% of implementationof workplace policy funded by USAID.	FHI provides TA to 50 companies in Year II and 60 companies in Year III on developemnt HIV/AIDS workplace policy according to ILO code of practice. And 60% of implementationof workplace policy funded by partnership fund. In year II and III, FHI provide TA to 80 IAs funded by partnership fund.
- HPI			1	0	**1**	0		-		
Number of individuals trained in HIV-related policy development	0	0	55	60	**115**	56	72	**128**		
- FHI	0	0	40	60	**100**	48	72	**120**	There are 2 senior managers will be trained per company in 50 companies in year II and 60 companies in year III. It is estimated 40% of companies funded by USAID.	There are 2 senior managers will be trained per company in 50 companies in year II and 60 companies in year III. It is estimated 60% of companies funded by partnership fund.
- HPI			15		**15**	8		**8**	# of individuals trained in the RNM	
Number of individual trained in HIV-related institutional capacity building	116	0	1236	600	**1836**	834	720	**1554**		

USG Targets in Collaboration with Partners for FY07 to FY08									Justification for estmating targets,	
Indicators	**Baseline FY06 (9 months)**		**FY07**			**FY08**			**Direct Justification**	**Indirect Justification**
	(Oct 1,2005-June 30, 2006)		**(Oct 1,2006-Sept 30, 2007)**			**(Oct 1, 2007-Sept 30, 2008)**				
	Direct	Indirect	Direct targets	Indirect targets	**Total**	Direct targets	Indirect targets	**Total**		
- FHI	116		1234	600	**1,834**	834	720	**1,554**	Baseline is no. of IA staff trained until June 2006. Will train at least 2 persons from each IA in year II, 4 X 78 district KPA, 5 X 7 provincial KPA, 7 from national KPA and 4 X 50 prisons. In year II, will do refresher training for all KPA.There are 20 people will be trained per company, 50 companies in year II and 60 companies in year III. It is estimated 40% of companies funded by USAID.	There are 20 people will be trained per company, 50 companies in year II and 60 companies in year III. It is estimated 60% of companies funded by partnership fund.
- HPI			2		**2**	0		-	KPAD officials	
Number of individual trained in HIV-related stigma and discrimination reduction	n/a		912	600	**1,512**	480	720	**1,200**	Will train at least 3 persons from each IA, one each from district hospitals and 1 each from 2 provincial hospitals from 7 provinces in year II. There are 20 people will be trained per company, 50 companies in year II and 60 companies in year III. It is estimated 40% of companies funded by USAID.There are 20 people will be trained per company, 50 companies in year II and 60 companies in year III. It is estimated 40% of companies funded by USAID.	There are 20 people will be trained per company, 50 companies in year II and 60 companies in year III. It is estimated 60% of companies funded by partnership fund.
Number of individual trained in HIV-related community mobilization for prevention, care and/or treatment	n/a		1,440	1,512	**2,952**	560	720	**1,280**	Will train at least 3 persons each from 140 IA, 2 persons each from 50 prisons X 2 training courses (one prevention, one C&T) in year II. Will train 40 person from religious organization and 40 persons from tribal organization in Papua. There are 20 people will be trained per company, 50 companies in year II and 60 companies in year III. It is estimated 40% of companies funded by USAID.	There are 20 people will be trained per company, 50 companies in year II and 60 companies in year III. It is estimated 60% of companies funded by partnership fund.
Note 3.3.10 Treatment:ARV drug do not require tragets										