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SCALING
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MOST-AT-RISK POPULATIONS



Expanded Readiness Assessment Report DKI Jakarta

March 2011



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FHI/SUM I Task Order No. GHH-I-00-07-00043-00

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LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
APMG	AIDS Projects Management Group
APBD	Regional budgets
ARV	Antiretroviral
BI	Burnet Institute
CSO	Civil society organization
ERA	Expanded readiness assessment
FGD	Focus Group Discussion
FHI	Family Health International
FSW	Female sex workers
GF	Global Fund
GF SR	Global Fund Sub-Recipients
GF SSR	Global Fund Sub-Sub Recipients
HCPI	HIV Cooperation Program in Indonesia, AusAID
HIV	Human immunodeficiency virus
IBBS	Integrated Biological and Behavior Survey
IEC	Information, Education and Communication
IDUs	Injecting drug users
KPAK	City/District AIDS Commissions
KPA	Provincial AIDS Commission, Indonesia
MARP	Most-at-risk population
MMT	Methadone maintenance therapy
MoU	Memorandum of Understanding

MSM	Men who have sex with men
NSP	Needle sharing program
PKBI	Persatuan Keluarga Berencana Indonesia
PMTS	Program Pencegahan HIV melalui Transmisi Seksual
PKM	Community Health Center
RSPI	Rumah sakit infeksi Sulianti Suroso
RTI	Research Triangle Institute, International
STI	Sexually transmitted infection
SUM Program	Scaling Up for Most-at-Risk Populations Program (a joint program of SUM I and SUM II)
SUM I	Scaling Up for Most-at-Risk Populations: Technical Assistance
SUM II	Scaling Up for Most-at-Risk Populations: Organizational Performance
UNFPA	The United Nations Population Fund
USAID	U.S. Agency for International Development
VCT	Voluntary, Counseling and Testing
YIM	Yayasan Inter Medika

EXECUTIVE SUMMARY

The HIV epidemic in Indonesia remains largely concentrated among individuals who engage in high-risk behavior groups such as injecting drug users (IDUs), men who have sex with men (MSM), female sex workers (FSWs) and transgenders (MOH et al., 2008). A high HIV prevalence has been reported among these most-at-risk populations (MARPs) in DKI Jakarta, but the prevalence rates of HIV varied considerably. For example, HIV prevalence of 55%, 34%, 10%, 8%, and 5.7% had been found among IDUs, transgenders, direct FSWs, MSM, and indirect FSWs, respectively (MOH et al., 2008). Scaling Up for Most-At-Risk Populations (SUM) is a five-year USAID-funded program aimed at scaling up the HIV response in Indonesia by: 1) documenting and disseminating innovative approaches, best practices and lessons learned; and (2) providing assistance to develop the technical and organizational capacities, especially for civil society organizations, required to design and implement the comprehensive, integrated HIV interventions that are critical to the overall success of the HIV response in Indonesia. The SUM program will focus on up to eight provinces and up to 18 districts/municipalities in Indonesia.

In order to determine the level of readiness of the target intervention areas for the HIV/AIDS response, the first part of the Expanded Readiness Assessment (ERA) was conducted in DKI Jakarta with the following specific aims:

- To measure the degree of readiness which can describe a community in responding to the issue of HIV/AIDS;
- To gather basic information that can be used in identifying target communities for the SUM program; and
- To gather basic information for the development of community-based intervention strategies.

Between November and December 2010, eight MARP communities were selected based on the following criteria: a) evidence of significant numbers of MARPs in each geographical area; b) the availability of HIV/AIDS-related CSOs and their working areas; c) the availability of HIV/AIDS-related services; and d) the supportive political situation in the area to allow the continuation of program implementation.

Thirty-seven interviews/focus group discussions (FGDs) were conducted in the eight MARP communities. Semi-structured questionnaires were used to measure the six dimensions of a community preparedness model. Three to five informants who represented the MARPs and multiple stakeholders were interviewed. The overall stage of readiness of the community was determined by the total of all calculated scores divided by the number of dimensions (6). The scores correspond with the numbered stages and are “rounded down” to represent the stage rather than up. A score between a 1.0 and a 1.99 would be the first stage. A score of 2.0 to 2.99 would be the second and so forth.

The following are key findings of the stages of readiness from the eight communities in DKI Jakarta:

Target areas	Level of Readiness
1. IDU communities in West and North Jakarta	Advanced implementation
2. IDU communities in South and Central Jakarta	Implementation
3. IDU communities in East Jakarta	Advanced implementation
4. FSW communities in West Jakarta	Implementation
5. FSW communities in East Jakarta	Implementation
6. MSM communities in South, West, and Central Jakarta	Implementation
7. MSM communities in North and East Jakarta	Implementation
8. Transgender communities in Jakarta	Implementation

The results show that out of eight communities at the targeting intervention areas, only two communities are at the advanced implementation stage (e.g., IDU communities in West and North Jakarta and IDU communities in East Jakarta). The rest of the communities are at the implementation stage (e.g., IDU communities in South and Central Jakarta; FSW communities in West Jakarta; FSW communities in East Jakarta; Transgender communities in Jakarta; MSM communities in South, West, and Central Jakarta; and MSM communities in North and East Jakarta). This means that HIV/AIDS has been recognized as a problem but efforts to address this issue are still limited. Further work should be done to increase 1) MARPs' knowledge regarding the correct modes of HIV/AIDS transmission and prevention; 2) access to HIV care as well as the quality of each type of care; 3) MARPs' involvement in HIV/AIDS program planning and evaluation; 4) supportive regulations and policies related to HIV/AIDS prevention efforts; and 5) resources (people, money, time and space) to ensure the continuation of HIV/AIDS prevention programs in each area. Finally, important precursors to this effort are the changing of local regulations regarding prostitution, the exchange of clean needles and condom distribution. Another is providing support to the MARPs and establishment owners and pimps/*mami*, so they will not be harassed and/or prosecuted when trying to adopt and/or support the proper HIV risk reduction strategies.

I. BACKGROUND

The HIV epidemic in Indonesia remains largely concentrated among individuals who engage in high-risk behavior groups such as injecting drug users (IDUs), men who have sex with men (MSM), female sex workers (FSWs) and transgenders (MOH et al., 2008). In 2010, DKI Jakarta had the highest cumulative number of AIDS cases in Indonesia, which was 3,995, and its prevalence was 3.4 times more than the national average. The number of AIDS deaths and new cases was 576 and 125, respectively. More than 50% of AIDS cases in DKI Jakarta can be attributed to IDU (MOH, 2010). In 2009, the Ministry of Health reported national estimates of adult HIV Infection, which included estimates of the sizes of the populations vulnerable to HIV among MARPs in DKI Jakarta. For example, there was an estimated 99,146 MSMs, 36,011 FSWs, 27,852 IDUs, and 2,008 transgenders in DKI Jakarta, with estimates of the average number of MSM, FSWs, IDUs and transgenders living with HIV/AIDS at 7,992, 2,646, 15,324, and 682, respectively (MOH, 2010). Furthermore, prevalence rates of HIV varied considerably among MARPs in DKI Jakarta. For example, HIV prevalence of 55%, 34%, 10%, 8%, and 5.7% had been found among IDUs, transgenders, direct FSWs, MSM, and indirect FSWs, respectively (MOH et al., 2008).

Scaling Up for Most-At-Risk Populations (SUM) is a five year USAID-funded program aimed at scaling up the HIV response in Indonesia by: 1) documenting and disseminating innovative approaches, best practices and lessons learned; and (2) providing assistance to develop the technical and organizational capacities, especially for civil society organizations, required to design and implement the comprehensive, integrated HIV interventions that are critical to the overall success of the HIV response in Indonesia.

The SUM Program is a joint undertaking of two USAID-funded projects: the SUM I Project being implemented by FHI, and the SUM II Project being implemented by the Training Resources Group (TRG), along with partners, RTI International, Burnet Institute and AIDS Projects Management Group (APMG).

The SUM program will focus on a maximum of eight provinces in Indonesia, namely DKI Jakarta, West Java, Central Java, East Java, Riau Islands, North Sumatra, Papua and West Papua. Within these eight provinces, 18 districts/municipalities where Most-At-Risk Populations (MARPs) are prevalent will be prioritized. The MARPs include Injecting Drug Users (IDUs), Men who have Sex with Men (MSM), *Waria* (transgenders), and Female Sex Workers (FSWs).

As a part of the assessment and selection process for identifying targeted intervention sites, Expanded Readiness Assessments (ERAs) were undertaken in selected communities and/or hotspots where integrated interventions have the potential to achieve significant coverage of the at-risk populations and have a measurable impact.

The ERA has several objectives, including:

- To measure the degree of readiness which can describe a community in responding to the issue of HIV/AIDS;

- To gather basic information that can be used in identifying target communities for the SUM program; and
- To gather basic information for the development of community-based intervention strategies.

This report documents the results from the first ERAs, which were conducted in DKI Jakarta.

II. METHODOLOGY

Between November and December 2010, thirty-seven interviews/FGDs from eight selected MARP communities were conducted in DKI Jakarta. Semi-structured questionnaires were used to measure the six dimensions of the community preparedness model. Interviews were conducted in groups of three to five informants each. The informants included a representation of MARPs, CSOs, the brothel working group/*pokja lokasisasi*, pimps or *mami* of the brothels and establishment owners, health care service providers, City/District health offices (DHOs), City/District AIDS Commissions (KPAK), the Provincial AIDS Commission (KPA), and Global Fund Sub- Recipients/Sub-Sub Recipients (GF SR/SSR). The interviews were conducted at the locations where the informants were based. Each dimension was scored independently by two interviewers. The combined scores were determined by consensus. The calculated scores for each dimension were determined by the total score of each interview divided by the number of interviews. The overall stage of readiness of the community was determined by the total of all calculated scores divided by the number of dimensions (6). The scores correspond with the numbered stages and are “rounded down” rather than up. For example, a score between a 1.0 and a 1.99 would be the first stage. A score of 2.0 to 2.99 would be the second and so forth.

2.1 The Community Readiness Model

The model was adopted from the Tri-Ethnic Center for Prevention Research Community Readiness model (Pleasted *et al.*, 2006).

The six dimensions of readiness were used to measure and diagnose the community’s level of readiness for the HIV/AIDS prevention program:

- A. The MARPs’ knowledge of HIV/AIDS
- B. Community knowledge about HIV/AIDS efforts
- C. Existing HIV/AIDS prevention efforts
- D. Resources related to HIV/AIDS prevention efforts
- E. HIV/AIDS related regulations and policies
- F. Leadership.

The following lists the nine stages of readiness of the Community Readiness Model:

Score	Stage of Readiness	Description
1	No Awareness	<ul style="list-style-type: none"> • The majority of community members have not heard about HIV/AIDS • HIV/AIDS is not generally recognized by the community or leaders as a problem (or it may truly not be an issue) • No efforts or resources available in the community to lower HIV transmission among MARPs • Most HIV/AIDS-related regulations and policies are not supportive
2	Preparation	<ul style="list-style-type: none"> • The MARPs are not familiar with the basic HIV/AIDS information • At least some community members recognize that it is a concern, but most have no idea on how to tackle this issue • There is a plan for HIV/AIDS programming, but it has not been implemented • Some appointed and community leaders recognize that something must be done • Some groups are working on securing resources, but it is still inadequate • Some HIV/AIDS-related regulations and policies are available, but their use is not optimal
3	Initiation	<ul style="list-style-type: none"> • A few members of MARPs are familiar with the basic HIV/AIDS information • A few members of the community recognize that HIV/AIDS is a problem. Efforts to lower HIV transmission have begun taking place, but in a very limited manner • Some appointed and community leaders have started taking action • Resources related to HIV/AIDS prevention programs (e.g., people, space and money) are available, but are very limited • Only a few of the HIV/AIDS prevention programs are conducted in line with the regulations and policies which have been provided
4	Implementation	<ul style="list-style-type: none"> • The majority of MARPs are familiar with the basic HIV/AIDS information and are aware of other HIV positive MARPs • The majority of communities recognize that HIV/AIDS is a problem. There is clear recognition

Score	Stage of Readiness	Description
		<p>that something must be done, and members of MARPs have been involved in the HIV/AIDS prevention programs</p> <ul style="list-style-type: none"> • There is an annual work plan on HIV/AIDS prevention programs. Some have been implemented • Active leaders begin planning in earnest • Resources related to HIV/AIDS prevention programs (e.g., people, space and money) are available, and there are appointed leaders working on securing the resources for the continuation of HIV/AIDS prevention programs in the community • The majority of HIV/AIDS prevention program are conducted in line with the regulations and policies provided
5	Advanced implementation	<ul style="list-style-type: none"> • The majority of MARPs are familiar with the basic HIV/AIDS information, and are aware of other HIV positive MARPs, as well as know how to access HIV/AIDS-related services • Almost all segments of the communities recognize that HIV/AIDS is a problem. The community offers good support for the efforts. The members of MARPs are actively involved in the HIV/AIDS prevention programs • There is an annual work plan on the comprehensive HIV/AIDS prevention program. All work plans have been implemented. There are clear indicators and all targets have been achieved • Most appointed and community leaders have become actively involved in HIV/AIDS prevention efforts • Resources related to the comprehensive HIV/AIDS prevention program (e.g. people, space and money) are available from several sources • All HIV/AIDS prevention programs are conducted in line with the supportive regulations and policies which have been provided
6	Integration	<ul style="list-style-type: none"> • Almost all MARPs are familiar with the basic HIV/AIDS information, and aware of other HIV positive MARPs, as well as know how to access HIV/AIDS-related services. Most MARPs know that they can transmit and acquire HIV • Almost all segments of the communities recognize that HIV/AIDS is a problem. Efforts are in place. Members of MARPs are actively involved in the HIV/AIDS prevention program

Score	Stage of Readiness	Description
		<ul style="list-style-type: none"> • There is an annual work plan on the comprehensive HIV/AIDS prevention program. All work plans have been implemented. There are clear indicators and all targets have been achieved. The indicators are a part of the local government HIV/AIDS plan and strategy, and are developed together with the key members of MARPs • Most appointed and community leaders have become actively involved in HIV/AIDS prevention efforts, and make them a priority • Resources related to the comprehensive HIV/AIDS prevention program (e.g. people, space and money) are available from several sources, with the local budget as the biggest resource • All HIV/AIDS prevention programs are conducted in line with the supportive regulations and policies which have been provided. There are no longer any non-supportive regulations and policies in the community.
7	Stabilization	<ul style="list-style-type: none"> • The majority of MARPs recognize that HIV/AIDS is their problem. They know the HIV prevalence in their community. They know in detail how to access HIV/AIDS-related services. Most MARPs know that they can transmit and acquire HIV • Almost all segments of the communities recognize that HIV/AIDS is a problem. Efforts with good mechanisms are in place. The members of MARPs have been actively involved in the HIV/AIDS prevention programs over the last few years • The annual work plan includes the comprehensive HIV/AIDS prevention program and budget allocations. All work plans have been implemented. There are clear indicators and all targets have been achieved. The indicators are a part of the local government's HIV/AIDS plan and strategy, and were developed together with the key members of MARPs • Most appointed and community leaders have become actively involved in HIV/AIDS prevention efforts and make it a priority, as well as provide sufficient resources • Resources related to the comprehensive HIV/AIDS prevention program (e.g., people, space and money) are available from several sources, with the local budget as the biggest resource. There are systematic efforts to secure resources for the MARPs

Score	Stage of Readiness	Description
		<ul style="list-style-type: none"> All HIV/AIDS prevention programs of past few years were conducted in line with the supportive regulations and policies that were provided
8	Confirmation / Expansion	<ul style="list-style-type: none"> Almost all MARPs recognize that HIV/AIDS is their problem. They know the HIV prevalence in their community and are familiar with the HIV/AIDS prevention programs for them. They know in detail how to access HIV/AIDS-related services. Most MARPs know that they can transmit and acquire HIV Almost all segments of the communities recognize that HIV/AIDS is a problem. Efforts with good mechanisms are in place. The key people of MARPs have become focal points in the HIV/AIDS prevention program The annual work plan includes the comprehensive HIV/AIDS prevention program and budget allocations. All work plans have been implemented. There are clear indicators and all targets have been achieved. The indicators are part of the local government's HIV/AIDS plan, and the strategy was developed together with the key members of MARPs. Regular evaluation have been conducted with active involvement from all segments of the community Most appointed and community leaders have become actively involved in HIV/AIDS prevention efforts and make this a priority, as well as provide sufficient resources. They support expansions of program coverage Resources related to the comprehensive HIV/AIDS prevention program (e.g., people, space and money) are available from several sources, with the local budget as the biggest resource. There are systematic efforts to secure resources for the MARPs, including program expansions There are HIV/AIDS-related regulations and policies to support program expansions, which also include written regulations to conduct regular evaluations
9	High Level of Community Ownership	<ul style="list-style-type: none"> Almost all MARPs recognize that HIV/AIDS is their problem. They know the HIV prevalence in their community and are familiar with the effective HIV/AIDS prevention programs for them. They know in detail how to access HIV/AIDS-related services. Most MARPs know that they can transmit and acquire HIV

Score	Stage of Readiness	Description
		<ul style="list-style-type: none"> • Almost all segments of the communities recognize that HIV/AIDS is a problem. Efforts with good mechanisms are in place. The key people of MARPs have become focal points in the HIV/AIDS prevention program in the last few years, and are involved in the regular evaluation of the program • The annual work plan includes the comprehensive HIV/AIDS prevention program and budget allocations. All work plans have been implemented. There are clear indicators and all targets have been achieved. The indicators are a part of the local government HIV/AIDS plan and strategy, and were developed together with the key members of MARPs. Regular evaluations have been conducted with active involvement from all segments of the community. Only effective HIV/AIDS prevention programs continue to be implemented • Most appointed and community leaders have become actively involved in HIV/AIDS prevention efforts, and make this a priority, as well as provide sufficient resources. They support expansions of the program coverage and facilitate regular program evaluation • Resources related to comprehensive HIV/AIDS prevention programs (e.g., people, space and money) are available from several sources, with the local budget as the biggest resource. There are systematic efforts to secure resources for the MARPs, including program expansions and innovations • There are HIV/AIDS-related regulations and policies to ensure the availability of sufficient resources to fund the effective programs

2.2 Instrument

The instrument reflects each dimension and elicits information on the following topics:

- (a) The MARP's knowledge of HIV/AIDS, which included questions about whether the MARP ever heard of an illness called AIDS or a virus called HIV, their knowledge of HIV transmission and its means of prevention, the sources of HIV/AIDS information, and types of HIV/AIDS prevention activities and services that are mostly accessed by the MARP.
- (b) Community knowledge about HIV/AIDS efforts, which included questions about the percentages of the community who think that HIV/AIDS is a problem, numbers of individuals or group efforts to prevent HIV transmission in the community, and whether

or not there are members of MARPS that have become a focal point in HIV/AIDS prevention efforts.

- (c) Existing HIV/AIDS prevention efforts, which included questions about the extent to which community members know about local HIV/AIDS prevention efforts and their effectiveness, and whether or not the efforts are accessible to all segments of the community.
- (d) Resources related to HIV/AIDS prevention efforts, which included questions about the extent to which local resources such as people, time, money, and space are available to support HIV/AIDS prevention efforts.
- (e) HIV/AIDS-related regulations and policies, which included questions about the availability of supportive and/or non-supportive regulations and policies related to HIV/AIDS prevention efforts.
- (f) Leadership, which included questions about the extent to which appointed leaders and influential community members are supportive or non-supportive regarding HIV/AIDS issues.

2.3 Selection and Recruitment

2.3.1 Community

A community was defined based on the following criteria: 1) a city, district, or municipality in which there is (a) a significant number of MARPs and (b) evidence of a high prevalence of behaviors that are known to be associated with an elevated likelihood of HIV transmission; or 2) a smaller concentration of MARPs or “hotspot” for which there is a rationale for more specific geographic targeting.

Prior to the selection of communities, preliminary information regarding the target intervention areas was gathered. The information included identification of the following factors: a) the type of MARPs and their characteristics; b) HIV/AIDS-related services available in the areas; and c) the working areas of CSOs. Additionally, the HIV prevalence among MARPs in DKI Jakarta, along with the population estimate of MARPs was also considered.

Based on this preliminary information, a set of criteria to select communities in DKI Jakarta were established. These included:

1. Evidence of significant numbers of MARPs in each geographical area;
2. The availability of HIV/AIDS-related CSOs and their working areas;
3. The availability of HIV/AIDS-related services; and
4. A supportive political situation in the area to allow the continuation of program implementation.

Below is the list of participating communities in DKI Jakarta:

- IDU communities in West and North Jakarta
- IDU communities in South and Central Jakarta
- IDU communities in East Jakarta
- FSW communities in West Jakarta
- FSW communities in East Jakarta
- MSM communities in South, West and Central Jakarta
- MSM communities in North and East Jakarta
- Transgender communities in Jakarta

2.3.2 Participants

Two layers of participant recruitment were implemented. The first layer consisted of personnel from the following groups: 1) Four MARPs (e.g., IDU, FSW, MSM, and Transgender populations); 2) Three to five CSOs; and 3) Three to five health care service providers. The second layer consisted of personnel from the following groups: 1) Three City/District AIDS Commissions (KPAK) or Provincial AIDS Commission (KPA); 2) Three City/District Health Officers (DHOs); and 3) Two to three sub-recipients/sub-sub recipients (SR/SSR) of the Global Fund (GF). Additionally, a pimp or *mami* and personnel from brothel working groups or *pokja lokalisasi* were recruited for FSW communities. In total, 37 interviews/FGDs were conducted in DKI Jakarta.

2.3.3 Interviewers

The interviewers consisted of seven to eight teams taken from the national and provincial staffs of the SUM program. One team consisted of two people to independently score each dimension.

III. RESULTS

3.1 IDU Communities in West and North Jakarta

The informants included representatives of IDUs and personnel from the following groups: a) Kios Atmajaya (CSO); b) Rumah Sakit Infeksi Suliarti Saroso (RSPI) (Service provider); c) Sudinkes Jakarta Barat (DHO); d) Sudinkes Jakarta Utara (DHO); e) KPA Kota Jakarta Barat; f) KPA Kota Jakarta Utara; and g) GF SR from DHO.

Table 1 provides the overall scores of IDU community readiness in West and North Jakarta. The findings show that opinions regarding each dimension varied between and within informants. For example, the IDU population and CSO personnel have similar opinions regarding each dimension, with the tendency to score the IDU's knowledge of HIV/AIDS and community knowledge about HIV/AIDS efforts higher than the rest of the dimensions

(e.g., existing HIV/AIDS prevention efforts, HIV/AIDS related resources, regulations, policies, and leadership). However, service providers and other stakeholders (e.g., GF SR) tended to report sufficient resources, regulations and policies related to HIV/AIDS. Of additional interest, opinions regarding leadership differed significantly between the IDU population and CSO personnel versus stakeholders, with a higher score rated by the stakeholders (e.g., GF SR).

The average score of 5.1 indicates that the communities are at the advanced implementation stage. In this stage, HIV/AIDS prevention efforts are in place, but efforts need to improve. The areas which needed to be improved included funding sustainability, stronger leadership, and more supportive HIV/AIDS regulations and policies for this group. The accessibility and quality of HIV/AIDS programs to this community also need to improve.

Table 1. The overall scores of IDU communities in West and North Jakarta

Interview	MARP	CSO	Service Providers	DHO	KPAK	GF SR (DHO)	GF SR (CSO)	Average score
Dimension A	6	7	7	8	5.5	6	7.5	6.7
Dimension B	5	6	5	5.5	4.5	6.5	6.25	5.5
Dimension C	3	4	4	5.3	4.25	6	6.25	4.7
Dimension D	3	3	6	6	3.75	6	5.25	4.7
Dimension E	3	3	8	5	4	5	5	4.7
Dimension F	2	3	6	4.6	4.75	5	6.5	4.6
The average score: 5.1 (Advanced implementation stage)								

Dimension A. The IDUs' knowledge of HIV/AIDS

- Almost all segments of the community recognized that IDUs have heard about HIV/AIDS but their understanding about transmission and prevention needs to improve. For example, some believe that HIV can be transmitted by mosquitoes. The sources of information regarding HIV/AIDS were outreach workers, peers and media (e.g., TV). Information received included information about HIV transmission and prevention, STIs, hepatitis, TB, ARV medications and basic health services.
- Some communities revealed that most IDUs knew other HIV positive IDUs. Most of them recognized that IDUs can transmit HIV as well as acquire HIV.

- All segments of the community revealed that IDUs can name several HIV/AIDS related services. These services included: needle sharing program (NSP), methadone maintenance therapy (MMT), and voluntary counseling and testing (VCT). However, not all IDUs were familiar with their operating hours and payment procedures.

Dimension B. Community knowledge about HIV/AIDS efforts

- Opinions regarding the recognition that HIV/AIDS is a problem for the IDU population varied. For example, all stakeholders said that IDUs recognized this is as a problem, but the IDU population did not share the same viewpoint.
- Almost all segments of the community admitted that there were individual and group efforts to lower HIV transmission among this group. This included CSOs which provided peer support groups and dissemination of HIV/AIDS and MMT information. However, this effort was not recognized by the service providers.
- There were parties who assisted the prevention efforts. These included CSOs, KPAK, and service providers.
- IDU populations have been involved in the program both as intervention targets and outreach workers. There were key figures who were actively involved in HIV/AIDS prevention programs.

Dimension C. Existing HIV/AIDS prevention efforts

- HIV/AIDS prevention efforts were available in both areas. These included outreach activities, MMT, NSP, VCT, condom distribution, ARV, TB/HIV, and STIs counseling and referral system.
- Health services for IDUs have been provided by CSOs, DHOs, public and private hospitals. Opinions regarding access to these services varied. For example, the IDU population and the CSOs believed that access to NSP was easiest, followed by outreach activities, ARV distribution, and VCT. The MMT program was the least accessible for IDUs. Meanwhile, other stakeholders believed that all HIV/AIDS services for IDUs were adequate and accessible to the target population.
- Opinions regarding the quality of each service also varied. For example, the quality of outreach activities and ARV distribution was good, but others (e.g., NSP, condom distribution, MMT) need to be improved.
- All stakeholders, except the IDU population, were aware that there were annual work plans on HIV prevention programs in both areas. The funding was available from KPAK, GF, and APBD. All recognized that the IDU population has not been involved in the planning process.

- Almost all stakeholders admitted that HIV/AIDS programs for IDUs have been evaluated quantitatively; however, this was not the case according to the IDU population and CSOs.

Dimension D. Resources related to HIV/AIDS prevention efforts

- Resources were available to prevent HIV/AIDS in this community. These include people, space and money (e.g., GF, KPAK). However, the IDU population and CSO were not aware of the sources of funding available.
- Most stakeholders believed that there were systematic efforts to secure resources for this population, but the sustainability of programs was questionable.

Dimension E. HIV/AIDS related regulation and policies

- Not all segments of the community acknowledged the availability of written and verbal regulations to support HIV/AIDS prevention efforts among this group. Several regulations pertinent to ARV distribution, NSP, TB treatment and strategic plans were mentioned as supportive regulations. Both the IDU population and CSOs considered that the NSP policy which required members of the IDU population to take sterile needles to the community health center (PKM) was viewed as a non-supportive regulation in HIV/AIDS prevention efforts.

Dimension F. Leadership

- There were appointed leaders involved in the HIV/AIDS prevention program for IDUs, but their contribution to the program was limited. Some community leaders were not supportive of the existing HIV/AIDS prevention efforts.
- Some were aware of the appointed and community leaders who worked on securing funds for the continuation of HIV/AIDS prevention programs (e.g. KPAK, DHO). However, the IDU population and CSO said otherwise.

3.2 IDU Communities in East Jakarta

The informants included the representative of IDUs and personnel from the following groups: a) Karisma (CSO); b) PKM Jatinegara (Service provider); c) Sudinkes Jakarta Timur (DHO); d) KPA Kota Jakarta Timur; f) GF SR CSO; and g) GF SR DHO.

Table 2 provides the overall scores of IDU community readiness in East Jakarta. The findings highlight the variation in scoring each dimension. For example, the IDU population and stakeholders rated the resources related to HIV/AIDS prevention efforts in the community lower than other informants. The representatives of service providers rated HIV/AIDS related regulations and policies higher than other stakeholders. Likewise, the IDU population and CSO personnel thought that there was no strong leadership to take significant

actions on HIV/AIDS-related issues in the community, an opinion that was not shared by service providers and other stakeholders (e.g., GF SR and KPAK).

The average score of 4.9 indicates that the community is at the implementation stage. In this stage, HIV/AIDS is recognized as a problem but efforts are still limited (e.g., funding sustainability, weak leadership, and lack of HIV/AIDS regulation and policies that facilitate HIV/AIDS prevention programs among this group). There were distinct opinions between the IDU population and most stakeholders regarding accessibility, quality, and level of commitment of the existing HIV/AIDS related services.

Table 2. The overall scores of IDU communities in East Jakarta

Interview	MARP	CSO	Service providers	DHO	KPAK	GF SR (DHO)	GF SR (CSO)	Average score
Dimension A	5	5	7	6	5	6	7.5	5.9
Dimension B	5	5	4	4.25	3.5	6.5	6.25	4.9
Dimension C	3.5	4.5	5	4	4	6	6.25	4.8
Dimension D	2.5	5	5	6	3.5	6	5.25	4.8
Dimension E	3.5	3.5	7	5	4	5	5	4.7
Dimension F	1.5	2	6	4	6	5	6.5	4.4
The average score: 4.9 (Implementation stage)								

Dimension A. The IDUs' knowledge of HIV/AIDS

- Almost all segments of the community recognized that the IDUs have heard about HIV/AIDS but they have just moderate knowledge about how HIV/AIDS was transmitted. Although most said sharing needles and sexual intercourse without a condom as the modes of HIV transmission were most known by the IDU population, some IDUs had incorrect knowledge about HIV transmission. For example, many believed that they can tell that a person has HIV infection by simply looking at their physical appearance.
- The sources of HIV information for this group were CSOs, PKM and peer educators. They received information on HIV transmission and prevention, STIs, HIV testing and treatment, MMT and NSP. The majority knew other HIV infected IDUs.
- All stakeholders, except the IDU population, could mention HIV prevalence in this group.

- Almost all knew about HIV-related services for IDUs, but only half of the IDU population knew about the operating hours and procedures. Most knew that this population can transmit and acquire HIV.
- Only small numbers of the IDU population were aware of the comprehensive HIV/AIDS prevention program for this population.

Dimension B. Community knowledge about HIV/AIDS efforts

- Almost all revealed that IDUs have recognized that HIV/AIDS is a problem for them. All segments of the community, except PKM, admitted that there were individuals and group efforts to lower HIV transmission. These included CSOs, KPAK and PKM. The IDU population has been involved in the program.
- CSO staff has become a focal point on HIV/AIDS prevention programs in the community. However, none recognized any key figures from the IDU population who are actively involved in HIV prevention efforts.

Dimension C. Existing HIV/AIDS prevention efforts

- HIV/AIDS related services available for this group included: outreach activities, MMT, NSP, VCT, condom distribution, ARV, TB/HIV, and STIs. Both the IDU population and CSOs said that outreach activities were the most accessible to IDUs, followed by condom distribution and TB/HIV. Both also mentioned that there was low access to the ARV supplied. They also reported that the quality of these services needs to be improved. Meanwhile, other stakeholders said that IDUs have high accessibility and there is a good level of quality for most HIV-related services. However, other stakeholders felt that the services were good and adequate.
- All stakeholders were aware that there were annual work plans on HIV prevention programs, particularly from CSOs, PKM and KPAK. The funding was available from KPAK, GF, and APBD. All admitted that the IDU population has not been involved in the planning process. Although some believed the program has been evaluated, target prevention was low.

Dimension D. Resources related to HIV/AIDS prevention efforts

- Resources were available to prevent HIV/AIDS in this community. The sources of funding included the International Health Organizations (e.g., HCPI, UNFPA, GF), KPAN, and APBD.
- Most recognized that there were systematic efforts to secure resources for this population, such as was done by CSOs, KPAK, and DHO, but the success rate of these efforts was low.

Dimension E. HIV/AIDS related regulation and policies

- Most recognized that there were written and verbal regulations related to HIV/AIDS prevention programs. These included Governor Decrees regarding access to rehabilitation centers and health services for IDUs, as well as the national strategic plan on HIV/AIDS prevention programs by the KPA.
- There were non-supportive regulations from the police department, which arrested anyone who brought needles. In court, needles were also used as evidence of a criminal act. However, a letter of support has been issued by the East Jakarta Police Department to secure the use of needles by the IDU population.

Dimension F. Leadership

- All members of the community, except KPAK personnel, felt that support for HIV/AIDS prevention programs for IDUs from appointed and community leaders was very limited.
- All parties except CSOs were aware of the appointed leaders who had worked on securing funds for the continuation of HIV/AIDS prevention programs (e.g. KPAK, DHO, and GF).

3.3 IDU communities in Central and South Jakarta

The informants included representatives of IDUs and personnel from the following groups: a) Layak (CSO); b) PKM Gambir (service provider); c) Tarakan hospital (service provider); d) Sudinkes Jakarta Pusat; e) Sudinkes Jakarta Selatan; f) KPA Kota Jakarta Pusat; g) KPA kota Jakarta Selatan; h) GF SR DHO; and i) GF SR CSO.

Table 3 provides the overall scores of IDU community readiness in Central and South Jakarta. Some stakeholders (e.g., DHO and GF SR) rated the IDU's knowledge of HIV/AIDS higher than other informants. Similar patterns as seen in other IDUs communities, the IDU population and CSO personnel reported limited supportive HIV/AIDS-related regulations and policies, as well as weak leadership, an opinion that was not shared by the majority of stakeholders.

The average score of 5.1 indicates that the community is in the advanced implementation stage. In this stage, HIV/AIDS prevention efforts are in place, but efforts to address this issue are not optimal. The IDU populations' involvement is limited. The resources and leadership regarding HIV/AIDS-related programs need to be improved.

Table 3. The overall scores of IDU communities in Central and South Jakarta

Interview	MARP	CSO	Service providers	DHO	KPAK	GF SR (DHO)	GF SR (CSO)	Average score
Dimension A	5.5	6.3	6.5	7	5	6	7.5	6.3
Dimension B	4.5	5.5	4	5.75	5	6.5	6.25	5.4
Dimension C	4	4.8	4	4.5	5.5	6	6.25	5.0
Dimension D	5.25	4.5	4	6	5	6	5.25	5.1
Dimension E	3	3.8	5.5	4.5	4	5	5	4.4
Dimension F	3	4	4.5	4	5	5	6.5	4.6
The overall score: 5.1 (Advanced implementation stage)								

Dimension A. The IDUs' knowledge of HIV/AIDS

- Almost all segments of the community recognized that IDUs have a high level of knowledge about HIV/AIDS. However, some misconceptions regarding HIV transmission still exist. Some believed that they can tell that a person had AIDS by looking at their physical appearance. The sources of HIV information were CSOs and service providers. The information received included the modes of HIV transmission and its means of prevention, as well as HIV testing and treatment.
- The majority reported that the IDU population knew other HIV infected IDUs.
- All parties except the IDU population could mention the HIV prevalence among this group, which ranged between 50 to 90%. This number was obtained through VCT and surveillance.
- Almost all knew about HIV-related services for IDUs, but only a small fraction knew how to access it. This, however, was not the case according to the KPAK personnel, who believed most IDUs knew how to access those services.
- Most knew that this population can transmit and acquire HIV. Only small numbers of the IDU population were aware of the comprehensive HIV/AIDS prevention programs for this population.

Dimension B. Community knowledge about HIV/AIDS efforts

- All segments of the community, except service providers, revealed that IDUs recognized HIV/AIDS is a problem. This also applied to the availability of individual and group efforts to lower HIV transmission, which included CSOs and KPAK. However, the involvement of the IDU population in these programs was very limited (e.g., only as an intervention target).
- None recognized any key figures actively involved in the HIV prevention efforts.

Dimension C. Existing HIV/AIDS prevention efforts

- There were comprehensive HIV/AIDS programs in the community, provided by CSOs and PKM. These included NSP, VCT, ARV distributions, TB/HIV and STIs. According to the IDU population, the accessibility and quality of these programs were moderate. VCT was the most accessible to the IDUs in this area. Likewise, the highest quality was for ARV supply and distribution. In contrast, most CSOs and stakeholders revealed that the accessibility and quality of HIV/AIDS prevention programs in this community were good. Both the IDU population and CSOs said that outreach activities were the most accessible for IDUs, followed by condom distribution and TB/HIV. Both also mentioned low access to the ARVs supplied. They also said the quality of these services needs to be improved. Meanwhile, most stakeholders said that the IDU populations have high accessibility to and good quality of the HIV/AIDS programs.
- All segments of the community, except the IDU population, were aware that there were annual work plans on HIV prevention programs, particularly from CSOs, GF, HCPI and KPAK. All recognized that the IDU population has not been involved in the planning process. Despite this, some believed that the program has been evaluated regularly but the quality of the program was far from the expectation.

Dimension D. Resources related to HIV/AIDS prevention efforts

- Resources (e.g., people, money and facilities) were available to prevent HIV/AIDS in this community, but fund availability was limited. The largest sources of funds were the GF and HCPI. Most funds went to the service providers. There were limited funds available for CSO activities.
- Opinions regarding efforts to ensure continued funding varied. The CSOs and service providers said no one worked on this issue, but others said otherwise.

Dimension E. HIV/AIDS related regulation and policies

- Most admitted that there were written and verbal regulations related to the HIV/AIDS prevention programs. However, non-supportive regulations and discrimination toward the IDU population still existed. This included mandatory HIV testing when applying for a job.

Dimension F. Leadership

- All members of the community admitted that the appointed leaders were supportive of HIV/AIDS prevention programs for IDUs, but the attitude of community leaders was not very supportive.
- Most stakeholders were aware that the appointed leaders were working on securing funds for the continuation of HIV/AIDS prevention programs (e.g., KPA and DHO). However, the IDU population, CSOs and service providers said otherwise.

3.4 FSW Communities in West Jakarta

The informants included representatives of the FSW population and personnel from the following groups: a) Yayasan Kusuma Buana (CSO); b) PKM Mangga Besar (service provider); c) Sudinkes Jakarta Barat (DHO); d) KPA Kota Jakarta Barat; f) managers/owners of entertainment establishments; g) *Pokja lokalisasi*; h) GF SR DHO; and i) GF SSR Tegar.

Table 4 provides the overall scores of FSW community readiness in West Jakarta. The findings show varied opinions regarding each dimension. For example, the FSW population, CSO personnel, and the representatives of service providers and GF SR reported lack of resources related to HIV/AIDS and supportive HIV/AIDS-related regulations and policies in the community. Interestingly, good leadership related to HIV/AIDS was reported by the FSW population and CSO personnel, whereas service providers' representatives were of a different opinion. Service providers also scored all other dimensions low. By contrast, GF SR reported higher scores on all dimensions than other stakeholders (e.g., DHO and KPAK).

The average score of 4.7 indicates that the FSW communities in this area are at the implementation stage. In this stage, HIV/AIDS-related services and policies are in place, but efforts need to be improved. Resources related to HIV prevention efforts are also limited. There was not enough support from stakeholders and the establishment owners for FSWs to change their behavior. Meanwhile, almost all FSWs have heard about HIV/AIDS, but their understanding of transmission and prevention needs to be improved. The FSW population in this area has low knowledge about how HIV/AIDS is transmitted. Moreover, the majority of FSWs in West Jakarta did not adopt proper HIV risk reduction strategies. Ineffective HIV prevention strategies, including regular antibiotic injections, were still practiced.

Table 4. The overall scores of the community of FSWs in West Jakarta

Interview	MARP	CSO	Service Provider	DHO	KPAK	GF SR (DHO)	GF SR (CSO)	Managers / owners	Pokja lokalisasi	GF SSR	Ave score
Dimension A	5	7	3	6	6	5	7.5	5	5	7	5.7
Dimension B	4	6	3	5	5	5	6.25	5	6	6	5.1
Dimension C	4	5	3	5	4.5	5	5.5	4	6	4	4.6
Dimension D	3	3	3	6	4	6	5.25	3	3	3	3.9
Dimension E	3	4	3	5	4	5	5	4	4	3	4.0
Dimension F	6	6	2	4	4	5	6.5	5	6	4	4.9
The average score: 4.7 (Implementation stage)											

Dimension A. The FSWs' knowledge of HIV/AIDS

- The majority of the FSW populations have heard about HIV/AIDS, except for newcomers to FSWs. The sources of information regarding HIV/AIDS were outreach workers, peer educators, IEC materials produced by health providers/CSOs, the managers/owners of entertainment establishments, and media (e.g., TV, magazines). Information received included modes of HIV transmission (e.g., sexual intercourse without a condom and sharing needles), prevention, basic information on STIs, VCT, and the referral system for HIV/AIDS-related services.
- The majority of FSWs knew the modes of HIV transmission and its means of prevention. The total population of FSWs in this area was 3,000. Out of 3,000, 2,000 FSWs have been reached. The most commonly known HIV transmission included vaginal and anal intercourse without use of condoms, sharing needles, and having sex with bisexual men. However, significant numbers of FSWs still believed that HIV can be transmitted by mosquitoes and that they can detect HIV infection by simply looking at the physical appearance of their clients. Their action taken to reduce their risk for HIV was also low. For example, condom use among this group differed by type of partner, with a higher tendency of condom use when the client was commercial and not regular.
- No FSWs knew other HIV positive FSWs. FSWs did not know the HIV prevalence among this group, but most stakeholders reported that HIV prevalence among this group ranged from 6% to 19%. This prevalence was based on the VCT and surveillance results.
- The majority of FSWs can name several HIV/AIDS-related services, which included outreach activities, behavior change communication, condom distributions, STIs,

VCT and antibiotic and vitamin injections. The majority of FSWs knew how to access those services (e.g., its operating hours and procedures).

- Most FSWs knew that they can transmit and acquire HIV. A few knew if there was a comprehensive HIV/AIDS program for the population.

Dimension B. Community knowledge about HIV/AIDS efforts

- A few FSWs believed that HIV/AIDS is a problem. According to the CSO personnel, they were more concerned about STIs than HIV due to the severity of most STIs and its consequences (e.g., loss of income by not serving any clients). There were individual and group efforts from the population to reduce HIV transmission among this group. These efforts, however, were still limited. These included routine STI and HIV tests (every three months), and condom promotion.
- There were several organizations and multiple stakeholders that helped the population in their prevention efforts. These included CSOs, service providers, DHO, KPAK, and local policemen. The services included a mobile clinic that provided regular STI and HIV/AIDS-related services to FSWs in this area. FSWs were involved as intervention targets.
- Most reported there were key figures who were involved in the efforts. The FSW population named several criteria in selecting key figures, which included: 1) having a good disposition; 2) seniority; and 3) be able to approach male clients. The job description included: 1) promoting safe sex; 2) being a role model; and 3) assisting their peers in seeking HIV/AIDS-related services. The FSW population viewed the key figures positively as people who communicate easily and were good listeners. Likewise, outsider views of these key figures varied. Some viewed them as influential people who liaised between the FSW population and stakeholders. Others viewed them as barriers to the HIV/AIDS prevention efforts because their seniority made others reluctant to discuss their HIV/AIDS-related problems and/or needs.

Dimension C. Existing HIV/AIDS prevention efforts

- There were several HIV/AIDS-related services available to the population since 2005. These included: outreach activities, behavior change communication, condom distributions, STI and VCT services, and ARV distributions. Most said that these services have good accessibility and quality.
- Few mentioned the availability of HIV/AIDS program annual work plans for this group. These included CSOs, KPAK, and DHOs with funding from APBD, GF and HCPI.
- A majority of the community reported that the FSW population has not been involved in the HIV/AIDS program planning. Most programs have clear targets and indicators, but the targets have not been reached. Few mentioned that the programs have been evaluated regularly.

Dimension D. Resources related to HIV/AIDS prevention efforts

- Almost all segments of the community recognized that the existing human resources for the HIV/AIDS prevention efforts were moderate, but there were limited facilities and funds. The biggest resources were from CSOs and DHO.
- Opinions regarding systematic efforts to secure resources for the continuation of HIV/AIDS prevention programs among this group varied. *Pokja lokalisasi* and DHO said there were no systematic efforts, but others said otherwise. The success rate for this effort was low. Furthermore, *pokja lokalisasi* suggested forming a team that consisted of members from all parties (e.g., CSO, DHO and KPAK). This team would do regular monitoring and work together on ensuring the success of the program.

Dimension E. HIV/AIDS related regulation and policies

- Most recognized that there were written and verbal regulations related to HIV/AIDS prevention programs. These included the Batavia MoU regarding HIV prevention through sexual transmission (PMTS), supportive local regulations to allow establishment owners to actively participate in HIV prevention efforts without jeopardizing their business, universal access to health services, pick up and drop off services available to help the FSW population to access VCT, routine screening and treatment of STIs, as well as HIV testing. However, non-supportive regulations still existed. These included the fact that most of the time this population became a target of the policemen or local religious groups who disapprove of prostitution. Additionally, they were required to pay registration fees when accessing HIV/AIDS-related services, and the fees increased from time to time.

Dimension F. Leadership

- There were not many supportive appointed and informal leaders to combat HIV transmission among this group. Despite this, several appointed leaders have worked on securing funds for the continuation of HIV/AIDS prevention programs among this group (e.g., KPAK, CSOs, service providers and DHO).
- Lack of support from policemen was also reported. Their level of support/protection was still based on how much money was given by the pimp.

3.5 FSW communities in East Jakarta

The informants included representatives of the FSW population and personnel from the following groups: a) Yayasan Bandungwangi (CSO); b) Sudinkes Jakarta Timur (DHO); c) KPA Kota Jakarta Timur; d) Pimps; e) GF SR DHO; f) GF SR CSO; and h) GF SSR Tegar Tegar.

Table 5 provides the overall scores of FSW community readiness in East Jakarta. The findings show that the FSW population, CSO and GF SSR personnel shared similar opinions regarding all dimensions, except opinions regarding leadership. The FSW population and their pimp reported weak leadership in the community. Additionally, the pimp scored all

dimensions lower than the average score. KPAK personnel also reported lower score on community knowledge about HIV/AIDS efforts and resources related to HIV/AIDS prevention efforts. DHO and KPAK personnel also reported that the FSW's knowledge of HIV/AIDS was low, an opinion reported differently by other informants, particularly the FSW population, pimp and GF SR from CSO.

The average score of 4.6 indicates that the FSW communities in this area are in the implementation stage. In this stage, HIV/AIDS-related services and policies are in place, but insufficient. FSWs in this area have low knowledge about how HIV/AIDS is transmitted. Few had accurate knowledge about HIV transmission. For example, many believed mosquito bites can transmit HIV. Resources related to HIV prevention efforts are also limited. There was not enough support from stakeholders and pimps on HIV/AIDS prevention efforts in this population. Supportive HIV/AIDS related regulations and services need to be improved.

Table5. The overall scores of FSW communities in East Jakarta

Interview	MARP	CSO	DHO	KPAK	GF SR (DHO)	GF SR (CSO)	Pimps	GF SSR	Average score
Dimension A	7	6	4	4.5	5	7.5	6	7	5.9
Dimension B	6	6	4	3.5	5	6.25	3.5	6	5.0
Dimension C	4	5	4	4	5	5.5	3	4	4.3
Dimension D	3	3	6	3.5	6	5.25	3	3	4.1
Dimension E	2	3	5	4	5	5	3	3	3.8
Dimension F	3	5	4	6	5	6.5	2	4	4.4
The average score: 4.6 (Implementation stage)									

Dimension A. The FSWs' knowledge of HIV/AIDS

- The majority of FSW populations have heard about HIV/AIDS. The sources of information regarding HIV/AIDS were outreach workers, referral clinics (e.g., PKBI), and service providers. Information received included: basic information on STIs and HIV, HIV testing and referral services, condom use, reproductive health and empowerment.
- The majority of FSWs knew the modes of HIV transmission and its means of prevention. These included sexual intercourse without condom, oral sex, sharing needles, kissing and contact with infected blood/wounds. Half of FSWs believed that HIV can be transmitted through mosquito bites. Half of FSWs also reported that they could identify someone with HIV by simply looking at their appearances.

- Few FSWs knew other HIV positive FSWs. FSWs did not know the HIV prevalence among this group, but most stakeholders reported that HIV prevalence among this group ranged from 5 to 15%. This prevalence was based on the VCT and surveillance results.
- The majority of FSWs can name several HIV/AIDS-related services, including outreach activities, behavior change communication, condom distributions, STIs, pap smears, VCT and ARV distributions. Half of these FSWs knew how to access those services (e.g., their operating hours and procedures).
- Most FSWs knew that they can transmit and acquire HIV. No one knew about the comprehensive HIV/AIDS program for the FSW population.

Dimension B. Community knowledge about HIV/AIDS efforts

- The majority of FSWs considered that HIV/AIDS is a problem. There were individual and group efforts from the population to reduce HIV transmission among this group. These included condom promotion, not using any drugs, and assisting their peers to access HIV care. However consistent condom use was low. Out of 3,000 FSWs, 60 used condoms consistently.
- There were parties who assisted the population in their prevention efforts. These included pimps, CSOs and service providers. Their assistance included providing accurate information on HIV/AIDS, referral system to VCT, mobile clinics, and distribution of free condoms. FSWs were involved as intervention targets.
- Most reported there were key figures who were involved in the efforts. They included pimps, senior FSWs, and personnel from *pokja lokalisasi*. Their job descriptions included dissemination of HIV/AIDS information and related services, and condom supply and distribution. Most FSWs and outsiders positively viewed their role as peer educators.

Dimension C. Existing HIV/AIDS prevention efforts

- There were several HIV/AIDS-related services that have been available for the population since 2005. These included outreach activities, behavior change communication, condom distributions, STI and VCT services, and ARV distributions. Most said that these services have good accessibility and quality.
- There were institutions with annual work plans. These included CSOs, KPAK, and DHO with funding from APBD, GF and HCPI.
- A majority of the community reported that the FSW population has not been involved in HIV/AIDS program planning. Most programs have clear targets and indicators, but targets have not been reached. Few mentioned that the programs have been evaluated regularly.

Dimension D. Resources related to HIV/AIDS prevention efforts

- There were limited resources available for dealing with HIV/AIDS issues. Most of the resources available were people and space. The largest amounts of resources were from CSOs and DHO. The source of funding was the GF.
- There were parties who worked on securing resources for the continuation of HIV/AIDS prevention efforts. These included CSOs, KPAK and DHO. Their success rate was low.

Dimension E. HIV/AIDS related regulation and policies

- Most recognized that there were written and verbal regulations related to HIV/AIDS prevention programs. These included pick-up and drop-off services to the VCT clinics, routine screening and treatment of STIs, as well as HIV testing. However, non-supportive regulations still existed, such as most of the time this population was a target of the policemen or local religious groups who disapprove of prostitution. Additionally, they were required to pay registration fees when accessing HIV/AIDS-related services and the fees increased from time to time. Finally some pimps did not grant permission for the FSWs to attend HIV education sessions conducted by CSOs or VCT clinics.

Dimension F. Leadership

- There were not many supportive appointed and informal leaders to combat HIV transmission among this group. Despite this, several appointed leaders have worked on securing funds for the continuation of HIV/AIDS prevention programs among this group. These included KPAK, CSOs, service providers and DHO.

3.6 Transgender communities in Jakarta

The informants included the representatives of transgenders and personnel from the following groups: a) Yayasan Srikandi Sejati (CSO); b) PKBI health clinic (service provider); c) Sudinkes Jakarta Pusat (DHO); d) Sudinkes Jakarta Selatan (DHO); e) Sudinkes Jakarta Barat (DHO); f) Sudinkes Jakarta Timur (DHO); g) Sudinkes Jakarta Utara (DHO); h) KPA Kota Jakarta Pusat; i) KPA kota Jakarta Selatan; j) KPA Kota Jakarta Barat; k) KPA Kota Jakarta Timur; l) KPA Kota Jakarta Utara; m) GF SR DHO; n) GF SR CSO; and o) GF SSR Tegak Tegar.

Table 6 provides the overall scores of transgenders community readiness in Jakarta. The result shows that the transgender population rated almost all dimensions low, particularly on leadership. Although CSO personnel tended to have similar opinions to the transgender population, the results show a different opinion between two informants on existing HIV/AIDS prevention efforts, which was rated higher by CSO personnel than the transgender population. The representatives of KPAK and DHO also rated all dimensions lower than other stakeholders (e.g., DHO and GF SR), particularly on resources related to HIV/AIDS.

The average score of 4.9 indicates that the transgenders community is in the implementation stage. In this stage, HIV/AIDS prevention efforts are in place, but efforts are still limited. The transgender population and stakeholders have different views regarding the availability of resources, access and quality of the services. Despite familiarity with the existing HIV/AIDS-related services and programs, only small fractions of the population have accessed the services. Lack of HIV/AIDS comprehensive program was also observed in the community. Although the transgender population's perception of personal susceptibility to HIV was high, their actions taken to reduce their risk was low.

Table 6. The overall score of transgender communities in Jakarta

Interview	MARP	CSO	DHO	KPAK	GF SR (DHO)	GF SR (CSO)	GF SSR	Average score
Dimension A	7	7.5	5.1	5.5	6	7.5	7	6.5
Dimension B	6.25	7	4.7	4.2	5	6.25	5	5.5
Dimension C	3.5	6.5	4.4	4.7	6	5.5	4	4.9
Dimension D	3	3.75	6	3.8	6	5.25	3	4.4
Dimension E	3.25	3.75	5.1	4	5	5	3	4.2
Dimension F	2	3.5	3.9	5	4	6.5	4	4.1
The average score: 4.9 (Implementation stage)								

Dimension A. The transgenders' knowledge of HIV/AIDS

- The majority of transgenders have heard about HIV/AIDS. Most of them were familiar on how the virus is transmitted and prevented. A few had a misconception on the modes of HIV transmission (e.g., by mosquitoes and by looking at the appearance of others). The majority of transgenders knew other HIV positive transgenders.
- The majority of them were familiar with HIV/AIDS-related services and programs, but few have accessed the services. A few believed that the existing HIV/AIDS prevention programs for transgenders were comprehensive. Most transgenders knew that they can transmit and acquire HIV, but few did anything to reduce their risk for contracting HIV.
- Knowledge about HIV prevalence among this group varied. Some stakeholders mentioned the range was between 15-33%, others said it was more than 50%. The source of HIV prevalence was surveillance results.

Dimension B. Community knowledge about HIV/AIDS efforts

- Most informants believed that the transgender population has recognized HIV/AIDS is a problem, but there has been little individual or group efforts to lower HIV transmission among the population.
- There were organizations and health officers who helped the HIV/AIDS prevention programs. These included CSOs, KPAK, and DHO
- Opinions regarding key figures who were actively involved in the HIV/AIDS prevention program varied. Some believed there were key figures, but others said differently.

Dimension C. Existing HIV/AIDS prevention efforts

- All segments of the community agreed that there were comprehensive HIV/AIDS programs for the population, mainly provided by CSOs and PKM. These included outreach, ARV, condom distribution, STIs and VCT. The population thought the accessibility and quality of the programs were moderate, but stakeholders believed all programs have good quality and were easily accessed by the population. The sources of funding for the programs were GF and APBD, but the populations were not aware who provided the funding.
- All parties, but the transgender population, reported that the annual work plans for HIV/AIDS prevention efforts were available. However, they admitted that the population has not been involved in the planning programs. The majority believed the programs have not been evaluated properly. All believed that the target interventions and quality of programs were still low.

Dimension D. Resources related to HIV/AIDS prevention efforts

- There were not enough resources to combat HIV/AIDS in this community. Little has been done to ensure the continuation of resources for HIV/AIDS prevention among this group. Currently, GF and APBD are the source of funds.

Dimension E. HIV/AIDS related regulation and policies

- Most recognized that there were written and verbal regulations related to HIV/AIDS prevention programs. These included the national strategic plans of HIV/AIDS prevention programs and governor decrees regarding free access to health services. However, non-supportive regulations still existed. These included extensive requirements to access the free health services at the public hospitals and/or PKM. Furthermore, the population has to pay the co-payment. The population often became the target of the policemen or local religious groups who disapproved of prostitution.

Dimension F. Leadership

- All members of the community, except the transgenders population, recognized that the appointed leaders were supportive of HIV/AIDS prevention programs, but this was limited. The attitude of community leaders was not very supportive.
- Some were aware that the appointed leaders were working on securing funds for the continuation of HIV/AIDS prevention programs (e.g., KPA and DHO). However, the transgender population was not aware.

3.7 MSM communities in West, South and Central Jakarta

The informants included representatives of MSM and personnel from the following groups: a) Yayasan Inter Medika (CSO); b) PKBI health clinic (service provider); c) Sudinkes Jakarta barat (DHO); d) Sudinkes Jakarta Selatan (DHO); e) Sudinkes Jakarta Pusat (DHO); f) KPA Kota Jakarta Barat; f) KPA Kota Jakarta Selatan; g) KPA Kota Jakarta Pusat; h) GF SR DHO; i) GF SR CSO; and h) GF SSR Tegal Tegar.

Table 7 provides the overall scores of MSM community readiness in Jakarta. The findings show that the majority of informants rated low to moderate scores on each dimension. Only the representatives of GF SR rated most dimensions higher than the rest of informants. The MSM's knowledge of HIV/AIDS was rated moderately by the majority of informants. Only service providers rated high score on HIV/AIDS-related regulations and policies. Weak leadership continued to be the lowest score rated by the majority of informants, particularly the MSM population, CSO and DHO personnel.

The average score of 4.5 indicates that the MSM community in these areas is in the implementation stage. In this stage, HIV/AIDS prevention efforts are in place, but the community understanding regarding HIV/AIDS prevention efforts or what should be done to lower the transmission rate were varied. The MSM population in these areas has a good knowledge on HIV/AIDS prevention efforts. They also have a high level of involvement and ownership for the current HIV/AIDS prevention programs. However, the enabling environment needs to improve. There was a negative attitude from local religious groups and community leaders regarding their existence as a part of society. The CSO and stakeholder involvement in the efforts also needs to improve.

Table 7. The overall scores of MSM communities in West, South and Central Jakarta

Interview	MARP	CSO	Service provider	DHO	KPAK	GF SR DHO	GF SR CSO	GF SSR	Average score
Dimension A	5.5	5.5	5	4.3	5.3	5	7.5	7	5.6
Dimension B	3	3	3	4.9	5	5	6.25	5	4.4
Dimension C	4	3.5	5	4	5.2	6	5.5	4	4.6

Interview	MARP	CSO	Service provider	DHO	KPAK	GF SR DHO	GF SR CSO	GF SSR	Average score
Dimension D	3	3	3	6	4	6	5.25	3	4.2
Dimension E	3	3	7	4.7	4	5	5	3	4.3
Dimension F	3	2.5	5	3.5	4.7	4	6.5	4	4.1
The average score: 4.5 (Implementation stage)									

Dimension A. The MSM' knowledge of HIV/AIDS

- The majority of MSM have heard about HIV/AIDS. The sources of information regarding HIV/AIDS were outreach workers, peers, internet, and social networking websites (e.g., Facebook). Information received included the basic information about HIV, HIV transmission and prevention, and HIV testing and treatment. Additionally the social consequence of HIV/AIDS was discussed. This included dealing with discrimination and stigmatization for being MSM.
- The most common modes of HIV transmission known by MSM were sexual intercourse without condom and oral sex while having a wound in the mouth. A few have misconceptions about HIV transmission (e.g., HIV transmission can be transmitted by mosquitoes and they can tell someone has HIV by looking at their appearance). A few knew other HIV infected MSM.
- The MSM did not know the HIV prevalence among this group, but most stakeholders reported that the HIV prevalence ranged between 4-10%. This prevalence was based on the integrated biological and behavior survey (IBBS) among most-at risk population report in 2007.
- About half of the MSM knew where to get HIV/AIDS-related services, which included outreach activities, condom supplies and distribution, STIs and VCT. The majority of MSM knew how to access those services (e.g., their operating hours and procedures) but most stakeholders said that few MSM had accessed those services.
- Most MSM knew that they can transmit and acquire HIV, but few did anything to reduce their risk for contracting HIV. A few knew that there was a comprehensive HIV/AIDS program for MSM community.

Dimension B. Community knowledge about HIV/AIDS efforts

- Most MSM believed that HIV/AIDS is a problem. There were individual and group MSM efforts to reduce HIV transmission among this group. These included

dissemination of HIV/AIDS information to their peers, promoted HIV testing, and free condom distributions.

- Many parties were involved in these efforts (e.g., CSOs, DHO and KPAK). The activities included outreach, distribution of IEC (Information, Education and Communication) materials, condoms and lubricants distribution, as well as conducting regular tri-monthly meetings between CSO personnel and the MSM population.
- Most recognized that the MSM have actively been involved in the HIV/AIDS prevention efforts. They were not only involved as intervention targets, but also as planners and implementers of the programs. There were key figures who were involved in the efforts. Their involvement including dissemination of HIV information to their peers, helping their peers to access the HIV/AIDS-related services, and finding donors to fund HIV/AIDS prevention programs for this group. The majority of the MSM population and stakeholders said that these opinions leaders were very helpful and respectful.

Dimension C. Existing HIV/AIDS prevention efforts

- There were several HIV/AIDS-related services available for the community. These included outreach activities, condom distribution, a referral system for STIs and VCT, TB counseling and ARV distribution. According to the MSM population, the accessibility and quality of these programs were still low, especially ARV distribution. However, most stakeholders reported that the existing HIV/AIDS programs have good accessibility and quality for the target population.
- There were annual work plans on HIV/AIDS programs for this community, particularly CSOs and KPAK. The majority said that the MSM population knew the donors for HIV/AIDS programs. These included APBD, GF, and HCPI.
- Opinions regarding the involvement of the MSM population in HIV/AIDS program planning varied. Most stakeholders recognized that they have not been involved, but the MSM population and CSOs said that they were actively involved in the planning process. Their involvement included being a source of information during the meetings and implementer for several HIV/AIDS-related activities. They also said that most programs have clear targets and indicators, but the targets have not been reached due to lack of funding. These programs have not been evaluated.

Dimension D. Resources related to HIV/AIDS prevention efforts

- According to the MSM population, existing resources related to HIV/AIDS prevention efforts were low, but most CSOs and stakeholders said otherwise. Most funding came from donors such as USAID, GF, CSO and self-help.
- The MSM population was not aware of systematic efforts in securing funds for the continuation of HIV/AIDS prevention programs among this group. However, CSOs and stakeholders said otherwise. There were efforts to secure resources for continuing

HIV/AIDS prevention programs. These included KPAK, USAID, PKM and CSO. Their success rate was moderate.

Dimension E. HIV/AIDS related regulation and policies

- Most admitted that there were written and verbal regulations related to HIV/AIDS prevention programs. These included local regulations to ensure the availability of VCT in places where most-at risk populations congregate, and a MoU between several stakeholders and the CSO forum regarding HIV/AIDS prevention efforts among this group. Despite this, participation of male sex workers and gays was prohibited by some local religious groups, thus there is a high stigmatization among this group.

Dimension F. Leadership

- All members of the community reported that the appointed leaders were supportive of HIV/AIDS prevention programs. The attitude of community leaders was not very supportive. These leaders tended to not admit the existence of MSM groups as members of the society.
- The majority were aware that the appointed leaders were working on securing funds for the continuation of HIV/AIDS prevention programs among this group (e.g., KPAK and DHO).

3.8 MSM communities in East and North Jakarta

The informants included representatives of the MSM and personnel from the following groups: a) LPA Karya Bakti (CSO); b) PKBI health clinic (service provider); c) Sudinkes Jakarta Timur (DHO); d) Sudinkes Jakarta Utara (DHO); e) KPA Kota Jakarta Timur; f) KPA Kota Jakarta Utara; g) GF SR DHO; h) GF SR CSO; and i) GF SSR Tegak Tegar.

Table 8 provides the overall score of MSM community readiness in Jakarta. The result shows that the majority of informants revealed that the MSM population has high knowledge of HIV/AIDS. However, the representatives of DHO and KPAK said otherwise. Opinions on community knowledge about HIV/AIDS efforts were also varied. For example, the representatives of service providers, DHO and KPAK reported inadequate community knowledge about HIV/AIDS, an opinion that said differently by other informants (e.g. the MSM population and GF SR personnel). In terms of leadership, the representatives of DHO and GF SR reported weak leadership. This, however, was reported differently by CSO personnel, which considered leadership to be good in the community. By contrast, the MSM population revealed a very weak leadership related to HIV/AIDS issues in the community.

The average score of 4.7 indicates that the MSM communities in this area are in the implementation stage. In this stage, HIV/AIDS prevention efforts are in place, but they are limited. Little has been done to ensure the sustainability of the program and securing funds for the continuation of HIV/AIDS prevention programs. The environment needs to be more positive. Many disadvantageous regulations hampered the programs.

Table 8. The overall score of MSM communities in East and North Jakarta

Interview	MARP	CSO	Service provider	DHO	KPAK	GF SR DHO	GF SR CSO	GF SSR	Average score
Dimension A	7	7.5	5	3.25	3.75	5	7.5	7	5.8
Dimension B	6	5	3	2.5	3	5	6.25	5	4.5
Dimension C	3	4.5	5	4.75	3.75	6	5.5	4	4.6
Dimension D	3.5	3.5	3	6	3.5	6	5.25	3	4.2
Dimension E	3	3	7	5.5	4	5	5	3	4.4
Dimension F	2	5	5	3.75	5.5	4	6.5	4	4.5
The average score: 4.7 (Implementation stage)									

Dimension A. The MSM' knowledge of HIV/AIDS

- The majority of the MSM have heard about HIV/AIDS. The sources of information regarding HIV/AIDS were outreach workers, peers, IEC materials, and media (e.g., newspaper, TV, internet and radio). Information received included the basic information about HIV, HIV transmission and prevention, HIV testing and treatment, and peer support.
- The majority of MSM knew the modes of HIV transmission and its means of prevention. These included sexual intercourse without a condom, blood transfusions and sharing needles. A few had misconceptions about HIV transmission (e.g., HIV can be transmitted by mosquitoes or that they can tell someone has HIV by looking at their appearance). A few knew other HIV infected MSM.
- The MSM did not know the HIV prevalence among this group, but most stakeholders reported that HIV prevalence among this group was around 9%. This prevalence was based on the VCT and surveillance result.
- About half of the MSM knew where to obtain HIV/AIDS-related services, which included outreach activities, condom supplies and distribution, mobile clinics, STIs and VCT. The majority of MSM knew how to access those services (e.g., their operating hours and procedures).
- Most MSM knew that they can transmit and acquire HIV, but few did anything to reduce their risk for contracting HIV. A few knew that there was a comprehensive HIV/AIDS program for the MSM community.

Dimension B. Community knowledge about HIV/AIDS efforts

- Most MSM believed that HIV/AIDS is a problem. There were individual and group efforts from the population to reduce HIV transmission among this group. These included dissemination of HIV/AIDS information to their peers, promoting HIV testing, peer support groups, and suggesting to their peers to reduce their number of sexual partners and practice safe sex.
- Many parties were involved in these efforts (e.g., CSO, DHO, and KPAK). The activities included outreach, behavior change communication, IEC materials, condoms and lubricants distribution, as well as funding to support peer support groups.
- Almost all segments of the community admitted that MSM have been involved in the HIV/AIDS prevention efforts, both as intervention target and outreach worker. Most reported there were no key figures involved in the efforts. However, informants from the GF and DHO reported otherwise. They said that the key figures assisted in the access to HIV care and as a source of HIV information and the availability of funding.

Dimension C. Existing HIV/AIDS prevention efforts

- There were several HIV/AIDS-related services available for the community from 2007 until now. These included outreach activities, condom distributions, STI and VCT services, and ARV distributions, and several public hospitals in the areas (e.g., Persahabatan, Cipto Mangunkusumo and Tarakan). Most believed that the accessibility and quality of these programs were good.
- There were annual work plans on HIV/AIDS programs for this community, particularly from, CSOs, DHO, and KPAK. The majority said that the MSM population knew the donors for these programs. These included APBD, GF, and HCPI.
- All except CSOs reported that the MSM population has not been involved in the HIV/AIDS program planning. Most programs have clear targets and indicators, but the targets have not been reached. A few mentioned that the programs have been evaluated regularly (every three months).

Dimension D. Resources related to HIV/AIDS prevention efforts

- Most believed that the existing human resources and facilities for the HIV/AIDS prevention efforts were moderate. However, funding for most programs was still limited. Most funding came from donors such as USAID, GF, CSO, UNFPA, etc.
- The MSM population was aware of systematic efforts in securing funds for the continuation of HIV/AIDS prevention programs among this group. These included KPAK, USAID, PKM and CSO. Their success rate in obtaining more funds was moderate.

Dimension E. HIV/AIDS related regulation and policies

- Most admitted that there were written and verbal regulations related to HIV/AIDS prevention programs. These included local regulations to ensure access to HIV care for the most-at risk population and national strategies for HIV programs. Despite this, local religious groups and policemen have regulated the raiding of several entertainment places where most MSM congregate, particularly during special occasions such as the fasting month and election days. Having condoms was used as evidence of prostitution.

Dimension F. Leadership

- All members of the community reported that the appointed and informal leaders were supportive of HIV/AIDS prevention programs.
- The majority were aware that the appointed leaders were working on securing funds for the continuation of HIV/AIDS prevention programs among this group (e.g. KPA, CSO and DHO).

IV. CONCLUSIONS AND RECOMMENDATIONS

The findings of this assessment show that opinions regarding each dimension varied across the eight communities in Jakarta. Despite this, a similar pattern of opinions was observed. For example, the first layer of informants (e.g., the MARP population and the representatives of CSO and service providers) tended to have similar opinions on the resources related to HIV/AIDS, the availability of supportive HIV/AIDS regulations and policies as well as leadership), an opinion that usually was not shared among the majority of second layer of informants (e.g., the representatives of DHO, KPAK and GF SR). However, almost all agreed that the MARPs' knowledge of HIV/AIDS was adequate, but their understanding of transmission and prevention needs to be improved.

The results further show that out of eight communities at the targeting intervention areas, only two communities are at the advanced implementation (e.g., IDU communities in West and North Jakarta and IDU communities in Central and South Jakarta). The rest of the communities are at the implementation stage (e.g., IDU communities in East Jakarta; FSW communities in West Jakarta; FSW communities in East Jakarta; Transgender communities in Jakarta; MSM communities in West, South and Central Jakarta; and MSM communities in East and North Jakarta). It is recommended that each community prepares a strategic plan based on their readiness to address HIV/AIDS prevention efforts.

The majority of the MARPs have knowledge of HIV/AIDS transmission and prevention, but few did anything to reduce their risk for contracting HIV. Significant numbers of MARPs still believed that HIV can be transmitted by mosquitoes and that they can detect HIV infection by simply looking at the physical appearance of others.

There were several HIV/AIDS-related services available for the MARPs, but the accessibility and the quality of each service needs to be improved. The comprehensive HIV/AIDS prevention programs in most communities were still limited.

It is recommended to encourage more individual and group efforts from MARPs to reduce HIV transmission in their groups. They also need to be involved in HIV/AIDS prevention programs not only as the targets of intervention but also implementers, thus increasing ownership of the program. Continuing collaboration efforts to multiple stakeholders are required to secure funds and other resources for the continuation of the HIV/AIDS prevention program. The HIV/AIDS-related regulations and policies should be in favor of the MARPs.

Clearly further work should be done to increase: 1) MARPs' knowledge regarding the correct modes of HIV/AIDS transmission and prevention; 2) access to HIV care as well as the quality of each type of care; 3) MARPs' involvement in the HIV/AIDS program planning and evaluation; 4) supportive regulations and policies related to HIV/AIDS prevention efforts; and 5) resources (people, money, time and space) to ensure the continuation of HIV/AIDS prevention programs in each area. Finally, one important precursor to this effort is the changing of local regulations regarding prostitution and the exchange of clean needles and condom distribution. Another is providing support to the MARPs, establishment owners and pimps/*mami*, so they will not be prosecuted when trying to adopt and/or support the proper HIV risk reduction strategy.

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