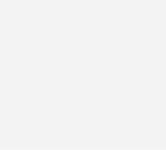
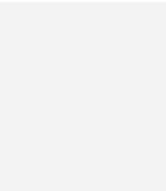




FAMILY HEALTH INTERNATIONAL

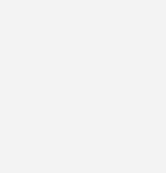


AKSI STOP AIDS PROGRAM

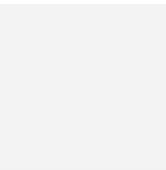


Year Four Workplan

October 1, 2008 – September 30, 2009



Approved: October 14, 2008



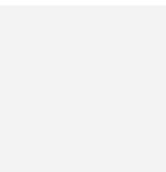
A Joint Program for HIV/AIDS Prevention, Care, Support, and Treatment
funded by

The United States Agency for International Development,
The Global Fund to Fight AIDS, Tuberculosis and Malaria, and
The Indonesian Partnership Fund for HIV/AIDS

in collaboration with

The Indonesian National AIDS Commission
and

The Indonesian Ministry of Health



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ABBREVIATIONS USED IN THE WORKPLAN

ADPEL	Port Administration Authority
APRO	Asia Pacific Regional Office
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
HCPI	HIV/AIDS Cooperative Program Indonesia (AusAID)
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
ILO	International Labor Organization of the United Nations
IMAAI	Integrated Management of Adult/Adolescent Illnesses
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
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
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
<i>Waria</i>	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 Four of the joint program, October 1, 2008 to September 30, 2009. 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, 2009.

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 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 August 2008 to extend the program for one additional year until September.

All USAID funded activities will continue to follow 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 their 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.

The contract between UNDP/Indonesian Partnership Fund and FHI has been extended until December 31, 2008 at no additional cost. Implementation of all subagreements funded under this contract will end by September 2008, and are therefore not included in this workplan although some support activities including close out procedures will continue until December 2008.

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.

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, and the national prison system 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.

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. In Tanah Papua (consisting of the two provinces of Papua and West Papua), the epidemic has already spread to the general population, with as estimated 2.4% of the general population being infected as of 2006.

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.

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 eight target provinces and at least 40% of the general population in Papua with two effective interventions. A major emphasis in Year Four is to ensure that this extensive coverage is 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 will be accomplished through a comprehensive and coordinated approach to delivering STI/HIV/AIDS prevention, 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. FHI and its partners will also help build institutional capacity to design and implement comprehensive programs for HIV/AIDS within the national prison system, an institution that has a critical role in play in reducing transmission of the virus. Overall program activities will focus on raising demand for prevention services and supplies; delivery of accurate and comprehensive information concerning the epidemic; and increasing the quality and coverage of outreach and peer education activities; and reducing barriers to accessing clinical services.

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 technical assistance to the development of an effective and efficient second generation HIV/AIDS surveillance system in Indonesia, as feasible.

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. Although interventions in Papua will no longer directly target the general populations, the focus in key MARG in Papua (sex workers and high-risk men in particular) will contribute towards reducing the incidence of STI/HIV/AIDS within the general population in Papua by shrinking the pool of HIV infection among FSW and thus limiting its spread to male clients, an important “bridge” population for accelerating the spread of HIV infection into the general population.

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 80 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

West P a p u a	East Java	West Java	
1 Fak-Fak District	1 Surabaya City	1 Bandung City	
2 Kaimana District	2 Sidoarjo District	2 Bandung District	
3 Teluk Bintuni District	3 Malang City	3 Cimahi City	
4 Manokwari 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	
P a p u a			
1 Merauke District	7 Kediri City	7 Cirebon City	
2 Jayawijaya District	8 Kediri District	8 Cirebon District	
3 Jayapura District	9 Pasuruan City	9 Sumedang District	
4 Nabire District	10 Pasuruan District	10 Depok City	
5 Biak Numfor District	11 Tulungagung District	11 Bekasi District	
6 Paniai District	12 Nganjuk District	12 Bekasi City	
7 Puncak Jaya District	13 Gresik District	13 Subang District	
8 Mimika District	14 Madiun City	14 Karawang District	
9 Mappi District	15 Madiun District	15 Tasikmalaya City	
10 Asmat District	DKI Jakarta		
11 Pegunungan Bintang District	1 West Jakarta	16 Indramayu District	
12 Keerom District	2 North Jakarta	17 Sukabumi City	
13 Jayapura City	3 East Jakarta	Central Java	
North Sumatera			
1 Medan City	4 South Jakarta	1 Semarang City	
2 Deli Serdang District	5 Central Jakarta	2 Semarang District	
3 Serdang Bedagai City	Kep. Riau		
4 Toba Samosir District	1 Tanjung Balai Karimun District	3 Surakarta City	
5 Tanjung Balai Asahan District	2 Batam City	4 Banyumas District	
6 Langkat District	3 Tanjung Pinang City	5 Tegal District	
7 Simalungun District	4 Bintan District	6 Batang District	
8 Pematang Siantar City		7 Pati District	
9 Dairi District		8 Kendal District	
10 Karo District		9 Salatiga 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 Four, with the results of the latest round of biological and behavior surveillance becoming the basis for review and refinement of all program strategies.

- **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 three years of the ASA program, October 2005 to September 2008, 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 80 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 completed, beginning with a ground-breaking survey among the general population in Papua in 2006 and the latest round among most-at-risk groups which was finalized in July 2008.
- **Substantial progress was made toward the achievement of program coverage targets.** “Outreach” targets for some MARG (female prostitutes and waria) have been reached or exceeded by the end of Year Three, and program strategies have been recently revised to focus more effort on reaching the targets for high-risk men, MSM and IDU during Year Four, 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.

Critical Changes in Program Strategy

Due to a dramatic decrease in financial resources available for Year Four, several major changes in program strategy will be instituted, including:

- **Surveillance will not longer be maintained as a component of the program.** The next round of surveillance for MARG, which is expected to commence in mid 2009, will be implemented by the MOH with funding from GFATM Round Four. FHI expects to be able to provide limited technical assistance to the MOH if requested.
- **General population prevention activities in Tanah Papua will be discontinued.** These important activities will be handed over to the new AusAID program, HCPI, which is charged with the responsibility to develop one, unified communication strategy for Papua under the auspices of the Provincial AIDS Commission and has been given the resources to implement behavior change communications based on the strategy across both provinces in Papua. FHI will actively contribute to the development of the communications strategy, and adjust all BCI activities for MARG in Papua to fit within this unified concept.
- **Increased attention to high performing partners.** During the initial stages of planning for Year Four, all partner organizations were evaluated based on a comprehensive list of indicators which included measures of both quantity and quality of program coverage, as well as management capacity, and only those organizations that were able to meet the stick criteria will be continued into Year Four.
- **Transitioning from a program assistance model to a technical assistance model to support HIV/AIDS clinical services.** During Year Four, ASA will no longer directly support the operational costs of government clinical service units, but will emphasize technical assistance and capacity building, with a major focus on helping the MOH to establish QA/QI systems for all major program components at all levels. FHI has discussed this transition with the Ministry of Health, provincial and district level health services, and all partner community health centers well in advance, and has worked with each to ensure that there will be minimal impact on the delivery of services in the field. In the vast majority of cases, the local health services have expressed gratitude for the support provided in the past, but readily admitted that it was now time for them to assume the responsibilities for all operational costs. In cases where the local budgets do not have sufficient funding allocated to cover these costs during the current financial year, FHI has negotiated transitional support, mainly in the procurement of reagents, until appropriate funding can be allocated in next year's budgets. FHI will continue to monitor the situation in the field, and will offer additional assistance as necessary.

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 64 with USAID funding and 18 with GFATM funds, 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, assisting the National AIDS Commission to develop a resource allocation model, and facilitating the development of a national MSM network. Additional areas for collaboration are being explored including working with the NAC on national condom policy and supply issues, helping to develop a national waria network, and policy work related to risk reduction for IDU.

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 new AusAID-funded *HIV/AIDS Cooperative Program for Indonesia (HCPI)* will continue to be an example 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 the Health Services Project managed by *John Snow Incorporated* for basic and reproductive health services. This will include development of PMTCT training modules and supporting materials based on the newly revised national guidelines and protocols; implementation of a national level training of trainers; and training and mentoring of PMTCT in selected community health centers. FHI will also continue close collaboration with TB-CAP managed by *KNCV* on tuberculosis prevention, diagnosis and treatment for PLWHA. Activities will include assisting with the development of TB/HIV working groups within the health services at the national and provincial levels, development of national guidelines and protocols, establishment of HIV/TB referral systems for prisons, and training of case managers, counselors, and community health center staff in the management of the co-infections.

The **Global Fund to Fight AIDS, Tuberculosis and Malaria** (GFATM) has also entered into a contract with FHI to fund prevention and care interventions for injecting drug users (IDU). These activities are scheduled to begin in September 2008 and continue through September 2009, with the goal of providing comprehensive risk reduction services to a majority of IDU in six provinces. These activities are not included as a formal part within this Workplan, but a brief description of them including proposed targets and a list of partner NGOs to be funded may be found in Annex IX.

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 have been 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.

A Note on Program Targets for Year Four

Several changes in the ASA Program in Year Four have had major implications for the program targets included in the workplan. First, because ASA funding from the Indonesian Partnership Fund ends as of December 2008, the reach and intensity of program activities in Year Four will necessarily have to be curtailed. The largest impact will be on the number of IAs supported by ASA, which will be reduced from 130 in Year Three to 64 in Year 4. In addition, program accomplishments will be constrained by the fact that implementation will be limited to nine months during the final year of FHI's Cooperative Agreement with USAID in order to allow adequate time for program close-out. Program targets have been adjusted accordingly to reflect what is thought to be feasible with reduced funding, fewer IAs and only a nine-month implementation period.

Second, because of a change in strategy in which ASA will no longer provide direct financial support to public sector health facilities (but will continue to provide technical assistance, mentoring and other forms of assistance), the number of outputs that are reportable as "downstream" results will be significantly reduced in comparison with the first three years of the program. However, while downstream results will decline significantly, the revised strategy under which ASA seeks to support health systems in priority provinces and districts is expected to result in significantly increased "upstream" results. Downstream results will continue to be reported quarterly, while upstream results will be reported semi-annually in connection with PEPFAR reporting.

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 annual 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 HCPI, 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 will also involve helping provincial and district level AIDS commissions as well as health services to report into and utilize the results of the national data base. 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 HIV Counseling and Testing (HCT)
- 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.
- Risk Reduction for IDU (using GFATM Funds)
- Community-Level Interventions: including community mobilization, local and central-level advocacy, interactive multimedia campaigns, edutainment and social marketing; 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.

1. Reducing STI/HIV Transmission in Commercial Sex

Focusing on female and male sex workers and their clients and partners, in Year Four 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 HCT.

A. Female Sex Workers

As in previous years, the priority will be on empowering female sex workers through better information concerning HIV/AIDS and how it is transmitted, 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 has provided 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 techniques for 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 by FHI staff on a regular basis.

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

- **Increased outreach quality and coverage.** The network of FHI partner NGOs delivering outreach and peer-led interventions to female sex workers (FSW) will be maintained across all target provinces. Each organization has been tasked with covering the majority of FSW in their respective areas 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. Emphasis will be placed on contacting new FSW as soon as possible after they begin working in a new site, and providing them with a “welcome package” of IEC materials and safer sex packages including condoms and lubricant, introducing them to the local health services, and inducting them into a peer support group. FHI will continue to work with selected implementing partners to better assess the motivation and ability of FSW 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. A priority will be placed on increasing the quality and effectiveness of these 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 NGOs 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 HCT, and to discourage self-treatment with antibiotics;
 - 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; and
 - The local AIDS commission to enhance their capacity to guide and support activities in the field, track implementation, and assist local “gatekeepers’ in problem solving.
- **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 and other condom producers, local governments, and the network of NGOs to develop more effective approaches to engage sex industry gatekeepers to increase the availability, accessibility, affordability and acceptability of condoms. 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;
- Implementing rapid situation assessments of condom availability across all priority provinces, developing appropriate condom supply and distribution strategies for each area, and developing tracking systems to monitor condom supply in collaboration with the NAC, the MOH and other relevant government sectors;
- Establishment of sustainable, local sources for procuring condoms in collaboration with DKT and other condom suppliers, and working with the condom suppliers to provide revolving funds to set up local vendors 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.
- **Increased STI screening and HCT.** Routine STI screening for all FSW will ensure lower levels of STIs and a lower risk of HIV infection. FHI will provide technical assistance to provincial and district level health services to expand and improve the quality of the local networks of clinics providing routine STI screening (at least four times a year) and treatment services to FSW in the target areas. FHI will also actively promote a new drug regimen for the treatment of STIs which should have a dramatic effect on STI rates across the program area. HCT 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 encouraged 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 (with continued direct support from ASA) 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/HCT services will be provided through mobile clinics, which will include simple lab facilities in order to provide a one-day service.

FHI will 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 eight priority provinces, and that overlap and competition among clinics is kept to a minimum. FHI will continue to provide technical assistance to 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.)

- **Pilot comprehensive community interventions.** FHI will continue to implement comprehensive community-based interventions for female sex workers in specific brothel complexes based on the successful model established in Malang, East Java and replicated in Tanjung Pinang, Riau Islands; Bekasi, West Java; Semarang, Central Java; and Banyuwangi, East Java during Year Three.

FHI will focus the combined resources of partner NGOs, local government, and local health services in implementing a model approach which includes:

- Establishment of a local “working group” consisting of stakeholders from within the brothel complex which is trained and mentored to manage the pilot activities. This should include establishing local regulations on condom use and uptake of clinical services and determining effective ways to track and reward adherence, as well as to organize recurring and reinforcing local promotional activities;
- Provision of user-friendly, accessible, inexpensive, and high quality local clinical services, especially for STI diagnosis and treatment and HIV counseling and testing;
- Mobilization of the entire brothel community including brothel owners, local shops and other small businesses, pimps, security personnel, and the local neighborhood government to understand and actively support all program activities and assist in establishing a strongly conducive environment;
- Assessment and establishment of sustainable, consistent, sufficient condom supply;
- Capacity building for the local AIDS commission to strengthen their ability to guide and support these pilot interventions in the field, as well as to tract, analyze, understand, and use specific monitoring data generated by these activities.

These pilots will be expanded during Year Four to include Tanjung Elmo in Papua, and other brothel complexes in each of the priority provinces as experience grows and resources become available.

- **Empowering Female Sex Workers.** FHI will also continue work with the Komisi Perempuan Indonesia (Indonesian Women’s Coalition) on a range of activities aimed at reducing STI infection and promoting consistent condom use, gender equality, and reproductive health. Working through its extensive network, KPI is focusing on empowering female sex workers 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 sex workers. 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 sex workers and the responsibility of local governments to affirm them. This will also serve as a strong advocacy tool to promote appropriate policy change at the

local level. These activities will continue in Jakarta and Central Java, and culminate in a National Workshop to share lessons learned and advocate for expansion.

Support activities

- FHI will continue to mentor all partner NGOs on behavior change skills based on the extensive training organized during Year Three, including the application of skills to analyze behaviors, identify opportunities for change and assess knowledge levels of individual target groups; the implementation of outreach methodologies and the management of peer education; and efforts to assess and improve program effectiveness.
- FHI will revise and update its communication strategy and develop appropriate IEC materials specifically for direct and indirect female sex workers.
- FHI will also organize a workshop on condom supply and use in each of the priority provinces for partner NGOs to identify ways to improve the effectiveness of condom promotion, assess the condom supply situation in all major hotspots, and find practical solutions to ensure that condoms are consistently available at all times.
- In collaboration with the National AIDS Commission, FHI will also organize a national workshop focusing on behavior change interventions for sexual transmission, including the lessons learned from ASA pilot activities, in order to raise awareness and begin the process of policy change and program expansion 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 fourth 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 sex workers; as well as businessmen and civil servants, who are the principal clientele of indirect sex workers.

Activities in Year Four will continue to incorporate the two principal strategies: outreach and a targeted media campaigns, augmented by delivery and/or facilitation of STI and HCT 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, transportation hubs, and construction and extraction industries.

Activities under the key strategies are outlined below:

- **Increased outreach quality and coverage.** Having previously identified 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. During Year Three, ASA conducted a comprehensive mapping of high-risk industries in all eight target provinces. The results will be the basis for Year Four action, which will focus on maintaining active, responsive workplace programs in companies currently collaborating with ASA. A priority will be to expand and strengthen behavior change communications, with an emphasis on one-on-one interpersonal dialogues, peer education, counseling, as well as increasing referrals to HCT 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.
- 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.
- **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 HCT 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/HCT training for port health officials. Implementation will be focused on key ports and highways from North Sumatra to East Java, and in Tanah Papua.
- **Targeted media campaigns.** FHI will continue to implement a series of targeted campaigns for high-risk men in workplace and non-workplace settings, prioritizing large ports, key transport routes in Java, and large transportation and natural resource companies. The purpose of the campaigns will be to intensify ABC messaging, increase demand for appropriate STI services and communicate the benefits of HCT 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 design developed in Year Three with the assistance of Matari Advertising Agency has been successfully implemented in Subang, West Java and Banyuwangi, East Java reaching several thousand high risk men in each area and stimulating reactivation of the local AIDS commissions. These campaigns specifically targeted high risk men, and used a variety of media including signboards in port areas, billboards along highways, and advertisements in truck stops, gas stations, and entertainment areas. A special “edutainment” event highlighting local music performances, dialogues on HIV/AIDS by local dignitaries, and HIV testing services were organized in each area in collaboration with local authorities and partner implementing agencies which 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 were also utilized. Additionally, partner NGOs provided direct outreach in ports, highways and entertainment areas and delivered messages that reinforced the campaign.

These very successful campaigns will be expanded within East Java and West Java, and extended to Central Java and Tanah Papua during Year Four.

Support activities

- FHI will organize a workshop for selected partner NGOs to exchange lessons learned during implementation of programs for high risk men and through the careful analysis of results refine strategies and approaches to reach this important target groups with more appropriate interventions.

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 Achievement (Up to Jun 2008)	Year 4 Target
Indicators				
A. Commercial Sex				
Outreach for Behavior Change				
- Female Sex Workers Reached (new contact)	32,287	94,731	119,508	150,000
- Female Sex Workers Repeated Contacts	69,050	323,917	478,032	750,000
- High Risk Men Reached through Outreach	46,467	307,796	640,633	750,000
- High Risk Men Reached through Events	214,463	523,085	807,428	1,000,000
- Pimps Educated	2,733	8,279	10,041	11,000
- Community Leaders Educated	1,403	11,261	15,945	18,500
- Average Active Peer Educators/Volunteers	580	1,160	1,742	1,750
- IEC/BCC Materials Distributed to High Risk Men	289,733	900,633	1,580,141	2,000,000
- IEC/BCC Materials Distributed to Female Sex Workers	40,669	130,750	200,937	250,000
- Condoms Distributed to High Risk Men (<i>For Promotional Purposes</i>)	257,558	647,700	827,162	1,000,000
- Condoms Distributed to Female Sex Workers (<i>For Promotional Purposes</i>)	94,842	328,749	509,294	600,000
- Condoms Distributed to Pimps/Local Stakeholder (<i>For Promotional Purposes</i>)	-	54,934	105,130	150,000
STI Services				
- Female Sex Workers Screened for STI (First Screening)	11,136	27,027	37,764	39,500
- Female Sex Workers Screened for STI (Total Screening)	25,402	71,907	112,823	121,000
- Female Sex Workers Received STI Treatment (Total STI Treatment)	18,696	63,198	95,244	105,000
- High Risk Men Received STI Treatment	667	3,533	4,759	5,400
VCT Services				
- Female Sex Workers Received Pre-Counseling Services	2,145	11,595	23,743	28,700
- Female Sex Workers Tested for HIV	1,863	10,102	21,075	23,600
- Female Sex Workers Received Post-Counseling Services	1,264	8,438	18,306	22,000
- High Risk Men Received Pre-Counseling Services	486	3,550	6,304	8,200
- High Risk Men Tested for HIV	464	3,381	5,880	6,700
- High Risk Men Received Post-Counseling Services	336	2,523	4,666	6,200
CST Services				
- Female Sex Workers Receiving Case Management Services	96	719	1,561	1,750
- High Risk Men Receiving Case Management Services	53	182	330	400

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

Partner Organizations for Commercial Sex

I. Commercial Sex			
No	Institution	Location	Activities
North Sumatera			
1	Pusat Pengkajian dan Pemberdayaan Masyarakat Nelayan (P3MN)	Medan	BCC for FSW and Clients in Hot Spot
2	Yayasan Solidaritas Perempuan Pekerja Seks (SP2S)	Deli Serdang and Serdang Bedagai	BCC for FSW and Clients in Hot Spot, Transvestites, and Case Manager
3	Yayasan Komunikasi Karya Anak Bangsa (KARANG)	Tanjung Balai Asahan	BCC for FSW and Clients in Hot Spot, MSM & Transvestites
4	Yayasan Penguatan Rakyat Pedesaan (PARAS)	Langkat	BCC for FSW and Clients in Hot Spot, MSM & Transvestites
5	Yayasan Peduli Buruh Independen (PBI)	Simalungun and Pematang Siantar	BCC for FSW and Clients in Hot Spot
6	Community Based Rehabilitation (CBR)	Medan	BCC for FSW and Clients in Hot Spot, MSM
7	Jaringan Kesehatan Masyarakat (JKM)	Medan, Deli Serdang and Serdang Bedagai	BCC for Transvestites, MSM, Client, Counselors and Case Manager
Riau Islands			
1	Yayasan Srimersing (YSM)	Karimun	BCC for FSW and Clients
2	Yayasan Bentan Serumpun (YBS)	Tanjung Pinang	BCC for FSW and Clients
3	Yayasan Batam Tourism Development Board (YBTDB)	Batam	BCC for FSW and Clients
DKI Jakarta			
1	Yayasan Kusuma Buana (YKB)	West, Central, & East Jakarta	BCC for FSW and Clients in Hot Spot
2	Yayasan Perkumpulan Bandungwangi	East Jakarta	BCC for FSW and Clients in Hot Spot
3	Institute for Community Development and Social Advocacy (ICODESA)	East Jakarta	BCC for FSW and Clients in Hot Spot
4	Perkumpulan Keluarga Berencana Indonesia (PKBI) Jakarta	East Jakarta	BCC for FSW and Clients; STI Services & VCT
5	Yayasan Karya Peduli Kita (KAPETA)	Central and South Jakarta	BCC for FSW and Clients in Hot Spot
6	Komisi Perempuan Indonesia (KPI)	Jakarta, Central Java, East Java, West Java	BCC for FSW
7	Yayasan Pelayanan Anak dan Keluarga (LAYAK)	Jakarta	Case Manager
8	Yayasan Tegak dan Tegar	Jakarta	Home Based Care
9	Yayasan Gema Indonesia	North Jakarta	BCC for FSW and Clients in Hot Spot
West Java			
1	Yayasan Mitra Sehati	Bekasi	BCC for FSW and Clients
2	Yayasan Gerakan Penanggulangan Narkoba dan Aids (YGPNA)	Cianjur, Sukabumi	BCC for FSW and Clients
3	Lembaga Swadaya Masyarakat (LSM) Warga Siaga	Cirebon City and Cirebon District	BCC for FSW and Clients;
4	Himpunan Konselor HIV/AIDS (HIKHA) Jawa Barat	Bandung City, Sumedang and Subang District	VCT
5	Tbd	Bandung City	BCC for FSW and Clients
6	Yayasan Kita Kita	Karawang	BCC for FSW and Clients
7	Yayasan Resik Subang	Subang	BCC for FSW and Clients
Central Java			
1	Yayasan Fatayat Nahdatul Ulama (NU)	Tegal & Batang	BCC for FSW and Clients
2	Lembaga Kalandara	Semarang City	BCC for FSW and Clients
3	Lembaga Swadaya Masyarakat Tegakkan Empaty Gapai ASA dan Rasa Percaya Diri (TEGAR)	Salatiga City & Semarang District	BCC for FSW and Clients
4	Yayasan Solidaritas Perempuan untuk Kemanusiaan dan Hak Asasi Manusia (SPEKHAM)	Surakarta City	BCC for FSW and Clients
5	Lembaga Penelitian dan Pengembangan Sumberdaya dan Lingkungan Hidup (LPPSLH) Banyumas	Banyumas City	BCC for FSW and Clients
6	Perkumpulan Keluarga Berencana Indonesia (PKBI) Semarang	Semarang City, Kendal	BCC for FSW and Clients; STI Services & VCT

I. Commercial Sex			
No	Institution	Location	Activities
East Java			
1	Yayasan Media	Surabaya City, Gresik, Sidoarjo	BCC for Clients
2	Pusat Kesehatan Masyarakat (Puskesmas) Pembantu Putat Jaya	Surabaya City	BCC for FSW & Clients
3	Kelompok Kerja Bina Sehat (KKBS) Banyuwangi	Banyuwangi	BCC for FSW and Clients
4	Palang Merah Indonesia (PMI) Banyuwangi	Banyuwangi	BCC for FSW and Clients
5	Yayasan Genta Surabaya	Surabaya City, Sidoarjo, Gresik	BCC for FSW and Clients
6	Yayasan Bambu Nusantara	Madiun City & Madiun District, Nganjuk	BCC for FSW and Clients
7	Lembaga Paramitra	Malang City and District	BCC for FSW and Clients
8	Perkumpulan Suara Nurani (SuaR)	Kediri City and District	BCC for FSW and Clients
9	Yayasan Centre for Studying Milieu Development (CESMID)	Tulungagung	BCC for FSW and Clients
Papua			
1	Perkumpulan Keluarga Berencana Indonesia (PKBI) Jayapura	Jayapura District	BCC for FSW and Clients; STI Services & VCT
2	Yayasan Harapan Ibu (YHI)	Jayapura City	BCC for FSW, MSM, Clients
3	Perkumpulan Terbatas Peduli Sehat (Pt.PS)	Manokwari	BCC for FSW and Clients
4	Yayasan Sosial Pengembangan Kawasan Timur (YASOBAT)	Fak Fak	BCC for FSW and Clients
5	Tbd	Sorong	BCC for FSW and Clients
6	Yayasan Usaha Kesejahteraan Ekonomi Masyarakat Desa Indonesia (YUKEMDI)	Jayawijaya	BCC for FSW and Clients

2. Reducing HIV Transmission among MSM

The goal in Year Four will be to continue to expand and improve the quality of coverage to the key sub-target groups of waria, male sex workers, and other MSM. 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 HCT 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, dispersed, and hidden nature of the gay community in Indonesia and the urgent need to intensify BCC activities and uptake of health services, FHI has developed a state-of-the-art **website, itsmylifeclub.com targeting MSM**, as the core medium of targeted media campaign, which also includes special events at the community-level and interpersonal communications through outreach workers, as well as the distribution of collaterals (including a packages of condom and water-based lubricants). The website is aimed to provide information on different areas of interest for MSM and to generate interaction. Links to four hotline services combined with SMS gateways are being established. The website comprises the following sections: a forum for MSM; a chat room; personal ads; columns on lifestyle, sexual health and position preventions including role model stories; links and contacts to MSM-friendly prevention, care and treatment services; games; polls; quizzes; and a photo and video gallery. A forum for positive MSM is under construction. The columns will be updated on a regular basis by four experts in each area of interest. A positive MSM will also respond to

specific questions through the forum and update the specific column related to positive prevention. The campaign will be closely monitored in terms of coverage and acceptability throughout implementation.

- In Year Four, FHI will continue to **increase outreach quality and coverage**, working through its network of NGO partners. Increasing emphasis will be placed on the use of peer-level educators and the basic outreach skills that were reinforced during the BCI training course during Year Three. Strategies for scaling up both the extent and the quality of coverage will include the following:
 - In selected IAs working with MSM 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 provided by Satu Dunia during Year Three, several selected MSM implementing agencies, including IGAMA, Abiasa, and Gessang, have developed innovative approaches to using SMS gateways and web-based communications to promote HIV/AIDS awareness and preventions, specifically targeting MSM who are notoriously hard to identify and reach through traditional outreach activities. These activities will be continued and strengthened during Year Four.
 - 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 continue 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 other condom suppliers) and uptake of STI and HCT services. FHI is currently collaborating with the owners/managers of male massage establishments in Jakarta in the provision of BCC and STI/HCT services. In Year Four, advocacy will be intensified to increase their participation in implementing structural interventions by establishing regulations and supporting strategic activities such as BCC efforts, marketing condoms and water-based lubricants, and training of their employees. Owners/managers will be encouraged to take over the program and work directly with service providers and condom distributors to ensure sustainability.

Support activities

- A series of special community-based events will continue to be organized at gay venues in the larger cities across the ASA target provinces, such as the Heaven Club and Starlight Disco in Jakarta. These events will emphasize HIV/AIDS awareness, safer sexual practices, HIV testing and STI check-up through messages and approaches tailored to the gay community.

- A rapid assessment of drug use among MSM and waria will also be undertaken to help inform program strategies concerning this growing problem.
- A communication strategy and associated IEC materials will be developed specifically for the waria 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 Achievement (Up to Jun 2008)	Year 4 Target
Indicators				
B. MSM				
Outreach for Behavior Change				
- Waria Reached (new contact)	7,635	14,807	18,521	21,000
- Waria Repeated Contacts	21,662	83,892	222,252	300,000
- Community Leaders Educated for War a	480	1,480	2,133	2,500
- Gay Men/MSW Reached through Outreach (new contact)	14,481	43,374	102,353	110,000
- Gay Men/MSW Repeated Contacts through Outreach	18,980	99,672	168,731	248,731
- MSM Reached through Events	2,081	9,839	13,011	31,011
- MSM Reached through Web	1,731	6,134	8,846	26,846
- MSM Reached through Hotline	52	98	148	418
- Average Active Peer Educators/Volunteers for Waria	85	636	570	550
- Average Active Peer Educators/Volunteers for Gay Men/MSW	36	273	244	250
- IEC/BCC Materials Distributed to Waria	11,659	69,176	101,520	125,000
- IEC/BCC Materials Distributed to Gay Men/MSW	47,580	142,127	223,186	300,000
- Condoms Distributed to Waria (For Promotional Purposes)	133,715	569,713	797,439	1,000,000
- Condoms Distributed to Gay Men/MSW (For Promotional Purposes)	150,547	325,490	448,193	600,000
STI Services				
- Waria Screened for STI (First Screening)	1,115	3,008	4,575	4,900
- Waria Screened for STI (Total Screenings)	2,499	7,148	10,316	11,000
- Waria Received STI Treatment	836	4,816	6,470	7,200
- Gay Men/MSW Screened for STI (First Screening)	104	605	1,809	2,000
- Gay Men/MSW Screened for STI (Total Screening)	234	2,411	4,351	4,700
- Gay Men/MSW Received STI Treatment (Total STI Treatment)	56	2,075	3,236	3,600
VCT Services				
- Waria Received Pre-Counseling Services	538	1,949	4,061	5,100
- Waria Tested for HIV	536	1,895	3,962	4,500
- Waria Received Post-Counseling Services	472	1,611	3,419	4,400
- Gay Men/MSW Received Pre-Counseling Services	440	2,194	4,101	5,100
- Gay Men/MSW Tested for HIV	427	2,042	3,866	4,300
- Gay Men/MSW Received Post-Counseling Services	370	1,727	3,320	4,000
CST Services				
- Waria Receiving Case Management Services	152	332	636	1,000
- Gay Men/MSW Receiving Case Management Services	3	106	307	500

Partner Organizations for MSM

II. MSM			
No	Institution	Location	Activities
North Sumatera			
1	Yayasan Solidaritas Perempuan Pekerja Seks (SP2S)	Deli Serdang and Serdang Bedagai	BCC for FSW and Clients in Hot Spot & Workplace, Transvestites, and Case Manager
2	Yayasan Komunikasi Karya Anak Bangsa (KARANG)	Tanjung Balai Asahan	BCC for FSW and Clients in Hot Spot & Workplace, MSM & Transvestites
3	Yayasan Penguatan Rakyat Pedesaan (PARAS)	Langkat	BCC for FSW and Clients in Hot Spot & Workplace, MSM & Transvestites
4	Jaringan Kesehatan Masyarakat (JKM)	Medan, Deli Serdang and Serdang Bedagai	BCC for Transvestites, MSM, Client in Workplace, Counselors and Case Manager
5	Community Based Rehabilitation (CBR)	Medan	BCC for FSW and Clients in Hot Spot, MSM

II. MSM			
No	Institution	Location	Activities
Riau Islands			
1	Yayasan Gaya Batam (YGB)	Batam	BCC for Transvestites & Gay Men
DKI Jakarta			
1	Perkumpulan Keluarga Berencana Indonesia (PKBI) Jakarta	East Jakarta	BCC for FSW and Clients; STI Services & VCT
2	Yayasan Intra Medika (YIM)	Jakarta	BCC for Gay Men
3	Yayasan Srikandi Sejati (YSS)	Jakarta	BCC for Transvestites & VCT
4	Lembaga Peduli AIDS (LPA) Karya Bakti	North and East Jakarta, Depok	BCC for Gay Men and MSW
5	Tbd	Jakarta	MSM Website
West Java			
1	Paguyuban Srikandi Pasundan (PSP)	Bandung City, Bandung, Cimahi	BCC for Transvestites
2	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 and MSW
3	Himpunan Konselor HIV/AIDS (HIKHA) Jawa Barat	Bandung City, Sumedang and Subang District	VCT
Central Java			
1	Perkumpulan Keluarga Berencana Indonesia (PKBI) Semarang	Semarang City, Kendal	BCC for FSW and Clients; STI Services & VCT
2	Lembaga Swadaya Masyarakat Graha Mitra	Selected districts (9 cities & districts)	BCC for Transvestites & Clients
3	Yayasan Gerakan Sosial, Advocacy dan Hak Asasi Manusia untuk Gay Surakarta (GESSANG)	Surakarta City	BCC for Transvestites Sex Workers and Clients
East Java			
1	Yayasan Gaya Nusantara (GN)	Surabaya	BCC for Gay Men
2	Lembaga Swadaya Masyarakat katan Gaya Arema Malang (IGAMA)	Malang City	BCC for Gay Men & Partners
3	Yayasan Persatuan Waria Kota Surabaya (Perwakos)	Surabaya City, Gresik, Sidoarjo, Jember, Madiun, Nganjuk	BCC for Transvestites
4	Kelompok Kerja Waria Malang Raya Peduli AIDS (KK WAMARAPA)	Malang City & Malang District	BCC for Transvestites
Papua			
1	Perkumpulan Keluarga Berencana Indonesia (PKBI) Jayapura	Jayapura District	BCC for FSW and Clients; STI Services & VCT
2	Yayasan Harapan Ibu (YHI)	Jayapura City	BCC for FSW, MSM, Clients

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 users, 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 Achievement (Up to Jun 2008)	Year 4 Target
Indicators				
# of Partner Organizations Attending Regular Coordination Meeting	67	127	133	80
# of Implementing Agencies Provided with Technical Assistance for Strategic Information Activities	78	132	132	80
# of Individuals Trained in Strategic Information (Incl. M&E, Surveillance and/or MIS)	303	977	1,084	1,244

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 Four, FHI's role will continue to change as the National AIDS Commission assumes greater responsibility for the development of the national, provincial and district AIDS commission network.

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

- 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, MSM, 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.

Monitoring by Indicators

Key indicators for this component include:

Result Area III: Strengthening the Institutional Response	Year 1 Achievement	Year 2 Achievement	Year 3 Achievement (Up to Jun 2008)	Year 4 Target
Indicators				
A. National, Provincial, District AIDS Commission				
# of KPAD with a Strategic Plan				
-Provincial	3	7	8	8
-District	21	53	58	58
# of KPAD with Active Secretariat				
-Provincial	5	7	8	8
-District	48	57	72	72
# of KPAD with an Annual Work plan				
-Provincial	4	7	8	8
-District	22	49	67	67
# of KPAD Implementing Regular Coordination Meeting				
-Provincial	6	7	8	8
-District	34	44	66	66
# of KPAD whose Budget is Increased over the Previous Year Relative to Overall Development Spending				
-Provincial	5	6	8	8
-District	36	40	42	42

2. Strengthening STI/HIV/AIDS Clinical Services

Support for clinical services will continue 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 Four, 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.

In the past, ASA has directly supported a number of strategically located clinics in each province, both technically and financially. As this model is no longer practical nor appropriate, ASA will transition from a “program assistance model” to a “technical assistance model”, wherein ASA will provide technical support to provincial and district health systems as a whole in priority provinces, and assist them to improve, expand, and better manage the networks of clinical services providers related to HIV/AIDS in their respective areas. FHI will actively collaborate with the MOH, the GFATM, and other donors at all levels to ensure that appropriate clinical services are available to the target groups in all “hotspots” in each of the eight priority provinces. FHI will also continue to provide technical assistance to all clinical services training organized by the MOH regardless of funding sources. Support will be focused on the development of one harmonized, effective, well-managed clinical network under the auspices of the MOH at each level.

Strategies and activities in Year Four will focus on the following:

A. Improvement of hospital and clinic networks for MARG in eight priority provinces.

FHI will support training, mentoring, and Quality Assurance/Quality Improvement assistance, in order to increase the capacity of STI/VCT clinic networks to align with the national monitoring, coordination, logistics and reporting systems and promote stronger management by local health systems. Accomplishing this will entail:

- **Assisting the MOH and local health services to build systems for basic health 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 facilitation and technical assistance for policy development; development of national guidelines, protocols, and standard operating procedures for each component of the continuum 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. Emphasis will be on provinces and districts that demonstrate their commitment by providing local resources for service delivery and cost-sharing capacity building expenses.
- **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, HCT, and CST service providers (including PMTCT) to ensure optimal synergies, rational allocation of resources, and adequate coverage of all crucial target groups; and

- **Facilitating the development of standard recording and reporting systems** throughout the health services at all levels, beginning with HCT and expanding into STIs and CST as quickly as possible, to ensure compatibility of data and the efficient tracking of services. FHI M&E staff are working with MOH staff in rationalizing the national health information system (HIS), as well as with several Provincial Health Offices and AIDS Commissions who have requested assistance in improving strategic information at the provincial level. This support will continue.

B. Continuum of care (CoC) for MARG in selected cities. ASA will support the development and implementation of several CoC sites, continuing in the pilot areas of Malang, East Java; Jayapura, Papua; and Sorong, West Papua; and expanding into Semarang, Central Java and Tanjung Pinang, Riau Islands. The primary focus of these services are MARG who are in need of prevention, care, support, and treatment services. Each site will consist of one district referral hospital linked to two to three satellite health centers. Each center will link to local NGOs or community groups to provide home-based and community care. Demand for services will be generated through intensive outreach efforts by NGOs working directly with MARG. While the delivery of such services is not new, emphasis will now be placed on the development of a replicable and sustainable model inclusive of training systems, manuals and protocols (both clinical and managerial) and community outreach materials. This initiative will include the following:

- **Integration of targeted TB/HIV and PMTCT (PMTCT Prong I and II)** into other services. All STI, HCT, and case management services for FSW, men who buy sex, IDU, and MSM/MSW (some MSM and MSW also have female partners) will include information and counseling on TB/HIV co-infection and the possibility of the client or their partner getting pregnant, the risk of transmitting STI or HIV to the baby, and available prevention measures. Both individual and couple counseling will be encouraged.
- **TB/HIV and 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 and Sumber Pucung 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 HCPI. In Papua, one-stop CoC services 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 referral hospitals. These services will target HIV-positive pregnant women, and will provide appropriate ARV treatment, safer delivery, medical follow-up of the newborn, and counseling on breast feeding and informed choice.
- **Basic health care services and addiction-related health services for 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.

C. Health systems strengthening in ten districts in Tanah Papua. In the extension year, FHI will continue expansion and improvement of CoC network sites from five to ten districts. As described above, CoC pilot sites connect the services of one district referral hospital to several satellite health centers, and these to community based support groups or NGOs whenever possible. FHI will also introduce provider-initiated HIV counseling and testing in Tanah Papua. 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 offered CCT and followed up with case management and CST for positive patients. Post-test counseling on prevention, STI screening and treatment will be provided to negative patients. ASA will also continue to work closely with other donor funded programs in Tanah Papua, including efforts to control the high levels of TB infection, STIs, malaria, poor maternal and child health services, low rates of basic childhood immunizations, and to increase access to safe water and sanitation services.

D. Palliative and home and community based care (HCBC) initiatives will be implemented in Jakarta and Papua as a first step in developing long-term care services for PLWHA followed quickly by expansion into East and West Java. A model program has been defined and appropriate training curriculum and management systems have been developed. Key components of the program include proactive linkages among PLWHA, case managers, clinical service providers and HCBC service providers, and home visit teams to provide direct care and adherence support in the community.

E. Strengthening integration of HIV and TB services: FHI will continue to work closely with the National TB Program (NTP) and KNCV, using TBCAP, GFATM and ASA funding, to support the implementation of national TB/HIV policies, guidelines, and strategic plans developed in prior years with FHI TA. ASA will continue to provide direct support for two TB/HIV clinics, PPTI in Jakarta and BP4 in Semarang. ASA will also assist in the development and implementation of training in TB for HIV clinical service providers and in HIV/AIDS for TB service provides in priority areas. Direct support through subagreements for high quality comprehensive HIV and TB clinical services at PPTI in Jakarta and BP4 in Semarang will also continue during Year Four.

Coordinated efforts between the National TB Program and the National HIV/AIDS Program within the prison system will also be pursued where feasible. With FHI assistance, a number of prisons have begun TB screening and treatment along with HCT with outsourcing of CST for HIV-positive prisoners.

Support activities

- FHI will organize **Workshops to Share Lessons Learned** among local stakeholders within the pilot PPT and Condom Use Intervention sites to analyze the process, evaluate results and determine appropriate next steps, as well as develop SOPs and associated training materials to use in the expansion of the approach to other areas.
- At the request of the MOH or local health services, FHI will also continue to facilitate **training for clinical care providers** in each priority program area using the standard

methodologies and curriculums developed previously with the expectation of significant cost sharing. These may include:

- **IMAAI Training** on acute, chronic, and palliative care.
 - **Training of Trainers (TOT) in STI clinical management** to deepen the pool of experienced trainers in support of national and provincial scale-up.
 - **Refresher Training for Master Trainers for VCT and Case Management** to further strengthen and build capacity within these important cadres of trainers.
 - **PMTCT** for selected staff from pilot sites in Jakarta, Papua and East Java.
- A new **Course in QA/QI for STI/HIV/AIDS Laboratory Technicians** will be developed in collaboration with the MOH Directorate for Laboratory Services and selected provincial laboratories to establish a quality control system in three pilot provinces.
 - FHI will also develop a new **Course on HIV Program Management** for provincial and district level health services including estimating most at risk population size, analysis of IBBS and other relevant data, program planning, reporting and recording, QA/QI, logistics and supervision.
 - **Training in Home and Community Based Care** as well as **Training in Positive Prevention** will be organized for select staff from partner NGOs and community health centers, and people living with HIV/AIDS in selected pilot areas.
 - In addition, FHI will also use USAID funding to procure additional US FDA approved **HIV test kits and STI reagents** as required to support selected clinics, hospitals, and pilot program sites during Year Four.

Monitoring by Indicators

Key indicators for this component include:

Result Area III: Strengthening the Institutional Response	Year 1 Achievement	Year 2 Achievement	Year 3 Achievement (Up to Jun 2008)	Year 4 Target
Indicators				
B. MoH Health Services Network				
- Number Districts with Enhanced Continuum of Care	-	-	-	3
- Number of STI Clinics	33	66	76	3
- Number of VCT Clinics	39	91	107	15
- Number of Hospitals and Other Health Facilities Trained and Mentored on CST	-	-	-	10
- Number of Staff Trained in Treatment or Care of HIV/AIDS	169	787	857	877
- Number of Individuals Receiving Community and Home Based Care	1,503	3,528	6,026	8,850
- Number of TB Patients Receive VCT Services	1,536	5,094	7,621	10,000
- Number of Staff Trained in STI Clinical Management	217	566	807	827
- Number of Individuals Trained in Counseling	175	382	495	515
- Number of Individuals Trained in Testing	71	163	184	204
- Number of Case Managers Trained	236	548	610	630
- Number of Districts with Integrated Monitoring System	-	-	-	5

Partner Organizations for Health Service Network

III. MOH Health System			
DKI Jakarta			
1	Perkumpulan Keluarga Berencana Indonesia (PKBI) Jakarta	East Jakarta	BCC for FSW and Clients; STI & VCT Services and CM
2	Kios Informasi Kesehatan Pusat Kajian Pembangunan Masyarakat UNIKA Atma Jaya	Central, West & North Jakarta	BCC for IDUs, Counselors and CM
3	Yayasan Pelayanan Anak dan Keluarga (LAYAK)	Jakarta	CST & Training
4	Perkumpulan Pemberantasan Tuberkulosis Indonesia Jakarta (PPTI)	Jakarta	VCT and CST Services
5	Yayasan Tegak dan Tegar	Jakarta	CM Services
West Java			
1	Himpunan Konselor HIV/AIDS (HIKHA) West Java	Bandung District, Bandung City, Sumedang District and Subang District	VCT
2	Yayasan Insan Hamdani-Bandung Plus Support (BPS)	Bandung District, Bandung City, Kerawang District, Subang District, Sukabumi City, Tasikmalaya City, Cianjur District, Cimahi City	Case Management Services
Central Java			
1	Perkumpulan Keluarga Berencana Indonesia (PKBI) Semarang	Semarang City, Kendal	BCC for FSW and Clients; STI Services & VCT
2	Balai Pencegahan & Pengobatan Penyakit Paru (BP4) Semarang	Semarang City and 6 Cities / District	VCT & Case Management Services
East Java			
1	Yayasan Hotline Surabaya	Surabaya Municipality	BCC for FSW, Clients & IDU; VCT, CST & Case Management
Papua			
1	Perkumpulan Keluarga Berencana Indonesia (PKBI) Jayapura	Jayapura District	BCC for FSW and Clients, MSM; STI Services, Case Management

3. Building Capacity: Cross Cutting Activities

During Year Four, FHI will continue to place a strong emphasis on building the capacity of all partner organizations involved in responding to the epidemic in each of the eight target provinces. This will include collaboration with the national, provincial and district level AIDS commissions, the Ministry of Health and the national prison system as outlined in the previous sections of this workplan; as well as specific work with each of the local NGOs funded by the program. These capacity building activities will include both formal training and one-on-one, on-site mentoring to ensure that appropriate knowledge and skills are thoroughly understood and put into actual practice. Since there has already been a significant investment in a large variety of training during the first three years of the program, the emphasis during Year Four will be on filling in the gaps with refresher training, but more importantly, providing practical mentoring in the application of improved skills in the field. Major issues to be addressed through these capacity building efforts include strategic information management, enlightened policy development, stigma and discrimination reduction, community mobilization for prevention and care, trafficking, program management and financial administration, and the appropriate branding of activities.

In addition to the various training activities to improve the technical skills of our various partners as detailed in previous sections, FHI will also organize the following:

- During the first quarter of Year Four, a series of provincial level workshops for all partner NGOs to focus on assessing condom availability and establishing effective

condom supply systems for each high risk group, and promoting the correct branding of all donor funded activities.

- FHI will organize a national level workshop on female drug users in collaboration with the NAC, HCPI, UNODC, partner NGOs, and a number of local women’s organizations to begin the dialogue to increase understanding and advocate for more interventions targeting is unique group.

Monitoring by Indicators

Key indicators for this component include:

Result Area III: Strengthening the Institutional Response	Year 1 Achievement	Year 2 Achievement	Year 3 Achievement (Up to Jun 2008)	Year 4 Target
Indicators				
C. Building Capacity: Cross Cutting Activities				
- Number of local organizations provided with technical assistance for strategic information activities	78	348	1,325	1,334
- Number of individuals trained in strategic information (includes HMIS, M&E, and/or surveillance)	303	1,478	1,585	1,686
- Number of local organizations provided with technical assistance for HIV-related policy development	54	875	1,862	1,871
- Number of local organizations provided with technical assistance for HIV-related institutional capacity building	85	875	1,862	1,871
- Number of individuals trained in HIV-related policy development	114	3,931	4,235	4,312
- Number of individuals trained in HIV-related institutional capacity building	143	4,485	4,774	4,992
- Number of individuals trained in HIV-related stigma and discrimination reduction	3	1,727	1,808	2,026
- Number of individuals trained in HIV-related community mobilization for prevention, care, and/or treatment	543	4,150	6,274	6,492

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 70% of technical and program staff placed in the provinces, and quality assurance through centralized, responsible financial, contracting, and reporting systems. A total of 65 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 USAID, UNDP and GFATM 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 2009 PEPFAR HIV/AIDS Implementer's Meeting in Viet Nam.

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:

- **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.
- **Jerry Marcellinus Winata** will provide assistance in managing the MSM website as well as on the design and implementation of other MSM support activities.
- **Tetty Rachmawati, 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.
- **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.
- **Jonathan Ronald** will assist in the training and mentoring of clinical service providers, especially in the areas of STI and CST.
- **Marcel Latuihamallo** will continue to support the strengthening of HIV/AIDS counseling through operational research and training.

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

VII. EXIT STRATEGY

As this is the final year of the FHI/ASA Cooperative Agreement with USAID, as well as the final quarter of funding under the Indonesian Partnership Fund, FHI is conscious of the need for a practical, appropriate Exit Strategy to ensure the sustainability of the important efforts in HIV/AIDS prevention and care currently supported by the program. Throughout FHI's work in Indonesia, the overall program strategy has been based on the premise that FHI's role is to assist the government and civil society to design and manage their own interventions to respond to the epidemic; and that this role would end one day. This approach has translated into the development of a large network of stronger, more experienced local organizations and government units that are ready to continue their individual programs in a coordinated manner following FHI's exit from the scene, if given the necessary opportunities, resources, and motivation.

FHI has worked closely with the National AIDS Commission and the provincial and district commissions in the eight program target provinces, offering strong technical assistance, guidance, and financial support during the beginning of the program. This support has decreased over time as these organizations have developed and strengthened. FHI's work with the Ministry of Health and other government sectors has always focused on assisting them to develop policies, guidelines, protocols, training programs and other management systems that are practical, consistent, and sustainable, although often start-up activities, pilots, and some training has required a larger cost share from FHI. All of these policies and systems are in place and should continue to be implemented for the near future, again if adequate resources are available.

FHI has also invested heavily in developing capacity of a large network of local NGOs across the country, with the very large majority able to continue their individual interventions following FHI's exit from a technical and management perspective, if adequate financial resources are available to them. All partner organizations are aware that their subagreements with FHI will end in June 2009. Prior to that date, FHI will assist each organization to identify prospective funding opportunities; facilitate contacts, provide references, and lobby possible donors; and help each organization to develop technically sound proposals responding to each donor's unique criteria. After years of collaboration with FHI, all of our partner organizations should have the technical capacity and management/financial systems in place to enable them to successfully compete for whatever funding becomes available in the future.

ANNEX I

Program Coverage Targets

Program Coverage Target

Riau Island

Most at Risk Populations (MARPs)	# Estimated Population of provinces*	# Estimated Population in hot spot districts	60% of provinces	ASA Coverage (Actual)	ASA Coverage (Actual)	ASA Coverage (Target)	ASA Coverage (To 30 Jun 08)	ASA Coverage (%To 30 Jun 08)	ASA Coverage (Target)	ASA Coverage (% Target)
				Year I	Year II	Year III	Year III	Year III	Year IV	Year IV
IDU	5,140	5,050	3,084	159	665	2,081	1,112	36%	1,567	51%
Female sex workers	9,265	8,380	5,559	5,673	12,196	13,517	15,217	274%	18,896	340%
Waria Sex Worker	365	340	219	504	670	670	719	328%	722	330%
High Risk Men	97,360	90,030	58,416	22,870	88,390	88,390	117,040	200%	139,632	239%
MSM	5,855	5,540	3,513	1,079	1,851	3,513	2,337	67%	2,511	71%
Total	117,985	109,340	70,791	30,285	103,772	108,171	136,425	193%	163,328	231%

North Sumatera

Most at Risk Populations (MARPs)	# Estimated Population of provinces*	# Estimated Population in hot spot districts	60% of provinces	ASA Coverage (Actual)	ASA Coverage (Actual)	ASA Coverage (Target)	ASA Coverage (To 30 Jun 08)	ASA Coverage (%To 30 Jun 08)	ASA Coverage (Target)	ASA Coverage (% Target)
				Year I	Year II	Year III	Year III	Year III	Year IV	Year IV
IDU	18,385	11,150	11,031	933	4,233	9,774	5,015	45%	5,496	50%
Female sex workers	8,920	4,590	5,352	2,553	7,551	8,149	9,655	180%	9,981	186%
Waria Sex Worker	1,430	740	858	79	3,049	3,549	4,128	481%	4,703	548%
High Risk Men	189,955	98,130	113,973	12,578	66,861	113,831	144,568	127%	153,870	135%
MSM	41,585	26,640	24,951	-	1,396	25,042	2,628	11%	3,142	13%
Total	260,275	141,250	156,165	16,143	83,090	160,344	165,994	106%	177,192	113%

Jakarta

Most at Risk Populations (MARPs)	# Estimated Population of provinces*	# Estimated Population in hot spot districts	60% of provinces	ASA Coverage (Actual)	ASA Coverage (Actual)	ASA Coverage (Target)	ASA Coverage (To 30 Jun 08)	ASA Coverage (%To 30 Jun 08)	ASA Coverage (Target)	ASA Coverage (% Target)
				Year I	Year II	Year III	Year III	Year III	Year IV	Year IV
IDU	33,615	33,610	20,169	3,805	10,053	10,053	19,282	96%	28,021	139%
Female sex workers	31,520	31,510	18,912	3,790	15,633	18,564	20,715	110%	30,266	160%
Waria Sex Worker	1,340	1,340	804	2,060	3,054	2,704	3,401	423%	3,715	462%
High Risk Men	401,170	401,180	240,702	84,695	248,964	335,309	463,587	193%	549,106	228%
MSM	45,630	45,610	27,378	7,188	21,735	30,409	39,220	143%	48,961	179%
Total	513,275	513,250	307,965	101,538	299,439	397,039	546,205	177%	660,069	214%

West Java

Most at Risk Populations (MARPs)	# Estimated Population of provinces*	# Estimated Population in hot spot districts	60% of provinces	ASA Coverage (Actual)	ASA Coverage (Actual)	ASA Coverage (Target)	ASA Coverage (To 30 Jun 08)	ASA Coverage (%To 30 Jun 08)	ASA Coverage (Target)	ASA Coverage (% Target)
				Year I	Year II	Year III	Year III	Year III	Year IV	Year IV
IDU	27,445	24,620	16,467	2,635	11,957	10,457	12,501	76%	13,642	83%
Female sex workers	29,560	27,750	17,736	5,344	18,175	18,602	22,964	129%	30,767	173%
Waria Sex Worker	3,420	3,200	2,052	1,785	2,536	2,186	3,039	148%	3,367	164%
High Risk Men	380,795	357,690	228,477	32,825	82,139	228,922	142,088	62%	193,896	85%
MSM	170,210	134,100	102,126	1,528	7,511	101,916	18,120	18%	25,665	25%
Total	611,430	547,360	366,858	44,117	122,318	362,083	198,712	54%	267,337	73%

East Java

Most at Risk Populations (MARPs)	# Estimated Population of provinces*	# Estimated Population in hot spot districts	60% of provinces	ASA Coverage (Actual)	ASA Coverage (Actual)	ASA Coverage (Target)	ASA Coverage (To 30 Jun 08)	ASA Coverage (%To 30 Jun 08)	ASA Coverage (Target)	ASA Coverage (% Target)
				Year I	Year II	Year III	Year III	Year III	Year IV	Year IV
IDU	26,390	14,770	15,834	2,027	7,392	9,804	9,610	61%	11,870	75%
Female sex workers	22,535	16,140	13,521	4,264	18,679	19,242	23,101	171%	30,129	223%
Waria Sex Worker	3,590	2,570	2,154	2,982	4,208	4,137	5,379	250%	5,830	271%
High Risk Men	415,300	309,920	249,180	62,528	189,708	260,044	287,220	115%	351,425	141%
MSM	132,010	83,200	79,206	4,053	7,276	79,040	13,517	17%	15,197	19%
Total	599,825	426,600	359,895	75,854	227,263	372,267	338,827	94%	1,206,951	335%

Central Java

Most at Risk Populations (MARPs)	# Estimated Population of provinces*	# Estimated Population in hot spot districts	60% of provinces	ASA Coverage (Actual)	ASA Coverage (Actual)	ASA Coverage (Target)	ASA Coverage (To 30 Jun 08)	ASA Coverage (%To 30 Jun 08)	ASA Coverage (Target)	ASA Coverage (% Target)
				Year I	Year II	Year III	Year III	Year III	Year IV	Year IV
IDU	8,955	5,660	5,373	700	4,369	5,819	6,441	120%	8,168	152%
Female sex workers	13,305	10,400	7,983	8,519	17,847	18,317	21,390	268%	23,509	294%
Waria Sex Worker	1,560	1,110	936	225	1,208	1,479	1,728	185%	2,198	235%
High Risk Men	205,070	157,580	123,042	41,657	130,958	168,915	256,741	209%	282,797	230%
MSM	98,695	46,320	59,217	616	3,513	59,290	6,107	10%	10,552	18%
Total	327,585	221,070	196,551	51,717	157,895	253,820	292,407	149%	315,224	160%

Papua

Most at Risk Populations (MARPs)	# Estimated Population of provinces*	# Estimated Population in hot spot districts	60% of provinces	ASA Coverage (Actual)	ASA Coverage (Actual)	ASA Coverage (Target)	ASA Coverage (To 30 Jun 08)	ASA Coverage (%To 30 Jun 08)	ASA Coverage (Target)	ASA Coverage (% Target)
				Year I	Year II	Year III	Year III	Year III	Year IV	Year IV
IDU	-	-	-	-	-	-	-	0%	-	0%
Female sex workers	5,020	4,680	3,012	2,144	4,650	4,234	6,466	215%	8,496	282%
Waria Sex Worker	285	295	171	-	82	330	127	74%	300	175%
High Risk Men	48,930	20,325	29,358	3,777	23,861	44,319	36,817	125%	44,319	151%
MSM	4,730	750	2,838	17	92	3,252	153	5%	505	18%
Total	58,965	26,050	35,379	5,938	28,685	52,135	40,412	114%	53,620	152%

National Total

Most at Risk Populations (MARPs)	# Estimated Population of provinces*	# Estimated Population in hot spot districts	60% of provinces	ASA Coverage (Actual)	ASA Coverage (Actual)	ASA Coverage (Target)	ASA Coverage (To 30 Jun 08)	ASA Coverage (%To 30 Jun 08)	ASA Coverage (Target)	ASA Coverage (% Target)
				Year I	Year II	Year III	Year III	Year III	Year IV	Year IV
IDU	119,930	94,860	71,958	10,259	38,669	47,987	53,960	75%	68,764	96%
Female sex workers	120,125	103,450	72,075	32,287	94,731	100,625	119,508	166%	152,044	211%
Waria Sex Worker	11,990	9,595	7,194	7,635	14,807	15,055	18,521	257%	20,835	290%
High Risk Men	1,738,580	1,434,855	1,043,148	260,930	830,881	1,239,729	1,448,061	139%	1,715,045	164%
MSM	498,715	342,160	299,229	14,481	43,374	302,462	82,082	27%	106,533	36%
Total			1,493,604	325,592	1,022,462	1,705,858	1,722,132	115%	2,063,221	202%

ANNEX II

Partner Organizations

FHI Partner Organizations

No	Institution	Location	Activities	Funding Source
North Sumatera				
1	Pusat Pengkajian dan Pemberdayaan Masyarakat Nelayan (P3MN)	Medan	BCC for FSW and Clients in Hot Spot & Workplace	USAID
2	Yayasan Solidaritas Perempuan Pekerja Seks (SP2S)	Deli Serdang, Serdang Bedagai	BCC for FSW and Clients in Hot Spot & Workplace, Transvestites, and Case Manager	USAID
3	Yayasan Komunikasi Karya Anak Bangsa (KARANG)	Tanjung Balai Asahan	BCC for FSW and Clients in Hot Spot & Workplace, MSM & Transvestites	USAID
4	Yayasan Galatea	Medan	BCC for IDUs and Partner, Counselor & CM	GFATM
5	Yayasan Penguatan Rakyat Pedesaan (PARAS)	Langkat	BCC for FSW and Clients in Hot Spot & Workplace, MSM & Transvestites	USAID
6	Yayasan Peduli Buruh Independen (PBI)	Simalungun, Pematang Siantar	BCC for FSW and Clients in Hot Spot	USAID
7	Jaringan Kesehatan Masyarakat (JKM)	Medan, Deli Serdang and Serdang Bedagai	BCC for Transvestites, MSM, Client in Workplace, Counselors and Case Manager	USAID
8	Medan Plus Support	Deli Serdang, Serdang Bedagai, Pematang Siantar & Simalungun	BCC for IDUs and Partner, Counselors & CM	GFATM
9	Community Based Rehabilitation (CBR)	Medan	BCC for FSW and Clients in Hot Spot, MSM	USAID
Riau Islands				
1	Yayasan Srimersing (YSM)	Tanjung Balai Karimun District	BCC for FSW and Clients	USAID
2	Yayasan Bentan Serumpun (YBS)	Tanjung Pinang City, Kepulauan Riau District	BCC for FSW and Clients	USAID
3	Yayasan Batam Tourism Development Board (YBTDB)	Batam City	BCC for FSW and Clients; IDU; Workplace	USAID & GFATM
4	Yayasan Gaya Batam (YGB)	Batam City	BCC for Transvestites & Gay Men; VCT & MK Services	USAID
DKI Jakarta				
1	Komisi Perempuan Indonesia (KPI)	All sites	Support for Enabling Environment	USAID
2	Yayasan Kusuma Buana (YKB)	West, Central, & East Jakarta	BCC for FSW and Clients in Hot Spot and Workplace	USAID
3	Yayasan Perkumpulan Bandungwangi	East Jakarta	BCC for FSW and Clients	USAID
4	Institute for Community Development and Social Advocacy (ICODESA)	North Jakarta	BCC for FSW and Clients	USAID
5	Perkumpulan Keluarga Berencana Indonesia (PKBI) Jakarta	East Jakarta	BCC for FSW and Clients; STI & VCT Services and CM	USAID
6	Yayasan Intra Medika (YIM)	Central, West and South Jakarta	BCC for Gay Men and MSW	USAID
7	Tbd	Jakarta	MSM Website	USAID
8	Lembaga Penduli AIDS (LPA) 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	GFATM
10	Pusat Penelitian Kesehatan, Universitas Indonesia	South Jakarta & Depok	BCC for IDUs, Counselors and CM	GFATM
11	Yayasan Karisma	East Jakarta	BCC for IDUs & CM	GFATM
12	Gerbang Foundation	Central Jakarta	BCC for IDUs, Counselors and CM	GFATM
13	Kios Informasi Kesehatan Pusat Kajian Pembangunan Masyarakat UNIKA Atma Jaya	Central, West & North Jakarta	BCC for IDUs, Counselors and CM	GFATM
14	Yayasan Partisan Club	Jakarta and Tangerang	BCC for Prisoners	GFATM
15	Yayasan Srikandi Sejati (YSS)	Jakarta and Depok	BCC for Transvestites & CM	USAID
16	Yayasan Pelayanan Anak dan Keluarga (LAYAK)	Jakarta	CST & Training	USAID
17	Perkumpulan Pemberantasan Tuberculosis Indonesia Jakarta (PPTI)	Jakarta	VCT and CST Services	USAID
18	Yayasan Karya Peduli Kita (KAPETA)	Central and South Jakarta	BCC for FSW and Clients	USAID
19	Yayasan Tegak dan Tegar	Jakarta	CM Services	USAID
20	Yayasan Gema Indonesia	North Jakarta	BCC for FSW and Clients	USAID

No	Institution	Location	Activities	Funding Source
West Java				
1	Yayasan Mitra Sehati	Bekasi	BCC for FSW and Clients; VCT & MK Services	USAID
2	Yayasan Gerakan Penanggulangan Narkoba dan Aids (YGPNA)	Cianjur District, Sukabumi City	BCC for FSW and Clients	USAID
3	Lembaga Swadaya Masyarakat (LSM) Warga Siaga	Cirebon City and Cirebon District	BCC for FSW and Clients;	USAID
4	Yayasan Resik Subang	Subang	BCC for FSW and Clients	USAID
5	Yayasan Kita Kita	Karawang	BCC for FSW and Clients	USAID
6	Tbd	Bandung City	BCC for FSW and Clients	USAID
7	Yayasan Bahtera Bandung	Bandung City, Bandung, Cimahi Bekasi, Bekasi City, Sumedang	BCC for IDUs, VCT & CST	GFATM
8	Yayasan Permata Hati Kita (Yakita)	Bogor City & Bogor District	BCC for IDUs, VCT & CST	GFATM
9	Lembaga Studi Paradigma Rakyat (LESPRA)	Bekasi City and Bekasi District	BCC for IDUs, VCT & CST	GFATM
10	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 and MSW	USAID
11	Yayasan Masyarakat Sehat	Bandung District and Subang District	BCC for IDUs, VCT & CST	GFATM
12	Paguyuban Srikandi Pasundan (PSP)	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 Di	BCC for Transvestites; VCT & MK Services	USAID
13	Himpunan Konselor HIV/AIDS (HIKHA) Jawa Barat	Bandung District, Bandung City, Sumedang District and Subang District	VCT	USAID
14	Yayasan Insan Hamdani-Bandung Plus Support (BPS)	Bandung District, Bandung City, Kerawang District, Subang District, Sukabumi City, Tasikmalaya City, Cianjur District, Cimahi City	Case Management Services	USAID
Central Java				
1	Yayasan Fatayat Nahdatul Ulama (NU)	Tegal & Batang	BCC for FSW and Clients	USAID
2	Lembaga Kalandara	Semarang City, Karanganyar District, Sukoharjo District, Sragen District, Klaten District	BCC for FSW and Clients (Workplace Program)	USAID
3	Lembaga Swadaya Masyarakat Tegakkan Empaty Gapai ASA dan Rasa Percaya Diri (TEGAR)	Salatiga City & Semarang District	BCC for FSW and Clients	USAID
4	Yayasan Solidaritas Perempuan untuk Kemanusiaan dan Hak Asasi Manusia (SPEKHAM)	Surakarta City	BCC for FSW and Clients	USAID
5	Lembaga Penelitian dan Pengembangan Sumberdaya dan Lingkungan Hidup (LPPSLH) Banyumas	Banyumas District	BCC for FSW and Clients	USAID
6	Perkumpulan Keluarga Berencana Indonesia (PKBI) Semarang	Semarang City, Kendal	BCC for FSW and Clients; STI Services & VCT	USAID
7	Yayasan Wahana Bakti Sejahtera (YWBS)	Semarang City, Semarang, Salatiga City	BCC for IDUs & VCT	GFATM
8	Yayasan Mitra Alam (YMA)	Surakarta & Salatiga Cities	BCC for IDUs & VCT	GFATM
9	Lembaga Swadaya Masyarakat Graha Mitra	Selected districts (10 cities & districts), Tegal City, Pemalang District	BCC for Transvestites & Clients	USAID
10	Yayasan Gerakan Sosial, Advocacy dan Hak Asasi Manusia untuk Gay Surakarta (GESSANG)	Surakarta City	BCC for Transvestites Sex Workers and Clients	USAID
11	Balai Pencegahan & Pengobatan Penyakit Paru (BP4) Semarang	Semarang City and 6 Cities / District	VCT & Case Management Services	USAID

No	Institution	Location	Activities	Funding Source
East Java				
1	Yayasan Media	Surabaya City, Gresik, Sidoarjo	BCC for Clients	USAID
2	Kelompok Kerja Bina Sehat (KKBS) Banyuwangi	Banyuwangi	BCC for FSW and Clients	USAID
3	Pusat Kesehatan Masyarakat (Puskesmas) Pembantu Putat Jaya	Surabaya City	BCC for FSW & Clients; STI Services & VCT	USAID
4	Palang Merah Indonesia (PMI) Banyuwangi	Banyuwangi	BCC for FSW and Clients	USAID
5	Yayasan Genta Surabaya	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, VCT and Case Management	USAID & GFATM
7	Perkumpulan Suara Nurani (SuaR)	Kediri City and District	BCC for FSW and Clients	USAID
8	Yayasan Centre for Studying Milieu Development (CESMID)	Tulungagung	BCC for FSW and Clients	USAID
9	Yayasan Hotline Surabaya	Surabaya Municipality	BCC for FSW, Clients & IDU; VCT, CST & Case Management	USAID
10	Yayasan Gaya Nusantara (GN)	Surabaya, Sidoarjo, Jember, Banyuwangi	BCC for Gay Men	USAID
11	Lembaga Swadaya Masyarakat Ikatan Gaya Arema Malang (IGAMA)	Malang City	BCC for Gay Men & Partners	USAID
12	Yayasan Sadar Hati	Malang City & Malang District	BCC for IDUs & VCT	GFATM
13	Yayasan Bina Hati	Sidoarjo District & Surabaya City	BCC for IDUs, VCT & Case Management	GFATM
14	Yayasan Persatuan Waria Kota Surabaya (Perwakos)	Surabaya City, Gresik, Sidoarjo, Jember, Madiun, Nganjuk	BCC for Transvestites & VCT	USAID
15	Lembaga Paramitra	Malang City & Malang District	BCC for FSW and Clients	USAID
16	Kelompok Kerja Waria Malang Raya Peduli AIDS (KK WAMARAPA)	Surabaya City	BCC for Transvestites & VCT	USAID
Papua				
1	Perkumpulan Keluarga Berencana Indonesia (PKBI) Jayapura	Jayapura District	BCC for FSW and Clients, MSM; STI Services, Case Management	USAID
2	Yayasan Harapan Ibu (YHI)	Jayapura City	BCC for FSW, Transvestites, Clients, Case Management	USAID
3	Perkumpulan Terbatas Peduli Sehat (Pt.PS)	Manokwari	BCC for FSW and Clients	USAID
4	Yayasan Usaha Kesejahteraan Ekonomi Masyarakat Desa Indonesia (YUKEMDI)	Jayawijaya	BCC for FSW and Clients	USAID
5	Yayasan Sosial Pengembangan Kawasan Timur (YASOBAT)	Fakfak	BCC for FSW and Clients	USAID
6	Tbd	Sorong City	BCC for FSW and Clients	USAID

ANNEX III

Program Budgets

TOTAL JOINT PROGRAM FUNDING BY PROVINCES - FY09

No.	Donors	Papua	East Java	Central Java	West Java	DKI	North Sumatra	Riau	Total
I.	USAID	1,070,875	1,636,291	1,190,375	1,324,568	1,326,316	888,082	623,830	8,060,337
II.	Partnership/UNDP	57,919	75,907	56,029	69,724	69,732	32,563	40,567	402,441
III.	GFATM	-	194,342	141,453	304,570	528,186	169,976	61,474	1,400,000
		1,128,794	1,906,540	1,387,856	1,698,861	1,924,234	1,090,622	725,871	9,862,778

**FAMILY HEALTH INTERNATIONAL
USAID Funded FY09
BUDGET SUMMARY BY PROVINCES**

Program Cost	Papua	East Java	Central Java	West Java	DKI	North Sumatra	Riau	Total
I. Salaries	199,064	259,607	180,278	188,160	259,950	130,885	111,685	1,329,628
II. Fringe Benefit	41,480	71,686	50,890	56,612	63,230	38,694	26,257	348,848
III. Consultant	11,459	19,803	14,058	15,639	17,467	10,689	7,254	96,370
IV. Travel and Transportation	210,640	234,045	198,938	234,045	58,511	140,427	93,618	1,170,224
V. Non Capital Equipment/Facilities	-	-	-	-	-	-	-	-
VI. Supplies	6,243	10,788	7,659	8,520	9,516	5,823	3,952	52,500
VII. Other Expenses	67,520	116,689	82,837	92,152	102,925	62,986	42,741	567,850
VIII. Subaward/Subagreement/Contracts	395,557	683,604	485,290	539,854	602,966	368,993	250,390	3,326,654
IX. Indirect Cost	138,912	240,069	170,425	189,587	211,752	129,585	87,934	1,168,263
Total	1,070,875	1,636,291	1,190,375	1,324,568	1,326,316	888,082	623,830	8,060,337

FAMILY HEALTH INTERNATIONAL
Partnership/UNDP Funded FY09
BUDGET SUMMARY BY PROVINCES

Program Cost	Papua	East Java	Central Java	West Java	DKI	North Sumatra	Riau	Total
I. Salaries	22,225	25,639	18,009	20,266	25,312	6,115	19,193	136,760
II. Fringe Benefit	3,366	5,175	3,762	5,065	5,605	2,603	2,242	27,817
III. Consultant	-	-	-	-	-	-	-	-
IV. Travel and Transportation	10,827	12,030	10,226	12,030	3,008	7,218	4,812	60,150
V. Non Capital Equipment/Facilities	-	-	-	-	-	-	-	-
VI. Supplies	4,265	6,558	4,767	6,419	7,102	3,298	2,840	35,250
VII Other Expenses	7,507	11,544	8,391	11,299	12,502	5,806	5,000	62,050
VIII Subaward/Subagreement/Contracts	-	-	-	-	-	-	-	-
IX. Indirect Cost	9,729	14,961	10,874	14,643	16,202	7,524	6,480	80,414
Total	57,919	75,907	56,029	69,724	69,732	32,563	40,567	402,441

FAMILY HEALTH INTERNATIONAL
GFATM Funded FY09
BUDGET SUMMARY BY PROVINCES

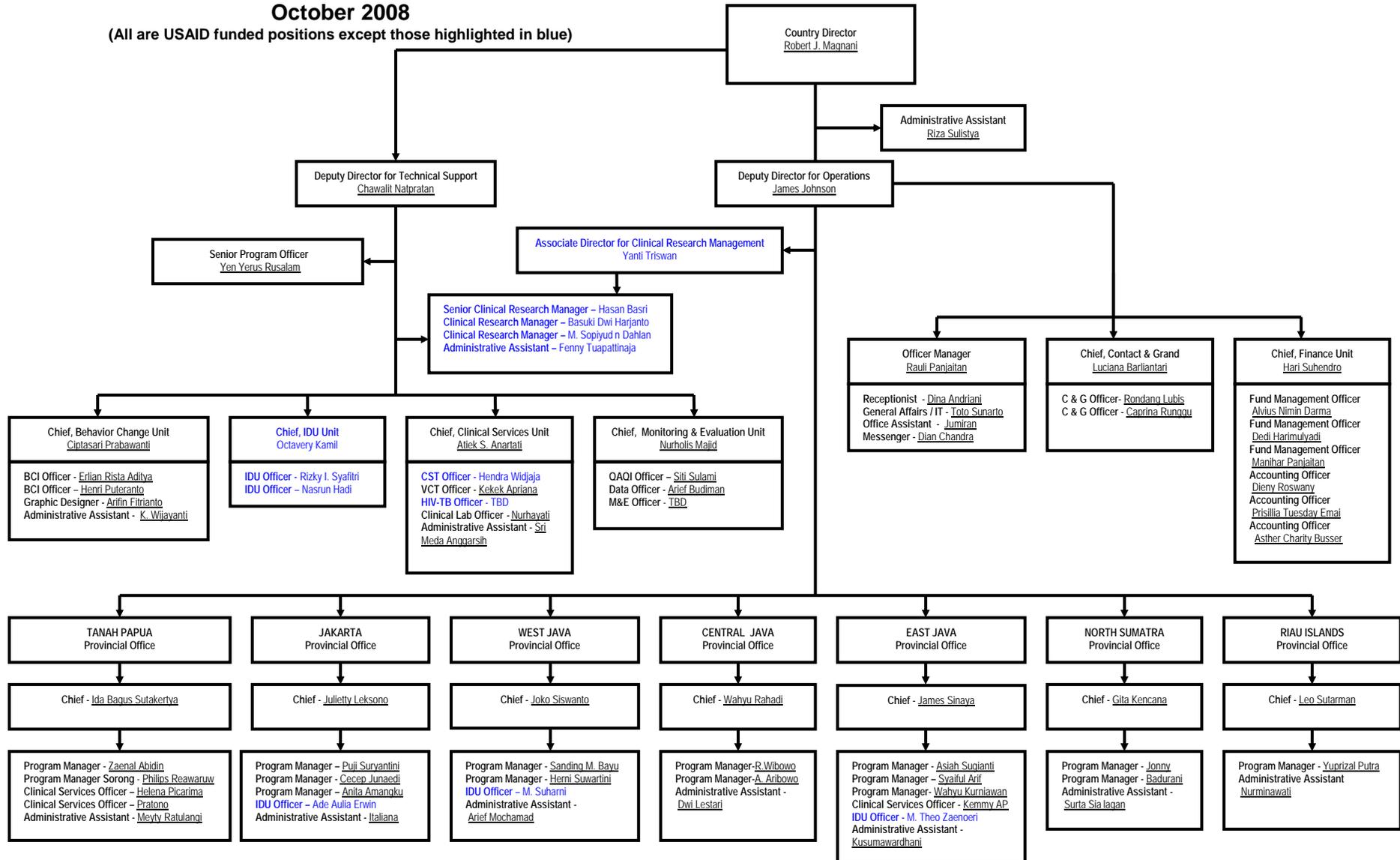
Program Cost	Papua	East Java	Central Java	West Java	DKI	North Sumatra	Riau	Total
I. Salaries	-	14,425	10,418	22,897	41,910	12,593	4,354	106,598
II. Fringe Benefit	-	2,934	2,119	4,657	8,524	2,561	886	21,682
III. Consultant	-	81	59	129	236	71	25	600
IV. Travel and Transportation	-	19,703	15,324	27,365	20,797	17,514	8,757	109,460
V. Non Capital Equipment/Facilities	-	-	-	-	-	-	-	-
VI. Supplies	-	-	-	-	-	-	-	-
VII Other Expenses	-	4,228	3,053	6,711	12,283	3,691	1,276	31,242
VIII Subaward/Subagreement/Contracts	-	126,000	91,000	200,000	366,075	110,000	38,035	931,110
IX. Indirect Cost	-	26,971	19,479	42,811	78,360	23,546	8,142	199,308
Total	-	194,342	141,453	304,570	528,186	169,976	61,474	1,400,000

ANNEX IV

Organizational Chart

Annex B
FHI Indonesia Country Office Organization Structure
October 2008

(All are USAID funded positions except those highlighted in blue)



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															
	Liesbeth Bollen	QA/QI and Analysis	USAID	80	■	■	■	■	■	■	■	■	■			
	Sally Wellesley	Report Writing	USAID	30			■	■		■	■		■	■		■
	Local Consultants															
	Mitu Prie	Communications	USAID	150	■	■	■	■	■	■	■	■	■			
	Jerry Marcellinus Winata	MSM Website and Support	USAID	150	■	■	■	■	■	■	■	■	■			
	Made Efo Suarmartha	BCI Training and Mentoring	USAID	50	■	■	■	■	■	■	■	■	■			
	Supriyanto	BCI Training and Mentoring	USAID	50	■	■	■	■	■	■	■	■	■			
	Tetty Rachmawati	BCI Training	USAID	50	■	■	■	■	■	■	■	■	■			
	Flora Tanujaya	Clinical Services	USAID	20	■	■	■	■	■	■	■	■	■			
	Jonathan Ronald	Clinical Services	USAID	40	■	■	■	■	■	■	■	■	■			
	Trio Mardjoko	M&E Data Management	USAID	50	■	■	■	■	■	■	■	■	■			
	Marcel Latuihamallo	Counseling	USAID	40	■	■	■	■	■	■	■	■	■			
	Pandu Riono	Advocacy and Data Use	USAID	10	■	■	■									

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 APRO														
Tony Bondurant, Senior Director	Bangkok - Jakarta 1 trip x 5 days							■						
Guy Morineau (Surveillance)	Bangkok - Jakarta 1 trip x 12 days						■							
Philippe Girault (BCI)	Bangkok - Jakarta 2 trips x 12 days		■			■								
Kevin Mulvey (IDU)	Hanoi - Jakarta 1 trips x 5 days						■							
Conferences / Workshops/ Trainings														
Pepfar Conference 2 Staff	Jakarta - Hanoi 2 trips x 5 days										■			
FHI Regional Meetings/Workshops 8 Staff	Jakarta - Bangkok 8 trips x 5 days		■			■	■		■					
FHI Global Management Meeting 1 Staff	Jakarta - U.S.A. 1 trips x 7 days											■		
Demobilization														
Robert Magnani	Jakarta - U.S.A. 2 trips												■	
James Johnson	Jakarta - U.S.A. 1 trip												■	
Chawalit Natpratan	Jakarta - Bangkok 1 trip												■	

ANNEX VIII

PEPFAR Indicators

USG Indonesia FY 2008 Mini Country Operational Plan Target Justification Document

JUSTIFICATION FOR USG INDONESIA PEPFAR TARGETS

During the Mini-COP development process, all program area targets and target justifications were developed by the integrated USG Indonesia SI Team (SI Advisor from USAID/RDMA, technical staff from the Office of Health from USAID/Indonesia Mission, SI Advisor from USAID/Washington, and the Department of Defense (DOD) Technical Officer). Meetings and discussions were held with USAID partners to review and set downstream (direct) and upstream (indirect) targets for FY 2008 to FY 2009 based on partners' 2007 program results, work plan for FY 2008, their projected programmatic growth, and expected expansion. Meetings were also held with the National AIDS Commission (KPA) Officers to obtain updated national level reporting data and estimates in order to use them to estimate USG Indonesia upstream (indirect) targets. Finally, proposed USG targets have been reviewed by KPA and Ministry of Public Health (MOH) in order to obtain an official concurrence.

Please note that all program area targets and justifications for FY 2008 were described and outlined in last year's mini-COP SI "Justification for USG Indonesia PEPFAR Targets" uploaded document. Since these FY 2008 targets were provided last year, this document will only focus on the description of program area targets and justifications for FY 2009. For any FY 2008 target questions, please refer to last year's mini-COP documentation. Additionally, after COP FY 2008 has been submitted, the USG Indonesia Team will be reviewing FY 2008 targets for any potential adjustments that are needed due to reprogramming or other issues.

USG PEPFAR Intervention Program and Sites

In FY 2009, the USG PEPFAR program is focused on the following (please refer to uploaded document "Indonesia Intervention Area Map"):

- (1) Three Pilot Continuum of Care (CoC) Sites for MARPs in the cities of Jakarta, Malang, and Bandung;
- (2) In Papua there are 2 provinces and a total of 29 districts. The USG will now focus on intensive integrated health systems strengthening for 10 priority districts. Additionally, USG will continue prevention programming efforts for MARPs in Papua; and
- (3) Continued support to existing NGOs in 8 priority provinces implementing comprehensive preventing targeting MARPs, STI/VCT, and Case Management services for MARPs

Estimation of Downstream (Direct) Targets:

The downstream target estimates are provided by USAID partners and Department of Defense (DOD) for 2008 to 2009. 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 USG activities, which implements HIV/AIDS activities in USG priority districts and provinces, and other implementing partners. 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 (IPF) managed by UNDP contributes significant resources to USG implementing partners to support implementation the ASA project, which will end in 2008. Additionally, USG partners work closely with MOH/KPA and the Global Fund to implement HIV/AIDS activities in country. Therefore, the upstream (indirect) targets are estimated in accordance with National and Global Fund strategic framework and work plan for prevention, counseling and testing, as well as palliative care.

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 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.

**Explanation of Downstream (Direct) and Upstream (Indirect)
Summary Target Calculations for Core Indicators in Table 2.1 and Table 2.2
(Final 7/9/2007)**

Family Health International: ASA Program

PART I:

Table 2.1 and Table 2.2 : USG Indonesia Targets for FY 2008 and FY 2009 (Supporting documents for target justification)						
Indicators	FY 2008 (Oct 1, 2007 – Sept 30, 2008)			FY 2009 (Oct 1, 2008 – 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	54	414	468	1,680	500	2,180
Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting	2	19	21	49	15	64
COUNSELING AND TESTING						
Number of individuals who received counseling and testing for HIV and received their test results (including TB VCT)	11,829	60,880	72,709	9,387	37,013	46,400
CARE						
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease during the report period	168	480	648	655	500	1,155
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)	996	4,742	5,738	2,444	25,272	27,716
TREATMENT						
Number of individuals receiving antiretroviral therapy at the end of the reporting period	350	6,030	6,380	725	6,293	7,018

PREVENTION

Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting and number of pregnant women who received HIV counseling and testing for PMTCT and received their test results

Indicators	FY 2008 (Oct 1, 2007 – Sept 30, 2008)			FY 2009 (Oct 1, 2008 – Sept 30, 2009)		
	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	54	414	468	1,680	500	2,180
Number of HIV-infected pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting	2	19	21	49	15	64

The PMTCT activities are a small component of the FHI/ASA program in Indonesia. Therefore, FHI will focus its efforts to prioritize and reach the most-at-risk populations and their partners who are getting pregnant in the priority 3 pilot CoC sites and priority districts in Papua.

Explanation of Calculation for Downstream Targets:

In FY 2009, FHI downstream support is designed to develop PMTCT models in 3 pilot CoC sites for MARPs in Jakarta, Malang, and Bandung. In Papua, there will be 10 sites in the priority districts for MARPs.

Based on 2007 program monitoring data, for the 3 pilot CoC sites, it is estimated that 150 pregnant women/clinic/year will receive HIV counseling and testing for PMTCT and receive their test results. In Papua, there are 10 sites that will receive substantive system strengthening support from FHI. It is estimated that 60 pregnant women/per clinic/year will receive HIV counseling and testing for PMTCT and receive their test results.

Based on findings of the most recent IBBS and adjusted for PMTCT clients, it is estimated a 3% HIV prevalence among pregnant women in Papua and most-at-risk populations or partners who are pregnant tested HIV positive. In the other provinces (not Papua), we expect higher prevalence among clients at PMTCT sites, which is about 2%. One hundred percent of all positive pregnant women will receive antiretroviral prophylaxis.

Downstream Target Calculation		
PMTCT indicator	2008	2009
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	= 54 (3 PMTCT clinics x 2 pregnant women who received HIV counseling and testing for PMTCT and received their test results x 9 months).	= 1,680 ([10 PMTCT clinics x 150 pregnant women who received HIV counseling & testing for PMTCT and received their test results] + [3 PMTCT clinics x 60 pregnant women who received HIV counseling & testing for PMTCT and received their test results] x 12 months)

Downstream Target Calculation		
PMTCT indicator	2008	2009
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	= ~3 (54 x 0.045; HIV prevalence = 0.03%)	= 49 [(10 x 150 x 0.03) + (3 x 60 x 0.02)]; HIV prevalence: Papua = 0.03%; other provinces = 0.02%

Explanation of Calculation for Upstream Targets:

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

Upstream targets will focus on Papua. FHI will train staff on counseling and testing and on components of the integrated health systems strengthening approach outside of the 10 focus districts in Papua. Additionally, we expect other sites within the network of 10 focus districts in Papua as well as the MOH will learn from this USG approach. We believe these other network sites and the MOH will uptake the program at the own sites and pay for implementation costs. It is estimated that 500 pregnant women in total for 12 month will receive HIV counseling and testing for PMTCT and receive their test results.

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 (150 pregnant women/clinic/year). HIV prevalence among pregnant is 0.03% in Papua and all of them will be provided with a complete course of antiretroviral therapy.

Upstream Target Calculation		
PMTCT indicator	2008	2009
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	= 414 (23 PMTCT clinics x 2 pregnant women who received HIV counseling and testing for PMTCT and received their test results x 9 months).	= 500 (pregnant women who received HIV counseling and testing for PMTCT and received their test results in 12 months).
Number of pregnant women provided with a complete course of antiretroviral prophylaxis in a PMTCT setting	= 19 (414 x 0.045; HIV prevalence = 0.045%)	= 15 (500 x 0.03, HIV prevalence = 0.03%)

Total USG Targets	
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	<p><u>Total Target: FY 2008</u> Downstream = 55 Upstream = 414 Total = 468 (55+414)</p> <p><u>Total Target: FY 2009</u> Downstream = 1,680 Upstream = 500 Total = 2,180 (1,680 + 500)</p>

Total USG Targets	
Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	<u>Total Target: FY 2008</u> Downstream = 2 Upstream = 19 Total = 21 (2+19)
	<u>Total Target: FY 2009</u> Downstream = 36 Upstream = 11 Total = 64 (49 + 15)

COUNSELING & TESTING

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

Indicators	FY 2008 (Oct 1, 2007 – Sept 30, 2008)			FY 2009 (Oct 1, 2008 – Sept 30, 2009)		
	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*	11,829	60,880	72,709	10,737	37,013	47,750
Total MARP	8,316	60,080	68,396	7,337	36,013	43,350
TB patients	187	800	987	3,400	1,000	4,400

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

Explanation of Calculation for Downstream Targets:

In 2009, FHI has a more strategic VCT approach, which will focus only on model sites. There are 3 pilot CoC sites targeting MARPs: each site has 1 hospital + 2 health centers per each site, for a total of 9 sites. VCT clinics: Malang (in East Java) for FSW and Waria; Bandung for FSW; and Jakarta for FSW. In Papua, there are 4 sites for MARPs: Jayapura, Sorong, Nabire, Maranke, which are all for FSW. In addition, FHI will continue to support work in 16 VCT (all 8+8 sites) out of 29 sites. 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

- FSW: In 2007, 8% of FSW were reached with outreach, of those 88% visited VCT and got tested, and 67% of those tested were informed of their test results. In 2009, FHI will strengthen its efforts to improve STI screening and VCT in areas where it has VCT clinics, which is an estimated 14% (11 sites out of 78 sites). At these sites, FHI will increase VCT to 60% of FSW reached from outreach activities. In 2009, at these clinics, it is estimated that 90% of FSWs will get tested and 90% of those tested will be informed of their test results.
- Waria: In 2007, 12% of Waria were reached with outreach, of those 100% visited VCT and got tested, and 88% of those tested were informed of their test results. MSM: In 2007, 5% of MSM were reached with outreach, of those 97% visited VCT and got tested, and 86% of those tested were informed of their test results. In

2009, for Waria, it is estimated that 30% of them located in FHI direct support VCT sites will be reached with outreach and an estimated 25% of Waria reached will show up at VCT clinics, and 90% of them will get tested, and 90% will be informed of their test results. MSM/MSW and identified gay men: it is estimated that 20% of them will be reached with outreach in the FHI direct support sites, 8% will show up at VCT sites and 90% will get tested and 90% will be informed of their test results.

- High-Risk Men: In 2007, 0.2% of men reached with outreach activities visited VCT and 95% got tested and 72% of those were informed of their test results. It is estimated that 30% of high risk men will be reached in 2009 in FHI support areas. FHI expects 0.5% will get pre-test, 90% will get tested, and 90% will get their results.
- **TB patients:** The PPTI program, in 2006 reported 1,400 patients. Because of limited infrastructure and capacity, it is estimated that there will be only an additional 100 patients in 2009 for a total of 1,500. In addition, in 3 pilot CoC programs, there are 9 sites for MARPs and in Papua there are 29 sites for a total of 38 sites. It is estimated that an average of 50 TB patients get tested and received their results per year.

Downstream Target Calculation		
Number of individuals who received counseling and testing for HIV and received their test results		
Target Population	2008	2009
MARP	= 8,316 (40 clients x 9 months x 35 sites x 60% received their test results) x 10% increase	= 5,987 (4,405 + 1,218 + 363) FSW: 4,405 (64,744 x 14% x 6 % x 90% x 90%) MSM (MSW/Waria): 1,218 (6925 Waria x 9%) x 30% x 25% x 90% x 90 % + (81,000 MSW x 8%) x 20 % x 8% x 90% x 90% Other High-Risk Population (Clients of FSWs & Other High-Risk Men): 363 (299,000 High risk men x 3% x .05% x 90% x 90%)
General Population in Papua	= 3,326 (40 clients x 9 months x 14 sites x 60% received their test results) x 10% increase	0
TB patients	= 187 (187/9x 9 months)	= 3,400 (1,500 estimated TB patients + 50 TB patients x 38 sites)
Total	11,829	9,387

Explanation of Calculation for Upstream Targets:

There are two tiers of upstream (indirect) target estimates: (1) at the national level –FHI helps to develop national counseling and testing guidelines, quality assurance/quality improvement (QA/QI), and training; (2) at the provincial and district level – FHI provides TA to transfer technical expertise and training for counselors, lab technicians, M&E, mentoring, developing M&E systems, QA/QI to MOH sites plus national trainings, test kits, supplies, and operational costs. Therefore, based on this substantive support we will claim as upstream support all of the national estimates for VCT. USG has also provided technical assistance

developing guidelines and standard operation of practice manuals to support the ongoing accelerated scale up of counseling and testing services which is supported by GFATM.

- **MARPs:** Using national estimates by MARPs in the most recent National HIV/AIDS Action Plan 2007-2010, 28 June 2007.
 - FSW: It is disaggregated by Direct FSW + Indirect FSW = 48,380 (2009 target) - 34,050 (2008) + 35,120 (2009) - 24,580 (2008) = 24,870.
 - Waria: National estimates are disaggregated by Waria +MSM = Waria 10,640 (2009 target) - 8,940 (2008) + 62,130 (2009)-50,820 (2008) = 13,010.
 - Other High-risk (Clients of FSWs): National estimate is 10,670 (2009 target) - 6550 (2008) = 4,120.
- **TB patients:** FHI provides training to staff at GFATM sites on TB-VCT and HIV counseling. Based on most update info, it is estimated 1,000 TB-VCT in the GFATM sites.

Upstream Target Calculation		
Number of individuals who received counseling and testing for HIV and received their test results		
Target Population	2008	2009
MARP	= 60,080 (PTF: 40 clients x 9 months x 54 sites x 60% received their test results) + 10% increase +GFATM=47,250	= 36,013 (20,465 + 11,792 + 3,757) (National estimate – USG direct) FSW: 20,465 (24,860 - 4,405) MSM (Waria, MSW): 11,792 (13,010 – 1,218) Other high-risk (Clients of FSWs): 3,757 (4,120 -363)
TB patients	= 800	= 1,000
Total	60,880	37,013

TOTAL USG TARGETS	
Number of individuals who received counseling and testing for HIV and received their test results	<p><u>Total Target: FY 2008</u> Downstream = 11,829 Upstream = 60,880 Total = 72,709 (11,829+60,880)</p> <p><u>Total Target: FY 2009</u> Downstream = 10,737 Upstream = 37,013 Total = 47,750 (10,737 + 37,013)</p>

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) and Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease during the report period

Indicators	FY 2008 (Oct 1, 2007 – Sept 30, 2008)			FY 2009 (Oct 1, 2008 – Sept 30, 2009)		
	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 <i>including</i> those HIV-infected individuals who received clinical prophylaxis and/or treatment for tuberculosis (TB)	996	4,742	5738	2,444	25,272	27,716
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease during the report period	168	480	648	655	500	1,155

Explanation of Calculation for Downstream Targets:

FHI does not provide funds for pediatric care. However, it works closely with the KPA/MOH in Jayapura to work on advocacy, development of service guidelines, and policy development. UNICEF and the Clinton Foundation currently are the main donors supporting pediatric HIV/AIDS in Indonesia. FHI will continue to assist in preparing the local health centers to address these pediatric HIV/AIDS issues.

FHI will directly support health facilities providing clinic based care with a link to NGO/CBOs providing home and community-based care. The 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 and follow-up with home and community-based care program.

In 2009, FHI will continue case management in 23 sites out of 31 sites based on availability of VCT. It is estimated 200 PLHA per year. In addition, through the intensive integrated systems strengthening approach, FHI will initiate palliative care in:

- 1) 3 pilot CoC programs for MARP in Jakarta, Bandung, and Malang (each pilot CoC site will consist of 1 hospital + 2 health centers). In 2007, the reported data for these three cities (Jakarta, Bandung, and Malang) an estimated 300 PLHA average per site received case management. All of these CoC sites will be linked to home and community-based care (HCBC), which will provide additional services to supplement the case management effort. It is estimated an annual 10% increase in 2008 and 2009.
- 2) In Papua, FHI will work in 10 districts directly (8 hospitals and 22 health centers) but cover the remaining 19 districts indirectly through systems strengthening. This coverage area is for a total of 29 districts. It is estimated 500 PLHA from all 29 districts.

For TB patients who got HIV test and their test results, it is 14% get HIV positive. Among PLHA reached by FHI care program, about 10% develop TB.

Downstream Target Calculation		
Care Indicators	2008	2009
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	= 828 PLHA (11,829 VCT clients x 14% tested positive and 50% received case management services).	= 1,789 (200 patients + [300 patients x 10% x 10%] x 3 sites + 500 PLHA)
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease during the report period	= 168 (7 TB clinics x 24 clients)	= 655 (3,400 TB patients x 14%) + 1,789 PLHA x 10%)
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 = 996 (828 +168)	Total = 2,444 (1,789 + 655)

Explanation of Calculation for Upstream Targets:

There are two tiers of upstream (indirect) target estimates: (1) at the national level –FHI provides TA to help develop national palliative care guidelines, quality assurance/quality improvement (QA/QI), and home and community-based care training; (2) at the provincial and district level – FHI provides TA to transfer technical expertise and training for counselors, lab technicians, M&E, mentoring, developing M&E systems, QA/QI to MOH. Therefore, based on this substantive support we will claim as upstream support all of the national estimates for palliative care. Based on the national report, in June 2007, 20,084 PLHA were in care (in December 2006, 14,787). The definition of “being in care” means receiving cotrimoxazole or any OI at a minimum. Based upon MOH data, it is estimated a 15% increase annually in 2008 and 2009 resulting in 27,716 PLHA in care. The same calculation method is applied for estimation of upstream targets.

In 2009, there are three specific activities for upstream support include:

- 1) FHI will provide TA to develop TB/HIV training-of-trainers (TOT) curriculum at the national level.
- 2) TBCAP in 2009, will cover 10 big hospitals (KNCV) through HDL (Hospital DOTS Linkage Program).
- 3) FHI will provide training to new puskesmas (health centers) at national level to build up the system. There are no national estimates. Upstream support will estimate only TBCAP program, which is 50 patients per hospital = 500.

FHI will also continue to provide training GFATM staff at GFATM sites on TB-VCT. Most GFATM sites are only in hospitals and there is currently no good system for implementing TB-DOTS. Additionally, there are inadequate linkages between HIV and TB in the hospitals.

Upstream Target Calculation		
Care Indicators	2008	2009
Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	= 4,262 PLHA (60,880 VCT clients x 14% tested positive and 50% received case management services)	= 24,772 (National estimate – USG direct) (26,561 - 1,789)
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease during the report period	= 480 (20 TB clinics x 24 clients)	= 500 (50 patients x 10 sites)
Number of individuals provided with facility-based, community based and/or home-based HIV-related palliative care <i>including</i> those HIV-infected individuals who received clinical prophylaxis and/or treatment for tuberculosis (TB)	Total = 4,742 (4,262 +480)	Total = 25,272 (24,772 + 500)

TOTAL USG TARGETS	
Number of individuals provided with facility-based, community based and/or home-based HIV-related palliative care <i>including</i> those HIV-infected individuals who received clinical prophylaxis and/or treatment for tuberculosis (TB)	<u>Total Target: FY 2008</u> Downstream = 996 Upstream = 4,742 Total = 5,738 (996+4,742) <u>Total Target: FY 2009</u> Downstream = 1,789 Upstream = 655 Total = 2,444 (1,789+655)
Number of HIV-infected clients attending HIV care/treatment services that are receiving treatment for TB disease during the report period	<u>Total Target: FY 2008</u> Downstream = 168 Upstream = 480 Total = 648 (168+480) <u>Total Target: FY 2009</u> Downstream = 1,155 Upstream = 26,561 Total = 27,716 (1,155 + 26,561)

TREATMENT

Number of individuals receiving antiretroviral therapy at the end report period

Indicators	FY 2008 (Oct 1, 2007 – Sept 30, 2008)			FY 2009 (Oct 1, 2008 – Sept 30, 2009)		
	Downstream (Direct)	Upstream (Indirect)	Total	Downstream (Direct)	Upstream (Indirect)	Total
TREATMENT						
Number of individuals receiving antiretroviral therapy	350	6,030	6,380	725	6,293	7,018

Explanation of Calculation for Downstream Targets:

FHI does not provide funds for pediatric treatment services. However, it works closely with the KPA/MOH in Jayapura to work on advocacy, development of service guidelines, and policy development. UNICEF and the Clinton Foundation currently are the main donors supporting pediatric HIV/AIDS in Indonesia. FHI will continue to assist in preparing the local health centers to address these pediatric HIV/AIDS issues.

ARV medication and services are supported by Government of Indonesia and GFATM. In 2009, FHI 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. 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 FHI 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 2009, there are 3 hospitals in 3 pilot CoC areas (Jakarta, Bandung, and Malong) for MARPs scaling-up to implement CoC including adherence support to ART patients through case management and home-community based support. In Jakarta, there is 1 hospital + Layak (NGO) that supports adherence; there were 380 ART patients in 2007 and it is estimated 400 in 2009. In Bandung, it is estimated 100 ART and in Malong, it is estimated 75 ART patients in the reference hospital. In Papua, 5 hospitals will be strengthened for ART services and will provide follow-up adherence at home and community. It is estimated 30 ART per hospitals (30 ART patients x 5 sites) and ever received ART will be 50 patients per sites (50 x 5 = 250).

Downstream Target Calculation		
Treatment Indicators	2008	2009
Number of individuals receiving antiretroviral therapy	= 350 (996 x 25%) + (144 x 70%)	= 725 (400+100+75 estimated ART patients in 3 sites) + (30 estimated ART patients x 5 sites)

Explanation of Calculation for Upstream Targets:

FHI continues to provide upstream (indirect) support to GOI and GFATM to scale up national ART services. FHI has worked extensively to provide technical assistance on developing ART national guidelines, developing ART patient monitoring, and comprehensive CST in collaboration with WHO and other donors, as well as provide technical assistance for ART care and support training curricula. Specifically in 2009, FHI will continue efforts to train clinical staff who serve as front-line trainers for the expansion of sites offering ART under the national plan and provide support for strengthening record-keeping to manage ART patients.

In June 2007, the national level report of number of individuals receiving antiretroviral therapy is 5,800. GOI/MOH did not provide national estimates for 2009, but we anticipate an annual increase of 10% for in 2008 and 2009. The upstream target estimates of number of individuals receiving ART are based on national estimates minus direct USG targets, which is 6,293 (7,018 - 725) in 2009.

Upstream Target Calculation		
Treatment Indicators	2008	2009
Number of individuals receiving antiretroviral therapy	= 6,030 (6,380-350) *	= 6,293 (7,018 - 725)

* For 2008, National updated size estimations for ART were used.

TOTAL USG TARGETS	
Number of individuals receiving antiretroviral therapy	<u>Total Target: FY 2008</u> Downstream = 350 Upstream = 6,030 Total of National estimates = 6,380 (350 + 6,030) <u>Total Target: FY 2009</u> Downstream = 725 Upstream = 6,293 Total of National estimates = 7,018 (725 + 6,293)

OVC

Due to the nature of epidemic in Indonesia, there is not a great demand for OVC care related to HIV. Currently, the needs of OVC are supported by Department of State through Save the Children, US. Therefore, there is no proposed programming/targets for this Mini-COP FY 2008 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 should funding be programmed in this area.

Additional core indicator proposed for Indonesia PEPFAR

PREVENTION

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

Indicators	FY 2008 (Oct 1, 2007 – Sept 30, 2008)			FY 2009 (Oct 1, 2008 – Sept 30, 2009)		
	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*	857,530	811,883	1,669,413	437,220	123,628	560,848
- IDU	0	33,000	33,000	0	0	0
- FSW	36,326	36,326	72,652	64,744	98,356	163,100
- MSM/MSW (MSM & Waria)	172,394	172,393	344,787	71,033	0	71,033
- High risk men (clients of FSWs & other high-risk men)	370,814	556,222	927,036	299,000	0	299,000
- Prisoners	30,000	9,000	39,000	0	0	0
- PLHA	996	4,942	5,938	2,444	25,272	27,716
- General Population in Papua	247,000	0	247,000	0	0	0

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

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 is the primarily focus of the FHI HIV/AIDS strategy.

In 2009, overall PEPFAR Indonesia prevention targets are decreased because of the change of USG strategic focus due to overall funding cuts. Please note that the decrease in targets for: MSM/MSW, and high-risk men; and not targets set for: IDU, prisoners, and general population in Papua. Also, please note that there is a 40% reduction in the number of implementing agencies.

Explanation of Calculation for Downstream Targets:

The downstream (direct) target estimates are provided by FHI 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 in all priority

provinces/districts. The mini-COP targets are calculated based on estimating size of MARPs and the percentage of target population that will be exposed to community outreach activities. Size estimations among most-at-risk populations was conducted in 2006 in the 8 provinces by USG. Updated size estimations are planned for 2009 by USG and stakeholders by using a “response mapping methodology”.

MARPs:

- **FSW:** It is estimated 80,930 FSW (2006) in FHI implementation areas, covering 48 districts out of 79 districts in 8 provinces. FHI plans to achieve 80% coverage of FSW.
- **MSM/MSW:** Waria: In 2009, USG plans to reach 90% of Waria in implementation areas. There are 40 districts in 8 provinces. It is estimated 6,925 Waria in 40 districts. MSM: In 2009, FHI will focus efforts to reach identified gay and MSW. Based on mapping from CBOs, it is estimated 81,000 MSW in 40 districts. FHI will increase coverage to 80% among this group. When compare to 2008, it is dramatic drop of targets based on more focus BCI strategy targeting higher sub MSM/MSW/Waria. Please note this size estimation does not include hidden MSM.
- **High risk men:** Based on 2006 FHI reporting, an estimated 260,000 high risk men were reached. In 2009, it is estimated a 15% increase of coverage from 2006.
- **PLHA:** PLHA is a critical target population for the prevention program component of the USG Indonesia strategy. FHI will integrate prevention with positives (PwP) messages and behavior change intervention that is tailored for positive people into the case management package. All PLHA (100%) who have accessed basic care and TB/HIV programs will also receive prevention activities which is 2,444 will be reached with prevention intervention. ART patient is subset of care patients.

Downstream Target Calculation		
<i>Number of individuals that are reached through community outreach that promotes HIV/AIDS prevention through other behavioral change beyond abstinence and/or being faithful</i>		
Target population	2008	2009
- FSW	= 36,326 (117,180 x 62% coverage x 50% direct funded by USG)	= 64,744 (80,930 FSWs x 8%)
- MSM/MSW	= 172,394 (574,646 MSM/MSW size estimation x 60% coverage x 50% direct fund by USG)	= 71,033 (6925 Waria x 9%) + (81,000 MSW x 8%)
- High-risk men	= 370,814 (1,404,600 high risk men size estimation x 66% coverage x 40% direct fund by USG)	= 299,000 (260,000 x 15%)
- Prisoners	= 30,000 (50 sites x 600 inmates)	0
- PLHA	= 996 (refer to care calculation)	= 2,444
- General Population in Papua	= 247,000 (230,000 from community outreach activities + 17,000 from workplace program)	0
Total	857,530	437,220

Explanation of Calculation for Upstream Targets:

Please note that in 2009, upstream (indirect) targets are reduced because USG used more recently updated size estimations. Additionally, there is no national plan for MOH/KPA in 2009 for MSM and high-risk men intervention.

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

- 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.
 - FSW: There is aggregated Direct FSW + Indirect FSW = 94,500 (direct FSW) + 68,600 (indirect FSW)=163,100. National level use 70% of coverage for FSW.
 - MSM/MSW (Waria and MSW): FHI is the only a major implementing agency in country for MSM/Waria and MSW.
 - High-risk Men: FHI will train KPA to undertake high-risk men interventions and provide TA on M&E system. In 2009, KPA does not currently have a concrete plan to implement prevention programs for high-risk men.
- PLHA: All PLHA who have accessed basic care and TB/HIV programs will also receive prevention activities. FHI will advocate to integrate PwP for all care packages (25,272 = number of all PLHA provided with care).

Upstream Target Calculation		
<i>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</i>		
Target population	2008	2009
- IDU	= 33,000 (55,000 IDU size estimation x 60 % coverage)	0
- FSW	= 36,326 (117,180 x 62% coverage x 50% direct fund by USG)	= 98,356
- MSM/MSW	= 172,393 (574,646 MSM/MSW size estimation x 60% coverage x 50% direct fund by USG)	0
- High-risk men	= 556,222 (1,404,600 high risk men size estimation x 66% coverage x 60% direct fund by USG)	0
- Prisoners	= 9,000 (15 sites x 600 inmates)	0
- PLHA	= 4,942 (refer to care calculation)	= 25,272
Total	811,883	123,628

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	<u>Total Target: FY 2008</u> Downstream = 857,530 Upstream = 811,883 Total = 1,699,413 (857,530+ 811,883)
	<u>Total Target: FY 2009</u> Downstream = 437,220 Upstream = 123,628 Total = 560,848 (437,220 + 123,628)

USG Indonesia FY 2008 Mini Country Operational Plan

**Explanation of Downstream (Direct) Summary Target Calculations
by Program Area in Table 3.3
(Final 7/9/2007)**

PART II:

Required Targets by Program Area	FY 2009 Downstream Targets	Explanation of Downstream (Direct) Summary Target Calculations
Table 3.3.01 Prevention of Mother to Child Transmission		
1.1 Number of service outlets providing the minimum package of PMTCT services according to national and international standards	13	FHI will implement the integration of PMTCT into the Continuum of Care (CoC) models in 3 MARP sites. In Papua, PMTCT services are integrated in the CoC network. USG will continue support in 5 districts sites (since 2007) and additional 5 district sites in 2009.
1.2 Number of pregnant women who received HIV counseling and testing for PMTCT and received their test results	1,680	See part one core indicator explanation
1.3 Number of HIV pregnant women who received antiretroviral prophylaxis for PMTCT in a PMTCT setting	49	See part one core indicator explanation
1.4 Number of health workers newly trained in the provision of PMTCT services according to national and international standards	206	Structured mentorship will be provided in order to refresh formal trainings which were planned in 2008. 1) There are 28 health centers (PMK) where 2 counselors, 2 midwives, and 1 doctor per health center will be trained (28X5=140). 2) There are 11 hospitals (RS) where 2 midwives and 2 doctors and 2 counselors will be trained per each hospital (6X11=66).
Table 3.3.02 Abstinence/Be Faithful		
2.1 Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	29,900	

2.1.A Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence	0	
2.2 Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful	0	
Table 3.3.05 Condoms and Other Prevention		
5.1 Number of targeted condom service outlets	0	
5.2 Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	437,220	See part one core indicator explanation
5.3 Number of individuals trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful	610	FHI will provide intensive training in 2007 and 2008 for all IAs. To build upon previous years efforts, in 2009 BCI trainers will provide structured mentoring for new staff and follow-up with staff who have already been trained. It is estimated 10 staff for each 61 implementing agencies (10X61=610). In addition, 120 peer educators will be trained to promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful.
Table 3.3.06 Palliative Care: Basic Health Care and Support		
6.3 Number of service outlets providing HIV-related palliative care (excluding TB/HIV)	39	There are 9 sites in 3 model areas including Jakarta, Bandung and Malang (3x3=9), 8 hospitals and all 22 Public health centers (PKM) clinics in Papua.
6.4 Number of individuals provided with HIV-related palliative care (excluding TB/HIV)	1,789	See part one core indicator explanation
6.5 Number of individuals trained to provide HIV palliative care (excluding TB/HIV)	148	In 3 model areas for MARPs, there are 3 people who will be trained per site (3x9=27). In Papua, 5 staff from each of the 2 big hospitals, 3 staff for each of the 6 medium sized-hospitals will be trained. There are 8 big PKMs where 3 staff will be trained and 14 small PKM that 2 staff will be trained. Finally, 8 staff from Layak (NGO), 4 staff from Bandung plus support to NGOs, which will be 1 staff for each 29 NGOs will be trained in 2009.
Table 3.3.07 TB/HIV		
7.1 Number of service outlets providing clinical prophylaxis	39	There are 9 sites in 3 model areas for MARP (3x3=9) and in Papua 8

and/or treatment for tuberculosis (TB) to HIV-infected individuals (diagnosed or presumed) in a palliative care setting		hospitals and all 22 PKM clinics.
7.2 Number of HIV-infected clients attending HIV care/ treatment services that are receiving treatment for TB disease	655	See part one core indicator explanation
7.3 Number of individuals trained to provide clinical treatment for TB to HIV-infected individuals (diagnosed or presumed)	83	USG partner will provide training on TB/HIV. There are 78 staff per clinic from 39 sites (2 personsX39=78) and additional 5 staff from 1 NGO where 5 staff will be included for the training.
7.4 Number of registered TB patients who received counseling and testing for HIV and received their test results at a USG-supported TB service outlet	3,400	See part one core indicator explanation
Table 3.3.09 Counseling and Testing		
9.1 Number of service outlets providing counseling and testing according to national and international standards	41	There are 9 sites in 3 model areas (3x3=9). In Papua 8 hospitals and 8 PKM out of 22 clinics will be strengthened for VCT services. In addition, USG partner will continue to support 10 NGOs VCT. Also, DOD will support test kit at six military medical facilities and staff will receive VCT training.
9.2 Number of individuals who received counseling and testing for HIV and received their test results	9,387	See part one core indicator explanation
9.3 Number of individuals trained in counseling and testing according to national and international standards	80	There is an aggregated number from: 1) There are 2 people will be trained per site in all model areas (25 VCT clinics x2 people). 2) Under system approach, FHI will provide training to VCT staff from districts surrounding model areas with estimated 20 staff (10 sites x 2 staff =20). 3). One staff from each of 10 NGO-VCT will be trained (10x1=10).
Table 3.3.11 Treatment: ARV Services		
11.1 Number of service outlets providing antiretroviral therapy	8	There are 3 hospitals in 3 model areas for MARP and 5 hospitals out of 8 hospitals in Papua will provide ART services.
11.2 Number of individuals newly initiating antiretroviral therapy during the reporting period	215	In 2009, it is estimated 20 newly initiating ART patients from Layak (NGO) 20, Bandung 30, Malang 40, and Papua 125 patients.

11.3 Number of individuals who ever received antiretroviral therapy by the end of the reporting period	990	Targets are aggregated numbers from: 1) Estimated 200 ART patients who ever received treatment at the end of 2008 and dropped out from the system, 2) Estimated 725 currently ART patients in 2009, and 3) estimated 65 patients or 15% of newly ART patients in 2009 will be dropped out from the service (215X30%=65).
11.4 Number of individuals receiving antiretroviral therapy at the end of the reporting period	725	See part one core indicator explanation
11.5 Total number of health workers trained to deliver ART services according to national and/or international standards	42	There is 15 staff from 3 hospitals in 3 model areas for MARP (5x3=15) and 5 hospitals in Papua 5 staff will be trained (5x5=25). In addition, 2 staff trained from 1 Layak (NGO).
Table 3.3.12 Laboratory Infrastructure		
12.1 Number of laboratories with capacity to perform 1) HIV tests and 2) CD4 tests and/or lymphocyte tests	0	
12.2 Number of individuals trained in the provision of laboratory-related activities	0	
12.3 Number of tests performed at USG-supported laboratories during the reporting period: 1) HIV testing, 2) TB diagnostics, 3) syphilis testing, and 4) HIV disease monitoring	0	
Table 3.3.13 Strategic Information		
13.1 Number of local organizations provided with technical assistance for strategic information activities	281	There are 66 IAs, 11 hospitals, 28 PKMs , 79 district KPAD, 79 district health officers, 8 provincial health offices, and 8 provincial KPAD, 1 MOH, and 1 KPA will receive TA on SI in 2009.
13.2 Number of individuals trained in strategic information (includes HMIS, M&E, and/or surveillance)	303	1) One staff from each 66 IA, 11 hospitals, 28 PKMs, 79 district KPAD, and 79 district health offices will be trained (66+11+28+79+79)x 1 staff=263. 2) 2 staff from 8 provincial KPAD and 8 provincial health office will be trained (8+8)x2=32, and 3) 4 staff from each MOH and KPA will be received training in 2009.
Table 3.3.14 Other/Policy Analysis and Systems Strengthening		
14.1 Number of local organizations provided with technical assistance for HIV-related policy development	176	There are 79 district KPAD, 79 district health offices, 8 provincial health offices, and 8 provincial KPAD, 1 MOH, and 1 KPA will receive TA from FHI.

14.2 Number of local organizations provided with technical assistance for HIV-related institutional capacity building	279	There are 66 IAs, 11 hospitals, 28 PKM, 79 district KPAD, 79 district health offices, 8 provincial health offices, and 8 provincial KPAD will receive TA from FHI.
14.3 Number of individuals trained in HIV-related policy development	176	There are 180 organizations that will be provided with TA and it is estimated that one staff per organization will be trained by FHI.
14.4 Number of individuals trained in HIV-related institutional capacity building	295	1) There is one staff per organization who will be trained including 66 IAs, 11 hospitals, and 28 PKM, 79 provincial health offices, and 79 district KPAD. 2) Two staff from 8 provincial KPA and 2 staff from provincial health offices will receive training from FHI.
14.5 Number of individuals trained in HIV-related stigma and discrimination reduction	240	There is one staff from 66 IAs, 79 district KPAD, 79 district health offices, 8 provincial health offices, and 8 provincial KPA who will receive training from FHI.
14.6 Number of individuals trained in HIV-related community mobilization for prevention, care, and/or treatment	240	There is one staff from 66 IAs, 79 district KPAD, 79 district health offices, 8 provincial health offices, and 8 provincial KPA will receive training from FHI.

ANNEX IX

IDU Activities Funded by GFATM

Reducing STI/HIV Transmission among IDU **Funded by GFATM**

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 and gender.

In the first three 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 53,000 IDUs reached by program activities to date. During Year Four a total of 18 IAs will be carrying out interventions in communities and/or in prisons, all under funding from GFATM. This should translate into continued expansion of program coverage and significant increase in quality during Year Four.

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

- **Maintaining coverage and improving quality** by:
 - Continuing to build capacity of all partner NGOs and to improve the skills of outreach workers in each implementing agency to ensure that high levels of motivation are maintained.
 - Improving the quality 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. 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 adapting the coupon system for use in reaching partners of IDU within a pilot program in Malang. Technical assistance on managing this system will continue to be provided by FHI as needed.
 - Expanding the use of alternative models for “secondary” distribution of clean needles and syringes through networks of IDU and volunteers, while increasing utilization of needle exchange programs in fixed locations such as drop-in centers and community health centers.
 - 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 more partners of IDU. The majority of partners will be reached through the expansion of counseling activities and

special support groups organized by female outreach workers, focusing on relevant issues 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 TB, STIs, Hepatitis, and female drug users. Formative research on a new series of materials was completed during Year Three and production of these innovative materials will be completed early in Year Four. ASA will also begin experimentation with more innovative forms of communications for IDU, such as audio and video messages.
- **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.

Improving the effectiveness of STI, HCT 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 continue to provide comprehensive care to serve the special needs of IDU and their partners and additional training and technical assistance will be provided as the network expands. 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 continue to be expanded through trained case managers.
- **Improving the take-up of services offered by IAs** including HCT, 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 providers 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. Assisting all IDU, both HIV negative and HIV positive, to access appropriate clinical services is the goal.

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, the National Police Force, and HCPI 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.
- Over the past five years, FHI has played an important role in advancing HIV/AIDS programming in **prisons** in Indonesia. This included assistance in the development of the National Strategy for HIV/AIDS Interventions in Prisons and the guidelines for their implementation, facilitation of an MOU between the Ministries of Health, Home Affairs, and Justice & Human Rights delineating responsibilities for providing services both in prisons and in the community following inmate release, and training of "the national response team" in HIV/AIDS related areas. Through partner IAs, FHI will continue to provide **outreach** and assist prison staff to implement prevention and risk reduction activities for prisoners. IAs will work with prison staff to identify **inmate peer leaders**, who will be trained to work specifically on risk reduction for IDU. FHI IAs will also seek to improve **access to prevention materials** (condoms and bleach) in priority prisons.

Support activities

- Advanced training for all IDU IAs to expand and reinforce technical skills for IDU interventions will be implemented in collaboration with the National AIDS Commission and national experts, and focus on such priority topics as gender, and access to CST and MMT. A special training course on writing skills will also be implemented.
- FHI will also organize a national level workshop to discuss IDU program achievements to date and establish priorities and approaches for continuing this important work in the future.

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 Achievement (Up to Jun 2008)	Year 4 Target
Indicators				
A. IDU				
Outreach for Behavior Change (Global Fund)				
- IDU Reached (new contact) (Life of Program)	10,259	38,669	53,960	57,500
- IDU Reached (new contact) (2008-2009)	-	-	-	14,000
- Total Number of Contacts (IDU) (life of Program)	23,288	165,501	278,433	350,000
- Total Number of Contacts (IDU) (2008-2009)	-	-	-	84,000
- IDU Sex Partner Reached (new contact)	295	3,754	4,791	5,750
- IDU Sex Partner Reached (new contact) (2008-2009)	-	-	4,791	1,100
- Total Number of Contacts (IDU Sex Partner)	460	4,846	8,030	3,300
- Average Active Peer Educators/Volunteers	70	450	560	350
- IDU referred for Substitution Therapy	1,032	8,788	17,905	28,000
- Printed IEC Materials Distributed	77,183	267,614	377,370	500,000
- Condoms Distributed (For Promotional Purposes)	39,943	180,039	322,553	450,000
- Number of Needles Distributed	74,053	665,574	1,378,328	3,500,000
- IDU Received Needles	1,608	10,795	17,467	25,000
- Alcohol Swabs Distributed	12,848	353,793	859,884	3,000,000
VCT Services				
- IDU Received Pre-Counseling Services	914	4,575	7,366	10,400
- IDU Tested for HIV	802	3,556	5,657	6,400
- IDU Received Post-Counseling Services	551	2,852	4,669	6,800
- IDU Sex Partner Received Pre-Counseling Services	87	547	971	1,400
- IDU Sex Partner Tested for HIV	66	457	803	950
- IDU Sex Partner Received Post-Counseling Services	54	417	736	1,100
CST Services				
- IDU Receiving Case Management Services	1,107	2,294	3,475	4,600
- IDU Sex Partner Receiving Case Management Services	69	284	498	600

Result Area III: Strengthening the Institutional Response	Year 1 Achievement	Year 2 Achievement	Year 3 Achievement (Up to Jun 2008)	Year 4 Target
Indicators				
B. Prison				
- Prison's Staff Trained in HIV/AIDS	435	1,887	2,776	3,000
- Prisoners Reached	4,510	16,863	29,389	45,000
- Prisoners Reached (2008-2009)	-	-	-	14,500

Partner Organizations for IDU

III. IDU			
No	Institution	Location	Activities
North Sumatera			
1	Yayasan Galatea	Medan	BCC for IDUs and Partner, Counselor & CM
2	Medan Plus Support	Deli Serdang, Serdang Bedagai, Pematang Siantar & Simalungun	BCC for IDUs and Partner, Counselors & CM
Riau Islands			
1	Yayasan Batam Tourism Development Board (YBTDB)	Batam	BCC for FSW and Clients; STI Services & VCT

III. IDU			
No	Institution	Location	Activities
DKI Jakarta			
1	Yayasan Rempah	North Jakarta	BCC for IDUs and Partner, Counselors and CM
2	Pusat Penelitian Kesehatan, Universitas Indonesia	South Jakarta & Depok	BCC for IDUs, Counselors and CM
3	Yayasan Karisma	East Jakarta	BCC for IDUs & CM
4	Gerbang Foundation	Central Jakarta	BCC for IDUs, Counselors and CM
5	Kios Informasi Kesehatan Pusat Kajian Pembangunan Masyarakat UNIKA Alma Jaya	Central, West & North Jakarta	BCC for IDUs, Counselors and CM
6	Perkumpulan Pemberantasan Tuberkulosis Indonesia Jakarta (PPTI)	Jakarta	VCT and CST Services
7	Yayasan Pelayanan Anak dan Keluarga (LAYAK)	Jakarta	CST & Training
8	Yayasan Partisan Club	Jakarta	BCC for IDUs in Prison Counselors and CM
9	Yayasan Tegak dan Tegar	Jakarta	CM Services
West Java			
1	Yayasan Bahtera Bandung	Bandung City, Bandung, Cimahi	BCC for IDUs, VCT & CST
2	Yayasan Permata Hati Kita (Yakita)	Bekasi, Bekasi City, Sumedang	BCC for IDUs, VCT & CST
3	Lembaga Studi Paradigma Rakyat (LESPRA)	Bogor City & Bogor District	BCC for IDUs, VCT & CST
4	Yayasan Masyarakat Sehat	Bekasi City and Bekasi District	BCC for IDUs, VCT & CST
5	Himpunan Konselor HIV/AIDS (HIKHA) West Java	Bandung District and Subang District	BCC for IDUs, VCT & CST
6	Yayasan Insan Hamdani-Bandung Plus Support (BPS)	Bandung City, Sumedang and Subang District	VCT
6	Yayasan Insan Hamdani-Bandung Plus Support (BPS)	Bandung District and Bandung City	VCT & Case Management Services
Central Java			
1	Yayasan Wahana Bakti Sejahtera (YWBS)	Semarang City, Semarang, Salatiga City	BCC for IDUs & VCT
2	Yayasan Mitra Alam (YMA)	Surakarta & Salatiga Cities	BCC for IDUs & VCT
3	LSM Peduli HIV/AIDS(PEDHAS)	Banyumas & Cilacap Districts	BCC for IDUs & VCT
East Java			
1	Yayasan Sadar Hati	Malang City & Malang District	BCC for IDUs & VCT
2	Yayasan Bina Hati	Sidoarjo District & Surabaya City	BCC for IDUs, VCT & Case Management
3	Yayasan Bambu Nusantara	Madiun City & Madiun District, Nganjuk	BCC for IDUs, VCT & Case Management