



PROCUREMENT SENSITIVE INFORMATION

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**EVALUATION OF THE INDONESIAN
AKSI STOP AIDS PROGRAM**

Submitted to USAID/Jakarta

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EXECUTIVE SUMMARY

Scope of Work: Over a three-week period, a 10-person team conducted an evaluation of the Aksi Stop AIDS (ASA) program. The evaluation concentrated on achievement of the program's five Results Packages. The fundamental question was whether or not ASA should be continued, either as designed or with modifications. The team spent the first week interviewing ASA staff and other informants, the second week visiting implementing agencies (IAs) in Papua, North Sulawesi, and Central Java. Most of the third week was spent drafting the report and debriefing USAID, ASA, the Ministry of Health (MOH), and others.

The Epidemiological Situation: Indonesia's epidemic remains a concentrated one, with the possible exception of Papua, which appears to be spreading to the general population. In addition to Papua, the provinces with the largest number of infections appear to be Jakarta DKI and East Java. The groups most at risk are injecting drug users (IDUs), clients of female sex workers, partners of high-risk groups, men who have sex with men (MSM), female sex workers (FSW), and transvestites. Behavioral surveillance surveys have shown that knowledge about HIV/AIDS is high, but that this knowledge has little effect on behavior. Condom use remains low, as do visits to centers for treatment of sexually transmitted infections (STIs) and for voluntary counseling and testing, while sharing of contaminated needles remains high.

Achievements: ASA must be lauded for carrying out a very complex program in its 10 provinces under very difficult conditions. Its achievements go well beyond the process indicators described in this report to include successes in advocacy, policy development, leveraging, networking, and public relations. In the view of the Evaluation Team, there is no doubt that this important program should be continued.

RP 1: Most-At-Risk (MARG) Behavior Change: Some 66 Implementing Agencies (IAs) are conducting outreach, peer education, harm reduction, mass media communication, condom distribution, and STI referrals in the 10 program provinces. Outreach and peer education are reaching more than 700,000 high-risk individuals. As of July 2004, outreach contacts had reached twice the target number for FSWs and MSM, but only half the target for IDUs. ASA has been most successful in reaching FSWs and their high-risk clients but less so with IDUs, MSM, and transvestites. Condom distribution is on target. However, the most recent data available show that over 50 percent of FSWs, but only 29 percent of clients reported using a condom during their most recent sexual act.¹

RP 2: STI; VCT; and Care, Support and Treatment (CS&T) Services: ASA supports 29 comprehensive STI clinics in 9 provinces through 28 IAs. Each clinic is staffed by at least four health professionals trained in clinical management and is equipped to provide enhanced syndromic management of STIs. Quality control is excellent, and ASA's minimum laboratory standards are a model for other countries around the world. However, ASA is falling short of its one outcome target for this Results Package: 100 percent of FSWs and other clients diagnosed and treated for STIs. Coverage averages 42 percent for FSWs and

¹ FSW data from the BPS 2002-2003 and client data from BSS 2004.

MSM, and 9 percent for clients.² There are now 23 VCT sites in 10 cities and CS&T teams in 25 hospitals nationwide. The caseload is low because services are just getting underway and promotion has been limited thus far.

RP 3: Surveillance systems: ASA has been instrumental in developing the first HIV/AIDS surveillance systems in Indonesia. Behavior Surveillance Surveys (BSS) of MARGs are now operational in 14 sites, and a national sentinel surveillance system is under development. ASA has provided significant technical assistance to the Central Bureau of Statistics (BPS) and the MOH, which are now capable of carrying out these surveys on their own, though they still require assistance with data analysis and utilization. Additionally, ASA successfully conducted exercises in 2001 and 2003 on estimating the size of populations at risk for HIV. This estimation methodology designed by ASA has been recognized as a global best practice and is now being utilized by other countries in the region.

RP 4: Capacity development: ASA has made significant investments in the development of national and local management and technical capabilities, including major advocacy efforts with the Indonesian Forum of Parliamentarians on Population and Development (IFPPD) to increase budget allocations for HIV/AIDS. However, the National Commission on HIV/AIDS (KPD) and the Regional AIDS Commissions (KPADs), in particular, will need additional assistance over the next several years. Nongovernmental organizations (NGOs), many of which have improved their administrative capabilities, still need mentoring, supervision, refresher training, and technical assistance, especially in technical areas.

RP 5: Leveraging: ASA's leveraging initiative focuses on workplace programs. Other areas include programs for the uniformed services; the Global Development Alliance with British Petroleum in the Bird's Head; and collaboration with other donors, including the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). Workplace activities are a low-cost strategy because the companies often pay many of the direct costs, and reach is good because many companies are large (thousands of employees). However, the majority of people reached are low-risk workers. To strengthen the program, future efforts should focus on high-risk companies and most at-risk men within companies. Leadership and collaboration with other donors are critical to leveraging resources to address the HIV/AIDS epidemic in Indonesia and should be continued.

Management, M&E: By and large, the management of this very complex ASA program has been very good. The administrative, financial, and monitoring systems ensure that the more than the 100 subprojects currently underway are well managed. However, the processes are highly centralized and time-consuming, which may be limiting the provision of adequate and timely technical assistance and support to the subprojects. Based on the experience gained during the last three years, perhaps now is the time to decentralize control to the provinces. This will further strengthen ASA's ability to provide timely and adequate technical support to the IAs. Extensive monitoring is conducted to ensure that the program is implemented as intended. Evaluation is limited to BSS indicators, which are only available every two to three years. There is little evaluation of program interventions to determine what does and does not work.

² Source: ASA PowerPoint presentation on STI Program.

Issues: ASA is to be commended for achieving as much as it has in a very difficult environment. Nevertheless, a number of issues still need to be addressed. Donor and Government of Indonesia (GOI) coordination is improving but still needs strengthening. Integration of HIV/AIDS into other Mission Strategic Objectives is needed, as HIV/AIDS is a multisectoral problem. Papua is a special case and needs a special strategy. Sustainability, while not a USAID concern where HIV/AIDS is concerned, is a significant concern of IAs and should be addressed as part of capacity development. Program continuity deserves immediate action.

Overall Conclusions

- ASA is achieving significant results in a very difficult environment. The program has strong leadership, a highly qualified staff, and a commitment to coordination and achievement of results that enable it to be successful.
- ASA's approach is "ecological," in that its components are all interrelated, which promotes synergy and results in the whole program's being greater than the sum of its parts.
- ASA has made substantial progress in meeting targets for four of its five Results Packages, including improved quality, accessibility and utilization of STI, VCT, and CT&S services; improving surveillance systems; capacity development; and leveraging.
- Although BSS data were not available to the team on the effects of the program on behavior change and its impact on HIV prevalence, the qualitative data (and the preliminary analysis from North Sulawesi) indicate that the program has, indeed, had an impact.
- However, ASA is spread too thin under its current organizational structure. It is attempting to do too many things through too many subprojects and a highly centralized structure. The resulting situation affects the quantity and quality of technical and administrative support provided to the field.
- Supervision and mentoring in the field are greatly appreciated by the IAs. But more is needed in both the technical and the administrative areas. ASA's centralized structure is hard-pressed to meet these needs.
- Continuity is a major concern at this time. All fieldwork is scheduled to end in nine months. If ASA is to be continued, action is necessary soon to ensure that there is no break in continuity. Once the subprojects end, it could take years to rebuild them, and that would have a serious effect both on USAID's ability to have an impact on HIV transmission in Indonesia and on the national response to the epidemic.

Overall Recommendations

- ASA's mandate is to prevent the spread of HIV/AIDS by changing the behavior of most at-risk groups. It has done an excellent job in identifying and reaching these groups with risk-reduction messages. Coverage of all of these groups has expanded markedly. Outreach among FSWs and their clients has been very effective. The quality of STI services is excellent. The surveillance systems are seen as models for other countries to emulate. ASA has been very effective in leveraging funds from other donors and

businesses. All of these interventions have come together in to have an effect on the bottom line – behavior change among the most at-risk groups. The 2004 quantitative data on behavior change trends should become available in the next month or two. The Evaluation Team believes that these data will reinforce the qualitative conclusion that the program has had an impact and is on the right track. To ensure that this trend continues, the Evaluation Team believes that ASA should be extended for at least five more years.

- For reasons of continuity, USAID should not wait for those data to be published before making a decision to continue its HIV/AIDS program and begin its follow-on procurement process. The quantitative BSS data should be used, as they become available, to further inform the follow-on program design and procurement process.
- The focus of ASA should remain where it is now, on prevention of the spread of HIV among most-at-risk groups. Papua should have a separate strategy that addresses its generalized epidemic and its unique characteristics. Capacity development at the central and local levels should also remain a focus.
- ASA should begin to streamline and decentralize its administrative and technical functions right away, rather than wait for the follow-on program to do so. There is enough time left to do this, and these modifications would ensure that any follow-on program inherits a decentralized system.
- The heavy reliance on BSS data for evaluation has made it difficult for the Evaluation Team to demonstrate that individual program interventions have had any effect on behavior, much less an impact on HIV prevalence. Although the 2004 data should be available soon, they may not provide sufficient evidence of the effectiveness of ASA activities on behavior/prevalence change. ASA should undertake rapid, inexpensive evaluations of selected key interventions to demonstrate the effectiveness of those interventions. This type of evaluation should be built into all interventions in the follow-on program.
- ASA may need external technical assistance to improve current behavior change interventions, and to develop process evaluation and monitoring tools that can be used at local levels to assess progress and make needed revisions.

ABBREVIATIONS AND ACRONYMS

AHRN	Asian Harm Reduction Network
ARO	Asia Regional Office
ASA Program	Aksi Stop AIDS Program
AusAID	Australian Agency for International Development
BCC	Behavior change communication
BCI	Behavior change intervention
BKKBN	Badan Koordinasi Keluarga Berencana (Family Planning Coordinating) National Board
BNN	Badan Narkotika Nasional (National Narcotics Board)
BNP	Badan Narkotika Propinsi (Provincial Narcotics Board)
BPS	Biro Pusat Statistik (Central Bureau of Statistics)
BSS	Behavior surveillance survey
CDC	Center for Communicable Disease Control (P2M)
CHR/MBI	Centre for Harm Reduction, Macfarlane Burnet Institute
CMFPW	Coordinating Ministry for People Welfare
CST	Care, Support and Treatment
DfID	Department for International Development (British)
DKI Jakarta	Daerah Khusus Ibukota Jakarta (the provincial-level administrative unit covering Jakarta)
DPR	Dewan Perwakilan Rakyat (House of Representatives)
FBO	Faith-based organization
FHI	Family Health International
FSW	Female sex worker
GDF	Global Development Alliance
GFATM	Global Fund for HIV/AIDS, TB and Malaria
GIPA	Greater Involvement of People with HIV/AIDS
GOI	Government of Indonesia
HIV	Human Immunodeficiency Virus
HQ	Headquarters
IA	Implementing agency
IDU	Injecting drug user/Injection drug use
IFPPD	Indonesian Forum of Parliamentarians on Population and Development
IHPCP	Indonesia HIV/AIDS Prevention and Care Project Phase 2 (AusAID)
ILO	International Labour Organization of the United Nations
ILOM	Indigenous Leader Outreach Model
KPA	Komisi Penanggulangan AIDS (National AIDS Commission)
KPAD	Komisi Penanggulangan AIDS Daerah (Regional AIDS Commission)
KKI	Komite Kemanusiaan Indonesia
LPDS	Lembaga Pers Dr Soetomo
MARG	Most at-risk group
MOE&C	Ministry of Education and Culture
MOH	Ministry of Health
MOSA	Ministry of Social Affairs
MORA	Ministry of Religious Affairs

MOJ&HR	Ministry of Justice and Human Rights
MSM	Males who have sex with males
NESP	Needle and Syringe Exchange Program
NGO	Non-governmental organization
P2M	Dit. Pemberantasan Penyakit Menular (Directorate of Communicable Disease Control)
PKBI	Perkumpulan Keluarga Berencana Indonesia (Indonesian Planned Parenthood Association)
PLWHA	People Living With HIV/AIDS
PSA	Public Service Announcement
RP	Result Package
RRF	Rapid Response Fund
RSPI	Rumah Sakit Penyakit Infeksi, Infectious Diseases Hospital
STI	Sexually transmitted infection
TA	technical assistance
TOT	Training of trainers
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Fund for Population Activities
UNDP	United Nations Development Program
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
WHO	World Health Organization
YKB	Yayasan Kusuma Buana

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I. INTRODUCTION

Summary: Over a three-week period, a 10-person team conducted an evaluation of the Aksi Stop AIDS (ASA) program. The evaluation concentrated on achievement of the program's five Results Packages. The fundamental question was whether or not ASA should be continued, either as designed or with modifications. The team spent the first week interviewing ASA staff and other informants, the second week visiting implementing agencies in Papua, North Sulawesi, and Central Java. Most of the third week was spent drafting the report and debriefing USAID, ASA, the Ministry of Health, and others.

A. Background

Since 1993, USAID/Indonesia has supported Government of Indonesia (GOI) and community efforts to address HIV/AIDS. The economic, political, and social crises of 1997–1998 exacerbated the epidemic as many Indonesians adopted coping behaviors that put them at greater risk of contracting HIV/AIDS. The country is experiencing new, rapidly developing sub-epidemics in several provinces and communities. The GOI now perceives HIV/AIDS as a serious threat to its national development, prosperity, and stability.

USAID/Indonesia's response to this situation is a multisectoral strategy designed to provide the programmatic structure for an expanded USAID response to the HIV/AIDS epidemic in Indonesia. The first phase (2000–2002) focused on areas where local epidemics were clearly evident and expanding: Papua, DKI Jakarta, East Java (Surabaya/Malang), North Sulawesi (Manado/Bitung), and Riau (Pekanbaru and the Riau Islands). These programs were to be expanded with the objective of achieving 80 percent coverage of key vulnerable groups by 2007.

The second phase (2002–2003) added five additional areas: West Java (Bandung), North Sumatra (Medan), Central Java (Semarang), South Sumatra (Palembang), and the Maluku Islands (Ambon). These sites started with surveillance and assessments of nongovernmental organization (NGO) and government capacity. They were then expanded to support focused interventions to reach selected most-at-risk groups (MARGs) and to develop NGO and local government capacity.

Activities in these 10 sites were expected to help maintain HIV prevalence below 1 percent among 15–49-year-olds and to provide a comprehensive package of prevention activities for 80 percent of the targeted population by 2007.

B. The ASA Program

The principal vehicle for this strategy is the "Aksi Stop AIDS" program (ASA), which began in August 2000 and runs through September 2005. The ASA program is managed by Family Health International (FHI), a U.S.-based nongovernmental organization, in collaboration with the Ministry of Health (MOH/(DepKes), local government agencies, provincial AIDS commissions (KPAD), national and local NGOs, and private sector partners.

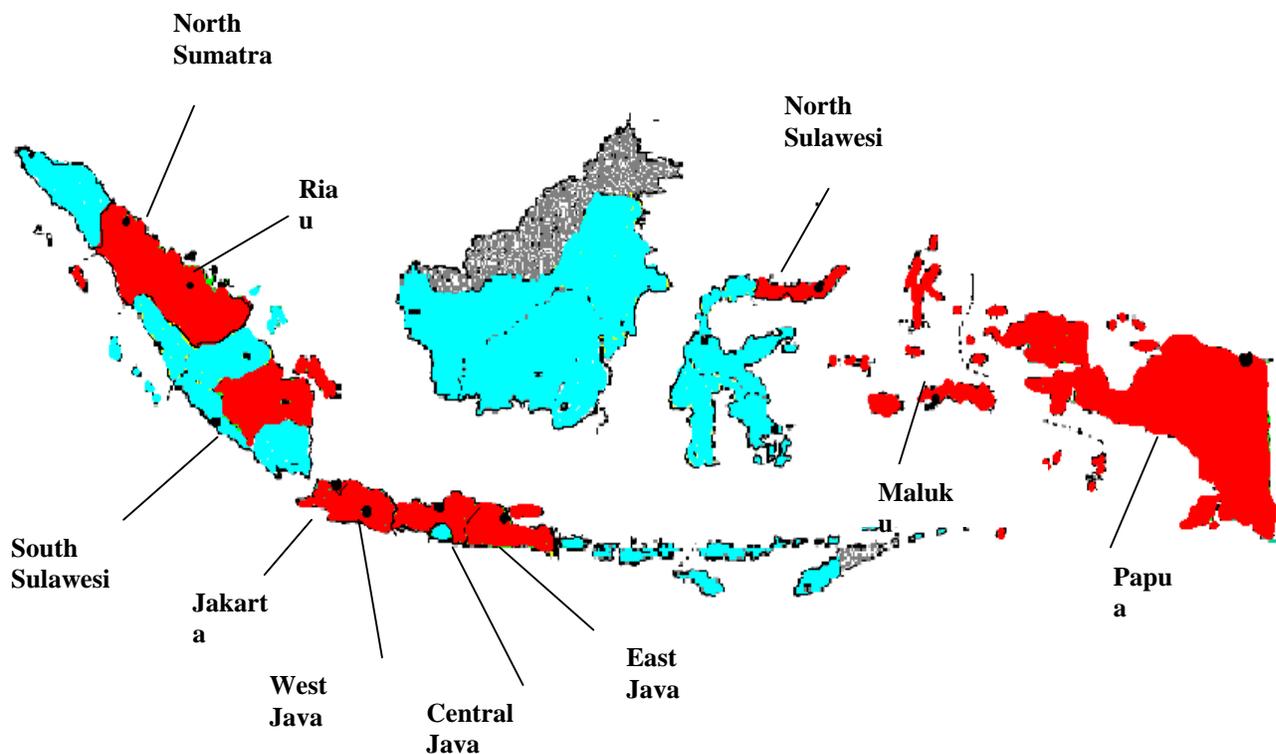
The ASA program provides technical assistance and financial support in the 10 provincial

sites mentioned above for a variety of interventions ranging from interpersonal and outreach communications to prevention marketing and condom promotion, harm reduction strategies, the strengthening of sexually-transmitted-infection (STI) services and systems, sero- and behavioral-surveillance surveys, policy dialogue, skills training for community organizations, and strategic network building for private sector partners.

These activities have been designed to achieve five Results Packages (RPs):

- RP 1: Increased risk-reduction behavior and practices among individuals most at risk for HIV and STIs
- RP 2: Strengthened quality, accessibility, and utilization of prevention, care and treatment services for individuals most at risk for STI/HIV/AIDS
- RP 3: Enhanced capacity and quality of GOI HIV/STI surveillance systems and their use in decision-making
- RP 4: Strengthened capacity of local organizations to plan, finance, manage, and coordinate HIV/STI responses
- RP 5: Increased leveraging of programmatic interventions and financial resources

The ASA program sites are shown in the map below and are listed in Annex D.



C. The Evaluation

USAID/Indonesia requested The Synergy Project to provide technical support in conducting an external evaluation of its ASA program. The purpose of the evaluation was to assess: FHI/ASA's progress toward meeting program goals, objectives and target indicators; major achievements; and the current and future HIV/AIDS intervention needs in Indonesia that are most suited to USAID assistance. The evaluation would not only assess the success of the program to date, but would also identify continuing and new challenges and lessons learned from implementation experiences. Additionally, the evaluation was to assess the best course of future USAID assistance and to make recommendations regarding whether or not the ASA program should be continued, either as currently designed or with modification. An abbreviated version of the scope of work can be found in the Annex A.

Synergy provided a team leader (Jack Reynolds) and four other local and international consultants (Gani Perla, Izhar Fihir, Suriadi Gunawan, and E. Haran). USAID/Washington provided one advisor (Billy Pick), and USAID/Indonesia provided two staff members (Ratna Kurniawati and Lisa Kramer). The Ministry of Health provided one representative from the Directorate for Communicable Disease Control (CDC), (Jeanne Uktolseja). A representative was seconded from the UNAIDS regional office in Bangkok (Swarup Sakar). The evaluation was to be designed, undertaken, and completed over a three-week period. Two deliverable products were required: a detailed evaluation plan and a complete evaluation report.

D. The Methodology

The methodology was limited to the review of relevant documents; interviews with program staff, stakeholders, implementing agencies' (IA) staff and clients; and observations. A major constraint was the unavailability to the team of the most recent Behavior Surveillance Survey (BSS) data, which are still being collected in some provinces and remain to be analyzed. Thus, the team concentrated on the implementation of activities and interventions designed to achieve the five Results Packages listed above.

The team spent the first week interviewing ASA staff and a variety of other informants in Jakarta. Most of the second week was spent in the field conducting interviews and making observations. The team was split into three sub-teams that went to Papua (Sorong and Jayapura), Central Java (Semarang and Tegal City), and North Sulawesi (Manado and Bitung). Most of the third week was spent preparing a draft report and conducting debriefings for USAID, ASA and the MOH. A detailed schedule can be found in the Evaluation Plan.³

³ This is a separate document required in the SOW and prepared by the Team Leader.

II. THE EPIDEMIOLOGICAL SITUATION

Summary: The epidemic in Indonesia remains a concentrated one, with the possible exception of Papua, where it appears to be spreading to the general population. After Papua, the provinces with the largest number of infections appear to be Jakarta DKI and East Java. The groups most at risk are IDUs, clients of female sex workers (FSWs), and partners of FSWs, males who have sex with males, and transvestites. Behavioral surveillance surveys have shown that knowledge about HIV/AIDS is high, but this understanding has little effect on behavior. Condom use remains low, as do visits to STI and voluntary counseling and testing centers; needle-sharing remains high.

The first confirmed AIDS case was found in Bali in 1987. The number of reported AIDS cases increased at a slow pace until 1999, when numbers began to increase rapidly, especially among injecting drug users (IDUs). As of June 2004, a total of 1,524 AIDS cases and 2,865 HIV cases had been reported to the Ministry of Health.

Underreporting is significant, however, since reporting is only based on an instruction from the Minister of Health, and no law requires reporting.

The Ministry of Health estimated in 2002 that there were 90,000 to 130,000 HIV cases in Indonesia with the following breakdown: 38 percent IDUs, 30 percent clients of FSWs, 14 percent partners of high-risk groups, 9 percent males who have sex with males (MSM), 8 percent FSWs, and 1 percent transvestites.

Sentinel surveillance among female sex workers since the early 1990s found prevalence of less than 1 percent. Since 1998, increased prevalence was found in a number of sentinel sites, notably among female sex workers: 8.2 percent in Karimun (Riau), 16.7 percent in Sorong (Papua), 6.5 percent in Bali, 5.5 percent in West Java, 5.5 percent in West Kalimantan, and 3.6 percent in North Jakarta.

Table 1: Reported AIDS Cases, a/o June 2004

Province	Number	Percent
Papua	404	26.5
Jakarta DKI	358	23.5
East Java	213	14.0
West Java	117	7.7
Bali	89	5.8
Riau	87	5.7
North Sumatra	51	3.3
West Kalimantan	43	2.8
North Sulawesi	26	1.7
Central Java	25	1.6
South Sumatra	21	1.4
Other	90	5.9
Total	1524	99.9

A new phenomenon appeared in 1999 when HIV infection among IDUs began to rise rapidly. An increase from 16 percent to 41 percent in 2000, and to 48 percent in 2001 was found among those treated at the Jakarta Drug Dependence Hospital. Similar increases were found at the Yayasan Kita Rehabilitation Center in Bogor. Among prisoner IDUs, HIV prevalence was 53 percent in Bali, 22 percent in Jakarta, and 20 percent in Bogor. Among transvestites (*waria*) in Jakarta, HIV infection rose from 6 percent in 1997 to 21 percent in 2002, while a survey of MSM in Jakarta found a prevalence of 2.5 percent in 2002.

European Union surveys in the late 1990s of antenatal mothers in Riau and Papua found HIV prevalence to be relatively low, at 0.35 percent and 0.25 percent, respectively. In Jakarta, pregnant women who came for voluntary counseling and testing (VCT) had higher and rapidly increasing rates of 1.5 percent in 2000 and 2.7 percent in 2002. These data came from Yayasan Pelita Ilmu, which was the only clinic providing service for prevention of mother-to-child HIV transmission at the time.

HIV prevalence among blood donors also began to increase in 1999, and by 2002 had risen from 2 to 7 per 100,000 nationally, and to 20 per 100,000 in Jakarta.

The conclusion is that Indonesia has a concentrated HIV epidemic among certain at-risk groups, i.e., injecting drug users, commercial sex workers and their partners, transvestites and males who have sex with males. The epidemic is concentrated in the provinces of Riau, Jakarta, West Java, East Java, Bali, and Papua. In Papua the epidemic already appears to be expanding into the general population. Other provinces that are entering the concentrated epidemic phase are North Sumatra, West Kalimantan, and North Sulawesi.

The Behavior Surveillance Surveys in 2002 showed that although knowledge of HIV and how it is transmitted is fairly high, this understanding

Table 2: Most-At-Risk Groups in Indonesia

Injecting drug users
Female sex workers
Clients and partners of sex workers
Transvestites and male sex workers

has had little impact on behavior. Although condoms are available in places where sex is for sale (prostitution locations/brothels/bars), condom use is still quite low. Most sex workers and their clients know that condoms prevent HIV/STIs; nonetheless, the BSS found consistent condom use in commercial sex was only 12.1 percent, and

condom use during the most recent sex act was around 40 percent.

Almost all IDUs know that HIV can be transmitted through sharing of needles, 85 percent had shared others' needles and had passed their needles to others in the previous week. One reason that IDUs share needles is the fear of being caught by the police in possession of needles. Recent data showed that over two-thirds of IDUs were sexually active, 48 percent had multiple sex partners, and 40 percent had bought sex from female sex workers in the last year. Consistent condom use was practiced by only 10 percent of IDUs.

An important risk factor that increases vulnerability to HIV infection is the high prevalence of STIs among the commercial sex workers as well as the general population. The prevalence of STIs among FSWs is 10–25 percent for chlamydia, 10–20 percent for gonorrhea, and 2–10 percent for syphilis. Surveys of STIs among pregnant women (a surrogate for the general population) found a prevalence of 5–7 percent for chlamydia, 1–4 percent for trichomoniasis, and 1 percent for gonorrhea. Around 50 percent of STI patients do not go to health facilities, but self-treat by buying over-the-counter antibiotics.

In general, we can conclude that the expanding HIV epidemic in Indonesia, while still largely concentrated among IDUs, FSWs, and their clients, is promoted by the following factors:

- Rapidly expanding injecting drug use

- An extensive sex industry (formal and informal, females and males)
- A highly mobile population
- Increasing urbanization
- High STI rates
- Low condom use
- Unsupportive legislation (for harm reduction)
- Limited STI services
- The aftermath of a major economic crisis (poor women in search of survival, children living on the streets)
- Recent government decentralization (with a still-unclear division of health care responsibilities between central, provincial, and district/city governments)
- Limited resources to deal with the expanding epidemic
- Widespread discrimination and stigmatization

III. FINDINGS

This chapter begins with a listing of some of ASA’s overall achievements, including successful initiatives that have gone beyond the formal scope of work. The rest of the chapter examines progress on each of the five Results Packages.

A. Achievements

Summary: ASA must be lauded for carrying out a very complex program in its 10 provinces under very difficult conditions. Its achievements go well beyond the process indicators described in this report to include successes in advocacy, policy development, leveraging, networking, and public relations. In the view of the Evaluation Team, there is no doubt that this important program should be continued.

Over the first four years of the program, ASA has been very busy. This program is the only USAID-funded HIV/AIDS initiative in Indonesia and as such has taken a very broad approach. The program has addressed policy issues, capacity development, systems design, coordination with other donors, a mass media campaign, research, advocacy, behavior change interventions, establishment of clinics, collaboration with the military and police, and a score of other activities that might normally be separate programs in their own right.

The Year Five Workplan includes more than four pages that describe major accomplishments over the last four years.⁴ A few of these are summarized here:

- Assistance to the government in developing and setting up both behavioral and sero-prevalence surveillance systems
- Generating evidence to focus the national strategic plan on most-at-risk groups
- A nationwide mass media prevention campaign that reached more than 700,000 people

⁴ ASA, Year Five Workplan, pp. 9–14.

- Comprehensive prevention interventions introduced in all 10 provinces
- Prevention interventions initiated with the military and police
- Successful outreach and peer education programs that have reached 700,000 most-at-risk individuals
- A workplace intervention program that is ongoing in 94 companies and that has reached more than 450,000 workers
- Assistance in the development of national guidelines for HIV care, support, and treatment
- Assistance in the development of the Sentani Commitment⁵
- Assistance in organizing a national working group on prisons
- Assistance to East Timor in development of its HIV/AIDS program
- Assistance in developing the first estimates of HIV/AIDS prevalence in Indonesia
- Assistance to the MOH in preparation of a successful application to the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) for financial assistance
- Collaboration with more than 30 faith-based organizations (FBOs)
- Involvement of HIV-positive individuals in planning and implementation of interventions
- Establishment of 25 clinics for FSWs, their clients, and MSM
- Assistance in developing a Healthy Ports and Highways Strategy
- Development of an HIV/AIDS counseling training program and training of approximately 400 counselors
- Assistance in developing surveillance systems and their implementation in all 10 provinces
- Support in developing capacity of local KPADs in all 10 provinces
- Development and implementation of traditional puppet performances throughout the island of Java, organized by more than 200 puppet masters trained by ASA
- Exhibition of Tegak Tegar HIV/AIDS photos in various cities, including the first-ever such exhibition in the Indonesian Parliament
- A decree by the Minister of Manpower and Transmigration on HIV/AIDS prevention and control in the workplace

⁵ A resolution signed by key policy makers from six high prevalence provinces to actively promote condom use, harm reduction, provision of care and treatment of PLWHA, and breaking down stigma and discrimination.

B. Results Package 1: Increased Risk-reduction Behavior and Practices among Individuals Most at Risk of HIV and Sexually Transmitted Infections

Summary: Some 66 IAs are conducting outreach, peer education, harm reduction, mass media communication, condom distribution, and STI referrals in the 10 program provinces. Outreach and peer education are reaching more than 700,000 high-risk individuals. As of July 2004, outreach contacts were twice the target number for FSWs and MSM, but only half the target for IDUs. ASA has been most successful in reaching FSWs and their high-risk clients, but less so with IDUs, MSM, and transvestites. Condom distribution is on target. However, the most recent data available show that over 50 percent of FSWs, but only 29 percent of clients, reported using a condom during their most recent sexual act.⁶

ASA has developed a strong network of IAs that is focusing its best efforts on providing high-quality outreach and peer education to those populations most at risk for HIV/AIDS. After several years of developing programs and providing a large amount of technical support, ASA appears to be making substantial gains. Table 3 shows that ASA is on target for condoms and safe-sex packages distributed.

Table 3: Condoms and Safe-Sex Packages Distributed

Indicators	Target FY 2004	Total FY 2004 to date	Percent of target
Condoms distributed	2,382,287	2,084,491	87.5
Safe-sex packages	77,800	77,800	100.0

Source: Special Team request to ASA, September 2004

Repeated cross-sectional prevalence surveys of MSM, FSWs, IDUs, and clients of FSWs are expected to show improvements in both outcome and impact indicators. Although the results of such surveys cannot always be causally linked to USAID-sponsored interventions, nevertheless they are expected to provide evidence that the combined activities of multiple interventions by ASA, GOI, and other programs are having the desired effects on MARG behavior and impact on HIV/STI prevalence.

That said, a preliminary analysis of 2004 BSS data from North Sulawesi makes a strong case that ASA's outreach program has made a significant contribution to changes in behavior among FSWs and their male clients.⁷ Outreach by ASA-supported NGOs has provided female sex workers and their male clients with information that has increased their knowledge of HIV, its transmission, and how condoms can prevent HIV transmission. This knowledge, coupled with increased availability of condoms provided by the same ASA-supported NGOs and the government, has led to increased use of condoms by clients of FSWs in the target sites (see Table 4 and Annex G for selected findings). BSS findings from other ASA sites are

⁶ FSW data from the BPS 2002–2003 and client data from BSS 2004.

⁷ But does it work? Using BSS and programme data to understand ASA programmes. The example of North Sulawesi, ASA External Review, August 2004.

expected to show similar changes in target group behavior that can be plausibly linked to ASA interventions.

Table 4: Selected Findings on Outreach from the 2004 BSS in North Sulawesi

Findings on condom knowledge, availability and use	2002	2004	Change
FSWs who know that condoms prevent HIV	53%	69%	+16
Condoms more available to sex workers (direct FSW)	20%	74%	+54
FSWs asks all clients to use condom	23%	38%	+15
FSWs who have participated in HIV prevention activities in last year	39%	67%	+28
FSWs who participated in prevention activities organized by NGOs	11%	48%	+37
FSWs who used condom with last client	NA	NA	NA
Clients who used condom with last FSW	NA	NA	NA

Source: ASA, September 2004

1. Female Sex Workers

FSWs takes center stage in ASA behavior-change intervention efforts. ASA’s largest MARG intervention is with FSWs. There are an estimated 134,261 FSWs in ASA’s program areas. The program is working in 39 sites in 10 provinces through 39 IAs. Multi-pronged strategies have been implemented to reach this high-risk group. ASA has segmented this group into “direct” and “indirect” FSWs. The former refers to street and brothel-based sex workers (they primarily receive their income from providing sex services). The latter refers to massage parlor, bar and freelance sex workers (they have other sources of income). While mass media communications target all categories, individualized communications strategies vary depending on the implementing agencies.

The different working environments of FSWs also add to the difficulty and effectiveness of coverage. Some interventions are more effective than others. For instance, sex workers in bars, massage parlors and brothels are easier to reach through group sessions or one-on-one interaction in their work places. Street and freelance sex workers, being highly mobile and less visible, are more difficult to reach, both as a group and one-on-one. In addition, the high turnover rates among these FSWs (direct and indirect) require a more frequent and sustained information campaign to maintain high levels of awareness.

ASA’s primary intervention is made up of four components: outreach education (preferably peer outreach); preventive services (provision or sale of condoms); preventive treatments (for STIs); and a locally supportive environment.

ASA works through local NGOs or IAs in each province. The IAs with the most relevant experience with one or more MARGs are selected and given a one-to-two-year sub-agreement to carry out one or more of the functions listed above. Each IA goes through a rapid capacity development stage that emphasizes training of trainers on behavior change interventions (BCI) and referrals for STI treatment. STI services are set up concurrently to receive referrals from MARG IAs. A central team located in Jakarta provides ongoing technical assistance and conducts quality control activities.

ASA has adapted this procedure for rapid scale-up. As a result, ASA has been able to set up

activities in all 10 provinces of operations. The IAs have been contracted, structures have been put in place, and, overall, the commitment of the staff and the IAs to their roles has been extraordinary.

ASA has done a good job in reaching FSWs in areas where there is an assigned FSW IA. The field workers were observed to have established strong working relationships and trust among the employers of FSWs and the FSWs themselves. ASA field workers are playing valuable roles as counselors and suppliers of condoms, and are often sought after for HIV/STI medical advice.

In most places, the outreach work has reached 50 to 80 percent of the target population (and more than double the target in 2004). While STI referrals are not as successful in all sites, overall they are well on track (see Table 5).

Table 5: Outreach Contacts and Referrals for Female Sex Workers

Indicators	Target FY 2004	Total FY 2004 to date	Percent of target
Outreach and BCI contacts*	21,811	51,106	234.0
Referrals made to STI clinics	12,400	12,944	104.0

Source: Special Team request to ASA, September 2004

Although 2004 data are not yet available, the team observed that both intention to use and actual condom use are relatively high and have increased among FSWs in areas covered by ASA. Many of the FSWs are sufficiently aware of the risks of STI/HIV infection from unprotected sex. The non-use of condoms is attributed more to client resistance and the FSWs' inability to persuade the client than low awareness or intentions among FSWs.

Many FSWs still lack the skills to persuade their clients to use condoms, and many FSWs are still not reached by ASA's one-on-one counseling interventions, even within ASA's 10 provinces. There is a need for increasing peer outreach, as opposed to NGO (IA) staff outreach; adoption of peer-pressure models; better implementation of 100 percent condom policies; and linkages and referrals of FSWs to urgently needed, non-HIV basic services. The communications strategy could be improved by complementing mass media messages with public relations interventions, location-specific media messages, and one-on-one education and counseling.

The primary intervention, which is standardized for rapid scale-up, does not take into account the differences among the "subcultures" of the MARG subpopulations. ASA provides generic BCI, generic STI services, generic outreach training, etc. There is a need to adapt the components to address the specific characteristics and needs of each at-risk group. ASA should consider developing and adopting specific training tools, packages, and mentoring approaches rather than relying on workshop-based training. STI services could be more accessible to FSWs if provided at locations, times, and prices that FSWs can afford.

The targets seem to be based on secondary data and have not been validated. Primary data must be collected on which to set more realistic targets. At this point it is impossible to state

whether or not the achievements in target coverage are affected by under- or overestimation of the size of each target group. There is also a need to develop tools and methods to measure behavioral outcomes at the subproject level, ideally, those simple enough to be interpreted by local staff and peer counselors to make their FSW interventions more effective.

Conclusions and Recommendations

ASA has done a remarkable job in developing and implementing a strategy that has reached thousands of FSWs in all 10 provinces where it is working. The integrated approach to outreach and referral in such sites as Manado/Bitung appears to be especially effective. Although 2004 data on condom use are not yet available, it appears that significant improvements have occurred.

The primary outreach/referral intervention should not only be expanded to other MARG sites, but should also be tailored to address the characteristics and needs of each subpopulation. A more synchronized communication strategy is also needed to expand coverage to all FSWs. If possible, mapping studies should be conducted to set more precise targets. Technical assistance may be needed to develop and operationalize more effective peer education, peer pressure, 100 percent condom use, and monitoring and evaluation tools at the subproject level.

2. Clients of Female Sex Workers

Clients of FSWs are the largest group at risk. Clients are also the most vulnerable group for the entry of the AIDS virus into the general population. An estimated ten million FSW clients in Indonesia play a major role in the rapid transmission of HIV and STI. ASA estimates that there are about 1,650,000 in its program areas. This is probably ASA's second largest intervention, with 50 IAs working in 41 sites in 10 provinces.

ASA has implemented a multi-pronged, risk-reduction strategy to reach this group and influence its behavior. The components include a mass media communication program, peer education, and workplace interventions. There is also a special program for uniformed servicemen (see III. B. 8. Special Interventions in Special Groups).

While there are visible behavior changes in many areas covered by ASA, the overall use of condoms among clients of FSWs remains low. The partial results of the 2004 BSS indicate that use of condoms among clients of FSWs is unchanged at less than 30 percent⁸.

Observations gathered from female sex workers indicate that many clients are reluctant to use condoms and that this reluctance remains the major reason for much unprotected sex. Clients dislike condoms, and FSWs are largely powerless in negotiating condom use. Clients have not yet internalized the risks associated with unprotected sex sufficient to alter personal behavior.

⁸ Based on the preliminary results of the 2004 BSS (five provinces), only 29 percent of clients of FSWs reported use of condom during last sexual encounter, which represents no significant change over the 2000 BSS baseline of 28 percent.

ASA is on track to meet its program targets for FY 2004 for outreach and BCI contacts, but STI clinic referral with clients of sex workers remains problematic. The numbers in Table 6 include men who have been reached through workplace interventions. It is unknown how many of those are actual or potential clients of FSWs, but the figure is probably relatively low. In addition, the figures include female workers. Thus, while the percentage of target reached is probably accurate, the actual number of most-at-risk men reached is probably much lower than indicated.

Table 6: Outreach Contacts and Referrals for Clients of FSWs

Indicators	Target FY 2004	Total FY 2004 to date	Percent of target
Outreach and BCI contacts	1,203,000	1,203,000	108.0
Referrals to STI clinics	6,800	6,331	93.0

Source: Special Team request to ASA, September 2004

The team observed that mass media execution has had major shortcomings in reaching this audience. The HIV TV public service announcement (PSA) was only implemented for three months in 2002. It was withdrawn for 17 months due to some religious resistance and then implemented again for four months in 2004. The overall exposure of seven months over a three-year period is largely insufficient to achieve the desired reach and frequency needed to be effective.

On the other hand, the FSW outreach strategy spills over to clients, as well. FSW outreach workers often run into clients before or after they have had sex with an FSW and take advantage of those encounters to provide some education and counseling to the clients. ASA has done a very good job of identifying and targeting the most-at-risk subpopulations of FSW clients. These include sailors, dockworkers, long-distance truckers, government officials, high-school students, *ojek* drivers, and other “mobile men with money.” Some IAs work exclusively with just one of these MARGs. Peer educators within each group help to educate and motivate other group members to adopt risk-reduction behaviors. Anecdotal evidence seems to show that this strategy is working very well.

Conclusions and Recommendations

Significant progress has been made in working with clients of sex workers, increasing knowledge among clients and building a foundation for further behavior change. Mass media communications need to be implemented for a longer duration, to be supported by public relations events for added coverage and exposure, and further supplemented with location-specific media in areas frequented by these clients. ASA’s one-on-one counseling and peer education should be continued and expanded, as these have proven to be effective in reaching captive audiences. More needs to be done to identify and counsel the most-at-risk members of these groups. Where already adopted, actual implementation of 100 percent condom policies needs to be promoted. Given the difficulty in reaching clients, it would be prudent to conduct assessments of the current interventions and to build on that information to develop and test best practices.

3. Males who have Sex with Males

This is a much smaller MARG than FSWs, and this population is more difficult to find. There are an estimated 330,842 MSM in ASA’s program areas, and 12,000 of them are transvestites. The program priorities are transvestites, male sex workers, and their clients. ASA works through existing networks and organizations that are currently serving transvestite and other MSM subpopulations to enhance the coverage and quality of behavior change interventions. At present, ASA is working through eight IAs in five sites in five provinces. Key prevention activities include community outreach, behavior change interventions, promotion of condom use, promotion of safe sex practices; condom social marketing; development and distribution of information, education, and communications (IEC) materials; referrals to STI screening; HIV counseling; and linkages to VCT and other health services.

One innovative approach to behavior change among MSM is the “positive deviance” model that was started in Year Four. This approach attempts to identify and then promote positive behaviors that are practiced by a respected member of the group. The model emphasizes achievable changes rather behaviors that are hard to live up to. A pilot project involving transvestite and MSM groups in Jakarta will continue with weekly meetings of concerned field workers and program managers to continually assess and improve the model. ASA plans to extend IA capacity to implement this model.

The ASA program has already exceeded its MSM and transvestite coverage targets for FY 2004 (see Table 7). A 2004 BSS has been conducted among MSM, but the data have not yet been analyzed.

Table 7: Outreach Contacts and Referrals for MSM and Transvestites

Output indicators	Target FY 2004	Total FY 2004 to date	Percent of target
MSM			
Outreach and BCI contacts	6,730	9,099	135.0
Referrals to STI clinics made	500	1,149	230.0
Safe sex packages distributed	49,800	49,800	100.0
Transvestites			
Safe sex packages distributed	49,800	49,800	100.0
Outreach and BCI contacts	4,690	6,309	135.0
Referrals to STI clinics made	1,000	2,799	280.0

Source: special Team request to ASA, September 2004

Capacity building of the various MSM organizations, while challenging in certain areas, has produced good results in terms of NGO capacity to mount a response. However, sub-agreements with two MSM NGOs were not continued due to improprieties.

The research on MSM sexual networks in Indonesia has been helpful in gaining a better understanding of the sexual networks of MSM, the nature and significance of relationships, and their perceptions of risk. Assessments will be conducted among transvestites, MSW and

gays in Medan, Batam, and Pekanbaru. A decision will then be made regarding the need for interventions should funding be available.

Conclusions and Recommendations

ASA has done a commendable job in working with a hard-to-reach population. The level of technical assistance and training in program planning, outreach, and behavior change interventions was reported to be excellent by the IAs.

ASA should continue to support MSM activities, but should base them on results from the BSS and technical input from field staff. If, for example, transvestites and their clients engage in more risky behavior than other MSW, priorities may need to be revised. It would also be important to evaluate MSM interventions to determine what works, what doesn't work, and why.

4. Injecting Drug Users

The number of drug users in Indonesia continues to rise, especially among young people. HIV prevalence among IDUs has been recorded at well above 50 percent in several cities. There are few NGOs that deal with this group, and little is known about the dynamics of HIV/AIDS transmission among IDUs.

There are approximately 91,431 IDUs in ASA's program area. The program is operating in 14 sites in seven provinces through nine IAs. ASA supports interventions for IDUs in two areas, advocacy and community intervention. Advocacy activities are carried out in collaboration with two partners/subcontractors: the Asian Harm Reduction Network (AHRN) and the Center for Harm Reduction (CHR). AHRN and CHR work with the National AIDS Commission (KPA), the National Narcotics Board (BNN), police departments, and prisons to create an enabling and supportive environment for IDU harm reduction initiatives. Major achievements include: the formation of a National IDU Harm Reduction working group as the national authority for IDU harm reduction based on a memo of understanding between KPA and BNN; development of a pilot Needle and Syringe Exchange Program (NSEP) in Jakarta and Bali; and advocacy for IDU harm reduction in prisons. Advocacy activities are done both at the national and the provincial level. CHR also formed a media control group and has distributed clippings, written articles, and held a number of public relations events. AHRN worked on narcotics law reform for the protection of staff and clients engaged in IDU outreach activities. AHRN also formed a national network of 34 institutions and 25 individuals involved in harm reduction to advocate and facilitate community interventions for IDU harm reduction initiatives.

In community interventions, ASA supports NGOs using a comprehensive approach based on the Indigenous Leader Outreach Model (ILOM) to gain access to IDUs in community settings, to promote individual risk assessments, and to promote a wide range of risk-reduction alternatives. ASA's focus is on establishment of strong outreach systems and adoption of risk-reduction behaviors. At a later stage, ASA will work on referrals to other services for IDUs.

Kios Atma Jaya is a model NGO, implementing integrated outreach and intervention services

for IDUs. It provides VCT, basic health services, and integrated referral to narcotics rehabilitation, methadone maintenance treatment, and antiretroviral therapy services. Kios Atma Jaya has been selected as one of the two National NSEP pilot sites starting in July 2004.

Institutional outreach to prisons is a relatively new intervention for ASA. Some of the highest levels of HIV associated with injecting drugs have been recorded in prisons. ASA is working with the Department of Justice as well as wardens and guards in several prisons to address this problem (see section 1.7 for more on prison interventions).

ASA support for advocacy activities with BNN, KPA, and the prison system has laid a strong foundation for an IDU harm reduction initiative. Monitoring data indicate improvements in IDU basic knowledge of HIV/AIDS, prevention of sexual transmission of HIV/AIDS, and cleaning of needles and syringes with chlorine solution.

On the other hand, the IDU program has faced challenges in meeting set targets (see Table 8). This may be a function of underestimating the difficulty in reaching and working with the client population. In Manado, for example, there is only one NGO that deals with IDUs, and it only works with college students, who make up only 6 percent of the IDU population. A serious obstacle in many locales is the police, who enforce the laws on drug abuse by arresting IDUs for possession of needles and syringes.

Table 8: Outreach Contacts and Referrals for IDUs

Indicators	Target FY04	Total FY04 to date	Percent of target
Outreach and BCI contacts	8,000	8,176	102.0
Referrals to STI clinics	37	869	2,349.0
Disinfectant kits (bleach)	10,000	5,931	59.0

Source: special Team request to ASA, September 2004

Conclusions and Recommendations

IDUs are a difficult at-risk group to identify and work with. ASA has made a good start with its dual advocacy and BCI strategy. Both need to be continued and expanded, if feasible. The harm reduction pilot projects in Jakarta and Bali need to be implemented as soon as possible as time is running out. Work with the Department of Justice and prison staff should also be accelerated.

5. Greater Involvement of People Living With HIV/AIDS

ASA has implemented the following key activities to ensure that there is greater involvement of people living with HIV/AIDS (PLWHA) in the response to the HIV/AIDS epidemic: capacity building for PLWHA groups; support for a public campaign to decrease stigma and discrimination toward those living with HIV/AIDS; and training in advocacy to increase access to care, support, and treatment.

ASA has provided assistance to nine support groups for PLWHA in five provinces. These groups receive funds and technical assistance for a range of activities including outreach to

PLWHA, supervision of adherence to antiretroviral therapy, care and support services, formation of family support groups, training in communication skills, public speaking, and counseling. To date, 702 PLWHA have benefited from these services. However, this is a small portion of the estimated 110,000 PLWHA in the country.

ASA supports Tegak Tegar, an organization that developed out of a successful photographic exhibition at the national parliament, to “give a face to AIDS” while advocating for positive living and a more accepting environment for PLWHA. The organization, whose objective is to decrease the effects of stigma and discrimination, has mounted several successful exhibitions, including some funded by the private sector. The organization is continuing the campaign in junior high schools and universities in Jakarta, as well as taking the exhibition on the road. Exhibitions outside Jakarta have been held on a cost-sharing basis with local governments or with private sector support. Tegak Tegar is managed and staffed entirely by HIV-positive people. Their exhibitions have reached an estimated 300,000 people, including those in national and local government, and business, and religious leaders.

ASA also supports Yayasan Spiritia’s efforts to link PLWHA groups across the ten provinces into a national network that will ensure a stronger voice for HIV-positive people. ASA collaborates with Spiritia on directly-funded workshops and on strengthening links between Spiritia and district KPAs. This will hopefully lead to the development of a feedback system through which national or local PLWHA groups can monitor and provide valuable feedback to KPAs on HIV programming from the client’s perspective.

In Year Five, ASA will continue to provide assistance to a number of PLWHA support and advocacy groups. Tegak Tegar will continue to build their capacity to organize similar exhibitions around the country. Direct funding from ASA will be provided as seed money for these activities, with donations from the local government and the private sector expected to cover the majority of expenses.

ASA has made important contributions to the application of GIPA principles in Indonesia. It has provided excellent funding and technical assistance to nascent support groups and has found mechanisms through the Rapid Response Fund to support projects, such as Spiritia, that do not have the capacity or inclination to deal with the sub-agreement process.

Conclusions and Recommendations

ASA has done an excellent job in following a cross-program strategy of creating opportunities for HIV-positive people to be more visible and contribute their expertise and experience: 1) as resource persons and facilitators on training programs for care, support, and treatment; 2) in peer education and workplace prevention programs; 3) as advocates to national and local government, and the private sector; and 4) as resource persons in media activities.

While this type of support for PLWHA deserves to be continued, there are no output indicators or targets for this intervention, which makes it difficult to assess success. Data could be collected on numbers of PLWHA trained in advocacy, numbers of support groups developed, and the like. Behavior change indicators also need to be collected.

6. Prevention Marketing and Mass Communication

Communication is a major component of behavior change interventions. ASA's careful attention to the communication development process is commendable; its execution, however, needs strengthening. ASA's communication interventions are divided into the following components: 1) mass media; 2) group communication; and 3) one-on-one communication (individual counseling) to reach the high-risk populations and lead to adoption of risk-reduction behaviors.

ASA's national communication strategy appears to be well thought out. Media plans were rational and well developed. As a result, acceptance and message recall were high during the pretest. There was some resistance to the TV PSA that resulted in its withdrawal from the air after only three months of airing. This has adversely affected both the reach and frequency objectives. First of all, continuity and momentum were lost. The revised versions of the PSAs were only resumed in April 2004, almost a year and a half after they were pulled. Second, only three of the five spots have been put back on the air. Third, plans to adapt the messages to location-specific audiences have not yet been implemented.

Total airing time for the mass media campaign was limited to reach the high-risk groups (FSWs, clients of FSWs, and IDUs) and to maintain high levels of awareness. Airing time and frequency appear to have been insufficient to reach the target audience.⁹ The execution of communications strategies was fairly uniform and did not take into account province- or area-specific differences. For instance, strategies used in Papua are not very different from those used in other provinces despite its demographic and psychographic differences. Major segments of the high-risk target audience, particularly clients of FSWs and direct FSWs, are mobile, and the mass media communication was unable to reach many of them.

There was little coordination among the various communication approaches used in the program. Mass media (TV and radio), public relations events, group counseling, and one-on-one information campaigns appear to have been sporadic and unsynchronized, thus losing the synergy needed in successful marketing campaigns.

The limited execution of public relations activities weakened the communication strategy. Generally, communication is most effective when a public relations program is implemented alongside mass media. The approved public relations program was not implemented due to some internal problems. Instead, limited public relations events were held sporadically within the three-month broadcast period. Most of the events, while important, were not in synch with mass media communications. For instance, a number of provincial workshops and road shows were scheduled as part of the public relations program to raise awareness about HIV and STI prevention. They did not happen. In addition, radio talk shows for the various high-risk groups that would have strengthened advocacy were not undertaken. Overall, the limited execution of public relations events weakened the effectiveness of the communication program.

⁹ 982 TV spots on 4 TV stations were placed in 3 months in 2002 and another 142 TV spots were placed in 6 TV stations for 4 months in 2004, radio was implemented for the same period. (Mass media was off air for 17 months).

There was also a deficiency in the IEC materials used. Many implementing agencies (particularly in Papua) indicated that the current IEC materials are inadequate. The brochures and booklets are less informative and compelling. ASA has not yet evaluated the effectiveness of these IEC materials, which makes it difficult to make strategic changes in communication plans.

Supplementing mass media with location-specific media would increase the chance of reaching many of the high-risk audience. More importantly, message recall would be higher.¹⁰ Location-specific presentations could be done through TV/radio messages in bars, brothel lounges, hotel reception areas, karaoke/KTV lounges, bus stations, *ojek* and taxi terminals, ports and dry-docks, etc. This suggestion was included in an earlier evaluation, but it has not yet been implemented.

ASA's communication strategies for IDUs need to be situation-specific. For instance, mass media (TV and radio) for IDUs who are prison inmates is not likely to be effective. ASA's current approach using group sessions in prisons for awareness building appears to be effective, but it is dependent on the cooperation of prison staff as well as the availability of time slots and space to convene. With the current overcrowding of Indonesian prisons, group activities have become increasingly difficult to plan and implement. ASA may want to explore holding a public relations event especially developed for inmates to supplement group and individualized counseling sessions. Many other IDUs are still harder to reach due to limited knowledge on who they are and where they are located. Thus, mass media need to be supplemented with public relations events to reach this audience.

Conclusions and Recommendations

The mass media component of ASA's communication strategy was well designed, but for reasons beyond the control of ASA, it was not implemented as planned. This affected audience reach and retention. In addition, the lack of the other components, especially public relations and audience-specific variations of the main PSA messages, weakened the effect of the mass media campaign. The group and one-on-one components have been relatively more effective, but they are labor intensive.

All of the components of the communication strategy need to be implemented as a package. It is unclear whether that is possible at this late date. ASA and USAID should seriously consider the value of continuing with the mass media campaign if the other components cannot be run at the same time.

7. Prison-based Prevention

ASA works in five provinces at five sites with five IAs. The total target population of prisoners in ASA program areas is 75,563. ASA supports HIV/AIDS prevention efforts in prisons through direct funding to the Directorate of Correctional Institutions, Ministry of Justice and Human Rights (MOJ/HR). In collaboration with the AusAID-funded HIV/AIDS

¹⁰ Location-specific presentations are synonymous with "point of purchase" (pos) material. The reminders are most effective when presented at a time when decisions are about to be made.

project, this support has led to the formation of a National Working Group for HIV/AIDS prevention in prisons, and the formation of Provincial Working Groups in Bali, South Sulawesi, and West Java. The working groups facilitated the coordination between MOJ/HR, and local hospitals and health centers to promote HIV/AIDS prevention along with treatment of TB and scabies. ASA, in coordination with other donors, organized several study tours and conferences (Sydney, Melbourne, and Amsterdam). The lessons learned from these study tours and conferences helped the Directorate in the development of an HIV/AIDS prison program.

Table 9: Outreach Contacts with Prisoners

Indicators	Target FY 2004	Total FY 2004 to date	Percent of target
Outreach and BCI contacts	3,620	138	4.0

Source: Special Team request to ASA, September 2004

ASA assisted MOJ/HR in the development of training modules for staff. The training modules have been pilot-tested in Bali and Bogor. Training for staff and governors of prisons covered basic information on HIV/AIDS and drug abuse. Inmate education modules are being field-tested in Jakarta and West Java. They cover basic HIV information, harm reduction, and Narcotics Anonymous. The training has sensitized both staff and prisoners on the risk of HIV/AIDS and drug abuse issues in the prison.

ASA is working in five sites in six provinces with six IAs. MOJ/HR has identified 15 additional prisons where immediate interventions are needed and suggested the use of the Sentani Commitment (for IDU harm reduction) to initiate prison programs in nine priority provinces.

Conclusions and Recommendations

ASA is still in the initial phase of HIV/AIDS prevention in prisons. It will need to work intensively with the National Working Group to develop a national program strategy. The strategy should include assessment, drug referral, rehabilitation, substitution, and treatment of TB and STIs. ASA may also need to provide direct funding to facilitate the establishment of local working groups in ASA provinces.

8. Special Interventions in Special Groups

Faith-based organizations. ASA has established collaborative relationships in two provinces and has sub-agreements with a number of FBOs that have shown an interest in HIV/AIDS-prevention activities. This includes interventions directed at youth or student populations, which are emerging MARGs in some areas.

While some FBOs are utilizing their existing networks and structures to deliver STI/HIV/AIDS prevention messages to the general population, others are conducting outreach activities among such high-risk populations as FSWs. ASA has collaborated with

Muhammadiyah, one of the country's two leading mass Islamic organizations, to conduct large-scale, national dissemination of information among religious leaders through development of a book of HIV/AIDS-themed sermons. ASA is also working on similar activities with Nahdlatul Ulama (NU), the other leading Islamic organization.

Table 10: FBO Targets for FY 2004

Indicators	Target FY 2004	Total FY 2004 to date	Percent of target
Provinces	5	4	80
Sites	11	10	91
IAs	32	30	94

Source: Special Team request to ASA, September 2004

Other FBO activities are conducted locally, especially in Papua and Java. FBOs in Papua, which are predominantly Christian, have focused their activities on church-based youth and women's groups, as well as at-risk groups in regions bordering Papua New Guinea. ASA has sub-agreements with at least four FBOs in Papua that provide outreach, education about HIV/AIDS prevention, and distribution of condoms to married men. ASA has identified some counter-productive practices among some of the Christian FBOs in Papua. These include opposition to condom distribution to youth, recording the names of individuals receiving condoms, and using punitive measures, such as fines and community labor, to discourage premarital sexual activity.

In Java, PC Fatayat NU, a conservative Islamic organization, is conducting STI/HIV/AIDS prevention among direct FSWs and their clients along the 10 km. Northern Coastal Belt of Tegal, a trucking route and FSW hotspot. The organization is hardworking and has had some success in educating individuals about HIV/AIDS and its prevention. It has had less success meeting targets for STI screening among street-based FSWs, as have other NGOs. However they have significantly expanded their outreach to clients of FSWs. PC Fatayat NU is in negotiations with the local government to place an STI center near non-trucker clients of FSWs. (Truckers are covered by another IA.)

PC Fatayat NU is also leveraging the outreach training its staff has received from ASA to conduct HIV/AIDS prevention activities in high schools and universities (reaching more than 4,700 students at 22 schools in the past year), among women's groups, and in monthly educational meetings at mosques. PC Fatayat NU uses funds from other sources for these activities.

Students. Interventions targeting students include activities in three provinces (Papua, Manado, and Java). Work among Papuan youth is particularly important because they are at higher risk of HIV than youth from other parts of Indonesia. This is due to earlier sexual debut and multiple sexual partners among both Papuan girls and boys. Yayasan Binterbusih is an organization that was set up to support Papuan students who are sponsored to study at universities in Java, primarily Semarang, Yogyakarta, Malang, Surabaya, and Bandung. Their target population is the 4,000 Papuan university students (90 percent male) and their

non-Papuan student partners in Java. The organization has received training from ASA in outreach, peer education, finance, and management. Yayasan Binterbusih has translated ASA IEC materials into seven different Papuan languages.

Table 11: Youth Organization Targets for FY 2004

Indicators	Target FY 2004	Total FY 2004 to date	Percent of target
Provinces	1	2	200
Sites	5	6	120
Peer leaders trained	1	2	200

Source: special Team request to ASA, September 2004

Uniformed services. ASA has also worked with the military and police to establish HIV/AIDS prevention programs. The Ministry of Defense has set up a coordination mechanism and established a Peer Leadership Program. About 100 Peer Leadership Trainers have been trained by ASA. In June, an induction ceremony was held for 220 Army, Air Force and Marine peer leaders. Training for police peer leaders will begin after the elections. The armed forces and the police have assumed responsibility for implementing the Peer Leadership program, and there is strong support for these programs among the military and police leadership. However, much remains to be done to institutionalize the program. Among the challenges identified by ASA are the lack of financial support, the limited number of counselors for HIV positives, and the need for STI services.¹¹ Work within the uniformed services should be continued to institutionalize the program and expand it to include STI and HIV services.

Table 12: Uniformed Service Targets for FY 2004

Indicators	Target FY 2004	Total FY 2004 to date	Percent of target
Provinces	3	2	67
Sites	4	4	100
Peer leaders trained	480	400	83

Source: Special Team request to ASA, September 2004

The FBOs and youth-based NGOs, as well as the military and police, consider the strengths of ASA to be technical assistance, training, and IEC materials. All expressed satisfaction with their communications with ASA and with ASA's responsiveness. Each has highly committed and capable members, but most expressed the need for continued mentoring, closer supervision, or refresher training from ASA.

¹¹ The Uniformed Services Program for AIDS Prevention, ASA Power Point presentation, August 18, 2004.

Conclusions and Recommendations

As opportunities and needs have arisen among different groups, the ASA program has shown flexibility. Working with FBOs, student populations, and the uniformed services was not a requirement of the initial ASA agreement. As a result, there are no performance indicators for these activities. However, these activities complement the ecological approach used by the ASA program, adding additional layers of community-based activities and support for HIV/AIDS prevention programs. Activities with FBOs and the armed forces are also a way to leverage ASA funds, which is described further in RP 5.

ASA should be encouraged to continue its support of faith-based and student organizations as well as the military and police, particularly where such support can be leveraged to expand HIV/AIDS prevention activities among most-at-risk groups. ASA will need to continue providing mentoring, refresher training, supervision, and technical assistance to these organizations. Special attention is needed in Papua to make sure that counterproductive social policies are eliminated.

C: Results Package 2: Strengthened Quality, Accessibility and Utilization of Prevention, Care, and Treatment Services for Individuals Most at Risk of STI/HIV/AIDS.

Summary: ASA supports 29 comprehensive STI clinics in nine provinces through 28 IAs. Each clinic is staffed by at least four health professionals trained in clinical management and is equipped to provide enhanced syndromic management of STIs. Quality control is excellent, and ASA's minimum laboratory standards are a model for other countries in the region. However, ASA is falling short of its one outcome target for this RP: percent of FSWs and other clients diagnosed and treated for STIs. Coverage averages 42 percent for FSWs and MSM, and 9 percent for clients.¹² There are now 23 VCT sites in 10 cities and CS&T teams in 25 hospitals nationwide. The caseload is low because services are just getting underway, and promotion has been limited thus far.

Although the 2004 BSS data were not available to the team, the ASA preliminary analysis of North Sulawesi mentioned earlier does show that there have been significant improvements in health-seeking behavior at ASA program sites. ASA-supported outreach workers have referred more FSWs and clients who have reported symptoms of STIs to STI clinics, and more have sought treatment at ASA-supported STI clinics. Fewer are treating themselves. Although comparative data are not available on clients and FSWs referred by an ASA NGO, the high percentage of such referrals in 2004 indicate that ASA is responsible for much of this improvement. There is every expectation that similar results will emerge from BSS in other ASA-program areas.

¹² Source: ASA PowerPoint presentation on STI Program.

Table 13: Selected Findings on STI Health-seeking Behavior from the 2004 BSS in North Sulawesi

Findings	2002	2004	Change
Among FSWs and clients who reported STI symptoms:			
Clients who sought treatment at a medical service	40%	54%	+14
Clients who self-treated	51%	41%	-10
Clients referred by an NGO	NA	80%	NA
FSWs who sought treatment at a medical service	29%	64%	+35
FSWs who self-treated	51%	32%	-19
FSWs referred by an NGO	NA	74%	NA

Source: ASA, September 2004

1. STI Clinic Services

The objectives of STI treatment are to reduce the incidence and prevalence of STIs and related complications, and to reduce the period of infectiousness through early effective treatment. Strengthened quality and accessibility of STI services are significant achievements of the ASA program. Accuracy of diagnosis and treatment has continually improved over the course of the program, with occasional dips as new clinics were added to the program where staff were not yet trained in all aspects of ASA diagnostic and treatment protocols. In June 2004, ASA clinics reported 99 percent diagnosis accuracy, 95 percent treatment accuracy, and 94 percent MB slide accuracy.

The minimum standards and quality control at ASA clinics are the first major steps in achieving the objectives. Another major step is to screen high-risk women (FSWs) regularly, because STIs are asymptomatic in most women.

A continuing challenge is that ASA-supported clinics are not yet attracting sufficient numbers of clients to lower STI rates. ASA tracks low-performing clinics, which provides an opportunity for the STI team and clinics to analyze reasons for low clinic attendance. In at least one case, a low-performing clinic was dropped from ASA support, but in most cases the reasons for low utilization are complex. For example, clinics in Jakarta and Semarang are failing to reach their targets because target populations go to nearby community health centers, where diagnostic and treatment standards are sub-optimal but services are free or very low-cost. Recognizing that it would be counter productive to pull clients away from community health centers, the program has worked to improve the services at these facilities. Attendance at these clinics is not captured in ASA reports, so the true reach of ASA-supported STI is actually higher than the data would indicate.

Data from the latest ASA quarterly report indicate that ASA clinics are doing well with respect to numbers of target groups coming to the clinics and numbers of simple laboratory tests performed; but STI screening performed on FSWs is well below the target. The latest figures from ASA, which do not single out FSWs, show that coverage is well above targets for 2004 in all categories.

Table 14: Number of MARGs Served at STI clinics

Indicators	Target FY 2004	Total FY 2004 to date	Percent of target
Female	12,400	21,253	171.0
Male	3,400	4,609	136.0
MSM	750	1,968	262.0
Total	18,554	29,834	168.0

Source: Special Team request to ASA, September 2004

For the most part, clinics are strategically located in or near key target population gathering points. Clinics in Jayapura, Semarang, and Tegal are all located in or adjacent to brothel complexes and/or near street sex worker hotspots. While these locations are highly appropriate for FSWs, in some cases they may be less appropriate for clients of FSWs who do not want to be seen attending clinics in or near a brothel setting. Overall, 16 of the clinics cater to FSWs and 11 to their clients, but only two to transvestites, one to IDUs, and one to MSM.

The STI team at ASA has faced a number of challenges in achieving their targets for screening of high-risk populations and recognizes the need for creative solutions. For some clinics, ASA is implementing a new fee-for-service system whereby the IA receives 70 percent of staff salaries, as allocated under the sub-agreement, and the remaining salary is covered by a nominal fee paid by ASA for each client served. In Manado, the team found clinic and outreach programs to be highly integrated, referring to the individual NGO programs as beads on a string, all linked and working together as units of a larger whole. In Jayapura, the PKBI clinic located in the Tanjung Elmo brothel complex has introduced a pre-paid insurance program. FSWs pay Rp25,000 each month and then may visit the clinic as often as they like for any reason (e.g., STI, flu, injury) during the month. STI rates have decreased significantly, and condom use has increased significantly at the clinic.

Other challenges that face ASA include a greater reluctance than expected among some target groups, mainly MSM and transvestites, to access clinic services. Some of this reluctance is based on rivalries between competing transvestite groups in Jakarta and Papua. Other factors are stigma, unwillingness to travel, low levels of formal education, obtaining antibiotic injections from local injectionists, etc. ASA has scheduled a second conference for MSM with a major objective of solving the issue of low clinic attendance and STI screening. Mobile clinics are another innovation that is underway to improve accessibility to STI screening and treatment.

Clinic staff uniformly stated that strengths of the ASA program include high-quality clinical services, technical assistance, training, monitoring, and interaction/communication between the clinic and ASA staff. One clinic stressed that the strict monthly financial and programmatic reporting requirements of ASA are a strength because they enforce discipline and accountability. A number of clinic staff felt that while the training and communication are very good, increased mentoring, supervision, or refresher training are needed. Other clinics suggested that more flexibility in the sub-agreement process would allow for more freedom in meeting changing needs.

Year Five activities will focus on sustainability of clinic services. ASA will conduct three regional meetings to which representatives from ASA-supported clinics will be invited to share their experiences and practices. Another key activity in Year Five is to strengthen referral networks.

Conclusions and Recommendations

ASA has done an excellent job with the supply side of the STI intervention. Staff is well trained, commodities are available, service is excellent, and the clinics are conveniently located. However, demand is much lower than expected and ASA will need to take steps to address that issue, for example, by supporting mobile units and STI services at health centers. The innovations attempted so far bear watching, and those that look promising – such as the pre-paid insurance program of PKBI in Jayapura, which is not only financially successful but appears to be lowering infections – should be carefully evaluated and then replicated wherever appropriate. ASA should also strive to make the clinics more user-friendly by improving access (hours and location) and lowering fees.

2. Voluntary Counseling and Testing; Care, Support, and Treatment

One of the key constraints to making progress with effective HIV prevention is the very high percentage of people thought to be infected with HIV who are unaware of their HIV status. One problem is that too few facilities are available for VCT, and another is that too few people are accessing them. To address these problems, ASA supports 22 IAs in 17 sites within nine provinces.

Accessibility to VCT and CS&T has been greatly improved. ASA is supporting 23 VCT clinics and has trained 169 VCT staff. However, many are still new and are experiencing some delays in getting started due, for example, to the lack of reagents. ASA also supports 25 designated antiretroviral therapy hospitals; and through an HIV/AIDS counseling training program developed by Yayasan Mitra Indonesia, it has trained 385 counselors. Through support from ASA, LPM Widuri has developed Case Management and Supervision modules and trained 149 case managers from seven cities. In Year Five, all VCT-supported sites will be strengthened by adding case managers to the staff. Case managers will work as integral members of the CS&T medical team providing out-of-hospital psychosocial support, advocacy, and follow-up with adherence monitoring.

Two joint VCT Rapid Capacity Assessments have been conducted by ASA in 12 priority cities. ASA has also supported advocacy to local government officials (KPADs) for VCT support.

In preparation for VCT and CS&T activities, ASA has been active in establishing guidelines and laboratory capabilities. ASA supported the development of the National Guidelines for HIV Treatment, Care and Support. ASA has also supported a training course in HIV clinical management and laboratory skills that involved 128 health providers from 42 hospitals and clinics. ASA has taken the lead in establishing a national system for evaluating and approving new HIV test kits and has found one out of 36 that has 100 percent sensitivity and specificity. Another 34 test kits have been evaluated for use in confirmatory testing.

Unfortunately, too few people are accessing VCT and CS&T. Table 15 shows that ASA is likely to exceed its target for VCT in 2004. The actual number of procedures, however, is quite low, averaging just 34 tests per year per clinic, or fewer than one per day.

Table 15: Number of Clients Seen at ASA-supported VCT centers

Indicators	Target FY 2004	Total FY 2004 to date	Percent of target
Total clients	480	782	163.0

Source: special Team request to ASA, September 2004

To improve demand for VCT and CS&T, ASA is assisting its VCT partner, YMI, with social marketing to principal target groups: sex workers, their clients, MSM, IDUs and pregnant women. It is also exploring the potential of mobile VCT outreach in Papua and is working to improve clinic capability for one-stop/same day VCT service with rapid testing.

In July 2004, a pilot HIV/AIDS VCT site opened at the Bala Dewa TB clinic, which belongs to the Jakarta branch of PPTI. Its objective is to demonstrate effective TB/HIV diagnosis and management at a selected inner city TB clinic. In Jayapura and Sorong, where CS&T- and VCT-trained personnel are already in place, ASA will coordinate with GFATM on integrating its TB DOTS program with VCT and case management services.

Challenges remain in linking activities of different intervention areas. These include links between STI and other clinical services, and between VCT, IDU, Care and Support Teams, and field activities carried out by IAs. For example, VCT often fails to include STI screening. These are all significant missed opportunities.

Conclusions and Recommendations

As with STIs, ASA has done a very good job on the supply side. The VCT sites are ready to go, with some exceptions, but demand needs to be stimulated. As noted above, many people who are already infected with HIV are unaware of this. ASA should be encouraged to continue studying alternative ways to increase demand for VCT, especially among MARGs, as well as ways to link this service to case management and CS&T.

D. Results Package 3: Enhanced Capacity and Quality of GOI HIV/STI Surveillance Systems, and Use of Data in Decision Making

Summary: ASA has been instrumental in developing the first HIV/AIDS surveillance systems in Indonesia. Behavior Surveillance Surveys of MARGs are now operational in 14 sites and a national sentinel surveillance system is under development. ASA has provided significant technical assistance to the Central Bureau of Statistics (BPS) and MOH, which are now capable of carrying out these surveys on their own, though they still require assistance with data analysis and utilization. Additionally, ASA successfully conducted exercises in 2001 and 2003 on estimating the size of populations at risk for HIV. This estimation methodology designed by ASA has been recognized as a global best practice and is now being utilized by other countries around the world.

1. Enhanced Capacity and Quality of HIV/STI Surveillance

An important aspect of ASA's strategy is to ensure that there is a national surveillance system in place that produces credible data and follows acceptable standards.

The standard operating procedures (SOPs) for sero-surveillance were completely revised by the MOH with support from ASA and the Indonesia HIV/AIDS Prevention and Care Project Phase 2 (IHPCP). Training on the SOPs and on data management using the Sentinel Surveillance for HIV (SSHIV) software for district-level health staff have been completed.

ASA is assisting the development of a core national surveillance system that will include both sero- and behavior surveillance in 90 sites around the country. The proposed sites and target groups covered are shown in Table 16. Key MARGs that are not included are clients of sex

Table 16: National Surveillance Sites and MARGs

Provinces	FSWs	Trans-vestites	IDUs	Prisoners	Antenatal mothers
DKI Jakarta	X	X	X	X	X
Surabaya	X	X			
Batam	X	X			
Bandung	X		X		
Bali	X		X	X	
Bogor	X			X	
Riau	X				X
Papua	X				X
Other provinces (25)	X				

workers (especially truck drivers, military/police, sailors, and fishermen), male and female youth, and MSM/gays. Most of these, however, are picked via BSS.

Prevalence surveys of STIs among female sex workers have been undertaken annually since 2003 in seven

cities. Routine reporting from ASA partner clinics provides incidence data on STIs.

Behavior Surveillance Surveys were carried out in 12 provinces in 2002 and 2004. They were implemented by BPS and MOH with funding from ASA and IHPCP. Operational guidelines

and sampling methods for BSS were also updated and distributed. See Table 16 in Annex E for details on BSS sites and MARG sample sizes.

ASA has supported the establishment of a working group on surveillance at the MOH. The group incorporates representatives from MOH, KPA, BPS and schools of public health. This will be the focal point for quality assurance, analysis, and use of data.

ASA will collaborate with a group of experts from universities and the National Epidemiological Network to organize a training of trainers in surveillance, and the printing of modules and CD-ROMs on HIV/STI data analysis.

FHI/ASA successfully conducted exercises in 2001 and 2003 on estimating the size of populations at risk for HIV. Prior to these exercises, the GOI based

prevalence data on the number of reported cases, which were known to represent a fraction of the actual prevalence. The estimation methodology designed by FHI/ASA helps all stakeholders to realize the true magnitude of the HIV/AIDS epidemic in Indonesia. This methodology has been recognized as a global best practice and is now being utilized by other countries around the world.

2. Use of Data in Decision Making

The data collected through sero-surveillance, BSSs, and other surveys/studies were disseminated and used for decision making through a number of mechanisms:

- Strategic planning workshops at the national, provincial, and district level (10 provinces, 41 districts)
- National reports to the Cabinet and the Parliament (IFPPD) as part of advocacy for resources and legislative change
- HIV-case estimation exercises
- Dissemination to the press
- Reports and presentations at national and regional HIV/AIDS meetings/conferences
- Quarterly reports of MOH
- Publications of BPS (Results of BSS 2002)

Table 17: BSS Locations and Sample Sizes

	Province	City	Total N
1	N. Sumatera	Medan	1150
2	S. Sumatera	Palembang	850
3	Riau	Tg. Pinang	725
4	Riau	Batam	725
5	W. Java	Bandung	875
6	W. Java	Bekasi/Karawang	875
7	Jakarta		2,750
8	C. Java	Semerang	900
9	E. Java	Surabaya	2,750
10	N. Sulawesi	Manado	850
11	Maluku	Ambon	850
12	Jayapura		850
13	Merauke		800
14	Gorong		850
	Total		15,800

Source: BCS. MARGs are direct SW, indirect SW, truckers/transport workers, seamen/port workers, students, IDUs, MSM and transvestites.

Conclusions and Recommendations

ASA has made significant contributions to the development of surveillance systems and expertise in Indonesia. That assistance should and will continue, focusing more on data analysis and utilization now that Indonesian capacity to collect and process surveillance data has been so well developed.

E. Results Package 4: Strengthening Capacity of Local Organizations to Plan, Finance, Manage, and Coordinate STI/HIV Responses

Summary: ASA has made significant investments in the development of national and local management and technical capabilities, including major advocacy efforts with IFPPD to increase budget allocations for HIV/AIDS. However, the National Commission on HIV/AIDS and local KPADs, in particular, will need additional assistance over the next several years. NGOs, many of which have improved their administrative capabilities, still need mentoring, supervision, refresher training, and technical assistance, especially in technical areas.

There are three components of ASA support for capacity building of local organizations: 1) government institutions (provincial and district AIDS Commissions (KPADs)); 2) the Indonesian Forum of Parliamentarians for Population and Development; and 3) NGOs that are ASA's implementing agencies.

1. Government Institutions: KPADs and IFPPD

a. KPADs

ASA has facilitated the institutional and technical strengthening of provincial and selected district-level KPADs in the 10 target provinces. ASA provided technical assistance to build the capacity of KPADs to manage and coordinate a multisectoral response to HIV/AIDS epidemic. Key ASA support to KPADs includes support for a permanent secretariat, a competent senior executive secretary, and technical assistance for the development of a strategic plan and annual work plans.

ASA worked with KPADs to generate local budgets, to build networks with stakeholders, to facilitate formation of ad hoc task forces, and to lay a foundation for legal support for the HIV/AIDS response. Table 18 below shows the status of KPADs, along some key indicators of capacity.

ASA, in collaboration with the AusAID-funded HIV/AIDS project provided technical assistance in the formulation of the "Sentani Commitment" (January 2004). This is a commitment by six line ministers (MOH, BKKBN, MOSA, MOE&L, MORA, CMFFW) AND the governors of six priority provinces and KPA to promote 100 percent condom use, IDU harm reduction, care and support for PLWHAs, increased funding for HV/AIDS, and breaking down stigma and discrimination. The signatories of the Sentani Commitment meet quarterly to monitor the progress of the HIV/AIDS response in each of the provinces.

Table 18: KPAD Capacity Status

	Key Achievement/Function	Provincial KPAD Total =10	District KPAD Total=40
1.	Strategic plan	100%	63%
2.	Annual work plan	90%	63%
3.	Local budget funds	90%	53%
4.	Permanent secretariat	90%	70%
5.	Senior executive secretary	70%	45%
6.	Ad hoc task forces	60%	23%
7.	Legal support	20%	18%
8.	Networking: public, NGOs, and private	100%	90%
9.	Monitoring and evaluation	20%	13%
10.	Routine meetings	60%	50%

Major constraints on KPADs' ability to manage multisectoral responses to HIV/AIDS are the lack of legal support, financial resources, and strong leadership. KPADs also do not have skilled personnel for data collection, data analysis, and planning. KPADs usually do not have adequate capacity in advocacy, coordination, and monitoring and evaluation, all of which are necessary to sustain local HIV/AIDS programs over the long term.

b. IFPPD

The Indonesian Forum of Parliamentarians on Population and Development was established in 2002 to lobby national and provincial parliamentarians on HIV/AIDS prevention and care. ASA supported IFPPD to publicize a photo exhibition of people living with HIV/AIDS, public hearing events and a series of roundtable discussions to disseminate the National Strategy on HIV/AIDS and HIV prevention among IDUs. ASA also provided support for the publication of fact-sheets on HIV/AIDS and IDU harm reduction.

Advocacy carried out by IFPPD has increased understanding and awareness of the HIV/AIDS epidemic among members of parliament. Moreover, IFPPD supports legal reviews to amend five laws and regulations related to HIV/AIDS, which will culminate in a HIV/AIDS National Workshop in October 2004. IFPPD was instrumental in the formation of a consensus on a Plan of Action among national and local parliamentarians, government representatives, KPADs, and NGOs to initiate new policies and commitment to increase budget allocations for HIV/AIDS activities.

The major constraint on the IFPPD advocacy is that the current parliamentarian members at all levels will be replaced as the result of the parliamentary election held in July 2004. Therefore, ASA and IFPPD will need to start advocacy all over again with the new parliament members at all levels.

2. Nongovernmental Organizations

ASA supports NGOs and FBOs to build their capacity in project management, administration, financial management, and specific technical areas related to specific target audiences.

Capacity building in technical areas includes basic outreach and behavioral change communication for most-at-risk groups, clinical skills training for STI/VCT and CS&T, and training for workplace HIV/AIDS program.

Several ASA IAs became resource experts for other IAs and local government staff. These include Yayasan Mitra Indonesia for VCT, Kios Atma Jaya for IDU harm reduction, PKBI for STI clinics, and Komite Kemanusiaan Indonesia (KKI) for workplace programs. NGO activities reaching FSWs have rolled-out quickly, while program activities reaching MSM, PLWHA and IDUs have progressed steadily but more slowly. ASA is still looking for lessons learned and best practices/effective interventions. ASA support for capacity building in project management, and administration/finance has increased the quality and scope of activities and the soundness of the organizations. Many organizations now have greatly improved accounting systems and standardized financial reporting procedures. Several IAs are now able to develop higher quality proposals.

In North Sulawesi, an NGO forum has been established to coordinate NGO activities and to act as a buffer between the government and the NGOs. This has led to greater collaboration among the NGOs and smoother relationships with government agencies. The forum works as a clearinghouse for reaching, educating, and referring target groups to STI/VCT clinics or laboratory services. The networking is a “beads on the string” or “rosary” approach in which NGOs work together. For example, an NGO that works with motorcycle drivers (*ojek*) links with other NGOs that work with sailors, port workers, truck drivers, and FSWs. They all work together to expand coverage of the most-at-risk groups and referrals to ASA-supported clinics for STI diagnosis and treatment.

The major constraint on NGO outreach activities is limited effective networking among other NGOs and with hospitals, clinics, and laboratory services. North Sulawesi has an effective network in place, with strong collaboration among NGOs, and with the provincial and district government agencies. This network could be used as an example for other provinces.

Conclusions and Recommendations

ASA covers 10 Provincial KPADs, 40 District KPADs with more than 100 IA sub-agreements. There appear to be insufficient ASA staff to provide the necessary technical assistance to KPADs, NGOs, and other special groups. Technical assistance related to MSM and IDU interventions is especially needed, and NGOs still need a great deal of technical assistance in counseling, condom negotiation skills, VCT, and case management skills, as well as planning, and monitoring and evaluation skills.

ASA may need to look at alternative ways to develop capacity at the provincial and local levels. One option would be to decentralize technical and administrative assistance, including staff, to the provinces. This would reduce the management burden on the central office as well as ensure that there are adequate resources at the local level to provide the mentoring, training, and ongoing supervision needed.

F. Results Package 5: Increased Leveraging of Programmatic Interventions and Financial Resources

Summary: ASA’s leveraging initiative focuses on workplace programs. Other areas include programs for the uniformed services; the GDA with BP in the Bird’s Head; and collaboration with other donors, including the GFATM. Workplace activities are a low-cost strategy because the companies often pay many of the direct costs, and reach is good because many companies are large (thousands of employees). However, the majority of people reached are low-risk workers. To strengthen the program, future efforts should focus on high-risk companies and most at-risk men within companies. Leadership and collaboration with other donors are critical to leveraging resources to address the HIV/AIDS epidemic in Indonesia and should be continued.

One of ASA’s main initiatives for leveraging resources for HIV/AIDS is through workplace programs aimed at reducing risk behavior of male clients of FSWs. The general strategy is to provide BCI in companies whose workers are at high risk of contracting HIV. Some companies have more at-risk employees than others because of the nature of the work. These include natural gas, mining, trucking, shipping and forestry, among others. Banking, retail sales and fast food are examples of “low risk” companies. In addition, some employees within any given company are likely to be at greater risk than others because of their personal behavior patterns. Thus, the basic strategy is to concentrate on the most-at-risk employees in the most risky companies. Table 19 shows the 2004 achievements to date on ASA’s RP 5 indicators. ASA estimates that so far it has briefed 450 management teams, trained outreach workers in 80-94 companies and reached 450,000 workers.¹³

Table 19: Leveraging Process Indicators

Indicators	Target FY04	QI	QII	QIII	Total FY04 to date	Percent of target
No. IAs trained in promoting private sector leveraging	60	5	22	22	22	36.7
No. Private sector firms with workplace programs	100	71	91	94	94	94.0

Source: ASA, Fifteenth Quarterly Report, p. 24

ASA encourages companies to set up HIV/AIDS prevention programs for employees and surrounding communities. The framework for ASA’s HIV/AIDS workplace program is based on mass communication campaigns to raise awareness of risk for HIV/AIDS, followed by provision of basic knowledge of HIV/AIDS and promotion of risk-reduction behavior through IEC campaigns and worker education. Ideally, companies will also provide access to condoms and clinical services for VCT and STI. However, this is a longer-range aspect of the strategy.

¹³ The number 80 companies with workplace programs comes from the ASA PowerPoint presentation “Driving a Broad-based Private Sector Response in Low Prevalence Indonesia.” The number 94 comes from the ASA Fifteenth Quarterly Report, p. 24.

ASA works through local NGO partners to facilitate the development and implementation of workplace programs at the company level. Capacity building for NGOs includes the development of advocacy skills to convince businesses that HIV is an emerging problem that affects them. Capacity building also includes skills to facilitate planning and skills to support a company's core team during the implementation process. ASA has developed modules for NGO training and a tool kit for workplace HIV/AIDS prevention programs. Companies have integrated HIV/AIDS prevention programs into their existing occupational health and safety, human resources or communication programs. ASA has trained four first tier NGOs (KKI/all sites, YKB/Jakarta, Yayasan Mulia Abadi/East Java and PKBI/South Sumatra). The first tier NGOs facilitate the second tier NGO to expand workplace programs in their respective provinces.

When the workplace program began, ASA did not focus on "high-risk" companies. Instead, it found that high-profile companies that employ people in low-risk professions were more receptive to HIV/AIDS prevention programs. Working with these companies facilitated the development of "first tier NGOs." This allowed these NGOs to build portfolios of programs to present to more high-risk companies. Although it is true that ASA had been slow originally to focus its efforts on high-risk companies, it began to do so in FY 2004.

These "high-risk" companies can be divided into two segments. First are the prime targets for ASA workplace programs, which are companies with "mobile men with money," i.e., men who have disposable incomes and are required by the nature of their work to be away from their regular sexual partners for either short or extended periods. As noted above, these men are typically found in companies that deal with natural resources and transportation. KKI, which currently works with 87 companies, reported that only 30 percent of them fall into this category. However, a second target area of "mobile men" are the male-dominated, heavy manufacturing industries that employ younger men who are often migrants to large cities or industrial zones. These include such companies as steel, cement, automotive and petrochemical manufacturers. According to ASA, 80 of the 90 partner companies with which they have HIV/AIDS prevention programs fall into this group. ASA IAs are also working with managers of companies that do not fit into the above categories but, none-the-less, have segments of their workforce at risk; for example, the distribution and transportation arms of cigarette and water manufacturers.

Within these companies, workers were not generally segmented into high and low-risk groups. If this were done, it would enable the peer educators to provide more specific risk-reduction information to those who need it most. However, for most companies, especially those that are in the low-risk category to begin with, there is no simple way to do this..

ASA in collaboration with AusAID's IHPCP and ILO, have worked through tripartite members (employer associations, labor unions and Ministry of Manpower) to develop policy support for workplace programs. This includes the Ministerial decree for HIV/AIDS prevention programs at the workplace (April 2004) and an ongoing process for the amendment of the ministerial decree on STI/HIV/AIDS treatment and regional policies for HIV/AIDS workplace programs. ASA is also working on a strategy to require companies, along with public and private health insurers, to provide coverage for STIs and HIV/AIDS.

The uniformed services activities described earlier are another leveraging activity. These activities are provided by the uniformed services with ASA providing technical assistance.

As a member of the Country Coordinating Mechanism of the GFATM, ASA played a key role in drafting the Round 4 Global Fund application, which has resulted in an approved award of over \$64 million. A component of this award is to be used by ASA IAs to scale up the workplace prevention program in coordination with the Ministry of Manpower.

Conclusions and recommendations

ASA's investment in workplace programs is minimal but the number of people reached so far (450,000) is impressive. The workplace program and the uniformed services programs are vehicles for promoting the ABC messages and norms of condom use among current and potential clients of sex workers. To strengthen the program's focus on the most at-risk men, ASA should step-up efforts to target high-risk companies and most at-risk men within companies. Currently, ASA does not have a way to assess the impact of its workplace programs on behavior change. This should be a priority in the future. ASA has been a leader in collaboration and high-level technical assistance to the government and other donors, including the GFATM. This leadership should be continued in USAID's follow-on HIV/AIDS program.

G. Management, Monitoring, and Evaluation

Summary: By and large, the management of this very complex ASA program has been very good. The administrative, financial, and monitoring systems ensure that the more than the 100 subprojects currently underway are well managed. However, the processes are highly centralized and time-consuming, which may be limiting the provision of adequate and timely technical assistance and support to the subprojects. Based on the experience gained during the last three years, now may be the time to decentralize control to the provinces. This will further strengthen ASA's ability to provide timely and adequate technical support to the IAs. Extensive monitoring is conducted to ensure that the program is implemented as intended. Evaluation is limited to BSS indicators, which are only available every two to three years. There is little evaluation of program interventions to determine what does and does not work.

ASA works primarily through nascent NGOs. The profusion of new NGOs is a recent phenomenon. ASA may be the first large program in health in Indonesia to subcontract with so many NGOs. At the moment, it is overseeing 100 subprojects among 66 NGOs. To do so, ASA has had to provide large amounts of technical assistance to help these NGOs to develop and operate their individual management systems. ASA deserves full credit for its pioneering role in this regard.

1. Sub-agreement Management

ASA program resources and efforts are distributed among various activities as follows:

- Sub-agreements, rapid response funding, and partners 75%
- Capacity building of KPA and KPAD 10%

- Training of GOI staff 5%
- Prevention marketing 10%

In all, 124 sub-agreements have been generated; but if one includes amendments and renewals, the program has so far processed around 200 sub-agreements, as demonstrated below:

- Total sub-agreements (IAs) generated so far 124
- Terminated due to financial irregularity 7
- Not extended due to inadequate performance 14
- Amended and extended for another year 73
- Sub-agreements currently active 99

All sub-agreements are initially for one year and are then extended based on performance and financial integrity. This is by far the largest effort of ASA. All members of the Evaluation Team addressed the issue of management, and the management consultant focused on five IAs for in-depth assessment.

Komite Kemanusiaan Indonesia is a private-sector NGO that uses a number of part-time volunteers from various industries. They conduct advocacy and orientation workshops for core groups and staff of the industries, and help other NGOs to provide similar assistance.

Yayasan Kusuma Buana is a relatively large and well-established NGO that has worked in the field of HIV/AIDS for more than 20 years. YKB has two sub-agreements, one that provides BCI to FSWs and their clients, and the other which works with industries just as KKI does. Staff from both KKI and YKB felt that ASA should be concerned more about achievements than procedures, and should allow more flexibility in implementation strategies.

Yayasan Bandungwangi in Jakarta (BCI for FSWs and their clients), **Yayasan Bandung Plus Support** in Bandung (people living with HIV) and **Bahtera** in Bandung (IDUs) are smaller NGOs. They felt that the proposal development process was rather elaborate. The process took two years for Bandungwangi and six months for Bahtera.

Sub-agreement proposal development: The review, development, appraisal, and approval processes of sub-agreements are very comprehensive, and careful attention is given to ensure that every sub-agreement is technically and financially sound. However, these processes may be rather elaborate and time-consuming for some of the smaller sub-agreements, taking up to two years to complete. The steps include identification of an IA, preliminary assessment, concurrence by KPAD, the technical proposal development, reviews by the Contracts and Grants unit, pre-award assessment by the finance unit, and clearance by practically all units (finance, M&E, technical unit, Deputy Director for Program and Technical and the Deputy Director for Administration) before signature by the Country Director. There have been instances (e.g., Bahtera) of separate visits being made by technical and financial staff who gave conflicting advice, which resulted in further delays. Any amendment or modification to the sub-agreement also goes through a similar process.

Technical Assistance: All IAs that the Evaluation Team visited appreciate and value the

technical assistance provided by ASA, especially in proposal development, but also in the start-up process. All expressed the need for continued technical assistance and the opportunity to share and learn from the experience of other similar NGOs. All IAs had received some initial training but not enough visits by the technical staff. As per the program design, technical monitors are required to visit the projects at least once every six months but the frequency of visits varied. The larger NGOs, such as KKI and YKB, need epidemiological data and updated material while the smaller NGOs, like Bandungwangi in Jakarta or Bahtera in Bandung, need and would appreciate frequent visits by technical staff for problem solving and on-the-job training. Private sector NGOs such as KKI would like ASA to facilitate coordination among NGOs to avoid duplication/overlap of activities. Even while planning budgets for workplace programs, many of the larger companies (e.g., Pertamina) could finance or at least share costs.

Financial management of sub-agreements: Financial management seems to be working very well and is a strong point of the management system. The team did not hear a single complaint from the IAs. As soon as the sub-agreements are approved, the IAs are given funds for two months of operations. Outlays are replenished monthly based on Monthly Financial Reports (MFR). ASA provided technical assistance and initial training in setting up and operating a standardized accounting template. Even the smaller NGOs are able to submit their expenditure data without much problem. However, some of the more established and larger NGOs did express a preference for quarterly reporting. Currently any change of program activities or unplanned use of funds requires prior approval from ASA HQ. While this is fine from the point of view of tight financial control, it may be limiting the ability of the IAs to innovate or respond to changing needs.

Monthly reports: In addition to the MFR, all projects, irrespective of their size, also submit a monthly Performance Indicators Form and a narrative report. Although ASA only requires a one-page narrative report, the NGOs often prepare much longer reports (7–15 pages) and spend considerable time on this. Because 100 such reports come in every month to the ASA office, and because of the multiplicity of staff tasks, it is unlikely that the relevant technical staff is able to read these reports and provide technical feedback to the NGOs. At best the reports are probably only read by the provincial office staff. Feedback to the NGOs appears to be weak. In addition to the monthly reports, the NGOs are required to maintain a variety of Daily Logs that require such details as the names and addresses of each and every CSW contacted each day. Although all NGOs comply, these could be simplified to reduce the reporting workload of the NGOs.

Sharing of experience among NGOs: Many IAs expressed a need to learn about the experience of others and the desire to share their own. There are already some networks, such as the Asia Harm Reduction Network (AHRN), that provide such a forum for NGOs dealing with IDUs. However, many others do not have such vehicles.

2. Field Office Management, Capacity-building and Support

Five of the 10 provincial offices have one or two staff—a representative and an administrative assistant. Four other offices have an additional program manager. These have a variety of tasks: proposal development, monthly project monitoring visits to 10–15 IAs under their

responsibility, coordination with the KPADs, and responding to numerous requests from HQ. Where there is an additional program manager, he or she is responsible for IA monitoring, while the representative is responsible for coordination with and support to KPADs. Thus, the provincial representative may not be fully cognizant of the IAs activities or problems. An option would be for IA monitoring and KPAD support activities to be shared by both, with each responsible for a geographic area. All have written job descriptions and most, but not all, are clear about their tasks. However, neither the administrative assistants nor the provincial representatives have received any formal induction training. They seem to have learned their duties on the job through their own initiatives.

There are still significant coordination problems between the central ASA, especially the technical unit, and the provincial staff. Feedback to the IAs appears to be weak. There have been several instances of technical staff's dealing directly with the IAs without keeping the provincial representatives informed.

Sometimes the IAs have received multiple requests for the same report or have gotten different recommendations from different staff. For example, the technical staff might give approval for something to which the provincial program monitor does not agree. All these issues point to the need to have the Provincial Representative serve as the focal person for channeling all communication and support.

Limited delegation of authority: The provincial office currently only manages a petty cash fund. All decisions are made at the central level. Given the large number of sub-agreements managed by the program, some level of decentralization should be considered. The capacity of the provincial staff needs to be strengthened to enable them to become good supervisors who listen to the needs and ideas of the NGOs, and are willing to propose (or approve) necessary amendments.

Currently, before every trip, a request must be submitted to HQ for its approval. An option would be for the field office to submit a monthly activity and travel plan. Now only IA site visits are reported and no other activities. It would be very useful for the field offices to submit concise monthly reports that summarize all other activities, besides site visits to IAs, that relate to their next monthly plan, and problems and issues, if any (e.g., training, KPAD meetings, and new initiatives).

The Evaluation Team was impressed with the dedication and hard work of the provincial staff it visited, but ASA recognizes that some provincial representatives are weak and spend too much time on lobbying and not enough on monitoring and evaluating of IA activities. The provincial offices have a heavy workload and limited staff. The field offices have the potential to take on additional responsibilities, but this would require additional staff, and appropriate training and skills in project management, monitoring, and evaluation. The field offices would also require sustained supervision and support from the central ASA office.

The ASA Program Director should assess the staffing needs of this program, and develop a structure and job descriptions based on expected responsibilities. Effort should be made to recruit provincial managers who have both proven management skills and familiarity with the local situations.

3. Organizational Structure and Management

ASA appears to be very well managed, with excellent technical support for IAs during project development and start-up stages, combined with tight financial management. However, management is probably too tightly and too centrally managed from Jakarta. There is too little delegation of authority to the field offices, and the IAs have very little flexibility. Prior approval from HQ for even minor changes seems unwarranted. The program appears to have a “top-heavy organization structure.” Some 53 of the 82 staff—all technical, financial and M&E staff, and a majority of program management staff—are located in the HQ office.

External coordination: All donors (UNFPA, UNDP, and AusAID) complimented the work of ASA and stressed the importance of continuing such a program. ASA seems to have good coordination and working relations with the Department of Health, KPA, and the IHPCP project. In fact, both in Jakarta and Bandung, the ASA staff share office space with KPAD and IHPCP. Although ASA’s work cuts across many departments, its main focus is on providing technical assistance in BCI, VCT, and STI clinic services to the IAs and partners. Therefore, locating the ASA office within the Department of Health has promoted a close partnership with that department. However, KPA feels that ideally ASA should be located within KPA, because HIV/AIDS is more than a health problem and requires a multisectoral response that is best carried out through a multisectoral agency. Although the team supports that idea in principle, the KPA is a weak organization with limited staff and influence. It may not be ready to absorb such a large and complex project as ASA.

Internal coordination between units: As recommended in the June 2003 internal review, the ASA program management was restructured to bring the program and technical divisions together under a Deputy Director. This has helped improve coordination between the program and technical units, but there are still some bottlenecks, as expressed by many of the staff and even some of the IAs. In particular, the field offices are not receiving adequate supervision and support. The field staff currently goes to the Deputy Director or Country Director when faced with problems. The portfolios under the program and technical deputy may still be too large to provide adequate supervision and support to the technical program units and to the 10 provincial field offices.

4. Monitoring and Evaluation

The ASA program states that it has a “comprehensive monitoring and evaluation system that provides essential data for program management on a regular basis, as well as the data required to measure program success.”¹⁴ In reality, ASA has a comprehensive monitoring system located in a Management of Information System (MIS)/Monitoring and Evaluation Unit. Evaluation, which has no comparable unit, relies heavily on BSS data. This may change during Year Five, when “ASA will focus on refining the system, translating the data into practical initiatives for improving the quality of implementation, and evaluating the overall, final results of the program.”¹⁵

¹⁴ ASA, Year Five Workplan, p. 18.

¹⁵ Ibid.

Monitoring

ASA views *monitoring* as ensuring that program activities are occurring as planned, are on schedule, and are achieving desired results. ASA provincial representatives have the major responsibility to monitor the IA activities in their provinces. This monitoring consists of compiling and analyzing monthly reports based on mutually agreed-upon process indicators obtained by each IA and on routine monthly site visits. Written feedback is then provided to the IAs, and a compiled report is submitted to the ASA Jakarta office and the KPAD. Additional monitoring is provided by both the Technical and Program Units in Jakarta on a semiannual basis, as well as whenever an urgent need may arise.

Provincial project monitors assigned to each sub-agreement are required to conduct at least one site visit per month using a standard checklist. Alternatively, they may hold a consultation meeting with the IAs to ensure that regular monitoring feedback is provided and that required data are validated. ASA provincial offices then analyze the information for anything unexpected that may signal a potential problem in the future. The Monitoring and Evaluation Unit assists with the interpretation of data and ensures that documentation of results is properly disseminated to staff and partners for action.

Headquarters technical monitors are assigned to each sub-agreement. They are responsible for ensuring that each proposal is technically sound and that sufficient technical assistance is provided during implementation to guarantee that the intervention objectives and targets are met. The technical monitor reviews each proposal, final sub-agreement, and monthly implementation reports, as well as routinely monitoring implementation in the field in coordination with the program monitor.

All in all, this system appears to be working well. All the monitors and IA managers receive training in monitoring and in the forms that need to be filled out. The checklists and other forms are comprehensive and are directly linked to the results frameworks. For example, data on the number of target groups reached come from daily journals maintained by the outreach workers. The site visits and analytical feedback from the MIS/M&E unit appear to be appreciated by the IAs. The biggest gap identified by the MIS/M&E unit is that the data are not used enough by the technical monitors for problem-solving. The data seem to be used largely for closeout reports and, less often, to identify and fix implementation problems.

Evaluation

The program relies heavily on surveillance indicators for evaluation, especially those from the BSS. The principal evaluation criteria are stable or lowered HIV prevalence (impacts) and reductions in risky behavior (outcomes) among MARGs, which are both in line with USAID guidelines. The 2004 data are being analyzed now. As mentioned previously, these analyses will be able to track changes in condom use and related behaviors. In some provinces, staff may also be able to link these changes to ASA outreach and other activities. For example, in Manado, the 2004 BSS data show that the more frequently sex workers and their clients received condoms from NGO field workers, the more likely they were to use them. That is, the use of condoms in the last commercial sexual encounter increased with NGO efforts to

distribute them.¹⁶

The MIS/M&E unit notes that it does little or no evaluation. Unit staff consider that activity to be the responsibility of surveillance. However, the surveillance unit is concerned largely with providing technical assistance in the development and institutionalization of surveillance systems. The MIS/M&E Unit mentioned that it has done some focus groups and small surveys, and has held “participatory” meetings to evaluate subprojects. There have been a few analyses of secondary service and monitoring statistics to identify problems and to assess performance. These analyses have produced some interesting results, and the MIS/M&E Unit has hired an analyst to conduct more such analyses.

Aside from analysis of BSS data, evaluations do not seem to be carried out on interventions to determine whether they achieve the desired outcomes and, if not, why not. For example, does training result in better performance on the job? Do behavior change interventions for IDUs actually change behavior? This type of “process evaluation” is not required in ASA’s cooperative agreement and does not seem to be a priority for the program. But there are exceptions. During the field visits the Evaluation Team found a few examples of intervention evaluations. For example, the case management subproject of Widuri has already conducted an evaluation of the effect of its training on case managers and found significant improvements in performance. The subproject staff plan to evaluate the impact of this improved performance on client health and well-being. An anecdotal finding was that the improved case management procedures helped a client, who had been told he had only six months to live, to get additional services that extended his life for another two years.

On the other hand, another subproject that established a stand-alone VCT center operated for 14 months without any assessment of its very low caseload. When the service was changed to a mobile format, the caseload went up a hundredfold.

Another notable exception is found in the clinical interventions. The program carries out a number of “quality control” activities, which could be considered a form of evaluation, monitoring, or research, depending on one’s point of view. Examples are the validation of slides and medical records, the adherence to standards of care in HIV testing, and the monitoring of the susceptibility of STIs to certain drugs. This type of evaluation is done routinely and is very useful for ensuring that clinical procedures are effective and of high quality. There is no system like this for assessing behavioral change interventions.

Indicators

The Year Five plan states that “evaluation involves determining the quality and effectiveness of activities as measured by key indicators.” Impact indicators are produced by surveillance data and are used to assess overall progress in lowering HIV prevalence and reducing risk behavior among MARGs. There is no attempt to attribute changes in prevalence to ASA program interventions. As per USAID policy, such changes are seen as the result of the combined efforts of the program’s many activities and the efforts of other entities.

¹⁶ But does it work? op. cit., p. 14.

Outcome indicators are used to assess changes in the behavior of MARGs, in particular, their condom use. This information also comes from surveillance data and is used to assess ASA performance in reaching RP 1 targets, in particular. There is one outcome indicator for RP 2, i.e., treatment of STIs. There are no outcome indicators for RP 3, RP 4 and RP 5.

Most of the indicators used to assess performance in all the Results Packages are process or activity indicators, largely focused on reaching, serving, and referring clients through interventions supported by USAID. A list of all these indicators is found in Annex F. In general, the table shows that the program is following USAID guidelines and has an appropriate list of impact, outcome, and process/output indicators.

Table 20 shows the core *impact* indicators for the ASA program. These all measure changes in HIV prevalence. The intention has been to show pre-intervention/post-intervention changes over time in seroprevalence among the general population as well as the MARGs.

Table 20: Impact Performance Indicators and Data

Indicator	Base-line Year	Base-line Value	2003 Target	2003 Results	2004 Target	2005 Target
1.0 Percent of women aged 15–24 testing positive for HIV during routine sentinel surveillance at Jayapura, Papua, antenatal clinics	2003	NA*	NA*	NA*	TBD	TBD
2.0. Percent of FSWs testing positive for HIV						
DKI Jakarta: Indirect sex workers testing positive for HIV	2001	1.75%	Below 3.0%	5.9% **	Below 3.0%	Below 3.0%
Tanjung Pinang, Riau: Direct sex workers testing positive for HIV	2001	8.00%	10.0%	4.8%	10.0%	10.0%
Surabaya, East Java: Direct sex workers testing positive for HIV	2001	2.70%	Below 4.0%	4.1% ***	Below 4.0%	Below 4.0%
Percent of transvestites (waria) testing positive for HIV	2002	22.7%	25.0%	NA****	25.0%	25.0%

* No record of HIV + women appearing at antenatal clinics in Papua to date

** Start-up at interventions was delayed, resulting in limited access

*** Mobile populations of FSWs here cause high turnover and fluctuations in results

**** The baseline value reflects the results of the 2002 MSM study implemented by ASA. The MOH is responsible for further sampling among MSM, though this has not yet occurred.

One of the gaps in this table, and in the outcome indicators listed in Annex F, is the lack of data for baselines, results, and for certain target groups. The collection of BSS data only every two years or so, and the fact that they do not cover all MARGs in program areas make it even more important to conduct process evaluations of key interventions. This information would help ASA and its IAs to ensure that their interventions are effective and on track.

The following table lists ASA's outcome and output/process indicators. Note that the

behavioral (outcome) indicators are 3.1.1 to 3.1.11. Most of the remainder are output/process indicators. A few (2.1.5, 2.1.8) are actually input indicators.

Table 21: ASA Performance Indicators

RP 1 Performance Outcome Indicators
Sub-Intermediate Result 3.1: Increased risk-reduction behavior and practices among individuals at high risk for HIV and STI
3.1.1 % of FSWs reporting condom use during most recent sex act with client
3.1.2 % of FSWs reporting consistent condom use with clients during past week
3.1.3 % of Target Male Groups reporting commercial sex in the last 12 months
3.1.4 % of Target Male Groups reporting condom use during most recent sex act with commercial partner
3.1.5 % of IDUs who report sharing injecting equipment at least once in the last week
3.1.6 % of IDUs reporting condom use during most recent sex act with any partner
3.1.7 % of MSM Target Group reporting no unprotected anal sex in the past one month
3.1.8 % of MSM (gays) Target Group reporting condom use during most recent anal sex act with any partner
3.1.9 % of Transvestite (waria) sex workers using condom with last anal client
3.1.10 % of Male sex workers using condom with last anal client
3.1.11 Median age at first (penetrative) sex among young men and women aged 15–24 surveyed
3.1.12 The number of FSWs reached by outreach educators in USAID-sponsored activities
3.1.13 The number of USAID-supplied condoms distributed (to target groups)
2.1.3 % of commercial sex establishments having condoms available on-site for male clients at time of survey
RP 2 Performance Outcome Indicators
Sub-Intermediate Result 2.1 : Strengthened quality, accessibility, and utilization of prevention, care and treatment services for individuals at high risk for STI/HIV/AIDS
2.1.1 % of FSWs and other clients diagnosed and treated for STIs in accordance with the GOI-recommended STI treatment protocol in USAID-sponsored clinics
2.1.2 % of USAID-sponsored clinics reporting no stock outages of > 5 days of essential drugs
2.1.4 Number of clients provided services at USAID-sponsored STI clinics: Male clients, Female clients, total
2.1.5 Number of STI clinics with USAID assistance
2.1.6 Number of clients seen at USAID-sponsored VCT clinics
2.1.7 Number of persons reached by USAID-assisted community and home-based care programs
2.1.8 Number of USAID-assisted community and home-based care programs
RP 3 Performance Indicator
Sub-Intermediate Result 2.2: Enhanced capacity and quality of GOI HIV/STI surveillance systems and their use in decision-making
2.2.1 % of provinces in which USAID is active that have collected HIV surveillance and behavioral surveillance data from appropriate risk groups
2.2.2 % of provinces in which USAID is active that have held a “Second Generation Surveillance” workshop in the past year and input is used to review and analyze available HIV data and improve program planning
2.2.3 Monthly press reports on HIV-related issues supporting program objectives in sentinel newspapers
RP 4 Performance Indicators
Sub- Intermediate Result 2.3: Strengthened capacity of local organizations to plan, finance, manage and coordinate HIV/STI responses
2.3.1 % of districts in which USAID is active where the district budget for KPAD increased over the previous year, relative to overall development spending
RP 5 Performance Indicator
Sub-Intermediate Result 1.1: Increased leveraging of programmatic interventions and financial resources
1.1.1 % of provinces in which USAID is active where the number of private sector organizations with workplace HIV prevention programs or substantial in-kind donations to prevention activities increased over the previous year.
1.1.2 % of provinces in which USAID is active where the total cost share from non-USAID sources increased over the previous year.

Conclusions and Recommendations

ASA's administrative, financial, and monitoring systems help program management keep tight control over central and sub-agreement activities. While this may have been necessary at the start of the program, it may now be time to decentralize and reduce control, especially for those IAs that have demonstrated their ability to manage themselves. The field offices could be built up to take over both administrative and technical support to subprojects, which would reduce the heavy burden on central staff and ensure improved support for field projects. ASA should consider bringing all 10 field offices under a separate Deputy Director (Field Program Support) to assure adequate and timely supervision and support.

The monitoring system appears to be comprehensive, user-friendly, and useful, although it may also be overbearing. Evaluation seems to be limited to surveillance data, which are limited and collected only every two years or so. There seems to be little evaluation of the effects of interventions on behavior. If time and resources permit, it would be very helpful to evaluate the effects on behavior and health of such key interventions as outreach, VCT, case management, mass media, and workplace programs.

IV. ISSUES

Summary: ASA is to be commended for achieving as much as it has in a very difficult environment. Nevertheless, several issues still need to be addressed. Donor and GOI coordination is improving but still needs strengthening. Integration of HIV/AIDS into other Mission Strategic Objectives is needed, as HIV/AIDS is a multisectoral problem. Papua is a special case and needs a special strategy. Sustainability, while not a USAID concern where HIV/AIDS is concerned, is a significant concern of IAs and should be addressed as part of capacity development. Program continuity deserves immediate action.

A. General Obstacles and Constraints

ASA works under a larger number of obstacles and constraints that affect performance. Many of these have been present since the program began and will likely continue to be significant for any follow-on program. The following were listed recently by ASA:¹⁷

- The vast physical, ethnic, and cultural **diversity** of Indonesia
- Highly **mobile populations**, including large numbers of mobile men with money in the shipping and transport industries, in extractive industries, in export processing zones, in the military and as tourists; as well as the female sex workers who provide services to them
- The aftermath of a major **economic crisis** in which women, often divorced and without support for their dependent children, are in search of survival; increasing numbers of vulnerable children living on the streets
- A **low perception of risk** in the Indonesian population, reflected in very low levels of condom use, and lack of knowledge or misperceptions on how to appropriately

¹⁷ Year Five Workplan, p. 7.

- prevent or treat sexually transmitted infections
- Increasing **unemployment** among youth and an exploding drug problem, especially among young, casually employed men in major cities
 - Low levels of **investment and leadership** in HIV/AIDS on the part of the Indonesian government, and the relegation of the problem to the health sector with no multisectoral responsibility or accountability
 - Limited quality and availability of **counseling and laboratory testing** for HIV and STIs, and limited surveillance capacity, especially for STIs
 - Relatively new and inexperienced nongovernmental organizations working in HIV prevention
 - Limited **human resource capacity** among both government and NGO staff
 - Lack of experience in **behavior change interventions** in Indonesia
 - A newly instituted and not fully defined process of government **decentralization** of health service delivery, prevention programs, and revenue generation
 - **Complacency**, given low HIV prevalence, means priority is often given to other health, development, and political issues
 - Stress on **coordination and administrative capacity** within the government, particularly at the national level, as very large amounts of funding become available from other sources such as the Global Fund and the World Bank
 - Rising prominence of conservative **religious values** that inhibit the efficient use of mass media to reach groups most-at-risk
 - The **politicization** of HIV in Papua is diverting attention from prevention efforts to change high-risk behaviors in the general public
 - Increasing demands by HIV-positive individuals for **treatment**, which diverts attention from prevention issues

Several other issues deserve elaboration: coordination, integration, Papua, and continuity and sustainability.

B. Coordination

Coordination both among donors and within the KPA-KPAD mechanism is very important. Donor coordination has improved over the past few years with the strong support of UNAIDS, USAID and AusAID. As additional funds enter the system from such major donors as the Global Fund and Department for International Development (DfID) (via UNDP), donor coordination will become even more important. ASA is seen to be stretched too thin, but is also seen as a model for other donors. An opportunity exists to expand ASA-like activities to other provinces without over-burdening ASA itself.

An additional issue that needs to be addressed is the different philosophies of the various donors. While UNAIDS would like to see all donors pool their resources to implement a common strategy undertaken largely by Indonesians, USAID focuses more on achieving immediate results through U.S.-based implementing agencies. The Global Fund sees itself as a funding agency and leaves it up to each country to decide how it will address HIV/AIDS. In the long run, the UNAIDS philosophy should lead to greater capacity development and ownership of program interventions. USAID, however, views HIV/AIDS as an epidemic that needs to be addressed directly and quickly. Capacity development and ownership are lower-

level priorities for USAID.

The National AIDS Commission (KPA), and the provincial and district/city AIDS Commissions (KPADs) are the government agencies for policy, advocacy, and coordination of the HIV/AIDS response. Their capacity development is a major need. Although ASA is providing some assistance to both the KPA and the KPADs in the 10 provinces where it works, much more assistance is required before these agencies become true, influential coordinating commissions. The KPA has stated that it would like to see ASA moved out of the MOH and into KPA, arguing that HIV/AIDS is more than a health issue, that it is a multisectoral issue, and that KPA is the appropriate government entity to house ASA. On the other hand, ASA believes that HIV/AIDS is a disease; and while taking a multisectoral approach, ASA sees its fundamental mission to work through the disease control unit of the MOH.

This situation is exacerbated by the lack of coordination between the KPA and the KPADs. This may be addressed, at least in part, through the upcoming DfID/UNDP project, which will focus on strengthening both the KPA and the KPADs. UNDP has stated that it would like to replicate the ASA approach to capacity development that is ongoing in the 10 program provinces.

ASA intends to continue to provide technical assistance and funds to support the KPA and KPADs in the 10 provinces to help build their capacity for advocacy, coordination, and strategic planning. ASA also plans to continue promoting coordination in two ways: 1) by copying reports of its activities to the KPA and KPADs; and 2) by continuing to participate in KPA and KPAD subcommittees.

C. Integration with Other Components of USAID/Indonesia's Strategy

The USAID Strategic Plan for Indonesia 2003–2008 is based on the fundamental assumption that integrated program planning in a selected number of districts is the most feasible and effective way to achieve results. To the greatest extent possible, the Mission is seeking to bring together integrated district-level service delivery programs from the Democratic and Decentralized Governance, Education, and Basic Human Services teams. Like many other Missions, USAID/Indonesia is interested in ways to support HIV/AIDS prevention activities within the overall Mission strategy.

There are several selection criteria for determining how integrated programming at the district level should take place: the need to work with underserved populations; technical imperatives; coordination/collaboration with USAID programs; coordination/collaboration with other donor partners; and the presence of public-private partnership opportunities.

It is important to note that HIV/AIDS is one of President Bush's initiatives. In line with legislative mandates, HIV/AIDS funds cannot be used to fund HIV elements in other Strategic Objectives that do not contribute directly to the Mission's approved HIV/AIDS strategy. Within the context of the Mission strategy, and the parameters of the HIV strategy, in particular, Strategic Objective teams should look for opportunities to use their SO funds to support the Mission's HIV/AIDS goals.

The Strategic Plan is a tightly integrated one in which crosscutting values play a significant role in how results will be achieved. For example, ASA is working at the local level, directly engaging citizens, communities, the private sector and local governments. ASA has been a leader in focusing on transparent and evidence-based decision making and community participation in HIV programming and planning. Support for the activities that ASA has undertaken can be shared through improved coordination with other sectors in the delivery of the core package of decentralized local support activities.

For example, the new education Strategic Object may offer possible opportunities for integrating HIV/AIDS prevention messages into curriculum development. ASA relationships with the Ministry of Social Welfare, the Ministry of Religious Affairs, and UNICEF could be utilized or strengthened through coordination and assistance from the education sector.

The USAID-funded ASA program has been at the forefront in Asia and the world in developing public-private partnerships to address HIV/AIDS. Under RP 5, for example, ASA has helped 94 companies set up workplace programs. In addition, ASA has worked to establish workplace programs with BP Bureau under the umbrella of the USAID Global Development Alliance in the Bird's Head.

D. Papua

The HIV/AIDS situation in the province of Papua requires a different response than that proposed for the rest of Indonesia. Behavioral data, and HIV and STI prevalence data suggest that a more generalized epidemic may be underway in Papua. While Papua makes up only about 1 percent (2.2 million) of the total Indonesian population, it is responsible for 30 percent of the infections.

In 2002, HIV prevalence among brothel-based commercial sex workers in Papua ranged from 2.5 percent to 16.7 percent. These sex workers are mostly non-Papuan but have sex with both Papuans and non-Papuans. HIV rates, STI rates, and behavioral factors are unknown among the more inexpensive street-based sex workers, who tend to be Papuan.

The epidemic in Papua breaks down along ethnic lines, with native Papuans having higher rates of HIV and greater risk behavior than non-Papuans. For instance, data from the BSS show that more than twice as many Papuans (43 percent) have regular, casual, and commercial sex partners as compared to non-Papuans (20 percent). In addition, certain cultural practices, such as the lack of circumcision, make Papuans more vulnerable to HIV from a biological standpoint. While the data from voluntary counseling and testing clinics are sparse, when the team looked at the VCT statistics in each of the ASA-funded centers, it found that the vast majority of positive tests were found in native Papuans, and the male/female ratios were approaching those seen in early, generalized epidemics. Since these individuals were tested when they came in with opportunistic infections, there is some evidence that HIV has been transmitted differently in Papua than in the rest of Indonesia for some time.

Overall, Papuans tend to have lower levels of education than non-Papuans. Many Papuans still live in remote villages where there is a lack of any sort of health information. The

transportation infrastructure is weak and presents problems for scaled-up interventions in rural settings. Villagers migrate to the larger towns for work or come temporarily to buy and sell goods. In both cases, they are removed from traditional village restraints on sexual behavior. There is also a great deal of cross-border interaction with Papua New Guinea, which also has a nascent generalized epidemic of undetermined extent.

Urban Papuans are also affected by the breakdown in traditional support structures. Churches and other religious groups can play an important part in the response, but they need to be involved in a fashion that does not work at cross-purposes to effective public health interventions.

Structurally, the government in Papua continues to be affected by decentralization. New districts are being created, and there is some discussion about dividing the province into three. Officials in the new provinces and districts will need extra assistance in establishing KPADs, policies, and program plans to respond to HIV/AIDS. Mass media interventions will need to be well thought-out because local television is only broadcast for two hours per day.

Add to the above factors the presence of a large military component, a high degree of poverty, poor access to basic services, and a shortage of trained health-care workers, and you have the recipe for a serious HIV problem.

ASA, or whatever program follows on, should probably develop a separate strategy to respond to the epidemic in Papua. To the extent possible, the strategy should be undertaken in coordination with other donors, and with provincial and local governments as well as other stakeholders.

The strategy would likely involve a variety of elements ranging from a comprehensive general awareness campaign that is culturally appropriate and has a good chance of reaching the general audience, including youth, to targeted interventions for those groups that are most at risk, such as mobile men with money, females who are indirect or occasional sex workers or have multiple partners, and youth. Increased condom availability would need to be addressed. Any strategy should also take into consideration issues related to stigma and discrimination, and how these are related to general awareness.

The strategy would also need to encourage research into local sexual customs and behavior in order to formulate effective interventions. Policy, advocacy, and capacity-building with government, FBOs, community-based organizations, NGOs, the private sector, and other groups should also be included in the strategy.

Finally, adequate resources would need to be allocated to ensure a realistic chance to mitigate the effects of the epidemic in Papua. Decisions would be required as to how a Papuan strategy would affect the remainder of the USAID/Indonesia HIV/AIDS program.

E. Continuity and Sustainability

The ASA program is scheduled to end on September 30, 2005, but “Implementation of all

activities in the field will end by June 30, 2005.”¹⁸ Assuming that there will be a follow-on program, a key concern is what will happen to the field activities and subprojects between June 30 and the start-up date of the new program. If an agreement can be awarded before June 30, then there will be no problem. Core subprojects could be continued with no break in services. However, if the award is scheduled for any time after June 30, there will surely be a break in continuity.

The Evaluation Team asked a number of IAs what they would do in such a circumstance. Quite a few said that they would be able to carry on, although many of these said that they would continue at a diminished level. They expected that the training, technical assistance, key commodities, and networking support that ASA provides would not be continued. They also said that much would depend on the duration of the hiatus. The longer the break between projects, the less likely they could continue. This is a significant issue of which USAID is aware, and it is one that can only USAID can resolve. Obviously, the sooner it is addressed, the better for all concerned.

Related to continuity is the question of longer-term sustainability. ASA subprojects tend to be small and of short duration. Most of the IA staff with whom the team spoke expressed their hope that ASA would continue for at least another five years, and most were looking forward to collaborating with ASA again. However, many realize that ASA funding will not continue forever or for all subprojects. Thus, some are already looking for other sources of support, particularly from district and provincial governments. Funds for health are often limited at these levels, however, giving way to other priorities such as roads, schools, and even other health issues, like dengue and maternal-and-child health. Private-sector and parastatal industries, such as factories and ports, may be willing and able to pay for some of the costs, such as space, utilities, and even a few peer educators. In some cases, health insurance may cover some of the costs of STI and VCT services. The “permanent” solution may be direct government support for HIV/AIDS prevention services, especially in areas where most-at-risk groups are found.

Conclusions and Recommendations

The ASA program has been remarkably effective, considering the obstacles and constraints under which it has worked. These include geography, cultural diversity, the lingering effects of the economic crisis, limited human resources, and decentralization, to name a few. Nevertheless, a number of other issues require attention. Donor coordination is one, especially with the expected influx of new funding from the Global Fund, DfID, and others. Coordinated strategic planning among the KPADs and with the national KPA is another. The Mission needs to address the issue of integrating HIV/AIDS into its other Strategic Objectives. Papua, facing a generalized epidemic itself and with its unique characteristics, needs a broader, more intensive response. Finally, the continuity of ASA is itself a serious issue. The program will end all fieldwork in June 2005. Any break in continuity will have serious consequences for USAID’s HIV/AIDS strategy in Indonesia.

¹⁸ Year Five Workplan, p. 6.

V. OVERALL CONCLUSIONS AND RECOMMENDATIONS

Specific conclusions and recommendations have been summarized after each section of this report. The following are the broad, “bottom line” conclusions and recommendations for the program overall.

A. Overall Conclusions

- ASA is achieving significant results in a very difficult environment. The program has strong leadership, a highly qualified staff, and a commitment to coordination and achievement of results that enable it to be successful.
- ASA’s approach is “ecological,” in that its components are all interrelated, which promotes synergy, and results in the whole program’s being greater than the sum of its parts.
- ASA has made substantial progress in meeting targets for four of its five Results Packages, including improved quality, accessibility, and utilization of STI, VCT and CS&T services; improving surveillance systems; capacity development; and leveraging.
- Although BSS data on the effects of the program on behavior change and its impact on HIV prevalence were not available to the team, the qualitative data (and the preliminary analysis from North Sulawesi) indicate that the program has, indeed, had an impact.
- However, ASA is spread too thin under its current organizational structure. It is attempting to do too many things through too many subprojects and a highly centralized structure, thus affecting the quantity and quality of technical and administrative support provided to the field.
- Supervision and mentoring in the field are greatly appreciated by the IAs. But more is needed in both the technical and administrative areas. ASA’s centralized structure is hard-pressed to meet these needs.
- Continuity is a major concern at this time. All fieldwork is scheduled to end in nine months. If ASA is to be continued, action must be taken soon to ensure that there is no break in continuity. Once the subprojects end, it could take years to rebuild them, and that would have a serious effect both on USAID’s ability to have an impact on HIV transmission in Indonesia and on the national response to the epidemic.

B. Overall Recommendations

- ASA’s mandate is to prevent the spread of HIV/AIDS by changing the behavior of most at-risk groups. It has done an excellent job in identifying and reaching these groups with risk-reduction messages. Coverage of all of these groups has expanded markedly. Outreach among FSWs and their clients has been very effective. The quality of STI services is excellent. The surveillance systems are seen as models for other countries to emulate. ASA has been very effective in leveraging funds from other donors and businesses. All of these interventions have come together in to have an effect on the bottom line – behavior change among the most at-risk groups. The 2004 quantitative data on behavior change trends should become available in the next month or two. The

Evaluation Team believes that these data will reinforce the qualitative conclusion that the program has had an impact and is on the right track. To ensure that this trend continues, the Evaluation Team believes that ASA should be extended for at least five more years.

- For reasons of continuity, USAID should not wait for those data to be published before making a decision to continue its HIV/AIDS program and begin its follow-on procurement process. The quantitative BSS data should be used, as they become available, to further inform the follow-on program design and procurement process.
- The focus of ASA should remain where it is now, on prevention of the spread of HIV among most-at-risk groups. Papua should have a separate strategy that addresses its generalized epidemic and its unique characteristics. Capacity development at the central and local levels should also remain a focus.
- ASA should begin to streamline and decentralize its administrative and technical functions right away, rather than wait for the follow-on program to do so. There is enough time left to do this, and these modifications would ensure that any follow-on program inherits a decentralized system.
- The heavy reliance on BSS data for evaluation has made it difficult for the Evaluation Team to demonstrate that individual program interventions have had any effect on behavior, much less an impact on HIV prevalence. Although the 2004 data should be available soon, they may not provide sufficient evidence of the effectiveness of ASA activities on behavior/prevalence change. ASA should undertake rapid, inexpensive evaluations of selected key interventions to demonstrate the effectiveness of those interventions. This type of evaluation should be built into all interventions in the follow-on program.
- ASA may need external technical assistance to improve current behavior change interventions, and to develop process evaluation and monitoring tools that can be used at local levels to assess progress and make needed revisions.

ANNEXES

Annex A: Scope of Work

To save space and avoid duplication the following sections of the SOW have not been reproduced here: II Background (except for the last paragraph) and XI Period of Performance (see Evaluation Plan for a detailed schedule and assignments).

I. IDENTIFICATION OF TECHNICAL ASSISTANCE

General Description: USAID/Indonesia requests the Synergy Project to provide technical support in conducting an external evaluation of the Family Health International “*Aksi Stop AIDS*” (ASA) USAID-supported HIV/AIDS program (August 2000 – September 2005).

II. BACKGROUND

- **Client’s rationale in requesting the task – need for the task - what led to this request?**

FHI Cooperative Agreement No. 497-A-00-00-00038-00 for the “*Aksi Stop AIDS*” (ASA) program is nearing its end date (September 30, 2005). To assess FHI/ASA’s progress toward meeting the program goals, objectives and target indicators and program achievements and to assess the current and future HIV/AIDS intervention needs in Indonesia that are most suited to USAID assistance, this external evaluation is necessary. This evaluation should assess not only the success of the program to date, but also continuing and new challenges and lessons learned from implementation of the program. Additionally, within the scope of the best evidence currently available and within the context of the Expanded Response Strategy to HIV/AIDS 2002-2007 and the new Mission Country Strategy, 2004-2008, the evaluation should assess the best course of future USAID assistance and make recommendations regarding whether or not the FHI/ASA CA should be continued, either as currently designed or with modification.

III. OBJECTIVES OF THE ASSIGNMENT

General Description: The Synergy Project will provide technical assistance to USAID/Indonesia in the design and implementation of an evaluation of FHI/ASA implemented HIV/AIDS activities nationwide. This technical assistance will include the following activities:

- (1) Provide a team leader consultant who will design and lead the evaluation and report writing, on site in Indonesia;
- (2) Provide a second consultant, preferably someone from the Asia/Pacific region, who will participate in the design, evaluation, and report writing, on site in Indonesia;
- (3) Provide a third consultant who will participate in the design, evaluation, and report writing, specifically focusing on finance, administrative and management practices, on site in Indonesia;
- (4) Provide a fourth consultant, someone from within Indonesia, who will participate in the design, evaluation, and report writing, and who will also assist the team leader consultant with report finalization and logistics;

- (5) Prepare the finalized evaluation report and submit to USAID/Indonesia

IV. DELIVERABLES

The following will be key deliverables associated with this assignment:

- A detailed evaluation plan
- A complete report including the methodology and the evaluation findings and recommendations. Findings and recommendations should include progress against indicators/targets; major achievements; management performances; resource allocation and utilization *vis-à-vis* program activities and objectives; continuing or new challenges; assessment of the best course of future USAID assistance within the context of the Expanded Response Strategy to HIV/AIDS 2002-2007 and the new Mission Country Strategy, 2004-2008; the appropriateness of FHI/ASA activities within the scope of the current HIV/AIDS situation in Indonesia; recommendations regarding whether or not the FHI/ASA CA should be continued, either as currently designed or with modification

V. METHODOLOGY

- The team will do the following tasks
 1. Assess the current HIV/AIDS situation in Indonesia from an epidemiological, demographic, and geographic perspective to assist USAID/Indonesia in determining the best direction for future assistance. This will be accomplished through the review of key documents, meetings with GOI, other donors and selected field visits.
 2. The team will conduct field visits at selected FHI/ASA program areas. The team will be divided into three groups to facilitate visiting a number of sites within the limited time frame and budget of the evaluation.
 3. Assess accomplishments and progress toward meeting the goals, objectives and key indicators under *Aksi Stop AIDS (ASA)* program. As part of this assessment, the team will review FHI's Internal Assessment conducted June 2-13, 2003 and the April 2004 USAID/Washington, USAID/Indonesia, MOH two year review of the Expanded Response HIV/AIDS Strategy for Indonesia 2002-2007.
 4. Assess appropriateness of ASA program interventions
 5. Assess FHI management of ASA program
 6. Assess the efficient allocation and utilization of resources
 7. Assess budget allocations and performance by program activities and objectives
 8. Make recommendations for directing USAID HIV/AIDS resources and/or geographic focus after the completion of FHI/ASA Cooperative Agreement on September 2005.
 9. Provide recommendations for continued support to STI/HIV/AIDS activities for beyond September 2005 within the context of the Expanded Responses

Strategy to HIV/AIDS 2002-2007 and the new Mission Country Strategy, 2004-2008.

- Who will participate for the client

Ratna Kurniawati (USAID/Indonesia/HPN)
Lisa Kramer (USAID/Indonesia/HPN)
Billy Pick (USAID/Washington ANE/SPOTS)
Jeanne Uktolseja (MOH/GOI Representative)

- Who will liaise with the client?

The Team Leader, Jack Reynolds

- How and where will the work be accomplished?

The evaluation will be done through discussion and interviews with key stakeholders and donors, site visits, and review of key documents.

Assess what has been achieved to date under ASA program (adequacy of progress against indicators), geographic and behavior pattern of HIV/AIDS spread in light of the present state of the HIV/AIDS epidemic in Indonesia, other donor activities, prospects of sustainable impacts, a management review of FHI Cooperative Agreement practices, including FHI staffing.

This evaluation activity will be conducted in Jakarta, Indonesia, with site visits to priority provinces and districts.

- Special analysis that must be conducted

The Indonesia Demographic and Health Survey (IDHS) 2002-2003 indicates that among ever-married women, knowledge of important ways to avoid HIV/AIDS is very low. The team should review the IDHS and other documents for key findings relevant to HIV/AIDS and populations most at risk for HIV infection. To assist USAID in determining the future course of assistance the team should provide recommendations regarding high priority target populations, given the knowledge gap among ever-married women. Recommendations should be made in the context of evidence-based documentation of HIV/AIDS in Indonesia; best uses for limited resources available for interventions; needs covered by GOI, other donors and NGOs; lessons learned from HIV/AIDS interventions in Indonesia and other Asian countries; and evidence-based analysis of ASA program effectiveness.

VI. REFERENCE MATERIALS

- Special data sources to be considered:

1. FHI/ASA Small Needles and Big: Sex and Drugs in Indonesia Implications for HIV Programs, Elizabeth Pizani, FHI/ASA, Jakarta

2. FHI/ASA Implementation Plan, updated June 20, 2003
3. FHI/ASA Year Four Work plan, Revised September 26, 2003
4. FHI/ASA Fourteenth Quarterly Report (January – March 2004)
5. FHI/ASA financial reports and budgets
6. Review of FHI/ASA Program, June 2-13, 2003
7. FHI/ASA Implementation Status Report, April 2004

- Background documents:

1. USAID/Indonesia HIV/AIDS Expanded Responses Strategy 2002-2007
2. Two Year Review of the USAID/Indonesia HIV/AIDS Strategy 2002-2007
3. Indonesia Country Profile 2003
4. Indonesia Demographic and Health Survey 2002-2003
5. National Estimates of Adults HIV Infection, Indonesia 2002
6. TB + HIV Situation in Indonesia, Data Analysis Done by Chris Dyes, 2004
7. HIV/AIDS and the Workplace
8. Spiritia Foundation Documentation of Human Rights Violations Against People Living with HIV/AIDS in Indonesia

VII. TEAM COMPOSITION AND DESIRED QUALIFICATIONS

- Requirements

The Evaluation Team consists of one team leader, one regional consultant, one international consultant, one local/Indonesian consultant, two advisors from USAID/Washington, two USAID/Indonesia HIV/AIDS advisors, and one GOI/MOH representative. The nine (9) members are required for up to 30 days, including, but not limited to August 15, 2004 to September 3, 2004.

Team member roles and names are as follows:

1. One senior advisor from Synergy, as the Team Leader, preferable with previous Indonesia public health experience and facility with Bahasa Indonesia, with good writing skills. (Jack Reynolds)
2. One senior regional advisor with expertise in HIV/AIDS programming, including behavior change communication skills and administration (Gani Perla)
3. One senior consultant with expertise in evaluating finance, administration and management in the context of public health programming (Elapully Haran)
4. One senior Indonesian consultant, with very good English writing skills and familiar with HIV/AIDS programs in Indonesia (Izhar Fihir)
5. Two senior advisors from USAID/Washington, who are familiar with USAID/Indonesia HIV/AIDS Strategy and HIV/AIDS programs in Indonesia – Billy Pick and Clifton Cortez
6. Two USAID/Indonesia staff, who are Team Leader of HIV/AIDS and Infectious Diseases Team and member (Ratna Kurniawati and Lisa Kramer)
7. One GOI/MOH Representative, who is familiar with HIV/AIDS situation and programming in Indonesia

8. Note: The salaries and logistics for No 1 to 4 will be covered by Synergy.

VIII. REPORTING REQUIREMENTS (Products)

General Description:

- All reports should be done using Microsoft products.
- All drafts will be submitted to the clients and Synergy and be processed through The Synergy Project's technical quality review process
- The Synergy Project will edit the situation analysis for general distribution and posting on the USAID and The Synergy Project's websites. (This last activity will be supported by OHA core funds).
- The format and design of the products

IX. RELATIONSHIPS AND RESPONSIBILITIES

This section spells out the names, roles and responsibilities, and contact information of the client, Synergy staff and consultants.

External Experts	Position Title	Telephone Number)	Email
Jack Reynolds	Team Leader	808 395 8004	jackreynoldshnl@msn.com
Elapully Haran	Senior Consultant	91-124-5029129	haran@vsnl.com
Gani Perla	Regional Consultant		gperla@urc-chs.com
Izhar Fihir	Local Consultant		izharf@rad.net.id
Swarup Sarkar	UNAIDS Consultant		sarkars@un.org
Client			
Ratna Kurniawati	HIV/AIDS and Infectious Diseases Team Leader	(62) 21 – 3435-9407 HP: 08129497763	rkurniawat@usaid.gov
Lisa Kramer	HIV/AIDS and Infectious Diseases Advisor	(62) 21-3435-9323	lkramer@usaid.gov
Clif Cortez	Consultant GH/HIV-AIDS/IS	202-712-6776	clifcortez@usaid.gov
Billy Pick	HIV Technical Advisor	202-712-4911	bpick@usaid.gov
Prof. Dr. Umar Fekri Achmadi	DG for CDC&EH, MOU		

Fahmi Achmadi	MOH		
The Synergy Project			
Charles Katende	Senior Technical M&E Specialist (Technical Oversight)	202-842-2939, Ext. 139	ckatende@s-3.com
Rita Billingsley	Program Manager	202-842-2939, Ext. 131	rbillingsley@s-3.com
Virginia Lamb	Project Assistant	202-842-2939 Ext. 129	vlamb@s-3.com

X. LOGISTICS

Administrative support staff from SSS/Synergy will be responsible for arranging all travel, office space, secretarial/logistical support, and communications as well as other eligible expenses associated with the completion of the assignment.

USAID/Indonesia will provide basic logistics (hotel reservations, in country travel) and some administrative support for the team, as well as one workplace and access to a computer at the Mission, if necessary. The Contractor will be responsible for payment of additional workspace and equipment and will manage international travel. Local expenditures (including local expenditures for the MOH representative but not for USAID/Washington and USAID/Indonesia members) will be the responsibility of the team leader who will be given a budget before his departure.

XI. PERIOD OF PERFORMANCE

Tentative Schedule (see Evaluation Plan for detailed schedule and assignments)

Annex B: Contacts

I. JAKARTA

1. FHI/ASA

Dr. F. Steve Wignall, Country Director
Dr. Hudoyo Hupudio, Deputy Director Program and Technical
Dr. Arwati Soepato, Deputy Director for GOI Liaison
Mr. James Johnson, Deputy Director Administration
Dr. Rudi Nuriadi, Chief Technical Unit
Mr. Spto Adji Dharmoyo, Prevention Marketing Specialist
Ms. Dohreen Biehle, VCT, Care and Support Specialist
Mr. Richard Howard, Private Sector Initiative Specialist
Mr. Aang Sutrisna, Clinical Laboratory Specialist
Ms. Kekek Apriayana, VCT, Care and Support Assistant
Mr. Muhammad Juharto, GIPA Specialist
Dr. Kemmy Ampera Purnamawati, STI/HIV Support Specialist
Mr. Kharisma Nugoho, MIS/M&E Officer
Mr. Irene Sirait, FSW Specialist
Mr. Pandu Riono, Surveillance Specialist
Mr. Yen Yerus Rusalam, Program Management and Capacity Building Specialist
Dr. Mamoto Gultom, STI Specialist

2. GOVERNMENT INSTITUTIONS

Ministry of Health:

Dr. Umar Fahmi Achmadi, DG Communicable Disease Control
Dr. Azrul Azwar, DG Public Health Services
Dr. Haikin Rachmat, Directorate of Communicable Disease Control
Dr. Camelia, Subdirector TB
Dr. Jan Voskens, Consultant (KNVC)

Ministry of Justice and Human Rights

Mr. Soejoto, Director Correctional Institution
Dr. Hendra Salim, Deputy Director Health
Mr. Siswandi, Deputy Director
Mr. Supardal, Monitoring and Evaluation Section
Ms. Emi Sulitiyati, Drug Addict Section
Mr. Rachmat Tonde, Governor Paledang Prison – Bogor West Java
Mr. Rudi, Education Section, Paledang Prison – Bogor West Java
Dr. Djaelani, Clinic Doctor Paledang Prison – Bogor West Java
Dr. Benny, Clinic Doctor Paledang Prison – Bogor West Java

Ministry of Labor and Transmigration

Dr. Tjepi F. Aloewi, Secretary General
Dr. Amaruddin, Occupational Health and Safety
Mr. Hariyadi Agus, Center for Overseas Collaboration

Mr. Supangkat, Center for Occupational Health and Industrial Hygiene

National AIDS Commission (KPA)

Dr. Suharto, NAC Secretariat
Dr. Djoko Suharno, NAC Secretariat
Dr. Nadir, NAC Consultant

National Narcotic Board (BNN)

Mr. Muh. Arifin R., Deputy Acting Head
Mr. Muh Djusmin, Research and Development
Ms. Lina G. Padmo Hudoyo, Expert Staff
Ms. Noldy Ratta, Expert Staff
Dr. Nanang Parwoto
Dr. Kusman
Dr. Al Bachri Husin, Food and Drug Administration
Dr. Esther Sinsuw, Narcotic Rehabilitation Center

Indonesian Forum Parliament for Population and Development (IFPPD)

Ms. Ermalena

Central Bureau of Statistics

Mr. Ahrizal

Sulianto Saroso Hospital for Infectious Diseases

3. DONORS COMMUNITY

Ms. Jane Wilson, UNAIDS
Ms. Kindy Marina, UNFPA
Mr. Tauvik Ahmad, ILO
Mr. Gopinath Menon, GFATM Price Warehouse
Ms. Rachel Odede, UNICEF
Mr. Remy Rohadian, AusAID
Ms. Sara Knuckey, IHPCP/AusAID
Mr. Chris Purdy, DKT

4. NON GOVERNMENT ORGANIZATION (NGO):

Yayasan Bandungwangi /CSW

Ms. Anna Solikah, Project Director
Ms. Supri, Project Manager
Ms. Titien Suprihatin, Finance Manager
Ms. Yayuk, Field Coordinator
Ms. Asih, Outreach Worker
Ms. Dasiah, Outreach Worker
Ms. Aam, Outreach Worker
Ms. Maryati, Outreach Worker

Yayasan Kusuma Buana (YKB) / CSW

Dr. Joedo Prihartono, Project Director
Ms. Rediscovery Nitta, Project Manager
Mr. Chandra, Field Coordinator
Ms. Hikmawati, Outreach Worker
Ms. Novi, Outreach Worker
Ms. Lisa, Outreach Worker

Yayasan Srikandi Sejati (YSS) / MLM

Ms. Lenny Sugianto, Project Manager
Ms. Okky Darmianto, Field Coordinator
Ms. Dewi Agung Amelia, Field Coordinator
Ms. Lina Sagita, Outreach Worker
Ms. Mawasari, Counselor

Yayasan Pelangi Kasih Nusantara / MLM

Mr. Hendy Sahertian, Program Manager
Ms. Corry Kedarsari, Finance
Ms. Susy Seritulhidayah, Administrator
Mr. Tono Permana, Field Coordinator West Jakarta
Mr. Eko Ari S., Field Coordinator North Jakarta
Mr. Syamsul Komar, Field Coordinator East Jakarta
Mr. Al Muzzini, Field Coordinator South Jakarta
Mr. Rym Zefanya, Field Coordinator Central Jakarta

Lembaga Pers Dr. Sutomo / Media

Mr. Tribuana Said, Executive Director
Mr. Warief Djajanto, Lecturer
Mr. Basorie

Leo Burnett Kreasindo / Media

Mr. Dean Bramhan, Managing Director
Ms. Sulochana Puri, Account Director
Ms. Fitriana Dyah, Account Director

Asian Harm Reduction Network (AHRN) / IDU

Ms. Camille Lemouchoux, Country Coordinator

Center for Health Research – University of Indonesia / IDU

Mr. Heru Supono, Team Leader
Mr. Ferdinand PS, Field Coordinator
Mr. Amry Ismail, Data Management
Mr. Nugroho, Ethnography
Mr. Adhi Ardian, Outreach Worker

Kios Atma Jaya / IDU

Ms. Lamtiur Tampubolon, Project Director
Ms. Sundari

Yayasan Mitra Indonesia / VCT

Mr. Cecep Junaidi, Project Coordinator
Mr. Agus T. Sugeng, Counselor
Mr. Wibisono, Promotion and Social Marketing Coordinator
Ms. Habasiah, Training Coordinator

Widuri Institute for Social Worker / Case Management

Ms. Evie Tarigan, Program Director
Ms. Frieda Girsang, Program Coordinator
Ms. Wati, Finance
Ms. Tien Gosana, Chairman Inst. For Social Worker
Ms. Tika, Case Manager

Pulmonary Clinic Baladewa / Indonesian Association for TB Eradication

Ms. Heru Gumadi, Deputy Chairperson Jakarta
Ms. Rini Pranowo, Deputy Chairperson Jakarta
Ms. Harsono, Finance
Dr. Yulismar, Pulmonologist, Clinic Doctor
Dr. Wia, Counselor
Mr. Sulardi, Case Manager
Ms. Evayanti, Case Manager

Yayasan Spiritia / PLWA

Ms. Frika, Field Manager
Ms. Adisty, Finance
Ms. Karni, Administrator
Mr. Siradj Okta, Field Manager
Ms. Herlin, Professional Staff

Komite Kemanusiaan Indonesia (KKI) / Workplace

Mr. Abdul Aziz, Project Director
Mr. Didi Wiryono, Project Officer

Yayasan Kusuma Buana / Workplace

Dr. Firman Lubis, Project Director
Dr. Adi Sasaongko, Project Consultant
Mr. Bahori, Project Officer
Ms. Yani Mulyani, Project Officer
Ms. Siti Hadiyati, Project Officer
Ms. Carolina P. Hendrawati Project Officer

II. CENTRAL JAVA**FHI/ASA**

Dr. Wahyu, Provincial Coordinator
Mr. R. Wibowo
Ms. Aprilia, Finance
Mr. Kristiadji, Prov. AIDS Commission

GOVERNMENT INSTITUTION

Provincial AIDS Commission

Mr. Ali Mufiz, Deputy Governor
Dr. Budihardjo, Deputy Head Prov. Health Office
Mr. Yoga Hardjono
Mr. Edi Purwanto, CDC Section

Municipality AIDS Commission City of Semarang

Mr. Muchatiff, Deputy Mayor
Mr. Tri Susilo, Municipality Health Office
Ms. Yuli M, Municipality Health Office
Mr. Sutikni, FP Coordinating Board
Mr. Wardoyo, Office of Social Affair
Mr. M. Ridwan, Office of Social Affair

District Health Office – Tegal

Ms. Riswatiningsih, Subdirector CDC
Dr. Sumaryati, Subdirector Public Health Service
Mr. Djoko Kurinato, Surveillance Section
Mr. Warnadi, District AIDS Commission

NON GOVERNMENT ORGANIZATION (NGO):

Yayasan Binterbusih/Papuan Student Organization

Mr. Paul Sudiyo, Director
Mr. Pascalis, Program Manager
Mr. Dolfinius, Field Worker, Malang East Java
Ms. Shanty, Field Worker, Semarang, Central Java
Mr. Ronald, Field Worker, Yogya
Mr. Julius, Field Worker, Bandung, West Java
Ms. Florence, Peer Educator, Semarang
Mr. Samuel, Peer Educator, Semarang

Yayasan Sosial Soegijapranata – Semarang / CSW

Dr. Agus Rianto, Program Manager
Mr. Agus Pribowo, Field Coordinator
Mr. Sonora, Finance
Mr. Agus Rudiyo, Field Worker
Ms. Catharina, Field Worker
Mr. Bagus Pamungkas, Field Worker

STI Clinic – PKBI (Indonesian Family Planning Association) – Semarang / CSW

Dr. Bambang Darmawan, Program Director
Dr. Yoga Yulianto, Clinic Coordinator
Mr. Hendra Susila Adi, Program Manager
Mr. Aries Sunarto, Field Coordinator
Ms. Merry Krismina Y., Finance
Ms. Ina Rohayati, Administrator
Ms. Sukaryo, Data Processing
Ms. Vita Ayu, Nurse
Ms. Suci Sari K, Midwife
Mr. Yoyok Wicaksono, Laboratory
Ms. Ari Istiadi, Field Worker
Ms. Rulia Iva D., Field Worker

Yayasan Wahana Bakti Sejahtera (YWBS) / IDU

Dr. Onny, Program Manager
Ms. Sri Peni Hernawati, Program Director
Mr. Ardham, Finance
Mr. Sony Noegroho, Field Coordinator
Mr. Bagus Prasetyo, Outreach Worker
Ms. Vitry Ratna Palupi, Outreach Worker
Ms. Mieke Yostenia, Volunteer

Fatayat NU (NU Women Association)- Tegal / CSW

Ms. Nur Khasanah, Program Director
Ms. Zakiyah Assegaf, Program Manager
Ms. Mulyatisyah, Finance
Mr. Madlani Tahyat, Field Coordinator CSW
Mr. Ali Nur Sidik, Outreach Worker CSW
Mr. Solikhun, Field Coordinator, Client
Mr. Musbichin, Outreach Worker Client

STI Clinic – PKBI (Indonesian Family Planning Association) – Tegal / CSW

Dr. H. Widodo Joko Mulyono, Project Director
Dr. Joko Wantoro, Program Manager
Dr. Guntur M. Taqwim, Clinic Manager
Ms. Yuyun Priatiningrum, Finance
Mr. Sadudin, Field Coordinator
Mr. Agus Salim, Field Coordinator
Mr. Guntur Gunawan, Field Coordinator
Ms. Etik Damayanti, Midwife
Mr. Papang Yudi Prasetyo, Field Worker
Ms. Heni Prastuti, Field Worker

III. NORTH SULAWESI

FHI/ASA

Dr. James Sinaya, Provincial Coordinator
Ms. Charlotte

Ms. Debby

GOVERNMENT INSTITUTION

Provincial AIDS Commission - Manado

Mr. Is L.A. Gobel, Assistant to Governor
Mr. A. Tahendung, Bureau Chief Social Affair
Dr. Jeanette Siby, Chief, MOH Provincial Office
Dr. Yvonne Kaunang, Chief MOH Municipality Office, Manado
Dr. Damas Waas, Chief Laboratory, MOH Provincial Office
Dr. Non Sondakh, MOH Municipality Office, Manado
Dr. Nora Lumentut, CDC Section MOH Provincial Office
Mr. Johnny Loardo, Bureau Chief Social Affair
Mr. G. Mawengky, Bureau Chief Social Affair
Ms. Nelly Ponggawa, Ministry of Labor and Transmigration

General Hospital – Manado

Dr. Ch R. Tilaar, Project Director VCT
Dr. Maxi Rondonuwu, Manager VCT
Ms. Juneke Kojuko, Laboratory Technician
Mr. Andreis Moningka, Laboratory Technician
Mr. Dedy Sondakh, Laboratory Technician
Ms. Jean Wotung, Case Manager
Ms. I Made R., Case Manager

NON GOVERNMENT ORGANIZATION (NGO):

Yayasan Bahagia Harapan Kita – STI Clinic – Manado

Dr. Alice Karendeng, Director
Dr. Edi Karendeng

Yayasan Mitra Masyarakat /IDU – Manado

Ms. Jenny Zebedues, Project Director
Mr. Mathew Z., Project Manager
Ms. Merry Tamboto, Field Coordinator
Mr. Michael Kodong, Project Officer
Ms. Rody Lolong, Project Officer
Ms. Etje Umboh, Project Officer
Mr. Jhon Pademangean, Project Officer

Port Authority – Manado

Lembaga Hidup Sehat – Bitung

Yayasan Pelangi Kasih – Bitung

Zero Population Growth – Bitung

Lurah Mahawu

Lembaga Kemaslahatan Keluarga NU

Mr. Suwarno Tuiyo, Director
Mr. Wahyudin Biga, Project Manager
Mr. Pangkarego, Field Coordinator
Ms. Siti Novita Djenaan, Field Coordinator
Ms. Maria Bolang Finance
Mr. Arman Razak, Outreach Worker
Mr. Rudimin Manyo, Outreach Worker
Mr. Iriyanto Adas, Outreach Worker

IV. PAPUA**FHI/ASA**

Dr. Gunawan Inggokusumo, Chief Representative
Mr. Zainal Abidin
Mr. Syane Soroinsong, Finance
Mr. Wahid Nurul K., Secretary

GOVERNMENT INSTITUTION**Provincial AIDS Commission - Jayapura**

Mr. Andi Baso Bassaleng, Executive Secretary to the Governor
Dr. Tiogor Siahaan, Chief Provincial MOH Office
Mr. Mumu H., Prov. AIDS Commission Secretariat

District AIDS Commission – Sorong

Mr. Hengky Rumbiak, Deputy mayor
Dr. H.E. Sihombing, Chief Municipality Health Office
Mr. Y.F. Momot, Sorong Police Department
Mr. P.A. Ramandey, Chief Ministry of Labo, Sorong
Ms. M. Kambuy, Ministry of Tourism

Sele Be Soli General Hospital

Dr. Ferhat
Dr. Edwel S.
Ms. Maria SU, Case Manager
Ms. Maria C.S., VCT Manager
Ms. Apollos Umpain, Counselor

Port Authority Hospital – Jayapura

Ms. Adriana J. Kopou, VCT Manager
Ms. Dina P. Manggara, Counselor
Ms. Siti Soltief, Clinic Manager
Mr. Barbalina Dekeniap, Counselor
Mr. Deny Abidin, Paramedic

Dian Harapan General Hospital

Dr. John Paot, Director
Dr. Evi Torki, STI/VCT Clinic

NONGOVERNMENT ORGANIZATION (NGO):

PKBI Papua

Mr. John Mahail, PKBI Chairman
Ms. Ais Reawaru, Program Manager
Ms. Lilis Rumadaul
Mr. Olaf F. Krey, Field Coordinator
Ms. Lilis Dasih, Outreach Worker Workplace
Ms. Emmy, Outreach Worker, Motorcycle Driver /*Ojek*
Mr. Eduardus, Outreach Worker Coordinator, Student Hostel
Ms. Dian N. Wellip, Outreach Worker, Tribe Community
Ms. Oktovina Lelang Aya, Outreach Worker, Tanjung Elmo
Ms. Deisy F. Ranti, Outreach Worker School
Mr. Robby Tompunu, Outreach Worker, Youth Group

Yayasan Harapan Ibu /YHI Papua

Mr. David Wambrauw, Director
Ms. Darni Rupang, Program Manager
Ms. Elda Y. Lallo, Administration
Ms. Ripa Katandek, Finance
Ms. Lince Yambise, Field Coordinator
Ms. Agustina Maware, Field Coordinator
Ms. Henny Asyerem, Outreach Worker
Ms. Maria Hukubun, Outreach Worker
Ms. Dolfice Howay, Outreach Worker

Kelompok Kerja Wanita

Ms. Elisabeth Resubun, Chairperson
Father John

Diocese

Mr. Leo L. Ladjar, Diocese
Father Robyn FHW, Bethel Church
Mr. Dominngus Watopa, Advent Church
Father Ms. H. Lesilolo
Father Petrus Done
Mr. Eddy Pranata, Kalam Kudus Church

PMI Clinic – Sorong

Dr. Theo, Project Manager
Dr. Yosefin, Clinic Doctor
Mr. Hendra, Lab Technician
Ms. Heny H. Sitorus, Nurse

Yayasan Sosial Agustinis / YSA Clinic – Sorong

Dr. Zita C.B., Project Manager

Dr. Risuari, Clinic Doctor

Mr. Ibrahim Musa, Field Coordinator

Mr. Petrus Titu, Lab Technician

Ms. Susanti, Clinic Administrator

Ms. Agustina, Midwife

Ms. Suzana M., Nurse

Mr. Agustinus Kabesi, Outreach Worker Workplace

Ms. Nurhayati, Outreach Worker, Ba

Annex C: List of Documents Reviewed

1. ASA 14th Quarterly Report
2. ASA Implementation Status Report (April 2004)
3. ASA Implementation Plan (June 20, 2003)
4. ASA Implementation Plan (November 30, 2000)
5. Small Needles and Big Sex and Drugs in Indonesia
6. ASA Work Plan FY04
7. FHI ASA Internal Review (June 2003)
8. USAID/Indonesia Expanded Response Strategy 2002-2007
9. Two Year Review of the USAID/Indonesia HIV/AIDS Strategy 2002-2007
10. Indonesia Country Profile
11. National estimates of adult HIV infection, Indonesia 2002: Summary
12. National Estimates of Adult HIV Infection, Indonesia 2002: Spreadsheet
13. USAID Program Description In RFA for STI/HIV/AIDS Prevention Support
14. Documentation of Human Rights Violations Against PLWHA in Indonesia
15. TB + HIV situation in Indonesia
16. USAID Program Description for FHI/ASA Program Amendment Justification
December 27, 2002
17. ASA Fifteenth Quarterly Report: April – June 2004 (July 30, 2004)
18. ASA Year Five Workplan FY 05: October 1, 2004 – September 30, 2005 (16 August
2004)

Annex D: Program Sites

Papua	North Sumatra
Jayapura City Jayapura District Sorong City Sorong District Merauke District Mimika District * Asmat District *	Tebing Tinggi City Deli Serdang District Medan City
Jakarta	South Sumatra
Central Jakarta South Jakarta West Jakarta North Jakarta East Jakarta	Prabumulih City Lubuk Linggau District Palembang City
East Java	North Sulawesi
Surabaya City Sidoharjo District Malang District Malang City Banyuwangi District Batu City *	Manado City Bitung City Minahasa District *
Riau	Central Java
Pekanbaru City Batam City Karimun District Tanjung Pinang City Kepulauan Riau District	Semarang City Tegal District
West Java	Maluku
Bandung City Bandung District Cimahi City Bekasi District Karawang District	Ambon City Maluku Tenggara District (Kei Island)

* Districts added in FY04.

Annex E: BSS Sample Size for Each Population Group, 2004

	Location	City	Direct SW	Indirect SW	Truckers / transport workers	Seaman, port workers	Students	IDU	MSM	Trans-vestites	Total
1	N. Sumatera	Medan	250	200	400	0	0	300	0	0	1150
2	S. Sumatera	Palembang	250	200	400	0	0	0	0	0	850
3	Riau	Tg. Pinang	125	125	0	200	0	0	150	125	725
4	Riau	Batam	125	125	0	200	0	0	150	125	725
5	W. Java	Bandung	125	125	0	200	0	150	150	125	875
6	W. Java	Bekasi/Karawang	125	125	0	200	0	150	150	125	875
7	Jakarta		250	250	0	400	1000	300	300	250	2750
8	C. Java	Semerang	250	250	400	0	0	0	0	0	900
9	E. Java	Surabaya	250	250	0	400	1000	300	300	250	2750
10	N. Sulawesi	Manado	250	200	0	400	0	0	0	0	850
11	Maluku	Ambon	250	200	0	400	0	0	0	0	850
12	Jayapura		250	200	0	400	0	0	0	0	850
13	Merauke		250	150	0	400	0	0	0	0	800
14	Gorong		250	200	400	0	0	0	0	0	850
	Total		3000	2600	1600	3200	2000	1200	1200	1000	15800

Source: BPS/BSS

Annex F: Indicators

Table 22: ASA Performance Indicators

RP 1 Performance Outcome Indicators	Baseline Year	Baseline Value	2003 Target	2003 Results	2004 Target	2005 Target
Sub-Intermediate Result 3.1 Increased risk-reduction behavior and practices among individuals at high risk for HIV and STI						
3.1.1 % of FSWs reporting condom use during most recent sex act with client.						
DKI Jakarta: Indirect sex workers	2000	50.1%	60.0%	NA	70.0%	75.0%
Tanjung Pinang, Riau: Direct sex workers	2002	57.0%	65.0%	NA	70.0%	80.0%
Surabaya, East Java: Direct sex workers	2000	45.0%	56.0%	43.67%	65.0%	72.0%
3.1.2 % of FSWs reporting consistent condom use with clients during past week.						
DKI Jakarta: Indirect sex workers	2002	18.0%	30.0%	NA	45.0%	55.0%
Tanjung Pinang, Riau: Direct sex workers	2002	17.0 %	30.0%	NA	45.0%	55.0%
Surabaya, East Java: Direct sex workers	2000	16.0%	30.0%	14.69%	45.0%	55.0%
3.1.3 % of Target Male Groups reporting commercial sex in the last 12 months.						
DKI Jakarta: Seamen	2002	42.0%	35.0%	NA	30.0%	30.0%
North Sumatra: Truckers	2002	56.0%	45.0%	NA	35.0%	30.0%
Riau: Seamen	2002	75.0%	60.0%	-	50.0%	40.0%
Surabaya, East Java: Seamen	2000	42.0%	42.0%	30.81%	35.0%	30.0%
3.1.4 % of Target Male Groups reporting condom use during most recent sex act with commercial partner.						
DKI Jakarta: Seamen	2002	15.0%	25.0%	NA*	35.0%	45.0%
North Sumatra: Truckers	2002	7.0%	20.0%		30.0%	40.0%
Riau: Seamen	2002	40.0%	50.0%		60.0%	65.0%
Surabaya, East Java: Seamen	2000	25.0%	40.0%	32.2%	52.0%	65.0%
3.1.5 % of IDUs who report sharing injecting equipment at least once in the last week.						
DKI Jakarta	2002	92.0%	75.0%	NA*	60.0%	45.0%
3.1.6 % of IDUs reporting condom use during most recent sex act with any partner.						
DKI Jakarta	2002	25.0%	40.0%	NA*	52.0%	65.0%
3.1.7 % of MSM Target Group reporting no unprotected anal sex in the past one month.						
DKI Jakarta: Transvestites (waria)	2002	49.0%	55.0%	NA**	65.0%	70.0%
DKI Jakarta: Male sex workers	2002	38.0%	45.0%		55.0%	60.0%
DKI Jakarta: Gay	2002	47.0%	55.0%		65.0%	70.0%

RP 1 Performance Outcome	Baseline	Baseline	2003	2003	2004	2005
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Indicators	Year	Value	Target	Results	Target	Target
3.1.8 % of MSM (gays) Target Group reporting condom use during most recent anal sex act with any partner. DKI Jakarta:	2002	31.0%	40.0%	NA**	50.0%	60.0%
3.1.9 % of Transvestite (waria) sex workers using condom with last anal client. DKI Jakarta	2002	48.6%	60.0%	NA**	70.0%	80.0%
3.1.10 % of Male sex workers using condom with last anal client. DKI Jakarta	2002	36.0%	45.0%	NA**	55.0%	65.0%
3.1.11 Median age at first (penetrative) sex among young men and women aged 15-24 surveyed DKI Jakarta: Men Women Papua : Men Women	2003 2003 2003 2003	16 years 16 years 16 years 14 years	16 years 16 years 16 years 14 years	NA*	17 years 17 years 16 years 15 years	17 years 17 years 17 years 16 years
3.1.12 The number of FSWs reached by outreach educators in USAID-sponsored activities	2001	4,235	15,000	20,141	18,000	22,000
3.1.13 The number of USAID-supplied condoms distributed (to target groups)	2003	0	500,000	504,475	1,500,000	1,500,000
2.1.3 % of commercial sex establishments having condoms available on site for male clients at time of survey.	2002	75.0%	85.0%	81.0%	100%	100%

* The Baseline value reflects results of the 2002-3 BSS. The next BSS will not be organized until 2004.

** The Baseline value reflects of the 2002 MSM study. The next MSM study will be organized in 2004.

RP 2 Performance Outcome Indicators	Baseline Year	Baseline Value	2003 Target	2003 Results	2004 Target	2005 Target
Sub-Intermediate Result 2.1 Strengthened quality, accessibility, and utilization of prevention, care and treatment services for individuals at high risk for STI/HIV/AIDS						
2.1.1 % of FSWs and other clients diagnosed and treated for STIs in accordance with the GOI recommended STI treatment protocol in USAID-sponsored clinics.	2002	96.0%	100%	70% *	100%	100%
2.1.2 % of USAID-sponsored clinics reporting no stock outages of > 5 days of essential drugs.	2002	100%	100%	100%	100%	100%
2.1.4 Number of clients provided services at USAID-sponsored STI clinics	2002	2,713	10,000	5,386 *	11,000	12,000
Female clients	2002	216	8,000	3,592 *	8,500	9,000
Male clients	2002	2,929	18,000	8,878 *	19,500	21,000
Total clients						

RP 2 Performance Outcome	Baseline	Baseline	2003	2003	2004	2005
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Indicators	Year	Value	Target	Results	Target	Target
2.1.5 Number of STI clinics with USAID assistance	2002	10	22	22	22	22
2.1.6 Number of clients seen at USAID-sponsored VCT clinics						
Male clients					540	720
Female clients					360	480
Total clients	2003	677	677	677	900	1,200
2.1.7 Number of persons reached by USAID-assisted community and home-based care programs						
Males					150	175
Females					150	175
Total	2003	100	100	250	300	350
2.1.8 Number of USAID-assisted community and home-based care programs	2003	15	15	15	20	25
RP 3 Performance Indicator	Baseline Year	Baseline Value	2003 Target	2003 Results	2004 Target	2005 Target
Sub-Intermediate Result 2.2 Enhanced capacity and quality of GOI HIV/STI surveillance systems and their use in decision-making						
2.2.1 % of provinces in which USAID is active that have collected HIV surveillance and behavioral surveillance data from appropriate risk groups:						
FSWs	2002	100%	100%	100%	100%	100%
Male	2002	40%	100%	100%	100%	100%
IDU	2002	20%	30%	30%	30%	30%
MSM	2002	10%	30%	30%	40%	50%
2.2.2 % of provinces in which USAID is active that have held a "Second Generation Surveillance" workshop in the past year and input is used to review and analyze available HIV data and improve program planning	2002	10%	100%	90%	100%	100%
2.2.3 Monthly press reports on HIV related issues supporting program objectives in sentinel newspapers.	2000	13/month (156/year)	20/month (240/year)	44/month (528/year)	20/month (240/year)	20/month (240/year)
RP 4 Performance Indicators	Baseline Year	Baseline Value	2003 Target	2003 Results	2004 Target	2005 Target
Sub- Intermediate Result 2.3 Strengthened capacity of local organizations to plan, finance, manage and coordinate HIV/STI responses						
2.3.1 % of districts in which USAID is active where the district budget for KPAD increased over the previous year, relative to overall development spending.	2002	30%	30%	48%	60%	90%
RP 5 Performance Indicator	Baseline Year	Baseline Value	2003 Target	2003 Results	2004 Target	2005 Target

Sub-Intermediate Result 1.1 Increased leveraging of programmatic interventions and financial resources						
% of provinces in which USAID is active where the number of private sector organizations with workplace HIV prevention programs or substantial in-kind donations to prevention activities increased over the previous year.	2002	0%	30%	30%	60%	80%
1.1.2 % of provinces in which USAID is active where the total cost share from non-USAID sources increased over the previous year.	2002	80%	100%	100%	100%	100%

Annex G: Manado/Bitung BSS Findings, 2002–2004

A preliminary analysis of 2004 BSS data concludes that ASA's outreach program is making a difference.¹⁹ Outreach by ASA-supported NGOs has provided female sex workers and their male clients with information that has increased their knowledge of HIV, its transmission, and how condoms can prevent HIV transmission. This knowledge, coupled with increased availability of condoms provided by NGOs and the government has led to increased use of condoms by clients of FSWs in the target sites. Information and advice about other STIs, as well as referrals by NGOs to STI clinics, has resulted in increases in treatment at medical facilities and reductions in self-treatment.

Table 23: Selected Findings from the 2004 BSS in North Sulawesi

Findings on condom knowledge, availability and use	2002	2004	Change
FSW who know that condoms prevent HIV	53%	69%	+16
Clients who know that condoms prevent HIV	38%	52%	+14
Condoms more available to sex workers (indirect FSW)	14%	64%	+50
Condoms more available to sex workers (direct FSW)	20%	74%	+54
Condoms more available to clients (sailors/port workers)	10%	14%	+4
FSW who didn't use condom because none available	37%	6%	-31
Clients who didn't use condom because none available	34%	16%	-18
FSW asks all clients to use condom	23%	38%	+15
FSW never asks client to use condom	35%	10%	-25
Clients who have seen ad for condoms recently	81%	87%	+6
FSW who have participated in HIV prevention activities in last year	39%	67%	+28
Clients who have participated in HIV prevention activities in last year	6%	45%	+39
FSW who participated in prevention activities organized by NGOs	11%	48%	+37
Clients who participated in prevention activities organized by NGOs	3%	36%	+33
FSW who negotiate condom use with all clients and who were successful		87%	
FSW who used condom with last client			
Clients who used condom with last FSW			
Findings on STI health seeking behavior	2002	2004	Change
Among FSW and clients who reported STI symptoms:			
Clients who sought treatment at a medical service	40%	54%	+14
Clients who self-treated	51%	41%	-10
Clients referred by an NGO		80%	
FSW who sought treatment at a medical service	29%	64%	+35
FSW who self-treated	51%	32%	-19
FSW referred by an NGO		74%	

¹⁹ But does it work? Using BSS and programme data to understand ASA programmes. The example of North Sulawesi, ASA External Review, August 2004.