HIV PROGRAMME DOCUMENT PALANG MERAH INDONESIA (INDONESIAN RED CROSS) PERIOD 2008-2010

GA HIV

Launched on 5 June 2008

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List of abbreviation

AIDS	: Acquired Immune Deficiency Sindrom
ARC	: Australian Red Cross
ART	: Anti Retroviral Teraphy
ARCHN	: Asian Red Cross and Red Crescent HIV Network.
ARV	: Antiretroviral virus
FHI	: Famly Health International
FSW	: Female Sex Worker
GA	: Global Alliance
HIV	: Human Immunodeficiency Virus
IDUs	: Injecting Drug Users
IEC	: Information, education and communication
IFRC	: International Federation of The Red Cross and Red Crescent
JRC	: Japanese Red Cross
KAP	: Knowledge, Attitude and Practice
M & E	: Monitoring and Evaluation
NAC	: National AIDS Commision
NAD	: Nanggroe Aceh Darussalam Province
NGO	: Non Governmental Organisation
NHQ	: National Headquarters
NLRC	: Netherlands Red Cross
NS	: National Society
OVC	: orphans and vulnerable children
PATS	: Performance and Accountability Tracing System
PE	: peer education
PLHIV	: People Living with HIV
PMER	: Planning, Monitoring, Evaluatioan and Reporting
PMI	: Palang Merah Indonesia (Indonesian Red Cross)
PNS	: Partner National Societies
PSP	: Psychosocial Support Programme
RCY	: Red Cross Youth
UNAIDS	: The Joint United Nations Programme on HIV/AIDS
UNFPA	: United Nations Population Fund
VCT	: voluntary counselling and testing
WAD	: World AIDS Day
YPE	: Youth Peer Education
YPEP	: Youth Peer Education Programme

EXECUTIVE SUMMARY

This document describes the proposal for the 2008-2010 scaling-up of Palang Merah Indonesia (PMI); or in English, the Indonesian Red Cross' human immunodeficiency virus (HIV) programme in Indonesia as a component of the South-East Asia HIV programme of the Red Cross and Red Crescent Global Alliance on HIV.

Palang Merah Indonesia or PMI (Indonesian Red Cross Society) is a nationwide humanitarian organization in Indonesia with 33 chapters nationwide. At the end of 1994, PMI joined the Asian Red Cross and Red Crescent HIV Task Force (ART) together with other national society members. In ART, PMI started the youth peer education programme as the entry point for participation in the effort to prevent the spread of HIV amongst youth groups. Since 2000 PMI has expanded the programme to the branches that are deemed to have the capacity and capability to implement the programme. Gradually PMI is scaling up the HIV and AIDS intervention programmes as a follow-up of the Geneva Declaration (2001). From the 33 Indonesian provinces and chapters, PMI's national headquarter has identified the nine chapters as high priority provinces which have the potential capacity and capability to implement the scaling up effort. They are North Sumatera, East Kalimantan, Riau, Bali, the special capital territory of Daerah Khusus Ibukota Jakarta (DKI Jakarta, more commonly known as Jakarta), Central Java, Nanggroe Aceh Darussalam (NAD), North Sulawesi and West Papua.

PMI also adheres to the three-pillar programme outputs i.e. 1) prevention, 2) care and support for people living with HIV and AIDS and 3) reducing stigma and discrimination of HIV+ people both within the workplace and in the community. In order for the national society chapters and branches to be able to sustain the scaling-up and to achieve the outputs, a fourth output is necessary: That is to say, strengthening PMI's capacity to carry out the scaling-up effort.

The overall purpose of scaling up between 2008-2010 is to substantially increase the activities and outputs towards the doubling up of achievements for the three programme outputs that are appropriate in the selected provinces. Some provinces chose not to carry out Output 2, as they do not have the capacity as yet.

At the national level, the scaling up programme already has some support from the Netherlands Red Cross (NLRC), the Japanese Red Cross Society (JRCS) and the Australian Red Cross (ARC) for some of the selected provinces. In addition, some chapters and branches are receiving assistance directly from United Nations Population Fund (UNFPA), Family Health International (FHI), and the Provincial AIDS Commission (PAC). In addition to new activities, existing activities will be continued in the scaling-up programme. Also an important addition is Output 4 (improving the capacity and capability of PMI to deliver the programme); thus, improve quality of outputs and expanding the coverage of high risk groups to additional provinces (North Sulawesi and West Papua). In order to carry out the activities in its entirety as proposed, additional funding support is still required.

Total funding required for the period 2008 - 2010 is **CHF4,037,022.** The total funds already pledged stands at CHF554,000 (from the International Federation and RCS) with a current funding gap of **CHF3,483,022**.

THE MAGNITUDE

Situation sketch of HIV and AIDS prevalence and the national scope and response in Indonesia

National data	
National population	222,781,000
Human Development Index	110
% of people with less than USD2 per day	52.4 %
HIV and AIDS indicators	
Number of people (all ages) living with HIV	170,000 (100,000 - 290,000)
Adults (15-19 years) HIV prevalence rate	0.1 (0.1-0.2 %)
Adults (15 and over) living with HIV	170,000 (100,000 - 290,000)
Women (15 years and over) living with HIV	29,000 (15,000 - 52,000)
Deaths due to AIDS	5,500 (3,300 – 8,300)
Children (0-14 years) living with HIV	Data not available
Orphans (0-17years) due to AIDS	Data not available
% of pregnant women receiving treatment to reduce mother to child transmission	0.7%
% of HIV-infected women and men receiving antiretroviral theraphy	30%
% women and men separately (15-24 years) who correctly identify ways to prevent HIV	Data not available
% women and men separately (15-24 years) who used a condom the last time they had casual sex	Data not available

Source: 2006 Report on The Global AIDS Epidemic, UNAIDS

Data from the ministry of health showed that from 1998 to December 2007 there were 9,689 cumulative cases of AIDS reported. Estimated number of adults living with HIV have increased from 110,000 cases in 2002 to 193,000 cases in 2007 (the population of Indonesia is estimated at 222,781,000). It has been suggested that these estimates do not reflect the true impact and magnitude of the epidemic in Indonesia, and is supported by the UNAIDS statement in 2006, i.e. that more investment is needed for an improvement of the surveillance system that is required to get more accurate data[1]. UNAIDS estimated in 2006 that there is an HIV+ prevalence rate of 0.1 [0.1-0.2] among adults aged 14 to 49. The prevalence of HIV+ adult group from 20 – 29 years old is 52.8 per cent and among 30 – 39 years old is 25.6 per cent.

From the 2006 figures provided by the ministry of health, people living with HIV are categorized in the following groups:

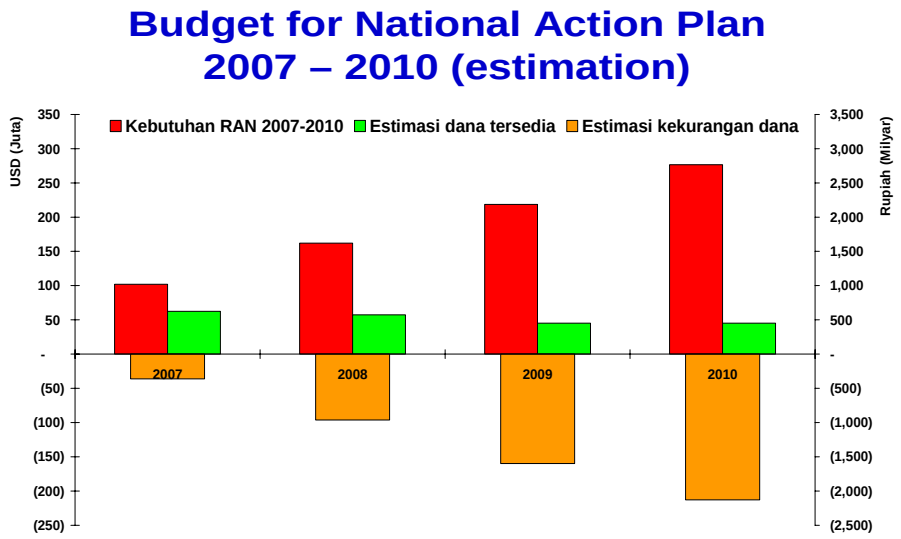
- 46% injecting drugs users (IDUs)
- 14% general population (Tanah Papua)
- 14% clients of female sex workers (FSW)
- 7% injecting drugs users' partners
- 5% female sex workers
- 5% men having sex with men (MSM)
- 3% partners of female sex workers' clients
- 3% prisoners
- 2% transgenders
- 1% clients of transgender

1

A significant proportion of young people (14 - 24 years) are reported to be engaged in high risk behaviors. The reported figures for youths in this age group are: 52 per cent of IDUs, 45 per cent of FSWs and 31 per cent of MSM.

According to figures of the National AIDS Commission, it is estimated that among the age group of 15-19 years the projected figures for new HIV infections for 2008, are around 8,000 among boys and 3,000 among girls.

Based on the National Action Plan 2007-2010 and the data from the National AIDS Commission, there are still the gap between the budget plan and the available fund, as follows:



------; budget plan 2007-2010
------: available fund (estimation)
------: expected fund (estimation)

The national AIDS commission prioritized the following three targets for 2007-2010:

- 80 per cent of people most at-risk are reached by comprehensive prevention programmes
- 60 per cent behaviour change of people most at risk
- 80 per cent of those who are eligible for antiretroviral combinations therapy receive it

Prioritized Provinces: National Action Plan 2007- 2010:

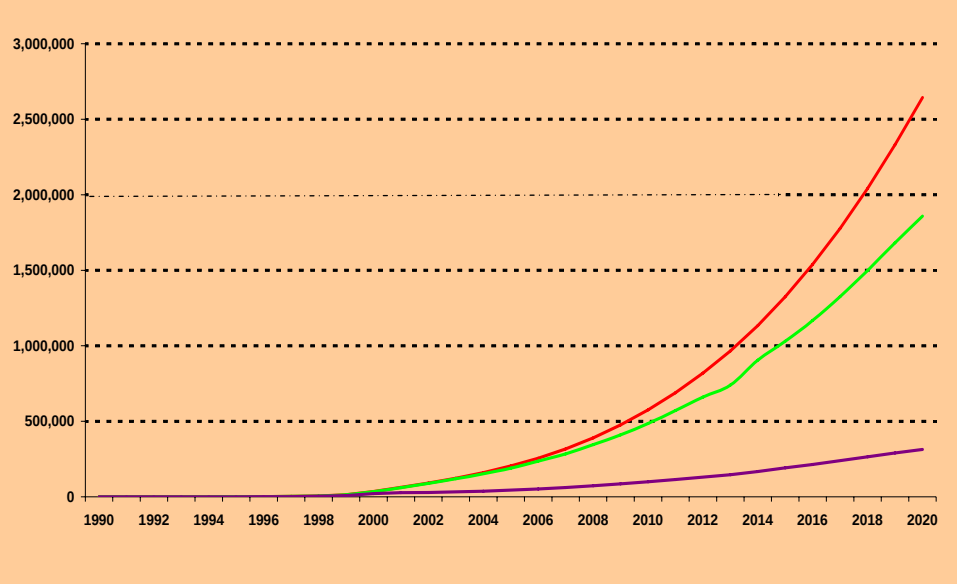
Source: National AIDS Commission
Note: Red is the highest priority, yellow is priority areas.

The estimated number of high risk population in prioritized provinces.

No	Propinsi	WPS	Penasun	Waria	LSL	WBP	ODHA	Kasus AIDS
1	Sumatera Utara	8,900	16,230	1,230	41,590	11,660	10,390	318
2	Riau	8,120	4,240	2,000	14,530	3,970	4,440	99
3	Sumatera Selatan	6,580	8,190	1,320	20,050	4,360	5,930	111
4	Lampung	4,140	4,870	630	21,030	1,400	3,380	102
5	Kepulauan Riau	10,920	5,160	370	5,860	320	3,990	208
6	DKI Jakarta	38,910	33,750	1,340	45,630	9,240	27,670	2,621
7	Jawa Barat	25,330	24,710	3,640	170,210	19,250	19,490	1,105
8	Jawa Tengah	13,620	7,910	1,560	98,700	5,760	7,970	330
9	DI Yogyakarta	2,690	5,590	520	11,600	950	3,320	92
10	Jawa Timur	26,070	27,330	3,710	132,010	11,560	20,810	930
11	Banten	3,330	9,650	250	37,930	4,440	6,590	42
12	Bali	8,540	3,420	370	11,730	1,240	5,570	488
13	Kalimantan Barat	3,710	4,300	1,070	14,900	1,110	3,020	553
14	Kalimantan Timur	11,450	9,500	2,580	12,600	1,180	6,130	62
15	Sulawesi Selatan	5,230	12,110	1,050	22,060	1,790	7,610	143
16	Sulawesi Utara	3,770	1,980	460	7,960	1,370	1,640	101
17	Maluku	3,400	820	400	3,690	340	1,190	136
18	Irian Jaya Barat	2,670	240	320	1,260	130	7,160	58
19	Papua	5,020	430	270	4,730	140	22,210	1,122
	Indonesia	221,000	219,000	28,000	766,000	96,000	193,000	8,988
	% 19 Propinsi : Indonesia	87%	82%	82%	89%	84%	87%	96%

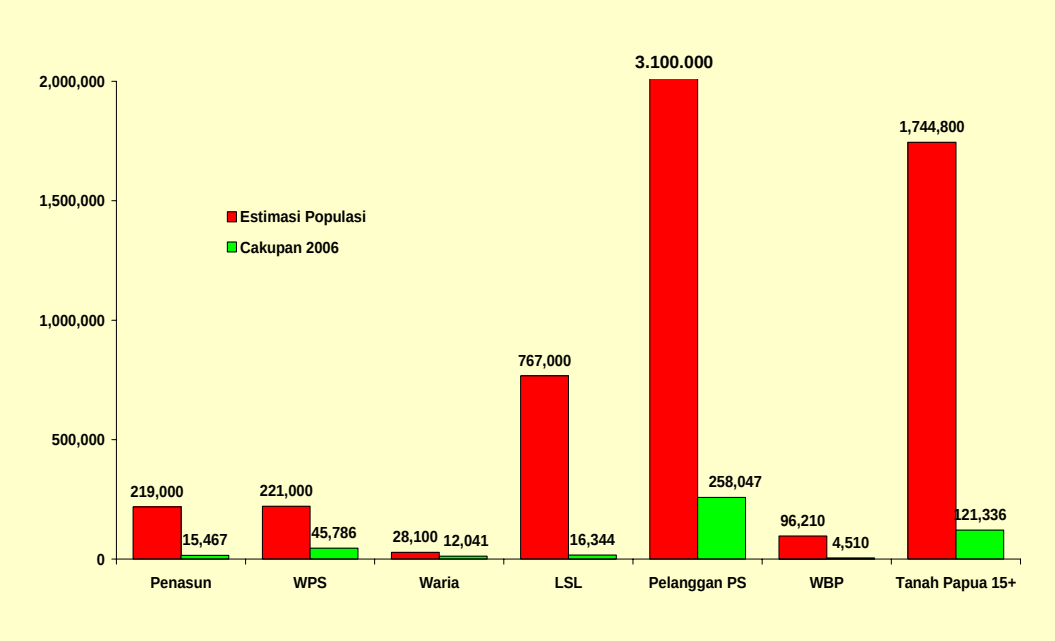
Source: National AIDS Commission

HIV Epidemic 1990 – 2020 in Indonesia



Red: Projection of HIV and AIDS cumulative cases
Green: Projection of People Living with HIV (PLHIV) who are still alive
Purple: Projection of new infection

Source: National AIDS Commission



Estimation of population and coverage of the programme in 2006

Source: National AIDS Commission

THE IMPACT

Although, there are reportedly only 9,689 cumulative cases of AIDS as of December 2007 (total cases 17,207), it was estimated that in reality there are about 193,000 people nationwide are infected with HIV. At present, Indonesia is still in the category as having a concentrated level

epidemic with certain areas such as Papua province demonstrating an epidemic in the general population, (having more than 5 per cent of female sex workers who are HIV+). Starting from the year of 2000, the cases among IDUs have been increasing very fast.

It is estimated that the HIV epidemic in Indonesia will be concentrated in a few sectors of the population[2], with the highest concentration within the population of Papua. Without an increased effort in the prevention of further infection the rate of prevalence within the general population will have reached 1 per cent by 2025. Meanwhile the rate for Papua is estimated to be 3.6%, with the greatest impact in the 15-49 age cohorts.

Currently, the highest prevalence is among IDUs. Infection by sexual transmission will become a generalized epidemic if there is no increased response. With an increased and effective response, the prevalence of HIV within the 15-49 age group is projected to rise only slightly and then gradually begin to decline. In Indonesia, at-risk groups identified are female sex workers, clients of female sex workers, and men who have sex with men.

Without increased response it is estimated that by 2025 260,000 women's deaths will be attributed to AIDS related illnesses and this will result in 110,000 maternal orphans, 33,000 of which are in Papua.

The economic impact of AIDS in Indonesia will be mostly felt in Papua and in the urban workforce. Without an increased response it is estimated that there will a decrease of 1 per cent of the workforce (as apposed to a decrease of 0.3 per cent with increased response).

The impact on the households will be significantly felt due to the loss of income and the cost of care and medication for AIDS related illnesses. The Indonesian Health budget ranges between 3 – 8.6 per cent of the total national budget, 10 per cent of which is expended on HIV and AIDS. With the increase in HIV and AIDS prevalence it will cause an increase in the strain on the health service system including the health service providers (doctors, nurses, counsellors).

POLICY ON HIV

The PMI HIV programme is part of the South East Asia Regional HIV programme which is a component of the Red Cross and Red Crescent Global Alliance on HIV.

The **purpose of our programme** is to reduce vulnerability to HIV and its impact in Indonesia through achieving the following **outputs**:

- Preventing further HIV infection
- Expanding HIV care, treatment, and support
- Reducing HIV stigma and discrimination

bolstered by a fourth output:

- Strengthening the national society's capacity to deliver and sustain a scaled-up HIV programme.

The PMI are working in accordance with the established principles of the Red Cross and Red Crescent Movement to support Indonesia's national HIV policies and programmes. The specific scope of the activities in this HIV programme have been developed in coordination with the National AIDS Commission and were harmonized with tasks agreed under international

[2] Source: www.ausiad.gov.au/publications/pdf/impacts_hiv.pdf

assistance arrangements in Indonesia, including UNAIDS and other UN agencies, non-governmental organizations, civil society groups, and donors.

TRACK RECORD AND LESSONS LEARNED

Output 1: Preventing further HIV infection.

Since the PMI joined the Asian Red Cross and Red Crescent HIV Network in 1994 it has continued the commitment to develop and implement the youth peer education programme (YPEP) on reproductive health, sexually transmitted diseases (STDs), and HIV and AIDS. The first collaborative effort to develop common regional standards was initiated in 1995. The core content of the YPEP manual was developed by the Asian Red Cross and Red Crescent HIV Network members, while the details were developed by the respective national society fitting to the socio-cultural context of each member country. This is the approach used for the prevention output.

In the year 2000, the PMI conducted an evaluation of the YPEP with support from the Australian Red Cross. At the time of the evaluation, 33 branches were found to have developed YPEP activities. The evaluation concluded that:

1. in general, the programme was well accepted by the branches;
2. various local adaptations to the manual were necessary;
3. more focus was needed on the personal development of youth and life skill building;
4. the programme could include more drug-use related issues;
5. the programme should be expanded to more higher risk target groups.

Based on these recommendations, PMI organized life skills training and the youth peer education manuals were revised, and now it includes a specific life skills manual. From 2000 onwards, the peer education programme was expanded to other provinces, and it was also expanded to the high risk groups such as sex workers, truck drivers and street children.

Many branches have been developing youth peer education programmes as part of their Red Cross Youth (RCY) or volunteer corps member programmes. It is used as an awareness raising programme amongst the youth groups. After 2004, more branches started to target high risk groups, including out-of-school youth, and started to shift from raising awareness to behaviour change interventions.

The youth peer education programme as an awareness raising strategy has been successful and was demonstrated in the youth contest on knowledge of HIV and AIDS. However, the changes in actual behaviours or attitudes were not measurable.

Voluntary counselling and testing (VCT) referral programmes are being carried out only in a few of the nine selected provinces; they are North Sumatera, Central Java, DKI Jakarta and Riau. Only a few have VCT services on the premises, while the others refer people to the VCT centres at the local hospitals or other institutions.

There is a concern mentioned by some of the chapters from both the blood transfer unit (BTU) and the social and community health unit (SCHU) in PMI with regard to the interpretation of the “informed consent, anonymity and unlinked reporting” policy imposed by the department of health. This has caused some controversy and conflicting opinions.

The PMI chapters of Bali, Central Java and Riau advised that there is a strong need for an inter-unit, national-level workshop to address “blood safety”, the connection with VCT and the right of the donors to know their HIV status and the effort of preventing further HIV infection (Output 1).

HIV programmes in North Sulawesi, East Kalimantan are currently being funded by the Netherlands Red Cross and the HIV programmes in North Sumatera, by the Japanese Red Cross Society. Both the Netherlands and Japanese Red Cross plan to carry out situational analysis in their programme areas to identify the appropriate outputs and activities needed for scaling-up the programme in their areas.

OUTPUT 2: Expanding HIV care, treatment and support.

In 1997 the Asian Red Cross and Red Crescent HIV Network committed to extend the activities to include developing community-based counselling, home-based care and programme evaluation. From 2000 onwards, the PMI started to shift towards other areas of the HIV and AIDS programme such as care and support for PLHIVs, albeit this is still in a limited scope as many chapters and branches currently do not have the capacity to carry out these programmes.

Activities related to care and support that have been conducted include: buddy training; a workshop in Bali on antiretroviral treatment; a hotline counselling service in East Jakarta; the development of a training module for home-based care of PLHIV; and the training of volunteers in home-based care. Several workshops were organized by PMI in 2002 and 2005 with HIV+ groups to discuss the possibilities of their participation and involvement in the PMI HIV and AIDS programme. Starting from 2003 there have been plans to integrate and extend the care and support activities to the projects in Sumatra, Java and Kalimantan as well as to other areas of Indonesia. However, the achievements of this approach were difficult to measure as to date indicators had not been clearly defined.

OUTPUT 3: Reducing HIV stigma and discrimination.

From 2000 onwards, the PMI also started to promote a campaign to eliminate “stigma and discrimination” of PLHIV as volunteers and staff of PMI. Based on the campaign initiated by the International Federation, PMI launched a country-wide campaign in 2002, by releasing 1 million balloons with text “The truth about AIDS, pass it on” in the air. Since that time other activities in this area included various anti-stigma and discrimination campaigns as well as participation in various events like message contests, candle light memorial and World AIDS Day.

The objective to have an HIV workplace policy in place is a clear indicator of the effort to reduce stigma in the workplace. At this stage, the draft of the policy has been submitted to the PMI board for approval. Once an HIV workplace policy is in place, together with appropriate stigma reduction training programmes conducted among PMI board members, staff and volunteers, it is hoped that with the improved knowledge of HIV and AIDS there will be a significant change in the attitudes and practices with regard to stigma and discrimination reduction. Thus, it is hoped that more chapters and branches would be more open to accept PLHIV to work as members of the peer support groups in their workplace and in the outreach programmes.

A very basic knowledge, attitudes and practice (KAP) survey on stigma and discrimination, and the need for a workplace policy on anti- stigma and discrimination have been carried out among PMI board members, staff and volunteers. Representatives of some of the selected chapters and branches stated that there is a need for a more in-depth and systematic survey of a simple random sample of the PMI board, staff and volunteers to be carried out at the start (baseline KAP) of the scaling-up programme and at the end of the programme (post-intervention KAP) specifically for Output 3: reducing stigma and reduction of discrimination. The KAP survey should also cover gender inequality issues as part of the effort to reduce discrimination.

OUTPUT 4: Strengthening the National Society

According to PMI policy guidelines and strategic plan 2004 – 2009, only about 50 per cent of the 33 chapters, and 30 per cent of branches are considered as having some success in implementing HIV and AIDS programmes in line with national policies, i.e. following the three-pillar approach.

At the moment, there are 16 chapters undertaking HIV intervention activities, but many of them would benefit from redefining their programmes and ensuring that they are being implemented based on PMI standards and policies.

Although, some of the chapters and branches were regarded as having being been successful, there is still a shortage of skilled and experienced staff members to implement the HIV and AIDS programme in an optimal way, both at headquarter as well as chapter and branch levels. The salary scales of staff members may be a factor in the lack of success in attracting and maintaining staff and sustaining quality programme performance. Due to the nature of the concept of volunteerism, PMI is having difficulties enforcing any performance standards and maintaining volunteers at all levels from volunteer outreach-workers to volunteer expert staff. Therefore, there is a constant need for recruiting new volunteers and conducting periodic basic training.

Even though there have been some specific training programmes to increase the capacity of chapters and branches, they are still not sufficient to make the chapters and branches self-sustainable to enable them to carry out their HIV and AIDS intervention programmes. For each of the participating branches, there is a need for staff and volunteer training on programme management, monitoring and tracking of indicators, and reporting following the set standards.

* Output 1: Preventing further HIV infection.			
Approach	**Key Activities**	**Geographic Target Areas (Province)**	**Target group(s)**
1.1. Peer education and community mobilization of youth and vulnerable communities to reduce their vulnerability to HIV	1.1.1. Conduct training of trainers for 200 persons and 1000 facilitators to train total of 17.900 educators to run peer education (PE) programmes	1. North Sumatera 2. East Kalimantan 3. NAD 4. DKI Jakarta 5. Central Java 6. Bali 7. Riau 8. North Sulawesi 9. West Papua	- PE Trainers - PE Facilitators
	1.1.2. Conduct a PE approach with peers and youth in school (40,000)and out of school youth (3,000)	- all 9 provinces	- students: schools and universities - youths outside of school
	1.1.3. Conduct PE training for taxi drivers and other at-risk groups (6,000) (prisoners, sex workers (SW), street children)	1. North Sumatera 2. East Kalimantan 3. DKI Jakarta 4. Riau 5. Central Java 6. Bali	- Taxi drivers - SWs - Prisoners - Street children - Transgender
	1.1.4 Integrate into Red Cross Youth (RCY) and volunteer corps programmes as part of the training curricula to be RCY or volunteer corps members	All 9 provinces	- RCY members - volunteer corps members
	1.1.5 Socialization or sensitization workshop on HIV and PE approach for 90 coordinators of target group; and management team at chapter; and branch level particularly in new chapters/branches (NAD, North Sulawesi, West Papua)	All 9 provinces	- management team - coordinators of key population at higher risk.

* Output 1: Preventing further HIV infection.			
Approach	**Key Activities**	**Geographic Target Areas (Province)**	**Target group(s)**
	1.1.6. Conduct Situational Analysis to identify appropriate activities needed.	1. North Sumatera 2. North Sulawesi 3. East Kalimantan	- at-risk groups
1.2. Information, Education, and Communication (IEC) materials for targeted vulnerable groups	1.2.1. Develop appropriate IEC materials for specific target groups	1. PMI national headquarter national level (generic messages) 2. All 9 provinces contribute suggestions for local adaptation	- RCY members - Volunteer corps members - Taxi drivers and other key population categories at higher risk
	1.2.2. Printing of IEC materials	National headquarter	-at-risk groups
	1.2.3. Disseminate 124,000 units of IEC materials to the targeted vulnerable groups	All 9 provinces	At-risk groups
	1.2.4. PMI staff Peer Information Education Communication training to 50 PMI staff on how share HIV information with other staff	**All 9 provinces**	- Staff and volunteers
	1.2.5. Hotline counselling service as a daily service from 5 to 9 pm, the service is related with HIV and AIDS, reproductive health, drug abuse	1. DKI Jakarta	- Youth in general in Jakarta

* Output 1: Preventing further HIV infection.			
Approach	**Key Activities**	**Geographic Target Areas (Province)**	**Target group(s)**
1.3. Voluntary Counselling and Testing (VCT)	1.3.1. Integrating VCT referrals into PE activities in the prison, by encouraging 600 peer referrals to the VCT service	1. North Sumatera 2. Central Java 3. East Kalimantan	- Prisoners
	1.3.2. Awareness raising to 20,000 blood donors and key population at higher risk on VCT and how to access VCT services by providing brochures, briefing/counselling prior to donating blood as part of the HIV prevention effort.	1. DKI Jakarta 2. Riau 3. Central Java 4. Bali 5. North Sumatera 6. North Sulawesi 7. East Kalimantan	- Blood donors - at-risk groups
1.4. Preventing Mother to Child Transmission (PMTCT)	NA		
1.5. Skills for personal protection, including condom use	1.5.1. 45,000 condoms distributed as part of the training in the PE programme	1. All 9 chapters from the17 Chapters running PE programmes	Clients of SW - Target groups of PE programmes
	1.5.2 Explore harm reduction activities for injecting drug users (IDUs) through collaboration with NGOs who are working with IDUs.	DKI Jakarta	- PMI staff/volunteers - IDUs
	1.5.3.In collaboration with other NGOs provide training for 50 (10 x 5) PMI branches and their staff/volunteers to sensitize them to working with IDU	DKI Jakarta	- PMI staff/volunteers - IDUs
	1.5.4 Conduct situational analysis on IDU and harm reduction to explore developing life skills programme with IDUs	DKI Jakarta	PMI staff/volunteers - IDUs

* **OUTPUT 2: Expanding HIV care, treatment and support.**			
Approach	Key Activities	Geographic Target Areas	Target group(s)
2.1 Assisting children and orphans (OVC) made vulnerable by HIV	NA		
2.2 Providing treatment, support and care (home or community based and through health institutions) for people living with HIV	2.2.1. Facilitate access to health services including opportunistic infections (OI) and antiretroviral services for adults and children by referring 225 PLHIV to existing referral hospitals; during home visits (PMI acts as an information centre for the referral system)	1. North Sumatera 2. Central Java 3. Riau 4. DKI Jakarta 5. Bali	PLHIVs and families
	2.2.2. Training of 24 Trainers for community/family home-based care.	1. North Sumatera 2. Central Java 3. Riau 4. DKI Jakarta 5. Bali	PLHIV's and families
	2.2.3. Training 120 community/ family members on home-based care	1. North Sumatera 2. Central Java 3. Riau 4. DKI Jakarta 5. Bali	PLHIVs and families
	2.2.4. Training of 24 case managers on how to apply the integrated referral system to provide a more holistic support for PLHIVs. This approach integrates the various referrals systems (testing, care, psychosocial support systems)	1. North Sumatera 2. Riau 3. Central Java 4. NAD	PLHIV case managers PMI staff and volunteers
	2.2.5 Train 24 volunteers on Psychosocial Support Programmes (PSP)	1. North Sumatera 2. Riau 3. Central Java 4. NAD	
	2.2.6. Provide PSP for 120 PLHIV	1. North Sumatera	PLHIVs and families

* **OUTPUT 2: Expanding HIV care, treatment and support.**			
Approach	Key Activities	Geographic Target Areas	Target group(s)
		2. Riau 3. Central Java 4. NAD	
2.3 Network with PLHIV support groups	2.3.1.Supporting 42 PLHIV Peer support groups and networks by facilitating meetings for support groups and networks for 300 PLHIV	1. Bali 2. Riau 3. North Sumatera 4. Central Java 5. North Sulawesi 6. DKI Jakarta 7. West Papua 8. West Kalimantan	- PLHIV Peer support groups - families of PLHIVs
	2.3.2 Providing 42 training sessions to empower the PLHIV peer support groups	1. West Kalimantan 2. Bali 3. Riau 4. North Sumatera 5. Central Java 6. North Sulawesi 7. DKI Jakarta	- PLHIV Peer support groups - families of PLHIVs
	2.3.3 Develop 6 drop-in centres to be a venue for peer support groups to meet each other and have activities	1. Bali 2. Riau 3. North Sumatera 4. Central Java 5. DKI Jakarta	- PLHIV Peer support groups - families of PLHIVs
	2.3.4. Provide training to 210 volunteers to be able to support/assist (become buddies of) PLHIV in their daily life	1. Bali 2. Riau 3. North Sumatera 4. Central Java 5. East Kalimantan 6. DKI Jakarta	- PLHIV Peer support groups - families of PLHIVs

* **OUTPUT 2: Expanding HIV care, treatment and support.**			
Approach	Key Activities	Geographic Target Areas	Target group(s)
	2.3.5. Provide buddies to accompany and provide support to 840 PLHIV in their daily life	1. Bali 2. Riau 3. North Sumatera 4. Central Java 5. East Kalimantan 6. DKI Jakarta	- PLHIV Peer support groups - families of PLHIVs
2.4 Providing livelihood and food support for the most vulnerable	NA		

* **OUTPUT 3: Reducing HIV stigma and discrimination**			
Approach	Key Activities	Geographic Target Areas	Target group(s)
3.1 Developing community support groups and networks of PLHIV, and partnerships with PLHIV organizations	3.1.1. Develop partnerships with 42 PLHIV groups/organizations (signing MoU)	1. PMI NHQ 2. North Sumatera 3. Riau 4. East Kalimantan 5. DKI Jakarta 6. Central Java 7. Bali	Peer support groups
	3.1.2. Facilitate the establishment of 21 peer support groups and improving the capacities of existing support groups.	1. North Sumatera 2. Riau 3. East Kalimantan 4. DKI Jakarta 5. Central Java 6. Bali 7. PMI NHQ	Peer support groups

* OUTPUT 3: Reducing HIV stigma and discrimination			
Approach	Key Activities	Geographic Target Areas	Target group(s)
3.2 Ensuring that an HIV in workplace policy and programmes for all staff and volunteers are in place for PMI	3.2.1 PMI HIV workplace policy approved by the board	PMI NHQ	PMI Board
	3.2.2. Conduct a baseline, mid-term and end of programme KAP surveys among PMI Board members, staff and volunteers on stigma HIV+ and discrimination, to track knowledge, attitude and behavioural changes	PMI NHQ, and all 9 chapters and branches	Simple random sample of : Board members Staff Volunteers
	3.2.3. Socialize HIV workplace policy for PMI Board members, staff and volunteers (200 in total) by conducting a workshop or outbound activities	PMI NHQ, and all 9 chapters and branches	Board members Staff Volunteers
	3.2.4. Conduct stigma reduction workshop/training and socialize HIV to internal PMI through meetings and workshops (200 in total)	PMI NHQ, and all 9 chapters and branches	Board members Staff Volunteers
3.3 Tackling gender inequalities and sexual and gender based violence	3.3.1. Advocate for the development of PMI gender policy for gender to be integrated into all PMI programmes	- PMI NHQ	PMI Board
	3.3.2. Conduct gender sensitivity workshop/training at least one training per chapter per year to reach 40 people per chapter (total 1,080 people)	- PMI NHQ and all chapters and branches	PMI staff and volunteers
3.4 Peer education, community mobilization, and population-based information, education and communication	3.4.1. Raising public awareness using special days such as Red Cross Day, World AIDS Day by arranging a gathering with some activities/contest that relates to HIV advocacy, particularly to fight against stigma and discrimination towards PLHIV reaching 50,000 people	- PMI NHQ and all chapters and branches	- general population (target: 50,000)

OUTPUT 4 : Strengthening the National Society's capacity to deliver and sustain a scaled-up HIV Programme			
Approach	Key Activities	Geographic Target Areas	Target group(s)
4.1 Improving governance, accountability, and leadership of the national society for discharging planned commitments	4.1.1.Conduct a national-level workshop to address "Blood Safety", the connection with referrals to VCT and the right of the donor to know his/her HIV status, with 50 participants	- All 9 chapters, with the participation of the rest (24 chapters) to be funded by other funding sources.	- NHQ Board members - Social and community health services - Blood transfusion unit - Head of divisions
	4.1.2.conduct HIV/AIDS annual meeting at the fourth quarter, with the objective to share information, experiences, progress, new methods, develop action plan for 150 staff per year	Chapters and implementing branches	PMI Board members, staff, PLHIV/Peer support group
	4.1.3 Recruit 20 new staff	- 3 staff at NHQ - 2 staff at each chapter and branch levels	- PMI NHQ - Chapters and branches
	4.1.4. recruit volunteers	- all 9 provinces	- general public
4.2 Improving volunteer; staff support; and management	4.2.1. Basic training for 900 new volunteers – followed by quarterly meeting for PMI volunteers in their respective branches	- 9 provinces /chapters and implementing branches in each province	
	4.2.2. develop and maintain a volunteer database (note: PMI has a policy of encouraging people to volunteer rather becoming paid staff)	- 9 provinces /chapters and implementing branches in each province	
	4.2.3. External training opportunities for 75 HIV and AIDS programme staff including computer skills, languages and project management	- staff in PMI NHQ, PMI chapter and branches that implement HIV and AIDS programmes	- PMI staff in PMI NHQ, chapter and branches that implement HIV and AIDS programmes
	4.2.4. To develop the PMI office at chapter and branch levels to become information centres for HIV and AIDS and become an operational referral system	1. DKI Jakarta 2. Riau	- PMI Volunteers

OUTPUT 4 : Strengthening the National Society's capacity to deliver and sustain a scaled-up HIV Programme			
Approach	Key Activities	Geographic Target Areas	Target group(s)
4.3. Strengthening programme cycle management	4.3.1. Develop a monitoring and evaluation (M and E) framework	- developed at NHQ standardized for all 9 provinces	- HIV programme managers at chapter and branch levels
	4.3.2. Training of 90 PMI staff on Planning, Monitoring and Evaluation, and Reporting (PMER), Project Design and Proposal Writing.	- all 9 provinces	- HIV programme managers at chapter and branch levels
4.4. Widening partnerships and expanding resource management	4.4.1. Establishing 25 partnerships with other organizations working in HIV programmes	- at NHQ and all 9 provincial levels	- UN Agencies, NGOs, community based organization (CBOs)
	4.4.2. Initiate and establishing partnership with ten new donors	- NHQ	- Local and international donor agencies - Local and international and private sector donors
	4.4.3. Securing three new sources of funding	- NHQ	- Local and international donor agencies - Local and international private sector donors

Coverage with partner national societies' support
2007 -2010 Japanese Red Cross to North Sumatra Chapter (5 branches)
2007 -2010 Netherlands Red Cross to East Kalimantan Chapter (4 branches)
2008- 2010 Netherlands Red Cross to North Sulawesi
2008 Australian Red Cross to NAD chapter

IMPLEMENTATION AND MANAGEMENT ARRANGEMENTS

The HIV programme will be implemented by the nine chapters of PMI with support of its national headquarter and the International Federation (through the regional HIV delegate in Bangkok), as a coordination body who will assist with the provision of tools, regional technical advisory support and programme integration. The PMI HIV programme will be implemented with support from bilateral partnerships with the Japanese Red Cross Society, Australian Red Cross, and the Netherlands Red Cross. Coordination meetings are to be held once every quarter. The role of the PNSs is to provide financial, technical and programme management advice and support.

The HIV sub-division in the national headquarter is under the health and social services division. The head of the health division is responsible for the implementation of the HIV programme. The HIV sub-division consists of only one staff member; previously there were three staff members in this sub-division with the international support for two full-time persons. However, starting from this year, there is no more financial support for staff in this sub-division. There is a need to add at least three more staff members (including one for monitoring and evaluation).

At three of the chapters supported by the PNSs there are HIV programme managers in place. At the branch level, there are project officers who are responsible for the HIV programme; these are paid by the PNSs and at the other chapters which do not have support from PNSs, there is a need for additional staff: programme managers and programme officers.

MONITORING AND REPORTING ARRANGEMENTS

This programme subscribes to the principles of the “seven ones” of the Global Alliance on HIV, including the “one performance monitoring system”. Programme reviews (including financial reporting), will be conducted on a regular basis (monthly, quarterly, and bi-annual progress updates and reviews, annual reports and reviews, a three-year completion report). A programme completion report will be produced at the end of the programme period. An external evaluation will be conducted in the final six months of the programme period. A monitoring and evaluation system still needs to be set in place to comply with the Global Alliance system to monitor the indicators. These will be the responsibility of all levels: NHQ, chapters, branches.

From January 2008, the International Federation launched the performance and accountability tracing system (PATS), which will provide an International Federation-wide approach to planning, performance management and accountability. During the next three years, PMI will strive to adopt the PATS system.

RISKS, ASSUMPTIONS AND UNDERTAKINGS

There is a discrepancy between the agreed PMI policy and professional advice regarding the need for more focus in a lesser number of selected areas to ensure more efficient programme implementation and greater impact.

There is also an issue with regard to staff salaries. Until the end of 2007, there were two full-time staff, supported by PNSs. But as of the beginning of 2008, while PMI has committed to join Global Alliance, there is only one person supported by PMI. By April 2008, the total number of staff lost is seven at the NHQ level: two of whom are from the HIV programme team.

There is high commitment from eight chapters to follow the PMI policy to be involved in HIV and AIDS intervention programmes, but they need financial and technical support to achieve set standards. Although 15 chapters have been carrying out HIV and AIDS intervention programmes, some implementing branches have been running the programmes not to the policy standards because of the limitation of their capacities. It should be noted that the chapters and branches have stated that they are highly committed to the programmes for the long term.

SUMMARY OF RESULTS-BASED BUDGETARY FRAMEWORK

(Currency: CFH)

OUTPUTS	Year 1 2008	Year 2 2009	Year 3 2010	TOTAL (in CHF)
1. Preventing further HIV infection	301,429	334,586	368,044	1,004,059
2. Expanding HIV care, treatment, and support	236,571	262,594	288,854	788,019
3. Reducing HIV stigma and discrimination	228,171	253,270	278,597	760,039
4. Strengthening the National Society's capacity to deliver and sustain a scaled-up HIV Programme	388,071	430,759	473,835	1,292,666
SUB-TOTAL of ALL OUTPUTS	**1,154,243**	**1,281,210**	**1,409,331**	**3,844,783**
Programme Support Recovery (PSR)	57,712	64,060	70,467	192,239
GRAND TOTAL	**1,211,955**	**1,345,270**	**1,479,797**	**4,037,022**

LOGFRAME FOR HIV PROGRAMME

Date of first formulation: 3 January 2008. Revision Date: 20 June 20 2008

Narrative Summary	Tracking Indicators	Means of Verification	Important Assumptions
Goal: To contribute to Global Agenda Goal 2: To reduce the number of deaths, illnesses and impact from diseases and public health emergencies	**IMPACT:** • Prevalence of HIV; • Survival rates of antiretroviral therapy (ART) recipients.	• UNAIDS reports • Monitoring and evaluation system of National AIDS Commission	**(Goal to super goal):** • National stability • Leadership is supportive of HIV and AIDS programme
Programme Purpose: To scale-up the International Federation's efforts in support of national HIV and AIDS programmes to reduce vulnerability to HIV and its impact in Indonesia	• People benefiting from PMI HIV services in targeted communities (124,000) • Proportion of national programming conducted by PMI (0.17%)	• Monthly; quarterly; bi-annual and annual programme reviews • Programme completion report • End of programme evaluation	**(Purpose to Goal):** • Resources and support mechanisms are available for planned scale up
Programme Outputs: 1. Further HIV infections are prevented	1.1 People reached by peer education programme (67,190)	1.1.1 Peer educators activity reports 1.1.2 Bi-annual and annual programme reviews 1.1.3 Programme completion report 1.1.4 End of programme evaluation	**(Output to Purpose):** • Community support and willingness to work with PMI • Community access to condoms, VCT services
	1.2 People reached through IEC programmes (124,000 persons)	1.2.1. IEC activity reports	

Narrative Summary	Tracking Indicators	Means of Verification	Important Assumptions
	1.3 People who were referred by PMI to VCT services (600)	1.3.1. PMI referral records and VCT records (no names, numbers only)	
2. HIV care, treatment, and support is expanded	2.1. Home base care or treatment clients receiving PMI services (1,080).	2.1 . PMI treatment records (no names, numbers only) Volunteer and activity reports	
	. 2.2 PLHIV reached by PMI peer support groups (300)	2.2.1. PMI peer support group activity reports 2.2.2. Six-monthly and bi-annual programme reviews 2.2.3. Programme completion report 2.2.4. End of programme evaluation	• PLHIV and medical service providers show interest • HIV treatment services are available in PLHIV communities
3. HIV stigma and discrimination is reduced	3.1. Discrimination incident reports (by age and sex) reported by HIV+ PMI staff and volunteers with appropriate follow-up action (5)	3.1. PMI Incident and follow-up reports	• Affected staff are wiling to report discrimination incidents

Narrative Summary	Tracking Indicators	Means of Verification	Important Assumptions
	3.2. PMI-developed and implemented HIV workplace policies, and staff participating in work place HIV education (200 staff members)	3.2.1 Workplace policies disseminated to PMI staff 3.2.2. Bi-annual and annual reports 3.2.3. Programme reviews 3.2.4. Programme completion report 3.2.5. End of programme evaluation	• Partnership with PLHIV groups continue • PMI HIV workplace policy approved by board
4. National society has the capacity to deliver and sustain a scaled-up HIV programme. Similarly, the HIV programme is strengthened	4.1. 900 new volunteers recruited. 4.2. Number of volunteer hours mobilised (not able to estimate). 4.3 National society that regularly reports following the standard guidelines (nine provinces, every nine months) 4.4. HIV appeals for nine provinces	4.1. PMI volunteer activity records 4.2. PMI reports 4.3. Bi-annual and annual 4.4. Programme reviews 4.5. Programme completion report 4.6.End of programme evaluation	• Limited staff turnover • Support from PMI HQ and branch management to help programme staff and volunteers balance workload
Approaches:			**(Approach to Output):**
Output 1. 1.1 Peer education and community mobilization	1.1.1. 200 Peer education training and workshops conducted with 18,065 peer educators trained 1.1.2. PE training with 40,000 in school and 3,000 out of school youth 1.1.3. PE training for at 6,000 people from key population at higher risk 1.1.4. integration of HIV into RCY	1.1.1.- 1.1.4 Training activity reports 1.1.5. Peer out-reach activity reports 1.1.6. Training activity report on coordinators/managers sensitivity training	• Support from stakeholders and community leaders • PMI branches has sufficient capacity and capability to carry out the intervention

Narrative Summary	Tracking Indicators	Means of Verification	Important Assumptions
	curricula 1.1.5. 90 at-risk group coordinators/managers sensitized 1.1.6. situational analysis North Sumatra, North Sulawesi and East Kalimantan		
1.2 Information, education and communication (IEC) for targeted vulnerable groups	1.2.1. At least five different IEC materials developed for special target groups produced and disseminated	1.2.1. IEC materials developed	• Acceptance and interest of the community
	1.2.2. 124,000 units of IEC materials printed	1.2.2. IEC materials printed	•
	1.2.3. 124,000 units of IEC materials distributed among the target groups	1.2.3 IEC materials distribution reports	•
	1.2.4. PMI staff peer information education communication training for 50 PMI staff on how to share HIV information with other staff	Training reports	• Staff and volunteers able to participate
	1.2.5. Hotline counselling service as a daily service from 5 to 9 pm, the service is related with HIV and AIDS, reproductive health, drug abuse	Counselling logs and reports	• Hotline is promoted and used by community
	1.2.6. 20,000 people reached with VCT messages	1.2.6.1. IEC materials distributed 1.2.6.2. Monitoring form	• Access to proper and accurate information
	1.2.7. 600 persons referred to VCT services	1.2.7. Activity reports	•

Narrative Summary	Tracking Indicators	Means of Verification	Important Assumptions
1.3 Volunteer Counselling and Testing (VCT)	1.3.1 VCT integrated into PE activities and 600 people referred to VCT 1.3.2 Awareness raising to 20,000 blood donors and key population at higher risk on VCT	1.3.1. VCT report	•
1.4 Preventing mother to child transmission (PMTCT)	NA		•
1.5 Skills for personal protection, including condom use	1.5.1. 45,000 condoms distributed as part of PE programme 1.5.2 Harm reduction activities explored with NGOs 1.5.3 Sensitization workshop for 50 staff/volunteers on IDU 1.5.4 IDU situational analysis and harm reduction programme implemented	1.5.1. PE training and condom distribution reports 1.5.2 meeting reports 1.5.3 meeting/training report 1.5.4 situational analysis report	•
Output 2. 2.1 Assisting children and orphans (OVC) made vulnerable by HIV	NA		•
2.2 Providing treatment, support and care for people living with HIV	2.2.1. 225 PLHIV referred for OI an ARV 2.2.2 Home-based care trainers trained - 24 2.2.3 PLHIV and family receive home care training - 120	Training reports Volunteer reports Monitoring reports	• Access to referral sites for ARV and OI • PLHIV and families accessible • Capacity of branches

Narrative Summary	Tracking Indicators	Means of Verification	Important Assumptions
	2.2.4 Case managers trained - 24 2.2.5 PSP volunteers trained - 24 2.2.6 Psychosocial support to 120 PLHIV		
2.3 Developing community support groups and networks	2.3.1 Support 42 PLHIV peer support groups to reach 300 PLHIV 2.3.2 PLHIV groups receive 42 training sessions 2.3.3 Develop 21 PLHIV drop-in centres 2.3.4 Train 210 volunteers to provide buddy support to PLHIV 2.3.5 Provide buddy support to 840 PLHIV	Support groups reports Training reports Minutes of meetings Monitoring reports Volunteers records and reports	• PLHIV groups interested in networking and collaborating • PLHIV and families accessible • Capacity of branches
2.4 Provide livelihood and food support for the most vulnerable	NA		
Output 3. 3.1 Developing community support groups and networks of people living with HIV and partnerships with PLHIV organizations	3.1.1. Develop partnership with 42 PLHIV groups and sign MoU 3.1.2 Facilitate establishment of 21 peer support groups	3.1.1. Project activity and monitoring reports	• PLHIV groups interested in networking and collaborating • Capacity of branches
3.2 Ensuring that HIV in workplace policy and programme for all staff and volunteers are in place in PMI	3.2.1. PMI HIV workplace policy approved by board 3.2.2 Conduct KAP survey with staff/volunteers and board of	3.2.1 Workplace policy ratified by the board and implemented.	• Leadership prioritises workplace policy

Narrative Summary	Tracking Indicators	Means of Verification	Important Assumptions
	PMI 3.2.3. 200 of staff trained on workplace policy 3.2.4. 200 staff participate in anti-stigma workshop	3.2.2 KAP survey 3.2.3 Training report 3.2.4 Training report	
3.3 Tracking gender inequalities and sexual and gender-based violence	3.3.1. Advocate development of PMI gender policy 3.3.2. 1,080 staff trained on gender issues	3.3.1. Gender assessment report 3.3.2. Gender training report 3.3.3. Project reports 3.3.4. KAP survey	• Leadership prioritize gender • Capacity of staff to implement
3.4 Peer education, community mobilization and population-based information, education and communication	3.4.1. 50,000 people reached with HIV messages through public awareness days and mass events	Post event report and media coverage /newspaper clippings	• Pre-event publicity is effective.
Output 4. 4.1 Improving governance, accountability and leadership of PMI in terms of discharging planned commitments	4.1.1. 50 staff attend VCT and blood safety training 4.1.2. 150 staff attend annual HIV and AIDS meeting 4.1.3 New staff recruited – 20 4.1.4 Volunteers recruited to conduct programmes	Training reports HRD documents KAP survey	
4.2 Improving volunteer and staff support management	4.2.1. Basic training for 900 new volunteers 4.2.2 Volunteer database established and functioning well 4.2.3 Staff (75) participate in external training	4.2.1.Availability of up-to-date and complete volunteer data-base 4.2.2. Volunteer unit activity reports 4.2.3. Staff/volunteer training	

Narrative Summary	Tracking Indicators	Means of Verification	Important Assumptions
	4.2.4 PMI branches and chapters act as information and referral centres	reports	
4.3 Strengthening programme cycle management	4.3.1. M and E framework developed 4.3.2. 105 staff trained per topic (PMER; M and E; project design; proposal writing).	4.3.1. M and E framework finalized and implemented 4.3.2. Training reports 4.3.3. Project activity monitoring reports	• That there are available qualified staff and volunteers
4.4 Widening partnerships and expanding resource mobilization	4.4.1. 25 partnerships established 4.4.2. 10 new donors approached 4.4.3. Three new sources of funding confirmed	4.4.1. MoU signed with agencies (UN/INGO/NGO/CBO)	• That there donors with ready funds • That there are no competing emergency events

Total Budget Committed funding as of 2008 (CHF)

	2008	2009	2010	TOTAL (in CHF)
International Federation	57,000	57,000		114,000
Japanese Red Cross	170,000	140,000	130,000	440,000
Netherlands Red Cross *	0	0	0	0
Total	**227,000**	**197,000**	**130,000**	**554,000**

Note: *Committed to support but not yet decided total amount for contribution*

Annex 1: Budget to the Programme Document

	Budget item	2008	2009	2010	Total (CHF)
Output 1					
1.A	Personnel	14,286	15,857	17,443	47,586
1.B	Capacity building / workshops, training & technical assistance	128,571	142,714	156,986	428,271
1.C	Capital expenses: equipment, supplies & materials	42,857	47,571	52,329	142,757
1.D	Transport and storage	8,571	9,514	10,466	28,551
1.E	Information, media, publications	42,857	47,571	52,329	142,757
1.F	Travel & communications	64,286	71,357	78,493	214,136
1.G	Other costs – specify	-	-	-	-
1.H	Other costs – specify	-	-	-	-
1.I	*Subtotal*	301,429	334,586	368,044	1,004,059
1.J	*Output 1 Total*				
Output 2					
2.A	Personnel	20,000	22,200	24,420	66,620
2.B	Capacity building / workshops, training & technical assistance	64,286	71,357	78,493	214,136
2.C	Capital expenses: equipment, supplies & materials	57,143	63,429	69,771	190,343
2.D	Transport and storage	13,714	15,223	16,745	45,682
2.E	Information, media, publications	17,143	19,029	20,931	57,103
2.F	Travel & communications	64,286	71,357	78,493	214,136
2.G	Other costs – specify	-	-	-	-
2.H	Other costs – specify	-	-	-	-
2.I	*Subtotal*	236,571	262,594	288,854	788,019
2.J	*Output 2 Total*				
Output 3					
3.A	Personnel	9,600	10,656	11,722	31,978
3.B	Capacity building / workshops, training & technical assistance	85,714	95,143	104,657	285,514
3.C	Capital expenses: equipment, supplies & materials	42,857	47,571	52,329	142,757
3.D	Transport and storage	27,429	30,446	33,490	91,365
3.E	Information, media, publications	24,000	26,640	29,304	79,944
3.F	Travel & communications	38,571	42,814	47,096	128,481
3.G	Other costs – specify	-	-	-	-
3.H	Other costs – specify	-	-	-	-
3.I	*Subtotal*	228,171	253,270	278,597	760,039
3.J	*Output 3 Total*				

Budget item		2008	2009	2010	Total (CHF)
Output 4					
4.A	Personnel	19,500	21,645	23,810	64,955
4.B	Capacity building / workshops, training & technical assistance	228,571	253,714	279,086	761,371
4.C	Capital expenses: equipment, supplies & materials	8,571	9,514	10,466	28,551
4.D	Transport and storage	8,571	9,514	10,466	28,551
4.E	Information, media, publications	8,571	9,514	10,466	28,551
4.F	Travel & communications	85,714	95,143	104,657	285,514
4.G	Programme monitoring, reviews and evaluations*	28,571	31,714	34,886	95,171
4.H	Other costs – specify	-	-	-	-
4.I	*Subtotal*	388,071	430,759	473,835	1,292,666
4.J	*Output 4 Total*				
K	**Subtotal of all Outputs**	1,154,243	1,281,210	1,409,331	3,844,783
L	Programme support recovery (PSR)	57,712	64,060	70,467	192,239
N	**Grand Total**	1,211,955	1,345,270	1,479,797	4,037,022

* As a guide, this should be 3% of K: subtotal of all Outputs

Explanation of costs

1. ***B:*** 9 Provinces + 1 NHQ x 5 times workshop/training; unit cost @ 4,286 CHF

Annex 2 to Programme Document

Programme Scaling up Targets
Global Alliance on HIV Programme - Indonesia

Target group	Baseline year 2007	2008	2009	2010	Total Scale up 2007 to 2010
Output 1					
Approach 1.1: Peer education and community mobilization					
Youth in school	2,700 peer educators[3] in school	2,000 peer educators in school	7,500 peer educators in school	7,500 peer educators in school	**Total increase in number of beneficiaries targeted: 17,000**
	27,000 beneficiaries students	10.000 beneficiaries	15,000 beneficiaries	15,000 beneficiaries	**Total increase in numbers of target population: 40,000**
Youth out of school	250 peer educators out of school youth	100 peer educators out of school youth	100 peer educators out of school youth	100 peer educators out of school youth	**Total increase in numbers of target population: 300**
	2,500 youth beneficiaries	1,000 peer beneficiaries	1,000 peer beneficiaries	1,000 peer beneficiaries	**Total increase in numbers of target population: 3,000**
Key population at higher risk : taxi drivers, SWs, prisoners, street children	175 peer educators of high risk group[4]	200 peer educators of high risk groups	200 peer educators of high risk groups	200 peer educators of high risk groups	**Total increase in numbers of target 600**
	875 beneficiaries	2,000 beneficiaries	2,000 beneficiaries	2,000 beneficiaries	**Total increase in numbers of target population: 6, 000**
Key population at higher risk	40 Key	30 Key	30 Key	30 Key	**Total increase**

[3] Dropout rate of Youth Peer Educators is estimated to be 30%
[4] Drop out rate of peer educators taxi drivers, SWs, prisoners estimated to be 30 %

Target group	Baseline year 2007	2008	2009	2010	Total Scale up 2007 to 2010
leaders	population at higher risk leaders[5] and management team	population at higher risk leaders and management team	population at higher risk leaders and management team	population at higher risk leaders and management team	**in numbers of target 90**
Trainers of trainers	100 trainers of trainers[6]	80 trainers of trainers	70 trainers of trainers	50 trainers of trainers	**Total increase in number of target 200**
Training of facilitator	300 Facilitator Train	300 Facilitator Train	300 Facilitator Train	400 Facilitator Train	**Total increase in number of target 10,000**
Approach 1.2: information education, and communication (IEC) for targeted vulnerable groups					
Beneficiaries of programmes	35,000 people received IEC and give information to their friends	38,000 people received IEC and give information to their friends	41,000 people received IEC and give information to their friends	45,000 people received IEC and give information to their friend	**124,000 units of IEC materials distributed**
Staff trained on IEC	15	20	15	15	**50**
Hotline clients	236	300	360	360	**1020**
Approach 1.3: voluntary counselling and testing (VCT)					
Estimated persons referred to VCT	317	150	200	250	**600 persons referred to VCT services**
Blood donors and key population at higher risk receive information on VCT	-	5,000	7,500	7,500	**20,000**
Approach 1.5: Skills for personal protection, including condom use					
High risk group	5,000 condom distributed [7]	10,000 condom distributed	15,000 condom distributed	20,000 condom distributed	**45,000 condoms distributed**
Staff sensitized to IDU/harm reduction	-	50	-	-	**50**

[5] Drop out rate for high risk group leaders is estimated to be 15 %
[6] Drop out rate of trainers of trainers is estimated to be30 %
[7] Estimated rate of condom use by high risk group is 35 %

Target group	Baseline year 2007	2008	2009	2010	Total Scale up 2007 to 2010
Output 2					
Approach 2.2: providing treatment, support and care (home or community based and through health institutions) for people living with HIV					
PLHIV	70 referred for OI and ARV	50 referred for OI and ARV	75 referred for OI and ARV	100 referred for OI and ARV	**225**
	8 community home based care volunteers	8 community home based care volunteers	8 community home based care volunteers	8 community home based care volunteers	**24**
	40 receive home care training	40 receive home care training	40 receive home care training	40 receive home care training	**120**
	Training 8 case managers	Training 8 case managers	Training 8 case managers	Training 8 case managers	**24**
	8 PSP community volunteers	8 PSP community volunteers	8 PSP community volunteers	8 PSP community volunteers	**24**
	40 receive PSP support	40 receive PSP support	40 receive PSP support	40 receive PSP support	**120**
Approach 2.3: Developing community support and networks					
PLHIV peer support group	36	14	14	14	**42**
PLHIV at meetings	120	100	100	100	**300**
PLHIV training		14	14	14	**42**
Drop in centres		7	7	7	**21**
Volunteers traineid as buddies		70	70	70	**210**
PLHIV buddies support		280	280	280	**840**
Output 3					

Target group	Baseline year 2007	2008	2009	2010	Total Scale up 2007 to 2010
Approach 3.1: Developing community support groups and networks of People living with HIV and partnership with PLHIV organization					
PLHIV partnerships and MOU	Collaboration with and PPN+ in 7 provinces	14	14	14	42
Peer support groups		7	7	7	21
Approach 3.2: Ensuring that HIV in workplace policy and programmes for all staff and volunteers are in place in PMI					
PMI board approve workplace policy					
PMI staff and volunteers trained on workplace policy		50	75	75	200
PMI staff trained on stigma		50	75	75	200
Approach 3.3: Tackling gender inequalities and sexual and gender based violence					
Red Cross staff and volunteers		360	360	360	1,080
Approached 3.4: Peer education, community mobilization, and population-based information, education and communication					
General community	5, 000	10, 000	20, 000	20, 000	50, 000
Output 4					
Approach 4.1: Improving governance, accountability, and leadership of the National Society concerning discharging planned commitments					
Staff – VCT and Blood safety training		50			**50**

Target group	Baseline year 2007	2008	2009	2010	Total Scale up 2007 to 2010
Staff and volunteers annual meeting		50	50	50	**150**
Staff recruited		10	5	5	**20**
Volunteers recruited					
Approach 4.2: Improving volunteers and staff support and management					
Volunteers	500	300	300	300	**900**
PMI staff external training	N/A	25	25	25	**75**
PMI branch becomes referral/information centre					
Approach 4.3: Strengthening programme cycle management					
M and E framework		9 provinces			9
PMI staff trained on Programme management	25 staff attended professional training	30	30	30	90
Approach 4.4: Widening partnerships and expanding resource mobilization					
Potential donors: UN/INGO/ NGO/ CBO		- 5 partnerships established - 3 new donors approached - 2 new sources of funding confirmed	- 10 partnerships established - 5 ten new donors approached - 1 new sources of funding confirmed	- 10 partnerships established - 2 ten new donors approached	- 25 partnerships established - ten new donors approached - three new sources of funding confirmed