UNIVERSITAS KATOLIK INDONESIA
ATMA JAYA

Outcome Measurement - 2015

United for Body Rights (UFBR) Program

December 2015

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Outcome Measurement 2015: United for Body Rights (UFBR)

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Submitted to Rutgers WPF Indonesia

December 2015

List of Abbreviations

ACT	:	Artesunate Combination Treatment
AIDS	:	Acquired Immuno Deficiency Syndrome
ANC	:	Ante Natal Care
ARI	:	Aliansi Remaja Independen (Independent Youth Alliance)
ART	:	Anti Retroviral Therapy
ARV	:	Anti Retro Viral
ASK	:	Access Services and Knowledge
ARC	:	Atmajaya HIV AIDS Research Center
CBO	:	Community Based Organization
CPR	:	Contraceptive Prevalence Rate
CSE	:	Comprehensive Sexual Education
CSI	:	Civil Society Index
CSO	:	Civil Society Organization
DHS	:	Demographic and Health Surveys
E&M	:	Electronic & Mobile
FGD	:	Focused Group Discussion
FP	:	Family Planning
HIV	:	Human Immuno Deficiency Virus
IPPF	:	International Planned Parenthood Federation
IUD	:	Intra Uterine Devices
KAP	:	Knowledge, Attitude, Practices
LGBTI	:	Lesbian Gay Bisexual Transgender Intersexual
MDG	:	Millennium Development Goals
MH	:	Maternal Health
MYP	:	Meaningful Youth Participation
NGO	:	Non Government Organization
OM	:	Outcome Measurement
OR	:	Operational Research
PLHIV	:	People Living with HIV
PME	:	Planning, Monitoring and Evaluation
PMEL	:	Planning, Monitoring, Evaluation and Learning
PMTCT	:	Prevention of Mother to Child HIV Transmission
PUSKESMAS	:	Pusat Kesehatan Masyarakat (Community Health Centers)
RA	:	Result Area
RTI	:	Reproductive Track Infections
SDKI	:	Survei Demografi Kesehatan Indonesia (Demographic and Health Survey)
SGBV	:	Sexual and Gender Based Violence
SOGIE	:	Sexual Orientation Gender Identity and Expression
STI	:	Sexually Transmitted Infection
SRH	:	Sexual Reproductive Health
SRHR	:	Sexual Reproductive Health and Rights
UFBR	:	Unite for Body Rights Programme
UNAIDS	:	Joint United Nations Programme on HIV AIDS
VCT	:	Voluntary Counseling and Services

WHO	:	World Health Organization
YFS	:	Youth Friendly Services
YP	:	Young People
YPLHIV	:	Young People Living with HIV

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SUMMARY

Background and Scope of Endline Outcome Measurement

Unite for Body Rights Program (UFBR) is a collaborative initiative of five Dutch NGOs focused on Sexual and Reproductive Health (SRHR) with aims to improve sexual reproductive health and rights in developing countries among women, men, adolescents and marginalized groups regardless of their cultural and religious background, age, gender and sexual orientation.

Focus of Endline Outcome Measurement

In Indonesia, UFBR is implemented in 4 provinces: DKI Jakarta, DI Yogyakarta, Lampung and Jambi from 2011 to 2015. Before the UFBR program was implemented, a baseline outcome measurement was conducted in 2011 (and in 2013 for SETARA curriculum intervention). This report will describe the results of an endline outcome measurement evaluation conducted in 2015 to track changes in SRHR target areas since the commencement of the UFBR program.

Methodology

The design of this study is a combination of quantitative and qualitative approaches. Primary data and secondary data were gathered using similar methods and tools to those developed for measuring baseline outcomes in 2011.

Main Findings

Result Area 2 – Strengthening SRHR Education

The End-line Outcome Measurement found that both HIV and SRHR general knowledge have increased from baseline testing to endline. In relation to attitude, endline participants demonstrated more empathy than the participants of the SETARA baseline outcome measurement. Skills scores relating to capacity to make safe and informed decisions regarding sexuality also increased. These results are supported by FGD findings that show participants are demonstrating positive changes in knowledge, attitude and skills. However, though health-seeking behavior is increasing, it is not significantly different from the baseline.

Participants in the endline demonstrated more independence when accessing health facilities than participants in the baseline. Similarly, participants in the endline survey reported positive trends in community and NGO help in accessing services. Health providers also demonstrated better quality of services at the endline than at the baseline, as shown by an increase in satisfaction level of young people when accessing health facilities.

Result area 2 – Strengthening SRH Services

Targeted SRHR health services that comply with IPPF standards for youth friendly services also demonstrated change. NGO-owned clinics tend to have higher scores on IPPF standard of YSF than government-owned puskesmas clinics. Similar trends are also evident for the satisfaction level among young people. Stock-out data regarding contraceptives (including condoms); HIV tests; ARVs and antibiotics is relatively stable, though more HIV tests are available now.

Mean satisfaction level of young people when accessing these facilities however, had increased at the endline, indicating there may be other factors contributing to the satisfaction of the targeted SRHR heath services (for example, the urgency to get treated may create higher satisfaction among those attending health services).
Secondary data revealed that in comparison with 2011 and 2013 baseline testing, there are more young people and female clients accessing health services. This includes an increase in the target area of number of births attended by skilled birth attendants. However, there was a decrease in the numbers accessing GBV services, therefore requiring urgent attention.

Result area 2 – Improved enabling environment on SRHR

Community leader involvement scores in 2015 were moderate to high, however there was a decrease from the baseline to the midline. Similarly, community acceptance of SRHR at community level is also decreasing; although qualitative data demonstrates that despite this there are varying forms of support and involvement from the community leaders and community members. Taboo and LGBT issues remain unpopular and are least accepted among the community leaders.
Partners showed that they continued approaching both community leaders and stakeholders, and engaging the local government to remove barriers to CSE/SRHR education and YFS. Some partners have achieved changes in practices, attitudes and supports. Some have also obtained supports in relation to funds, though funding support is still typically 'one off' as it is related to turn over of government leaders. These efforts tend to be pragmatic and localized in relation to the overall situation in Indonesia, where there are some legal barriers regarding provision of quality SRHR information and services at the national level.

Recommendations

The assessment also offers strategic recommendations to maximize the outcome of the program in the future. These recommendations are:
Access to HIV and SRHR knowledge (including condoms) among in-school young people needs to be improved. While partners strive to advocate school based CSE/SRHR education, alternative communications and information media, such as social media, needs to be developed and used. Further channels for CSE or SRHR education in schools must be considered, as targeting counseling teachers as information providers is not enough.

Additional strategies toward condom provision need to be developed, for example creating links between students who need condoms and non-school condom outlets outside of health services. Condoms remain taboo and there is still reluctance of stakeholders to engage in the issue of condoms.
Methods in conveying CSE/SRHR education need to be targeting not only knowledge and skills, but also the development of a positive attitude toward sexuality. Particular attention needs to be developed for girls: to challenge cultural norms related to women sexuality that put women and girls as passive subjects limiting their capacity to refuse non-consensual sexual acts.
Furthermore, during the provision of information, HIV, GBV, and other SRHR issues need to be framed using a gendered perspective to address the power imbalance among boys and girls. This may include working with boys at a young age to develop positive masculinity or to challenge harmful norms and practices related to masculinity.

GBV including dating violence among in-school young people needs particular attention and future programming must place a greater focus on GBV information services, in addition to stigma and discrimination issues related to PLHIV and LGBT communities. The relationship between HIV, violence and gender needs to be explored further and highlighted within the SETARA curriculum. Integration of GBV in existing HIV/SRHR services, or a referral system and directory of GBV services as well as legal assistance need to be developed. This is to ensure youth, and girls in particular, perceive there are tangible follow up options regarding GBV services, which may lead to more people accessing it.

The increasing popularity and availability of HIV counseling and testing among young people provides an opportunity to link young people with HIV to other SRHR services. Collaborative works with other programs may be conducted to encourage health-seeking behavior among youth. However, in some places in Indonesia the VCT providers may ask for parental consent for young people under 18 years old, creating additional problems to be addressed. This is one of the priority issues that the One Vision Alliance should consider in its advocacy agenda for 2016.

Promotion of targeted SRHR consultation and health services and exploration of the factors that encourage young people to visit SRHR services needs to be conducted. This can be conducted utilizing both teachers and social media campaigns. Technical assistance to government-owned health facilities needs to be prioritized. In this case, partners that own clinics may be engaged as technical assistance providers to encourage shared learning and more open communication, addressing taboo and stigma related to HIV and SRHR issues.

Whilst advocacy efforts directed towards the local government are more practical and realistic to undertake, advocacy works focusing on national level regulations which limit young people of the realization of SRHR comprehensive education and services need to be prioritized (e.g. accessibility of the services for unmarried young people/unmarried girls; provision of condoms and other contraceptives; or integrating CSE in school curriculums). The advocacy plan and design of the One Vision Alliance needs to be developed to target the national level regulation, with clear roles and responsibilities for each member of the alliance. Advocacy strategies need to be adapted to suit the Indonesian context and need to encompass condom and sexuality issues, including LGBT.

Program area improvements need to be conducted to ensure planned activities are in line with timing, resources and tools needed. For example, timely developed guidelines/modules; better planning of targeted intervention schools and health facilities (and alternative strategies for newly collaborating schools/health facilities); and closer coordination and shared leadership on advocacy works, whilst at the same time developing strategies to address high turn over of stakeholders.

The 2015 End-line Outcome Measurement

Introduction

As a collaborative action between five Dutch NGOs working in Sexual and Reproductive Health and Rights (SRHR), Unite for Body Rights Program (UFBR) aims to improve the sexual and reproductive health and rights of women, men, adolescents and marginalized groups in developing countries, regardless of their cultural and religious background, age, gender and sexual orientation. In Indonesia, the collaboration was established through the formation of a network of NGOs working in the area of SRHR, known as ONE VISION ALLIANCE.

Guided by shared ideals, One Vision Alliance work with young people, marginalized groups, including female survivors of violence, Lesbian, Gay, Bisexual and Transgender peoples. The intervention aims to increase awareness of sexual and reproductive health and rights among young people to build their capacity to protect themselves from unsafe sexual practice. Other marginalized groups might also be empowered from strategies targeting SRHR stigma and discrimination.

In 2011, prior to the initiation of UFBR, a baseline survey was conducted collecting preliminary information regarding the knowledge, attitudes and practice of youth in the areas of HIV and AIDS; contraception; SRHR; condom use; non-consensual sexual experience; and social norms related to sexuality. Additionally, basic survey data also aimed to collect information about the quality and use of services, including client satisfaction regarding SRHR services provided at community 'Puskesmas' clinics.

After two years of implementation, a midline outcome measurement was conducted in 2013. The changes measured include changes in attitudes and practice, SRHR knowledge amongst student program-recipients, and client satisfaction and quality rating with regards to SRHR services, following the implementation of program interventions in clinics. Other issues to be explored through the Outcome Measurement survey included whether changes were due to UFBR intervention programs or other factors; whether changes were also seen in non-intervention students and reproductive health services; and students' experiences and opinions of the in-school program.

Five years into the program implementation, there was a need to evaluate the success of the UFBR intervention. In 2015, an endline study was undertaken. This endline outcome measurement aimed to obtain data about knowledge of HIV and contraception, attitudes related to SRHR, use of condoms and other contraceptives, experience with non-consensual sex, and perceived social norms on sexuality among youth. Additionally, this study also collected information about the quality of services, the number of visitors to the SRHR clinic, and respondents' satisfaction towards health care services.

Introduction of country program

Short introduction to the country program

UFBR program in Indonesia is conducted by several NGO partners working in sexual and reproductive health and rights: RutgersWPF, dance4life, CHOICE and SIMAVI. These partners join their forces and expertise to form an alliance known as Alliansi Satu Visi (One Vision Alliance).

Objectives of the country program:

The objectives of the country program can be divided into four objectives:

1. Strengthening the capacity of civil society to advocate for and implement SRHR interventions.
2. Strengthening SRHR education to increase the capacity of young people and marginalized groups to make safe decisions with regards to SRHR issues
3. Strengthening SRHR services by improving the quality of services in clinics
4. Working towards an enabling environment for SRHR so that young people and marginalized groups can more fully exercise their SRHR

Description of the project areas

Figure 1. Map of Project Area in Indonesia

UFBR intervention sites are in four provinces: DKI Jakarta and DI Yogyakarta in Java Island represent the most populated island in Indonesia (60% of Indonesian people live in Java island); and Lampung and Jambi districts in Sumatera Island represent less populated islands. Most of the partners work only in the capital cities, with only PKBI Yogyakarta working in both urban and rural areas. Above is the map of the intervention sites.

The implementing NGOs in each province are:

Jakarta	Perkumpulan Keluarga Berencana Indonesia (PKBI) DKI Jakarta, Yayasan Pelita Ilmu (YPI), Ardhanary Institute, ARI
Yogyakarta	PKBI DI Yogyakarta and CD Bethesda
Lampung	PKBI Lampung
Jambi	PKBI Jambi and Sentra Informasi dan Konsultasi Orang Kito (SIKOK)

Description of the target groups

Table 1. Characteristics of the target groups of the SRHR program in Indonesia

Target groups	Characteristics of the target group	Community
Young people aged 10-14	**Junior high school students**	**Jambi, Lampung, DKI Jakarta and DI Yogyakarta**
Young people aged 15-19	**Senior high school students**	**Jambi, Lampung, DKI Jakarta and DI Yogyakarta**
Lesbian	**Women who have sex with other women**	**DKI Jakarta, DI Yogyakarta**
Gay, MSM and transgender	**Men who have sex with other men**	**DKI Jakarta, DI Yogyakarta**
Youth Clinic	**Clinic that has services for youth reproductive health**	**Jambi, Lampung, DKI Jakarta and DI Yogyakarta**
Stakeholders	**Decision/policy-maker**	**Jambi, Lampung, DKI Jakarta and DI Yogyakarta**

Besides marginalized groups such as lesbian, gay, transgender, and female survivors of violence, adolescents are one of the most important target groups for health education relating to SRHR. Other target groups include (youth) clinics and decision makers.

The partner organizations engaged in the End-line Outcome Measurement Survey are similar to those engaged in the baseline testing, with the exceptions of Rifka Annisa (DI Yogyakarta) and GWL-INA (Jakarta) who were not included in the Outcome Measurement since they did not receive any UFBR support/funding to run SRHR programs. In addition to PKBI DI Yogyakarta, CD Bethesda is included in this endline study as they are conducting a UFBR program in the DI Yogyakarta province. The table below describes the partner organizations involved in this measurement.

Table 2. List of Partner organizations

No	Service area	Institution	Description
1.	JAMBI PROVINCE	The Indonesian Planned Parenthood Association – Jambi Perkumpulan Keluarga Berencana Indonesia (PKBI) - Jambi	The National PKBI was established on 23 December 1957. Their vision is to establish an independent centre of excellence for the development of sexual and reproductive health programs and advocacy by 2020. Currently, PKBI has 25 representative organizations across the country. In Jambi, PKBI Jambi focuses on sexual and reproductive health issues. Originally, the focus of PKBI Jambi was on community empowerment through family planning. However, their focus has since shifted to other issues of sexual and reproductive health, including Sexually Transmitted Infections (STIs), HIV and AIDS, gender-based violence, and trafficking. Additionally, they aim to actively review and criticize the cultural, social, economic,

No	Service area	Institution	Description
			political and legal environments, including policies, which might prevent women and adolescents from accessing information, education, and services to achieve basic social rights. The main programs of PKBI Jambi include: (1)Adolescent empowerment; (2)Increase access to information and education relating to sex and reproductive health; (3)Management of STIs and HIV/AIDS, particularly in marginalized women and adolescents; (4)Management of unwanted pregnancy including prevention of unsafe abortion; (5)Advocacy to encourage policy change by prioritizing the reproductive health sector in community development.
2	JAMBI PROVINCE	Centre for information and consultation for our people Sentra Informasi dan Konsultasi Orang Kito (SIKOK JAMBI)	The SIKOK Foundation is a not-for-profit NGO established on 6 March 1997. This foundation focuses on adolescent-related issues by providing information, services and consultations to adolescents, as well as undertaking advocacy and media development in the areas of adolescent sexual and reproductive health, including HIV and drugs. All activities are based on principles of gender equality. Their programs include: (1)Communication, information and education services for adolescents (2)Organization of adolescents (3)Alternative education (4)Capacity building (5)Advocacy for adolescent's sexual and reproductive health
3.	LAMPUNG PROVINCE	The Indonesian Planned Parenthood Association – Lampung Perkumpulan Keluarga Berencana Indonesia (PKBI) - Lampung	As part of the National PKBI established in 1957, PKBI Lampung have setup the following aims: (1)To enhance the quality of life amongst pre-school children and adolescents; (2)To provide information, education, training, advocacy and reproductive health services for adolescents to increase their knowledge of reproductive health and prevent teenage abortion and STIs/HIV; (3)To provide and develop reproductive health services; (4)To achieve and develop gender equality; (5)To provide and develop services which empower elderly populations to increase their productivity and independence; (6)To provide an integrated education and encourage organization empowerment.
4.	DKI JAKARTA PROVINCE	Pelita Ilmu Foundation Yayasan Pelita Ilmu (YPI)	This foundation was established on 4 December 1989 with the aim of preventing and managing HIV through education, assistance and outreach, whilst acting according to the guiding principles of participation, partnership, equality, transparency, and accountability. Their programs include: (1)HIV prevention through peer education of HIV in school, and HIV prevention for high-risk adolescents outside of

No	Service area	Institution	Description
			school. (2)Counseling, testing and providing health-related services, including voluntary counseling and testing (VCT) and reproductive health clinics. (3)Support for HIV infected persons, including the buddies service, temporary shelter, referral service, support groups, and assistance in income generation.
5.	DKI JAKARTA PROVINCE	Ardhanary Institute	Established on 14 November 2005, this institute aims to eliminate all forms of discrimination against Lesbian, Bisexual and Transgender peoples (LBTs) in Indonesia through research and advocacy for LBT rights. The mission includes: (1)Strengthening individual capacity and building peer-groups to significantly contribute to society; (2)Transforming community attitudes towards sexuality; (3)Encouraging the formation of policy that is not discriminatory against citizen sexual choices; (4)Developing a crisis center for women LBT.
6.	DKI JAKARTA PROVINCE	The Indonesian Planned Parenthood Association – DKI Jakarta Perkumpulan Keluarga Berencana Indonesia (PKBI) DKI Jakarta	PKBI DKI Jakarta has adapted the vision and missions of the national PKBI to reflect the local situation in DKI Jakarta. The strategic vision of PKBI DKI Jakarta is to build critical awareness amongst marginalized communities, particularly those of reproductive age, and further fulfill sexual and reproductive health rights through reconstructed gender perspectives. PKBI DKI Jakarta also positions itself as an organization for learning & empowering. PKBI DKI Jakarta activities include: (1)Children and adolescents division Establishing the center for information and adolescent reproductive health (including HIV/AIDS), clinics in PKBI DKI Jakarta, etc. (2)HIV and AIDS division Harm reduction programs, prevention of HIV and AIDS for construction workers, etc. (3)Access and service division Providing access to health services, especially reproductive, STI and AIDS services, by building clinics for marginalized communities.
7.	DI Yogyakarta Province	The Indonesian Planned Parenthood Association – DI Yogyakarta Perkumpulan Keluarga Berencana Indonesia (PKBI) – DI Yogyakarta	PKBI DIY is the representative of the National PKBI for DI Yogyakarta Province. In its initial stage, PKBI DIY merely functioned as a training center. However their programs have since evolved to reach adolescents, married men and women, as well as unmarried women. Currently, PKBI DIY programs involve transgender, domestic and sex workers. PKBI DIY programs include: (1)Empowerment of children and adolescents; (2)Increase access to information, education and high quality services; (3)Develop IMS, HIV interventions;

No	Service area	Institution	Description
			(4)Develop the management of unwanted pregnancy; (5)Advocacy
8	DI Yogyakarta Province	CD Bethesda	CD Bethesda was established in 1974 as a not-for-profit institute concerned with health services and support for marginalized communities, particularly in rural areas. CD Bethesda is an independent unit of Bethesda Hospital and works in coordination with Yakkum (Yayasan Kristen untuk kesehatan Umum – Christian Foundation for Public Health) as one of biggest health service foundations in Indonesia. CD Bethesda activities focus on: • Sexual and reproductive health • Health advocacy • Capacity building • Environmental health • Communicable disease care
9	National	Independent Youth Alliance (IYA) Aliansi Remaja Independen (ARI)	IYA was established on 14 November 2007 with the aim to raise youth awareness of youth issues and rights; strengthen youth capacity to realize these rights; and increase community involvement and youth unity in the implementation of youth rights. As a youth-led organization, IYA prioritizes youth participation. Advocacy is the main activity of IYA. Members are trained and empowered to conduct advocacy activities for adolescent SRHR. IYA conduct hearings and have a close relationship with parliament, government agencies, non-government agencies, and UN agencies. IYA activities are aimed at ensuring youth are meaningfully involved in the program and policy development, implementation, and evaluation.

Methodology

A combination of quantitative and qualitative methods were employed in the design of this End-line Outcome Measurement Study. Quantitative methods were used to measure increased capacity of students in making safe decisions related to sexual health. Key areas measured are:

1. HIV related knowledge
2. Contraception related knowledge
3. SRHR related attitudes
4. Use of condoms and knowledge of other contraceptives
5. Experience with non-consensual sex
6. Perceived social norms on sexuality

To measure quality of youth friendly services, exit interviews were conducted to assess respondents' satisfaction with health services. In addition, secondary data regarding the increasing number of clients using these services was analyzed to evaluate service quality improvements.

Sampling and Procedure of OM

The sample used for the End-line Outcome Measurement Study was comprised of youth targeted in UFBR Programs; NGO staff; health provider staff; parents; school-teachers; headmasters and key stakeholders. All targeted districts where UFBR program was implemented are represented in this OM. Participation in the End-line OM was voluntary, therefore participation consent was obtained from all respondents prior to commencing surveys, interviews or focus group discussions.

The sampling frame used for the End-line OM Study were junior high schools who had participated in the UFBR program (in particular, SETARA module for 7th grade and 8th grade). These schools were then randomly selected to participate in the Endline OM using an online 'randomiser tool' from random.org.

In areas with large intervention target populations such as Jakarta and Yogyakarta, the total number of respondents was larger (180 and 144 respectively) than areas with smaller intervention target populations (Lampung and Jambi, both 108). The number of respondents from each school was determined by dividing the total number of respondents by the number of randomized schools. This was then divided by 2 to achieve even representation of males and females within each school.

Grade 7 and 8 Students at the selected junior high schools who were available at the time of the OM study were requested to participate. This process was facilitated by school-teachers from each school. Respondents were presented with a youth KAP survey and were asked to fill in the questionnaires by themselves following an enumerator's explanation of voluntary participation and informed consent.

Data Collection Methods

a. In depth Interviews, FGDs & Stories of Change

Informants for interviews, focus group discussions (FGDs) and stories of change (SoC) were selected through their characteristics and involvement with the programs. During the Baseline study most of the interviews and FGD instruments were focused on knowledge, attitudes and behaviour; whilst the Endline OM was focused on involvement, acceptance and support. These differences were a result of the program nearing the end of its 4-year duration.

b. Exit Interviews and Youth Friendly Services (YSF)

Clinics/puskesmas were selected to perform exit interviews or YSF checklist based on their engagement with the UFBR program. Initial design of the Endline OM included all the clinics and puskesmas that had participated in the baseline testing. However, not all those clinics or puskesmas could be asked to participate in the End-line OM due to changes in intervention puskesmas during the programme implementation. Therefore, some new clinics or puskesmas in each province were selected to replace those that could not participate. Due to the limited number of youth clients who had recently accessed services in the selected clinics or puskesmas, all young patients within the survey period were sampled for exit interviews. In relation to LGBT services, the clinics or puskesmas were selected based on recommendations arising from FGDs with the young LGBT group.

c. Secondary Data Collection.

Secondary data was collected from health offices, provincial, district and city AIDS commissions, family planning offices, Central Bureau of Statistics, hospitals, puskesmas clinics and other health clinics. The data period was January to December 2014. Secondary data included percentage of contraceptive use; number of people living with HIV who were accessing ARV and PMTCT; proportion of births attended by skilled health personnel, and number of ante natal care visits.

Table 3. Data Collection Method and Sample Size for the End-line OM

No	Activity/Method	UFBR		Planned	Realization
		# Activity; # participant	Indicators		
1.	KAP Survey	500 participants (of 15 junior high schools)	2.1	500	533
2.	FGD	10 FGDs with young people	2.1	12	15
		2 FGDs with young LGBT (re where they seek services, level of satisfaction with services and what changes perceived)	2.2f		
3.	In depth Interview (Stories of Change)	5 stories of young people (re capacity to make safe and informed decisions based on good knowledge	2.1	8	8
		1 story of change re changes related to YFS (IPPF standards)	2.2a		
		1 story of change with health service	2.2f		

		providers (re services to LGBT clients) who were identified during FGD with young LGBT.			
		1 story of change re increase of SRHR service use among youth and female clients	2.3a		
		1 story of change re increased use of GBV services among female clients	2.3e		
4.	Exit Interview	90 exit interviews	2.2b	90	84
5.	Observation (Checklist on Youth Friendly Services)	9 facilities/clinics incl. Ardhanary	2.2a	9	9
6.	In depth Interview (Stakeholders Mapping)	23 key informant/institutes (re involvement of community leaders in the realization of SRHR in 50% of targeted communities)	2.4b	23	17
		23 key informant/institutes (re increased acceptance of SRHR at community levels in 40% of the targeted communities)	2.4c	23	16
7.	Secondary Data (Statistical Data)		2.3a; 2.3e; 2.4a	- National reports: SDKI (Survei Demografi dan Kesehatan Indonesia/ Demographic and Health Survey) - Provincial/City Health Office Reports; - Puskesmas & Hospital Reports; - Partners' Reports	- National reports: SDKI (Survei Demografi dan Kesehatan Indonesia/ Demografic and Health Survey) - Provincial/City Health Office Reports; - Puskesmas & Hospital Reports; - Partners' Reports

d. Tools/Indicators

The End-line OM 2015 employed indicators and tools previously developed for the baseline study in 2013 with some adaptations necessary due to priority changes. The indicators and tools can be seen in the table below.

Table 4. Indicators and tools for UFBR End-line in Indonesia

	Indicators	Tools & Procedures
1	2.1a: % of the exposed target groups has an increased capacity to make safe and informed decisions	Tool 2.1 – KAP Survey + FGD Guideline for Youth + Stories of Change
2	2.2a: % of targeted SRHR facilities increasingly comply with IPPF standards for youth friendly services	Tool 2.2a – Checklist of YFS
3	2.2b: % of SRHR facilities demonstrate an increase in satisfaction by young people	Tool 2.1-3.3 – Exit Interview
4	2.2f: % of health facilities providing LGBT services demonstrate an increase in satisfaction by LGBT people.	Tool 2.1-3.3 - Exit Interview

5	2.3a: % increase in the use of targeted SRHR services by young people and women	Tool 2.1-3.3 – Secondary data
6	2.3e: % increase in the use of targeted SGBV services by women	Tool 2.1-3.3 - Secondary data
7	2.4b: Increased involvement of community leaders in realisation of SRHR in 50% of the targeted communities	Tool 3.5-3.7 – Stakeholders mapping
8	2.4c: Increased acceptance of SRHR at community level in 40% of targeted communities	Tool 3.5-3.7 – Stakeholders mapping

e. Data collection procedure

Two kinds of data were collected during the series of outcome measurements for KAP survey. UFBR baseline outcome measurement was conducted in 2011 prior to its intervention using dance4life curriculum. In 2013, a midline outcome measurement was conducted to map out the outcomes of the dance4life intervention. At the same time, a baseline survey was conducted for the SETARA intervention.
The End-line OM participants, as explained earlier, were students who received interventions that used SETARA curriculum. Therefore, the KAP data used for comparison within the End-line OM is the SETARA baseline.

Data collection was conducted by enumerators using instruments and tools developed for the End-line OM 2015. Tools and instruments were adapted from the previous SETARA baseline measurement through consultation with an Alliance expert. Procedure for data collection was implemented based on the Manual for UFBR Outcome Measurement 2015 developed by the Alliance.

The data collection plan was developed by the ARC team after the questionnaires and other instruments were adapted and approved by the Alliance. This process used data available from the baseline for reference, for example lists of schools and puskesmas clinics receiving intervention from UFBR. Data collection report forms were also developed by the ARC team to assist enumerators in data entry. Moreover, an online database using Googleform was developed for use by enumerators to enter all collected data.

f. Selection of enumerators

Criteria for recruiting the enumerators were developed and included experience in conducting health surveys (including baseline outcome measurements), willingness to work in a team and commitment to work during the data collection period. Two-day training for data collectors was conducted in each province to assist enumerators to understand sampling methods, learn various instruments, identify strategies for permission and data collection, learn how to use the online data base and increase interview skills. Within each enumerator training session, partner representatives also participated to ensure partners' continued support in data collection.

Data Management

Quality Assurance

To control the quality of data collected by the local interviewers, the consultants carried out random checks comparing data gathered online with hard copy questionnaires. In addition, all interviews and FGDs were recorded to ensure quality of data and to avoid losing information throughout the data collection process.

Data Entry

At the end of the data collection period, the OM team compiled all data from surveys, interviews, and FGDs in the online database to be cleaned. Survey data was exported from Excel Spreadsheet to SPSS v. 22 in order to be cleaned and analyzed. The other data (interview or FGD) was categorized based on agreed themes.

Data Analysis

After data cleaning and modification processes, distribution frequency tables based on required indicators were produced for survey data. Data analysis was conducted using SPSS 22. Data analysts were trained by the Alliance experts in the Netherlands to produce intended results and ensure that the analysis would be comparable to other countries. For qualitative data, thematic lists were developed to capture the objectives of the End-line OM.

In analyzing KAP survey data from the 2015 End-line UFBR Outcome Measurement, KAP survey data from 2013 (the baseline for SETARA curriculum intervention, which herein after will be referred to as 'baseline') were analyzed for comparison. Analysis of the two data sets was intended to detect changes in student capacity to make safe decisions relating to HIV and reproductive health. Indicators for the comparison of the two data sets were proposed by the OM team and were decided upon during data analysis training in the Netherlands in September 2015.

Descriptive analyses were used to describe the response to the variables of interest by using frequency tables and graphs. To measure the differences in knowledge, attitudes, and skills variables between baseline and endline testing, we used the chi square test (X2). Logistic regression was used to assess the likelihood of participants having 'insufficient' or 'at least sufficient' knowledge, attitudes and skills at the baseline and endline testing points.

Bloom's cut off point was used to categorize knowledge, attitudes and skills scores. Scores of knowledge, attitudes and skills were calculated based on correct answers and the responses were classified by an index of three Bloom's cut off points (insufficient: 0-59%; sufficient 60-79%; and really good 80-100%).

In order to simplify the analysis, three Boom's cuts off points were manipulated into two categories: 'insufficient' and 'at least sufficient', which also included 'sufficient' and 'really good'. To conduct logistic regression the two categories were then transformed into two values: 0 (insufficient) and 1 (at least sufficient).

Limitations

One limitation of this study was the schedule of the data collection, which overlapped with the led holiday and therefore affected not only local offices and clinics but also partner (including enumerators) availability. This then created delay in the process of data collection. To address this overlapping schedule, the period of the data collection was lengthened in order to meet the target number of participants.

Although most of the tools are similar, there were some differences in baseline and endline questions. There were also some changes in intervention sites (schools and clinics) in selected cities. Furthermore, in some secondary data from clinics, hospitals and health offices, there was no disaggregated data based on age and gender, therefore making it difficult to assess youth related data.

Ethical Issues

Informed consent and statement of study participant's willingness to participate were attached to each questionnaire. To ensure welfare and confidentiality of the respondents, the anonymous self-report method was conducted. Ethical clearance for this study was obtained from the Ethics Committee of Atma Jaya Catholic University.

There was no information asked regarding respondents' names and address. Field personnel ensured there was no interference from caregivers or community leaders during the study. The respondents were informed that if at any point they did not feel comfortable with the questions they could choose not to answer the question or quit from the survey anytime.

Permission was obtained from the local authority in each area of End-line Outcome Measurement, with permission also obtained from the local health offices, prisons, communities and clinics involved in this study.

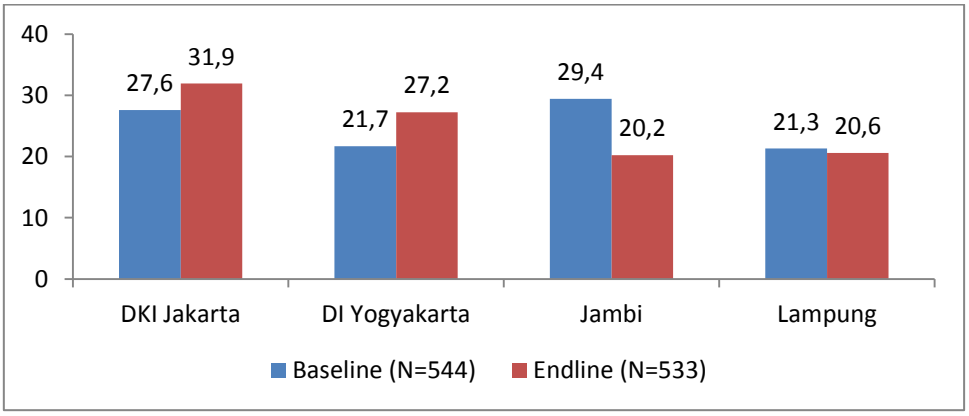
Results

A sample of 533 junior high school students in DKI Jakarta, DI Yogyakarta, Jambi and Lampung participated in the End-line OM Survey. There were some changes in the number of participants in each city between baseline and endline testing. In DKI Jakarta and DI Yogyakarta, the number of participants in the End-line OM survey increased, whilst in Jambi and Lampung there was a decrease. DKI Jakarta had the greatest number of participants and Jambi recruited the smallest number. Table 3.1. and Graph 3.1. present a comparison of the End-line OM survey participants to the SETARA baseline survey (n=544)

Table 5. Distribution of participants at baseline and endline in four provinces

Province	Baseline (N=544)	Endline (N=533)
DKI Jakarta	27,6	31,9
DI Yogyakarta	21,7	27,2
Jambi	29,4	20,2
Lampung	21,3	20,6

Graphs 1. Distribution of participants at baseline and endline in four provinces



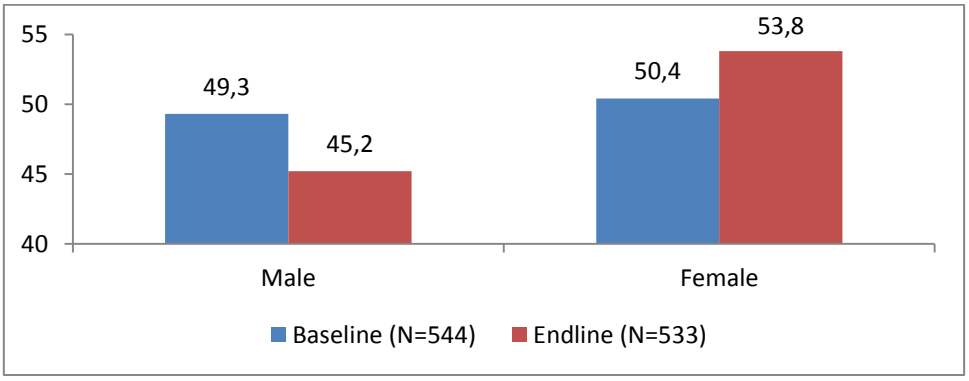
Characteristics of Participants

In terms of gender, the number of female participants was greater than male participants at both baseline and endline testing. This difference can be observed more significantly at the endline, while at the baseline the proportions were distributed more evenly (table 6 and graph 2). However, the difference in the number of female and male participants at both baseline and endline testing is not great enough (table 6) to cause significant gendered difference in survey results.

Table 6. Gender distribution

Gender	Baseline (N=544)	Endline (N=533)	Change (2013-2015)	Significant (yes/no)	P-value
Male	49,3	45,2	-4,1	no	p=0,213
Female	50,4	53,8	3,4		

Graphs 2. Gender distribution

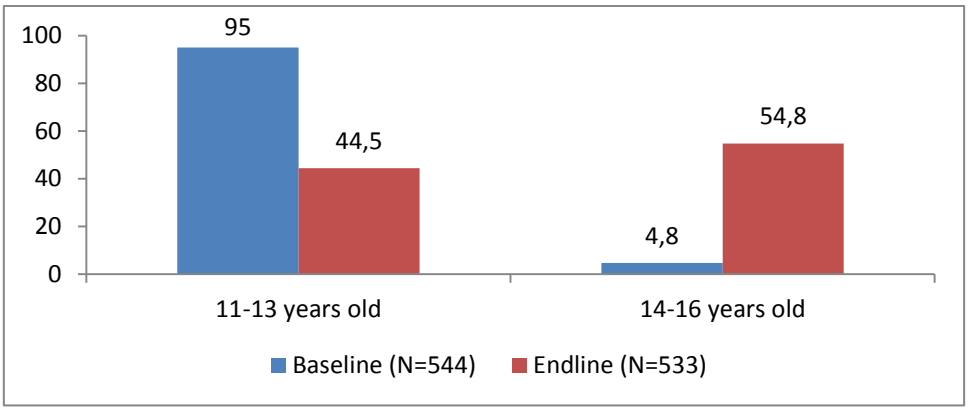


Although there were no significant gender differences between the baseline and endline survey participants, participants at the endline were older than those at the baseline (table 7). The proportion of participants in the 11-13 year old subgroup was much higher in comparison to the 14-16 year old subgroup at the baseline, while at the endline participants were more evenly distributed between the two age sub-groups. This significant difference may have potential impact on the responses provided by the participants of the two surveys. However, this difference may also be logically explained as baseline participants would have grown older over the 2 years between baseline and endline. Thus, if surveyed at the endline, they would be categorized into the older age bracket, making for a larger proportion of 14-16 year olds.

Table 7. Age distribution of baseline and endline outcome measurement participants

Age Group	Baseline (N=544)	Endline (N=533)	Change (2013-2015)	Significant (yes/no)	P-value
11-13 years old	95	44,5	-50,5	yes	p=0,000
14-16 years old	4,8	54,8	50		

Graphs 3. Age distribution of baseline and endline outcome measurement participants



At the baseline, the biggest age and gender sub group was boys aged 11-13 years (46.3%) and girls of the same age group (48.3%). Moreover, at the endline the gender and age sub groups were distributed more evenly with the biggest proportion being girls aged 14-16 years (29.1%) and the smallest proportion being boys aged 11-13 years (19.5%).

Table 8. Gender and Age Distribution of baseline and endline outcome measurement participants

Point of Measurement	Boys		Girls	
	11-13 (N=356)	14-16 (N=151)	11-13 (N=395)	14-16 (N=166)
Baseline	46,3	2,8	48,3	2
Endline	19,5	25,5	24,8	29,1

Program Exposure

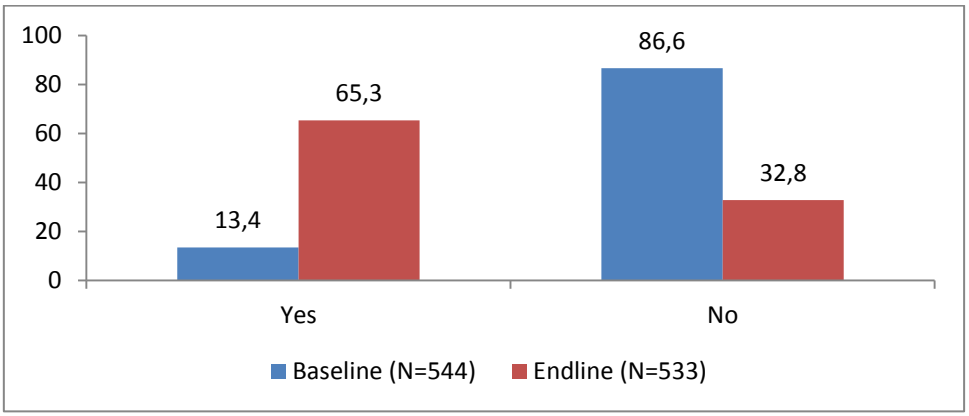
Baseline and endline participants had varying answers regarding which HIV and SRHR program they had been participating in from 2011. 12 activities at the baseline and 19 different activities at the endline were mentioned by participants. These activities were conducted by projects, schools (including a school based Red Cross program, Scouts program and government-owned young people reproductive health program), community health centers and CSOs. In particular, participants of the endline testing also reported engagement with Dance4life and DAKU programs.

Moreover, there was a significant increase in exposure to dance4life and SETARA from the baseline to the endline, as presented in table 9 and graph 4. This may indicate that the UFBR program can be attributed to changes in knowledge, attitudes and behaviour that will be further discussed within this report.

Table 9. Exposure to Program

Have you ever taken part in SETARA or Dance4Life?	Baseline (N=544)	Endline (N=533)	Change (2013-2015)
Yes	13,4	65,3	51,9
No	86,6	32,8	-53,8

Graphs 4. Exposure to Program

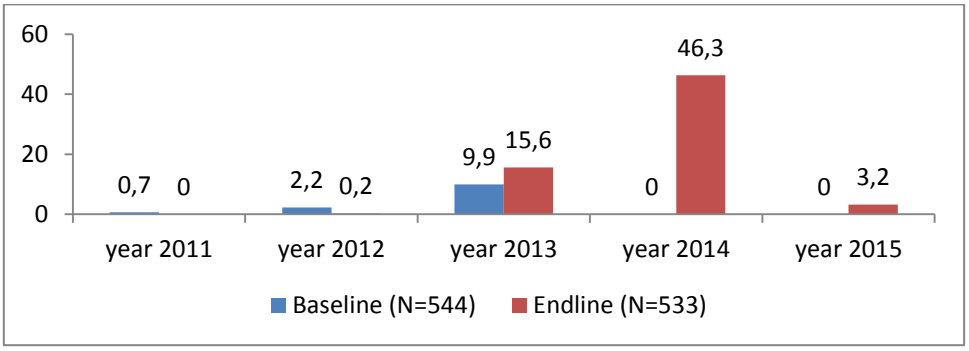


Most of the baseline participants were exposed to the program in 2013, whilst participants of the endline were exposed in 2014 (table 10 and graph 5).

Table 10. Time of Program Exposure

If you have ever been involved with the program, what year were you involved?	Baseline (N=544)	Endline (N=533)
Year 2011	0,7	0
Year 2012	2,2	0,2
Year 2013	9,9	15,6
Year 2014	n.a	46,3
Year 2015	n.a	3,2

Graphs 5. Time of Programme Exposure



Result Area 2 – Strengthening SRHR Education

Outcome Indicator 2.1 "% of the exposed target group that has an increased capacity to make safe and informed decisions"

(a) General Knowledge of HIV

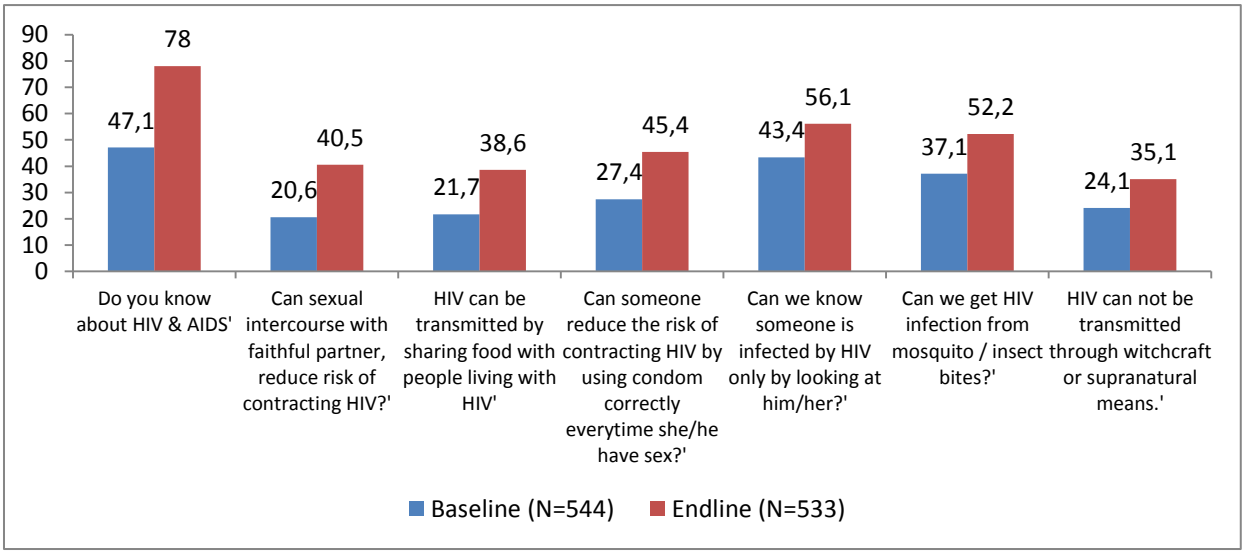
There were seven similar questions used to compare general knowledge of HIV from the baseline study to the endline. The result shows that participants at the endline have significantly higher HIV knowledge scores than participants in the baseline study. These differences can be observed in all of the seven questions (table 11). The increase of the HIV

general knowledge scores from the baseline to the endline (graphs 5) may be contributed by the UFBR programme (or SETARA curriculum intervention), or ASK programme - another programme conducted by Rutgers WPF Indonesia and its partners targeting 'out of school' youth. ASK provides SRHR information through the internet, partly through UFBR programme sites (DKI Jakarta and DI Yogyakarta). Whilst ASK and UFBR target different groups, their programmes overlap in shared programme sites, implementing partners, and intervention-targeted health service providers.

Table 11. Comparisan of General knowledge of HIV at the baseline and endline

HIV Knowledge	% correct answers		Significant (yes/no)	P-value
	Baseline (N=544)	Endline (N=533)		
Do you know about HIV & AIDS	47,1	78	yes	p=0,000
Can sexual intercourse with faithful partner, reduce risk of contracting HIV?	20,6	40,5	yes	p=0,000
HIV can be transmitted by sharing food with people living with HIV	21,7	38,6	yes	p=0,000
Can someone reduce the risk of contracting HIV by using condom correctly everytime she/he have sex	27,4	45,4	yes	p=0,000
Can we know someone is infected by HIV only by looking at him/her?	43,4	56,1	yes	p=0,000
Can we get HIV infection from mosquito / insect bites?	37,1	52,2	yes	p=0,000
HIV can not be transmitted through witchcraft or supranatural means.'	24,1	35,1	yes	p=0,000

Graphs 6. Comparisan of General knowledge of HIV at the baseline and endline (% of correct answers)



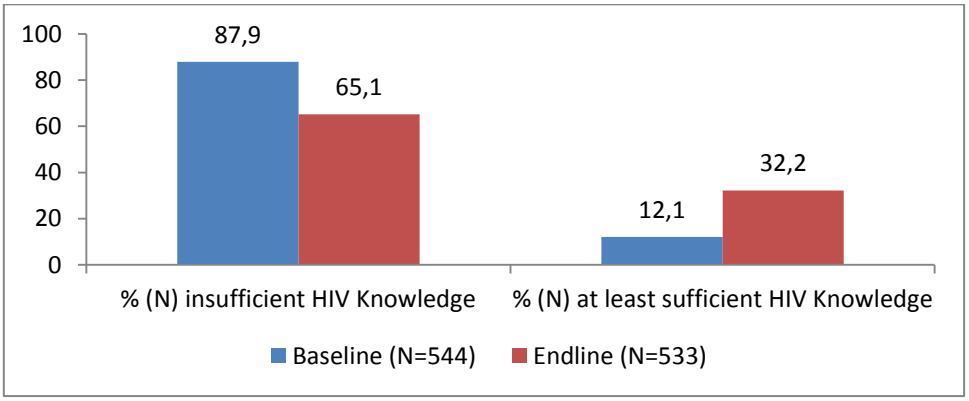
Data analysis found index scores of those with 'insufficient' HIV knowledge decreased from the baseline study to the endline (see Table 12, Graph 7). Conversely, index scores of those with 'at least sufficient' HIV knowledge was seen to increase from 12.1% (correct) at the baseline to 32.2% (correct) at the endline. The 'at least sufficient' group is characterized by those with at least 60% correct answers. Participants in endline study are three and half times more likely than participants in baseline study to have 'at least sufficient' HIV knowledge.ratio

(see odds ratio, Table 12). Whilst we did see an increase in knowledge index scores in 2015, the scores were still not high as expected. This may be due to the limitations and variation in the delivery of SETARA curriculum within each of the participating schools. Competing activities (i.e. preparation for national exam for third grade) among the students could also have influenced the results of the education activities.

Table 12. HIV Knowledge Index

HIV Knowledge Index	Baseline (N=544)	Endline (N=533)	Significant (yes/no)	P-value
Insufficient HIV Knowledge	87,9	65,1	yes	p=0,000
At least sufficient HIV Knowledge	12,1	32,2		
Odds Ratio (At Least Sufficient HIV Knowledge)	1.0	3,6	yes	p=0,000

Graphs 7. HIV Knowledge Index



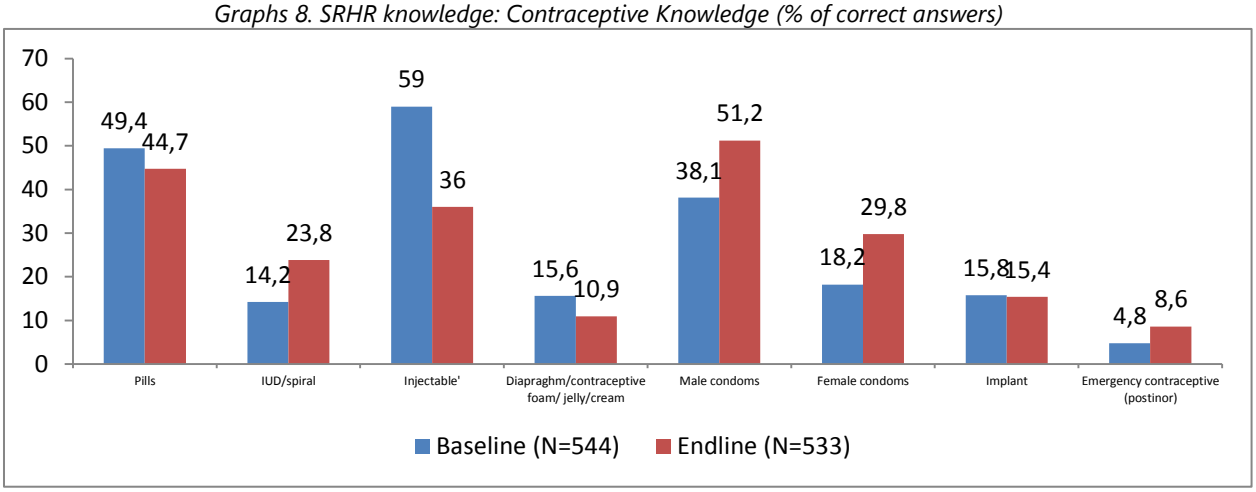
(b) SRHR Knowledge

We found variations in knowledge surrounding contraceptives between participants in the baseline survey and those in the endline (Table 11, Graph 7). The endline participants showed increased knowledge of four types of contraception (IUD, male condoms, female condoms, and emergency contraception), and decreasing knowledge on the other four (pills, injectables, diaphragm, and implanon). Decreasing knowledge scores on pills, diapragms, and the implanon, however, from the baseline to the endline survey were not found to be significant.

Table 13. SRHR knowledge: Contraceptives Knowledge (% of correct answers)

Contraceptives Knowledge	(% of correct answers)		Significant (yes/no)	P-value
	Baseline (N=544)	Endline (N=533)		
Pills	49,4	44,7	no	p=0,307
IUD/spiral	14,2	23,8	yes	p=0,000
Injectable	59	36	yes	p=0,000
Diapraghm/contraceptive foam/jelly/cream	15,6	10,9	no	p=0,053
Male condoms	38,1	51,2	yes	p=0,000
Female condoms	18,2	29,8	yes	p=0,000
Implant	15,8	15,4	no	p=0,729
Emergency contraceptive (Postinor)	4,8	8,6	yes	p=0,004

Graphs 8. SRHR knowledge: Contraceptive Knowledge (% of correct answers)



There was a significant increase in SRHR knowledge from participants in the baseline study to those in the endline (measured via five questions, see Table 12; Graph 8). In relation to the modern contraceptive knowledge index, there was significant increase from baseline scores (20.4%) to endline scores (30.4%). We saw changes in relation to the SRHR index scores, with a significant decrease in participants with 'insufficient' knowledge, and a significant increase in participants with 'at least sufficient' knowledge. Participants in the endline study were three times more likely to have 'at least sufficient' SRHR knowlegde than those in the baseline study (see odds ratio). Like with the increase in HIV knowledge, UFBR may contribute to the increase of SRHR knowledge through the provision of information to the target groups, combined with other SRHR programmes in which they may have taken part.

Table 14. SRHR knowledge (% correct anwers)

SRHR Knowledge	(% of correct answers)		Change (2013-2015)	Significant (yes/no)	P-value
	Baseline (N=544)	Endline (N=533)			
Transmission of STIs (sexual transmitted infections) can happen through lip kissing	26.1	45.2	19.1	yes	p=0,000
Virginity can be assessed by looking at the way someone walks	15.4	28.3	12.9	yes	p=0,000
Pregnancy could happen although someone is having sexual intercourse once	53.9	65.1	11.2	yes	p=0,000
Pregnancy will not happen if someone clean his/her genital after he/she having sexual intercourse'	25.4	38.8	13.4	yes	p=0,000
Do you know about lesbian / gay / homosexual?	53.3	81.6	28.3	yes	p=0,000
Modern contraceptive knowledge index (correct at least 4 from 8)	20.4	30.4	10	yes	p=0,000

Graphs 9. SRHR knowledge (% correct anwers)

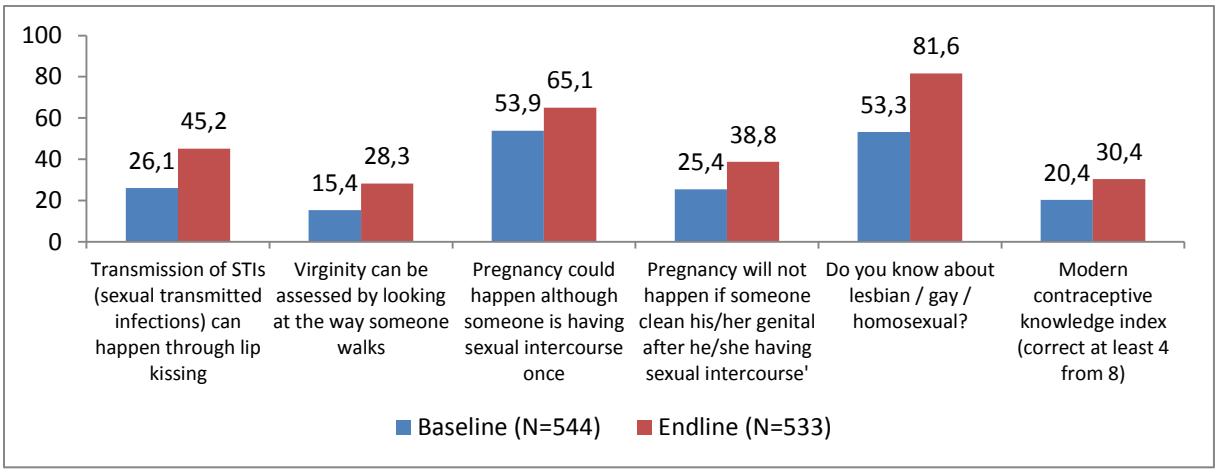
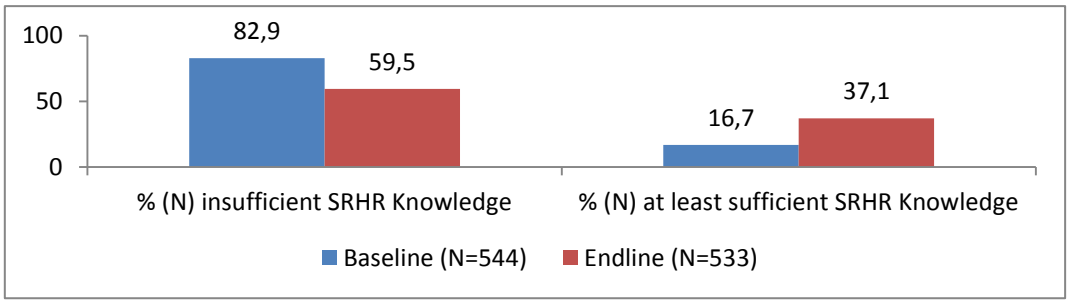


Table 15. SRHR Knowledge Index

SRHR Knowledge Index	Baseline (N=544)	Endline (N=533)	Significant (yes/no)	P-value
Insufficient SRHR Knowledge	82,9	59,5	yes	p=0,000
At least sufficient SRHR Knowledge	16,7	37,1		
Odds Ratio for At Least Sufficient SRHR Knowledge	1.0	3,1	yes	p=0,000

Graphs 10. SRHR Knowledge Index

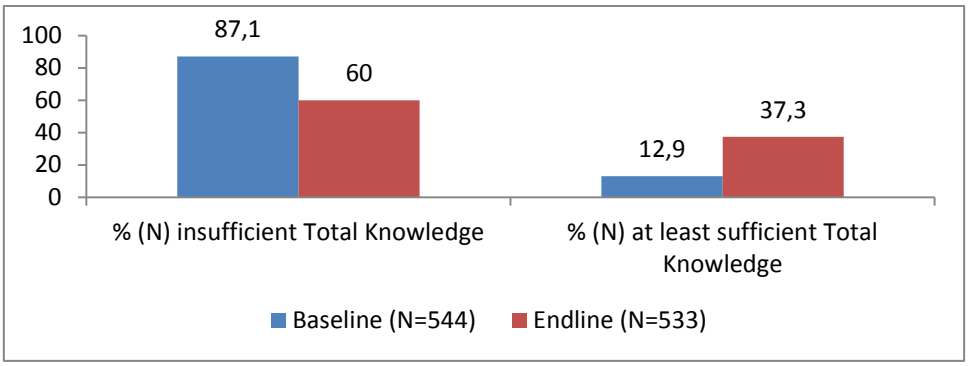


The 'total knowledge' index scores (combined HIV and SRHR knowledge scores) also increased significantly from the baseline study (12.9%) to the endline (37.3%)for 'at least sufficient' scores. The likelihood of participants in the endline have 'at least sufficient' HIV and SRHR knowledge is four times higher than participants in the baseline.

Table 16. Total Knowledge Index Score

Total Knowledge Index	Baseline (N=544)	Endline (N=533)	Significant (yes/no)	P-value
Insufficient Total Knowledge	87,1	60	yes	p=0,000
At least sufficient Total Knowledge	12,9	37,3		
Odds Ratio Insufficient vs At Least Sufficient Total Knowledge (wave)	1.0	4,2	yes	p=0,000

Graphs 11. Total Knowledge Index Score



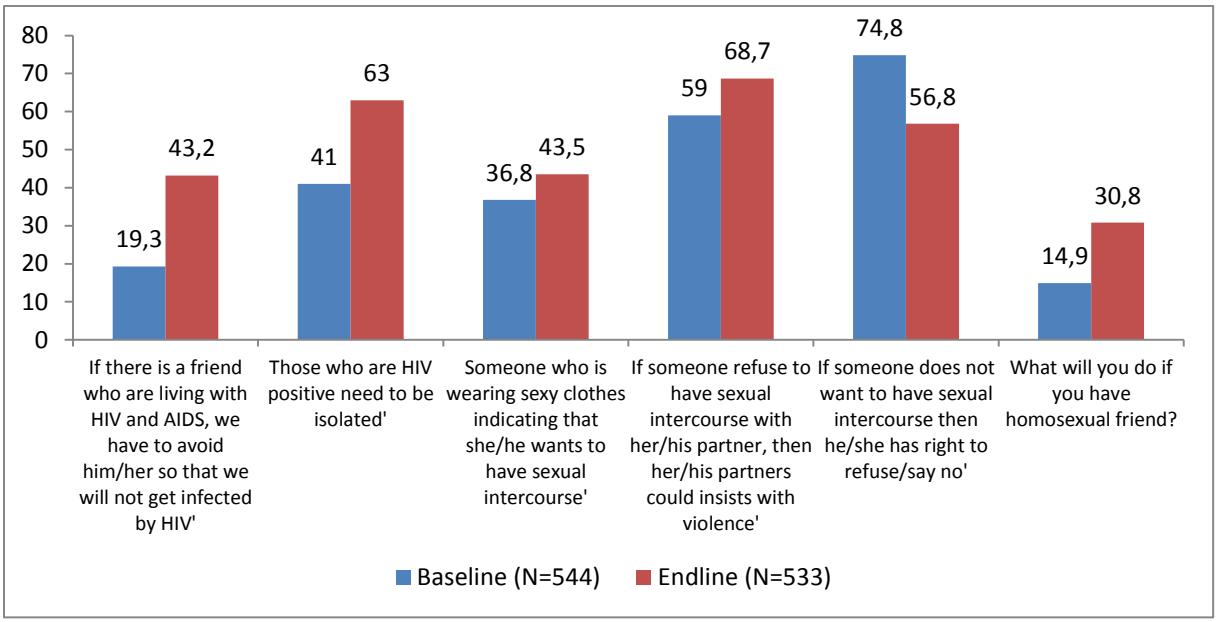
(c) Attitude

There was an increase in positive answers in 5 out of 6 attitude questions from the baseline study to the endline. Only one question related to the 'right to refuse sexual intercourse' showed a decrease in correct answers. Explanations for this unexpected finding may due to cultural norms (especially for girls, hesitant to refuse when boyfriends request sexual intercourse) that are not expanded upon by the endline OM participants. All of the changes in attitude were found to be significant. The UFBR programme may have contributed to this result, particularly the SETARA module which promotes discussion and reflection on sexuality, people living with HIV, sexual violence, and same sex attraction. The FGD results supports this, in particular regarding PLHIV and sexuality. More exposure to PLHIV (directly or indirectly) may also create positive perception among the target group.

Table 17. Attitudes to HIV and SRHR Issues (% correct answers)

Attitude	% Correct Answers		Change (2013-2015)	Significant (yes/no)	P-value
	Baseline (N=544)	Endline (N=533)			
If there is a friend who are living with HIV and AIDS, we have to avoid him/her so that we will not get infected by HIV'	19.3	43.2	23.9	yes	p=0,000
Those who are HIV positive need to be isolated'	41	63	22	yes	p=0,000
Someone who is wearing sexy clothes indicating that she/he wants to have sexual intercourse'	36.8	43.5	6.7	yes	p=0,008
If someone refuses to have sexual intercourse with her/his partner, then her/his partners could insist with violence'	59	68.7	9.7	yes	p=0,000
If someone does not want to have sexual intercourse then he/she has right to refuse/say no'	74.8	56.8	-18	yes	p=0,000
What will you do if you have homosexual friend?	14.9	30.8	15.9	yes	p=0,000

Graphs 12. Attitude to HIV and SRHR Issues (% correct answers)

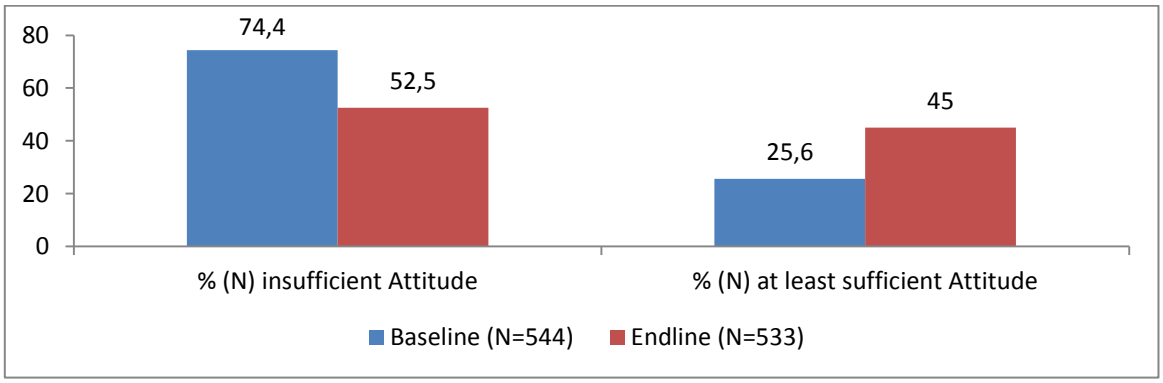


In terms of attitude index scores, there was a significant increase in participants with an 'at least sufficient' attitude from the baseline study to the endline study (table 14 and graph 14). The table also shows that participants in the endline group are two and half times more likely to have a positive attitude towards HIV and SRHR issues than participants in the baseline group; see Odds Ratio, Table 18.

Table 18. Attitude Index Score

Attitude Index Score	Baseline (N=544)	Endline (N=533)	Significant (yes/no)	P-value
Insufficient Attitude	*74,4*	*52,5*	yes	p=0,000
At least sufficient Attitude	*25,6*	*45*		
Odds Ratio for At Least Sufficient Attitude	*1.0*	*2,5*	yes	p=0,000

Graphs 13. Attitude Index Score



(d) Skills

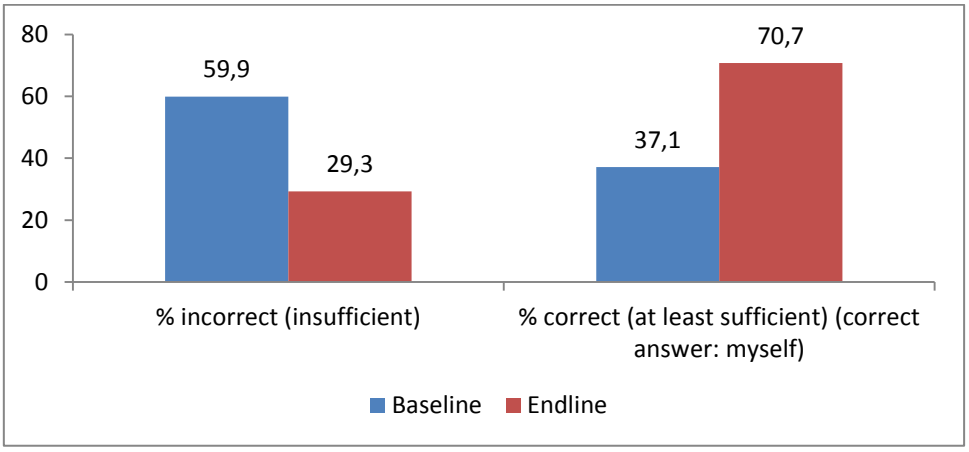
There was only one question used to assess skills both in the baseline and the endline survey; 'Who defines whether you may or may not have sexual intercourse?'(to which the correct answer is 'my self'). There was a significant decrease in incorrect answers from the baseline

survey (59.9%) to the endline (29.3%). The percentage of correct answers increased significantly from the baseline survey to the endline (37.1 to 70.7). The increased awareness surrounding consent may be due to increased education, and also the avaliability of discussion forums and other IEC activities around SRHR (including SETARA, dance4life, and also social media). This is supported by the FGD results, which are summarized in table 25 (summary of the FGD).

Table 19. Skills

SKILLS: *Who defines whether you may or may not have sexual intercourse?*	**Baseline (%)**	**Endline (%)**	**Significant (yes/no)**	**P-value**
Incorrect Response	59,9	29,3	yes	p=0,000
Correct Response	37,1	70,7		
Odds Ratio for Correct Answer	1.0	3,9	yes	p=0,000

Graphs 14. Skills



(e) Behaviour

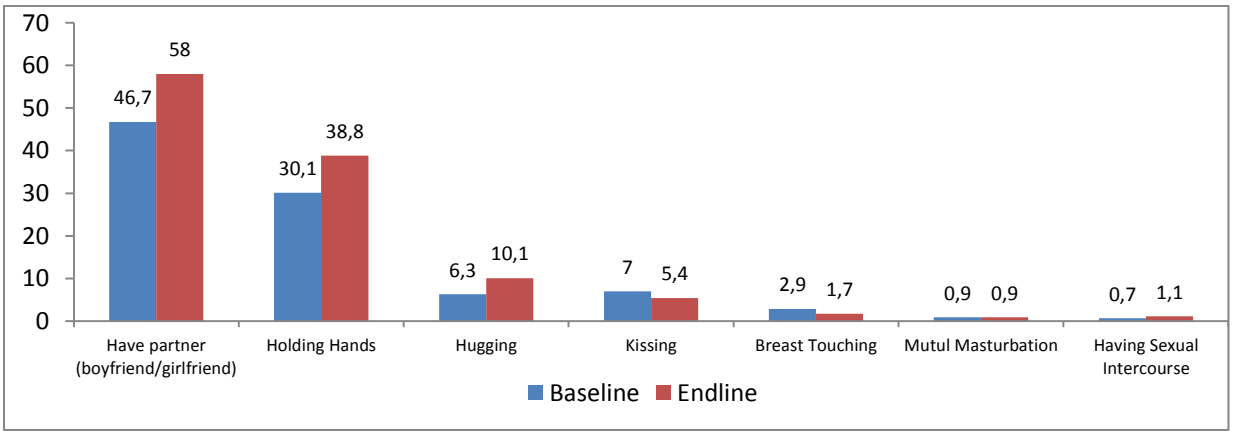
Table 20 shows that more participants in the endline survey have partners than participants in the baseline survey (58% and 46.7%, respectively), suggesting a variation in sexual behaviour between groups. Among the reported sexual behaviors among the baseline and the endline, holding hands is most common, followed by hugging and kissing. A small number of participants reported that they had engaged in breast touching, mutual masturbation and sexual intercourse. The number of participants that reported having sexual intercourse is higher in the endline survey than in the baseline (1.1% vs 0.7%, respectively).

Table 20. Behaviour

BEHAVIOUR	**Baseline (%)**	**Endline (%)**
Do you have (or ever had) a partner/boyfriend/girlfriend?	46,7	58
Have you ever done the following activities when you were with your partner?		
Holding Hands	30,1	38,8
Hugging	6,3	10,1
Kissing	7	5,4
Breast Touching	2,9	1,7

Mutual Masturbation	0,9	0,9
Having Sexual Intecourse	0,7	1,1

Graphs 15. Behaviour

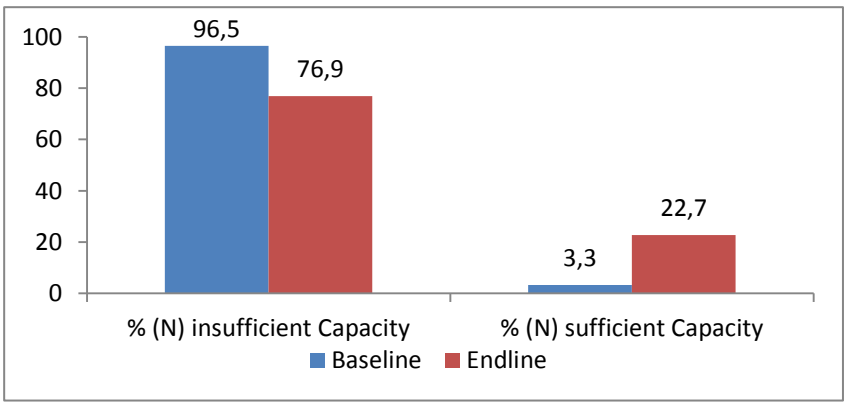


We saw a significant increase in mean SRHR capacity scores (defined as confidence, self-efficacy, empowerment, attitudes, knowledge and behaviour) from the baseline survey to the endline (see Table 21). Capacity scores were calculated from the combined index scores of the knowledge, attitudes and skills measures. Accordingly, we found an increase in participants who represented 'sufficient capacity" surrounding SRHR from the baseline to the endline survey, from 3.3% to 22.7%. The table also shows that the likelihood of endline participants to have sufficient SRHR capacity is eight and half times more than baseline participants.

Table 21. Capacity Index Score

Capacity Index	***Baseline***	***Endline***	***Significant (yes/no)***	***P-value***
Mean (SD)	*24,4*	*33,4*	*yes*	*p=0,000*
Median	*23,9*	*32,5*	*n/a*	*n/a*
Insufficient capacity	*96,5*	*76,9*	*yes*	*p=0,000*
Sufficient capacity	*3,3*	*22,7*		
Odds Ratio for Sufficient Capacity	*1.0*	*8,6*	*yes*	*p=0,000*

Graphs 16. Capacity Index Score



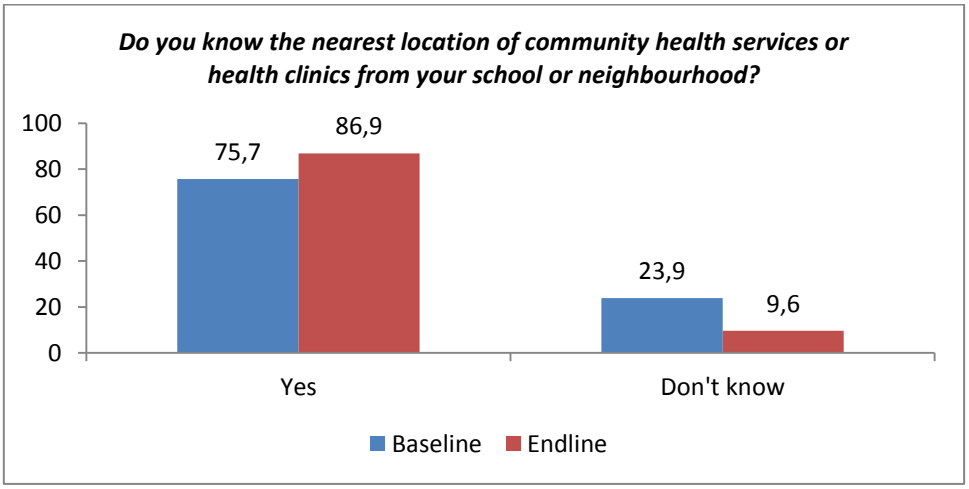
(f) Health Seeking Behaviour

More participants in the endline group knew the location of the nearest community health service (86.9%) than those in the the baseline group (75.7 %). There is smaller poportion of those who do not know the nearest location of a community health service in the endline group (9.6%) than the baseline group (23.9%). This is indicates that they may possess more information regarding community health clinics or health clinics than the target group, which the UFBR programme also disseminates through its programme activities.

Table 22. Know the nearest health facilities

HEALTH SEEKING BEHAVIOR	Baseline (%)	Endline (%)
Do you know the nearest location of community health services or health clinics from your school or neighbourhood		
Yes	75,7	86,9
Don't know	23,9	9,6

Graphs 17. Know the nearest health facilities



Although the number of participants who know the location of the nearest clinics is increasing, the number of participants that actually visit the clinics decreased from the baseline to the endline study for services surrounding HIV and SRHR (pregnancy test, HIV test, STIs test and treatment, and contraceptives and counseling). Among those who visited health clinics, most visited for general health check ups. This result indicates that participants of both the baseline and endline groups tended to visit health clinics for reasons other than HIV or SRHR related issues. However, participants in the endline group who visited health clinics were more likely to access general health services than participants in the baseline group. In relation to HIV or SRHR services, table 23 shows that participants in both the baseline and endline groups are more likely to utilize the counseling service than other HIV or SRHR services. This trend within our surveys indicates mental health or psychological problems were more common among the youth than other physical problems related to HIV or SRHR issues.

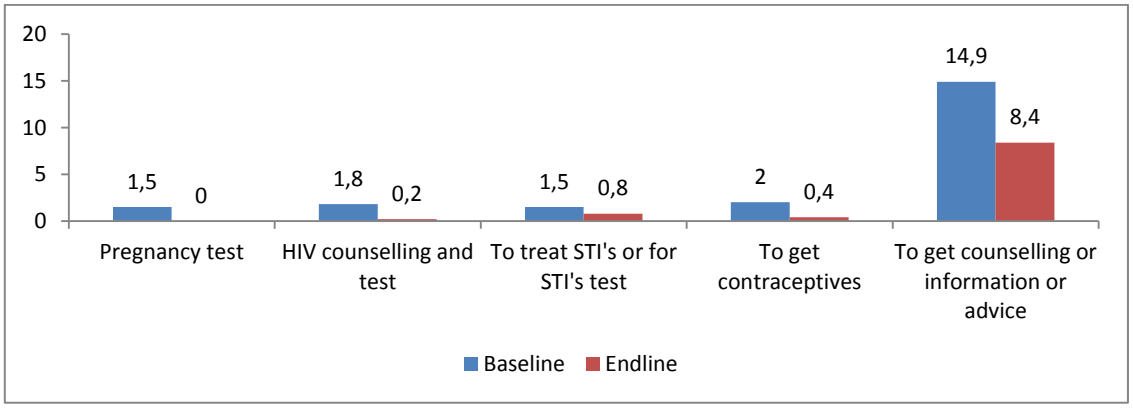
Based on discussions with the SRHR partners during our study validation meeting, these findings tie in with previous works on Indonesian (including youth) health behaviour; it is

shaped by culture and visiting health services tends mainly to occur only in the case of serious illness. This said, data from indicator 2.3a ('% increase in the use of targeted SRHR services by young people and women') indicates there has been an increase, from the baseline (2011) study to the endline study (2015), in the number of young people who are accessing health facilities. Our results did, though, find that participants in the endline group did not want to disclose (or discuss) their experiences visiting health facilities.

Table 23. Clinic Visit

Intention to Visit	***Baseline***	***Endline***
Pregnancy test	1,5	0
HIV counselling and test	1,8	0,2
To treat STI's or for STI's test	1,5	0,8
To get contraceptives	2	0,4
To get counselling or information or advice	14,9	8,4
Others (general health check up)	77,8	90,2

Graphs 18. Clinic Visit (only related to HIV and SRHR Services)

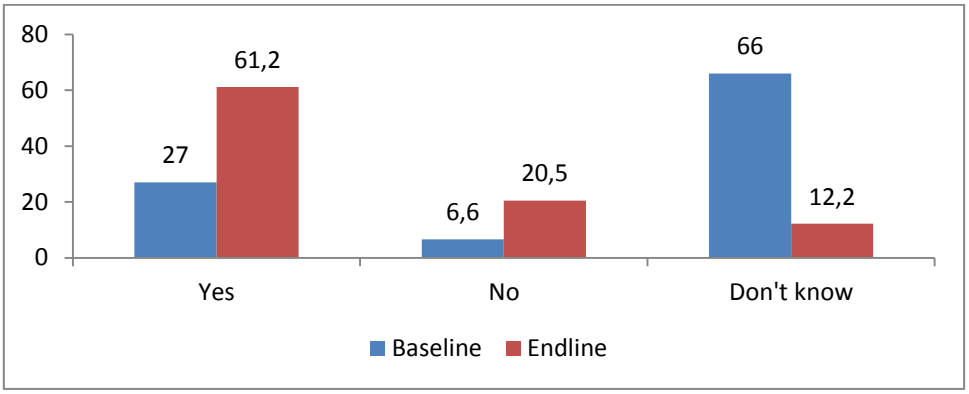


Participants in the endline group may have more information on HIV testing than participants in the baseline group. This is indicated by the decreasing proportion of participants who respond 'don't know' from the baseline study to the endline. There are more participants *willing* to undergo HIV testing in the endline group (61.2%) than in baseline (27%), however, more participants in the endline group (20.5%) do not *intend* to undergo testing than in the baseline group (6.6%). This suggests increased knowledge surrounding HIV does not always translate to increased intention undergo HIV testing, potentially because they do not feel at risk of HIV transmission. The changes in knowledge may relate to more available information, promotion and services on HIV testing - including the endorsement by Jakarta's Governor for HIV counseling and testing, which lead to various mobile events offering VCT outside the community health clinics.

Table 24. Intention to have HIV Testing

Question	Baseline %	Endline %
Do you want to conduct HIV test?		
Yes	27	61.2
No	6.6	20.5
Don't know	66	12.2

Graphs 19. Intention to have HIV Testing



(g) Results from Focus Group Discussions with Students

There were 15 FGDs conducted as part of the endline OM. Results from the FGDs are presented within the table below. The FGDs provides more in depth information related to the participants' perspective, which cannot be generalized to the survey of participants' knowledge, attitude and skills.

Table 25. Summary of the FGDs

Topic	Response
Opinions about the CSE/SRHR education	• SETARA and Dance4life are perceived as creative processes of learning among the FGDs participants. Support from schools, as well as parents and teachers, are main supporting factors for the CSE/SRHR education that they received. • Most of the FGDs participants agreed that CSE/SRHR education is important for them, as the topics are relevant with the needs of young people.
What have participants, according themselves, gained due to participation in the CSE/SRHR education	• The participants gained knowledge of HIV (how HIV is transmitted and how to prevent it) and SRHR (changes in their body; mood change and how to deal with it; risk of unprotected sex; STIs; dating violence; personal hygiene; pregnancy processes; and names of reproductive organs). • They know more about their own body and self. One participant said that he no longer feels awkward discussing reproductive health, for example, he now can say 'penis and vagina' without hesitation or feeling shy.
Have participants, according to themselves, realised changes in their	• The participants reported changes in their attitude regarding PLWH, reproductive health, and their physical and psychological development as young people. Participants also pointed out changes in behaviour.

personal lives because of the CSE/SRHR Education	For example, one participant stated that she is more motivated, while another participant said that she is now more confident and expressive in communicating her opinion. • Most of the participants pointed out SETARA and Dance4life, and the name of the partners' organization as source of information related to CSE/SRHR education. In addition, they also mentioned social media as source of SRHR information. Other participants explained that they now can discuss their personal issues through counselling services that they learned about from the programs (SETARA and Dance4life).

Result area 2 – Strengthening SRH Services

Outcome indicator 2.2a: % of targeted SRHR facilities increasing compliance with IPPF standards for youth friendly services

From this point forward, data of endline OM 2015 is compared with the UFBR baseline (2011) and the UFBR midline (2013).

There were 12 clinics that received intervention from the programme and which were assessed in the endline outcome measurement 2015. The lowest mean score (1.9) was obtained by Puskesmas Koni, a government owned clinic in Jambi, and the highest mean score (3.6) was obtained by Procare Clinic, an NGO owned clinic (PKBI) in DKI Jakarta. Overall, there were 5 clinics with mean scores under three, and they are all government owned health facilities (Puskesmas). All other health facilities obtained scores of three and above three.

Among these twelve clinics, there were six clinics that also participated to the baseline and the midline studies. Five clinics showed an increase in mean score toward the midline score, and three clinics showed an increase in mean score toward the baseline score.

In general, most of the healh facilities (excluding NGO owned clinics which have more service flexibility) obtained low scores on opening hours, accessibility for married and unmarried couple, and accessibility for payment. Therefore, although training and other forms of intervention have been conducted by partners, more advocacy work is needed to alter the situation related to these three realms.

Table 26. % of targeted SRHR facilities increasing compliance with IPPF standards for youth friendly services

	2011 Baseline	2013 Midline	Change 2011-2013	2015 Endline	Change 2013-2015	Change 2011-2015
	Mean score (range 1 - 4)	Mean Score (range 1 - 4)		Mean Score (range 1 - 4)		
Jambi:						
Puskesmas Koni	1.6	1.9	increase	1.9	no change	Increase
Puskesmas Tanjung Pinang	2.4	1.9	decrease	2.3	increase	decrease
Lampung:						
Puskesmas Susunan Baru	3.1	2.1	decrease	3	increase	decrease
Puskesmas Satelit	3.1	1.6	decrease	n.a		
Puskesmas SImpur	n.a	n.a	n.a	3.3		
Jakarta:						
Puskesmas Tebet	2.8	3.00	increase	3.3	increase	increase
PKBI DKI Jakarta (Procare clinic)	2.8	3.3	increase	3.6	increase	increase
SGBT (ardhanary) hotline	n.a	3.4	n.a	n.a		
YPI Clinic I	n.a	n.a	n.a	3.3		
YPI Clinic II	n.a	n.a	n.a	3.3		
Yogyakarta:						
Puskesmas Gedong Tengen	3.0	2.4	decrease	2.9	increase	decrease
Griya Lentera Clinic	2.5	2.4	decrease	n.a		
Puskesmas Mergangsan	n.a	n.a	n.a	2.1		
Puskesmas Tegalrejo	n.a	n.a	n.a	2.7		
Total number of facilities assessed	8 clinics 1 hotline	8 clinics 3 hotlines		11 clinics		
Total number of facilities with increased score			3	3/baseline and 5/midline		
Percentage facilities with an increased score			37.5%			

Outcome indicator 2.2b: % of SRHR facilities with an increase in satisfaction rated by young people

In 2015, satisfaction of SRHR facilities among young people were measured using exit interviews (n=84). Overall, participants were satisfied with the health facilities, with a mean score for all participants of 3.1. All facilities measured for satisfaction scored three and above three. Boys and girls within the sub group aged 15-19 were more satisfied than boys and girls within the sub group aged 20-24, while transgender within sub group aged 20-24 were more satisfied than transgender within sub group aged 15-19. The least satisfied sub group is boys aged 20-24 (mean 2.9) and the most satisfied sub group is transgender aged 20-24 (mean 3.4).

Table 27 Satisfaction of young people by age group 2015

Satisfaction with:	Boys			Girls				Transgender				Boys+Girls+Transgender			
	15-19	20-24	Total	<15	15-19	20-24	Total	<15	15-19	20-24	Total	<15	15-19	20-24	All
Information received	3.2	2.9	3.1		3.5	3.0	3.3		2.5	3.2	2.9		3.1	3.0	3.1
Medical/information received	3.3	2.8	3.1		3.3	3.2	3.3		3.0	3.6	3.3		3.2	3.2	3.2
Level of skills of service provider	2.9	2.8	2.9		3.5	3.0	3.3		3.5	3.2	3.4		3.3	3.0	3.2
Opening hours	2.7	2.7	2.7		2.8	2.6	2.7		3.5	3.6	3.6		3.0	3.0	3.0
Waiting time	3.3	3.4	3.4		2.9	3.1	3.0		3.5	4.0	3.8		3.2	3.5	3.4
Facilities in waiting room	3.0	3.0	3.0		3.0	3.0	3.0		3.0	2.8	2.9		3.0	2.9	3.0
Examination room	3.0	3.0	3.0		3.0	3.0	3.0		3.0	3.0	3.0		3.0	3.0	3.0
Price	3.3	3.0	3.2		3.7	3.3	3.5		3.0	3.2	3.1		3.3	3.2	3.3
Privacy and confidentiality	3.6	3.1	3.4		3.2	3.2	3.2		3.0	3.6	3.3		3.3	3.3	3.3
Treatment as person	3.5	3.0	3.3		3.4	3.2	3.3		3.0	3.2	3.1		3.3	3.1	3.2
Time for the consultation	3.3	2.7	3.0		3.0	2.9	3.0		3.0	4.0	3.5		3.1	3.2	3.2
Will return or not	3.3	2.7	3.0		3.4	3.2	3.3		2.0	3.8	2.9		2.9	3.2	3.1
Mean Clinic	**3.2**	**2.9**	**3.1**		**3.2**	**3.0**	**3.1**		**3.0**	**3.4**	**3.2**		**3.1**	**3.1**	**3.1**

The exit interviews were conducted on 13 clinics for the endline outcome measurement 2015. They are government owned health facilities (puskesmas) and NGO owned clinics (including Ardhanary Institute Clinic that provides counselling and consultation services, including referral). The clinic with the lowest mean satisfaction score was Puskesmas Rawasari Jambi (2.8) and that with the highest was YPI Clinic Jakarta (3.5). There were three facilities with mean scores under three, and they all are government owned facilities (puskesmas).

Interestingly, Puskesmas Koni, which has lowest mean score for the IPPF standards of YFS checklist (outcome indicator 2.2a), had a mean score of 3.1 at the endline 2015. This may indicate that there are differences in the way we perceive respondents satisfaction based of the type of checklist used.

Satisfaction among LGBT groups was explored through four FGDs. Health facilities mentioned by the participants include Puskesmas Rawasari Jambi; Puskesmas Simpur Lampung; Puskesmas Gedong Tengen; Adhiwarda (PKBI) Clinic DI Yogyakarta; Procare (PKBI) and YPI Clinic Jakarta. Most participants were accessing the clinics for VCT, STIs treatment, and consultation services. Most of the participants provided positive feedback and were satisfied with the services - including privacy and the friendliness of the health facilities' staff. They suggested improvement could be made via extended opening hours, facilities made available on weekends, and the addition of more facilities/equipment.

Overall, the mean satisfaction scores of all clinics has increased from the baseline measurement (2.7; n=8) to the midline (2.9; n=9) to the endline (3.1; n=13). Three facilities showed increased satisfaction scores from the midline survey to the endline OM; they were Puskesmas Koni, Procare Clinic (PKBI) DKI Jakarta and Puskesmas GedongTengen in DI Yogyakarta. Additionally, there were two health facilities that had increased satisfaction scores from the baseline study to the endline OM; Puskesmas Koni and Procare Clinic. Puskesmas GedongTengen's score remained the same from the baseline study to the endline.

As discussed with partners during validation meeting, cultural behaviours among Indonesian people (including youth) show they tend to only visit health facilities when they are ill or seriously ill. Those who visit health facilities tend to be satisfied or less critical regardless of services provided. Furthermore, SRHR partners perceived changes in the attitude, skills and practices of health service providers undergoing intervention (as reported through stories of changes and the validation meeting). Additionally, a system which enables SRHR screening and aggregates medical and demographic data electronically has been implemented within these clinics. This increase in positive perception may be associated with the intervention of UFBR programme that provided training and enabled/facilitated shared learning amongst partners and health clinics during the course of the programme.

Table 28. Facilities with an increase in satisfaction by young people

	2011	2013	2015	Change (increase/decrease/no change)		
	Mean	Mean	Mean	2011-2013	2013-2015	2011-2015
Jambi:						
Puskesmas Koni	1.6	2.6	3.1	increase	Increase	Increase
Puskesmas Tanjung Pinang	2.4	2.5	n.a	increase	n.a	n.a
Klinik Dara Jingga	n.a	n.a	3.4	n.a	n.a	n.a
Puskesmas Rawasari	n.a	n.a	2.8	n.a	n.a	n.a
Puskesmas Simpang 4 Sipin	n.a	n.a	2.9	n.a	n.a	n.a
Puskesmas Putri Ayu	n.a	n.a	3.2	n.a	n.a	n.a
Lampung:						
Puskesmas Susunan Baru	3.1	2.1	n.a	decrease	n.a	n.a
Puskesmas Satelit	3.1	2.8	n.a	decrease	n.a	n.a
Puskesmas Kedaton	n.a	n.a	3.1	n.a	n.a	n.a
Puskesmas Simpur	n.a	n.a	3.4	n.a	n.a	n.a
Puskesmas Sukaraja	n.a	n.a	3.0	n.a	n.a	n.a
Jakarta:						
Puskesmas Kecamatan Tebet	2.8	3.3	n.a	increase	n.a	n.a
PKBI DKI Jakarta (procare clinic)	2.8	3.2	3.4	Increase	Increase	Increase
Klinik YPI	n.a	n.a	3.5	n.a	n.a	n.a
Yogyakarta:						
Puskesmas Gedong Tengen	3.0	2.8	3.0	decrease	Increase	No change
Griya Lentera Clinic	2.5	3.1	n.a	Increase	n.a	n.a
Puskesmas Tegalrejo	n.a	n.a	2.9	n.a	n.a	n.a
Jakarta:						
SGBT (Ardhanary) clinic	n.a	3.4	3.0	n.a	Decrease	n.a
Total number of facilities assessed	8	9	13			
Total number of facilities with increased score			2	5		
Percentage facilities with an increased score			15%	62.5%		

Outcome indicator 2.3a: % increase in the use of targeted SRHR services by young people and women

In the endline outcome measurement, the number of boys that utilized the SRHR services was double that of girls. There was a significant increase in the number of young people and women who used the targeted SRHR services from the baseline study, to the midline, and to the

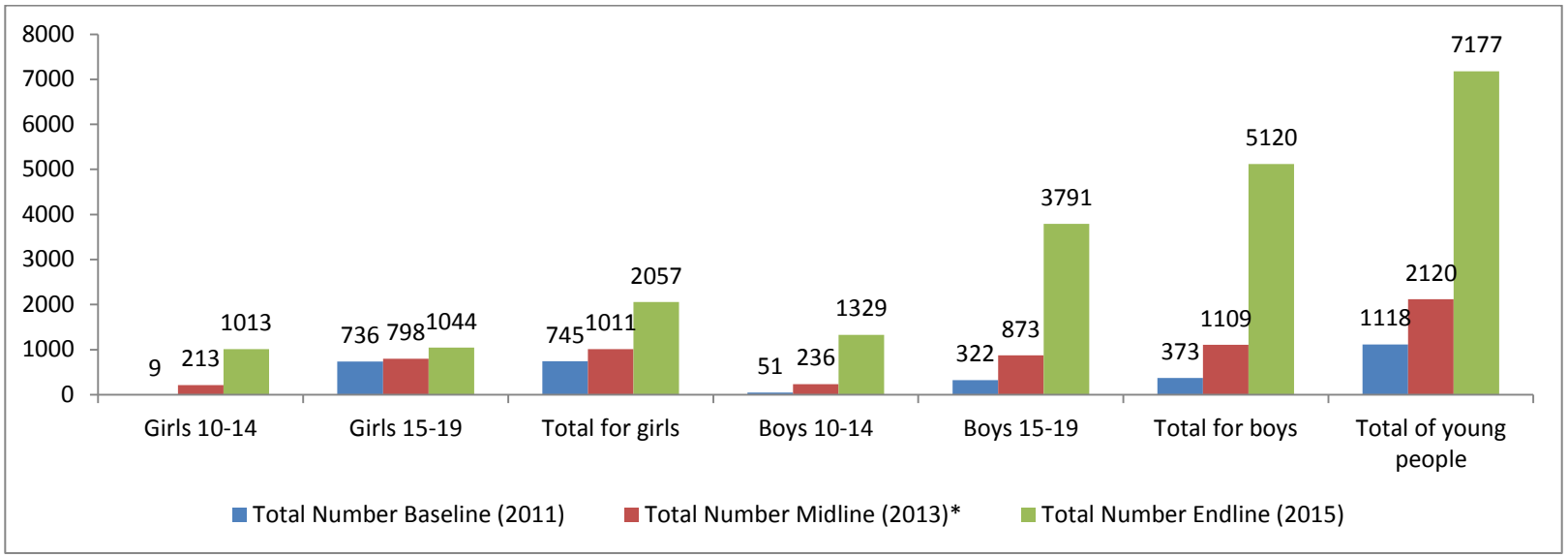
endline. The sub-group who least utilized the SRHR services in the baseline and the midline groups were girls and boys (aged 10-14), however, in the endline measure this number increased significantly. This result may indicate that there are better recording and reporting systems within the targeted health facilities (as pointed out by one of the partners during validation meeting), as well as the contribution of other programmes which brought more young people and women to the health services. A better functioning referral system among the health providers may also have influenced this result.

Table 29 SRHR service utilization among youth and female clients

Target Group	Total Number Baseline (2011)	Total Number Midline (2013)	Total Number Endline (2015)
Girls 10-14	9	213	1013
Girls 15-19*	736	798	1044
Total for girls	**745**	**1011**	**2057**
Boys 10-14	51	236	1329
Boys 15-19*	322	873	3791
Total for boys	**373**	**1109**	**5120**
Total of young people	**1118**	**2120**	**7177**
Women 24+	n/a	1194	n/a
Men 24+	n/a	2036	n/a
Total for adults	**n/a**	**3230**	**n/a**
Overall total	**1118**	**5350**	**7177**

*in 2013, the age range is 15-24 years old

Graphs 20 % increased of SRHR service utilization among youth and female clients



Outcome indicator 2.3b: % increase in number of births in targeted areas that were attended by skilled birth attendants

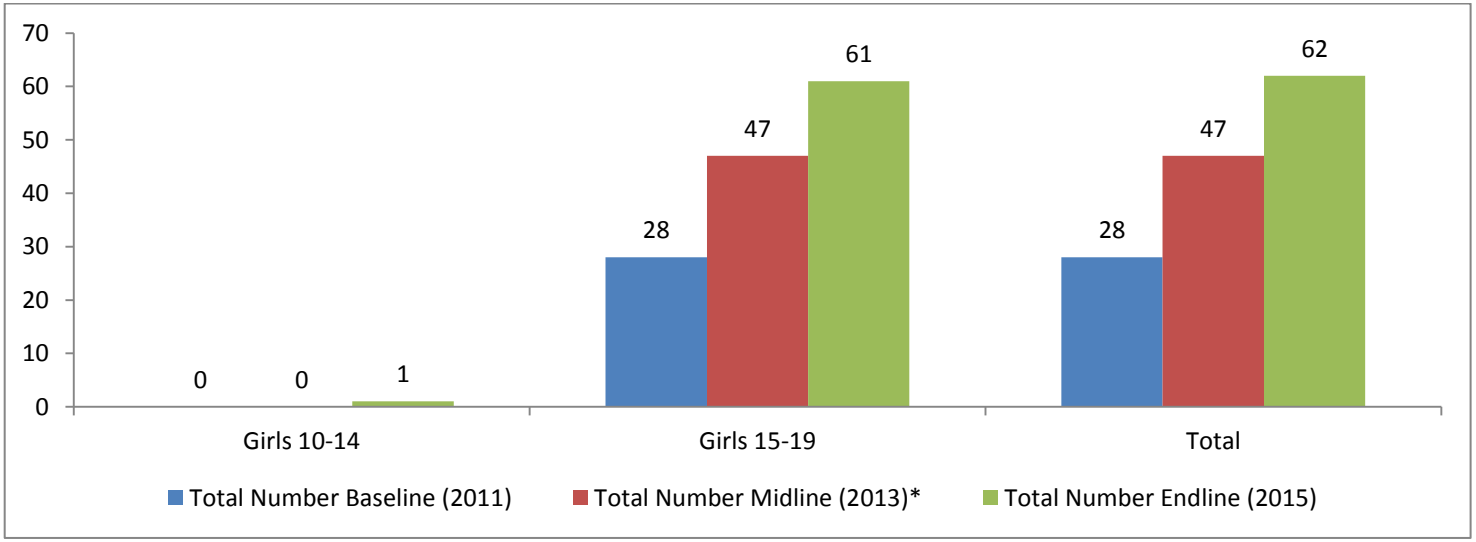
Table 30 and Graph 21 below show the number of births in the targeted areas that were attended by skilled birth attendants. The number from the baseline study to the endline for the sub-group aged 15-19 increased substantially. This overall increase may be linked to government and non-government (both at national and local level) programmes promoting Mother and Child Health that have gained increased awareness since their inclusion in the MDGs.

Table 30 Increase in number of births in targeted areas that were attended by skilled birth attendants

Target Group	Total Number Baseline (2011)	Total Number Midline (2013)*	Total Number Endline (2015)
Girls 10-14	0	0	1
Girls 15-19	28	47	61
Total	**28**	**47**	**62**

*in 2013, the age range is 15-24 years old

Graphs 21 Increase in number of births in targeted areas that were attended by skilled birth attendants



Outcome indicator 2.3d: Number of facilities with increased availability of contraceptives, ART, & antibiotics

In the endline outcome measurement, there were 10 health facilities assessed regarding availability of condoms, contraceptives other than condoms, HIV testing, ARVs and antibiotics. The assessment is was scored as follows:

4 = never out of stock
3 = out of stock only once a year
2 = out of stock more than once a year
1 = the contraceptives/condoms/HIV test/ARVs/Antibiotics are not available most of the time (more than 9 month a year)
0 = the contraceptives/condoms/HIV test/ARVs/Antibiotics are never available

Contraceptives and condoms were always available within all of the health facilities. HIV testing was always available at six health facilities and sometimes not available at two facilities (among the 8 health facilities that provide HIV testing). None of the three clinics that provide ARVs

have ever run out of stock. Antibiotics are always available within seven health facilities, and sometimes not available in one clinic. While condoms and other contraceptive were always available, it is important to note that young people still facing barriers in accessing them.

In comparison to the baseline measure (table 31), there were three health facilities whose stock condition remained stable; Procare Clinic, Puskesmas Koni Jambi and Puskesmas Susunan Baru Lampung. Improvements were found in Puskesmas Gedongtengen DI Yogyakarta and Puskesmas Tanjungpinang Jambi, where HIV testing is now is available.

Table 31 Stock Out Table 2015

Health Facilities	Contraceptive other than condom	Condom	HIV test	ARV	Antibiotics	Note
DI Yogyakarta						
Puskesmas Mergangsan, DI Yogyakarta	4	4	3	0	3	
Puskesmas Tegalrejo, DI Yogyakarta	4	4	4	4	4	
Puskesmas Gedongtengen, DI Yogyakarta	4	4	3	0	4	
DKI Jakarta						
Procare Clinic	4	4	4	0	4	
YPI I Clinic	4	4	4	4	0	
YPI II Clinic	4	4	4	4	0	
Jambi						
Puskesmas Koni	4	4	0	0	4	
Puskesmas Tanjungpinang	4	4	4	0	4	
Lampung						
Puskesmas Simpur	4	4	4	0	4	
Puskesmas Susunan Baru	4	4	0	0	4	

Table 32 Stock out 2015 in comparison to 2011

	Contraceptives	HIV test	ART	Antibiotics
Improvement Puskesmas Gedongtengen DI Yogyakarta 2015 compared to baseline?	Remain similar	Yes	n.a	Remain similar
Improvement Procare Clinic DKI Jakarta 2015 compared to baseline?	Remain similar	Remain similar	n.a	Remain similar
Improvement Puskesmas Koni Jambi compared to baseline?	Remain similar	Remain similar	n.a	Remain similar
Improvement Puskesmas Tanjung Pinang Jambi compared to baseline?	Remain similar	Yes	n.a	Remain similar
Improvement Puskesmas Susunan Baru compared to baseline?	Remain similar	Remain similar	n.a	Remain similar
Nr. of facilities with Improvement in 2015 (N= 5)	-	2	n.a	-
% of all health facilities assessed	-	40%	-	-

Outcome indicator 2.3e: % increase in utilization of gender based violence services among female clients

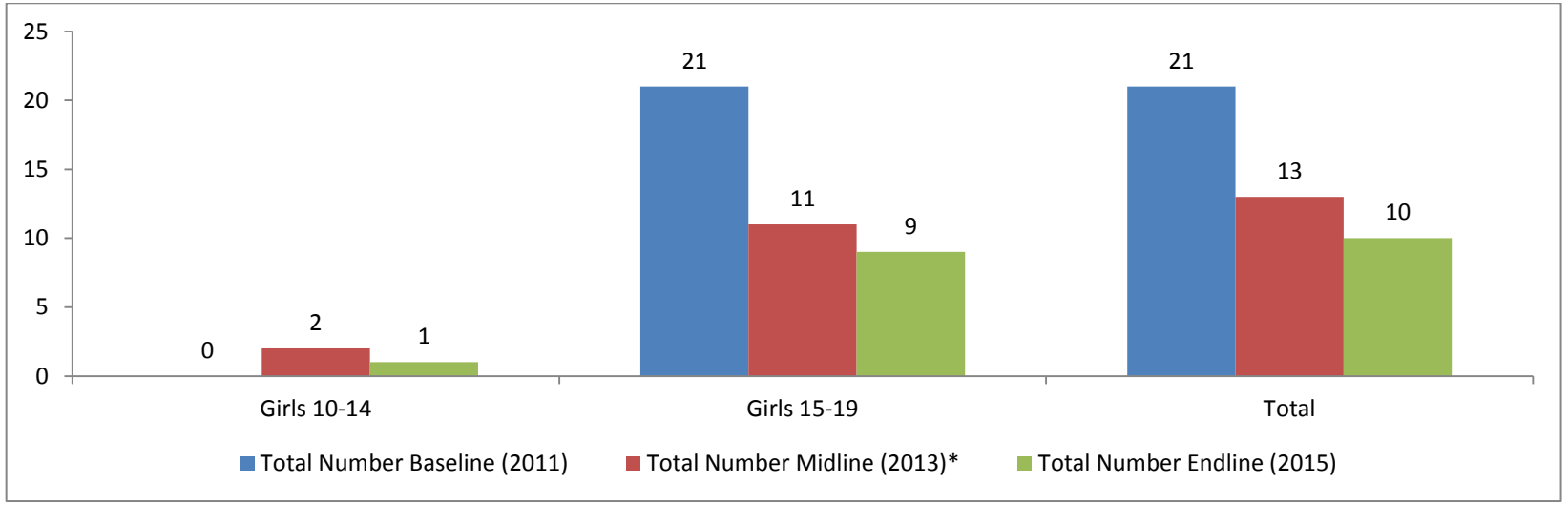
Our data (table) shows that the number of women utilizing GBV services from the baseline in 2011, to the midline 2013, to the endline OM in 2015 is decreasing. This may be due to reduced availability of GBV services or other factors that limit girls accessing GBV services, such as; low awareness of GBV, lack of perceived services and follow ups, or stigma surrounding GBVs (especially for young girls). There also appears to be less intervention on GBV services (or integration of GBV-HIV/GBV-SRHR) conducted by partners - in comparison to HIV and other SRHR intervention. For example, SETARA module (for 7th and 8th grade) addresses gender and dating violence in different chapters, and the relationship between dating violence and gender (and also HIV) is not explored or discussed further. Previously, GBV was seen as a separate issue to HIV or other SRHR programmes and has only recently become an important focus of HIV and SRHR responses in Indonesia. Within the Indonesian health system, however, HIV, SRHR and violence against women are still all managed by different ministries. The UFBR program needs to ensure more effort is made to integrate these issues in the future, particularly if linked with the decreased consent awareness score presented earlier within this report ('If someone does not want to have sexual intercourse then he/she has right to refuse/say no').

Table 33 Increase utilization of gender based violence services among female clients

Target Group	Total Number Baseline (2011)	Total Number Midline (2013)	Total Number Endline (2015)
Girls 10-14	0	2	1
Girls 15-19	21	11	9
Total	**21**	**13**	**10**

***data source: secondary data of services - Support for youth victims of sexual violence**

Graphs 22 Increase utilization of gender based violence services among female clients



Result area 2 – Improved enabling environment on SRHR

Outcome indicator 2.4a: SRHR policies and legislation implemented, changed, or adopted at local, institutional or national level, at least 2 per country

SRHR policies and legislation implemented, changed or adopted at local institutional or national level, at least 2 per country.

Most partners conduct SRHR advocacy work on various levels. The aim of advocacy work is to ensure local governments support the provision of CSE/SRHR education within targeted schools/communities and supports YFS within the targeted health services (and program related activities). The UFBR program contributed to the establishment of local forums and networks, as well as increased the capacity of young people to advocate for SRHR issues - which lead to changes in regulation (such as in DI Yogyakarta, DKI Jakarta, and Lampung) and partner involvement. In terms of budget allocation, there has been support from the local government towards CSE/SRHR education and/or provision of YFS within Puskesmas in DKI Jakarta, Makassar and Pati, Lampung and Jambi. The funding, though, remains ad-hoc and limited to partial activities/regions. Some partners have been focusing on internal mainstreaming of youth SRHR within their organization, such as PKBI East Java and CD Bethesda, resulting in changes in organization governance and attitudes/behaviour toward particular issues, i.e. sexual diversity and SOGIE/LGBT related issues. As yet, there have been no particular changes in national policy related to CSE and YSF. During the validation meeting partners acknowledged that there is no singular advocacy plan or design among the one vision alliance members, which leads to scattered, localized and pragmatic advocacy efforts conducted separately by each partner. Table 32 below shows the advocacy activities and the changes that have been achieved.

Table 34. Stepping stones towards policy and legislation change for CSE/SRHR education & YFS

Institution	Agenda setting	Policy Influencing
YPI	• Formed and established *Forum Guru Kesehatan Reproduksi* (Reproductive Health Teachers, a forum for SETARA and DAKU teachers) in 2014. • Formed and established Youth Forum YPI (YFYPI). YFYPI provided input within the set up stage of Youth Clinic at national level hospital in Jakarta, RSAB Harapan Kita. • Through *Musyawarah Guru Bimbingan Konseling/MGBK* (association of counselling tearchers), *Forum Guru Kesehatan Reproduksi* (Reproductive Health Teachers) Badan Pemberdayaan Masyarakat dan Perempuan dan Keluarga Berencana/BPMPKG (Community & Women empowerment & Family Planning Body), Provincial Health Office and National Family Planning Body, YPI with Aliansi Satu Visi advocate for: • Integration of DAKU and SETARA to schools which have *Pusat Informasi dan Konseling Remaja/PIK-R* (a government information and counselling program for young people reproductive heatlh); • Comprehensive SRHR module to Ministry of Education	• Sustainability of CSE through PIK-R in some schools that were supported by local government budget (APBD) through BPMPKB.
PKBI DKI Jakarta	• *PKBI* DKI Jakarta advocate for City Health Office and Community Health Centres to comply with the Governor decree on reproductive health (No. 31/2013). • *In* 2014, conducted advocacy to National Family Planning Board (BKKBN) and Ministry of Health regarding meaningful youth participation.	• *Circular* Letter of Provincial Government DKI Jakarta No. 17/SE/2014 regarding *Pelayanan Kesehatan Peduli Remaja/PKPR* (government innitiative for Youth Friendly Services). Within this letter, PKBI and YPI are acknowledged as NGOs focusing on youth SRHR and appointed to provide training, counseling services and other collaboration work with 10 puskesmas in Jakarta. The Circular letter promotes puskesmas to collaborate with PKBI DKI Jakarta in providing SRHR information and services. Moreover, there is visible shift of Jakarta health office's attitude toward adolescent SRHR, as attention and support toward PKPR (government's adolescent reproductive health programme) is increasing significantly. • Both National Family Planning Board (BKKBN) and Ministry of Health are now involving PKBI and youth

		representatives within their program planning.
ARI	• In 2013, providing input to Ministry of Health re Pelayanan Kesehatan Peduli Remaja/PKPR (government innitiative for Youth Friendly Services) guidelines. • In 2013, ARI Makassar Branch able to access local government fund for their activities. • In 2014, ARI Pati Branch is joining BPMPKB and able to access government fund. • In 2015, ARI, on behalf of ASV, advocate for inclusion of CSE into school curriculum. However it is challenging as competing issues brought by different parties are to be included in the curriculum. CSE is still advised to be part of extracurricular activities.	
Ardhanary Institute/AI	• In 2011, joining ASV. ASV is used by AI to mainstream LBT issues and to integrate SRHR and LBT advocacy. SOGIE issues are then included in the YFS curriculum. LBT crisis center established, aimed to provide counselling services and referral for LBT clients. • Internally, SRHR is mainstreamed within AI as SRHR of LBT becomes one of the focuses within the 2012-2015 AI's strategic planning. • In 2012, together with GWL INA, collected and documented violence against LGBTI cases, with support from National Women Commission (Komnas Perempuan).	• National Women Commission (*Komnas Perempuan*) within their general meeting in 2012 acknowledged the term *perempuan sosial* or social female to accomodate male to female transgender representative.
PKBI East Java	• Internal mainstreaming of young people SRHR within PKBI East Java, especially PKBI Pamekasan Branch and Jombang Branch. • Jombang Branch now accepts and implements youth SRHR through its youth clinic, Pamekasan Branch now supports LGBT community by conducting, organizing, outreaching and providing services to the LGBT community.	• (internal policy influencing) Integration of existing partner clinic with youth center.
PKBI DI Yogyakarta	• Developed and established 'Youth Friendly Consortium' in Yogyakarta aiming for referral system of specialized SRHR services such as VCT, safe abortion and shelter for GBV cases PKBI DI Yogyakarta). • Formed/established Youth Forum. Youth forum is also functioning as a youth advocate (YOUTHA) to bring forward gender based violence issues, in particular advocating school break for female students with unintended pregnancy. • Developed and established Techer Forum in DI Yogyakarta.	• DI Yogyakarta's Governor Decree regarding 'school break' for female students with unintended pregnancy so that they can continue their education after giving birth. • Although City Education Office is reluctant to the provision CSE/SRHR education in schools, the teachers are still including CSE within their learning subjects. • Kulon Progo Regent Decree (in DI Yogyakarta) #274/A/2015 regarding Establishment of team to develop

	• In Kulon Progo, SETARA is used as reference in the development if SRHR modul for elementary school, junior high school and senior high school. • Strengthening of *Perhimpunan Perempuan Pekerja Seks Yogyakarta/P3SY* (association of female sex workers in Yogyakarta) by developing Community Crisis Center (CCS)	'Reproductive Health book' for elementary schools & madrasah ibtidaiyah (Islamic school equal to elementary school), junior high schools & madrasah tsanawiyah (Islamic school equal to junior high school), and senior high schools (Islamic school equal to senior high school). • P3SY CCS now has assistance mechanism for violent cases and referral to health services supported by Rifka Anissa (local NGO working on violence issues), LBH Yogyakarta and LBH APIK (NGOs providing legal aid to community). • (internal policy influencing) Representation of 20 per cent young people (representing community of young sex workers, young LGBT, and students) in partner's advisory board (PKBI DI Yogyakarta).
CD Bethesda DI Yogyakarta	• Becoming part of ASV. • Internally: Changing perspective and skills of staff, including health staff, regarding youth SRHR issues through capacity building activities.	• Establishment of youth friendly clinic at Bethesda Hospital (Sifra Clinic) which will be starting in November 2015.
PKBI Lampung	• Advocate the local government (the Local Education Office, the Local Religious Office) regarding provision of CSE/SRHR education in junior and senior high school including religious based school as well as local government support on CSE program. • Advocate the Local Health Office to give recommendation and support to youth friendly services in puskesmas, including services for young LGBT. • Adcovate the inclusion of 'sexual and reproductive health education through formal or informal approach' as one strategy of HIV response into HIV local regulation (Lampung HIV local regulation No.1/2013).	• Support from the Local Education Office and Local Religious Office for SRHR education as extracurricular program. Moreoever, Local government (Metro city) allocated some of their local budget for teacher training on SRHR issues. • Support from the Local Education Office of the provision of FYS in Puskesmas. Support from Puskesmas to provide YFS to young people, including LGBT community. • The final/official signed version of the Lampung HIV local regulation (No.1/2013) mentioned 'sexual and reproductive health education through formal or informal approach' as one strategy of HIV response in Lampung.
PKBI Jambi & SIKOK	• Advocate the Local Education Office and schools' headmasters to gain permission to implement sexual and reproductive education in senior and junior high schools in Jambi. • Advocate the Local Health Office and Puskesmas regarding provision of YFS including LGBT friendly services. • Internal mainstreaming of youth SRHR in PKBI Jambi and SIKOK.	• Local support from the local education office together with the schools. • Local Health Office and Puskesmas commitment to providing YFS in Jambi. • Puskesmas have initiated capacity building activities for SRHR issues with their own funds.

		• PKBI and SIKOK is now prioritizing young people: there is now organizational regulation developed to ensure meaningful involvement of young people (30%) within PKBI and SIKOK. • Both PKBI Jambi and SIKOK are outreaching to a wider LGBT community at the moment, and have developed their networks (from HIV focused to broader relevant issues of SRHR). • Respect to sexual diversity is included into PKBI gender mainstreaming strategy, within PKBI Jambi's strategic planning.

Table 35. Policy and legislation changes

Institution	Extent to which the advocacy issue is taken up in policy documents and speeches of officials at local, national and/or international levels	Extent to which budget allocation has been obtained for the advocacy topics at local or national level	Extent to which the alliance advocacy has resulted in demonstrable institutional reforms, law enforcement and its effective implementation
YPI	n.a	Local/segmented (local budget for schools supported by BPMPKB)	n.a
PKBI DKI Jakarta	Circular letter	n.a	n.a
ARI	n.a	Local/segmented (ad hoc funds to ARI branch only)	n.a
Ardhanary Institute	n.a	n.a	n.a
PKBI East Java	n.a	n.a	n.a
PKBI DI Yogyakarta	DI Yogyakarta Governor Decree & Kulon Progo Regent Decree	n.a	n.a
CD Bethesda	n.a	n.a	n.a
PKBI Lampung	Lampung HIV local regulation No.1/2013) that include 'Sexual and Reproductive Health education'.	Local/segmented/one-off activity fund (Metro City fund for SRHR training)	n.a
PKBI Jambi	n.a	Local/segmented (Puskesmas own fund for SRHR capacity building activities)	n.a

Outcome indicator 2.4b: Increased involvement of community leaders in realisation of SRHR in x% of the targeted communities.

In contrast to the baseline and the midline surveys that are focused on knowledge, involvement and acceptance, the endline survey is focused on involvement, acceptance and support. The 9 points assessed are as follows: presence at SRHR and HIV meetings/discussions; providing input during the meetings; supporting SRHR programmes with resources; providing opinions related to SRHR & HIV; involvement in meetings related to puberty; involvement in 'sex before marriage' meetings; involvement in discussions related to taboo issues (condoms/sexuality); involvement in GVB in youth discussions; and involvement in youth LGBT discussions.

Most of the community leaders interviewed in 2015 show moderate (scores 3-5) to high involvement in SRHR activities (table 36 below). Only two people obtained scores under 3 (a youth movement coordinator and a representative of commission of youth empowerment), likely as their works are not directly related to youth SRHR education and services. The lowest involvement scores are related to taboos and LGBT topics.

Table 36. Community Leaders Support and Involvement 2015

Roles in Community	Presence	Inputs	Supports	Opinion	Puberty	Sex before married	Taboo	GBV	LGBT	Mean
1. Headmaster of Junior High School 24 Kota Jambi	4.0	4.0	4.0	4.0	1.0	2.0	4.0	3.0	1.0	**3.0**
2. Head of Health Promotion, DHO, Jambi	5.0	5.0	4.0	2.0	4.0	4.0	3.0	4.0	2.0	**3.7**
3. Head of Youth Program, DHO, Jambi	4.0	5.0	5.0	4.0	4.0	4.0	4.0	3.0	2.0	**3.9**
4. Head of DHO Jambi	4.0	4.0	5.0	5.0	5.0	5.0	5.0	2.0	2.0	**4.1**
5. Parliamentarian DPRS Jambi City (Health and Social)	3.0	3.0	3.0	3.0	3.0	3.0	3.0	4.0	3.0	**3.1**
6. Youth Movement Coordinator, Pamflet, DKI Jakarta	4.0	3.0	5.0	4.0	2.0	1.0	1.0	2.0	3.0	**2.8**
7. Parliamentarian D Commission DRPD Kota Bandar Lampung	3.0	5.0	5.0	4.0	3.0	1.0	2.0	2.0	2.0	**3.0**
8. Head of PKBI Branch Yogyakarta City	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	**5.0**
9. ObsGyn doctor Yogyakarta	4.0	4.0	4.0	4.0	4.0	4.0	1.0	4.0	4.0	**3.7**

10. Head of Tegalrejo Puskesmas Yogyakarta	4.0	4.0	4.0	1.0	4.0	4.0	4.0	2.0	2.0	**3.2**
11. Commision Young People Empowerment DKI Jakarta	2.0	2.0	3.0	2.0	1.0	2.0	2.0	2.0	2.0	**2.0**
12. Headmaster of SMP Kota Bandar Lampung (& head of teachers association)	4.0	4.0	5.0	3.0	5.0	5.0	1.0	4.0	3.0	**3.8**
13. Head of DHO, Bandar Lampung city	4.0	3.0	3.0	3.0	2.0	4.0	2.0	2.0	4.0	**3.0**
14. Head of Women Empowerment Yogyakarta	5.0	4.0	5.0	4.0	3.0	4.0	4.0	4.0	3.0	**4.0**
15. District Education Office Bandar Lampung	5.0	4.0	4.0	5.0	4.0	1.0	1.0	2.0	3.0	**3.2**
16. Counselling Teacher Jakarta	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	5.0	**5.0**
Mean per topic	**4.1**	**4.0**	**4.3**	**3.6**	**3.4**	**3.4**	**2.9**	**3.1**	**2.9**	**3.5**

Table 37 contrasts the involvement of community leaders in 2011, 2013 and 2015. Among 16 community leaders interviewed in 2015, there are 10 that can be compared to the baseline; 9 stakeholders show decreasing involvement and one stakeholder shows similar involvement from the baseline to the endline. The comparison is made based on the role of the stakeholders, as partners reported there was a high turnover of the stakeholders that were interviewed during the baseline and the midline. Mostly, scores depicting involvement have decreased (which is associated with new people filling the same role, resulting in the need for partners to re-approach them), except the score of a counselling teacher in Jakarta which remained steady. However, as explained earlier, even the decreased involvement scores are generally above three, which still indicates moderate to high involvement.

Table 37 Involvement of community leaders in 2011, 2013, 2015

Community	Level of involvement			Difference (INCREASE / DECREASE / NO CHANGE		
	2011	2013	2015	2013 - 2011	2015-2013)	2015-2011
Jambi						
Head of Senior High School. Jambi	5.0	n.a	3.0	n.a	n.a	DECREASE
Head of District Education Office (Jambi City)	1.0	2.6	n.a	INCREASE	n.a	n.a
District Health Office (Jambi City)	5.0	3.4	4.1	DECREASE	INCREASE	DECREASE
Local Parliament (Commission IV/Social & Health), Jambi	3.8	n.a	3.1	n.a	n.a	DECREASE
BKKBN Jambi	n.a	2.4	n.a	n.a	n.a	n.a
Lampung						

District Health Office (Bandar Lampung City), Lampung	4.0	2.7	3.0	DECREASE	INCREASE	DECREASE
Local Parliament (Commission D/Social & Health), Lampung	3.8	3.9	3.0	INCREASE	DECREASE	DECREASE
District Education Office, Lampung	3.8	3.8	3.2	NO CHANGE	DECREASE	DECREASE
Head of SMPN,1 Bandar Lampung/Head of School Principle Association (MKKS), Lampung	4.3	3.1	3.8	DECREASE	INCREASE	DECREASE
Jakarta						
Head of Health Centre, Jakarta	4.0	4.7	n.a	INCREASE	n.a	n.a
Community Youth Board, Jakarta	4.5	3.8	2.8	DECREASE	DECREASE	DECREASE
Counselling Teacher, Jakarta	5.0	n.a	5.0	n.a	n.a	NO CHANGE
Teacher, Jakarta	5.0	4.0	n.a	DECREASE	n.a	n.a
Province Health Office	n.a	3.9	n.a	n.a	n.a	n.a
Yogyakarta						
Gynaecologist Yogyakarta	4.5	4.7	3.7	INCREASE	DECREASE	DECREASE
The Wife of Yogyakarta City Mayor, Yogyakarta	2.8	2.7	n.a	DECREASE	n.a	n.a
Senior doctor, Yogyakarta	4.0	4.3	n.a	INCREASE	n.a	n.a
Local Parliament (Province & District), Yogyakarta	4.3	2.3	n.a	DECREASE	n.a	n.a
For LBT (Jakarta only)						
Religion Leader (Christian), Jakarta	4.5	4.4		DECREASE	n.a	n.a
Religion Leader (Moslem), Jakarta	5.0	4.3		DECREASE	n.a	n.a
National Parliament, Jakarta	1.8	3.1		INCREASE	n.a	n.a
Media Feminism, Jakarta	4.3	5.0		INCREASE	n.a	n.a
Religion Leader (Christian), Jakarta	4.5	3.6		DECREASE	n.a	n.a
Nr of communities with increased score				**7**	**3**	**0**

Outcome indicator 2.4c: Increased acceptance of SRHR at community level in x% of the targeted communities

Similar to previous indicators related to involvement, we have seen an increased acceptance of youth SRHR information and services by stakeholders and community representatives. However, their acceptance is selective, with the main focus on protecting young people from reproductive risks (including HIV) and unplanned pregnancy. Discussions related to puberty and GBV remained moderate, while acceptance toward taboo subjects such as condoms, sexuality, and LGBT issues is lower. Collective conservative norms and values related to sexuality (and heteronormativity) are still strong and dominating the perspective of stakeholders and community representatives. Similar to the previous indicator, it is important to note that whilst the targeted community role or stakeholder position remained the same, the actual person

interviewed during the baseline, midline and endline may have been different to a high turnover rotation. This makes comparison of the longitudinal results somewhat unreliable.

Table 38 Aggregated data on country level about the increased acceptance of SRHR

Name of Community and respondent group	Increased acceptance	Remained similar	Decreased acceptance
1. Head of Senior High School Jambi			√
2. Head of District Health Office, Jambi			√
3. Head of District Health Office Bandar Lampung			√
4. Head of Local Parliament (Commision D, Social & Health) Bandar Lampung			√
5. District Education Office, Bandar Lampung			√
6. Head of School Principle Association (MKKS), Bandar Lampung			√
7. Community Youth Board, DKI Jakarta			√
8. Counsellor Teacher, DKI Jakarta		√	
9. Gynaecologist, DI Yogyakarta			√
Total score			

From the qualitative data (this includes in depth interviews and stories of changes), the various changes perceived by stakeholders have been attributed to the UFBF programme and intervention (presented in the table below). The programme has promoted discussion surrounding sexuality and highlighted the role of stakeholders and partners in the provision of quality youth SRHR information.

Narrative information related to the outcome and how the programme contributed to these

Increased acceptance	**1. What are the main changes you have noticed?** *a. In School:* • Integration of SRHR topics to weekly meetings every Friday (Yasinan) • Integration of CSE to Counselling and Guidance (*Bimbingan Konseling/BK*) in BK subject, one hour per week • Dissemination and campaign of SRHR within head of schools forum *b. Education Office:* • Involvement and support to SRHR information sessions and encouraging Counselling and Guidance (*Bimbingan Konseling/BK*) teachers to conduct SRHR education within their sessions *c. Health Office:*

	• Supporting and developing PKPR Puskesmas through cross sector collaboration • Coordinating with planning & training division regarding SRHR training and promoting SRHR to religion based schools (pesantren) – Jambi • Supporting and promoting PKPR puskesmas to provide VCT services – Bandar Lampung *d. Community Youth Organization:* • Active involvement at the Judicial Review of Indonesian national education regulation/*UU Sistem Pendidikan Nasional N0. 23 tahun 2003* (inclusion of CSE into schools' curriculum) *e. Gynaecologist doctor:* • Supporting SRHR topic to be included in medical school curriculum *f. Head of Puskesmas:* • Promotion of SRHR information and services to cross sectors/multistakeholders at regular meetings, and become the resource base within SRHR information sessions, based on needs/invitation from other organizations. **What has been the role of the programme?** Mostly, the stakeholders were involved in/invited to various activities (e.g. campaign, meetings, information sessions, program/services launching, trainings etc) conducted by partners that discussed SRHR issues. Some of these activities are associated directly with UFBR, as well as other programmes.
Remained Similar	**What has been the reason for not reaching any change?** Things that remained similar are include issues related to puberty and gender based violence. **What has been the role of the programme?** These issues have been introduced by the program, however puberty and GBV are not always discussed within every SRHR related meeting/activity, as these issues were not directly related to most of the stakeholders' interest, roles and responsibilities (except the health office, health of puskesmas and gynaecologist).
Decreased acceptance	**What has been the reason for a decreased acceptance in SRHR?** Topics with lower acceptance include condoms, sexuality and LGBT issues. **What has been the role of the programme?** The programs have brought forward issues related to condoms, sexuality and LGBT, however, strong conservative norms and values among stakeholders are still evident.

Conclusion and Recommendation

Conclusion

Based on the core indicators higlighted in the 2015 Outcome Measurement for Unite for Body Rights, (UFBR) some conclusions can be drawn as follows:

- HIV general knowledge has increased from the baseline study to the endline. SRHR knowledge has also increased, including knowledge of modern contraceptives. In relation with attitude, the endline participants had higher empathy scores than the participants of the SETARA baseline outcome measurement. Positive attitude scores related to PLWHIV and sexuality (sexual expression and sexual violence) are increasing. Furthermore, skills scores related to better capacity to make safe and informed decisions regarding sexuality have seen an increase. These results are supported by the FGDs findings that suggest participants showed positive changes in terms of knowledge, attitude and skills.
- Although more participants of the endline survey were familiar with community health service locations, they were less likely than the baseline group to actually visit the health facilities for pregnancy tests, STIs test and treatment, HIV testing, and for counselling/information. In line with the evidence suggesting HIV general knowledge is increasing, those in the endline group are more willing to have a HIV test than those in the SETARA baseline group. This may be a result of the current increase in education and promotion of HIV testing from the UFBR programme and others with a similar target.
- Targeted SRHR health services that comply with the IPPF standard of youth friendly services are showing varied changes. NGO owned clinics tended to score better against IPPF standards of YSF than government owned puskesmas. Similar trends are also evident for the satisfaction level among the young people. Stock availability data regarding contraceptives (including condoms), HIV testing, ARVs, and antibiotics is relatively stable, with a trend toward increased availability of HIV testing at the endline.
- Mean satisfaction levels of youth accessing health care facilities are increasing, which may suggest there are other factors contributing to their satisfaction of the targeted SRHR health services (for example, increased urgency to get treated may improve satisfaction among those engaging with health services).

- Secondary data revealed that in 2015 (in comparison to 2011 and 2013), there were more young people and female clients accessing health services, and in the targeted areas more births were attended by skilled birth attendants. Contrastingly, the number of those accessing GBV services is decreasing, suggesting a need for urgent attention.
- Community leader involvement scores in 2015 are moderate to high, however, have decreased from the baseline and the midline scores. Similarly, acceptance of SRHR at the community level is also decreasing, although qualitative data demonstrated there are various forms of support and involvement from community leaders and community members. Issues related to taboo sexual practices and LGBT remain unpopular and are the least accepted among the community leaders.
- Partners showed that they continue to approach both community leaders and stakeholders, as well as engage the local government in order to remove barriers to CSE/SRHR education and YFS. Some partners have achieved changes in practices, attitude, and support. Some have obtained support in relation to funding, although this is often in the form of 'one off' payments as it is often related to turnover/rotation of government leaders. These efforts tend to be pragmatic and localized where the regional situation allows, however, there are some legal barriers regarding provision of quality SRHR information and services at the national level.

Recommendations

The assessment also recommends some strategic recommendation to maximize the outcome of the program in the future. These recommendations are:

- Access to HIV and SRHR knowledge (including condoms) among in school young people need to be improved. While partners strive to advocate school based CSE/SRHR education, other alternative communication and information media, such as social media, need to be used and developed. Existing channel on the provision of CSE or SRHR education in schools must be added, as targeting counselling teachers as the information provider would not be enough.
- Additional strategies toward condom provision, for example creating link between students who need condoms to condom outlets out of school that are not within the health services need to be developed, as condoms remain considered as taboo and there is still reluctance of stakeholders on the issue of condoms.
- Methods in conveying CSE/SRHR education needed to be targeting not only on knowledge and skills, but also on attitude to develop more positive attitude toward sexuality. Particular attention need to be developed for girls: to challenge cultural norms related to women sexuality that put women and girls as passive subject that would limit their capacity to refuse sexual acts without their consent.

- Furthermore, during the provision of information, HIV, GBV, and other SRHR issues needed to be framed using gender perspective to address the power imbalance among boys and girls. Working with boys early to develop positive masculinity (or to challenge harmful norms and practices related to masculinity) may also be one of the strategy.
- GBV including dating violence among in school young people need particular attention, more focus on GBV information services need to be added in the future programming, in addition to stigma and discrimination issues related to PLHIV and LGBT communities. Relation among HIV, violence and gender need to be explored further and highlighted within the SETARA curriculum. Integration of GBV toward the existing of HIV/SRHR services, or referral system and directory of GBV services as well as legal assistance need to be developed to ensure there are tangible follow up perceived by young people (and for girls in particular) regarding GBV services that may lead to more people accessing it.
- Increasing popularity and availability of HIV counselling and testing among young people is an opportunity to link young people with HIV and other SRHR care/treatment. Collaborative works with other programmes may be conducted to encourage health seeking behaviour among the youth. However, this may also create another problem that will need to be addressed as in some places in Indonesia the VCT providers may ask for parental consent for young people under 18 years old. This is one of the priority issues that the one vision alliance can take forward as advocacy agenda in 2016.
- Promotion of consultation and health services at the targeted SRHR services, as well as exploration of factors that encourage young people visiting SRHR services need to be conducted. This can be conducted utilising teachers as well as social media campaign. Technical assistance to government owned health facilities need to be prioritized, in this case, partners that owned clinics may be functioned as technical assistance providers to encourage shared learning and more open communication related to taboo and stigma related to HIV and SRHR issues.
- Whilst focusing advocacy efforts to the local government are more practical and realistic to do, advocacy works focusing on national level regulations which limit young people of the realization of SRHR comprehensive education and services need to be prioritized (e.g. accessibility of the services for unmarried young people/unmarried girls; provision of condoms and other contraceptives; or integrated CSE in the schools' curriculum).
- An agreement on advocacy plan and design of the one vision alliance need to be developed to target the national level regulation, with clear roles and responsibilities of each member of the alliance. More advocacy strategies that works and suits to

Indonesian contexts need to be developed in bring forward condom and sexuality issues including LGBT.

- Improvements of programmatic areas need to be conducted to ensure planned activities are in line with timing and or resources/tools needed. For example, timely developed guidelines/modules; better planning of targeted intervention schools and health facilities (and alternative strategies for newly collaborated schools/health facilities); closer coordination and shared leadership on advocacy works while at the same time considering strategies to address high turn over of stakeholders.