Blueprint for Change-Indonesia

Harm Reduction Advocacy in Asia (HRAsia)

HR Asia

The Global Fund

Rumah Cemara

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Introduction:

India HIV/AIDS Alliance is the Principle Recipient (PR) for the Global Fund regional Harm Reduction Advocacy in Asia project (2017-2019) that involves 7 countries in Asia (India, Vietnam, Indonesia, Cambodia, Thailand, Indonesia and the Philippines). The NGO Rumah Cemara is the Sub Recipient/ country partner in Indonesia. The project aims to maximize the impact of investments that help break the cycle of transmission of HIV among PWID in concentrated epidemics by addressing legal, policy and health system barriers that hinder necessary outreach, coverage and access to core services.

This Blueprint for change (BFC) outlines the core issues and strategic results to be achieved at the national level over the 3 years of funding (2017 – 2019) with sustainable outcomes beyond the tenure of the grant. It further helps to clarify the advocacy efforts required at the legal, policy or services level over the longer term and the sustainability of national partners' efforts within the national funding landscape. It describes the roles of key stakeholders (NGOs, international NGOs, community organizations / networks, various ministries / government departments, international organizations, i.e. UN, bilateral partners) and maps a course of engagement that will maximize the chances of success in achieving objectives. The BFC informs (i) situational analysis at the country level (ii) activities to be implemented to address barriers identified (iii) budget, and; (iv) results to be achieved (Performance Framework) both as activities to be implemented (work plan tracking measures) and overall impact (indicators of coverage & impact).

1. Background - Epidemiological situation HIV and Drug Use in Indonesia

Size estimate PWID:
- 74,326 (61,901– 88,320)[1]
- Women PWID: 5.7% of total

HIV prevalence among PWID: 36.4 %[1]
Overall HIV prevalence among PWID has decreased from 53% (2007) to 41% (2014), however, in specific locations Tengareng (West Java), Yogyakarta (Central Java) and Pontianak (Kalimantan) HIV prevalence increased from 27% in 2009 to 39.5% in 2014.

HIV incidence among PWID: Data not available

HCV prevalence PWID: 63.5% [1]

Hot Spots/distribution in country: 68 high burden districts

Drug Use patterns: There is a rapid shift from injecting to non-injecting drug use and switch from heroin to crystal methamphetamine (locally known as Shabu). Recent evidence suggests increasing trends of shifting to smoking crystal meth in Jakarta, Medan and Makassar. Heroin remains the preferred drug of choice but is not easily affordable for the majority of PWID.

Condom use/Use of sterile injecting equipment:
- Condom use at last sex 46%
- Safe injecting practise 89%[2]
- From 2009 until 2013 the proportion of PWID sharing injecting equipment at the last injection increased in 3 districts / cities, i.e. 18% to 26% in Yogkarta, 36% to 47% in Tangerang, and 23% to 45% in Pontianak.

2. Country Situational Analysis

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[1] Harm Reduction International "Global State of Harm Reduction 2016"

[2] Global AIDS response Progress Reporting 2016

2.1. Availablity of the Harm Reduction package of services for PWID

In Indonesia, the Ministry of Health, National Centre for AIDS and STD control is engaged in implementing the Comprehensive package of services for PWID as recommended by UNODC, INPUD, UNAIDS, UNDP, UNFPA and WHO.

S. No.	Services for PWID	Available	No of Service sites	Coverage	Funding source(s)
	Needle and syringe programmes (NSPs)		215 sites Public health centres, Yayasan Spirit (NGO) sites, Rumah Cemara and Persaudaraam Korban Napza Indonesia (PKNI)	87% in 2014 44 needles/ per person and year* (48% through NGOs)	Global Fund, International HIV and AIDS Alliance Mainline Foundation Government
	Opioid substitution therapy (OST) and other evidence-based drug-dependence treatment		87 OST sites (M) Drug dependence treatment centres**	2540 OST patients Data not available	Government procurement Global Fund (Infrastructure)
	HIV testing services (HTS)		Referral to government centres (990)	39% ***	Government procurement
	Antiretroviral therapy (ART) for people living with HIV		Referral to government centres (420)	Data not available	Government procurement
	Prevention and treatment of sexually transmitted infections (STIs) (and sexual and reproductive health services)		Referral to government centres (1287)	Data not available	Government procurement
	Condom programmes for people who inject drugs and their sexual partners		Provided in public health centres	Data not available	Government procurement
	Targeted information, education and communication (IEC) for PWID & sexual partners		Provided in public health centres	Data not available	Government procurement
	Community distribution of naloxone for prevention and treatment of opioid overdose	X			

	Prevention, vaccination, diagnosis and treatment of viral hepatitis B and C****	X			
	Prevention, diagnosis and treatment of tuberculosis (TB)		Referral to government centres	Data not available	

* Harm Reduction International ”Global State of Harm Reduction 2016“
**A variety of drug treatment centres are available for PWUD run by three different public entities. The Narcotics control agency (BNN), Ministry of Health (MoH) and Ministry of Social Affairs (MoSA) offer treatment using different approaches and are not connected in an integrated manner. The MoH uses harm reduction interventions, drug dependence counselling, and clinical or psychosocial intervention. The MoSA uses case management, after-care programs, self-help group, spiritual counselling, and vocational programs.
The BNN runs compulsory drug treatment centres and uses therapeutic community methods.
Overall the target is to reach 100,000 PWUD with treatment services, however, data on current reach is not available. Another type of drug treatment centre, in general run by NGOs and coordinated by the National AIDS Commission (NAC), are the Community-based Drug Dependence Treatment Centres. Harm reduction advocates consider these centres a good alternative to the compulsory detention centres. NNB also support 160 CRI’s and rehabilitation, MoS support 166 CRI’s and rehabilitation.
***AIDS DATA HUB ASIA-PACIFIC
**** National Health Insurance covers HepC treatment, but the President Regulation on National Insurance excluded PWUD

Table: Availability status of UNODC, WHO and UNAIDS recommended package of harm reduction services in Indonesia.

2.2. Current harm reduction funding landscape

The Global Fund is currently the major donor supporting HIV prevention services for PWID. The current NFM grant of USD 62 million has a component on prevention services for PWID and their partners of USD 2.9 million. The grant covers harm reduction for NSP, outreach and KIE services in 68 priority districts and is supported until December, 2017. The Government of Indonesia is supporting harm reduction service delivery through its static community health centre (Puskesmas), primarily meant for the general population. The Ministry of Health and Ministry of Social Affairs provides resources for drug treatment of PWUD. The case for increased and more strategic investment in HIV in Indonesia was developed by National AIDS Commission in collaboration with UNAIDS. The document is based on the findings of Asian Epidemic Modeling (AEM) and provides a good insight on the resources needed to tackle HIV by 2020 and 2030.

According to the UNAIDS Country Snapshot 2016, the AIDS financing for key populations was only 1% in 2014.

Harm reduction funding overview:

National	International Funding
National Budget: Methadone-procurement MoSA for Community-based treatment NNB for Community-based treatment	Global Fund: NSP, Intrastructure OST, outreach, hr in prisons, community-based treatment
Provincial Budget: MMT programme and outreach in Jakarta	USAID: outreach in Jakarta

City/dictrict budget (very limited): MMT program and outreach in Badung – Bali	Dutch Foreign Ministry: outreach in Jakarta, Bandung, Surabaya, Denpasar

3. Drug Law and Policy landscape

2.3.1 Laws and policies that enable access to services

Topic	Laws and policies
OST and NSP in community settings	The legal framework for OST and NSPs is provided by a series of Ministry of Health Regulations: Regulation on HIV and AIDS Prevention #21/2013; Regulation on Harm Reduction #2/2007; Health Ministerial Decree No. 567/2006 on Harm Reduction of Narcotics, Psychotropic and Addictive Substances. There is clear policy support for harm reduction from the National HIV and AIDS Strategy and Action Plan 2010 – 2014 which supports NSPs & OST (methadone). Health Ministerial Decree No. 567/2006 states MMT is accessible to persons at a minimum age of 18. Persons under 18 years can access OST if supported by a second opinion from a medical professional (child specialist). MoH Regulation Number 57 Year 2013 provides Technical Guidance of Methadone Maintenance Therapy. Discretion may be exercised to provide access to NSP to persons under 18 (Larasati, A. 2012). Guidelines relevant for harm reduction: Outreach guidelines MMT guidelines Community-based treatment guidelines
Prisons- condoms, OST NSP	There is policy support for harm reduction from the National HIV and AIDS Strategy and Action Plan 2010–2014 which supports OST in prison and information on access to condoms in prison (see Annex 2 of the Strategy, Prisoners: "Provide information for accessing condoms, lubricants, bleach to prevent HIV infection") and confirms that an SOP for Methadone Service in Prisons and Detention Centres has been issued. There is a condom distribution program in Kerobokan prison in Bali with plans to extend this to other prisons in the country. Sources: WHO-SEARO (2008). HIV prevention, care and treatment in prisons in South-East Asia. Delhi: World Health Organization, https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/TR.290.pdf Tim Lindsey, Pip Nicholson (2016), Drugs Law and Legal Practice in Southeast Asia: Indonesia, Singapore and Vietnam, fn 415.

Prisons- HIV&TB treatment	HIV services in prisons are supported by National HIV and AIDS Strategy and Action Plan 2010 – 2014, National Strategy to Respond to HIV and AIDS and Drug Abuse in Prison and Detention Centres; Master Plan for System Strengthening and Provision of Clinical Services Related to HIV and AIDS in Prisons and Detention Centres; Technical Guideline for prison-based HIV and AIDS Care, Support and Treatment; Circular Letter from Directorate General of Prisons on Monitoring and Evaluation of the response to HIV and AIDS in Prisons and Detention Centres. TB services in prisons are supported by the TB Strategic Plan and the Indonesia Action Plan-TB in Prison 2012- 2014
Diversion	Drugs Law 35/2009 requires 'addicts and victims of narcotics abuse' to undergo medical and social rehabilitation (Article 54). Supreme Court notices lay down the rules by which rehabilitation may be ordered instead of prison, including applicable threshold quantities. Article 128 allows PWUD under 17 years of age to be sentenced to rehabilitation instead of imprisonment. PWUD may be diverted by courts or police to community-based services or residential drug rehabilitation.

2.3.2 Laws and policies that impede access to services

Topic	Laws/policies

	Drug use and drug possession are criminalized by the Drugs Law 35/2009. Drug use is punishable with imprisonment (Article 127) and the law requires 'addicts and victims of narcotics abuse' to undergo medical and social rehabilitation (Article 54). A Supreme Court notice lays down the rules by which rehabilitation may be offered instead of prison, including applicable threshold quantities of drugs below which the offender is eligible for rehabilitation. Article 128 of the Drugs Law states if a drug user is undergoing a treatment programme for two periods, s/he cannot be prosecuted. Article 10 Government Regulation Number 25 of 2011 states that a drug user registration card can be used for two periods of treatment. If a person relapses after two attempts at treatment, they may be charged and imprisoned. (LBHM, 2016)
Use and possession offences	The death penalty does not apply to possession unless there is a 'transaction' (buying, selling, trafficking). The death penalty applies if a person offers to be sold, sells, purchases, receives, being an intermediary within transaction, exchanges, or delivers, produces, imports, exports, or distributes large quantities of drugs, or gives narcotics to another person to use causing death or permanent handicap. In Aceh province, penalties under sharia law may include corporal punishment for consumption of intoxicating drinks. (Arskal Salim, 2015). Sources: Arskal Salim (2015), Contemporary Islamic Law in Indonesia: Shari'ah and Legal Pluralism, Edinburgh University Press. LBHM (2016), The Trip to Nobody Knows Where. Jakarta: LBHM. http://lbhmasyarakat.org/wp-content/uploads/2016/04/310316_IPWL-Research-Report_LBHM_Mainline.pdf
Compulsory urine testing	No provisions for urine testing are found in the Narcotics Law. People enrolled for MMT must pay for urine tests, urine testing is a precondition for lowering methadone dose.
Compulsory registration and family reporting	The Narcotics Law 35 of 2009 Articles 54 & 55 and Government Regulation 25 of 2011 require compulsory reporting of all people dependent on drugs. People dependent on drugs are required to report to designated institutions for treatment and rehabilitation, including community health centres operated by Ministry of Health. The Ministry of Health has designated 129 facilities (mental health hospitals, general hospitals and community health centres) as reporting facilities, alongside two non-medical facilities operated by Bureau of Narcotics. Article 55 of the Narcotic Law 2009 requires family members to report relatives who are dependent on narcotics to designated institutions; this includes a requirement for parents/guardians of minors to report children who are drug dependent to the designated institutions.

3. Assessment of gaps in policy and programme implementation

Components assessed	Key challenges identified	Operational recommendations:

Coverage and Quality of services	The coverage of harm reduction services both NSP and MMT through public health centers (Puskesmas) is decreasing. Fear of being recognized as drug user, arrested or forced into drug treatment while accessing services seems to be the main barrier. Overall coverage has been reported as 87% in 2014, however, the number of syringes distributed per PWID per year was 44, which contradicts that coverage value. Treatment of drug dependence: Different treatment approaches are implemented, depending on the provider. Compulsory drug treatment is dominant. Voluntary, community-based drug treatment is available but only for a very small proportion of PWUD. Nat. AIDS commission has been merged in the MoH and has no authority to implement community based treatment. National narcotic board is responsible for drug treatment. Increased funding for harm reduction intervention is needed.	Scale up NSP and MMT along with other harm reduction services as recommended by WHO/UNODC. Revision of the Ministry of Health regulations on harm reduction / guidelines. Identify barriers for PWID to access NSP and MMT offered by public health centres. Increase the capacity of harm reduction providers to reach out to PWID. Advocacy for an coherent treatment approach Development of National Action Plan of Drugs Treatment condut by Coordinating Ministry and National Narcotic Board Scaling up the voluntary community based treatment based on evidence Evaluate domestic funding on harm reduction services. Allocate funds for harm reduction in proportion to the PWID population and the WHO recommended services/requirements. Evidence to advocate for nat. and int. resources to meet gaps and sustainability Evidence based mobilisation of domestic resources in accordance with nat. strategic plan.
OST (MMTP)	Despite ambitious policy targets, MMT coverage remains low, mainly because of high costs, shift to ATS, lack of capacity and the recent tightening of drug laws. Often the capacity of public health centres staff is too low due to the high rotation of staff. People without ID (homeless) or below the age of 18 without permission of their parents cannot enter OST. Patients often have to pay for treatment (around 1 US dollar per day). There is a major shift from opioids to ATS use, public health centres can not meet their targets in regard to OST patients	Inclusion of community staff in public health centres. Or agreements with local NGOs working in the field (already implemented, need to scale up). Regulations to make OST available for people without ID and under 18 years_ update guidelines. Services free of costs for patients (quota system) Services for ATS users in public health centres, training of staff to meet the needs

HIV testing and ART for PWID	Fear of urine testing for drugs discourages PWID to go the HIV testing sites. ART coverage was expected to increase from approximately 30,000 patients in 2008 to almost 87,000 patients in 2014,but only 24 % of PLHIV who are eligible for treatment in Indonesia receive ART. The Government needs to expand ART services, which puts pressure on the already-constrained budget for HIV/ AIDS control in Indonesia. HIV+ PWID rarely access ART in the early phase of infection.	Implementation of community based HIV testing Improvement of referral models to ART Case management Reduce costs by implementing ART early and apply alternative laboratory tests with caution. Scale up ART at the community level in certain high prevalence settings to potentially improve early uptake and adherence (and consequently reduce transportation costs).
Women who inject drugs (WWID)	There are no specific harm reduction services for WWID available (such as sexual/reproductive health services, pre- and post-natal care, safe spaces)	Acknowledge that WWID have additional needs and concerns and that, in some cases, services must be provided separately from males who inject drugs. Independently consider and design services to reach and meet the needs of WWID. Build resources specifically intended to reach WWID.
Size estimation / Drug Use Pattern/ Data collection	Evidence of drug use behaviours and demographic distribution of PWID has not been thoroughly updated since 2011 and availability of current data is scarce. Programmatic data of the PWID interventions is either not available or not being analysed. Such data are essential for optimizing coverage and quality of services	Generate updated and desegregated data on size estimates, demographic distribution and drug use patterns to better inform interventions, policy development and program implementation. Improve data collection, management and dissemination systems for programming and reprogramming/ production of credible and reliable local evidence. Utilize current programmatic data to inform, measure and improve quality and coverage of services

Law enforcement & Policy Implementation (Enabling Environment)	Criminalization of drug use continues to be the biggest deterrent for PWID to make use of the available services despite increased coverage. The criminalization also undermines the efforts made by NGO and CBO to provide services, commodities and education on the local and national level. The existing legal framework restricts client access to available services. PWID fear arrest and forced treatment detention. Harm reduction services are available but underutilized due to this dynamic with law enforcement. Strict policies resulting from the "War on Drugs" (initiated by the present government in Dec. 2014) are in place against PWID. This includes extreme punishment, including death penalty, for drug trafficking, forced drug testing, detention, compulsory treatment, extortion and pressure on health facilities to disclose personal details and medical records. The regulation of Mandatory Self-Reporting of Narcotic Users is another fear among PWUD that primarily intends to provide drug users with access to medical and social rehabilitation by compulsorily reporting themselves to certain appointed institutions Under the national health insurance scheme, drug use is considered a "self-inflicted" condition and PWID are not covered. A regulation on agreements/procedures that puts PWUD in rehabilitation with access to healthcare was signed between BNN, Police, Supreme Court, Attorney General's Office, Ministry of Health, Ministry of Social Affairs and Ministry of Law and Human Rights, but this regulation is not being followed. Stigma against PWUD by general public is pervasive.	Decriminalize drug use and possession of drugs for personal use (long-term goal). Sensitization and training of law enforcement, BNN/police on the importance of harm reduction. Sensitization of relevant representatives/ staff of the National Narcotic Board, staff of relevant ministries. Development of recommendations for the revision of the Drug Law Research of the gramatur (drug threshold) for revision of drug regulations Monitoring the revision of the Penal Code System Judicial Review of the President Regulation on health insurance Awareness campaigns to improve public opinion on drug users and understanding of drug use

Testing, Diagnosis & Treatment of Hepatitis C	There is a national strategy and treatment guidelines for HepC But no access to free of costs Hepatitis C treatment with DAAs. Governement implemented pilot project using DAAS for 6000 patients Treatment free of costs, tests need to be paid	Advocacy to scale up free of costs HepC treatment with DAAs, including costs for needed lab. tests
ATS	Prevention, treatment and harm reduction strategies for ATS users are in their initial phases: There is a lack of professional expertise and counselling training in dealing with the differing psychosocial and mental health problems associated with stimulant use. There is a major shift from opioids to ATS use, public health cewnters can not meet their targets in regard to OST patients. Services for ATS users are neede in public health center, staff need to be trained accordingly	Develop and implement harm reduction/ treatment services that consider the unique needs of ATS (stimulant) users. Assessment of service needs of ATS user. Inclusion of harm reduction for ATS users in national harm reduction guidelines. Services for ATS user in public health centres based on assessment Training of staff to meet the needs
Services in prison	OST sites have been providing these services in priority districts. OST is also available in 11 prisons and NSP has been piloted in one of the prisons.	Scale up harm reduction services in prison settings, including developing models for prison based test and treat.

4. National Strategic Plans

National AIDS Strategy and Action Plan (NASAP) for 2015-2019. The main objective of the NASAP is to achieve “The Three Zeroes” – Zero New Infections, Zero Stigma, and Zero Discrimination – through preventing the transmission of HIV; expanding access to HIV treatment and increasing retention rates among those receiving treatment; increasing the quality of life of people living with HIV; and reducing the socioeconomic impact of the AIDS epidemic on PWID, their families, and society. One of the key strategic elements of the NASAP is the mission to strengthen the provision of care for HIV-related health services in primary health care facilities and hospitals. In addition, the role of civil society is emphasized in the area of advocacy, prevention, and treatment.

Although the NASAP has defined targets and outlined strategies to achieve them, financial resources are not sufficient at the moment, especially at the district level, and there exist a number of challenges in monitoring its implementation.

Existing data indicate that over the last five years the GDP program has generally managed to curb HIV incidence among PWID. To maintain this program, the distribution and number of Public Health Centres (PHCs) with NSP needs to be improved especially in 141 priority districts. Currently 194 PHC with NSP are spread across 72 cities/ districts. It is expected that in the next 5 years, 240 PHC with NSP will be available in all priority towns/districts, consisting of 200 PHC and 40 NGOs and other private clinics. The existing NSP services will be reviewed by taking into account the number of PWID served (50 minimum, adjusted for PWID populations) per service.

The NSP site development plan aims to reach 34 provinces with 110 districts / cities and 240 PHC, as shown in the table below:[3]

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3 *National Action Plan for HIV-AIDS Control 2015-2019*

Level	NSP Site Quantity						Total
	Baseline	2015	2016	2017	2018	2019	
Province	19	15	--	--	--	--	34
District	72	18	10	10	--	--	110
Hospital	--	--	--	--	--	--	--
Public Health Centre	162	18	10	10	--	--	200
Others	32	4	4	--	--	--	40
Total Expand Yearly	194	22	14	10	--	--	240

Activities which will implemented during the 2015-2019 strategy are:

1. Provide updated guidelines for implementing NSP and methadone at PHCs and private partners.
   a. Update Harm Reduction guidelines
   b. Update LASS Technical Guidelines
   c. Update MMT Technical Guidelines
2. Increase the capacity of outreach workers, cadres and health workers in organizing outreach activities, support groups for communities, couples and families (PWID and patients with methadone).
   a. Increase capacity of outreach officers / cadres supporting the Harm Reduction program in the form of workshops
   b. Implement PWID outreach to be referred to MMT or NSP services
3. Conduct socialization of services to stakeholders in each of the existing districts/cities.
4. Develop NSP partnership network with pharmacies especially in the supply of sterile syringes for PWID who have accessed sterile syringes independently.
   a. Meet with dispensary pharmacy (DKI)
   b. Recruit consultants
   c. Develop the concept of partnership with pharmacies
   d. Conduct operational testing of NSP partnership implementation with pharmacy
   e. Evaluate operational test results
   f. Gradually expand NSP partnership network with pharmacies
5. Increase understanding and change of group behavior collectively and behavior of each individual PWID in group

5. Strategic Goals to Increase Impact of Harm Reduction Interventions

To reach an 80% coverage of harm reduction services for PWID and the UNAIDS 90-90-90 target, the following strategic goals need to be achieved. These goals will require a more consistent and long-term investment of resources, capacity building, advocacy and mobilization. Multiple stakeholders including the Government, Civil Society and the community will have to work together in realizing these goals.

Data:

- Updated, desegregated data on size estimates and demographic distribution
- Updated data, research and innovation to changing drug use patterns and addressing regional variations

Law &Policy:

- Decriminalization of drug use and possession of drugs for personal use (long-term goal)
- Revision of the Drug Law
- Enabling environment at national and provincial/district -level:
  Solutions with police that enable clients' free access to harm reduction services (and security for outreach and peer workers)
- Increased funding for harm reduction services
- Inclusion of PWID in national health insurance scheme

- Revision of harm reduction guidelines, inclusion of ATS use
- Coherence in drug treatment approaches, development and implementation of national guidelines
- Reduction of stigma and discrimination by the general public

Service delivery:

- 80% coverage of comprehensive services also in prison settings
- Availability of quality services, incl. MMT (this includes enhanced technical capacity of staff; facilities with attractive and need-based services; improved outreach, psycho-social support for MMT clients)
- Service delivery and quality monitoring of all harm reduction services
- PWID appropriate policies and procedures towards the roll out to the test and treat strategy to increase testing and improve access to ART, adherence support and follow up
- Implementation of prevention, treatment and harm reduction strategies for ATS users

Capacity Building:

- Appropriate capacity of harm reduction service providers to offer diversified need based quality services, including services for ATS users

Community mobilization:

- Meaningful participation of PWUD in decision making, planning and implementation of services at national and provincial level

6. Existing National Level Harm Reduction Advocacy /Strategic Partners

Key stakeholder	National level advocacy
PITCH project implemented by Rumah Cemara	- Development of recommendations for the revision oft he Drug Law from CSO - Judicial Review of the President Regulation on health insurance - Research of the gramatur (drug threshold) for revision of drug regulations - Documentation of Human Right violation focusing on Bail on the legal process - Legal assistance and strengthening of lawyers network for PUD - High level advocacy to strengthen Harm reduction - Strengthing CSO related social campaigns and organizational development - Monitoring the revision of the Penal Code System

Advocacy Targets and their role in drug law enforcement & policy implementation				
Ministry of	**Department of**	**Specific role**	**External stakeholders**	**Specific Law & Policy**
Health	Mental Health (Drugs Sub Directorate)	Policy development for MMT		

Health	Prevention and Controlling Disease (AIDS Sub-Directorate)	Policy Development and Harm Reduction Guidance Development	UNAIDS, WHO	Ministry of Health Regulation about harm reduction. Strengthening the harm reduction program position on a national scale implemented by all related stakeholders. Dissemination to all related stakeholder and law enforcement about the public health approach for PWUD
Health	National AIDS Commission	Harm Reduction (NSP) and Cross Coordinating Function to all related stakeholder for HIV-AIDS		
Narcotic National Board	Deputy of Rehabilitation	Policy Development, Services Implementing and Cross Coordinating to all related stakeholder for Drugs Policy	UNODC	Support and Engage NNB related to expand the Harm Reduction Definition into drugs treatment oriented. Engaged NNB to put the Harm Reduction as one of the Evidence-based approach for drugs treatment in National, Provincial and District Level.
Ministry of Social Affairs	Directorate of Drugs	Policy Development and Treatment Services		Ministry of Social Affair Regulation about Harm Reduction. Strengthening the harm reduction position and increasing the quality of Drugs treatment applied by NGO under Ministry of Social Affair with involving community organizations to do the Monitoring and Evaluation also developed the M&E Frame work for Drugs Treatment Services
Parliament	Commission 9	Health Sector Policy Development		Support and Engage Parliament related to Narcotic Law Revision especially, put the Harm Reduction Definition into the rehabilitation chapter. Sensitizing the parliament to decriminalizing drugs user also regulate the individual threshold.

7. Rumah Cemara Strategic Plan through - HRAsia 2017-2019

Strategic Objective	Key Activities	Country Partners & Stakeholders Engagement	Regional Partners & Stakeholders	Expected Outcomes
Strategic Objective - 1				

Sensitization of stakeholders (law enforcement /BNN / police) on importance of harm reduction interventions Meetings to advocate for less strict penalties on possession of drugs and mandatory self-reporting of narcotics use for easy access to services Advocacy activities carried out with Parliamentarians, Policy makers and City mayors and Bappeda on requirement of domestic funding at national and city level	Meeting/consultations with city councils to engage municipal authorities, local CSO to raise awareness among stakeholder about HR program	Ruham Cemara, City Council representatives, CSOs	HRI, ANPUD	Enabling Friendly Harm reduction Policies that reduces criminalisation, discrimination and violence against PWUD and improves equal access to services. Inclusive and friendly Harm reduction and Voluntary Community-based Treatment services are accessible, affordable and provide appropriate services to PUDs/ PWID Increased funding for PUDs/PWID & CSOs from local, national and international budgets
	Joint meeting with parliaments member and representatives of city council, Bappeda (govt. body), related stakeholders	Rumah Cemara, UNAIDS, Ministry of Health, Ministry of Social Affairs, BNN, CSOs	IDPC	
	Monthly meetings with parliamentarians in Jakarta. National Meetings with relevant Stakeholders and CSOs			
	National Workshop to raise finding on domestic HR funding analysis	Ruham Cemara, Local government representatives, parliament members, national government representatives, parliamentarians, media representatives, CSOs	IDPC, LEAHN	
	Meetings with Bappenas and parliament member at local and national levels Local Level workshop to raise awareness on domestic HR funding analysis (8 Cities)			
Strategic Objective - 2				
Advocacy for more voluntary community-based drug dependence treatment opportunities Building capacity of the community organizations in monitoring and timely reporting gaps in service delivery as well as human rights	National meetings with relevant stakeholders for community groups to inform and finalize the strategies for TGF regional grant National workshop to provide inputs at national Level about strategic plan on AIDS engaging local CSO as resource person	MoH, National Narcotic Board, National AIDS Commission, Drug User Networks, CSOs, UNAIDS, UNODC, UNDP	ANPUD/ IDPC/ LEAHN	Champions for Harm Reduction are built among law enforcement agency Change in attitudes and understanding of harm reduction among law enforcement officials, local authorities, and prosecutors which

human rights violations Bringing together community networks to one unified voice in support of PWID	National training involving CSO from 10 cities to empower CSO to have knowledge related to health issue (HIV, TB, HCV, Overdose) National training involving CSO from 10 cities to empower CSO to have knowledge related to legal issue and media campaign like SportsArt and music as advocacy material Serial meeting each on 8 cities between CSO and municipal level stakeholder National serial dialogue meeting among HR CSO with other organizations	Rumah Cemara, CSOs and User Networks	ANPUD/IDPC/ LEAHN	prosecutors which will lead to more support for evidence-based treatment and decrease in arrest and incarceration. Meaningful involvement of Harm Reduction advocates in Local and national response. Inclusive advocacy coalitions organized and trained among Drug user Organization and Harm reduction Civil Societies
Strategic Objective - 3				
Collection of evidence to advocate for national and international resources to meet the harm reduction coverage gaps and sustainability	Carry out interview to gather information on HR funding at local level Sharing the findings from the Study with stakeholders	Rumah Cemara, CSOs, User Networks, UNAIDS, UNODC, MoH, NAC, BNN	IDPC, HRI	Increased domestic funding for HR programs

8. Activities recommended by CSOs in Jakarta, Indonesia

In keeping with the objectives of the regional grant, multi-stakeholder consultations were conducted with relevant government, CSOs and UN agencies to further consolidate work-plans that support achievement of the strategic goals for the Philippines. The tables below indicate what needs to be covered additionally:

Removing legal barriers	TARGET	ACTIVITIES	Organisations responsible	EXPECTED OUTCOME

Objective 1: 2017 till 2019, a Community led Media centre is established and running with ownership of all NGOs, CBOs and Networks	Media, NNB, MoH and other related ministries; Parliamentarians, officials at district governance level and national level, Judiciary, and law enforcement agencies.	This Media centre will be responsible for collecting and collating information like case studies, incident reports, success stories, evidence of good practice for HIV and harm reduction services in the county, along with updates on activities that are conducted by NGOs, CSOs, Networks, etc. for final distribution into media stream.	PKNI, Yakeba, Malen Plus, ICJR, MaPPI FHUI, LBHM,	The media is engaged in a positive and constructive manner towards a collective advocacy aim for HIV and Harm reduction services in Indonesia. Decrease in Stigma and Discrimination though meaningful involvement of PWUDs/PWID as well as CBOs and NGOs for Harm Reduction.

i. Appendix

ACRONYMS

AEM- Asian Epidemic Modeling
AIDS- Acquired Immune Deficiency Syndrome
ANPUD- Asian Network of People Who Use Drugs
ART- Anti-Retroviral Therapy
ATS- Amphetamine Type Stimulant
BFC- Blueprint For Change
BNN- National Narcotics Agency (Indonesia)
CBDDT- Community-Based Drug Dependence Treatment
CBO- Community-Based Organisation
CBT*- Computer-Based Training programme*
CSO- Civil Society Organisation
DAA- Direct-Acting Antiviral
DDT- Drug Dependence Treatment
DOT(S)- Directly Observed Treatment (Short course)
FHUI- Fakultas Hukum Universitas Indonesia
HCV- Hepatitis C Virus
HIV- Human Immunodeficiency Virus
HR- Harm Reduction
ICJR- Institute for Criminal Justice Reform
IDPC- International Drug Policy Consortium
IEC- Information, Education and Communication
INPUD- International Network of People who Use Drugs
LASS- Leicestershire AIDS Support Services
LBHM- *Lembaga Bantuan Hukum Masyarakat*
LEAHN- *Law Enforcement and HIV Network*
MaPPI*- Indonesian Society of Appraisers (Masyrakat Profesi Penilai Indonesia)*
MMT- Methadone Maintenance Therapy
MoH- Ministry of Health (Indonesia)
MoSA- Ministry of Social Affairs (Indonesia)
NAC- National AIDS Commission (Indonesia)
NASAP- National AIDS Strategy and Action Plan (Indonesia)
NNB- National Narcotics Board (Indonesia)
NSP- Needle and Syringe Programme

OST- Opioid Substitution Therapy
PHC- Public Health Centre
PKNI- Indonesian Drug Users Network (Persaudaraan Korban NAPZA Indonesia)
PR- Principal Recipient
PWID- People Who Inject Drugs
PWUD- People Who Use Drugs
SOP- Standard Operating Procedure
STD/STI- Sexually Transmitted Disease/Infection
TB- Tuberculosis
TGF- The Global Fund
UNAIDS- Joint United Nations Programme on HIV/AIDS
UNDP- United Nations Development Programme
UNFPA- United Nations Population Fund
UNODC- United Nations Office on Drugs and Crime
USAID- United States Agency for International Development
USD- US Dollars
WHO- World Health Organization
WHO-SEARO- World Health Organization South-East Asia Region
WWID- Women Who Inject Drugs