HARM REDUCTION FINANCING LANDSCAPE ANALYSIS IN INDONESIA

HARM REDUCTION INTERNATIONAL

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Harm Reduction International (HRI) is a leading non-governmental organisation (NGO) dedicated to reducing the negative health, social and legal impacts of drug use and drug policy. We promote the rights of people who use drugs and their communities through research and advocacy to help achieve a world where drug policies and laws contribute to healthier, safer societies. The organisation is an NGO with Special Consultative Status with the Economic and Social Council of the United Nations.

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LIST OF ABBREVIATIONS

AD	Articles of Association
APBD	Anggaran Pendapatan dan Belanja Daerah
APBN	Anggaran Pendapatan dan Belanja Negara
ART	Organizational Guidance
ARV	Antiretroviral therapy
CBO	Community Based Organization
CCM	Country Coordinating Mechanism
CLO	Community Lead Organization
CSO	Civil Society Organization
FITRA	Forum Indonesia untuk Transparansi Anggaran
FSW	Female Sex Worker
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
ICJR	Institute for Criminal Justice Reform
IDU	Injecting Drug User
IEC	The Information, Education & Communication
IPPNI	Ikatan Pemerhati Kebijakan Pengguna Napza Indonesia
MMT	Methadone Maintenance Treatment
MoH	Ministry of Health
MSM	Men Who Have Sex With Men
NA	Not Available
NSP	Needle and Syringe Program
OAMT	Opioid Agonist Maintenance Treatment
OAT	Opioid Agonist Therapy

PDBN	Harm Reduction
PIMS	Disease and Sexual Transmission Infection
PKNI	Persaudaraan Korban Napza Indonesia
PPH	Pusat Penelitian HIV AIDS
PR	Principal Recipient
PUD	People who Use Drugs
PWBP	Perempuan Warga Binaan Pemasyarakatan (Female Prisoners)
PWID	People who inject drugs
RLI	Real Local Income
RPJMN	Rencana Pembangunan Jangka Menengah Nasional
RPJPK	Rencana Pembangunan Jangka Panjang Bidang Kesehatan
SN	Serial Number
TB	Tuberculosis
TWG	Technical Working Group
UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
WBP	Warga Binaan Pemasyarakatan (Prisoner)
WHO	World Health Organization
WSTI	Sexually Transmitted Infections

EXECUTIVE SUMMARY

The implementation of the harm reduction program in Indonesia was initiated in 2007. It began with the signing of a Memorandum of Understanding between the National Narcotic Board and the National AIDS Commission with aims to prevent HIV transmission among people who inject drugs.

Currently, the harm reduction program is heavily funded by the international donors, largely the Global Fund. The limited domestic funding on harm reduction and an absence of budget transition plan from external funding to the domestic funding can negatively impact service quality and access to harm reduction programs in the long run in Indonesia

The role of CSOs, CBOs, NGOs, and the National Network of People who use and inject drugs in designing the harm reduction program, monitoring the service quality and accessibility is crucial and strategic. However, the existing process to formulate the health program and budget allocations does not adequately place community at the center. The funding for advocacy and organizational core costs are shrinking and there is no adequate government funding available in Indonesia for the CSOs or CBOs. The existing government social contracting mechanism has not been implemented for HIV or harm reduction programmes.

The formulation of harm reduction budget advocacy roadmap in Indonesia is a new initiative and is necessary to boost the advocacy for increased domestic harm reduction funding. The active role of CSOs/CBOs and national networks in advocating for the domestic financing should be prioritized. Different stakeholders such as decision makers (government agencies), activists' group (CSOs/CBOs and national networks), academia and international partners need to harmonize their programs and priorities to ensure the availability of a comprehensive harm reduction program in accordance with global guidelines.

Key recommendations for increasing the domestic harm reduction financing

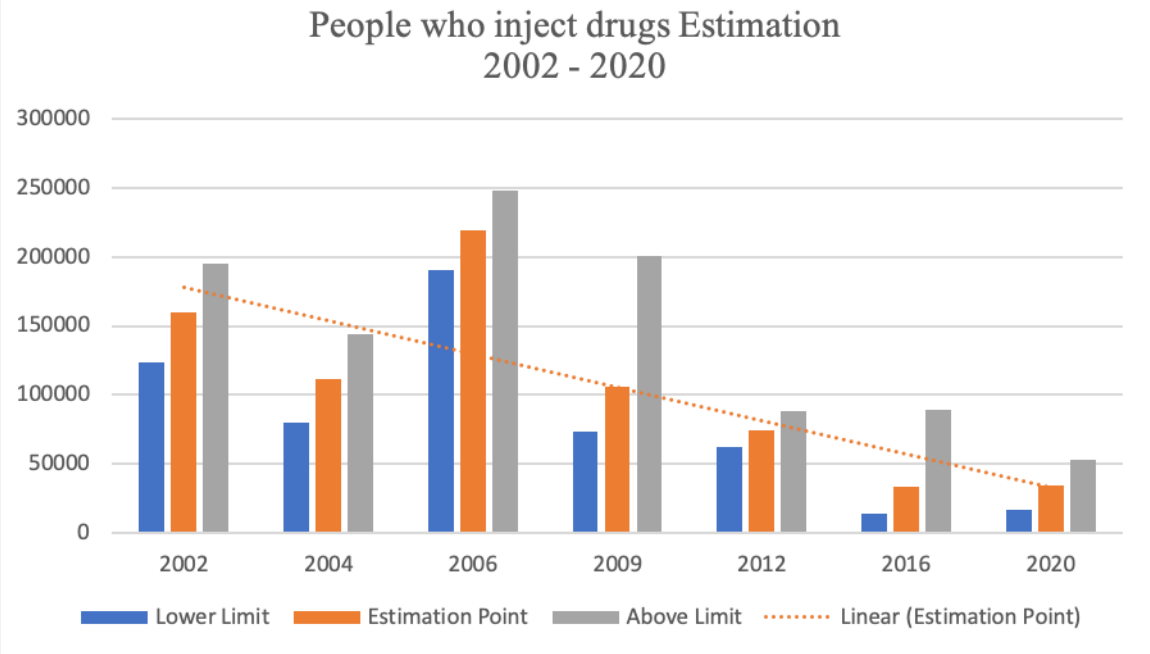
SN	Main Finding	Responsible Sector		Recommendation
		Gov't	CSO/ CLO/ CBOs	
1	**Financial**			
	The unavailability of domestic financing to support activities involving CSOs, CLOs, and CBOs in a comprehensive harm reduction programme.	√		Develop harm reduction programme for people who use and inject drugs based on the recommendations of the World Health Organization.

	The unavailability of a harm reduction programme in the financing transition plan from international to domestic grants as an effort to strengthen the exit strategy.	√		Develop a harm reduction financing transition plan by involving other financing sectors (Social Security Administering Agency) as potential funding source in providing harm reduction programme budgets.
	Limited authority of local/ sub-national governments in proposing financing for comprehensive harm reduction programmes.	√		Synchronize harm reduction programme financing based on the authority of each level and prioritising based on national and sub-national health development plans.
2	**Community participation**			
	The lack of active participation from CSOs, CLOs, and CBOs in accessing community information, participating in the programme planning and financing processes carried out by the government.		√	1. Reactivate harm reduction working groups at the national and sub-national levels to increase the active participation of civil society in every stage of the planning and financing process. 2. Develop a harm reduction road map as an effort to initiate a joint work programme among harm reduction implementers.
	There is a priority shift away from CSOs, CLOs, and CBOs implementing harm reduction due to decreasing funding in harm reduction.		√	
	Lack of community knowledge regarding the bureaucratic system and programme planning and financing mechanisms that operate in Indonesia.		√	Disseminate community information and build the capacity of CSOs, CLOs, and CBOs implementing harm reduction related to the bureaucratic system, as well as work planning systems and government funding.
3	**Legislation/Policy**			
	Availability of space for communities to actively participate in every stage of the process of planning and financing harm reduction programmes.	√	√	1. Disseminate community information to CSOs, CLOs, and CBOs implementing harm reduction-related policies. 2. Develop partnerships and networks between the implementers of the harm reduction programmes and CSOs working on budget advocacy issues in general.
	Availability of a social contracting financing regulation for CSOs, CLOs, and CBOs to actively participate in implementing government programme plans, however not yet implemented for health and HIV.	√	√	

SECTION 1: OVERVIEW

The estimated number of people who inject drugs in Indonesia in 2020 was 34,517, ranging between 16,925 and 52,669 nationally, or from 0% to 0.094% of the total male population aged 15-49 years per district/city. This percentage is much lower than the global estimate (0.31%) in Asia and in Southeast Asia (0.25%). The downward trend in the number of people who inject drugs in Indonesia is shown below.[1]

Figure 1.1: People who inject drugs estimation chart in Indonesia from 2002-2022



This trend is assumed to be related to the high mortality rate of people who inject drugs and lack of heroin supply in recent years. In addition, data on narcotics cases reported in the Indonesia Drug Report 2022 show five types of drugs (see table 2) distributed and used.[2]

Table 1.1: Illegal Drugs Distribution Cases in Indonesia

SN	Types of drugs	Number of Cases	
		National Police Dept.	National Narcotic Board
1	Ice / Sabu / Methamphetamine	42,829	975
2	Ganja / Cannabis / Marijuana	3,563	127
3	Benzodiazepam	1,584	0
4	Ecstasy	973	13
5	Illegal Prescription Drugs	869	0

1 Ministry of Health, Technical Report of Estimated Population on HIV Risk Transmission, 2020
2 National narcotic board, Indonesian drug report 2022

Currently, the Ministry of Health is updating the estimate by implementing a size estimation. It projects key populations vulnerable to HIV in 2022-2024 and preliminary data shows an increase in the previous estimate of 33,492 to 34,517 people who inject drugs.

Injecting drug use accounts for approximately 10% of new HIV infections globally (UNAIDS, 2020). Moreover, an estimated 23–39% of new Hepatitis C virus (HCV) infections occur among people who inject drugs. Globally, 1 in 3 HCV deaths is attributable to injecting drug use. In some regions, such as Eastern Europe and Central Asia, prevalence rates for both HIV and HCV are particularly high. Furthermore, there are approximately 2.3 million HIV–HCV co-infections worldwide, of which more than half (1.3 million) occur in people who inject drugs (WHO, 2016). Unfortunately, Indonesia doesn't have the aggregate data specifically on HCV infection among people who inject drugs.

WHO recommends a package of harm reduction interventions to reduce transmission of HIV, HCV, and Hepatitis B virus (HBV), as well as overdose deaths among people who inject drugs. These interventions also allow people who inject drugs to access the healthcare system and engage with TB care and mental health services. Harm reduction, including needle and syringe programs (NSP), opioid agonist therapy (OAT), and community distribution of naloxone, is an evidence-based approach to HIV and HCV prevention, treatment, and care for people who inject drugs. Other United Nations agencies also strongly support it. Harm reduction interventions are essential to achieve the global targets for viral hepatitis elimination and control of the HIV and AIDS epidemics.

The recommendations submitted by WHO have not been matched by the government's commitment to maintain sustainability and improve the quality of harm reduction services in Indonesia. The existing harm reduction services are more oriented towards programmes supported by international grants. This can be seen through the fact that financing commitments for government funds are increasingly being reduced. The portrait of harm reduction services in Indonesia based on the consolidated guidelines of the World Health Organization is as follows[3]:

Table 1.2: Number of Harm Reduction Services Sites and the Services Operated by the Government and CSOs

SN	Services	Availability				Report Status[4]		Remarks
		Available	Sites		Not Available	Reported	Not Reported	
			Govt.[5]	CSO				
1	Opioid Agonist Maintenance Treatment	√	94	0		57%	43%	people who inject drugs target
2	Needle Syringe Program	√	120	15[6]		41%	59%	people who inject drugs target

3 Ministry of Health, Oct-Dec 2021 HIV Quarterly Report, HIV AIDS Information system
4 Status column shown number of services sites who submit report or not submit in the current reporting period.
5 Ibid.
6 The number of SSR and implementing partners under community principal recipients conduct the needle/

3	Peer Driven Naloxone for Overdose Prevention		unknown	0	√	unknown	unknown	people who inject drugs target
4	HIV Testing Services	√	10.397	unknown		85%	15%	General
5	Care Support Treatment Services	√	2.546	unknown		72%	28%	General
6	Sexual Transmission Infection Services	√	7.209	unknown		81%	19%	General

The table 3 below shows that the active participation of the community in HIV prevention programmes in the health system is still suboptimal in Indonesia. The result is in conflict with the target of 30:80:60[7], which the government also committed to at the global level.

Table 1.3: 30:80:60 Target and Community Engagement in Indonesia

Target	Community Roles
Community will deliver 30% of testing and treatment services	The HIV Regulation, formulated by MoH, stated the HIV testing can be conduct by the certified health workers. The CBOs/CLOS/CSOs can conduct the HIV screening but should refer to the authorized health facility to confirm the test result and continue the treatment.
Community will deliver 80% of HIV prevention services	The CSOs/CLOs/CBOs are allowed to distribute the clean needles and connect people who inject drugs to the health services in public health facility. However, such prevention activities are limited. The CSOs/CLOs/CBOs are not allowed to manage OAT and distribute the naloxone for overdose prevention
60% Programmes supporting the achievement of social enablers	NA

syringe distribution through outreach programs in 60 cities.

7 The term community-led refers to leadership by and for people living with and affected by HIV, including and especially key populations, women and young people. The 30–60–80 targets are defined as follows in the Global AIDS Strategy: 30% of testing and treatment services to be delivered by community-led organizations; 60% of the programmes to support the achievement of societal enablers to be delivered by community-led organizations; 80% of service delivery for HIV prevention programmes for key populations and women to be delivered by community, key population and women-led organizations.

There are no operational plans that involve or are led by communities of people who use drugs or civil society organizations (CSOs) working on harm reduction issues. Each activity planned in the HIV National Action plan is led by Ministry of Health. This indicates the lack of community involvement in the planning, implementation, and monitoring stages of evaluating the effectiveness of harm reduction services in Indonesia.

Table 1.4: Operational Work Plans for the Harm Reduction Program in Indonesia

SN	Activity Plan	Level
1	Conduct orientation on the Methadone Maintenance Therapy Program using the technical guidelines in province, district and city	National, Provincial, and District Level
2	Conduct awareness and sensitization meeting with law enforcement officials and the mass media on the Methadone Maintenance Therapy Program	National, Provincial, and District Level
3	Provide Methadone maintenance therapy to people who inject drugs	National, Provincial, and District Level
4	Provide harm reduction services to those key populations who use methamphetamine and/or other illegal drug	National, Provincial, and District Level

SECTION 2: METHODOLOGY

This review used the normative-empirical method; a method that combines normative and empirical approaches (written regulation, report-focused approach based on several theoretical aspects, philosophy, comparison, structure or composition, consistency, general explanation and detailed article elaboration, formality and strength of a regulation) using legal materials (secondary data) obtained from literature review with primary data from the field related to normative legal provisions.

The output of this study will address the following issues:

1. Current situation regarding the role of CSOs, CLOs, and CBOs in implementing harm reduction, both programmatically and in terms of domestic budget access opportunity;
2. Current situation on harm reduction financing in Indonesia, including identified challenges or gaps within the existing law and regulations related to harm reduction financing programmes in Indonesia;
3. Mapping the opportunities and highlighting stakeholder champions for harm reduction programmes and CSO, CLO, and CBO sustainability.

The data collecting technique necessary for this study was as follows:

2.1 Literature Review

Literature review of documents focusing specifically on statutory regulations related to financing and implementing HIV programmes in Indonesia was dissected into three schemes: programme-related, financial, and legal status for CSOs, CLOs, and CBOs.

2.2 Community Consultation

Interviews were conducted using an in-depth interview method. Guiding questions constructed as semi-structured and indicative. Practically, the questions were adapted further as necessary during the interview, and probing was carried out to enhance responses from the respondents. Prior to the interview, respondents were informed of their rights and freedom to provide or decline responses. The interviewer then started by asking the respondent's willingness to participate in the process. All respondents were asked to sign an Informed Consent Form and to confirm their consent for the interview to be recorded for documentation purposes.

2.3 Data Analysis

Descriptive analysis with elaboration was provided for secondary data. Interview content analysis was carried out by grouping the main themes and ideas. This analysis plot starts from the understanding of the laws and regulations as the basis of work, the role of the CSO, CLO, or CBO based on national regulation, the current situation on harm reduction finance based on national/sub-national budget and international grants (Global Fund), synchronised with the implementation of the HIV National Strategic plan.

2.4 Limitations

This study describes the roles and responsibilities of the community, based on the prevailing laws and regulations in general and is not limited solely to harm reduction programmes. There are several financing budgets that are not known due to limited data that cannot be accessed by the public, and public consultations for several CSOs outside Jakarta which were carried out through online consultation.

SECTION 3: OPERATIONAL LANDSCAPE

3.1 Legal Status of CSO, CLOs, and CBOs

In the prevailing laws and regulations of Indonesia, there are two laws at the highest level in the regulatory hierarchy which regulate the formation of community organisations, the registration process, and the legitimacy of community-based organisations. These are:

- Law No. 16 of 2017 on Stipulation of Government Regulation in place of Law No. 2 of 2017 on Amendments to Law No. 17 of 2013 on Social Organizations.
- Law No. 28 of 2004 on Amendments to Law No. 16 of 2001 on Foundations.

These two laws provide space for civil society to achieve the state's goals where, in this context, the goal is to create and realise the highest quality of health for every citizen. There are twelve prohibitions against community-based organisations where these prohibitions are not related to the implementation and provision of harm reduction programme services. The prohibitions referred to in the regulation include:

Table 3.5: Prohibition for CSOs based on current regulation

SN	The CSOs are prohibited from
1	Using the same name, symbol, flag, or attribute as the color, emblem, flag, or attribute of a government institution
2	Using without permission names, symbols, and flags of other countries or international institutions/agencies as names, symbols, or flags of community organizations
3	Using names, symbols, flags, or graphic signs that have similarities in principle or whole with the names, symbols, flags of other community organizations or political parties
4	Receiving from/or giving to any party donations in any form that is contrary to the provisions of the laws and regulations
5	Raising funds for political parties
6	Performing acts of hostility towards ethnicity, religion, race, or group
7	Abusing, blaspheming, or desecrating the religious practice in Indonesia
8	Committing acts of violence, disturbing public peace and order, or damaging public facilities and social facilities
9	Carrying out activities that are the duties and authorities of law enforcement as per the provisions of laws and regulations
10	Using the name, emblem, flag, or symbol of an organization that has similarities in essence or its entirety to the name, symbol, flag, or symbol of a separatist movement organization or prohibited organization.

11	Carrying out separatist activities that threaten the sovereignty of the unitary state of the Republic of Indonesia
12	Adhering to, developing, and spreading teachings or understandings that are contrary to Pancasila

The participation and contribution of community-based organisations in implementing the drug harm reduction programme (PDBN) has been regulated through Minister of Health Regulation No. 55 of 2015 on Reducing Harm to Injecting Drug Users. Several components of harm reduction, such as needle and syringe programmes, communication, and informational materials that involve community-based organisations in their implementation include:[8]

Table 3.6: Harm Reduction intervention based on MoH Regulation

Interventions	Implementers	Funders
Needle Syringe Program	1. Community health center with harm reduction services for people who inject drugs 2. Non-Governmental Organizations or other community organizations that carry out activities to reduce harm for people who inject drugs	International Grant for the package procurement
Opioid Agonist Therapy (Methadone Maintenance Program)	1. Hospital/Public Health Facility with harm reduction services 2. Prison under hospital supervision	• Domestic Budget for the Procurement • International Grant for the Supporting activity
Other drug dependence therapy	1. General Hospital 2. Mental Health Hospital 3. Drug Addiction Hospital 4. Health Center 5. Medical and social rehabilitation institutions	Domestic Budget
Communication, Information, and Education for IDU and their sexual partners	1. Non-Governmental Organizations or Other Community Organizations implementing harm reduction programs for people who inject drugs. 2. Community health center that provides harm reduction services to people who inject drugs.	Domestic Budget for general population (HIV IEC)

8 Ministry of Health Regulation No. 55 2015 on Harm Reduction.

Promotion of condoms for IDUs and their sexual partners	1. Hospital 2. Community health center 3. Government Institutions/Institutions 4. Non-Governmental Organizations or Other Community Organizations	International Grant
Prevention and treatment of sexually transmitted infections (STIs)	1. Non-Governmental Organizations or Other Community Organizations implementing harm reduction programs for people who inject drugs. 2. Health services with harm reduction services for people who inject drugs(hospitals, community health centers, prisons, and others).	• Domestic Budget • International Grant
HIV Counselling and Testing	1. Hospital 2. Health Center 3. Non-Governmental Organizations or Other Community Organizations carry out activities to reduce harm to people who inject drugs. 4. Clinics that have HIV testing services.	• Domestic Budget • International Grant for Community based screening
Prevention, Diagnosis, and Therapy for Hepatitis	1. Hospitals with trained experts in the management of Hepatitis B and C. 2. Non-Governmental Organizations or Other Community organizations implementing Hepatitis B and C prevention activities.	Domestic Budget
Antiretroviral (ARV) Treatment	1. Government-appointed ARV referral hospital. 2. Other public health service providers such as satellites clinics (Pusat Kesehatan Masyarakat), 3. Non-Governmental Organizations, Community Organizations and private clinics with capacity to provide ARV therapy services.	Domestic Budget

Tuberculosis Concomitant Disease Treatment	1. Hospital 2. Community health center 3. Correctional Clinics and Detention Centers appointed by the Government. 4. Non-Governmental Organization and Other Community Organizations clinics 5. Other service providers such as Balai kesehatan masyarakat.	• Domestic Budget for the Medical Procurement • International Grant for the supporting activity

The Regulation of the Minister of Health of the Republic of Indonesia, Number 48 of 2017 on Guidelines for Planning and Budgeting in the Health Sector, stated that there are five approaches in the national development planning system. These are the Political Approach, the Technocratic Approach, the Participatory Approach, the Top-down Planning Approach, and the Bottom-Up Planning Approach. Policies at the national level open up space for civil society to actively participate in the planning process, which has implications for the budgeting of the priority work plans that have been set.

However, in practice, there is still a lack of community participation in the planning process. Some of the causes of this include:

- Lack of information and communication on the exact time and date for the plan development meetings;
- Lack of participation and meaningful involvement of civil society in accessing information and engaging with the process due to the complex bureaucracy system and organisational workplan prioritisation;
- Lack of existing mechanism for the representation of civil society who sit in the working plan development formulation team.

The mechanism that applies nationally, based on national regulations on the national development plan system and government regulations on public participation in local governmental management, still places civil society as a party whose participation should be heard in the process. However, in reality, there are no specific systematic processes that regulate the role and responsibilities of civil society. The current mechanism considers community involvement as a mere administrative and formality process.

There is a different approach and mechanism for the international grants system. The Global Fund developed a system where civil society has specific roles and responsibilities. The Country Coordinating Mechanism (CCM) and Technical Working Group (TWG) must provide the community representatives with the rights to vote and decide on every process (plan development, monitoring, and evaluation).

Some of the differences between civil society participation mechanisms in the process of developing work plans, implementing, and evaluating health priorities in domestic and international funding sources are outlined in table 3.7.

Table 3.7: CSO engagement in the budget formulation process as per the policy

SN	Form of Participation	Domestic Budget		International Grant (The Global Fund)	
		Yes	No	Yes	No
1	Access and space for civil society to participate in planning and budgeting processes	√		√	
2	Participation of civil society/affected communities at every stage of the process.	√		√	
3	Space to discuss specific topic on harm reduction and prioritize the programs.		√	√	
4	Written information about the general implementation period of the planning process	√		√	
5	Announcement/socialization of the date and time of the planning meeting widely.		√	√	
6	The representation of civil society/affected communities in the planning implementation process		√	√	
7	Space for civil society/communities to lead and facilitate the planning process		√	√	
8	The civil society/community representation in the decision making process		√	√	
9	Transparency and updated information on the planning process at every level (district – provincial – national)		√	√	
10	Space for appointing and selecting program implementers by civil society/communities		√	√	
11	Space for civil society and communities to monitor the program implementation.		√	√	

Civil society involvement in Global Fund mechanisms is one of the requirements and obligations for country grant recipients. The meaningful participation and involvement of community is highlighted in the Global Fund Principles, where one of the principles is engagement of key populations, people living with or affected by diseases, and civil society. Each CCM should establish a mechanism to engage key populations, people living with or affected by diseases, and civil society in a way that allows their input and voices to really be heard. Such engagement should continue throughout the grant lifecycle to provide input to strengthen the delivery of programmes and achievement of targets. The current Indonesian CCM Structure engages civil society representatives at each stage: co-chair of the CCM, member of the CCM from civil society, national networking representatives, representatives of people living with HIV (PLHIV), members of the oversight committee, and chairman of the HIV Working group.

3.2 Policy Framework and Mechanism of Social Contracting of CLOs, CBOs, and CSOs

Presidential Regulation N o. 16 of 2018 on The Procurement of Government Goods And Services, regulates the type of *swakelola* (self-management) permitted, and consists of four types of self-management. Self-management type 3 is considered as the only type that means social contracting that provides space for civil society organisations to be involved in implementing the procurement of goods and services planned by the government. The definitions and requirements of the different types of self-management are as follows[9]:

Table 3.8: Type of government self-management fund

Self Management Type	Definition	Requirement
TYPE 1	Self-Management is planned, implemented, and supervised by the Ministry/Institution/Regional stakeholder in charge of the budget;	Not relevant for CSO
TYPE 2	Self-Management is planned and supervised by the Ministry/Agency/ Regional stakeholder in charge of the budget and implemented by other Ministries/Regional Apparatus Institutions implementing Swakelola	Not relevant for CSO
TYPE 3	Self-Management is planned and supervised by the Ministry/ Institution/Regional Apparatus in charge of the budget and implemented by the community organization in the form of Social-contracting.	1. Legal entity Foundation or legal entity association that has obtained legal entity ratification 2. Have a valid status of Taxpayer information based on the results of Confirmation of Taxpayer Status 3. Have an organizational structure/ management; 4. Have Articles of Association (AD) and Bylaws (ART) 5. Have a field of activity related to the goods/services held 6. Have permanent personnel with the knowledge and technical experience in providing or working on similar goods/services that are self-managed.

9 Presidential Regulation No. 12 2021 on Procurement of Goods and Services.

		7. Own or control an office with a correct, permanent and clear address in the form of own or leased. If the candidate for implementing Social-contracting will enter into a partnership, it must have a partnership cooperation agreement containing the responsibilities of each representing the partnership.
TYPE 4	Self-Management is planned by the Ministry/Institution/Regional Stakeholder in charge of the budget and/or based on the proposal of the Community Group, and implemented and supervised by the Community Group implementing the Swakelola.	Not relevant for CSO

It is important to note that these self-managed procurement regulations are general for all sectors of the ministries and agencies, and do not specifically regulate certain sectors or fields (i.e., health, HIV, harm reduction). There are two mechanisms for selecting type III social-contracting CSOs.[10]

Table 3.9: Government self-management fund type 3 - social contracting

Mechanism	Stage	Remarks
Direct offer	1. Social-contracting offer to organization that meet the criteria and conditions 2. Confirmation of offer (approval/rejection) with identified organization 3. Contracting process	This mechanism is carried out when there is only one community organization that meets the criteria and requirements set
Bidding	1. Notification of the self-management fund plan to the public 2. Call for application from the eligible organizations 3. Selection of organization, budget review, work-plan finalization 4. Contracting process	

The supervision stage is one of the stages in implementing type III social-contracting as a form of ensuring public accountability for implementing programmes that use public funds.

10 Regulation of goods and services procurement policy institutions No. 12 2021 on Goods And Services Procurement.

This stage consists of:

- Verification of administration, documentation, and reporting;
- Technical supervision of the implementation and results of social-contracting to determine the realisation of the implementation of activities which include:
  - » Monitoring the progress of the implementation of activities;
  - » Supervision of the use of labour (experts, skilled workers, or support personnel), consulting services, infrastructure/equipment, and materials
  - » Supervision of the procurement of goods and services (if any).
- Orderly supervision of financial administration.

Since the enactment of *Presidential Regulation No. 12 of 2021 on Government Procurement of Goods and Services,* the Ministry of Health as the person in charge of the HIV prevention programme, which includes harm reduction, has never implemented this type of social-contracting in the implementation of the national harm reduction programme. Some of the considerations considered to be justification include:

1. The harm reduction programme financed through domestic funds at the national level is an activity under the authority of the government and/or an activity with job specifications carried out by pharmaceutical companies, in this case, the procurement of drugs, procurement of class 3 narcotics (methadone);
2. The Ministry of Health has made no decision on the implementation of social contracting type III for the harm reduction programme. There is no stipulation on the implementation of type III social contracting after the work plan and financing budget have been approved;
3. There is no involvement of civil society organisations in the planning and budgeting process starting from the sub-district to the provincial and national levels.

3.3 Integration of Harm Reduction in National Planning Processes

The implementation and support of the harm reduction programme in Indonesia have a fairly open space. This can be seen in the applicable national policies as follows:

Table 3.10: National health planning documents and harm reduction

National Health Strategic Plan 2020-2024		**HIV National Action Plan 2020-2024**
Policy statements	**Remarks**	**Policy statements**
An educational approach to prevention activities (safe sex, safe use of syringes for people who inject drugs);		Conduct orientation on the Methadone Maintenance Therapy Program using the technical guidelines in province, district and city

Percentage of infectious disease screening in risk groups	Number of districts/cities that carry out early detection of Hepatitis B and/or Hepatitis C in a population at risk (pregnant women, health workers, WBP, IDU, PLWHA, HD patients)	Conduct awareness and sensitization meeting with law enforcement officials and the mass media on the Methadone Maintenance Therapy Program
Infectious Disease Prevention and Control	The number of people at risk (pregnant women, STI patients, TB patients, female sexworkers, mem who have sex with men, people who inject drugs, PWBP, and trans women) infected with viruses that weaken the human immune system who received HIV screening.	• Providing access to Methadone maintenance therapy • Provide access to harm reduction in key populations who use methamphetamine and/or other drug use

The inclusion of harm reduction programmes and HIV prevention services for key populations of people who inject drugs in the Ministry of Health's strategic plan and the National HIV Action Plan indicates the acceptance of the importance of harm reduction services in reducing new HIV infections.

Unfortunately, this policy does not merge with planning for harm reduction financing within the Ministry of Health under the coordination of the HIV work team, drug work team, or other related work teams (TB, Hepatitis). Several components of harm reduction financed through the domestic budget are considered out of sync with what is stated in the applicable health and HIV policies outlined in the table below.

Table 3.11: National Action Plan on people who inject drugs and Domestic Budget

People who inject drugs interventions in HIV National Action Plan	**Domestic Budget Availability**		
	Yes	**No**	**Remarks**
Screening for Hepatitis B and C for people who inject drugs		√	Hepatitis prevention and treatment is coordinated by Deputy director of Hepatitis, and targets only general population, not people who inject drugs, within the domestic budget.
HIV Screening for people who inject drugs[11]		√	Funded by international grants
Education for people who inject drugs		√	Funded by international grants
Provision of Harm Reduction services for people who use drugs (non-injecting)		√	No targeted Harm Reduction services for non-injecting people who use drugs due to lack supporting data and policies.

11 Ministry of Health, HIV National Action Plan 2020-2024, On minimum services standard state that HIV Screening must be done on 8 key population including people who inject drugs.

The process of the Health Strategic Plan Development is one of the responsibilities of the Ministry of Health. In this context, the Minister of Health is responsible for coordinating the preparation of a national health strategic plan with the following provisions.

Table 3.12: Process of Health Strategic Plan Development

POLICY	STAGE
Government Regulation (Number 40) of 2006 on National Development Plan process	Lead line-ministries prepare for the next period of Strategic Plan-beginning with the preparation of a technocratic development plan in their sector.
	While preparing the technocratic draft, the Head of Ministries/ Agencies collects: a. The evaluation result from the previous year implementation; and b. Community aspirations.
	The national Ministries/Agencies coordinate with Regional Governments in achieving national targets.

In the process of the strategic plan development, there is a space for civil society organisations to submit their aspirations and recommendations. This space is reaffirmed through the National HIV Action Plan 2020-2024, which highlights the roles and functions of civil society organisations. The community are defined as PLHIV organisations, beneficiaries, or key populations as per the definition provided in the National HIV strategic plan.

Table 3.13: CBOs and CSOs role stipulated in the HIV Actional Plan 2020-2024

SN	Organization	Roles/Responsibilities
1	Community-Based Organization	1. Support the government in achieving the national HIV targets 2. Support and facilitate innovations in HIV response 3. Encourage harmonization of HIV AIDS and PIMS programs across health and other development sectors 4. Encourage and ensure compliance in HIV AIDS and PIMS services 5. Increase public awareness of HIV, AIDS, and STIs and health seeking behaviors 6. Mobilize support, resources, and efforts from various stakeholders at national and international levels through strategic partnership 7. Influence policy changes related to HIV AIDS and PIMS through advocacy

2	Civil Society Organization	• Finding/outreaching people at high risk to HIV infections • Refer to the health facility • Assistance in taking medication • Education and promotion of HIV AIDS and PIMS • Capacity building of HIV AIDS and PIMS patients

3.4 Community and Civil Society Perspectives on Participation and Involvement in Planning and Decision-Making Platforms

Based on the interviews and community consultations conducted with CSOs, CLOs, and CBOs implementing harm reduction programmes in three cities and the National Network, the respondents had the same perspectives: the meaningful involvement and participation of community organisations in each step of the planning and budget development process remains quite low. Complex bureaucratic planning mechanisms, budgeting development processes, and decision-making on work plans, strategic plans, and any policies related to harm reduction are some of the reasons that CSOs, CLOs, and CBOs struggle to be consistently involved in the process, even though the policy provides the space for them to do so.

The challenge that most often arises among civil society organisations is when the final results and policies have been determined, but do not meet expectations. In addition, several civil society organisations have not yet completely understood the mechanism of the planning and budgeting process.

Below is a summary of the perspectives of key community-based/-led organizations on people who inject drugs engagement in the harm reduction budget.

Rumah Cemara (Bandung)

Most CSOs, CBOs, and CLOs have not been significantly involved in health sector planning. Several reasons are lack of funding to conduct domestic budget advocacy, lack of human resources, and lack of knowledge of government bureaucracy and procedure. This is unfortunate, considering there is a platform and space for CSO involvement at the national, provincial, and district levels through Development Plan Deliberation activities.[12]

PKNI

In the last 3 years, CSOs, CLOs, and CBOs have not engaged in meaningful participation of groups of people who use drugs policy making. The cause of low level of engagement is the lack of human resources and programme management, meaning that the vision and mission that should deliver the optimal goals of the organisation are not represented in the drug harm reduction programme.

12 The Development Planning Deliberation, abbreviated as MUSRENBANG, is a forum between actors in preparing National and Regional development plans. The Development Plan Deliberation is regulated in Law no. 25 of 2004 on the National Development Planning System and regulated by the Minister of National Development Planning/Bappenas for the national level and the Regional Development Planning Agency (Bappeda)

PEKA (Medan)

The involvement of CSOs, CLOs, and CBOs in the health sector planning process has not been optimal, especially when it comes to the national harm reduction programme. Within the existing mechanisms for the Development Plan Deliberations at the district, city, and provincial levels, the inclusion of these organisations is somewhat tokenistic, used to fulfil administrative requirements in the preparation process, but not for providing input and being actively involved in its development.

SECTION 4: FINANCIAL LANDSCAPE

4.1 Current level and sources of funding for the harm reduction response

Based on the budget data for the 2019-2021 period, the amount of the domestic budget allocated to the national harm reduction programme – which includes the TB-HIV drug supply and other health components is much larger than the international grant fund (Global Fund). However, the domestic budget does not reflect the availability of a budget for the harm reduction component that directly targets people who use drugs long-term.

The harm reduction component financed through international grants specifically aims at people who inject drugs. The table shows specific intervention components, such as procurement of sterile syringes and outreach and support activities for overdose prevention and management components. The government's financing is more focused on the components of drug procurement and the methadone maintenance treatment (MMT) programme without being accompanied by financing for its supporting activities.

The challenges that arise in accessing financing data for the implementation of harm reduction programmes in Indonesia include the spread of harm reduction components to different sectors and the non-aggregation of financing, specifically for people who inject drugs, as shown in the table below:

Table 3.14: Funding sources of harm reduction components in Indonesia

SN	Services	People in Charge	Target	Funding source
1	Opioid Agonist Maintenance Treatment	Sub Directorate Narcotic, MoH	People who inject drugs	• Domestic Budget • International Grant (Supporting Activity)
2	Needle Syringe Program	• Sub Directorate HIV, MoH • Community	People who inject drugs	International Grant
3	Peer Driven Naloxone for Overdose Prevention	Health Facility	People who inject drugs	Unknown The naloxone availability is limited to the hospital intensive care unit and health workers on emergency situation (Overdose).
4	HIV Testing Services Community-Based Screening	• Sub Directorate HIV, MoH • Community clinic	General	• Domestic Budget • International Grant (Supporting Activity)

5	Care Support Treatment Services	Sub Directorate HIV, MoH	General	• Domestic Budget • International Grant
6	Sexual Transmission Infection Services	Sub Directorate HIV & STI, MoH	General	• Domestic Budget • International Grant
7	TB Screening and Treatment Services	Sub Directorate TB, MoH	General	• Domestic Budget • International Grant
8	Hepatitis B & C Testing and Treatment	Sub Directorate Hepatitis, MoH	General	Domestic Budget
9	Pre-Exposure Prophylaxis for HIV	• Hospital • Public Health Facility • Community Clinic	Key Population	Pilot Project supported by International Grant and Technical assistance by UNAIDS Indonesia
10	Condom and Lubricant	Sub Directorate HIV, MoH	Key Population	• Domestic Budget • International Grant
11	IEC Material Development	Sub Directorate HIV, MoH Sub Directorate Narcotic. MoH	Key Population	• Domestic Budget • International Grant

Domestic financing at the national and sub-national levels cannot be compared considering that there is a division of authority between the two levels. This is regulated in the *Law on Regional Autonomy* which provides different directions and authorities for each level. Several harm reduction components related to the procurement of goods are carried out at the national level. At the same time, financing activities listed in the sub-national budget are a supporting activity of the programme carried out at the national level.

The availability of international grants for harm reduction programmes fills the gap for several harm reduction activities that is not supported by the domestic budget, such as syringe procurement, salary for outreach workers, community strengthening, and other supporting activities. Unfortunately, it is not synchronised with the efforts to develop a transition plan for harm reduction financing.

The government has not shown any commitment to improving the existing harm reduction programmes. This is particularly highlighted by the unavailability within the domestic budget for harm reduction as one of the HIV Prevention strategies. This lack of commitment can be seen from the government's new strategies in the National HIV Strategic Plan 2020-2024, which have not been comprehensively adapted to the WHO recommendation or best practices from the harm reduction Asia programme.

4.2 Domestic Funding for Harm Reduction

Domestic financing for implementing the harm reduction programme in Indonesia began in 2010 with the initiation of the methadone maintenance programme in three hospitals in Jakarta, Bandung, and Bali. Opioid agonist maintenance treatment (OAMT), as a component of harm reduction, is considered effective in preventing HIV transmission and changing circumstances or social factors that make people who inject drugs more vulnerable to acquiring HIV. Since methadone maintenance treatment (MMT) has been officially part of the government strategy, funding for the MMT programme has consistently been provided every year. However, given the shift in the trend of drug use from injection to oral, funding for this programme has also decreased, having been adjusted according to the estimation of the number of people who inject drugs in each city with MMT clinics.

The decrease in funding has occurred not only in the MMT programme, but also in almost all harm reduction components. Unfortunately, the government is still using international grants to procure needles and syringes for the NSP program. This is a threat to the sustainability of the NSP programme after the transition of financing to domestic funds.

Coordination between international donors and the government in developing an exit strategy is not optimal, especially for harm reduction services. The Ministry of Health, as the leading actor in the harm reduction programme, seems ambiguous in its commitment to strengthening harm reduction services. This could be due to misperceptions among government institutions and law enforcement about harm reduction.

Social health insurance

The national health insurance system is regulated under *Presidential decree no. 64/2022.* There are several exceptions for health services that cannot be covered by the national health insurance programme, including:

1. Health problems due to high-risk activities (i.e., extreme sports).
2. Health problems due to drug use and alcohol.

Exception number 2 creates financial pressure for people who use or inject drugs when accessing health services. Additionally, any prevention and treatment programmes that use government funding are not covered by national health insurance. Currently, all HIV prevention and treatment services, such as ARVs and TB-HIV tests, are free for key populations to access as it is still utilising government funding.

Things that need to be done by CSOs, CLOs, and CBOs in advocating for sustainability and strengthening harm reduction services in Indonesia include: submitting the results of a comparative study by the government of countries showing best practices of harm reduction (such as Portugal); and harm reduction domestic budget advocacy, which involves several key stakeholders, including the Ministry of Health, the National Narcotics Agency, the Ministry of Finance, the National Planning and Development Agency, the Legislature (Commissions 3 and 9), UN Agencies, and the CSOs, CLOs, and CBOs themselves.

Table 3.15: National (domestic) Budget on harm reduction (in USD)

SN	Component	Target	Year		
			2019	2020	2021
Ministry of Health					
1	Procurement of TB and Antiretroviral Drugs[13]	General	99,904,632.95[14]	62,103,293.42[15]	
2	STI Services	General	-	-	-
3	Hepatitis Services	General	-	-	-
4	Procurement of Sterile Syringes	People who inject drugs	-	-	-
5	Procurement of Methadone[16]	People who inject drugs	61,829.56	61,829.56	61,829.56
6	IEC Services[17]	General	12,953.89		
7	Procurement of Naloxone	People who inject drugs	-	-	-
8	Implementation of the people who use drugs[18] medical rehabilitation program	people who use drugs	1,755,280.16	1,867,213.00	1,965,487.37[19]
National Narcotic Board					
1	Strengthening people who use drugs rehabilitation institutions[20]	people who use drugs	-	-	1,096,017.12

13 Ministry of Health, *Directorate general of Pharmacies and health equipment budget execution list 2019-2020*
14 TB-ARV budget available for General PLHIV Include 33.492 people who inject drugs out of 543.100 PLHIV based on estimation year 2020
15 Ibid.
16 Ministry of Health, *Directorate of Mental Health and Narcotics budget execution list 2019-2021*
17 Ibid.
18 Ibid.
19 *Funding for community information is obtained through the results of the target drug users who are treated in that year multiplied by the standard of financing for medical rehabilitation as stated in the regulation of the Ministry of Health no. 4 of 2020 on the organizers of the recipient institutions must report.*
20 National narcotic board, *Deputy of Rehabilitation budget execution list 2021*

Table 3.16: Provincial (domestic) Budget (Kota Medan) - (in Rupiya) 1 USD= 15,450 Rupiya

SN	Component	Target	Year			Provinces
			2020	2021	2022	
Provincial Health Office						
1	Care Support Treatment (Supporting Activity)	General			62,300,000.00	Kota Medan
2	HIV AIDS Program Monitoring Evaluation	General	-	-	34,600,000.00 9,175,000.00	Kota Medan Bandung
3	HIV & STI Data Validation	General	-	-	20,250,000.00	Kota Medan
4	Partner Notification Workshop for Hospital and Public Health Officer	General	-	-	35,100,000.00	Kota Medan
5	Outreach worker Coordination Meeting	People who inject drugs	n.a		1,680,000.00	Kota Medan
6	Pengadaan Methadone	People who inject drugs	n.a	n.a	n.a	
7	Needle/Syringe Program	People who inject drugs	n.a	n.a	n.a	
8	Peer Driven Naloxone for Overdose Prevention	People who inject drugs	n.a	n.a	n.a	
9	Harm Reduction Community Strengthening	People who inject drugs	n.a	n.a	20,000,000.00 9,175,000.00	Kota Makassar Bandung

4.3 International Funding for Harm Reduction

The largest international grant in Indonesia for HIV prevention and treatment programmes comes from the Global Fund. Support for the 3-year implementation programme does include interventions for people who inject drugs (harm reduction). Apart from the Global Fund, there are several international grants, such as USAID through Epic and Linkages, but these do not include specific support for harm reduction interventions.

The principal recipients (PR) of the Global Fund in Indonesia consist of three institutions/ organisations: the Ministry of Health, the Spiritia Foundation, and the Indonesia AIDS Coalition. Each PR has their respective modules as their responsibility. The harm reduction programme implementation is classified into the prevention module through several activities, including outreach, supporting activity for MMT, needle and syringe procurement, and other general components including TB-HIV screening and testing, and antiretrovirals, for example.

The table below shows financing support from the Global Fund specifically for the implementation of harm reduction programmes in Indonesia.

Table 3.17: Global Fund Funding on HIV and Harm Reduction (in USD)

SN	Component	Target	Year				
			2019	2020	2021	2022	2023
Ministry of Health							
1	Testing (HIV – STI)	General					
	a. Community-Based Testing		607,037	2,008,633	733,669	913,458.26	671,982.30
	b. Facility Based Testing					1,541,915.89	2,483,543.63
2	OST Supporting Activity	People who inject drugs				63,600.50	8,907.48
3	Condom and Lubricant Procurement	General	-	-	-	197,734.95	232,251.05
4	Condom and Lubricant Procurement for people who inject drugs	People who inject drugs	-	-	-	-	-
5	Needle/Syringe Procurement	People who inject drugs	-	-	-	15,379.22	16,436.54

6	IEC Development	General	-	-	-	44,711.52	32,073.01
7	ARV Medicine	General	4,538,568	1,934,639	709,628	-	-
8	Care Treatment and Support	General	6,804,514	4,135,021	5,506,591	-	-
9	Comprehensive Prevention program for people who inject drugs	People who inject drugs	23,049	81,663	97,636	-	-
10	Program to reduce human rights-related barriers to HIV services	General	815,680	740,695	479,043	-	-
Spiritia Foundation							
1	Community-Based Testing for people who inject drugs	People who inject drugs	-	-	-	100.041.30	100,041.30
2	People who inject drugs Outreach	People who inject drugs	-	-	-	272,040	297,933.97
3	OST Supporting Activity	People who inject drugs			-	16,484.29	16,484.29
4	people who inject drugs Working Group	People who inject drugs			-	15,318.18	15,318.18
5	Overdose prevention and management training	People who inject drugs	-	-	-	66,288.62	-
6	Harm Reduction refresh training	People who inject drugs	-	-	-	15,835.68	-
7	IEC Material Development	General	-	-	-	52,941.79	-
8	Collecting used syringe	People who inject drugs	-	-	-	22,235.55	22,235.55

9	Comprehensive prevention program for people who inject drugs	People who inject drugs	511,395	376,679	198,566	-	-
10	Care, Treatment, and Support	General	2,002,147	3,086,301	3,233,288	-	-
11	Program to reduce human right related barriers to HIV services	General	162,908	54,147	-	-	-

Table 3.18: NASA Report - Resources Category (in USD)

SN	Category	Domestic		International	
		2019	2020	2019	2020
1	HIV Care Support Treatment	33,662,545	63,687,167	14,707,498	15,670,344
2	HIV Prevention	12,133,633	1,862,227	11,615,044	10,103,602
3	Community Mobilization	211,511		1,332,002	1,238,942
4	Management and Sustainability	4,378,842	2,713,452	20,698,961	17,108,458
5	TB-HIV Coinfection, Diagnose, and Treatment	1,096	15,355	34,339,193	27,559,369

Table 3.19: NASA Report - HIV funding expense category (in USD)

SN	Category	Fiscal Year			
		2019	Percentage	2020	Percentage
1	HIV Care Support Treatment	48,309,084		79,360,280	
2	HIV Prevention	23,748,677		11,965,828	
	OAMT	248	0.0010%	92,250	0.77%
	Prevention, promotion of testing, and referral to treatment programs for IDUs	973,48	4.100%	691,379	5.77%
3	Community Mobilization	1,543,513		1,238,942	
4	Management and Sustainability	25,077,803		19,821,910	

5	TB-HIV Coinfection, Diagnose, and Treatment	34,340,289		27,574,724	

Note: The absorption of funding for injecting drug users as a whole is only 4-5.7% of the total absorption of HIV prevention programs

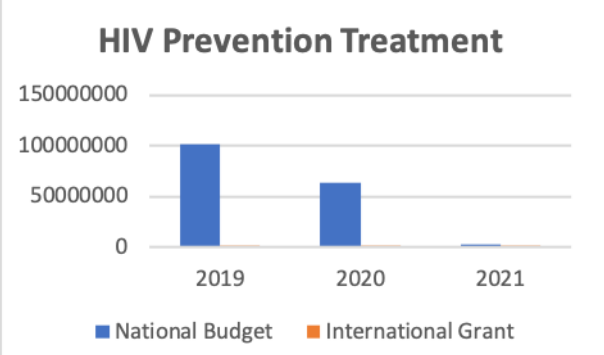
4.4 Resource Gaps, Needs, and Allocative Efficiency

Based on the financing table above, a comparison of the amount of financing between the domestic budget and international grants can be made. The available national budget for the implementation of harm reduction programmes concentrates on the procurement of ARVs and methadone, while there are other harm reduction components that are still covered by international grants (Global Fund) without a clear transition plan. The HIV prevention treatment chart below shows that the allocation of funding for ARV procurement dominates the total funding for HIV prevention and treatment programmes. The available budget for ARVs does not separate the target based on the needs of people who inject drugs as one of the key populations, but for the general needs of all PLHIV.

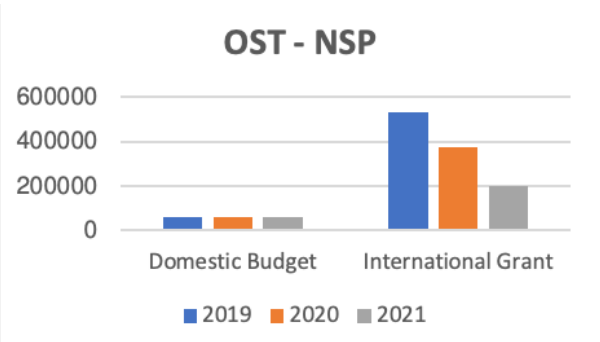
There are several harm reduction components that have not transitioned into the domestic budget, such as the procurement of needles and syringes, peer-driven naloxone programmes, hepatitis B and C screening for people who inject drugs, and harm reduction services for PWUID. There has been no study regarding the need for comprehensive harm reduction financing in Indonesia according to WHO guidelines.

Currently, there is a reduction in financing for harm reduction programmes in Indonesia. The justification for this reduction is generally due to a decrease in the estimated number of people who inject drugs, as well as the fear experienced by people who inject drugs when accessing the public health services. This is due to the strict implementation of a criminal justice approach through national laws on narcotics. Seen from the public health perspective, the decreasing number of people who inject drugs is not a reason to reduce the number of services, or even financing. It can be a threat if, at any time, injecting drug use cases occur as before.

Figure 1.2: International vs National grants for HIV (in USD)



Note:
The HIV prevention treatment cost includes the cost of procuring TB-HIV treatment packages for general PLHIV which is around 98.3% of total the domestic budget. There were 33.492 people who inject drugs living with HIV (out of 543.100 PLHIV) based on 2020 estimate. Other financing components are limited to procuring methadone and medical rehabilitation services for drug users.



Note:
The Global Fund is still the main source of financing for OST and NSP programs.

4.5 Challenges in Accessing Harm Reduction Services from The Government

Drug Policy Reform (DPR)

The best lesson that CSOs, CLOs,and CBOs can learn is how to manage funds according to their values and needs, and how to provide government standard reports. Legality and recognition are the main factors. Namely, the government requirement that the organisation is legally recognised in order to receive funding. While this recognition is a status that is not obtained in a short time, meaningful involvement and evidence of the impact of a CSO's work in an area are the main factors in obtaining recognition.

The current national budget (APBN) and sub-national Budget (APBD) for the last 3 years cannot be accessed by CSOs, CLOs, and CBOs in a formal way. There are, however, other informal ways to access them through approaching local institutions (i.e. provincial or district AIDS commission) where the budget amount is quite small. Some CSOs in regions with good Real Local Income (RLI) have provided grants or social assistance through local institutions with budgets that are also not too large for community-based strengthening programmes for people who use drugs, but not specifically for drug harm reduction programmes. Since the sub-national budget (APBD) is not large, it certainly has many shortcomings, including the fact that the programme component is only for community meetings and strengthening. There are no staff financing components or programme support financing facilities.

Peka Medan

Possible domestic funding is available today in the sub-national budget in Medan. It is placed through the Medan Health Office in the form of HIV and AIDS prevention programmes, where the harm reduction programme is one of the programmes, but the available support is very limited.

- Factors that support CSOs, CLOs, and CBOs in accessing domestic funding include:
- The existence of legal instruments in the form of regulations ranging from laws, government regulations, presidential regulations, ministerial regulations, and local regulations allowing CSOs to access domestic funds.
- The existence of an accessible social contracting type III mechanism.
- Legal entity organisation and internal governance.

Some of the challenges faced in accessing domestic funds include:

- Harm reduction programmes are not a priority in the health sector development plan.
- Organisational capacity and readiness to participate in bidding or funding applications at the domestic level are still limited.
- Some cities and districts do not yet have legal instruments for planning budgets for harm reduction programmes.
- CSO capacity to implement the good governance organisation is limited, especially for programme management, financial reporting, and accountability.

Rumah Cemara Bandung

Rumah Cemara has been involved in the implementation of a harm reduction advocacy programme, one element of which is budget advocacy. The experience of conducting budget advocacy in five cities (Medan, Pontianak, Makassar, Bandung, and Bali) shows a process that has potential if it is consistently carried out without relying on international grant funds. The experience of the inflow of funds intended for financing the harm reduction programme component at the sub-national level (Pontianak) in human resource capacity-building activities indicates a fairly good space and network between the community and local policymakers. The biggest challenges generally still revolve around the political commitment of policymakers and the justification for the lack of financing in the local area being the low number of people who inject drugs.

Policymakers who can become targets for harm reduction financing advocacy include:

Department of Health, Provincial AIDS Commission, law enforcement, Legislative/City Council, Provincial Planning and Development Board, Academics, and CSOs, CLOs, and CBOs.

Some of the challenges faced in accessing domestic financing for the implementation of harm reduction programmes include:

Table 3.20: Challenges faced in accessing domestic financing for the implementation of harm reduction programs

SN	Challenge	Status			Recommendation
		Yes	No	Limited	
Financial					
1	Harm reduction funding through domestic financing at the national/sub-national level			√	There is need of an active participation from CSO/CLO/ CBO in accessing community information related to plans for implementing planning meetings at the beginning of the year and being proactively involved in overseeing the process by submitting data-based proposals and recommendations
2	Domestic financing to fund the management of CSO/CLO/ CBOs implementing harm reduction		√		
3	Availability of financing for capacity building of CSO/CLO/ CBO in the implementation of the harm reduction program		√		
Human Resources / Organizational Capacity					
4	The capacity of human resources and organizations in the implementation of harm reduction programs			√	Conduct internal capacity building and regular evaluations, which are not only limited to health issues but include understanding related to program and budget advocacy efforts

5	Health workers' understanding of the harm reduction program			√	Periodically update health workers on community information and the latest information/guideline on harm reduction
Policy / Legal					
6	Policies, laws, and regulations that prohibit or limit the implementation of harm reduction programs		√		Carry out evidence-based advocacy to influence policies and regulations targeting specific stakeholders
7	Legislations and policies that provide space for CSOs/CLOs/ CBOs to implement overdose prevention and management programs		√		Carry out evidence-based advocacy to influence policies and regulations targeting specific stakeholders
8	Legislation that applies punishment for narcotics users	√			Carry out evidence-based advocacy to influence policies and regulations targeting specific stakeholders
9	Legislations and policies that provide space for CSOs/CLOs/ CBOs to access domestic financing	√			There is need of an active participation from CSO/CLO/ CBO in accessing community information related to plans for implementing planning meetings at the beginning of the year and being proactively involved in overseeing the process by submitting data-based proposals and recommendations
Coordination Level					
10	There are regular coordination meetings among the implementers of the harm reduction program.		√		There is a need of an active participation from CSOs/ CLOs/CBOs in initiating and proposing periodic cross-sectoral coordination meetings at the sub-national to national levels
11	Regular coordination meetings between national/sub-national government agencies to implement harm reduction programs.		√		
12	The existence of periodic evaluations/satisfaction surveys from service recipients on the implementation of the harm reduction program		√		

SECTION 5: MAPPING ADVOCACY OPPORTUNITIES

The National Action Plan for HIV for 2020-2024 has included an operational plan for implementing HIV prevention and control programmes. The operational plan for implementing the harm reduction programme me is limited to the following four activity plans (please see table 4)[21]:

Generally, the mechanism for formulating priority programs is carried out at the ministerial level by referring to the National Medium Term Development Plan (RPJMN). The policy directions and national health development strategies for 2020-2024 are part of the Long-Term Development Plan for Health (RPJPK) 2005-2025. There are 15 Strategic Target Indicators of the RPJMN 2020-2024, which are the responsibility of the Ministry of Health. The indicator related to harm reduction is the HIV incidence per 1,000 population, which was initially 0.24 to 0.18 in 2024. This indicator is implemented through prevention and control strategies in key populations, including people who inject drugs.

National priority programmes are prepared in order to achieve the 15 indicators of the national strategic targets. The five national priority health programmes are:

Priority Programmes

1. Improving maternal and child health, family planning, and reproductive health.
2. Accelerating nutrition improvement.
3. Improving disease control.
4. Strengthening the health system.
5. Strengthening the healthy community movement.

Advocacy efforts towards strengthening harm reduction services are integrated with indicators for improving disease control where the sub-indicators determined are:

Sub Indicators

1. Prevention and control of disease risk factors, including expansion of coverage of early detection, strengthening of real-time surveillance, vector control, and expansion of smoking cessation services.
2. Strengthening health security, especially capacity building for prevention, detection, and rapid response to disease threats, including strengthening the alert system for extraordinary events and health quarantine.
3. Increasing the scope of case finding and treatment as well as strengthening the management of disease and injury management.
4. Control of antimicrobial resistance.
5. Community empowerment in disease control and community-based total sanitation strengthening.

21 Ministry of Health, *HIV National Action Plan 2020-2024 - Operational Plan in HIV Prevention and Treatment*

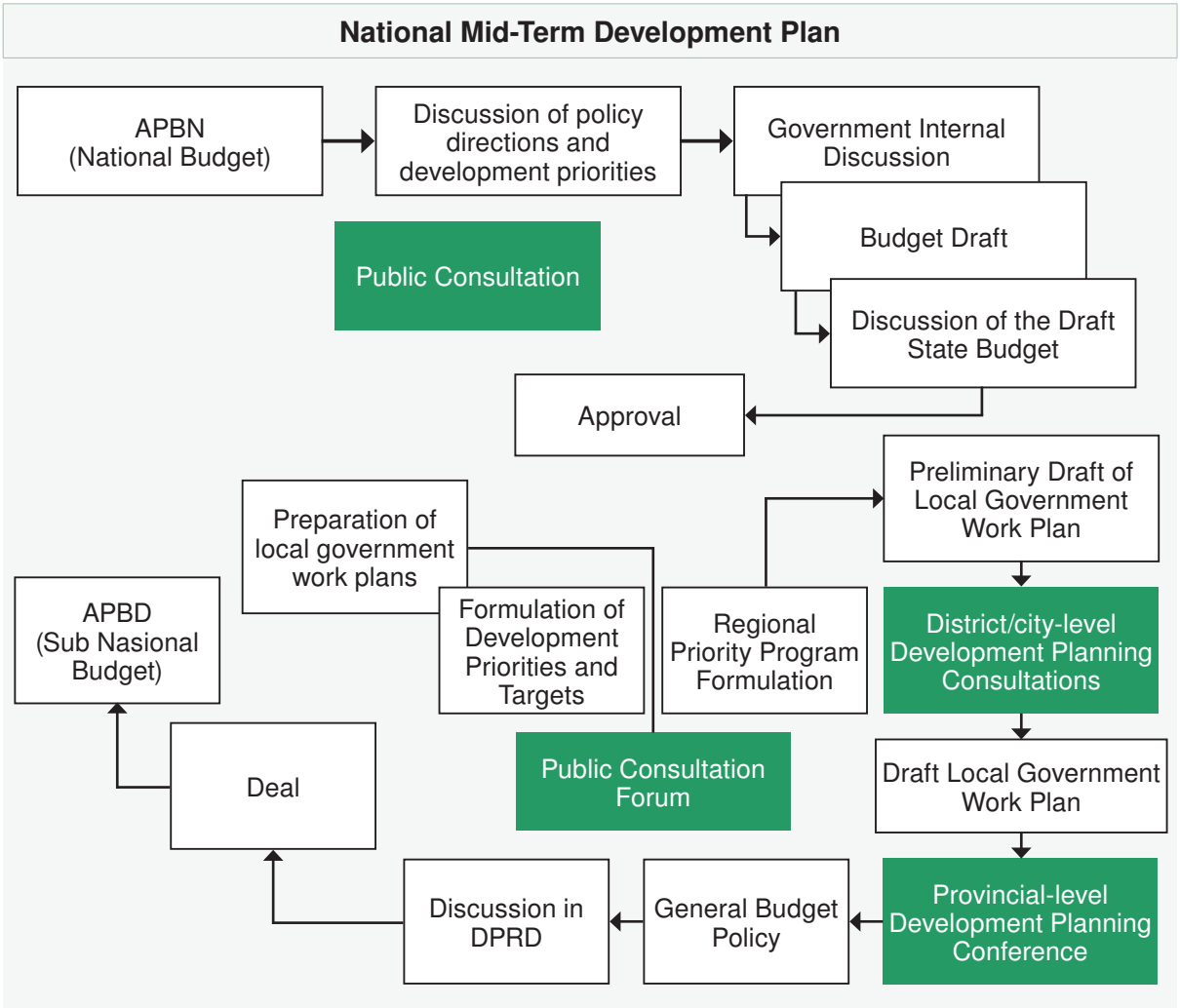
Preparing the government's annual work plan is one space for civil society to submit recommendations for harm reduction programme priorities. The process of planning and determining programme work plans will have implications for budgeting at the national level. Governments can encourage citizen participation in the budgeting cycle by creating conditions that enable them to do so meaningfully. Accessibility to public budgeting information at each stage is a prerequisite for that. The challenge is that the National Budget document prepared by the government is a technocratic technical document.

In contrast to the mechanisms that apply in the planning and budgeting process at the national level, the planning and budgeting mechanism with international grant funding sources (Global Fund) requires a national coordination mechanism consisting of government agencies and community representatives. The community representatives are divided into CSO representatives, PLHIV representatives, and national network representatives (CLOs). During the proposal submission phase of the budget planning process, every community representative at the national or sub-national level has the same opportunity to submit their proposals and recommendations. This mechanism is considered to be a good lesson for the implementation of transparency and public accountability

Table 3.21: The policy opportunity for CSOs/CLOs engagement

SN	Opportunities	Level	
		National	Sub National
1	**Programmatic**		
	There is a policy that provides space for CSOs/CLOs/CBOs to participate	√	√
	Health priority program, which includes the implementation of harm reduction services	√	√
	A policy provides space for CSOs/CLOs/CBOs to carry out their oversight function on public accountability.	√	√
	There is a policy that regulates the implementation of comprehensive harm reduction services.	√	√
2	**Finance**		
	There is a constitutional policy that mandates minimum financing for the health sector.	√	√
	The existence of best practices and the results of the evaluation of harm reduction services from the beginning was initiated as a database for budget advocacy.	√	√
	The inclusion of harm reduction services in the operational plan of the national HIV strategy as a basis for formulating budget policies	√	√

Figure 1.3: National plan formulation process in Indonesia



Note: The boxes highlighted in green provide space for the CSOs/CBOS/CLOs to engage.

Community Perspectives

Rumah Cemara

Some of the priorities that can be utilised to advocate for the sustainability of the harm reduction programmes are to be involved in the policy change process that is currently underway. Efforts to include harm reduction regulations at the national level will greatly affect domestic financing.

Drug Policy Reform (DPR)

There is an opportunity to enter into the Shopping Object Plan in the Regional Health Sector and or Regional Social Welfare OPD with the current policy of the Ministry of Home Affairs Regulation. At the Ministry level, it can enter into Social-Contracting type III. To budget with a normal process, the budget target must be projected to increase, even if it starts with a small initial budget value. Then that is the achievement of advocacy work.

PEKA Medan

The problem of drugs and other related issues is still included in the world's sustainable development goals (SDGs), so the problem of reducing harm will still be a concern of international institutions in Indonesia. Health problems in Indonesia are still a priority programme for the central government and several provincial and city/district governments, so it is still possible for this harm reduction programme to become a programme that receives budget support.

5.1 Mapping Partners

Law No. 23 of 2014 on Regional Government guarantees community participation in planning and budgeting. The local government encourages community participation by opening up space for transparency regarding public information on governance and community capacity-building for community groups and organisations to play an active role in governance. Based on the Regional Government Law, public participation can be done through public consultation, deliberation, partnership, conveying aspirations, monitoring, and/or other involvement by the provisions of the legislation.

Law No. 14 of 2008 on the Openness of Public Community Information also regulates the openness of public information organisations. It encourages the community's active role to be taken into account in formulating public policies. In addition, as a norm, public participation is open to all levels of society. The public is given space to submit suggestions, opinions, and criticisms.

The opportunities for CSOs, CLOs, and CBOs to participate in every stage of the process can be utilised in efforts to strengthen harm reduction services in Indonesia. Opportunities that can be optimised are illustrated in the figure 3.3

Based on the results of the FITRA National Secretariat's Local Budget Index in 2018, out of 70 districts/cities in Indonesia, the average participation index is 0.37 out of 1. The low level of community participation impacts the exploration of community problems and needs, so they are not part of development planning and budgeting. The research conducted by the FITRA National Secretariat portrays public participation in general. However, the results also illustrate the participation of community organisations in the health sector, especially harm reduction programmes.

It should be noted that it is not easy to access data, especially data related to national and sub-national budgets. The most common challenges encountered in efforts to monitor funding, especially harm reduction in Indonesia, include:

Table 3.22: Common challenges encountered monitoring government funding, especially harm reduction in Indonesia

SN	Challenges	Remarks
1	The harm reduction components are scattered and one-door comprehensive harm reduction services is not available.	More than 3 Sub Directorates in the Ministry of Health are responsible for harm reduction components, (i.e., TB, HIV, Hepatitis, Mental Health, Narcotics)
2	Unavailability of dis-aggregated data of harm reduction components targeting the general population	Some harm reduction components are provided for the general public or key populations as a whole, (i.e., TB, Hepatitis, ARV, STI, HIV Testing)
3	The community information system is not optimal to have financial transparency at every stage (planning, implementation, and supervision)	

4	The lack of public financial / budget information on the government website for public access	
5	The bureaucracy takes a relatively long time to provide any data or information to the the community.	
6	CSOs/CLOs/CBOs overburdened as the implementers to play effective role as watch-dog on the fund monitoring.	

The space provided for civil society as stated in the regulations is also supported by potential stakeholders who can provide support for policy advocacy efforts, financing, and implementing harm reduction programmes in Indonesia. Some partners classified as potentially supporting these advocacy efforts are:

Table 3.23: List of partners of harm reduction funding advocacy

Government Institutions	CSO/CLOs/ CBOs	Academic	International Partner
Ministry of Health	IPPNI	PPH Atmajaya	UN Agency (WHO, UNAIDS, UNODC)
Ministry of Law and Human Right	PKNI	ICJR	International Donor
National Human Right Comission	Local CSO	Community Legal Aid	
National Women Comission	National CSO		
National Plan and Development Board	FITRA		
National Narcotic Board			
Presidential Staff Office			
Ministry of Finance			

LIST OF REFERENCES

1. Ministry of Health Republic of Indonesia, HIV Quarterly Report Period Oct – December 2021, www.siha.kemkes.go.id
2. Ministry of Health Republic of Indonesia, 2019 – 2020 Budget Implementation List, Directorate General of Pharmacy and Medical Devices, https://farmalkes.kemkes.go.id/2021/03/dipa-2020-direktorat-jenderal-kefarmasian-dan -medical devices/
3. National Narcotic Board, *Indonesia Drug Report 2020-2022,* https://puslitdatin.bnn.go.id/konten/uploadan/2022/07/IDR-2022.pdf
4. Ministry of Health Republic of Indonesia, *National Action Plan for the Prevention and Control of HIV AIDS and PIMS in Indonesia 2020-2024*
5. UNAIDS, *Indonesia National AIDS Spending Assessment 2019-2020,* https://www.nasaindonesia.org/#
6. Republic of Indonesia. *Law Number 28 of 2004 on Amendments to Law Number 16 of 2001 on Foundations.*
7. Republic of Indonesia. *Law Number 16 of 2017, dated November 22, 2017, on the Stipulation of Government Regulation in place of Law Number 2 of 2017 on Amendments to Law Number 17 of 2013 on Community Organizations into Law*
8. Republic of Indonesia. *Law Number 36 of 2009 on Health.* State Gazette of the Republic of Indonesia Year 2009 Number 144, Supplement to the State Gazette of the Republic of Indonesia Number 5036 State Secretariat. Jakarta.
9. Republic of Indonesia. *Law Number 35 of 2009 on Narcotics.* State Gazette of the Republic of Indonesia of 2009 Number 143, Supplement to the State Gazette of the Republic of Indonesia Number 5062 of the State Secretariat. Jakarta.
10. Republic of Indonesia. *Law Number 40 of 2004 on the National Social Security System.* State Gazette of the Republic of Indonesia of 2004 Number 150, Supplement to the State Gazette of the Republic of Indonesia Number 4456 of the State Secretariat. Jakarta.
11. Republic of Indonesia. *Law Number 14 of 2008 on Transparency of Public Community Information.* State Gazette of the Republic of Indonesia Year 2008 Number 61, Supplement to the State Gazette of the Republic of Indonesia Number 4846 State Secretariat. Jakarta.
12. Republic of Indonesia. *Presidential Regulation No. 72 of 2012 on the National Health System.* State Gazette of the Republic of Indonesia Year 2012 Number 193.
13. Republic of Indonesia. *Presidential Regulation No. 64 of 2020 on the Second Amendment to Presidential Regulation No. 82 of 2018 on National Health Insurance.* State Gazette of the Republic of Indonesia Year 2020 Number 130.
14. Republic of Indonesia. *Minister of Health Regulation №. 21 of 2013 on Preventing HIV and AIDS.*
15. Republic of Indonesia. *Minister of Health Regulation №. 13 of 2022 on the Strategic Plan of the Ministry of Health 2020-2024*
16. Republic of Indonesia. *Minister of Health Regulation No. 82 of 2014 on Control of*

Infectious1Diseases

17. Republic of Indonesia. *Minister of Health Regulation No. 55 of 2015 on Combating the Adverse Effects of Drugs*
18. Republic of Indonesia. *Minister of Home Affairs Regulation No. 99 of 2019 on Amendments to the Regulation of the Minister of Home Affairs No. 32 of 2011 on Guidelines For The Provision Of Grants And Social Assistance*

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