HARM REDUCTION INTEGRATION INTO PRIMARY HEALTH CARE CENTER

A CASE STUDY FROM BANDUNG, INDONESIA

HARM REDUCTION INTERNATIONAL

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Designed by Bikas Gurung

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HARM REDUCTION INTERNATIONAL

Harm Reduction International is a leading non-governmental organisation (NGO) dedicated to reducing the negative health, social and legal impacts of drug use and drug policy. Through research and advocacy, we promote the rights of people who use drugs and their communities 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.

Andika Wirawam carried out research and analysis for this report in consultation with Catherine Cook, Gaj Gurung, Ailish Brennan and Ardhany Suryadarma (Rumah Cemara).

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EXECUTIVE SUMMARY

Harm reduction in Indonesia was introduced in the early 2000s by the people who inject drugs community and civil society to address rising HIV transmission among people who inject drugs. With backing from international donors including USAID, AusAID, and the Global Fund, these programmes expanded across multiple provinces in partnership with the Ministry of Health, proving effective in reducing HIV transmission. In particular, harm reduction services became prominent public health programmes for people who inject drugs in Bandung city due to consistent advocacy by people who inject drugs and positive stewardship from the government of Bandung City. Eventually, integrated harm reduction services within primary health centres (Puskesmas) began in 2005 in Bandung at a few selected sites.

Funding presents a significant challenge. According to Indonesia 2023 National AIDS Spending Assessment, 77.36% of HIV programme funding is from government sources, with 22.64% from international donors.[1] However, international funding has been critical in supporting key population programmes, including outreach for people who inject drugs. Research by Harm Reduction International highlights that the withdrawal of US international funding in 2025 negatively affected HIV prevention services such as counselling and outreach.[2]

To ensure sustainability amidst fragile donor funding, availability of domestic funding, comprehensive integration of harm reduction services into Puskesmas and advocating for social contracting across government levels are key. However, a rushed integration process undertaken without careful planning could further dismantle already inadequate HIV prevention and harm reduction services for key populations.[3]

Integrated HIV and harm reduction services, into puskemas, in many cities of Indonesia are facing numerous challenges related to governance, coordination, financing, human resource constraints, and, thus, poor service delivery.[4] However, integrated harm reduction services in Bandung city offered evidence on a model that works. Thus, Harm Reduction International and Rumah Cemara conducted a rapid assessment to document the process, context, enabling factors for integration, opportunities and challenges of this integration, highlighting Puskesmas (primary health care center) Tamansari case, to provide evidence on an integration model that works. The findings of this study will be useful for countries of diverse contexts that are planning to integrate harm reduction services into their primary health care centres.

1 Ministry of Health of the Republic of Indonesia, 2023. National AIDS Spending Assessment Report 2020-2021
2 HRI 2025. The Impact of US funding cuts on harm reduction in Indonesia. https://hri.global/publications/the-impact-of-us-funding-cuts-on-harm-reduction-in-indonesia/
3 HRI 2026. Key Harm Reduction Messages on Integration for Grant Cycle 8. https://hri.global/publications/key-harm-reduction-messages-on-integration-for-grant-cycle-8/
4 Karsima Foundation 2025. Strengthening Integrated Services for HIV, Drug Use, and Mental Health through Collaboration of Primary and Community Health Care Systems: An Analysis of Implementation and Advocacy Strategies in Four Cities in Indonesia

The study employed a qualitative approach to assess and document the case study. Key informant interviews were conducted with diverse stakeholders, including government representatives, service providers, and people who inject drugs. Focus group discussions were also held with people who inject drugs.

Further details of the methodology can be found in Annex 1.

Puskesmas Tamansari was selected as a case study for documenting harm reduction service integration in Bandung City due to its location in one of the sub-districts with the highest number of people who inject drugs, serving an estimated 31 individuals. Harm reduction and HIV services at Puskesmas Tamansari were established in 2019 following key population mapping by the Bandung City Health Office and City AIDS Commission (KPA), and were formally ratified by Bandung City Health Office decree.

Current integrated services include needle and syringe provision- the entry point to integrated services-, HIV counselling and testing and TB screening whilst opioid agonist therapy (OAT), antiretroviral therapy (ART) are accessed via referral to nearby Puskesmas and Hasan Sadikin Hospital. Despite limited space and a shortage of healthcare staff, Puskesmas Tamansari successfully integrated harm reduction-related services with broader health provision, including reproductive health, paediatric, and dental care.

The key enabling factor for successful integrated include functional and high-level working group comprising people who inject drugs, civil societies, and government agencies such as Health Office, hospitals, Police, and BNN (National Narcotics Board), providing stewardship to harm reduction programmes in Bandung. The Working Group has been hosted and funded by the Bandung City AIDS Commission (KPA). Other enabling factors include meaningful engagement of community and local leaders in encouraging people who inject drugs to access the integrated services; trained human resource within Puskemas Tamansari and quality service delivery.

People who inject drugs reported high level of satisfaction with services at Puskesmas Tamansari, expressing comfort with healthcare staff and noting the absence of stigma or negative treatment throughout their experiences. The continuity of care has been well maintained, as any unavailable staff member can be seamlessly replaced by a colleague offering the same standard of friendly, supportive service.

With the integration of harm reduction services into Puskesmas, funding responsibility has shifted to the local government of Bandung City. Programme costs, covering both services and personnel, are managed through the Health Operational Fund (BOK) in accordance with Ministry of Health guidelines. Commodities - including needles and syringes, alcohol swabs, condoms, HIV diagnostic kits, and medical consumables - are predominantly funded by the Bandung City Health Office, representing a significant shift from previous reliance on international donors and the Ministry of Health. The current funding composition stands at 70% local and 30% from the Ministry of Health, covering the harm reduction programme prevention package and HIV diagnostic sets.

The key recommendations for the policy makers, planners in different context

planning to design integration are as follows. The detailed recommendations can be found in a separate section in the report.

- **Involve people who inject drugs in the planning, implementation, and monitoring of harm reduction service integration.** Community engagement provides a detailed understanding of needs, enabling welcoming and responsive harm reduction services. Involvement should occur at both city level, through community and civil society groups or multi-stakeholder working groups, and at service level through joint activities with healthcare workers.
- **Design sustainability and transition planning into the integration process from the outset.** Advocacy for supportive regulations and long-term funding must include clearly defined scenarios, including dedicated low-threshold community-led service delivery and outreach in addition to integrated services, timelines, and transition projections to ensure financial and regulatory sustainability.
- **Provide comprehensive harm reduction and related services training for Health Office staff and healthcare workers, with regular refresher training.** Training covering harm reduction, HIV, TB, STIs, and Hepatitis should be delivered during both the initial and implementation phases of integration to ensure stigma-free and welcoming services.
- **Strive to develop comprehensive harm reduction services within a single service setting.** Consolidating harm reduction services minimises referrals, reducing the risk of treatment discontinuation and out-of-pocket costs for people who inject drugs.
- **Integrate harm reduction services with broader health services and administrative systems.** Integration should encompass maternal and child health, family planning, dental, and adolescent health services, aligned with medical records systems, reporting standards, and public health insurance access to ensure equitable service delivery.

1. THE HISTORICAL CONTEXT OF HARM REDUCTION INTEGRATION IN BANDUNG

Focus group discussion with a group of people who inject drugs
PHOTO BY HERAWATY

The integration of harm reduction interventions into primary healthcare centres in Indonesia, including Bandung, was largely initiated through the Indonesia HIV Prevention and Care Project (IHPCP) (2005–2007), an AusAID-funded initiative. In Bandung, this was implemented in partnership with Rumah Cemara, Yayasan Grapiks, and PKBI West Java.

The dominant role of NGOs in HIV prevention was considered insufficient without establishing a balanced system of health service referrals as part of a comprehensive response. Studies[5] identified significant gaps in available healthcare services and people who inject drugs, alongside regulatory barriers hindering harm reduction implementation. Advocacy for supportive national and local regulations, as well as improvements to the quality of healthcare services aligned with the needs of people who inject drugs, became central to developing this integration model. This advocacy was carried out jointly by the harm reduction NGO network (Jangkar)[6] and the National AIDS Commission at the national level, and by provincial and district AIDS Commissions at the sub-national level. Integration was also recommended following efforts to align harm reduction approaches with law enforcement agencies, recognising drug use as a public health issue rather than a criminal matter.

The IHPCP (Indonesia HIV Prevention and Care Project) initiated collaboration with the Health Office as the lead agency, delivering harm reduction and HIV training to Health Office staff and Puskesmas personnel. Trained healthcare workers were required to cascade this training to colleagues, ensuring a shared understanding of harm reduction services. Community health cadres, recruited from the local people who inject drugs community, served as liaisons between NGO outreach workers and Puskesmas services. Logistical support was initially provided by the IHPCP and gradually absorbed into local government funding.

Needle and syringe programmes (NSP), provided within PHC and through outreach workers, serve as the entry point for people who inject drugs, enabling integration with wider health services including HIV testing, ARV therapy, TB, STIs (Sexually transmitted infections), and PMTCT (Prevention of Mothers to Child Transmission), with the harm reduction service pathway fully embedded within the broader healthcare triage system.

5 SKEPO, 2006. Rapid Situation and Response Assessment: The Spread of HIV/AIDS among People Who Inject Drugs in 10 Districts of West Java. Indonesia HIV Prevention and Care Project 2006 and Indonesia HIV Prevention and Care Project, 2007. Harm Reduction: Expanding West Java's Response to the HIV Epidemic among People Who Inject Drugs

6 Jangkar (Jaringan Aksi Nasional Pengurangan Dampak Buruk Narkoba Suntik/Indonesia Harm Reduction Network)

2. PUSKEMAS TAMANSARI: INTEGRATION STORY

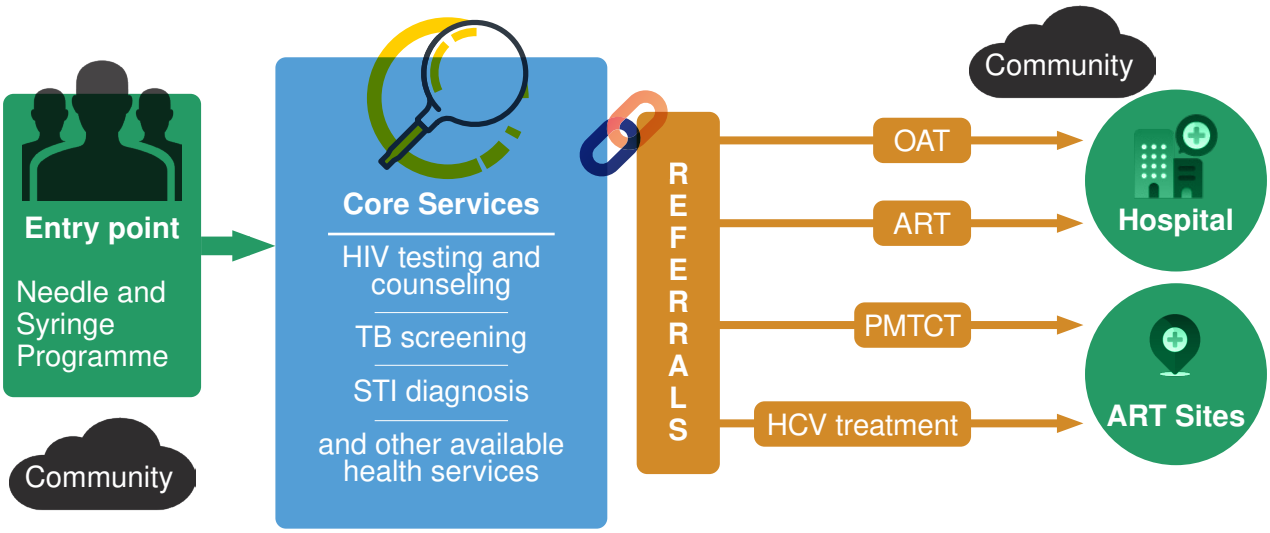
Puskesmas Tamansari Building
PHOTO BY TRI IRWANDA

Puskesmas Tamansari was selected as a case study for documenting harm reduction service integration in Bandung City due to its location in one of the sub-districts with the highest number of people who inject drugs, serving an estimated 31 individuals. Established in February 2005 as an extension of Puskesmas Salam, it became independent in early 2006 whilst remaining part of the same network. Situated in Tamansari Village, Bandung Wetan Sub-district, the area is particularly vulnerable to infectious diseases owing to its dense population and status as one of Bandung City's established slum areas.

Harm reduction and HIV services at Puskesmas Tamansari were established in 2019 following key population mapping by the Bandung City Health Office and City AIDS Commission (KPA), and were formally ratified by Bandung City Health Office decree. Alongside people who inject drugs, the sub-district also serves other key populations, including sex workers and men having sex with men (MSM).

Current services include needle and syringe provision (NSP), HIV counselling and testing and TB screening whilst other harm reduction and HIV services, such as opioid agonist therapy (OAT), antiretroviral therapy (ART) are accessed via referral to nearby Puskesmas and Hasan Sadikin Hospital. Despite limited space and a shortage of healthcare staff, Puskesmas Tamansari successfully integrates harm reduction-related services with broader health provision, including reproductive health, paediatric, and dental care. Whilst access to referral services has increased out-of-pocket costs for patients, adherence to ART and OAT remains good overall, with a notably low rate of loss to follow-up recorded across the key population groups served (see table below). harm reduction services have been integrated into the Puskesmas periodic quality assessment system under Cluster 4 of communicable disease services. The Puskesmas collaborates with Yayasan Grapiks, the local civil society organisation on harm reduction, for outreach and the Bandung City PKBI for other groups, with each population maintaining its own Peer Support Group.

Fig 1: An illustration of harm reduction integrated services at Puskesmas Tamansari



2.1 ENABLING FACTORS FOR SUCCESSFUL INTEGRATION IN BANDUNG

The high-level functional working group comprising communities and relevant government representatives was key to providing district-level stewardship for harm reduction programmes. The Working Group consisted of communities of people who inject drugs, NGOs, and government agencies such as the Health Office, hospitals, the Police, and the BNN (National Narcotics Board). In particular, the engagement of the Police and BNN was crucial in ensuring safer passage for people who inject drugs to access integrated services at public facilities, amidst harsh criminal laws in the country.

The Working Group has been hosted by the Bandung City AIDS Commission (KPA) and served as a forum for discussing issues and challenges related to the implementation of harm reduction programmes in Bandung City, including initiatives to advocate for regulations and funding, evaluate implementation, and coordinate across programmes and sectors. As at June 2026, a representative from Rumah Cemara7 served as the Working Group's coordinator. Furthermore, the Working Group has also played a role in raising public awareness of harm reduction through education and outreach to professional networks and the general public. On an annual basis, the Working Group holds six regular meetings fully funded by the Bandung City KPA. For 2026, due to national government budget constraints, the Working Group's meetings were scheduled only twice a year for programme evaluation and cross-sectoral coordination.

Similarly, the Puskesmas selected for harm reduction integration joined hands with community leaders and civil society organisations in encouraging people who inject drugs to access integrated services. Community and civil society outreach workers were also trained to ensure increased access for people who inject drugs to integrated services. Support services provided by outreach workers were expanded from an initial focus on preventive activities - such as the distribution of needles and syringes, bleach, and condoms - to include referrals for health screening and treatment for those in need. Meanwhile, Puskesmas prepared themselves by training healthcare workers in harm reduction, alongside various other training programmes, to provide stigma-free services to people who inject drugs.

7 Rumah Cemara is the community-led organisation working on HIV and harm reduction. They are country partner of Harm Reduction International in implementing budget advocacy grant from 2023-2026.

2.2 ACCESS TO INTEGRATED SERVICES BY PEOPLE WHO INJECT DRUGS AND KEY POPULATION GROUPS

Each Puskesmas has a different estimated target number for each key population group that requires support in accessing services. This is adjusted based on the results of key population mapping within each Puskesmas's catchment area.

NSP services serve as the primary entry point for people who inject drugs accessing broader health services at Puskesmas Tamansari, whether through NGO referrals or self-referral. The Puskesmas provides NSP, HIV, hepatitis B and C, and STI testing, and TB screening, but does not independently provide ART, instead functioning as a satellite provider under Puskesmas Salam. Whilst all Puskesmas offer HIV diagnostic testing, ART provision varies across facilities. A referral system directs people to the nearest available services, approximately 4 kilometres away, to minimise out-of-pocket costs and reduce the risk of patients being lost to follow-up from ART. This also applies to hepatitis B and C treatment services, which still require referral to hospitals, where people who inject drugs face barriers to access due to distance and a lack of JKN8 coverage. STI and TB screening services are available at all Puskesmas, including at Puskesmas Tamansari, but demand remains low amongst people who inject drugs (despite demand generation) due to additional stigma and discrimination.

Currently, the average number of people accessing harm reduction services at Puskesmas Tamansari exceeds the estimated target of 31 people who inject drugs within its catchment area. Regarding the OAT service, which is currently only available at Hasan Sadikin Hospital in Bandung, the relatively low and declining willingness of people who inject drugs to access OAT services, coupled with the shrinking population of people who inject drugs, means that OAT services remain concentrated at that hospital. Further information gathered from the focus group discussion revealed that reluctance to begin OAT was also due to cost factors – people are required to pay Rp15,000 (USD 0.84) each time OAT is accessed - as well as continuing concerns about dosing and withdrawal symptoms whilst receiving OAT. Over the past three years (2023–2025), the number of OAT clients at Hasan Sadikin Hospital has remained at 64.

8 The JKN is a compulsory social health protection programme run by the Indonesian government (administered by BPJS Kesehatan since 1 January 2014) to ensure that all citizens have access to comprehensive, high-quality healthcare. The system is based on mutual aid, with contributions (self-funded or subsidised). Anyone can be covered by the National Health Insurance Scheme, regardless of their background, provided they are registered as an active participant.

Table 1: Integrated service accessed by people who inject drugs at Puskesmas Tamansari (2023–2025)[9]

Year	People who inject drugs who accessed service at Puskesmas	Total NSP distributed on annual basis	Total condom distributed on annual basis	Total HIV test on annual basis	OAT referred and accessed	ARV referred and accessed
2023	60	516	54	22	4	3
2024	32	319	128	13	4	3
2025	40	516	84	8	4	-

One-fifth of people accessing services at Puskesmas Tamansari come from outside its catchment area. Service uptake is influenced by several factors, including where substances are obtained, feelings of safety and comfort, proximity to Puskesmas staff, and the presence of outreach workers and support staff.

People who inject drugs reported high levels of satisfaction with services at Puskesmas Tamansari, expressing comfort with healthcare staff and noting the absence of stigma or negative treatment throughout their experiences. The continuity of care has been well maintained, as any unavailable staff member can be seamlessly replaced by a colleague offering the same standard of friendly, supportive service. The presence of peer workers was highlighted as particularly valuable, not only for people who inject drugs themselves but also for their partners and families seeking healthcare services. Peer workers play a practical role in facilitating access for those without official identification, assisting them in obtaining letters of confirmation from relevant stakeholders to ensure uninterrupted access to services. Overall, the findings reflect a welcoming and inclusive service environment at Puskesmas Tamansari.

9 Secondary data source: Puskemas Tamansari, 2026

2.3 ENGAGEMENT OF PEOPLE WHO INJECT DRUGS

People who inject drugs have made substantial contributions to the design, decision-making, and monitoring of integrated harm reduction services in Bandung City. Through their roles within the Bandung City KPA working group, they have helped strengthen local regulations to create an enabling environment for integrated service delivery. Within Puskesmas, community members serve as outreach workers, peer educators, and mentors, whilst also mobilising peers and volunteers during mobile HIV testing and awareness campaigns. Some have transitioned into community organiser roles, providing valuable feedback to Puskesmas and the Health Office on the evolving needs of people who inject drugs. As harm reduction service delivery has shifted from civil society to Puskesmas, the community role has evolved towards advocacy, paralegal work, and demand generation, contributing to a continuous increase in service uptake.

3. FINANCING

KPA Kota Bandung Building
PHOTO BY TRI IRWANDA

With the integration of harm reduction services into Puskesmas, funding responsibility has shifted to the local government of Bandung City. Programme costs, covering both services and personnel, are managed through the Health Operational Fund (BOK) in accordance with Ministry of Health guidelines. Commodities - including needles and syringes, alcohol swabs, condoms, HIV diagnostic kits, and medical consumables - are predominantly funded by the Bandung City Health Office, representing a significant shift from previous reliance on international donors and the Ministry of Health. The current funding composition stands at 70% local and 30% from the Ministry of Health, covering the harm reduction programme prevention package and HIV diagnostic sets.

Local government funding has proved advantageous in allowing supplies to be tailored to the specific preferences and needs of people who inject drugs, as informed by community feedback. Nationally procured supplies have historically been less well received, as they often differ from those the community is accustomed to using. Logistics procurement is guided by programme performance reports and input from the harm reduction Working Group.

However, sustaining harm reduction programme support activities, particularly outreach, remains a challenge as international funding continues to decline. The Global Fund currently supports only four outreach workers across Bandung City, which is widely considered insufficient for reaching the broader community. Whilst the Bandung City KPA has deployed 30 community organisers - one per sub-district - this number is also deemed inadequate, given that each organiser is simultaneously responsible for reaching multiple key population groups, including MSM, sex workers, transgender individuals, and people living with HIV. Previously, outreach was conducted in partnership with Yayasan Grapiks staff, supported by Global Fund financing. As this external support diminishes, developing sustainable strategies to maintain adequate outreach coverage across Bandung City remains a critical priority for the programme.

4. TOWARDS SUSTAINABILITY

Social Contracting Informants: PKBI Jawa Barat (left), Yayasan Grapiks (second left), KPA Kota Bandung (second right), and the Consultant (far right)
PHOTO BY KPA KOTA BANDUNG

The provision of harm reduction services in Bandung is legitimised and protected by a robust framework of national and sub-national laws and policies. At the national level, harm reduction is referenced in HIV response regulations10 and a dedicated Minister of Health Regulation on Harm Reduction11, establishing the legal basis for harm reduction services to be available at the primary care level within Puskesmas. This is further reinforced by a Health Office Decree at the local level. Bandung City Regional Regulation No. 12 of 2015 on Narcotics, Psychotropic Substances and Precursors (NAPZA) and HIV/AIDS additionally mandates that the city provides drugs-related services, including harm reduction. The harm reduction Working Group within the Bandung City KPA has played a crucial role in translating these regulations into practice, ensuring services remain accessible for people who inject drugs.

At the systems level, the Ministry of Health is transforming the national health system through the Integrated Primary Care (ILP)12 approach, implemented across Puskesmas, Auxiliary Community Health Centres, and Posyandu facilities (community health posts). This framework organises health services into four clusters, with harm reduction falling under Cluster 3 (productive age and elderly health services) and Cluster 4 (communicable disease control), embedding harm reduction within broader integrated health service delivery.

Additionally, all Puskesmas in Indonesia are required to undergo periodic accreditation assessments evaluating managerial administration and service delivery, including compliance with standard procedures and the recording of service planning and outcomes. The inclusion of harm reduction services within this accreditation framework ensures their quality is subject to continuous improvement, as performance in this area directly influences overall assessment results. Together, these regulatory, systemic, and quality assurance mechanisms provide a strong enabling environment for the sustained and accountable delivery of harm reduction services across Bandung City.

10 Ministry of Health Regulation No. 23 of 2022 on the prevention and control of HIV and STIs
11 Ministry of Health Regulation No. 55 of 2015 on Harm Reduction for People Who Inject Drugs
12 ILP: Primary Care Integration (PCI) is a re-organisation of the primary healthcare system that focuses on the life cycle (from pregnant women to the elderly), rather than on specific diseases. PCI aims to bring comprehensive services (promotive, preventive, curative and rehabilitative) closer to the community through service clusters and the strengthening of networks down to the Posyandu (Community Health Post) level

5. CHALLENGES AND OPPORTUNITIES

Despite National and Bandung City's robust regulatory framework, several challenges remain in the integration of harm reduction services within Puskesmas, as evidenced by the experience of Puskesmas Tamansari.

- The uneven distribution of comprehensive harm reduction and HIV services across facilities means patients are frequently referred elsewhere, increasing out-of-pocket costs and the risk of loss to follow-up.
- Regulatory gaps persist, with the Health Office advocating for the inclusion of at least one harm reduction programme indicator such as NSP uptake within the city's Minimum Service Standards (SPM)[13].
- Staffing shortages remain a critical concern, as the insufficient ratio of healthcare workers to patients means people who inject drugs are often served only by designated HIV staff. This is compounded by a lack of formal harm reduction training, with workers relying on on-the-job learning from previously trained colleagues.
- Access barriers linked to documentation present further challenges. People without national identity documents cannot be registered in the Puskesmas electronic medical records system[14], limiting their ability to receive comprehensive assessments and continuity of care.
- The absence of documentation also restricts access to the National Health Insurance scheme (JKN), preventing people from utilising covered services such as Hepatitis C treatment, a condition affecting nearly 90% of people who inject drugs.
- Financial barriers, driven by stigma and social marginalisation, further limit access to fee-based services for some individuals.

Despite these challenges, Bandung City is well positioned to address them. The city government's strong commitment to harm reduction programmes, the existence of binding local regulations, and the collaborative relationships between communities, NGOs, and local government collectively provide a solid foundation for sustained programme growth. With targeted investment in staffing, training, documentation support, and regulatory strengthening, Bandung City has significant potential to further develop and sustain its integrated harm reduction services.

13 SPM: The Minimum Service Standards (SPM) for Health refer to the basic services that citizens are entitled to receive in full (100%) and constitute a priority for local government development

14 Ministry of Health Regulation No. 24 of 2022 on Medical Records

6. RECOMMENDATIONS

Based on the analysis and review of data and information regarding the integration of harm reduction services at Puskesmas Tamansari, the following recommendations can be drawn to guide the integration of harm reduction services in different contexts and in different countries.

1. **Involve people who inject drugs in the planning, implementation, and monitoring of harm reduction service integration.** Community engagement provides a detailed understanding of needs, enabling welcoming and responsive harm reduction services. Involvement should occur at both city level, through community and civil society groups or multi-stakeholder working groups, and at service level through joint activities with healthcare workers.
2. **Conduct stakeholder mapping at the outset of planning.** Early mapping identifies potential allies and parties with opposing views, enabling the development of appropriate and targeted advocacy strategies.
3. **Prioritise socialisation and training on the harm reduction approach during the initial planning stage.** Aligning perceptions and building a shared vision is critical, encompassing stakeholders with differing perspectives, such as the police and traditional local leaders, as well as collaborative partners in the health sector.
4. **Design sustainability and transition planning into the integration process from the outset.** Advocacy for supportive regulations and long-term funding must include clearly defined scenarios, timelines, and transition projections to ensure financial and regulatory sustainability.
5. **Conduct regular and accurate mapping of healthcare facilities and their proximity for key populations.** Facilities should be selected based on current population mapping data, updated periodically to reflect changes in the residential patterns of people who inject drugs.
6. **Provide comprehensive harm reduction and related services training for Health Office staff and healthcare workers, with regular refresher trainings.** Training covering harm reduction, HIV, TB, STIs, and Hepatitis should be delivered during both the initial and implementation phases of integration to ensure stigma-free and welcoming services.
7. **Strive to develop comprehensive harm reduction services within a single service setting.** Consolidating harm reduction services minimises referrals, reducing the risk of treatment discontinuation and out-of-pocket costs for people who inject drugs.
8. **Integrate harm reduction services with broader health services and administrative systems.** Integration should encompass maternal and child health, family planning, dental, and adolescent health services, aligned with medical records systems, reporting standards, and public health insurance access to ensure equitable service delivery.
9. **Build a shared commitment with community, civil society and peer support groups to strengthen community outreach.** Collaborative frameworks should be established to improve healthcare access for people who inject drugs, including support for broader social needs such as livelihood assistance and identity documentation.

ANNEX 1:

1. STUDY METHODOLOGY

This rapid study employed a qualitative approach to document the integration and social contracting of the harm reduction programme in Indonesia, focusing on the process and implementation of harm reduction service integration within primary health centres (Puskesmas) and social contracting of harm reduction programmes in Bandung. Data were collected through three methods: in-depth interviews with key informants from various groups; Focus Group Discussions (FGDs) with beneficiary groups to capture their experiences of accessing services; and literature reviews drawing on references relevant to the study objectives.

Document analysis — a systematic procedure for reviewing both printed and electronic material — was conducted using documents officially released by parties that have implemented or been involved in harm reduction programmes at national and sub-national levels. This approach was expected to provide a comprehensive overview from the perspectives of policymakers, service providers, and programme beneficiaries. Secondary data were also collected from the Health Office and Puskesmas to strengthen and enrich the analysis.

2. STUDY LOCATION

The study was conducted in Bandung City, selected in consultation with HRI and Rumah Cemara. Bandung was chosen because it has harm reduction services integrated within the primary healthcare system (Puskesmas) and because the local government has entered into social contracts with several NGOs implementing harm reduction programmes. The location was also selected to complement and deepen the findings of two earlier studies: Strengthening Integrated Services for HIV, Drug Use, and Mental Health through Collaboration of Primary and Community Health Care Systems, conducted by Yayasan Karisma and the Elton John AIDS Foundation (2025); and Best Practice: Sustainable Funding Transition Harm Reduction Programme in Indonesia — Case Study: Bali Province and Bandung City, conducted by Rumah Cemara and HRI (2025).

3. KEY INFORMANTS AND DATA COLLECTION

Key informant interviews were conducted using open-ended questionnaires with representatives from government agencies - including the Bandung City Health Office, the Bandung City National Unity and Politics Agency, and the Bandung City Komisi Penanggulangan AIDS (KPA) - as well as Puskesmas Tamansari and civil society organisations (Yayasan Grapiks, PKBI Bandung City, and PKBI West Java). FGDs were conducted solely with the people who inject drugs group. All interviews and FGDs were recorded with informed consent and managed in accordance with research ethics standards. Secondary data were sourced from relevant official documents published by various institutions.

4. DATA ANALYSIS AND MANAGEMENT

Data from interviews, FGDs, and document reviews were analysed using triangulation, with validation and clarification conducted with informants as needed. The study adhered to research ethics principles, including voluntary participation, informed consent, participant confidentiality, and data security. Limitations include those inherent to qualitative and descriptive approaches, the restriction of the study's scope to Bandung City with a limited sample, and constraints on the use of documents - particularly those relating to service integration that took place more than 20 years ago.

Needle and syringe program (NSP) Package of Puskesmas Tamansari
PHOTO BY ANDIKA WIRAWAN

CHARITY NUMBER: 1117375
COMPANY NUMBER: 3223265

A C/O Clockwise, Edward Pavilion, Royal Albert Dock, Liverpool, L3 4AF, UK
E INFO@HRI.GLOBAL
W WWW.HRI.GLOBAL

HARM REDUCTION INTERNATIONAL