HARM REDUCTION INTEGRATION IN PRIMARY HEALTHCARE

OPPORTUNITIES, CHALLENGES, AND LESSONS FROM INDONESIA

KARISMA

HARM REDUCTION INTERNATIONAL

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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.

Karisma Foundation is an Indonesian civil society organisation that has been working since 2001 to improve the health, dignity, and human rights of people who use drug, HIV, tuberculosis, viral hepatitis, and other socially excluded populations. Through community-led harm reduction programmes, policy advocacy, research, and capacity strengthening, Karisma works closely with government institutions, healthcare providers, and community organisations to promote evidence-based, people-centred, and rights-based health services. Karisma also supports the integration of harm reduction into Indonesia's primary healthcare system by generating research evidence, strengthening referral mechanisms, and advocating for meaningful community participation in health planning and service delivery. Its work aims to ensure that people who use drugs can access comprehensive, non-discriminatory, and sustainable health services while contributing to broader health system strengthening in Indonesia.

The report is based on original research conducted by Karisma Foundation (Karitas Sani Madani) 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.

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EXECUTIVE SUMMARY

Over more than fifteen years of consistent advocacy efforts by communities, civil society, technical partners, donors and government, Indonesia has expanded harm reduction programmes, for people who inject drugs, through policy development, domestic funding and service expansion. HIV rates among people who inject drugs went down- though the estimated HIV prevalence still stands at 39.1%,[1] which is higher than many other Asian countries. Efforts are also underway to strengthen the integration of harm reduction within broader national health system programming. However, substantial gaps still remain between national policy commitments and what actually happens in service delivery centers.

This document summarises the findings of a report published by the Karisma Foundation[2] in 2025, titled ***'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.[3] The study assessed how Indonesia is trying to bring HIV, drug use, and mental health services together at the primary health care level, guided by national and provincial policies. The study drew on interviews, group discussions, and review of policy documents and guidelines, conducted across Jakarta, Surabaya, Medan, and Makassar with health workers, policymakers, civil society organisations, and people who use drugs.

The findings show that integrating HIV, harm reduction, and mental health services at primary healthcare level continues to face structural challenges in the studied cities. These include fragmented inter-programme policies, limited human resources, inadequate and unreliable funding, and the lack of comprehensive technical guidelines on integration. The Integrated Primary Health Care (ILP) policy has been introduced, but its implementation remains poor. This is due to weak cross-sectoral coordination and ongoing sectoral bureaucracy. People who use drugs still have to visit different facilities for HIV, drug, and mental health services.

Communities play an important role as companions, educators, and links between service users and healthcare facilities. However, their contributions have not yet been

1 Global State of Harm Reduction 2024. https://hri.global/flagship-research/the-global-state-of-harm-reduction/the-global-state-of-harm-reduction-2024/

2 Karisma Foundation is a community based organisation organisation working on HIV and AIDS, harm reduction, viral hepatitis and tuberculosis, based on East Jakarta, Indonesia. More information can be accessed from https://karisma.or.id/perjalanan-karisma/

3 HRI received consent from Karisam Foundation on 13th March, 2026 via email to reproduce the summary report based on their original report.

formally recognised within the service system. They do this for free, without official recognition and under constant risk of arrest.

The rehabilitation system (IPWL), within the integrated service, is not trusted. People who use drugs fear their data will be shared with the police. That fear is not irrational; there are documented cases of people being arrested while enrolled in rehabilitation programmes. Health and criminal justice are pulling in opposite directions. As long as people fear arrest, they will not fully utilize available services.

Despite these challenges, the study also found what's working well in different cities:

- Jakarta demonstrates relatively developed governance arrangements for implementing Integrated Primary Health Care which reorganises primary healthcare services into functional clusters rather than disease-specific silos. HIV, mental health, tuberculosis, maternal-child health, and other programmes are expected to operate within coordinated service structures to improve continuity of care and efficiency. The arrangement emphasizes referral continuity across service levels, where PHC connect clients to hospitals and support services.
- In Jakarta and Medan, community members find missing patients, accompany them to service centers, remind them to take medication, and advocate on their behalf. This work is unfunded and done voluntarily. Official recognition and funding would create a genuine partnership between communities and formal health services.
- In Surabaya, the civil society organisations, Health Office, BNN (Narcotics Control Buerue), and Social Affairs Office collaborate on patient care without formal agreements. Their coordination relies on personal relationships rather than written procedures, enabling effective case handling and follow-up treatment.

RECOMMENDATIONS

For National Governments and Health Ministries:

- **Turn integration policy into enforceable rules and implementation technical guidelines.** Indonesia has national policies that say the right things. What is missing is the technical guidelines: clear instructions, specific responsibilities and budget commitments. Without these, nothing changes on the ground.
- **Create dedicated earmarked budget line for integration.** Health offices and Puskesmas cannot fund integrated activities if there is no budget category to put them in. Governments should create dedicated funding mechanisms—including Special Allocation Funds (DAK) and regional budget lines (APBD)—specifically for harm reduction integration.
- **Formally include communities and civil society organisations in service**

delivery and health planning. This means more than consultation and engagement. It means defined roles, written agreements, and access to operational funding for the work, such as community outreach and support, communities are already doing.

For Local Governments and Health Facilities:

- **Invest and retain competent human resource.** Conduct workload analysis of health workers to identify human resource needs and increase health workers capacity through consistent trainings and supervision.
- **Invest in the physical environment.** Private counselling rooms, adequate medicines, and spaces that feel safe and welcoming for key populations, women, LGBTQ+ people, and people with mental health conditions.
- **Strengthen internal and external coordination bodies.** Assess and improve how referrals between programmes in the same building are handled, and how patients are followed up if they drop out; encourage cross-sectoral collaboration with communities and CSOs to improve the quality, access, and desirability of services.,

For Civil Society Organisations and Communities:

- **Push for formal agreements with health centres.** Written agreements protect community workers from criminalisation. They also make community work visible in official systems—which is a precondition for getting it funded.
- **Build community monitoring tools.** Communities are already monitoring the quality of services informally. This capacity can be developed into structured tools that connect to official programme monitoring and create accountability.
- **Advocate for stable and multi-year funding.** Short project grants do not work for accompaniment, peer education, and case follow-up. These activities need stable operational funding—not project-by-project survival.

For Donors and Development Partners:

- **Fund the conditions for sustainability, not just the services.** Indonesia's experience shows clearly what happens when harm reduction depends entirely on outside funding: when the money stops, the services stop. Grants should actively support the development of domestic government financing for integration.
- **Fund integrated data systems that protect privacy.** HIV, drug use, and mental health data need to be connected. But any integrated system must guarantee patient confidentiality. Without that guarantee, people will not use the services.
- **Fund inclusion explicitly.** Women who use drugs, people with disabilities, and LGBTQ+ people who use drugs are excluded from services that were not designed with them in mind. Gender, disability, and social inclusion (GEDSI) must be a funded part of every programme, not an afterthought.

WHAT DOES "INTEGRATED SERVICES" ACTUALLY MEAN?

People use the word "integration" a lot. But what does it actually mean for the people who need these services? What exists in most integrated health centres right now is basic coordination. An HIV officer might refer someone to the mental health unit. A drug programme worker might pass a patient on to someone else. This is not the same as integration. Effective service integration should align with rights-based health frameworks emphasising availability, accessibility, acceptability, and quality (AAAQ), while ensuring dignity, confidentiality, and meaningful participation of affected communities.

People who use drugs describe what they actually need. They want to get all the care they need in one place, from one visit. They do not want to be sent to a different facility for each problem.

> "If HIV patients who also use drugs come to the health centre, usually they are only treated by the HIV section. The drug programme is not followed up."
>
> — Community member, Medan

> "There are no integrated services yet. If you want drug, health, and HIV services, you have to visit different places."
>
> — Community member, Makassar

Integration also means more than having services in the same building. It means the space feels safe and private. It means staff treat people with respect, without judgement. It means services work for women, for people with disabilities, and for people with mental health conditions.

> "Integration is not only about the service as one, but also how the place is safe and the officers are friendly, especially for female users."
>
> — Community member, Jakarta

And it means communities help design and run the services—not just receive them.

> “Integration can work if the community is involved. We know the conditions of the field and can help accompany patients.”
>
> — Community member, Jakarta

So real integration has three parts: services in one place; care that is welcoming and safe for everyone; and communities involved in how services are run. None of these three things currently exists fully in Indonesia’s integrated health system.

GOOD LAWS, WEAK ACTION: THE POLICY PROBLEM

Indonesia has some strong national policies on health, HIV and harm reduction. The Ministry of Health issued guidelines in 2021 saying that primary health centres—called Puskesmas—should be the main place for integrated HIV, drug use, mental health, tuberculosis, and hepatitis services. In 2023, a reform called the Integrated Primary Health Care policy (ILP) tried to reorganise Puskesmas into coordinated clusters. There are also proposals to change drug laws to treat drug use as a health issue rather than a criminal one.

These policies are real. But they have not been turned into clear instructions that health workers and service centers can actually follow. One stakeholder in Makassar described the problem directly:

> “The ILP (Integrated Primary Health Care Policy) has only been in the last two years, but the technical guidelines are not yet clear, so we are still confused about what kind of integration it will take in the field.”
>
> — Health stakeholder, Makassar

HIV, drug use, and mental health programmes sit in different parts of the Ministry of Health. There is no rule that says these parts must work together, share data, or plan jointly. When coordination does happen, it is because specific individuals make the effort. When those individuals are transferred, the coordination stops.

This matters because these health problems are not actually separate. Methamphetamine use—especially during sex—increases HIV risk. HIV makes mental health worse. Mental health problems make it harder to stick to treatment and more likely that someone will use drugs more heavily. And all three problems are more common among people who have been pushed to the margins by poverty and criminalisation. These are not three different problems. They are one problem that needs one integrated response. HIV vulnerability, substance use, and mental health conditions frequently intersect and reinforce one another, highlighting the need for integrated service delivery models.

For countries building their own integration programmes, the lesson from Indonesia is clear: writing a good policy is not enough. You also need clear instructions, dedicated money, and someone accountable for making it happen.

NO ONE IS IN CHARGE OF THE WHOLE PICTURE

For integration to work, someone has to be responsible for it. That responsibility cannot just be left to goodwill.

The 2023 ILP (Integrated Primary Care) reform reorganised Puskesmas services into clusters on paper. In practice, very little has changed. HIV sits in one cluster, mental health and drug programmes in others. Each unit still works separately. Health workers described the reform this way:

> “Overall, there is no difference between before and after the cluster, it’s just that the pronunciation is different.”
>
> — Health worker, Jakarta

The computer systems make this worse. HIV, mental health, and drug programme data are all stored in separate systems that cannot talk to each other. Workers have to enter the same patient’s information multiple times, in multiple systems. The systems crash regularly:

> “The system does not support. If there are already many openings, there is an error immediately. Sometimes I can’t open it all day, so I end up using spreadsheets, so I work twice.”
>
> — Health worker, Jakarta

At the city level, the committees that are supposed to coordinate services across sectors either do not exist, are not active, or only focus on severe mental illness — leaving drug use out entirely. There are efforts for such coordination in Makassar and Medab- between health offices, the National Narcotics Agency (BNN), and social services. But it is informal. It falls apart when leadership changes because there are no written agreements to hold it in place.

NOT ENOUGH STAFF, NOT ENOUGH TRAINING, TOO MUCH TURNOVER

Structures and policies matter. But services cannot work without enough trained, stable staff. In many Puskesmas across all four cities, one health officer is responsible for HIV, drug use, and mental health programmes all at once. Health centres have asked for more staff. The requests have been refused:

> “We have applied for an additional five doctors, but they are not approved.”
>
> — Health worker, Jakarta

Training on integrated services is minimal. Most of it is delivered online, while workers are simultaneously managing their normal caseloads. Many workers feel they do not know how to handle complex cases. Instead of treating patients directly, they refer them elsewhere. Skills in psychology and addiction counselling—which are officially required—are almost entirely absent:

> “If there are drug patients or mental disorders, we are often confused about where to start. They have never been taught how to handle it.”
>
> — Health stakeholder, Surabaya

Workers who have built up experience are regularly transferred to other posts before they can use what they know:

> “I just trained, and two months later it has been moved to another place. So the knowledge doesn’t have time to be put into practice.”
>
> — Health stakeholder, Medan

The cycle repeats: train, transfer, retrain. Integration never gets past the beginning stage. When one motivated worker leaves, the programme collapses. The answer is not to ask workers to try harder or care more. The answer is structural: written procedures that any new worker can follow, lighter workloads, and supervision that actually helps workers do their jobs.

NO ADEQUATE AND RELIABLE FUNDING FOR INTEGRATED WORK

Even if the will and the staff are there, integration cannot happen without money. Indonesia has two relevant mechanisms: Special Allocation Funds (DAK), which are central government transfers to regional governments, and regional budgets (APBD). Neither currently has a dedicated line for harm reduction integration.

As the result there were no budget lines for integration activities in any of the health offices studied, both in the Strategic Plan and in the Activity Plan and Budget (RKA). The budget is still sectoral and separate between programmes. This means there is no formal way to propose, track, or fund work that crosses programme boundaries:

> “If you want to make a joint activity, you are confused about where to put it. Because there is no budget line for joint activities of HIV, drug use, and mental health.”
>
> — Health stakeholder, Surabaya

HIV programmes have remained relatively stable because of Global Fund money and, until recently, USAID funding. Drug use and mental health programmes have no equivalent outside support. When budgets are tight, they lose out:

> “The drug programme is still considered not a favourite programme, so when submitting a budget, it is often not approved.”
>
> — Health stakeholder, Jakarta

The recent withdrawal of USAID funding exposed how dependent the system had become on outside money:

> “EpiC [USAID EpiC] has been cut off, USAID has also been cut off, so now a lot of financing is hanging on it.”
>
> — Health stakeholder, Jakarta

When donor funding ends, the services built on it collapse—unless domestic government budgets are already in place to continue them. Community workers end up paying for outreach from their own pockets. Civil society organisations survive on short project grants with no stable income.

COMMUNITIES ARE ALREADY DOING THE WORK—FOR FREE

One of the most striking findings of this study is not what the formal health system is failing to do. It is what communities are already doing, every day, without pay and without official recognition.

In a survey of 100 community members, 49 had accompanied people to health services, 44 had done peer education, 19 had collected case data, and 16 had provided emergency or harm reduction services. Communities function as peer navigators, treatment supporters, case trackers, and linkage facilitators within community systems strengthening approaches. These are roles the formal health system has not funded or filled.

In Jakarta and Medan, community organisations regularly help health centres track down patients who have dropped out of care:

> “We often help follow up patients who have lost contact. So if there is a name from the health centre, we will help find it in the field.”
>
> — Community member, Jakarta

Civil society organisations—including PKNI (the Indonesian Drug User Association), PKBI, and Rumah Cemara—have pushed for policy reform, built trust between people who use drugs and health workers, and in many cases are the only reason people ever reach rehabilitation services at all.

But none of this work appears in any official plan or budget. Communities are not invited to planning meetings. They are not paid for what they do:

> “We work using personal funds. If you accompany your clients every day, there is no cost.”
>
> — Community member, Jakarta

The barriers they face are serious. Of the survey respondents, 38 said fear of arrest was a main obstacle to their work. 28 said stigma from health workers was a barrier. 24 said it was hard to communicate with government at all.

These are not personal problems. They are problems that government policy has created—and that government policy must fix. Communities must be formally recognised, included in planning, and paid for the work they do. This is not a luxury. It is a requirement for any integration programme that wants to work.

WHY PEOPLE DO NOT TRUST THE REHABILITATION SYSTEM?

Indonesia has a network of government-designated rehabilitation facilities, where Puskesmas make referrals for people who use drugs for treatment. They are called IPWL, which stands for Institusi Penerima Wajib Lapor. In theory, these are places where people who use drugs can go for treatment instead of facing prosecution. In practice, the system has not delivered on this intent—not primarily due to resource constraints, but due to gaps in operational guidance, workforce orientation, and the trust of the communities it is meant to reach.

Many Puskemas are also designated as IPWL as part of integrated services for people who use drugs. Findings suggest implementation challenges are driven not only by limited resources but also by inconsistent operational guidance and uneven workforce capacity development. Many health workers do not understand what IPWL means. Several workers in Surabaya and Medan did not even know their health centre had been designated as an IPWL until they were told during an inspection. Others knew the name but thought it only meant paperwork—not actual rehabilitation:

> “IPWL is often misunderstood, thought to be just a place to report, when there should be a rehabilitation process.”
>
> — Health worker, Jakarta

Importantly, people who use drugs do not trust IPWL. They are afraid that if they register, their personal data will be shared with the police:

> “Patients are still afraid to come to IPWL because they are afraid that their data will be sent to the police or BNN.”
>
> — Community member, Jakarta

This fear is not irrational. The research found real cases where people who were registered in rehabilitation programmes were arrested during police operations. No data sharing system exists to protect them. People who use drugs are making a rational decision to stay away from services that could get them arrested.

Third, there is no dedicated budget for IPWL activities. Costs are borrowed from HIV or mental health budgets, or from general funds. Health centres do not know how to plan or propose activities:

> “There is no IPWL financing technique, so many health centres do not dare to propose activities because they do not know which account to enter.”
>
> — Health stakeholder, Medan

The IPWL system reflects the larger problem in miniature. The policy says the right things. But it has no money, no protection for patients, and no clear instructions for how it should work in practice.

HEALTH AND CRIMINAL JUSTICE ARE PULLING IN OPPOSITE DIRECTIONS

Any honest look at harm reduction in Indonesia has to address law enforcement. The two systems—health and criminal justice—are working against each other. Between October 2024 and May 2025, police recorded nearly 19,000 drug cases and over 26,000 suspects. This is happening at the same time as the government is trying to build a health-based approach to drug use. These two things contradict each other.

Health workers reported feeling unsafe doing outreach in areas where police were active. Some were summoned by police for doing their jobs:

> “There was once an officer who was called by the police for participating in a field rehabilitation programme. They don’t understand that this is part of health.”
>
> — Health stakeholder, Makassar

The different agencies—the National Narcotics Agency (BNN), police, health offices, and social services—have different goals and no shared accountability. When individual leaders build working relationships, things improve. But when those leaders change, the collaboration disappears:

> “If you change the head of BNN or the Chief of Police, the coordination can change again, because there is no binding system.”
>
> — Health stakeholder, Medan

THE PHYSICAL ENVIRONMENT MATTERS TOO

It is easy to overlook buildings and equipment when talking about policy and systems. But the research is clear: the physical environment of health centres is a real barrier to integration.

Most of the health centres studied have no private room for drug use or mental health consultations. Patients with stigmatised conditions are seen in shared spaces where anyone can overhear. This is not just a comfort issue. When people cannot speak privately, they do not disclose what is really happening. They do not ask for help:

> “Integration is important, but there must be a comfortable and safe space. Many female patients don’t want to come if the place is open.”
>
> — Community member, Jakarta

Many health centres also lack basic medicines and equipment for mental health and addiction treatment. As a result, patients are sent to hospitals—not because their condition is serious enough to need a hospital, but simply because the local health centre does not have what is needed to treat them.

Community-based rehabilitation facilities face the same problems. Many are operating out of borrowed rooms in health centres or civil society offices. They have no proper counselling capacity. Some can do little more than fill in forms and send people elsewhere.

Investing in safe, private, welcoming physical spaces—spaces that women, LGBTQ+ people, and people with mental health conditions feel comfortable entering—is not optional. It is a basic condition for integration to work.

WHAT IS ALREADY WORKING?

The research does not only document problems. It also finds places where integration is moving in the right direction. These examples show what is possible.

- Among the four study sites, Jakarta demonstrates the most developed governance arrangements for implementing Integrated Primary Health Care (Integrasi Layanan Primer – ILP), although implementation challenges remain. The model illustrates several operational elements that may inform integrated harm reduction programming in other settings.

  Jakarta has begun implementing the Ministry of Health's Integrated Primary Health Care (ILP) approach, which reorganises primary healthcare services into functional clusters rather than disease-specific silos. HIV, mental health, tuberculosis, maternal-child health, and other programmes are expected to operate within coordinated service structures to improve continuity of care and efficiency (Ministry of Health Republic of Indonesia, 2023). While drug-related services remain unevenly integrated, ILP provides an institutional platform for future integration of HIV, substance use, and mental health responses.

  The governance model increasingly emphasises referral continuity across service levels. Puskesmas act as primary entry points, with referral pathways connecting clients to hospitals, mental health services, rehabilitation facilities, and community-based support mechanisms. Study findings indicate that referral systems function more effectively where formal and informal collaboration between providers and community actors already exists.

  Jakarta also shows stronger internal coordination arrangements compared with other locations through cross-programme collaboration inside Puskesmas and district health systems. However, the study also identified persistent fragmentation between HIV, mental health, and drug programmes, indicating that coordination mechanisms remain dependent on leadership commitment and operational guidance rather than institutionalised systems.
- Community participation remains a central enabling factor. Community organisations contribute through peer navigation, treatment accompaniment, outreach, adherence support, and linkage to care. The study found that communities frequently function as social bridges between service users and facilities despite limited formal recognition within health system governance structures. Institutionalising these roles could strengthen integrated service delivery substantially.

  Taken together, Jakarta's experience suggests that governance reforms alone are insufficient. Sustainable integration requires operational guidance, financing mechanisms, workforce capacity, referral coordination, and formal recognition of

community roles within service systems.

Community accompaniment in Jakarta and Medan has expanded what kind of care is possible under current conditions. Communities engage in care that the formal health system cannot. In Jakarta and Medan, when patients stop coming to services, community members go and find them. They accompany people to Puskesmas who would not go alone because of fear, stigma, or previous bad experiences. Community members remind people to take their medication. They negotiate with health workers on behalf of patients who have been turned away. Community members lack funding for this and do it from their own pockets. If these activities were officially recognised and funded, they would represent a genuine partnership between formal health services and communities.

- In Surabaya, civil society organisations and health offices have built working relationships without any formal agreement in place. The Health Office, BNN, and the Social Affairs Office have built working relationships around case handling. When patients come through BNN and need follow-up treatment, the health office coordinates their care. This dynamic runs on personal relationships between individuals rather than written procedures. When those individuals move posts, the collaboration is at risk These relationshipsproved that trust between people can come before paperwork. That trust can then become the foundation for more formal structures.
- Community feedback is already improving services. In one case, community members advocated for a health centre to stop requiring ID documents from patients who did not have them. The health centre changed its practice. Informal community accountability can work—and with formal support, it could work at much greater scale.

The pattern across all these examples is the same. What is working depends on specific individuals and specific relationships. When those people leave, the progress is at risk. The job of policy is to turn what works informally into systems that do not depend on any one person.

CONCLUSION: WHAT REAL INTEGRATION LOOKS LIKE

Integration is not a technical problem. It is a commitment. It means committing to ensure that people who use drugs can get all the care they need—in one place, without fear, without being judged, and without being criminalised.

Indonesia shows what is possible and how far there still is to go. HIV rates among people who inject drugs have almost halved since 2007. Civil society organisations are delivering harm reduction every day. Government frameworks exist that, if properly implemented, could make integrated services a reality.

What is missing is not ambition. It is the practical connections: the clear regulations that make policy real; the budgets that make joint working possible; the agreements that protect patients from arrest; the recognition that makes community work visible and paid; and the training that helps health workers see and respond to the whole person in front of them.

The communities who took part in this research knew exactly what they needed. One place. Comprehensive care. A safe and welcoming environment. Services designed for everyone, not just some people. And communities at the table, not just at the door.

That is the standard. It is achievable. It requires political will, sustained investment, and the kind of honest research that the Karisma Foundation has produced here.

> “If the community is involved from the beginning, integration can be more effective because we can help detect and educate the community.”
>
> — Community member, Makassar

The communities were right. And they were already doing the work.

RECOMMENDATIONS

For National Governments and Health Ministries:

- **Turn integration policy into enforceable rules and implementation technical guidelines.** Indonesia has national policies that say the right things. What is missing is the technical guidelines: clear instructions, specific responsibilities and budget commitments. Without these, nothing changes on the ground.
- **Create dedicated earmarked budget line for integration.** Health offices and Puskesmas cannot fund integrated activities if there is no budget category to put them in. Governments should create dedicated funding mechanisms—including Special Allocation Funds (DAK) and regional budget lines (APBD)—specifically for harm reduction integration.
- **Formally include communities and civil society organisations in service delivery and health planning.** This means more than consultation and engagement. It means defined roles, written agreements, and access to operational funding for the work, such as community outreach and support, communities are already doing.

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- **Invest and retain competent human resource.** Conduct workload analysis of health workers to identify human resource needs and increase health workers capacity through consistent trainings and supervision.
- **Invest in the physical environment.** Private counselling rooms, adequate medicines, and spaces that feel safe and welcoming for key populations, women, LGBTQ+ people, and people with mental health conditions.
- **Strengthen internal and external coordination bodies.** Assess and improve how referrals between programmes in the same building are handled, and how patients are followed up if they drop out; encourage cross-sectoral collaboration with communities and CSOs to improve the quality, access, and desirability of services.

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- **Build community monitoring tools.** Communities are already monitoring the quality of services informally. This capacity can be developed into structured tools that connect to official programme monitoring and create accountability.

- **Advocate for stable and multi-year funding.** Short project grants do not work for accompaniment, peer education, and case follow-up. These activities need stable operational funding—not project-by-project survival.

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- **Fund integrated data systems that protect privacy.** HIV, drug use, and mental health data need to be connected. But any integrated system must guarantee patient confidentiality. Without that guarantee, people will not use the services.
- **Fund inclusion explicitly.** Women who use drugs, people with disabilities, and LGBTQ+ people who use drugs are excluded from services that were not designed with them in mind. Gender, disability, and social inclusion (GEDSI) must be a funded part of every programme, not an afterthought.

GLOSSARY OF KEY TERMS

APBD

Regional Revenue and Expenditure Budget (Anggaran Pendapatan dan Belanja Daerah). This is the main government budget at district and provincial level in Indonesia. At the moment, there is no dedicated line in this budget for harm reduction integration in any of the four cities studied.

BNN

National Narcotics Agency (Badan Narkotika Nasional). The main government body responsible for drug enforcement, prevention, and rehabilitation in Indonesia. It operates as a law enforcement agency, which often conflicts with health-based approaches to drug use.

DAK

Special Allocation Fund (Dana Alokasi Khusus). Money that the central government transfers to regional governments for specific priorities. At the moment, there is no DAK specifically for harm reduction integration.

GEDSI

Gender Equality, Disability, and Social Inclusion. A framework that requires programmes to actively address the different needs of women, people with disabilities, and marginalised groups. Global Fund grants require this.

HARM REDUCTION

A public health approach that aims to reduce the harms caused by drug use, without requiring people to stop using drugs. Examples include needle and syringe programmes, opioid substitution therapy (such as methadone), naloxone distribution, and HIV testing.

ILP

Integrated Primary Health Care (Integrasi Layanan Primer). A 2023 Ministry of Health policy that reorganised Puskesmas services into clusters, with the aim of improving coordination between programmes.

IPWL

Government-designated rehabilitation facility (Institusi Penerima Wajib Lapor). Under Indonesian law, people who use drugs can go to an IPWL to seek treatment instead of facing prosecution. In practice, the system is not well understood and is not trusted by many people who use drugs.

MSM

Men who have sex with men.

MUSRENBANG

A participatory planning forum where communities and government discuss local development priorities and budgets. People who use drugs and the organisations that support them are consistently excluded from these forums.

PKNI

Indonesian Drug User Association (Persaudaraan Korban Napza Indonesia). A national civil society organisation led by people who use drugs. Active in peer support, harm reduction work, and policy advocacy.

PUSKESMAS

Community health centre (Pusat Kesehatan Masyarakat). The main pub¬lic health facility in Indonesia at the local level. Under government policy, Puskesmas are supposed to be the primary location for integrated HIV, drug use, and mental health services.

TPKJM

Community Mental Health Implementation Team (Tim Pelaksana Kesehatan Jiwa Masyarakat). A body at district level that is supposed to coordinate mental health services across sectors. In most cities studied, it is inactive or does not address drug use at all.

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