WHAT WORKS?

SEXUAL AND REPRODUCTIVE HEALTH AND HIV LINKAGES FOR PEOPLE WHO USE DRUGS IN INDONESIA
INTRODUCTION TO SRH AND HIV LINKAGES

The evolution of the response to HIV and sexual and reproductive health (SRH) has involved the identification of important co-linkages as key catalysts in ensuring sustainability, continuity and ownership of comprehensive prevention, treatment, care and support initiatives. Sexual and reproductive health and HIV share many of the same root causes, including economic inequality, limited access to appropriate information, gender inequality, harmful cultural norms and social marginalization of the most vulnerable populations. A limited sexual and reproductive health and HIV response has often been characterized by widely scattered resources for many of the root causes are addressed in a more systemic and aligned manner.

The bi-directional linkages between SRH and infection-related policies and programmes can lead to a number of important public health, socio-economic, and individual benefits. It is envisaged that concerted action on the linkages agenda would enable health, socio-economic, and individual policies and programmes to be appropriately aligned and connected.

In general, it is accepted that SRH and sexual and reproductive health policies and programmes are the key to tackling the epidemics of HIV and STI. While SRH services differ in quality, scope and availability their reach and accessibility remains limited in many places and across the world. Poor health and rights are eroded by high levels of gender violence, gender inequality, poverty and other systemic factors.

In recent years, the need to integrate HIV and SRH programmes has been widely recognized as critical for making a difference in the lives of people affected by HIV/AIDS.

In 2005, UNAIDS reported that:

- AIDS prevalence has increased significantly among certain groups of people who use drugs and in some countries the rates have been exponential, particularly in Eastern Europe and Central Asia.
- HIV prevalence among key populations in Asia is being reviewed.
- High prevalence levels have been identified in many countries in the region, e.g. in 2010, 16 per cent of people who inject drugs in Asia are living with HIV.

OGG’s 2007 action report indicated that the importance of bi-directional linkages between SRH and HIV programs has increased in response to the many of the key root causes, including economic inequality, gender inequality, poverty and other systemic factors.

In order to implement the package, all HIV and SRH services have to be identified and that your organization will provide? Will they be provided through referral, for example, to FAS clinics?

Has a rapid community assessment been undertaken to:

- Identify the different groups of people who use drugs?
- Identify the needs of people who use drugs in relation to HIV and SRH?
- Map existing tri-level health services?

Based on your research, and in collaboration with community members, has a package of integrated services been developed that suitably responds to your organization?”

In order to implement the package, have the SRH and HIV services been identified that your organization will provide? Will they be provided through referral, for example, to FAS clinics?

6. Have relevant staff and volunteers received capacity building in attitudes and technical areas?

For example:

- Are attitudes such as stigma against people who use drugs long lived?
- Are technical areas such as the provision of OST, including contraception for non-users, relevant and effective?

7. Has a strong and effective referral system been developed?

For example:

- Has a strong and effective referral system been developed that suitably responds to your organization?”

8. Have protocols for integrated services been developed that suitably respond to people who use drugs?

For example:

- Are protocols for integrated services been developed that suitably respond to people who use drugs?

9. Within services, has particular attention been paid to the ‘bigger’ SRH needs of people who use drugs?

For example:

- Are protocols for integrated services been developed that suitably respond to people who use drugs?

10. How the environmental and physical infrastructure been adapted?

For example:

- Are protocols for integrated services been developed that suitably respond to people who use drugs?

11. Have creative and innovative service delivery methods been used to provide integrated services?

For example:

- Are protocols for integrated services been developed that suitably respond to people who use drugs?

12. Have logistics and management systems been adapted?

For example:

- Are protocols for integrated services been developed that suitably respond to people who use drugs?

13. Have people who use drugs been involved in designing, implementing and monitoring your work at an early stage?

For example:

- Are protocols for integrated services been developed that suitably respond to people who use drugs?

14. How advocacy been achieved with people who use drugs?

For example:

- Are protocols for integrated services been developed that suitably respond to people who use drugs?

15. How advocacy been achieved with local and national stakeholders to address the legal and structural barriers facing people who use drugs in accessing HIV and STI services?

For example:

- Are protocols for integrated services been developed that suitably respond to people who use drugs?

ABBREVIATIONS

AIDS acquired immune deficiency syndrome
ART antiretroviral therapy
CD4 Test or Therapy given in the immune system
EF efficacy
GGP Global Group of People living with HIV
HIV human immunodeficiency virus
IPTI intermittent preventive therapy
MMCT methadone maintenance therapy
MSM men who have sex with men
NAC National AIDS Commission
NGO non-governmental organization
NCP National and Community program
OST opium substitute therapy
PKI Perkumpulan Kemanusiaan Indonesia
PMTCT prevention of mother-to-child transmission
PKPB Perkumpulan Keluarga Berencana Indonesia
UNAIDS United Nations Programmes on HIV
UNAIDS United Nations General Assembly Special Session
UNFPA United Nations Population Fund
UNODC United Nations Office for Drugs and Crime
VCT voluntary counseling and testing
WHO World Health Organization

ACKNOWLEDGEMENTS

This paper is based on a report prepared by IPPF Asia & South East Asia and Oceania Region for Asia Pacific Women’s Health Network. The report benefited from the review and input of colleagues and experts from across the region, including colleagues from the United Nations agencies, non-governmental organizations, and local HIV networks. The Advocacy Brief was written by Sarah Mladinich-Leen (independent consultant) and Andrew Duncan (independent consultant). It has been reviewed by John Innes, John O’Cain, Elizabeth McDermott (IPPF) and Anne Maitland (WHO) as well as colleagues and experts from across the region. The report is also based on information from the UNAIDS website and a variety of other sources.

ORGANIZATIONS LINKING HIV AND SRH FOR PEOPLE WHO USE DRUGS

1. Do you link SRH with a ‘bigger’ SRH in your organization’s mission and objectives?

For example:

- Are protocols for integrated services been developed that suitably respond to people who use drugs?

2. Has an understanding and commitment to HIV and SRH related issues for people who use drugs and linkages been built among senior level management of your organization, including the Director and Board?

For example:

- Are protocols for integrated services been developed that suitably respond to people who use drugs?

3. Has a rapid community assessment been undertaken to:

For example:

- Are protocols for integrated services been developed that suitably respond to people who use drugs?

4. Map existing tri-level health services?

For example:

- Are protocols for integrated services been developed that suitably respond to people who use drugs?

5. In order to implement the package, have the SRH and HIV services been identified that your organization will provide? Will they be provided through referral, for example, to FAS clinics?

For example:

- Are protocols for integrated services been developed that suitably respond to people who use drugs?

6. Have relevant staff and volunteers received capacity building in attitudes and technical areas?

For example:

- Are protocols for integrated services been developed that suitably respond to people who use drugs?

7. Has a strong and effective referral system been developed?

For example:

- Are protocols for integrated services been developed that suitably respond to people who use drugs?

8. Have protocols for integrated services been developed that suitably respond to people who use drugs?

For example:

- Are protocols for integrated services been developed that suitably respond to people who use drugs?

9. Within services, has particular attention been paid to the ‘bigger’ SRH needs of people who use drugs?

For example:

- Are protocols for integrated services been developed that suitably respond to people who use drugs?

10. How the environmental and physical infrastructure been adapted?

For example:

- Are protocols for integrated services been developed that suitably respond to people who use drugs?

11. Have creative and innovative service delivery methods been used to provide integrated services?

For example:

- Are protocols for integrated services been developed that suitably respond to people who use drugs?

12. Have logistics and management systems been adapted?

For example:

- Are protocols for integrated services been developed that suitably respond to people who use drugs?

13. Have people who use drugs been involved in designing, implementing and monitoring your work at an early stage?

For example:

- Are protocols for integrated services been developed that suitably respond to people who use drugs?

14. How advocacy been achieved with people who use drugs?

For example:

- Are protocols for integrated services been developed that suitably respond to people who use drugs?

15. How advocacy been achieved with local and national stakeholders to address the legal and structural barriers facing people who use drugs in accessing HIV and STI services?

For example:

- Are protocols for integrated services been developed that suitably respond to people who use drugs?

IPF = In progress
IPR = Not Relevant

CHECKLIST FOR ACTION

<table>
<thead>
<tr>
<th>ISSUES TO THINK ABOUT</th>
<th>YES</th>
<th>NO</th>
<th>IR</th>
<th>NR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you link SRH with a ‘bigger’ SRH in your organization’s mission and objectives?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Has an understanding and commitment to HIV and SRH related issues for people who use drugs and linkages been built among senior level management of your organization, including the Director and Board?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Has a rapid community assessment been undertaken to:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Identify the different groups of people who use drugs?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Identify the needs of people who use drugs in relation to HIV and SRH?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Map existing tri-level health services?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. In order to implement the package, have the SRH and HIV services been identified that your organization will provide? Will they be provided through referral, for example, to FAS clinics?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Have relevant staff and volunteers received capacity building in attitudes and technical areas?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Has a strong and effective referral system been developed?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Have protocols for integrated services been developed that suitably respond to people who use drugs?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Within services, has particular attention been paid to the ‘bigger’ SRH needs of people who use drugs?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. How the environmental and physical infrastructure been adapted?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Have creative and innovative service delivery methods been used to provide integrated services?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Have logistics and management systems been adapted?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Have people who use drugs been involved in designing, implementing and monitoring your work at an early stage?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. How advocacy been achieved with people who use drugs?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. How advocacy been achieved with local and national stakeholders to address the legal and structural barriers facing people who use drugs in accessing HIV and STI services?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Empowering and meeting the needs of people living with HIV and key populations is at the crux of the SRH and HIV linkages agenda and fundamental to the joint universal access goals of SRH and HIV.

The following seven principles represent consensus on the key philosophical foundations and commitments upon which linked SRH and HIV responses must be built:

1. Address structural determinants.
2. Focus on human rights and gender.
3. Promote a coordinated and coherent response.
4. Meaningfully involve people living with HIV.
5. Foster community participation.
6. Reduce stigma and discrimination.
7. Recognize the centrality of sexuality.

A time-honoured concept espoused in the Declaration of Alma Ata on primary health care rests on “bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process” and this ‘people sense’ argument is probably one of the most compelling as a cornerstone approach to HIV and SRH linkages.

Imperative actions for providing evidence-informed action to support both SRH and HIV outcomes for key populations lies in addressing some of the recognized bottlenecks which include:

1. Addressing stigma and discrimination through the capacity building of front line service providers: Reducing stigma and discrimination about HIV and SRH means facing and talking openly about issues that include sexuality, drug use, sex work, sexual violence, poverty and gender inequality. Health workers need resources, information and skills and sensitivity training related to the specific needs of the diverse range of clients, including the importance of confidentiality.

2. Maximizing the understanding and promotion of SRH and HIV linkages in concentrated HIV epidemics: Addressing the SRH needs of key populations, people living with HIV, and other marginalized populations in countries and regions with concentrated epidemics is an area that requires increased focus. Increased operations research on issues such as the modalities of integration to better meet the additional needs of key populations will provide a strengthened evidence base for guidance on the relevance and effectiveness of SRH and HIV linkages in concentrated epidemics.

3. Creating an enabling policy environment to support rights: To enable outreach of sexual and reproductive health services to key populations as well as to people living with HIV, legal and social barriers need to be addressed through inclusion of the following programmatic elements: legal audit and law reform programmes, access to legal services, programmes to reduce stigma and discrimination, know your rights/law campaigns and training of key service providers – not only health care workers but also judiciary and police.

4. Recognizing the value and importance of community engagement: Enabling and fostering communities of the most vulnerable and marginalized people to play a leading role in the linkages agenda needs to be supported through adequate levels of resources and capacity development.

5. Improving access through bespoke service delivery: Meeting the SRH and HIV needs of key populations will have direct outcomes for both the SRH and HIV communities through the strengthening of current and expanding to additional essential services.
## THE CONTEXT

### OVERVIEW OF COUNTRY

### INDONESIA IN FACTS AND FIGURES

#### General context:
- **Population** (2010): 230.56 million (fourth largest in the world)
- **Geography:** 17,500 islands, divided into 33 provinces and 465 districts
- **Life expectancy** (2007): 68.4 years (male) and 72.4 years (female)
- **Population living below poverty line** (2007): 27.1%
- **Population in urban areas** (2007): 48%
- **Political characteristics:** 32 years of military dictatorship ended in 1998; undergoing a process of democratization and decentralization
- **Cultural characteristics** (2010): 88% of population are Muslim; social taboos and stigma around sexuality, HIV and drug use

#### SRH context:
- **Total fertility rate per woman** (2002): 2.6
- **Contraceptive prevalence for women** (2006): 61.4%
- **Maternal mortality ratio** (per 100,000 births) (2007): 228
- **Pregnant women receiving ANC** (2007): 93.3%

#### HIV context:
- **Adult HIV prevalence** (2007): 0.2%
- **Ratio of male to female cases of HIV** (2010): 2.1
- **Number of people living with HIV** (2009): 333,200
- **Mode of HIV transmission** (cumulative cases) (2009): 52.7% heterosexual, 38.3% people who use drugs, 3.0% men who have sex with men, 2.6% vertical (mother to child)
- **Number of women receiving PMTCT** (2009): 165 (out of 1,306 women testing HIV positive at ANC facilities)
- **Number of people living with HIV receiving ART** (2009): 18,982
- **Projection for epidemic** (2009): one of the fastest growing epidemics in Asia; by 2014, there may be 0.37% prevalence and 501,400 people living with HIV

#### HIV context for people who use drugs:
- **HIV prevalence among people who use drugs** (2007): 52.15% (male) and 57.14% (female)
- **Projection for epidemic among people who use drugs**: number of new cases will continue to rise; proportion of new cases will decrease (to 28% by 2014) in comparison to heterosexual sexual transmission
- **Number of people receiving methadone treatment** (2009): 2,575
- **People who use drugs who used a condom the last time they had sex** (2008): 35.8% (male) and 35.14% (female)
- **People who use drugs who had an HIV test in the last 12 months and know their result** (2008): 43% (male) and 57.1% (female)
- **People who use drugs who used non-sterile injecting equipment in the last month** (2008): 87.78% (male) and 86.96% (female)
WHAT WORKS?

SITUATION FOR PEOPLE WHO USE DRUGS

Indonesia is home to an estimated 3 million people who use drugs. Of these, some 25 per cent are using drugs, particularly heroin, through injecting.26 According to the country’s law, the possession or use of drugs is a criminal offence, while trafficking is punishable by death. Despite the scale of the practice, drug use remains highly stigmatized within both communities and health services – with discrimination exacerbated by the association between drug use and HIV. Although the proportion is decreasing (in comparison to heterosexual sexual transmission), to date, over a third of HIV cases have been associated with drug use.27

NATIONAL RESPONSE TO HIV, SRH AND HARM REDUCTION

Both HIV and SRH are housed within the Ministry of Health (MOH); though programmes are managed by a number of different departments. Action on HIV is led by the MoH and the National AIDS Commission (NAC). The NAC manages the multi-sectoral, national response, develops national policies and strategy, and oversees the prevention and support components of HIV programmes, while the MOH manages the delivery of antiretroviral therapy (ART) and care services. The country’s HIV priorities are set out in the National HIV/AIDS Strategy for 2010–14. Action on SRH is led by departments within the MOH, including the Directorate of Maternal Health, with the national strategy building on international commitments.

In relation to drug use, strategies to reduce demand and supply are led by the National Narcotics Board28 – a body attached to the National Police that reports directly to the President.29 However, harm reduction services, which were first permitted in 2004, have been led by the MOH, NAC and civil society.

Under the Indonesian National Strategy of HIV/AIDS Control through Harm Reduction of the Use of Narcotics, Psychotropics and Addictive Substances, there are currently 281 sites providing needle and syringe programmes (NSPs), including 51 run by non-governmental organizations (NGOs). Services for opiate substitution therapy (OST), including methadone maintenance treatment (MMT), are available in 65 sites, including government facilities, Pusat Kesehatan Masyarakat (Puskesmas) – community primary health centres, and NGOs. In 2010, these services reached 2,575 clients.30 Civil society has played a critical role in national responses, particularly in terms of advocacy and community-led programmes on HIV and harm reduction.

HARM REDUCTION, HIV AND SRH LINKAGES

Linking of harm reduction, HIV and SRH programmes and services make ‘good sense’ for Indonesia, as 90 per cent of infections are associated with either drug use or heterosexual sexual transmission, and the National HIV/AIDS Strategy cites the need to address the vulnerability of the sexual partners of people who use drugs.

In recent years, the issue of linkages has received increasing attention. For example, the NAC – which recognizes the potential of SRH and HIV linkages to strengthen health and community systems for key populations – has developed joint training modules. These modules target health workers at tertiary, secondary and primary levels and address HIV, sexual health, sexually transmitted infections (STIs) and reproductive health. Programmatic linkages include prevention of mother-to-child transmission (PMTCT) integrated into existing antenatal care (ANC) services through 37 referral centres in 24 provinces.31
While many key stakeholders support the concept of linkages, implementation faces a number of challenges, including:

- **At the local level:** decentralization has made decision-making and budget allocation difficult due, in part, to a lack of understanding about the importance of SRH and the resulting lack of investment.\(^{32}\)

- **At the national level:** harm reduction, HIV and SRH remain underfunded; SRH services have been predominantly ‘woman focused’; while harm reduction services have been ‘male focused’. There is a lack of comprehensive data and evidence, particularly in relation to the needs of women who use drugs or the female partners of men who use drugs.

To date, linkages have predominantly focused on developing referral systems for harm reduction and HIV and SRH services either within the same health facility or between facilities. The following case studies provide examples of models developed by the government (Puskesmas Gambir) and an NGO (Indonesian Planned Parenthood Association – PKBI), both of which, while facing challenges and limitations, provide insights and lessons for providing more comprehensive SRH and HIV support to people who use drugs.

“Health services attached to the harm reduction programme in Jakarta are not gender sensitive. Interviews with female intravenous drug users accessing reproductive health, methadone and VCT services found that their specific needs as women were misunderstood or ignored.

CASE STUDY 1: PUSKESMAS GAMBIR

A government Community Primary Health Centre integrating the services of three clinics – maternal and child health (MCH)/family planning (FP), HIV/voluntary counselling and testing (VCT) and harm reduction – for people who use drugs.

ORGANIZATIONAL FOCUS
One of 30 centres participating in a government harm reduction scale-up programme and one of five Puskesmas selected to become a ‘one-stop health shop’ for harm reduction/HIV services, including an NSP, MMT, basic health care, STI management, VCT and ART, for people who use drugs.

CONTACT DETAILS
Puskesmas Kecamatan Gambir
Jalan Tanah Abang 1, Kelurahan Petojo Selatan, Gambir Jakarta Pusat 10160
Phone: (021) 3810051/3844256

FOUNDED 1986

LOCATION
Central Jakarta

Steps towards SRH and HIV linkages
The Puskesmas Gambir model integrates three existing clinics within the same centre to provide – through a combination of combined services and internal referrals – a package of services for people who use drugs:
CASE STUDY 1: PUSKESMAS Gambir

Puskesmas Gambir’s key steps towards linkages

1. Building capacity: Providing training to staff on drug-related issues such as use patterns, behaviour and lifestyle to instil open attitudes towards people who use drugs and minimize negative reactions related to socio-cultural differences.

2. Working in partnership: Building relations with Kios Atma (a leading harm reduction NGO) to provide additional support to staff. This partnership began with an informal meeting between MMT staff and people who use drugs, followed by working with a wider group of staff – a process that, while challenging at the beginning, improved over time.

3. Creating a welcoming and supportive space: Refurbishing some rooms and providing separate entrances for the MMT and VCT services to promote privacy.

4. Adapting opening hours: Having the harm reduction clinic open from 11am to 2pm daily – to enable working clients to access MMT services during breaks.

Successes in SRH and HIV linkages

Puskesmas Gambir’s results and successes of linkages include:

• ‘One stop shop’: Puskesmas Gambir, operating at the level of local primary health care, is increasingly able to provide an comprehensive range of services for people who use drugs at the same centre, which expands access to clients who might otherwise not seek services for fear of stigma.

• Relationships of trust: Service providers report that by building good relationships with their clients, people who use drugs are beginning to seek support for their SRH-related needs.

• Strong leadership and resources: Puskesmas Gambir benefits from strong leadership, with its Head committed to providing integrated programmes and supporting people who use drugs. This support has contributed to Puskesmas Gambir securing government funding for its harm reduction/HIV programmes.

• Model for replication: Having developed and improved over time, the Puskesmas Gambir model is now being replicated and scaled up across Indonesia.

“For methadone patients, if they are already feeling comfortable, without us asking about their sexual behaviour, they sometimes share with us and open themselves up… Some patients even told me how many wives they have and what kind of sexual behaviour they are into… This shows me that, when there is a trusted relationship between me and the patients, this is the foundation.”

Doctor at MCH/FP clinic, Puskesmas Gambir
Issues and challenges with SRH and HIV linkages

• **Integrated protocols and guidelines:** While available for individual harm reduction, HIV and SRH services, the Provincial Health Department and the MOH have not developed technical guidance for the integration of harm reduction, HIV and SRH.

• **Referral system:** Better coordination is needed among staff from the different units – to improve the flow of clients, provide people with the full range of services they need, and ensure they are treated with dignity throughout the centre. Systems need to be strengthened to ensure that clients do not become ‘lost’, especially between services for harm reduction/HIV and those for MCH/FP.

• **Skills balance:** Within Puskesmas, staff providing services to people who use drugs can have different attitudes, skills levels and information to those supporting the general public, causing tension within integrated programmes.

• **Staff rotation:** Staff rotation managed by the Provincial Health Department, means losing staff who have been trained in linkages and who have established good relationships with clients, as well as requiring additional time and costs to train new staff.

• **Clinic workload:** As the number of clients and services provided has grown, human resources allocated to the programme have remained static – increasing the workload of staff and threatening the quality of care.

• **Laboratory support:** Puskesmas Gambir lacks laboratory infrastructure and medical personnel to provide CD4 cell counts and viral load tests.

This means that clients living with HIV still have to be referred to the district hospital for some ART services.

• **Hepatitis services:** Laboratory tests to diagnose and control hepatitis C are not offered free of charge or subsidized, despite the high prevalence among people who use drugs. Furthermore, routine hepatitis B vaccination is not yet offered to co-infected clients with HIV or hepatitis C.

• **SRH services:** Services for people who use drugs focus on harm reduction, HIV and STIs with broader SRH being poorly promoted, and no specific services (such as FP or cervical cancer screening) are provided for women.

• **Uptake of STI services:** Few people who use drugs have accessed STI services. This may be due to these services not being viewed as a community priority, or may reflect that staff do not address issues of sex and sexuality with clients. While some STI services are provided to male clients at the MMT clinic, women who use drugs are referred to the MCH/FP clinic.

• **PMTCT and pregnancy-related services:** Although staff receive training on PMTCT and can provide information, the MMT clinic lacks the necessary infrastructure to implement all four PMTCT prongs. While female clients can access ART at the clinic, they are usually referred to hospitals for care for pregnancy and birth or to NGOs offering counselling, referrals to hospitals/other health centres and providing information on safe infant feeding, though not FP counselling and contraceptive information post-delivery. For these services, clients are referred to the Indonesian Planned Parenthood Association, PKBI.

“We see that there is a service for SRH on the information board but it lacks implementation. I think Puskesmas has to do something real according to what we need and what they deliver regarding the service to SRH.”

Woman who uses drugs
CASE STUDY 2: PKBI (INDONESIAN PLANNED PARENTHOOD ASSOCIATION), KLINIK DKI (PISANGAN)

An SRH NGO integrating HIV and harm reduction services for people who use drugs.

ORGANIZATIONAL FOCUS
Programmes address the general public and cover family health medical services, SRH services, community-based distribution of FP methods, and community empowerment. PKBI works in partnership with the government, UN agencies, local institutions and individuals, guided by the principles of joint agreement and equality.

FOUNDED 1959

LOCATION
A network of 26 SRH clinics and community-level service delivery points in 28 provinces across the country. Klinik PKBI DKI (Pisangan) is located in East Jakarta.

CONTACT DETAILS
Perkumpulan Keluarga Berencana Indonesia (Indonesian Planned Parenthood Association)
Jl. Hang Jebat III/F3 Kebayoran Baru Jakarta 12120
Phone: (021) 7207372, 7394123, 7206413, 7205804
Fax: (021) 7394088
Website: http://pkbi.or.id
Klinik DKI Pisangan
Jl. Pisangan Baru Timur No. 2-A, Jakarta Timur
Phone: (021) 8566535
Fax: (021) 8590988

Steps towards SRH and HIV linkages
The Klinik PKBI DKI model involves integrating HIV and harm reduction with SRH – through a combination of service provision and referrals – to provide a package of support to people who use drugs:

- Needle and syringe programme
- Outreach
- Information on drug use
- HIV prevention and counselling for key populations
- Voluntary counselling and testing
- PMTCT information and counselling
- STI prevention, diagnosis and treatment
- Healthcare provider training for stigma-free services
- Support groups
- SRH services (FP, ANC, PNC, counselling, cervical cancer screening, prevention of unsafe abortion and management of post-abortion care)
- Training
Klinik PKBI DKI's key steps towards linkages

- **Integrating services**: The clinic undertook a process of adjusting each of its SRH, harm reduction and HIV services to ensure that they were effectively integrated.

- **Reorientating services and staff to key populations**: The clinic undertook a process to tailor services to key populations, including by providing training and refresher courses to staff.

- **Combining service delivery methods**: Both clinic-based and community outreach methods were used to ensure that PKBI's integrated programmes reached people who use drugs.

- **Development of referral system**: This works through an established network of key organizations. For example, many people who use drugs are referred to PKBI from drug rehabilitation centres, prisons or NGOs, while, the clinic refers clients living with HIV (including women who are pregnant) or in need of specialist care to government hospitals.

- **Laboratory support**: The clinic has limited laboratory capacity to undertake STI tests and rapid HIV tests. For more complicated procedures, clients are referred to government hospitals.

Successes in SRH and HIV linkages

- **Providing accessible and high quality services**: Despite using a cost-recovery scheme, PKBI's integrated services are affordable and accessible to most people. As a result of the excellence of its services, the NAC and Jakarta Health Department have recognized the clinic as a partner.

- **Being ‘key population-friendly’**: The clinic attracts and supports a large number of people from key populations. Many people who use drugs choose to attend the clinic due to the friendly attitudes of staff, relaxed environment and good quality of services.

- **Combining clinic and community-based services**: The clinic-based integrated services are complemented and enhanced by community outreach to people who use drugs.

Issues and challenges with SRH and HIV linkages

- **Ongoing capacity building**: There is a need to provide refresher training and on-the-job skills development to ensure that all health care providers are equipped with the latest information on SRH and HIV for key populations on issues such as safe conception for serodiscordant couples, methadone services for pregnant women who use drugs, and ART and contraceptive drug interactions.

- **Capacity to address SRH**: Although harm reduction programme staff and outreach workers have received training in SRH, there remains a need to strengthen their ability and confidence to raise issues with clients. Failure to do so is a ‘missed opportunity’ to discuss issues such as safer sex, sexuality, and their partners’ SRH needs.

- **Links with wider support services**: Due to the socio-economic background of many key populations accessing the clinic, PKBI needs to strengthen its links with organizations, providing services addressing microfinance, vocational training and income generation.

"I'd prefer to come all the way to PKBI Pisangan when I need to do anal paps. I even recommend and take my other transgender friends who need to check for STIs to come here... I feel comfortable and don't feel discriminated."

Transgender community member
TAKING LESSONS TO SCALE

The experiences of Puskesmas Gambir and Klinik PKBI DKI provide important lessons about ‘What works?’ in relation to developing, implementing and strengthening SRH, HIV and harm reduction linkages for people who use drugs at the policy, systems, and service delivery levels.

**POLICY LEVEL:**

1. Have strong government leadership on harm reduction, including HIV and SRH linkages for people who use drugs, providing a strong coordination role and clear messages down the health system chain, from national to provincial to local levels. This includes ensuring that individual policies are complementary, coordinating the responses of the different departments responsible for SRH, HIV and drug user issues, and involving all relevant stakeholders – including civil society, particularly people who use drugs – in developing a national plan to scale up integrated programmes. Programmes should be gender-sensitive, human rights- and evidence-based, developed through a national needs and services assessment and supported by the ongoing collection of data.

2. Agree, develop and cost a comprehensive package of essential harm reduction, HIV and SRH services and commodities for male and female people who use drugs. For example:
   - Use comprehensive definitions (for example, with SRH going beyond STIs to include FP, ANC, abortion and gender-based violence services).
   - Be holistic – treat people who use drugs as ‘real’ people who are also lovers, parents, etc.
   - Use a family-centred approach – addressing people’s partners and family members.
   - Include neglected or underserved areas, such as affordable services for hepatitis C.

3. Work towards legal and policy reform to support the implementation of linkages for people who use drugs and address major barriers to services. For example, this involves addressing how the criminalization of drug use drives people who use drugs underground and away from harm reduction, HIV and SRH services.

4. Enhance national linkages through appropriate technical and financial support from international partners. This includes UN agencies addressing all three areas (harm reduction, HIV and SRH) in relevant policies and tools; and donors having funding criteria that welcome integrated programmes.

5. Research and address issues of financial sustainability for harm reduction, HIV and SRH linkages. For example, this involves attention to providing services for free (or at a subsidized cost) to people who use drugs; and developing models (for example, based on government-funded systems) that are financially sustainable.

**SYSTEMS LEVEL:**

1. Develop mechanisms for collaborative planning, budgeting and monitoring for integrated programming for people who use drugs. For example, in Indonesia, this requires bringing together the different MOH departments, agencies and civil society organizations that work on harm reduction, HIV and SRH, and could involve establishing a national working group.

2. Roll out the national strategy and promote high quality services by developing agreed protocols and technical guidelines for integrated services for people who use drugs. Ensure that these are informed by evidence of national needs and international good practice. In Indonesia, this requires collaboration between the national (MOH) and provincial (Provincial Health Departments) levels.
3. Based on the protocols and technical guidelines, develop training modules for all those involved in service provision for people who use drugs. Ensure that these are incorporated into the formal training of relevant cadres of health care workers.

4. Strengthen or develop good practice models of harm reduction HIV and SRH linkages for people who use drugs. For example, in Indonesia, this involves:
   a. Developing models for both government and NGO sectors – to increase access to programmes, maximize comparative advantages and facilitate cross-learning.
   b. ‘Building on what’s there’ – broadening existing initiatives, rather than introducing new ones.
   c. Carrying out pilot projects – starting gradually, learning and enhancing models with a view to scaling up.
   d. Scaling up successes such as replicating existing models in other Puskesmas and PKBI clinics.

5. Develop mechanisms and protocols for effective referral systems to support harm reduction and HIV and SRH linkages for people who use drugs. These should be based on good practice such as ensuring follow-up of clients referred to other facilities, and monitoring the quality of services provided.

**SERVICE DELIVERY LEVEL:**

1. Support the provision of integrated harm reduction, HIV and SRH services by building demand among communities. For example, Puskesmas Gambir found it necessary to raise awareness of the benefits and availability of SRH services among people who use drugs and their partners.

2. Ensure the quality and accessibility of integrated harm reduction, HIV and SRH services. For example, Puskesmas Gambir’s and PKBI’s experiences suggest that this includes:
   a. Tailoring services to specific clients (including women or serodiscordant couples).
   b. Building non-judgemental inter-personal relationships and ‘safe spaces’.
   c. Using a variety of service delivery methods, in particular, complementing clinic-based services with outreach services and, where possible, having mobile units operating in communities.
   d. Providing a full range of options (for example, with SRH providing a range of services beyond condoms for contraception).
   e. Ensuring that services are informed by accurate and the most recent information.

3. Use systems to ensure that service integration is routine and efficient for people who use drugs. For example, this involves:
   a. Monitoring client flow to ensure that people who use drugs get the full range of harm reduction, HIV and SRH services that they need.
   b. Monitoring and continually improving referral systems to ensure that people who use drugs receive appropriate and high quality support throughout their ‘client journey’.
   c. Using staff supervision and client feedback to monitor the routine inclusion of, for example for PKBI, SRH discussions between service providers and clients.

4. Ensure buy-in and ongoing capacity building on linkages and work with people who use drugs at all levels of:
   a. Facilities. For example, ensuring ‘drug user friendliness’ among reception staff and support for integration by clinic managers.
   b. Programmes. For example, providing ongoing training (such as refresher courses and hands-on experience) for all staff, including outreach workers and those at referral sites.
   c. Ensure that capacity building addresses both technical issues (such as drug interactions between ART, methadone and contraceptives) and attitudes (such as prejudice against people who use drugs).

5. Actively involve people who use drugs in all stages of integrated programming. For example, involve community members in the design of programmes, identifying locations and service delivery methods, and approaches to tackle taboo subjects such as sexuality.
ENDNOTES

33. For example, at the time of writing, UNODC Indonesia was developing Drug Dependence Treatment and HIV Prevention training modules to standardize basic knowledge and skills among drug treatment centre staff. However, the modules do not address SRH.
The evolution of the response to HIV and sexual and reproductive health (SRH) has involved the importance of different issues. For instance, the world’s most powerful communities: the poorest, most disadvantaged, stigmatized and vulnerable populations. A linked sexual and reproductive health and SRH approach can have many of these root causes addressed at the same time, which can yield the following mutually beneficial results:

- Improved access to and uptake of key SRH and HIV services
- Better access of people living with HIV to SRH services tailored to their needs
- Reduction in stigmatized and discrimination
- Improved coverage of vulnerable populations
- Greater support for dual protection
- Improved quality of care
- Decreased duplication of efforts and competition for scarce resources
- Better understanding and protection of individuals’ rights
- Mutually reinforcing complementarities in policy and funding levels
- Enhanced programme effectiveness and sustainability, continuity and ownership
- Better utilization of scarce human resources.

It is generally accepted that HIV and SRH programmes and policies can lead to a number of important social, health, socio-economic, and individual benefits. It is envisaged that concerted action by key stakeholders on both HIV and SRH can contribute to achieving many of the same root causes, including prevention, care, treatment and support, ruling out the need to address the same root issues successively.

In order to implement the package, the SRH and HIV services have been identified that your organization will provide. The package has been adapted to cover the objectives of the action plan.

For example, to ensure that it provides a safe and confidential space for people living with HIV; to ensure that HIV services are available to pregnant women and children; to provide access to key services such as the prevention of HIV, including contraception for women, and ART.

A linked sexual and reproductive health and HIV approach can have many of these root causes addressed at the same time, which can yield the following mutually beneficial results:

- Improved access to and uptake of key SRH and HIV services
- Better access of people living with HIV to SRH services tailored to their needs
- Reduction in stigmatized and discrimination
- Improved coverage of vulnerable populations
- Greater support for dual protection
- Improved quality of care
- Decreased duplication of efforts and competition for scarce resources
- Better understanding and protection of individuals’ rights
- Mutually reinforcing complementarities in policy and funding levels
- Enhanced programme effectiveness and sustainability, continuity and ownership
- Better utilization of scarce human resources.

It is generally accepted that HIV and SRH programmes and policies can lead to a number of important social, health, socio-economic, and individual benefits. It is envisaged that concerted action by key stakeholders on both HIV and SRH can contribute to achieving many of the same root causes, including prevention, care, treatment and support, ruling out the need to address the same root issues successively.

In order to implement the package, the SRH and HIV services have been identified that your organization will provide. The package has been adapted to cover the objectives of the action plan.

For example, to ensure that it provides a safe and confidential space for people living with HIV; to ensure that HIV services are available to pregnant women and children; to provide access to key services such as the prevention of HIV, including contraception for women, and ART.
"What works?" is a series of Advocacy Briefs on experiences, lessons and good practice in linkages between sexual and reproductive health (SRH) and HIV for key populations. This Advocacy Brief focuses on SRH and HIV linkages for people who use drugs.

**Checklist for action**

The checklist summarizes 15 key steps towards sexual and reproductive health (SRH) and HIV linkages for people who use drugs. This can be used as a tool by organizations that are either 'getting started' on linking HIV and SRH or wish to strengthen their existing work with key populations.

**Completing the checklist for action**

To obtain the opinions and perceptions of a range of stakeholders associated with the organization, it is recommended that this checklist be completed in a collective format. Following discussion and debate on the questions, staff and other stakeholders can assess the organization's performance by marking the appropriate box: Yes, No, In progress, or Not relevant.

**Developing a plan for action**

After completing the checklist, a good starting point towards developing a plan for action is to review the questions that were answered 'in progress' and 'no'—these identify key areas in need of attention. Consider each question individually and reflect on how these areas could be strengthened and/or improved. Select the most relevant areas for the organization to improve upon in the short term. Based on this information, develop a plan for how these areas requiring more attention will be improved.

For more information on SRH and HIV linkages, a collection of current resources compiled by experts from the Interagency Working Group on SRH and HIV Linkages is available from www.ourhivlinkages.org.
Audience and purpose: This “what works?” brief is designed to help programme managers, advocates and policy makers from governmental and non-government organizations to effectively link SRH, HIV and harm reduction services at the policy, systems and service delivery levels for people who use drugs.

Photo: IPPF/Chloe Hall/Indonesia

IPPF Central Office is a signatory to the CONCORD European-wide NGO Code of Conduct on the use of photographs and images and is committed to upholding its principles.

Sexual and reproductive health and HIV linkages for people who use drugs.

CHECKLIST

The checklist summarizes 15 key steps towards sexual and reproductive health (SRH) and HIV linkages for people who use drugs. This can be used as a tool by organizations that are either ‘getting started’ on linking HIV and SRH or wish to strengthen their existing work with key populations.

Completing the checklist for action

To obtain the opinions and perceptions of a range of stakeholders associated with the organization, it is recommended that this checklist be completed in a collective forum. Following discussion and debate on the questions, staff and other stakeholders can assess the organization’s performance by marking the appropriate box: Yes, No, In progress, or Not relevant.

Developing a plan for action

After completing the checklist, a good starting point towards developing a plan for action is to review the questions that were answered “in progress” and “no” – these identify key areas in need of attention. Consider each question individually and reflect on these areas. These areas could be strengthened and/or improved. Select the most relevant areas for the organization to improve upon in the short term. Based on this information, develop a plan for how these areas requiring more attention will be improved.

For more information on SRH and HIV linkages, a collection of current resources compiled by experts from the Interagency Working Group on SRH and HIV: Linkages is available from www.srhhivlinkages.org

WHAT WORKS?

Checklist for action

The checklist summaries 15 key steps towards sexual and reproductive health (SRH) and HIV linkages for people who use drugs. This can be used as a tool by organizations that are either ‘getting started’ on linking HIV and SRH or wish to strengthen their existing work with key populations.

Checklist for action

The checklist summaries 15 key steps towards sexual and reproductive health (SRH) and HIV linkages for people who use drugs. This can be used as a tool by organizations that are either ‘getting started’ on linking HIV and SRH or wish to strengthen their existing work with key populations.
INTRODUCTION TO SRH AND HIV LINKAGES

The evolution of the response to HIV and sexual and reproductive health (SRH) has involved the identification of important linkages as key catalytics in ensuring sustainability, durability and ownership of comprehensive prevention, treatment, care and support initiatives. Sexual and reproductive health and HIV share many of the same root causes, including economic inequality, limited access to appropriate information, gender inequality, harmful cultural norms and social stigmatization of the most vulnerable populations. A limited sexual and reproductive health and HIV response has resulted in severe consequences for many of these root causes are addressed in a more systemic and aligned manner.

The bi-directional linkages between SRH and vulnerable/key populations can be found in a number of important public health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits.

The evolution of the response to HIV and sexual and reproductive health (SRH) has involved the identification of important linkages as key catalytics in ensuring sustainability, durability and ownership of comprehensive prevention, treatment, care and support initiatives. Sexual and reproductive health and HIV share many of the same root causes, including economic inequality, limited access to appropriate information, gender inequality, harmful cultural norms and social stigmatization of the most vulnerable populations.

The bi-directional linkages between SRH and vulnerable/key populations can be found in a number of important public health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits.

The bi-directional linkages between SRH and vulnerable/key populations can be found in a number of important public health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits.

The bi-directional linkages between SRH and vulnerable/key populations can be found in a number of important public health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits.

The bi-directional linkages between SRH and vulnerable/key populations can be found in a number of important public health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits.

The bi-directional linkages between SRH and vulnerable/key populations can be found in a number of important public health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits.

The bi-directional linkages between SRH and vulnerable/key populations can be found in a number of important public health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits.

The bi-directional linkages between SRH and vulnerable/key populations can be found in a number of important public health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits.

The bi-directional linkages between SRH and vulnerable/key populations can be found in a number of important public health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits.

The bi-directional linkages between SRH and vulnerable/key populations can be found in a number of important public health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits.

The bi-directional linkages between SRH and vulnerable/key populations can be found in a number of important public health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged thatconcerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits.

The bi-directional linkages between SRH and vulnerable/key populations can be found in a number of important public health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits.

The bi-directional linkages between SRH and vulnerable/key populations can be found in a number of important public health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits. It is envisaged that concerted health, socio-economic, and individual benefits.
'What works?' is a series of Advocacy Briefs on experiences, lessons and good practice in linkages between sexual and reproductive health (SRH) and HIV for key populations.

This Advocacy Brief focuses on SRH and HIV linkages for people who use drugs.

Audience and purpose: This “What works?” brief is designed to help programme managers, advocates and policy makers from governmental and non-government organizations to effectively link SRH, HIV and harm reduction services at the policy, systems and service delivery levels for people who use drugs.

Checklist for action

The checklist summaries 15 key steps towards sexual and reproductive health (SRH) and HIV linkages for people who use drugs. This can be used as a tool by organizations that are either ‘getting started’ on linking HIV and SRH or wish to strengthen their existing work with key populations.

Completing the checklist for action

To obtain the opinions and perceptions of a range of stakeholders associated with the organization, it is recommended that this checklist be completed in a collective forum. Following discussion and debate on the questions, staff and other stakeholders can assess the organization’s performance by marking the appropriate box: Yes, No, In progress, or Not relevant.

Developing a plan for action

After completing the checklist, a good starting point towards developing a plan for action is to review the questions that were answered ‘in progress’ and ‘no’ – these identify key areas in need of attention. Consider each question individually and reflect on how these areas could be strengthened and/or improved. Select the most relevant areas for the organization to improve upon in the short term. Based on this information, develop a plan for how these areas requiring more attention will be improved.

Checklist available online

For more information on SRH and HIV linkages, a collection of current resources compiled by experts from the Interagency Working Group on SRH and HIV Linkages is available from www.srhhivlinkages.org

Photo: IPPF/Chloe Hall/Indonesia

IPPF Central Office is a signatory to the CONCORD European-wide NGO Code of Conduct on the use of photographs and images and is committed to upholding its principles.