

RUMAH CEMARA STRATEGIC PLAN

INDONESIA WITHOUT STIGMA

LIFE



SICK !

DRUGS

2016-2021

Introduction to Rumah Cemara

Rumah Cemara is a community-based organization that aims to improve the quality of life for people living with HIV/AIDS and people who use drugs in Indonesia. Our vision is an Indonesia where all people can live without stigma or discrimination, have equal access to quality health services, are protected under rights-based laws, and have opportunities for development.

Founded in 2003 by five former drug users, we are committed to becoming the largest community-based organization that implements meaningful involvement of people living with HIV (PLHIV) and people who use drugs and who inject drugs (PWUD/PWID). We are staffed mostly by people who use drugs and are HIV positive, and our activities are based on a peer mentoring approach, albeit one combined with professional interventions by doctors and psychologists to ensure the provision of quality services and to promote the skills development of our community peers.

Our beneficiaries include PLHIV, PWUD/PWID, men who have sex with men (MSM), and transgender (TG) people, who may also be sex workers, youth, women, children, and/or from other marginalized groups such as street children. We actively engage with individuals and networks from these key populations (KP), which we refer to as the communities, and with other stakeholders too.

We take an approach to our work which is both evidence-based and rights-based, and we seek out and embrace innovative ways to support our beneficiaries. We lead several innovative initiatives to address the emerging needs of the communities we work with, which include not only health concerns but also social and economic ones. Through collaboration and partnerships, we encourage other organizations also to apply innovative approaches to facilitate social changes through sports, social entrepreneurship, and advocacy.

We currently work in the provinces of North Sumatra, Daerah Khusus Ibu Kota (DKI) Jakarta, East Java, West Java, Central Java, South Sulawesi, West Nusa Tenggara (NTB), Bali, Riau Islands, Daerah Istimewa Yogyakarta (DIY), Banten, South Kalimantan, and Papua. Over the next five years, our plans are to expand our work into East Kalimantan, Jambi, Central Kalimantan, North Sulawesi, South Sumatra, Bengkulu, and Lampung, making our total geographic coverage 20 provinces and 86 of the cities prioritized in Indonesia's HIV response.

Our ambitions will be achieved through:

- Developing integrated support facilities
- Strengthening institutional capacity and services
- Improving funding
- Working with partner organizations

Rumah Cemara: vision, mission, and values

Vision An Indonesia without stigma and discrimination, where all people have equal access to quality health services, are protected under rights-based laws, and have opportunities for development.

Mission To contribute to the national responses for HIV/AIDS and drug use, for rights-based policies, regulations and laws, and for opportunities for development.

Core Values Respect for diversity, community focus, good governance, partnership and collaboration, and learning and sharing.

Foreword

It is my great pleasure to introduce the new Strategic Plan of Rumah Cemara.

As one of the founders of Rumah Cemara, and as current Chair of the Board, I have witnessed how this organization has grown, step by step. We started small, with only personal decisions to manage. Now we have expanded into an organization with considerable impact on Indonesia's response to HIV and drug issues. It is clear we can no longer work alone. The need to reconsider and strengthen all parts of our organization has been essential and that is what this Strategic Plan is about. Over the past 13 years, as we have taken action on the streets and over social media, we have needed only to answer to our own consciences. Now that we are a movement and lead in our field, we need broader accountability.

I wish to thank the entire management team of Rumah Cemara, including staff and volunteers. Every member works hard to ensure that the positive impacts from the services they provide meet with indicators at national, provincial and global levels.

I would also like to thank the global partnership of the International HIV/AIDS Alliance (IHAA) for their cooperation and patient support as we strengthen all aspects of our organization. As humans, we often overlook our strengths and weaknesses; by working together we are reminded where we can make improvements to ensure further successes in the future.

Rumah Cemara's journey has not always been easy. However, we take pride in that journey which has brought us to where we are today. Congratulations to the big family of Rumah Cemara! May we and our communities be always blessed.

Long live Solidarity!



Deradjat Ginandjar Koesmayadi
Chair of Board

Executive summary

Indonesia's HIV epidemic is predominantly concentrated among groups of people who are marginalized in society. HIV prevalence is as high as 59% among people who inject drugs (PWID) and over 20% among men who have sex with men (MSM) in the bigger cities. The high burden of the epidemic is largely due to programmatic and institutional gaps, and conservatism in Indonesian society which has mitigated against an effective response to the epidemic.

Rumah Cemara is a community-based organization at the forefront of civil society's response to the HIV epidemic, working to improve the quality of life for people living with HIV/AIDS and people who use drugs (PWUD) in Indonesia. Our vision is an Indonesia where all people can live without stigma or discrimination, have equal access to quality health services, are protected under rights-based laws, and have opportunities for development.

The number of new HIV infections in Indonesia is rising, and the treatment coverage is low. This dire situation is recognized at both international and national levels: Indonesia is a Joint United Nations Programme on AIDS (UNAIDS) Fast-Track strategy country, and the Government of Indonesia has prioritized strengthening and extending the continuum of care model for HIV in its National AIDS Strategy and Action Plan (NASAP) 2015-2019. However, big challenges to stalling and reversing the epidemic remain, for example in the anticipated drop in foreign funding for HIV work, in ensuring minimum standards of care, and in guaranteeing access to affordable medicines, diagnostics, and vaccines, including new treatments.

Rumah Cemara's Strategic Plan 2016-2021 recognizes and responds to the shifting HIV/AIDS landscape in Indonesia, as well as the changing nature of our own organization as we grow and seek to improve our professionalism and accountability. The Strategic Plan embraces our rights-based and evidence-based approach, as well as our commitment to innovation, and we will implement it with regard to our core values of respect for diversity, community focus, good governance, partnership and collaboration, and learning and sharing. It will provide an effective guide to action over the next five years as we work, with our stakeholders and partners, to bring an end to AIDS – and achieve *Indonesia Tanpa Stigma* (Indonesia without stigma).

The Strategic Plan comprises four Goals:

1. Support sustainable programming

We will support sustainable programming primarily through innovations in the continuum of care model. Rumah Cemara is a recognized leader in innovation in HIV prevention and we will support community-centered and community-led combination prevention. To improve the quality of life of PLHIV, we will pursue a strategy that calls for PLHIV to be more hands-on in as many areas of care and support as possible. The rise of PWUD is a particular concern and the national response has not caught up with changing patterns, particularly in the rise of non-injecting drug users. We will work to prevent HIV in PWUD by identifying good practices in harm reduction and treatment, introducing them through appropriate partnerships and collaborations.

2. Improve the enabling environment

Improvements in the enabling environment for PLHIV, PWUD/PWID, MSM, and transgender (TG) people, as well as the other communities to whom they may belong, e.g. sex workers, youth, women, and children, will be achieved chiefly through intensifying our advocacy and lobbying efforts. At present, people affected by HIV and AIDS in Indonesia suffer discrimination in many areas of life. We will use evidence to back up our lobbying work, and we will broaden our network of stakeholders by bringing in, and working together with, civil society from other health concerns, as well as from social services, and from gender, women, and human rights groups. We will also empower PLHIV and PWUD/PWID groups to facilitate change, particularly through the use of technology in learning and knowledge-sharing. We will continue to build on our experience of establishing self-help groups among other marginalized people, specifically street children, and use sports, art, music, and other creative activities as entry points to HIV prevention and support.

3. Promote broader health and well-being

We will promote broader health and well-being by focusing on the Badan Penyelenggara Jaminan Sosial (BPJS) Kesehatan, Indonesia's national health insurance scheme. The BPJS is both progressive and wide-ranging, but has significant omissions in its services. We will lobby and advocate to support the removal of provisions that discriminate and deny key affected people access to the BPJS, in particular people who have previously or are currently using drugs (who are excluded from BPJS services for ill health traced to drug-related causes), and for street children (who because of the requirement of a birth certificate face challenges in enrolling for the BPJS). We will also campaign for the inclusion of an HIV benefits package in the BPJS, which is currently lacking. We will form wide-ranging partnerships with other organizations concerned with universal health coverage (UHC) to help us do this.

4. Strengthen institutional capacity

Our fourth goal, to strengthen institutional capacity, will ensure that we can meet the high standards we set for ourselves. In particular, our funding must be well-balanced to ensure sustainability, so we will expand our income-generating activities and diversify our funding. A re-branding exercise, accompanied by strong public relations activity, will help us achieve this. At the same time, our organization will embrace a number of modern management systems, procedures, and practices as part of a continuous improvement strategy to ensure we are working as efficiently and effectively as possible – and, importantly, have strong governance systems in place. This will include benchmarking our skill sets, computerizing our HR systems, strengthening our Board and establishing a finance and audit committee. Monitoring and evaluation of our governance systems will be an ongoing process.

Goal 4 though will not focus exclusively on our own organization. As we work largely through our implementing partners, we recognize the need for these partners to grow as we have grown, and to meet the same standards to which we aspire. To build the capacity of our partners, we will develop minimum quality standards that focus on their governance and management, and we will provide support as our partner organizations embark upon a similar journey towards accountability and quality standards to the one that we have been on.

Table 1 Strategic goals, strategies, and results

Strategic Goals	Strategy	Result
Goal 1: Support sustainable programming	Community-centred and community-led combination prevention; sustainable continuum of care by and for PLHIV; partner with groups that implement good practices for non-injecting drug users.	Invested community
Goal 2: Improve the enabling environment	Evidence-based advocacy and lobbying; partner with like-minded stakeholders; use technology such as apps and social media for learning and knowledge-sharing; promote self-help groups, creative activities and life skills.	Inclusive society
Goal 3: Improve broader health and well-being	Evidence-based advocacy and lobbying; partner with human rights and child-health organizations.	Healthier communities
Goal 4: Strengthen institutional capacity	Income-generating business and social enterprises; diversified fund portfolio; re-branding; benchmarking, combined with knowledge-building and knowledge-sharing; computerized systems; strengthened organizational structures and standards.	Sustainable organizations

Preface

Indonesia has a high HIV burden, with an adult HIV prevalence of 0.40%. Injecting drug use and sexual transmission are the main drivers of the epidemic, which is concentrated primarily among PWID/PWUD, MSM, TG people, and female sex workers (FSW). The island of Java – home to more than 60% of Indonesia’s 256 million populations – has the country’s largest cities with high numbers of PLHIV.

Table 2 HIV epidemic in Indonesia^{1,2}

People living with HIV (2014 data)	691,040
New HIV infections (2015 data)	72,062
AIDS-related deaths (2014 data)	69,316
Adult HIV prevalence (2014 data)	0.40%

HIV prevalence and key population groups

PWID HIV prevalence among PWID ranges from 27% to 59%. Harm reduction programs need to give priority in particular to the large numbers of PWID distributed across Java and in north Sumatra.

MSM Though MSM live throughout Indonesia, their numbers are higher in urban areas. HIV prevalence among MSM is highest in Surabaya (22.1%), followed by Bandung (21.3%), and Jakarta (19.6%). Prevention and treatment programs should prioritize these areas and surveillance expanded.

TG TG women in particular are concentrated in Java, Sumatra, and Sulawesi, with HIV prevalence exceeding 30% in two sites in Java. Prevention programs should prioritize areas of high concentration of TG people and high HIV prevalence.

FSW FSW work throughout the archipelago of Indonesia, with larger numbers found in the big cities of Java. Papua has the highest HIV prevalence among FSW. Programming for FSW is needed throughout Indonesia.

Source: UNAIDS 2015 report, ‘Focus on location and population’.

Indonesia is a UNAIDS Fast-Track strategy country. Programmatic and institutional gaps in the country’s HIV response have been responsible for a rising number of new HIV infections and critically low coverage of antiretroviral therapy (ART) at just over 50,000 in 2014³. The conservatism of Indonesia’s predominantly Muslim society has also acted as a barrier to an effective response to the epidemic.

¹ United States Department of State. FY 2015 Indonesia Country Operational Plan (COP)

² UNAIDS. Global AIDS Response Progress Reporting 2014

³ <http://www.aidsdatahub.org/Country-Profiles/Indonesia> - accessed 16 August 2016

However, the Government of Indonesia has placed HIV high on its agenda and important progress has been made. The NASAP 2015-2019 identifies as one of its highest priorities strengthening, and accelerating the roll-out of, the existing continuum of care model for HIV and sexually transmitted infection (STI) related health promotion, prevention, and treatment. This model is characterized by service provision that is decentralized through primary health care facilities and hospitals, and it reinforces the role of civil society organizations (CSOs). NASAP has also selected 75 districts for the ‘test and treat’ strategy to optimize interventions.

Government and civil society in Indonesia have generally enjoyed good, collaborative relations, and this has been reflected in a number of changes advocated by Rumah Cemara and other CSOs being embraced in recent years. Examples include:

- Diversion from prison and towards community-based treatment for drug use being implemented more consistently, including increased Government funding for four community-based treatment centers.
- The introduction of a pilot needle and syringe program in prisons.
- A ‘Support Don’t Punish’ campaign increasing its reach to include new audiences, such as the media and academia.
- The promotion of social change through sports.

However, there remain some areas which would benefit from continued and better collaboration between the Government and civil society, as well as the corporate sector.

First, Indonesia is a lower-middle-income country (LMIC) and, while Indonesia’s HIV response is still largely supported by foreign funding, donors are gradually reducing their financial support. The Government has set an ambitious target to increase its domestic funding for HIV, but this has so far proved difficult to achieve.

While the provision of HIV services has increased as a result of decentralization, the majority of these services are still provided as vertical interventions – in which the services at the different stages of the continuum of care are not well-coordinated – and providing a mandatory minimum standard of service everywhere has proved challenging. This suggests that further institutional capacity strengthening is needed.

There are policy agenda to tackle as well. Access to affordable medicines, diagnostics, and vaccines, such as hepatitis C tests and treatments, need to be assured by the Government when Indonesia joins the Trans-Pacific Partnership Agreement (TPP). Approval and introduction of the latest treatment regimens, such as Sofosbuvir, and their inclusion into the national health insurance scheme need to be achieved.

Programmatically, strategies related to combination prevention, increased testing, and raising adherence need to be developed to ensure that continuum of care and the ‘test and treat’ strategy are implemented effectively.

Lastly, the current conservatism of Indonesian society and influential individuals has to be challenged. Strong policy engagement, sensitization, and advocacy work needs to be in place to influence policies on issues related to lesbian, gay, bisexual, and transgender (LGBT) people, sex

workers, and drug trafficking and use – as well as to change the beliefs and attitudes of policymakers and of society at large.

Rumah Cemara Strategic Plan 2016-2021 will be supported by the organization’s policy engagement and advocacy plan, communication and knowledge sharing plan, and resource mobilization plan. Together with these plans, the Strategic Plan will provide an effective guide to action over the next five years as we work to bring an end to AIDS – and achieve *Indonesia Tanpa Stigma* (Indonesia without stigma).

Challenges to HIV response in Indonesia

- High HIV incidence, and low ART coverage
- Decreasing foreign funding
- Ensuring minimum standards of care
- Access to affordable medicines, diagnostics, and vaccines, including new treatments
- Sub-optimal implementation of HIV treatment and care strategies
- Social conservatism

Strategic Goal 1: Support sustainable programming

NASAP 2015-2019 calls for the “strengthening of and accelerated roll-out of the existing continuum of care model for HIV/STI-related health promotion, prevention, and treatment in primary health care facilities and hospitals with the role of CSOs reinforced”. It is the main strategy for delivering comprehensive prevention, treatment, care, and support for PLHIV and KPs in Indonesia.

Although the existing continuum of care model has been working well, changes in the country’s HIV situation need to be examined to determine whether this will continue to be the case. We believe that the model also needs to be reinvigorated by the introduction of innovations. Such innovations have proved successful when working at local level in Indonesia and when scaled-up in neighbouring countries, in particular when they are community-led and sustainable. For example, Rumah Cemara sports program developed confidence among PLHIV and helped reduce stigma in society, which contributed to improved treatment adherence.

Rumah Cemara’s contribution in this area has the potential to be significant. With our network of implementing and collaborating partners, we have been at the forefront of innovations in prevention, care, and support. In addition to our own and our partners’ experiences, we will reach out to other IHAA Linking Organisations and the IHAA Centres of Practice for further good practices.

The national response related to drug use is considerably less advanced. Currently, harm reduction is targeted solely towards PWID and is tied to HIV. Even the voluntary treatment regimen is geared towards injectors of opiates. Harm reduction and treatment for non-injecting drug users is little known, yet the number of non-injectors of non-opiate drugs has been growing fast in Indonesia. New practices will help address this obvious deficiency. With dwindling resources and the changing roles of PLHIV and KPs, particularly on service delivery, the communities and Rumah Cemara will achieve results by working together. Using our people, ideas, time, and available funds, we can advocate for and implement community-led interventions, innovations, and good practices for a sustainable response in the changing drug-use landscape.

Table 3 Strategic Goal 1: Objectives, strategies, and KPIs

	Objective	Strategy	Key Performance Indicators 2021
1	To reduce new HIV infection among PWID/PWUD, MSM, and TG people, including their cross-cutting populations.	Support community-cantered and community-led combination prevention.	<ul style="list-style-type: none">• 30,000 people reached.
2	To improve the quality of life for PLHIV through the sustained provision of HIV services.	Provide sustainable continuum of care by and for PLHIV.	<ul style="list-style-type: none">• 35,000 PLHIV reached with a minimum package of care and support.• 60% of the cities covered by Rumah Cemara have PLHIV care and support models financed from a sustainable source of

			funding (e.g. government funding or health insurance coverage).
3	To prevent HIV among PWUD (non-injecting) through the introduction of good practices on harm reduction and drug treatment for non-injecting drug users.	Partner with groups that implement good practices for non-injecting drug users in Indonesia and abroad.	<ul style="list-style-type: none"> At least one good practice piloted, documented, and disseminated.

With our implementing and collaborating partners, we aim to improve the quality of the continuum of care for the communities we work with. As a recognized leader of innovation in HIV prevention, we will offer combination prevention in packages appropriate to groups. These will be led by communities and implemented by their members, leading to a more sustained effort. Although some biomedical components, such as pre-exposure prophylaxis (PrEP), are not yet in use in Indonesia, and others, such as post-exposure prophylaxis (PEP), are not available for prevention except in clinics and hospitals, combinations are available that make effective prevention interventions. We will also involve ourselves in any future undertakings on PrEP and PEP. With our growing network of KP-driven implementing and collaborative partners providing sustainable community-centered and community-led combination prevention, we expect to reach tens of thousands of people affected by HIV. Over the years, our work with PLHIV has evolved and it continues to do so as the HIV landscape itself changes. We will pursue a strategy grounded in sustainability that calls for PLHIV to be more hands-on in as many areas of care and support as possible. With PLHIV engaged in almost all stages of the continuum of care, testing, referral for treatment, and adherence will improve. We will work with our communities and the Government for an effective minimum package of care and support that will increase self-reliance among PLHIV.

The spread of HIV among PWUD is becoming a major concern. We will introduce good practices in harm reduction and treatment for non-injecting drug users in an effort to reverse this situation. We will first identify these good practices from within and outside the country, and then we will establish links and eventual partnerships with successful implementers. With their help, we will pilot at least one good practice, document it, and present the experience to the community of PWUD and other stakeholders.

RESULT: Invested communities

Strategic Goal 2: Improve the enabling environment

In spite of existing constitutional and general laws on labour, human rights, and public health, and specific laws that prohibit discrimination on the grounds of HIV, people affected by HIV and AIDS in Indonesia continue to suffer from discrimination when trying to access health services, social safety nets, education, employment, and protection under the law. This has been documented by, among others, the United Nations Office on Drugs and Crime (UNODC) and AVERT, and many have raised their voices in attempts to right injustices. However, Indonesia's social, political, and legal systems have failed to respond adequately. Other marginalized groups, such as street children, are also subject to exploitation and violence, many with no recourse to protection.

Rumah Cemara believes in an environment that promotes the rights of people, regardless of their health, economic, and social status. This environment must also give people the opportunity to assert their rights, and recognize that communities, no matter how deprived, if given the chance can effect change by themselves.

Table 4 Strategic Goal 2: Objectives, strategies, and KPIs

	Objective	Strategy	Key Performance Indicators 2021
1	To achieve rights-based supportive legislation at national and city levels.	Use evidence-based advocacy and lobbying. Broaden partnerships with like-minded stakeholders.	<ul style="list-style-type: none"> • 10 cities have rights-based supportive legislation. • At least one rights-based supportive law passed by the National Parliament.
2	To facilitate PLHIV, PWUD/PWID, and MSM/TG to reach their full potential to bring changes in HIV, drug use and health services.	Increase KP's capacity to use technology such as apps and social media for acquiring both basic and advanced knowledge about rights to access information and services for HIV, drug use, and health. To foster KP's original spirit of self-help: i.e. commitment, volunteerism, mutual care, and advocacy.	<ul style="list-style-type: none"> • 80% of groups (and their members) acquire knowledge for empowerment using the technology and social media mix. • 50% of our implementing partners use social media and technology for advocacy. • 50% of self-help groups advocate on their own for their needs with Government or other institutions. • 80% of self-help groups hold regular meetings regardless of funding.
3	To facilitate the formation of self-help groups among other marginalized people, specifically street children.	Use sports, art, music, and other creative activities as organizing entry points. Focus on life skills, including those related to HIV, drug use, and other health matters.	<ul style="list-style-type: none"> • 43 operational self-help groups. • 20 of the 43 self-help groups are active in HIV and drug abuse prevention.

Rumah Cemara advocates and lobbies in the areas of HIV and drug use. We will intensify these activities to improve the environment for PLHIV, PWUD/PWID, MSM, and TG people, as well as their cross-cutting populations. In particular, working closely with our civil society partners and other stakeholders, we will reinvigorate the ways in which we address policies, regulations, and laws that contribute to the disenfranchisement of communities by:

- using evidence to back up our advocacy and lobbying work,
- seeking reliable data culled from new studies,
- seeking secondary data analysis of existing quality research, and
- undertaking learning exchanges of good practices.

To ensure our efforts have impact, we will broaden our network of stakeholders by bringing in, and working together with, civil society from other health concerns, as well as from social services, and from gender, women, and human rights groups. In addition to our traditional stakeholders such as government agencies and international donors, we will work with the business sector, religious groups, academia, and local groups engaged in arts and music, for example the band Jeruji, to bolster our efforts. In this way, our work with members of the National Parliament and key national government agencies whose regulatory and implementing powers affect the lives of people we work with will be more productive.

Using the same strategy, we will work in cities where local legislation on HIV, drug use, and health is less rights-based. We will support cities that are interested in, or are already working towards, more equitable protection and access for our communities.

We are an acknowledged leader in innovation. For example, our use of sports and music to bring information and services on prevention, treatment, care, and support to those most at risk of HIV has been praised by our colleagues and the Government, and funded by the corporate sector. We will use our talent for innovation to create a combination of technologies, primarily apps and social media, to use in learning and knowledge-sharing on topics such as HIV testing, harm reduction, ART and adherence, sexual and reproductive health (SRH), and drug abuse treatment and recovery. In this way, the communities we work with will be able to help themselves. It will also give them the dignity and confidence to face, and make requests of, government agencies and other institutions.

We have a long and rich experience of forming self-help groups which we will use to facilitate organizing street children. Organized as self-help groups, street children can be involved in HIV and drug use prevention, as well as other issues, such as violence. They can discuss and understand their rights and what these issues mean for them. Alone, they have no voice; together, they will be strong.

Result: Inclusive society

Strategic Goal 3: Promote broader health and well-being

In just three years, Indonesia's UHC scheme has succeeded in folding several large and disparate health insurance programs into one, the Badan Penyelenggara Jaminan Sosial Kesehatan (BPJS). Still a work in progress, it has the potential to cover even greater numbers of people and provide affordable quality services for HIV, drug use, and other health care. BPJS is progressive, and it has a provision that guarantees cover for people who are poor, in need, vulnerable, and at the margins of society. This includes PLHIV, PWUD/PWID, MSM, TG people, and their cross-cutting populations. There are, however, immense challenges for people who have previously or are currently using drugs, and for street children. The former group cannot get services for diseases or harm caused and traceable to past or current drug use. For the latter group, the requirement of a birth certificate to enrol in BPJS is an issue as, in spite of newly simplified requirements, getting a birth certificate is still a complex and expensive process.

BPJS aims to provide health care for all but does not offer any HIV products and services. This is a big concern at a time when donors who fund major components of the HIV response will soon be leaving Indonesia and funding from government ministries remains low. Even if allocations from ministries were to increase, they would have to be debated and endorsed at various levels within the relevant ministry and defended in Parliament every year.

BPJS needs to incorporate an HIV benefits package. In this way, services can be protected from changes in government and shifts in ministerial priorities, especially those in the Ministry of Health. Timely prevention, treatment, care, and support will not be put in jeopardy.

Table 5 Strategic Goal 3: Objectives, strategies, and KPIs

	Objective	Strategy	Key Performance Indicators 2021
1	To promote the understanding of the principles, benefits, and cost-effectiveness of UHC among the national parliamentarians, mayors and other influential persons.	Sensitization of the relevant policy makers and health insurance providers implemented in partnership with other organizations with common aims using readily available tools, studies, data, and past experiences.	<ul style="list-style-type: none"> RC establishes a strong partnership with at least 100 other organizations to form a coalition to advocate for UHC. 30 national parliamentarians, 15 mayors (including two special district mayors), and other influential persons are champions of UHC among policy makers and health insurance providers and collaborate with the coalition.
2	To create the grounds for the full implementation of UHC by: a) supporting the removal of provisions that discriminate and deny access of KPs to the BPJS; b) campaigning for the	Advocacy and lobbying for the full application of UHC including activities to identify current barriers and working out ways to remove	<ul style="list-style-type: none"> A minimum set percentage of the identified barriers have removal plans in place by the government. This percentage will be set after the barriers are identified. A civil society coalition appointed to monitor implementation of the plans.

	inclusion of an HIV benefits package in BPJS; and c) assisting street children to enrol in BPJS.	them.	
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We will lead an evidence-based advocacy and lobbying campaign for issues related to BPJS. This will be a new area of concern for Rumah Cemara so we will first learn all we can about it from others before sharing our learning with civil society and other stakeholders. To advocate and lobby to decision-makers and opinion leaders effectively, we will further analyse existing data, conduct new studies as necessary, and learn from experiences of other countries, prioritizing those from member states of the Association of Southeast Asian Nations (ASEAN), where UHC is a common goal. We will focus on three very important aspects:

- Ensuring access to care and services for drug users, including diseases traceable to drug use
- Inclusion of an HIV benefits package
- Enrolment of street children

UHC has been identified by the World Bank, UNAIDS and The Global Fund to Fight AIDS, Tuberculosis and Malaria as a financial tool for sustaining the HIV response, and a costing study funded by the World Bank has been completed. However, there has been no obvious movement towards the goal of including an HIV benefits package. As such, we will follow up and engage with the appropriate government ministries, the World Bank, and UNAIDS about next steps, including conducting other studies, to prove the cost-effectiveness of including HIV services in BPJS.

We will also explain the principles of UHC, as well as the details of BPJS, to civil society and like-minded stakeholders for possible grassroots advocacy. We will lobby selected members of the National Parliament to become our champions. We will localize the discussion at the city level to generate support from local officials and influential leaders. We will harness human rights advocates, sympathetic medical practitioners, local and international agencies, and non-governmental organizations (NGOs) to be our allies.

RESULT: Healthier communities

Strategic Goal 4: Strengthen institutional capacity

Rumah Cemara is evolving. This strategic period will see Rumah Cemara strive to meet the high standards we set for ourselves – those of an efficient, effective, dynamic, and committed organization that works with and for our communities in a sustainable manner. This means a Rumah Cemara that delivers rights-based, quality programming that is cost-effective, optimizes its human resources, and maintains professionalism while retaining its community-based organization (CBO) trademark of agility and commitment. It also means we must have a balanced portfolio of funding sources; one not overly dependent on a few donors, but rather expanding its international and domestic support through corporations, and generating income from a range of business and social enterprises. This is necessary for sustained engagement.

As we work largely through our implementing partners who like us come from the rubric of self-help, we recognize the need for these partners to grow at the same rate and achieve the same levels of efficiency and effectiveness to which we aspire.

Table 6 Strategic Goal 4: Objectives, strategies, and KPIs

	Objective	Strategy	Key Performance Indicators 2021
1	To build a robust financial core that can sustain programs.	Expand income-generating business and social enterprises. Diversify the fund portfolio to include the Government, Official Development Assistance (ODA), non-ODA, and the public. Re-branding.	<ul style="list-style-type: none"> • 15% contribution to the budget by business and social enterprises. • 30% contribution to the budget by the diversified fund portfolio.
2	To improve human resources in: <ul style="list-style-type: none"> • staff technical capacity to respond to changes in the operational environment, and • implementation of the human resource system to obtain efficiency. 	Benchmarking, combined with knowledge-building and knowledge-sharing. Computerize systems.	<ul style="list-style-type: none"> • 80% of the staff meet the technical requirements of updated job descriptions. • 80% of the HR system is computerized.
3	To bolster good governance.	Strengthen the Board. Improve the internal system for governance.	<ul style="list-style-type: none"> • Rumah Cemara achieves 98% of the major components of good governance.

4	To build the capacity of implementing partners.	Develop minimum quality standards system that focuses on governance and management of implementing partners.	<ul style="list-style-type: none"> • 100% of implementing partners meet all basic standards.
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Rumah Cemara has already embarked on efforts to strengthen financial sustainability. To date, we have met with modest but encouraging results. For example, our partnerships with the corporate sector have resulted in some successes, as have our efforts in business.

To bolster our prospects of financial sustainability, we will expand our horizons in resource mobilization. We will do this by implementing strong branding and public relations in order to attract a diverse base of donors, funders, and customers, both new and old. The new branding in particular will open more opportunities for Rumah Cemara in the corporate world and the international community. We will also look to our brand to bring us to public attention. With the right message, the public can provide steady support for us.

At the same time, we are committed to becoming a more impactful organization – one that leads HIV response and KP rights in Indonesia. To respond well to the country's current HIV strategy which articulates increased civil society involvement in health services provision, implying increased professionalism from civil society, we will further enhance our skills and systems. To do this, we will build new staff skills and update existing ones. We will use the technique of benchmarking, comparing the skills sets in our areas of work against the best in the development sector with similar processes. The results will be used to review and rewrite job descriptions, and to identify capacity gaps. We will address the gaps in various ways, including formal training, mentoring and coaching, and on-the-job training.

We will commit to computerizing not only our personnel data and salaries but also our manuals and forms. This will save time and ensure accuracy. Our database will consolidate data, studies, reports, and references, placing them in one location that is accessible to all staff. Our website will be our knowledge bank, available to our implementing and collaborating partners. We will ensure that records, documents, and data from our partners and other stakeholders is placed on the site, avoiding the danger of a 'one-way knowledge bank'. We will also provide web links to partners and others.

In a bid to become one of the leading organizations in Indonesia working on HIV and KP issues, we have already embarked on the path to good governance. During this strategy period, we will continue to work towards a strong governance system to ensure our accountability, compliance, and transparency, and to guide us in implementing our strategy effectively. We will continuously monitor and evaluate our governance practices, and we will aim to improve them all the time.

As part of our continuous improvement strategy, we will adopt the business practice of 'quality circles' and we will organize ourselves into quality circles corresponding to our areas work, e.g. programming, financing, human resources, and enterprises. These quality circles will meet regularly to consider ways to resolve problems and improve our work.

We will continuously build the capacity of our implementing partners. We will adapt the IHAA accreditation process to fit our needs and circumstances. Implementing partners will undergo an organizational capacity assessment which will emphasize governance and management (organizational, financial, and project). Being a new concept for all of our implementing partners, we will initially develop a small set of minimum quality standards, along with a manual, and use these as a guide to provide partners with organizational support. We know that it will not be an easy journey, but it is one of the best ways to build the capacity of our partners.

RESULT: Sustainable organizations

Glossary

Adherence (or adherence to HIV treatment) Sticking firmly to an HIV regimen, i.e. taking HIV medicines exactly as prescribed so the medicines can prevent HIV from multiplying and destroying the immune system and reduce the risk of HIV transmission. Poor adherence allows HIV to destroy the immune system, making it hard for the body to fight off infections and certain cancers. Poor adherence also increases the risk of drug resistance and HIV treatment failure. However, adherence can be difficult for several reasons, such as the side-effects of the medication, the complicated regimen, and the cost.⁴

Antiretroviral therapy (ART) The use of a combination of three or more antiretroviral drugs to achieve viral suppression. This generally refers to lifelong treatment.⁵

Badan Penyelenggara Jaminan Sosial (BPJS) Kesehatan (Healthcare and Social Security Agency) the comprehensive health care insurance scheme implemented in Indonesia under President Decree No. 12/2013, No. 111/2013, and under which universal coverage for all Indonesians will be achieved by 2019.⁶ There is no opting out for companies which already provide superior health insurance schemes. All employees, Indonesian citizens and Indonesian residents are required to join.

Alliance Centres of Practice Centers established by IHAA to increase and speed up the deployment of technical expertise and policy leadership rooted in practice. They bridge knowledge and practice, and are led and hosted by LOs with recognize expertise. IHAA has started with five global centres: one on harm reduction and hepatitis C, two on KP, one on adolescent health, and one on HIV treatment.⁷

Communities People who are connected to each other in distinct and varied ways. Community members may live in the same area or may be connected by shared experiences, challenges, interests, living situations, culture, religion, identities, or values. Communities are both diverse and dynamic, and a person may be part of more than one.⁸

Continuum of (HIV) care A comprehensive package of HIV prevention, diagnostic, treatment, and support services provided for people living with HIV and their families ranging across initial HIV diagnosis and linking to care; management of opportunistic infections and other comorbid conditions; initiating, maintaining and monitoring ART; switching to second-line and third-line ART; and palliative care.⁹

Incidence The frequency with which something, such as a disease or trait, appears in a particular population or area.¹⁰

⁴ AIDS Info. HIV Treatment, HIV Medication Adherence. <https://aidsinfo.nih.gov/education-materials/fact-sheets/21/54/hiv-medication-adherence> - accessed on 16 August 2016

⁵ WHO. Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. September 2015

⁶ KPMG Advisory Indonesia. . February 2014.

<https://www.kpmg.com/ID/en/IssuesAndInsights/ArticlesPublications/Documents/IES-Bulletin-February-2014.pdf> - acces5 July 2016

⁷ International HIV/AIDS Alliance. HIV, Health & Rights: Sustaining Community Action. Strategy Update 2016-2020.

⁸ Ibid

⁹ WHO. Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. September 2015

¹⁰ MedicineNet.com <http://www.medicinenet.com/script/main/art.asp?articlekey=11516> – accessed on 16 August 2016

Integrated support facility The integration of support services into *puskesmas* (government-mandated community health clinics in [_HYPERLINK "https://en.wikipedia.org/wiki/Indonesia" _Indonesia_](https://en.wikipedia.org/wiki/Indonesia)) to provide a one-stop-shop for HIV care and support to clients.

International HIV/AIDS Alliance (IHAA) A global partnership of NGOs with its main Secretariat in the United Kingdom. It was founded in 1993 to support community groups in countries that were most affected by the global AIDS crisis, and offered a vision and a way of working that would put communities at the centre of the response in order to provide effective local solutions. The partnership now works with communities in over 40 countries to take local, national and global action on HIV, health and human rights. Rumah Cemara has been a partner (Linking Organisation) since 2009.

Key populations (KP) Groups that are vulnerable to, or affected by, HIV and AIDS. Their involvement is vital to an effective response. Key populations vary according to the local context but are usually marginalized or stigmatized because of their HIV status or social identities. They include PLHIV, their partners and families, people who sell sex, MSM, TG people, PWUD, children affected by HIV and AIDS, refugees, migrants, displaced people, and prisoners.¹¹

Linking Organisations (LOs) National CSOs that form the Alliance partnership. They provide technical and financial support to community-based organizations and others, enabling them to respond effectively to HIV. They work as part of national HIV programs, and are often key to the scale-up of national community-based HIV responses. LOs are intermediary, non-governmental support organizations. Diverse in nature, some LOs provide direct HIV services or focus on policy work, while others supervise grants to CBOs and manage sector coordination.¹²

Peer mentoring A form of mentoring for community members provided by their peers. It is effective as the mentee starts his/her relationship with their mentor at a higher level of confidence that they share the same issues and challenges. As a result, the mentee opens up to the mentor more easily than in other forms of mentoring.

Pre-exposure prophylaxis (PrEP) The HIV medicines that HIV negative people who are at very high risk for HIV take daily to lower their chances of getting infected. A combination of two HIV medicines (tenofovir and emtricitabine), sold under the name Truvada, is approved for daily use as PrEP. Studies have shown that PrEP is highly effective for preventing HIV if it is used as prescribed. PrEP is much less effective when it is not taken consistently.¹³

Prevalence A statistical concept referring to the number of cases of a disease that are present in a particular population at a given time. (This compares to incidence, which refers to the number of new cases that develop in a given period of time.)¹⁴

Post-exposure prophylaxis (PEP) ART taken to prevent becoming HIV infected after being potentially exposed to the virus. PEP must be started within 72 hours after a possible exposure to HIV, but the sooner

¹¹ International HIV/AIDS Alliance. HIV, Health & Rights: Sustaining Community Action. Strategy Update 2016-2020.

¹² Ibid

¹³ Centers for Disease Control and Prevention. <http://www.cdc.gov/hiv/basics/prep.html> - accessed on 16 August 2016

¹⁴ MedicineNet.com <http://www.medicinenet.com/script/main/art.asp?articlekey=11697> – accessed on 16 August 2016

started the better. PEP is taken once or twice daily for 28 days. PEP is effective in preventing HIV when administered correctly, but not 100%.¹⁵

Quality circle A form of employee self-help group in which the members keep their motivation and spirit high over time to achieve improvements in the quality of life of each member.

Test and treat An approach to provide ART to everyone who tests positive for HIV as soon as possible after diagnosis. In 2015, with its 'treat-all' recommendation, the World Health Organization (WHO) removed all limitations on eligibility for ART among people living with HIV, meaning all populations and age groups are now eligible for treatment. Findings from clinical trials confirm that early use of ART keeps PLHIV alive and healthier, and also reduces the risk of their transmitting the virus to partners.¹⁶

UNAIDS Fast-Track strategy UNAIDS' approach to end the AIDS epidemic by 2030. Under it, there is a new set of targets to be reached by 2020, including the so-called 90-90-90 in which 90% of PLHIV know their HIV status, 90% of people who know their HIV-positive status receive sustained ART, and 90% of people on ART have suppressed viral loads. Other targets include reducing the annual number of new HIV infections by more than 75%, to 500 000, by 2020, and achieving zero discrimination. The targets are based on an approach to leaving no one behind that is grounded in human rights. If achieved, they would significantly improve global health outcomes.¹⁷

¹⁵ Centers for Disease Control and Prevention. <http://www.cdc.gov/hiv/basics/pep.html> - accessed on 16 August 2016

¹⁶ WHO news release, Geneva, 30 September 2015.
<http://www.who.int/mediacentre/news/releases/2015/hiv-treat-all-recommendation/en/> - accessed on 16 August 2016

¹⁷ UNAIDS press release, Geneva/Los Angeles, 18 November 2014.
http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2014/november/20141118_PR_WAD2014report - accessed on 16 August 2016

The history of Rumah Cemara

2003	<ul style="list-style-type: none"> • Rumah Cemara was founded as a community-based organization in West Java on 1 January by five recovering drug users who believed that if a change was to occur in society that change must begin from within the community of drug users. • After establishing its first drug treatment center, Rumah Cemara realized that HIV/AIDS was affecting most residents, particularly those who were injecting. Since then, Rumah Cemara's focus has also included people living with HIV/AIDS. This led to the formation of Bandung Plus Support, a special division to provide peer-led services to people living with HIV/AIDS, in March.
2004	<ul style="list-style-type: none"> • Rumah Cemara creates an outreach program for populations most at risk of contracting HIV.
2005	<ul style="list-style-type: none"> • Rumah Cemara opens branch offices in Sukabumi and Cianjur for service provision in these highly-affected cities.
2006	<ul style="list-style-type: none"> • The Rumah Cemara Football Club is founded with the aim of proving that addiction and HIV can be overcome by a healthy lifestyle, and also reducing stigma and discrimination.
2007	<ul style="list-style-type: none"> • Bandung Plus Support is officially named the Provincial Initiating Group of West Java by Spiritia, the National Network of HIV/AIDS support groups.
2008	<ul style="list-style-type: none"> • Rumah Cemara starts a mobile clinic program to provide basic health services to people in the rural areas of Bandung.
2009	<ul style="list-style-type: none"> • Rumah Cemara becomes the Indonesian Linking Organisation of IHAA. • Rumah Cemara wins the 'Changing Lives Through Football' competition held by Ashoka and Nike, with its ideas around engaging the public in discussions around HIV/AIDS and drug use.
2010	<ul style="list-style-type: none"> • Rumah Cemara launches 'For Life', a fundraising campaign to engage the local public as its supporters. • Rumah Cemara Football Club is appointed representative of Indonesia in the Homeless World Cup. • Rumah Cemara establishes #IndonesiaWithoutStigma for its campaign against stigma and discrimination.
2011	<ul style="list-style-type: none"> • Rumah Cemara initiates harm reduction work with IHAA in West Java. • Rumah Cemara takes part in the Homeless World Cup in France and wins 6th place, Best Newcomer Award, and Best Player Award.
2012	<ul style="list-style-type: none"> • Rumah Cemara expands its harm reduction program in the provinces of Bali and NTB. • Rumah Cemara develops Rumah Cemara Boxing Camp and registers it with Pertina, an amateur boxing association. • Rumah Cemara becomes a member of FIFA Football for Hope (FFH) and Streetfootballworld. • Rumah Cemara starts working with street children through the 'Croyom Market Street Football' program to improve the quality of life of youth who use drugs.
2013	<ul style="list-style-type: none"> • Rumah Cemara initiates its harm reduction advocacy work with IHAA and its regional partners, and launches 'Support Don't Punish' campaign with drug users' groups in 12 provinces.
2014	<ul style="list-style-type: none"> • Rumah Cemara works with General Motor for Chevrolet and Manchester United Football Club project on 'What Do You #PlayFor' global campaign to create meaningful change for marginalized children around the world. • Rumah Cemara opens its representative office in Jakarta.
2015	<ul style="list-style-type: none"> • Rumah Cemara becomes an official member of the International Drug Policy Consortium (IDPC).
2016	<ul style="list-style-type: none"> • Rumah Cemara opens a digital printing shop as a social enterprise business and employs 13 people from the drug users community following vocational training. • Rumah Cemara is invited to the Streetfootballworld Festival in Lyon, France, which involves 500 boys and girls from disadvantaged communities looking to change the world through football.

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