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UNIVERSITAS KATOLIK INDONESIA ATMA JAYA

STUDY REPORT

OPERATIONAL RESEARCH ON FEASIBILITY AND ACCEPTABILITY OF PREVENTION OF HIV TRANSMISSION AMONG METH USERS IN JAKARTA

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Operational Research on Feasibility and Acceptability of Prevention of HIV Transmission among Meth Users in Jakarta

Study Report

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SECTION 1: INTRODUCTION

1.1. Background

The use of crystal-methamphetamine (CM) contributes to various health defects. CM is a stimulant type drug, and its primary action is to elevate levels of extracellular monoamine neurotransmitters (dopamine, serotonin, and norepinephrine), by promoting their release from the nerve endings in the brain (Rothman & Bauman, 2003). Short-and long-term health effects of CM use include stroke, cardiac arrhythmia, stomach cramps, shaking, anxiety, insomnia, paranoia, hallucinations, and structural changes to the brain (Anglin et al, 2000). The use of CM at high doses can even cause death (Darke et al, 2008). The nature of the drug poses a risk to both psychological and physical health. A number of studies have also looked at the relationship between CM use and HIV transmission. According to UNODC (2009) estimates 60 out of 110 countries reported the use of CM by injection. Unsafe injecting practices may lead to the acquisition of HIV among the CM users, if needles are shared between individuals of unknown or different HIV status. Moreover, the drug is often used in a sexual context as a means to enhance and prolong sexual pleasure and to reduce sexual inhibitions (Semple, Patterson & Grant, 2004; Zule, 2007). CM use may result in increased risk taking, such as unprotected sex, sex with multiple partners and prolonged sexual episodes (Colfax & Shoptaw, 2005). In a recent systematic review and meta-analysis conducted by Thu Vu, Maher, & Zablotska (2015) it was found that CM use in men who have sex with men (MSM) was significantly associated with HIV infection, with CM users being 1.86 times more likely to be infected with HIV than non-users (PRR=1.86; 95% CI: 1.57 – 2. 17). Globally, an association between CM use and HIV risk among both MSM and heterosexual populations is apparent (Colfax & Shoptaw, 2005; Corsi & Booth, 2008; Mausbach, Semple, Strathdee, Zians, & Patterson, 2007; Sherman et al., 2009).

In Indonesia, the widespread use of crystal-methamphetamine has led to manifold legal, social and health consequences. The drug, locally known as shabu-shabu, is used by an estimated 800,000 Indonesians of various backgrounds and has become the second most popular drug in Indonesia after cannabis (BNN, 2014). The risk profile of CM users is similar to that of key affected populations, such as sex workers, MSM, people who inject drugs (PWID), transgender people, and young people who, for one reason or another, are more vulnerable to HIV infection (Benotsch, Lance, Nettles, & Koester, 2012; Couture et al., 2012; Fast, Kerr, Wood, & Small, 2014; Herman-Stahl, Krebs, Kroutil, & Heller, 2007; Uhlmann et al., 2014). The available data from Indonesia confirms this, with methamphetamine use found to be independently associated with an HIV-positive status among urban MSM (Morineau et al, 2011). Moreover, a recent case study from Indonesia showed that female sex workers are often requested by their clients to use amphetamine-type stimulants (ATS) to improve sexual experience. This in turn can increase the likelihood of engaging in risky sexual behavior, which may lead to

HIV transmission (Walk, 2014). CM users, also those that smoke or snort the drug, are thus at a heightened risk of HIV infection, similar to other key affected populations. Despite abundant resources on CM and related health consequences on a global level, there is still limited information available on CM and related practices in Indonesia.

In late 2015, ARC Atma Jaya and Mainline have conducted a qualitative study on the characteristics of CM users in three Indonesian cities in three provinces (Makassar in South Sulawesi; Medan in North Sumatra, and West Jakarta in Jakarta Special Capital Region). Its aim was to assess patterns of meth use and its correlation with HIV risk and to learn more about the health-seeking behavior of CM users. It was found that most CM users are sexually active, often with multiple sexual partners, and only few reported consistent condom use during sexual encounters. Overlapping social and sexual networks, and unbalanced power relations between female CM users and their sexual partners were common. Furthermore, myths and misperceptions related to sexual risk behavior and its various health consequences were common among CM users in the study. This situation is propelled by the absence of programs or health services in Indonesia that specifically target CM users.

Issues around addiction are also an important theme of the study. Most participants did not consider themselves to be addicted, feeling that they could manage their use and still perform their daily routines. Informants tended to associate drug addiction with heroin use and therefore concluded that the use of CM would not lead to addiction. However, financial and legal issues were seen as problem. This may have to do with the widespread belief that rehabilitation or drug treatment is only needed for heroin addiction, and not for meth use, as meth use, according to most informants, could be controlled by the user. However, some informants stated that they were in need of psychological services to help them deal with depression, anxiety and stress, or they required legal aid due to their meth use.

HIV risk behaviors among CM users might contribute to increasing HIV prevalence rates in Indonesia. Related risks can potentially be reduced if people have better access to CM related health services. Such services may include behavioral and or pharmacotherapy interventions (Colfax et al, 2010). Yet, despite its widespread use in Indonesia, there are currently no specific CM interventions in place, neither related to the prevention of HIV among CM users, nor drug treatment.

Considering the magnitude of the problem, it is of great importance that future interventions specifically targeting CM users will be developed to address HIV prevention and other health consequences related to CM use, including for people who smoke or snort meth. The only services currently available are those provided by the Ministry of Health, the National Narcotics Board (NNB), the Ministry of Social Affairs, and some private drug rehabilitation centers as mandated by Law No. 35/2009 (Kementerian Kesehatan, 2011; Kementerian Sosial, 2012) on voluntary and compulsory drug treatment. There are no outreach activities to reach CM users, except

general education for the community and general health promotion advertisement for drug prevention.

Considering the magnitude of the problem is likely getting higher and potential risks for CM users to be exposed to HIV transmission, there is an urgency to develop an intervention to address HIV prevention and other health consequences targeting CM users. When developing new interventions for CM users it will be important to take into account both behavioral characteristics of CM users and the social context of CM use. Only then will such interventions be feasible and acceptable for CM users and local stakeholders. To achieve these aims, an operational research has been conducted, in order to identify and solve specific problems ~~in~~ related to the development of a CM user specific intervention. The goal of an operational research is to increase the efficiency, effectiveness and quality of a planned intervention. (Global Fund, 2010; Population Council, 2000; Fisher et al, 2002). It is expected that with the help of this operational research study a more appropriate intervention can be developed, tailored to the needs of CM users, and thus acceptable for the community and stakeholder and feasible to be implemented in Jakarta. Potentially such interventions can then be expanded to other cities with similar contexts related to CM use.

1.2. Objectives

This operational feasibility study has five specific objectives, they are as follow~~s~~:

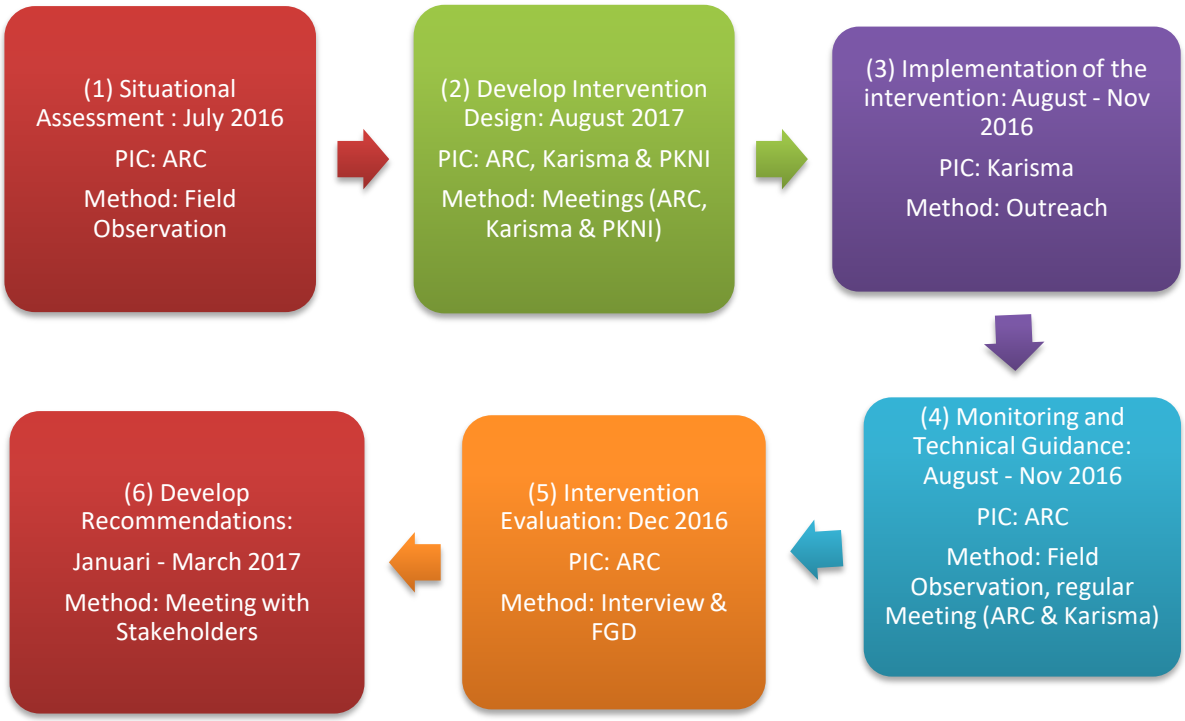
1. To design a new intervention targeting meth users, taking into account their specific characteristics and problems.
2. To develop an operational arrangement that supports implementation of the intervention.
3. To pilot the implementation of the intervention. design and its organizational arrangement
4. To measure the acceptability of the intervention ~~to~~ among the target population and key stakeholders.
5. To measure the feasibility of the intervention, which is going to be implemented by service providers (NGO and its referral system).
6. To provide evidence based recommendations for related policy makers and donor agencies to respond to CM related problems, including its social and health consequences.

1.3. Methods

The Population Council (2002) differentiates between four types of operational research: (1) diagnostic studies aimed at determining the parameters of a problem situation before programming begins; (2) evaluative studies to examine the effect of program activities (retrospectively or cross-sectionally); (3) field intervention studies, which are aimed at assessing alternative strategies to address specific problems during

program implementation, and (4) cost-effectiveness studies, looking at overall costs and cost-effectiveness of a particular program or intervention. The study at hand can be categorized as a diagnostic study, as it aims to examine the basic factors influencing the problem situation and to determine the acceptability and feasibility of the planned intervention. One aspect particular to operational research is the active involvement of program implementers, with the proposed intervention being piloted to assess its feasibility, acceptability and effectiveness. Therefore, this study requires the collaborative efforts of the research institute and program implementers. Karisma Foundation had been selected as the implementer of the intervention, due to the organization's technical capacity and solid experience implementing HIV programs targeting PWID in Jakarta, and the AIDS Research Center (ARC) had been chosen to be in charge of designing, monitoring, providing technical assistance and evaluating the proposed intervention.

In order to best achieve its objectives, this operational study has been rolled out along the following six stages:



Stages of the Operational Study

1. *Situational Assessment*
   The first step of this operational research consisted of a situational assessment, with the goal of estimating the number of CM users and gaining a better understanding of the characteristics of CM users, their drug-using patterns, sexual behaviors, social networks and the specific contexts and locations where CM is being used. This phase also included an assesment of the feasibility of the selected locations as intervention sites for the proposed intervention.

Intervention sites had been selected by Karisma Foundation based on the following criteria:

- Area known for having an active drug scene.
- Location never been reached by any intervention developed or implemented by Karisma Foundation.
- A minimum of two locations had to be selected for the assessment in order to be able to make comparisons in terms of users' characteristics and local stakeholders.

Based on the above outlined inclusion criteria, two neighborhoods (Kebon Bunga in West Jakarta and Pasar Buah in South Jakarta) had been selected as assessment sites. Assessment tools were developed by the ARC based on the objectives of the research. Inputs from drug user communities regarding the assessment tools were collected during a community meeting before conducting the assessment. The assessment was conducted by ARC researchers in collaboration with outreach workers from Karisma Foundation, which included data collection and field observations. All data were recorded, transcribed and analyzed using Nvivo 11. The assessment had been completed by the mid of July, 2016, including data analysis and data preparation for the subsequent development of the intervention design.

2. *Development of intervention design*

Based on the findings of the assessment an intervention for CM users has been designed. The intervention design has been largely based on the approach of the harm reduction program, with some modifications made related to the strategies on how to gain access to CM users based on findings during the assessment. An important element of the intervention are communication strategies, which include prevention messages aimed at increasing their wareness of HIV transmission risks and other potential harms related to meth use. For this purpose, a series of related information, education and communication (IEC) material have been developed by Karisma Foundation. Another area of the intervention deals with strategies on how to increase uptake of care services among CM users, either related to HIV or drug treatment. Furthermore, the intervention has also been aimed at encouraging CM users who have already been reached by the intervention to further promote the prevention messages among their peers and to make use of existing HIV and drug treatment facilities. During the design process aspects related to governance were also taken into consideration, such as planning, organizing, advocacy, monitoring and evaluation. During the design phase, a series of consultation meetings with existing drug user communities (PKNI) had also been undertaken to get a better sense of the intervention's acceptability and feasibility. This process has resulted in the development of an outreach manual, providing outreach workers with

guidance on how to best reach, educate, engage with, and refer CM users. The intervention design had been completed in August 2017.

3. *Implementation/piloting of the intervention.*

   After the outreach manual had been finalized, Karisma Foundation started piloting the intervention. A total of four outreach workers, in pairs, reached out to CM users at the two selected intervention sites. CM users who were encountered at each site were then provided with prevention messages through the previously developed IEC materials, and encouraged to access one of the existing health services for HIV testing or drug treatment. Since the outreach approach was based on the social networks of CM users, there were no strict geographic boundaries for the intervention. Consequently, the target areas extended beyond the two neighborhoods. This allowed the intervention to reach a more diverse group of CM users in terms of socio economic background (low, middle, and high) ~~or~~ and behavioral categories (MSM, FSW, Waria, PWID, and clients of sex workers). The pilot lasted for no more than three months (from August – November 2017), considering the time limitations of the grant period. As will be described in detail in the following section, the pilot succesfully identified barriers and problems to the intervention, as well as a number of enabling factors, so that the intervention could be improved in the future. Apart from technical aspects, Karisma Foundation also tested its operational arrangement model to support the implementation of the intervention, which included management aspects, capacity building for outreach workers, advocacy activities and a referral system.

4. *Monitoring of the implementation of the intervention*

   Monitoring of the intervention had been done in order to find out how far the intervention could be implemented based on the design/plan and to identify barriers, enablers and challenges that might be faced during the implementation. Monitoring also assessed what kind of modification would had been done during the course of the intervention and what would be the context of the problem. Results of monitoring were also used to improve or modify specific activities of the intervention in order to strengthen the intervention's acceptability, feasibility and effectiveness in the future. Monitoring was done by ARC Atma Jaya using a toolkit developed during the design phase. In addition to standard documentation of the intervention, other activities such as monitoring data during field visits, discussions with outreach workers, interviews with the intervention coordinator from Karisma Foundation, and discussions with the target population, was also collected to complete the research process. Monitoring was done at the same time as the implementation of the intervention (August – November 2016). Monitoring results will be presented in more detail in section 4.

5. *Evaluation of the intervention*
   The main objectives of the operational research were to assess the acceptability and feasibility of the intervention in terms of technical (outreach) and management (organizational arrangement) aspects. Detailed indicators to measure the acceptability and feasibility of the intervention were developed ~~in~~ during the design phase. indicators focused on measuring 'can the intervention work?', 'does the intervention work?' and 'will the intervention work?' as the proxy to measure the feasibility and acceptability of the intevention. The evaluation was conducted by ARC researchers using tools specifically adapted to CM users, outreach workers, stakeholders, and the management level of Karisma Foundation. Data collection was done using in-depth interviews and focus group discussions. The evaluation phase was conducted in December 2016. Detailed evaluation results will be discussed in the section 5.

6. Develop recommendations for improving the intervention
   Based on the evaluation of the intervention, a series of technical and managerial recommendations were formulated for Karisma as the implementing NGO. The recommendations have also been targeted at the government (National AIDS Commission and Ministry of Health) and donor agencies to pay more attention to the issue of CM use and related HIV risks and integrate this topic into their HIV responses. The recommendations concerned mainly technical aspects related to the development of an HIV intervention targeting CM users. Serial meetings with stakeholders to develop the recommendations were already conducted and a serial advocacy meeting will be conducted once the final recommendations are completed.

1.4. Research Ethics

This study constitutes an operational research and is part of the regular programmatic efforts implemented by an NGO, thus not necessarily requiring ethical approval for the study. However, to make sure that there was no potential violation of research ethics during the implementation of the research, the research protocol had been submitted to the Ethics Commission of Atma Jaya Catholic University to be reviewed. The study had then been approved by the Ethics Commission of Atma Jaya Catholic University number 167/III/LPPM-PM.10.05/02/2016. As part of the research ethics, written informed consent from each research participant was obtained before the data collection process (interview and discussion).

SECTION 2: SITUATIONAL ASSESSMENT

The assessment of the intervention sites played a central role in the operational research process. One of the main principles of operational research is to understand and work within real world conditions without trying to control or remove its influence and effects (Peter et al, 2014). Therefore, the social and physical contexts surrounding *Pasar Buah* and *Kebon Bunga*, the two selected intervention sites, were assessed to better understand what kind of intervention strategies needed to be developed in the design process. Through the assessment the researchers aimed to better understand the social, cultural, physical environment of each intervention site. This included: [1] to identify the extent of CM use and related problems, characteristics of CM users in each location, and physical characteristics of the places where CM users get together or hang out to procure or use drugs; [2] to explore adverse health consequences and the percieved risks of getting infected with HIV or being affected by addiction; and [3] to map available local resources that could potentially be utilized to respond to the drug and HIV problem.

A field observation and semi-structured interview guide was developed to help the researchers to collect the information relevant to the objectives of the assessment. As the assessment locations had not previously been reached by Karisma Foundation, the first step in the assessment process entailed identifying local contacts (key informants), who were recommended by members of the drug user community. Based on this information, the research team contacted the key informants to confirm their availability and willingness to help introducing the researchers into the neighborhood. The research team consisted of ARC researchers and outreach workers from Karisma. The research team was then devided into two groups, each of them responsible to assess one of the neigborhoods. The assessment had been conducted for two weeks from June 22 to 29, 2016. The research teams visited the locations at different times (morning, noon, night) to ensure that as many activities as possible could be captured. Data gathered during observation was documented in the form of field notes and location map illustrations to be used for further analysis.

2.1. Locations

Two locations were identified and selected during the two week assessment phase. Access to the area has been gained through key informants, most of whom were ex-users, who had been rehabilitated by Karisma or were otherwise known by the outreach workers. Key informants were present in both areas, but the experiences faced by the outreach workers varied between the two sites. Several CM hotspots were identified in both locations, four in *Pasar Buah* and three in *Kebon Bunga*. *Gang Paku, Gang Sabun, Gang Yakin* and *Gang Ayam* were the four meth hotspots in the *Pasar Buah* area, and *Elok*, *Indah*, and *Besar* were the

three hotspots in the *Kebon Bunga* neighborhood. Drug dealers were most numerous in *Elok,* thus constituting the main center of meth distribution in *Kebon Bunga*.

Communities in both neighborhoods seemed to be aware of the CM use by certain community members, but they seemed not to be overtly bothered as they considered it everyone's personal business. Despite many similarities between the locations, some differences were observed. For instance, outsiders seemed to be more welcome *Pasar Buah*. In *Kebon Bunga* people appeared to be familiar with the crystal-meth issue in their community, but they were more cautious towards people they ~~do~~ did not know.

Even within one neighborhood, there were different degrees of acceptance towards outsiders. In *Kebon Bunga*, the areas of *Elok* or *Indah* were more closed towards outsiders as compared to *Besar*. This has to do with the different characteristics of each area. *Elok* and *Indah* mainly consist of private houses and many boarding houses, which make it more closed to outsider. The neighbourhood community in *Elok* has been divide into two sides, one which wants to eradicate the drugs business, and one which 'supports' it because they get some kind of benefit from the drug–business. The climate of suspicion in the neighbourhood has been mainly caused by this condition and was not only directed against outsiders but was also prevalent within the community. Despite frequent raids, the *Pasar Buah* neighbourhood was more open and accessible to outsiders. During the two-week assessment it has been confirmed that the neighbourhood was open to the intervention program. Moreover, it turned out that older CM users and some of the more respected figures at the hotspots were open to being key informants and to assist the intervention program.

Different strategies were applied to gain access at each location. Stakeholders were consulted to help gain access in *Kebon Bunga*, some of whom served as key informants themselves. In *Pasar Buah* the situation was different, as CM users could be reached directly and with much less effort. The main strategy to establish a conversation and start socializing with CM users was by first offering them a cigarette or drink. Usually, conversations started by talking about general things such as hobbies and daily routines, with no difference between the two locations. At *Kebon Bunga* topics also included night life sex worker, and life at boarding houses, due to the neighbourhood's condition. Giving advice, playing with a gadget, or grouping were avoided during outreach activities at both sites. Below is a table summarizing the strategies used to gain access at each intervention site:

Figure 1: Summary of strategies at each intervention site

	Kebon Bunga	**Pasar Buah**
Topics of interest	• Drugs • Sex workers • Night entertainment	• Activities – social issues • Hobbies (esp. soccer) • Daily routines

	• Boarding houses • work	• food • Introduction and explanation of the program
Outreach strategy	• Introducing institution to stakeholders (local government, youth organizations) • Interacting and socializing with neighborhood community	• Offering cigarettes or drinks • Introducing and explaning the program • Interacting with neighbourhood community • Listening • Socializing with CM users
Restrictions	• Limited time available • Grouping • Playing gadget • Being too intrusive	• Being too intrusive • Investigating CM users • Playing gadget • Being too affable/amiable • Giving "unnecessary" advice

The *Elok* neighborhood in *Kebon Bunga* was found to be a center of meth distribution, with meth users from across *Kebon Bunga* going there to purchase good quality meth. The transactions have usually been carried out at food stalls along the narrow alleyways in *Elok*. This characteristic of the drug trade caused people in the neighbourhood to be cautious and closed towards outsiders, which was a challenge for outreach workers. CM users could also be found at several boarding houses, where sex workers working at nearby night clubs were staying, and at a number of beauty salons in *Elok.*

Also located in Kebon Bunga, the *Indah* neighborhood had similar characteristics as *Elok*. According to key informants, in *Indah* there were many hostels that rent rooms specifically to use meth. Nevertheless, during the two-week period of the assessment no CM users were found in this area. Unlike in *Elok* and *Indah,* no boarding houses with CM users were identified in *Besar* neighborhood, which is a densely populated area where CM users reportedly also reside and use meth.

While located in a different area of Jakarta, the characteristics of *Pasar Buah* neighborhood were relatively similar to *Kebon Bunga,* with congested housing areas and narrow alleyways. Less ~~of~~ boarding houses were identified in *Pasar Buah* as compared to *Kebon Bunga*. Most of the houses in *Pasar Buah* were also used as grocery or food stalls. These food stalls were sometimes used by CM users to socialize or as a place to do meth transactions. Apart from food stalls, motorcycle wash places and houses of drug dealers were also utilized by CM users to socialize, with people coming and going around the clock. Most hotpots were located in the vicinity of the two markets, *Pasar Bunga* and *Pasar Buah*, Some salons and massage parlours were even located within the market, on the second floor of *Pasar Bunga,* but they were mainly used for sexual transactions between sex workers and CM users.

Based on the assessment some key findings related to each intervention site could be formulated. While located in different regions of Jakarta, both neighborhoods were found to be densely populated and crisscrossed by narrow alleyways fit only for motorcycles. The main difference between the two areas was that *Kebon Bunga* district is considered a popular nightlife spot while *Pasar Buah* is not. Entertainment and nightlife venues, such as pubs, karaoke bars, and massage parlors, can easily be found across *Kebon Bunga*, making this neighborhood more crowded at night. Moreover, boarding houses and hostels, which were specifically used for the consumption of meth, were only found in *Kebon Bunga*. In terms of the security situation, raids were much more frequent in Pasar Buah, yet this did not seem to affect the situation of CM users.

Four types of hotspots were identified during the assessment: 1) alleyways; 2) food stalls; 3) outdoor/open spaces; and 4) boarding houses, with the latter only found in *Kebon Bunga*. In terms of numbers, most users were found alleyways and other outdoor spaces. Initiating contact has been more challenging in alleyways and boarding houses, as opposed to food stalls and other outdoor spaces. Limited space in alleyways proofed to be a challenge for the outreach workers, as it was difficult to socialize with CM users in the narrow lanes.

Information on the sexual behavior and practices of the target group was scarce and could not be explored during the assessment due to the limited time available However, several hotspots, where sexual transactions between CM users and sex workers take place, were identified during data collection.

2.2. Crystal-Meth Users

The characteristics of CM users partly are shaped by the type of environment they live and socialize in. In *Kebon Bunga* for instance, where a lot of nightlife was present, female CM users were commonly found. However, female users-were more exclusive, thus extra effort was needed to reach them. In *Kebon Bunga* some active CM users were found and the research team managed to engage in informal talks to confirm their CM habit. While female CM users mostly worked in night clubs, male CM users usually worked within the informal sector, often in or unsteady jobs, and some engaged in criminal activities to earn money. A large share of the money was used to buy meth. Users encountered in the field were between 20 and 40 years old.

Due to the more conducive and open environment in the *Pasar Buah* neighborhood, more detailed information on CM users' characteristics could be identified there. Unlike in *Kebon Bunga*, most users in *Pasar Buah* gathered in alleys or in other outdoor spaces in groups of three to five people. Yet, in some areas, the number of people hanging-out together could reach up to 20 people. Also, there were more male users as compared to female users in *Pasar Buah*. Their ages varied from as young as 14 years to above 60 years of age. Older

users enjoyed respected status within the drug user community, but they usually formed separate groups apart from younger users.

At each hang-out area there seemed to be a respected figure who was followed by the others. CM users shared many of their drug-related interests and concerns within a group of users. This included the pooling of money to buy drugs, using together in a group, and the sharing of information on drug channels. Meth users also communicated via Blackberry Messenger groups. In the evenings, the number of people who gathered at hangout places usually increased as compared to noon. Most young male CM users in *Pasar Buah* worked during the day, for instance at motorcycle wash places or as informal parking staff.

Overall, the characteristics of meth users at *Pasar Buah* and *Kebon Bunga* were relatively similar. Most of the users encountered were known to and introduced by ex users, some of whom have been rehabilitated at the Karisma rehabilitation center. However, in terms of accessibility and openness towards outsiders, the situation in *Pasar Buah* was more conducive. Compared to *Pasar Buah*, the number of CM users found in *Kebon Bunga* was smaller, and thus less data on their characteristics could be gathered during the assessment phase.

2.3. Patterns of Crystal-Meth Use

As mentioned before, limited information on the characteristics of meth users could be gathered from *Kebon Bunga*. According to informal conversations with some CM users, meth is usually used after working hours. Meth users tend to gathered in small groups, consisting of up to four people, to use meth in a hostel room or public toilet. It is also common in *Kebon Bunga* to rent a room in hostel specific to use meth after they work. However, some male CM users preferred to use meth individually at their home. Compared to male CM users, female users preferred to use meth at the privacy of their boarding house rooms, usually in small groups consisting of two couples. In contrast, CM users in *Pasar Buah* preferred to use meth in smaller to larger groups at outdoor locations, such as small alleys, public toilets, and other hang-out areas.

In *Kebon Bunga,* most meth was obtained from drug dealers at a number of hotspots in *Elok.* Users either met the drug dealers directly at one of the hotspots, or they placed the money at an agreed spot. The latter way, meth users did not have to directly meet with the courier or drug dealer. The frequency of meth use varied between individuals, with most using nearly everyday or at least several times a week, depending on the availability of money. Poly drug use seemed to be rather uncommon among CM users in *Kebon Bunga*. However, those who did take other drugs mostly used ecstasy, which is being widely used in the context of nightlife in Indonesia, and a few admitted to also use heroin. The situation in *Pasar Buah* was different, here users preferred to mix–CM with anti-depressants or painkillers. In both neighborhoods meth was usually smoked using foil. In *Pasar Buah* some

also used pipes to smoke. And in *Kebon Bunga* a small number of users injected meth mixed with heroin.

During the assessment it was found that patterns of CM use slightly differed between the two neighborhoods. For instance, the type of location used for drug consumption varied, with users in *Pasar Buah* more likely to use outdoors, while in *Kebon Bunga* drug use usually took place inside boarding house rooms or at home. Also, the type of drugs used in addition to or mixed with CM varied between the two neighborhoods, as explained earlier. Both locations, however, were more crowded at night, since users usually gathered after working hours. Different practices of CM use, depending on the social and physical environment of each neighborhood, may lead to different approaches when implementing the intervention. Issues specific to female CM users, as encountered in Kebon Bunga, will also need to be taken into account for future interventions.

2.4. Risks associated with Crystal-Meth Use

There had not been much discussion of CM users' health concerns during the assessment phase, due to limited time available and a certain reluctance of some informants to talk to strangers. However, limited information related to health issues were obtained during informal conversations with CM users. In *Kebon Bunga*, CM users stated that the effects of meth helped them to work. They felt vigorous and full or energy after useing meth, thus making users think that meth has not negatively affected their health.

Mostly older participants from *Pasar Buah* confirmed that their sexual behavior was influenced by meth use. They tended to engage in unsafe sexual behavior after using meth. Massage parlours or salons around *Pasar Buah* were the places they usually had sex, either with a partner/girlfriend or sex worker. They said that they did not use condoms and seemed not to have much knowledge of the associated risks. However, information related to the informants' sexual behaviors was not thoroughly explored due to limited time available for more in-depth investigation. Likewise, CM users' health seeking behaviors and knowledge related to health services had not been explored at this stage. The only thing assumed at this stage by the research team was that CM users have limited information available and do rarely access health services.

Another risk related to CM use is that of being arrested by the police, as the possession of CM is illegal in Indonesia. Most informants did not have enough information regarding their rights and the law. Some have experienced abuse ~~in~~ by the police after being arrested and they did not know what to do and where to seek help.

In summary, the assessment resulted in a number of important findings, which will have to be considered in the design phase of the intervention. Firstly, selecting the proper outreach workers is crucial to successfully completing this study and any future interventions. Not

less important, outreach strategies need to be tailored to the social and physical context and situation of the locationwhere the intervention takes place. The designing of appropriate IEC material and the subsequent provision of these in the field are also important, as adequate IEC material constitute a helpful tool to gain access to informants and raise awareness about the risks of meth use among CM users and the community at large. During the assessment, it turned out that working with respected figures at each hotspot, usually older users, access to the respective communities, both users and the neighborhood community, could be eased. Last but not least, it was found that specific strategies were needed to engage younger and also female users into the intervention program. An overview of the assessment findings can be seen in table 4.

Figure 2: Findings of Situational Assessment

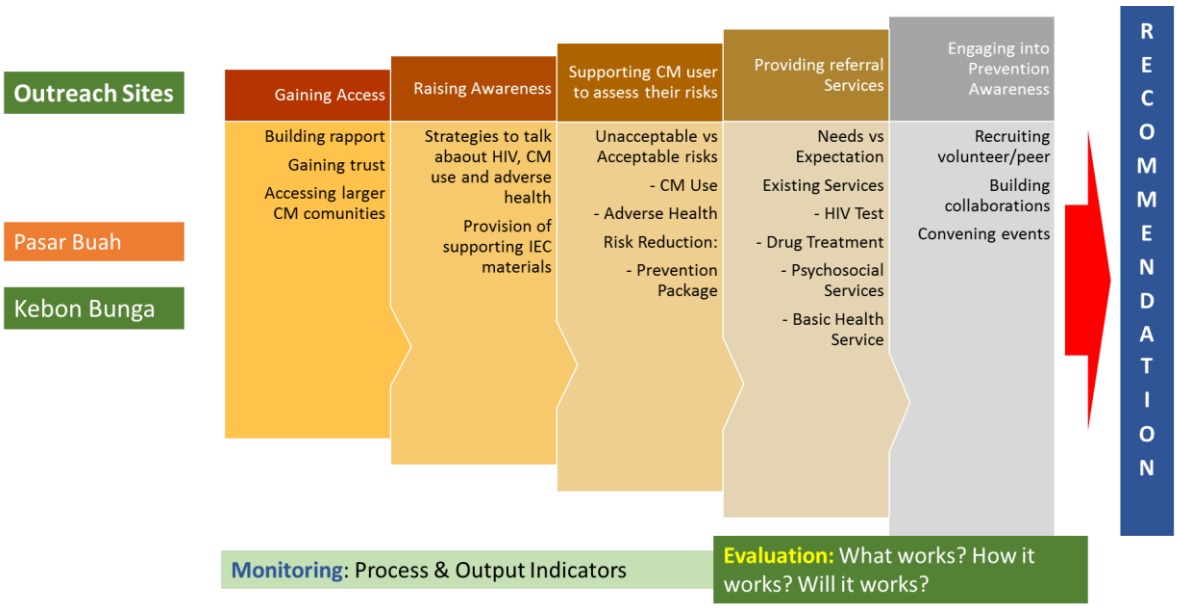
Hotspots	Characteristics of CM users	Drug use pattern	Sexual Behavior	Gathered Time	Outreach Strategy	Challenges
Alleys	• Mobile • In groups (3-5 people) • Separate groups of young and old users • Groups closed to outsider • Live in nearby & know each other • Work in informal sector • Crowded when drug dealer arrives • 25% females	• Drug dealer in each alley • Buying and using meth at home or in alley • Pool money to buy meth • Work as courier • 'Free' meth from drug dealer • Use pipe • Mix meth with barbiturate	• Young CM users: not sexually active (except at Taqwa hotspot) • Sexual partners: sex workers at beauty parlor/girlfriends • Unsafe sexual behavior	• Socialize/hang out in the afternoon • Use meth at night • Drug dealer appeared late at night	• Open acces through key informants • Familiarity with area • Outreach by walking • First introduction	• Limited space
Food Stalls	• Older users gathered in the daytime • Tidy appearance • Transit/transaction place for drug dealers & outsiders • Gather based on gender • Mix of young and older users in groups of 10 people • Use meth for work	• Use meth at food stall • Mix meth with cannabis and benzo • Pool money to buy meth	• Not yet explored • Limited access to talk about and explore sexual behavior	• Older users gathered in the daytime • Transactions take place at night • Activities based on food stall operational hours	• Buying something from the food stall	n/a
Other outdoor hang out spaces	• Workplace for CM users • Respected figures identified • Most users are male • Age range ± 20-45 year old • Education: high school/dropout • In groups of up to 20 people • Open to outsiders	• Pool money (up to 3 people) • Use meth with 'work friends'	• Unsafe sex with spouse, girlfriend, sex workers • Interested in condoms	• Gather around the clock depending on group of people	• Attendance based on work • Initiate conversation with respected figure	n/a
Boarding houses	• Closed to outsiders • Mostly female users from lesbian community or sex workers • High class/level and selective • 'Butchi' at boarding rooms, while 'femme'working at night clubs	• Drug dealer living at boarding house • Use meth at boarding house rooms • Groups of 2-4 people or couples	• Higher awareness about condom use • Changing partners with ~~an~~other couples	• Morning to noon • Nights (only 'butchi')	• Contact boarding house PIC	• Closed access • Males prohibited from accessing female or lesbian boarding houses

SECTION 3: INTERVENTION DESIGN

The intervention design for this study has been developed in close collaboration with the implementing team. Information gathered during the assessment, and resulting key insights, have been used during the design process to improve the quality of the future intervention plan. Findings from the assessment were in FGDs. Opportunities and challenges encountered in the field were thus identified, allowing the research/intervention team to come up with the best strategies to respond to the problems. Following a two-day consultation meeting, the final results were then translated into outreach guidelines, to be applied through the intervention for CM users ~~in~~ at the two intervention sites.

The document containing the Outreach Guidelines illustrates the various intervention strategies. The overall goal of the strategies has been to gain access to CM users at the two intervention sites and to achieve improved knowledge on HIV and other risks associated with CM use among the target population. Moreover, some of the strategies were aimed at increasing participation of CM users in the HIV prevention and crystal-meth harm reduction programs. Five key strategies and operational standards on how to manage the program were formulated as recommendations for the implementing team. In addition, a monitoring and evaluation plan had been developed. The intervention had been designed to be jointly implemented between outreach workers, field coordinators, and the management team.

Figure 3: Graphic of Crystal-Meth Intervention Design, Jakarta



A. Outreach Strategies

Strategy 1: Gaining Access to CM community

The first strategy has been aimed at finding the best way to gain access to the target population at the two intervention sites. The proposed steps of this strategy have been:

i. Identifying hotspots at each intervention site where a large number of CM users congregate;
ii. Regular presence of outreach workers at hotspots to familiarize themselves with and gain trust among the local community, both CM users and the wider community. This entails disclosing the purpose and objectives of the intervention to anyone involved in it, identifying potential sources of support at the intervention sites, and liaising with local stakeholders;
iii. Gaining a better understanding of interactions within the crystal-meth community to develop a "tailor-made" field strategy that fits the target groups' characteristics.
iv. Developing communication channels with the target group. In order to build a relationship of trust, time and good communication skills are needed. Starting with small talk about general topics, communication then progresses to more sensitive issues, such as HIV and AIDS, sexual behavior, and drug addiction. In this process informants must be treated with respect, considered equal, and encouraged to actively participate;
v. Building credibility and trust with the target group;
vi. Maintaining ongoing relationship with target group through regular visits at the hotspots and consistent communication.

The duration needed to gain access to the target group varies with context and the approaching skills of outreach workers. Persistency and cultural empathy are key to this process, as well as acknowledging that both positive and negative responses as a valuable part of the process.

Strategy 2: Raising Awareness ~~of~~ about HIV and Drug problems

The second strategy has been aimed at raising awareness about HIV and drug related issues among the target group and is to be implemented after the outreach workers have gained full access to the crystal-meth community and the related hotspots. This strategy entails the following steps:

i. Starting out with the provision of neutral information, moving from general health issues to HIV as part of general health. The discussion can then be further developed and enter a more personal level, including the discussion of individual risk and protective measures;
ii. Equipping outreach workers with IEC material i.e. pamphlets, brochures, stickers and prevention material such as condoms and lubricant, which can be accessed by target group for free;
iii. Developing key prevention messages aimed at reducing HIV transmission and crystal-meth use, to be provided by outreach workers during outreach.

iv. Using simple language in anticipation of the varying educational backgrounds of the target population;
v. Adjusting time of outreach to CM users' schedules in order to achieve maximum coverage;
vi. Finding best timing to share information related to HIV and drug addiction. Gradual progression from discussing more general issues to more sensitive issues;
vii. Providing consistent information during discussions using slogans such as "HIV is real", "the virus can be found in bodily fluids such as semen and blood", "HIV can be transmitted through unprotected sex and needle sharing between people of different HIV status", and "HIV transmission risk can be reduced by adopting harm reduction measures". Based on this information, the targeted group then may choose the most appropriate strategy to reduce their individual HIV risk;
viii. Expanding the network to other CM users by encouraging clients to share prevention information and introducing outreach workers to their peer groups. Due to the highly sensitive nature of the topic and widespread suspicion among CM users towards outsiders, it is important to avoid asking an excessive amount of questions related to users' drug networks;
ix. Provision of prevention material, such as condoms and lubricant, at hotspots;
x. Anticipating any challenges that might occur during outreach. For instance, stop conversation when CM users show any of the following symptoms: e.g. high levels of intoxication or withdrawal symptoms, paranoia, agitation, distraction, or suddenly change the topic. Conversation can be continued later;
xi. Ensuring that outreach workers are well informed and updated on relevant information related to the lives of CM users, drug laws and regulations, police arrestment processes, drug treatment, side effects of drug use, HIV and STI services, overdose management, gender issues, crystal-meth 101, and legal support.

Capacity improvement activities for outreach workers have been done on a continuous basis through weekly meetings.

Strategy 3: Supporting CM users to assess their risks

The third strategy has been aimed at improving clients' understanding of HIV-related risks in connection with their behavior. This strategy can only be implemented after the target group has been exposed to the necessary information related to HIV, sexual behavior and drug use, allowing them to subsequently assess their individual risks. A discussion on risk assessment can be initiated both by the beneficiaries or the outreach workers. It is important for everyone to understand that behavior change is a process. Therefore, risk assessments are expected to be performed repeatedly. Several key points of this strategy are highlighted as follows:

i. Making sure beneficiaries understand the principles of risk assessment so that they are capable to assess their own behavior. Continuous support from

outreach workers is needed once the beneficiaries have developped their individual risk assessment plan.

ii. Anticipating potential challenges related to the implementation of the risk assessment strategy. Challenges may include: difficulty to find suitable place to initiate discussion, deviation from agreed schedule, crystal-meth intoxication or withdrawal, reluctance to disclose and discuss personal matters and inadequate risk assessment plan.

iii. The Outreach Guidelines contain a nine-step manual to implement the individual risk assessment for CM users. *Firstly*, find a private and comfortable place to talk, chosen by the client. *Secondly*, provide information on HIV transmission through bodily fluids (blood and sexual fluids) and make sure the client understands each infection route. *Third*ly, respond to any related questions that may arise from initial discussion and clarify any myths and misconceptions. *Fourthly*, focus the discussion on acceptable and unacceptable risks related to HIV from the clients' point of view and provide opportunity for client to reflect on their own behavior. *Fifthly*, offer multiple risk reduction strategies, which are realistic to be adopted by client. *Sixthly*, discuss each risk reduction strategy in detail (if client is interested), making use of necessary IEC material to support the discussion. *Seventhly*, discuss local HIV situation and use statistical data to support outreach workers' argument. *Eighthly*, encourage client to become an HIV prevention advocate for their peers and families and offer any support needed. *Ninthly*, offer continuous support to target group and explain that behavior change is an ongoing process with successes and failures.

Strategy 4: Identifying and promoting referral services to support behavior change

The fourth strategy has been aimed at identifying health and drug-related services needed to support behavior change among CM users. After completing the risk assessment, the next step has consisted of identifying and promoting services for HIV and drug related problems, which may be needed by clients. Following an overview of the related steps:

i. Initiate discussion on the kind of problems generally faced by CM users. Limit discussion on problems related to health, drugs, the law and social issues. Allow clients to develop a priority list from the least to the most important problems and define ideal condition;

ii. Propose several plausible scenarios on how to solve problems. Offer direct support to solve the problem by providing prevention material, giving advice and encouragement, and linkage to referral services;

iii. Compile list of referral services appropriate for CM users, i.e. general health, HIV prevention, care and treatment, addiction and detoxification, support groups (HIV & addiction problems), rehabilitation centers, and creative entrepreneurship facilities;

iv. Collect data on referral visits on a regular basis to understand patterns of accessing services, and identify the most popular referral services. Discuss any difficulties that may have occurred when accessing the services;
v. Provide practical and emotional support where necessary to encourage positive attitudes.

Strategy 5: Engaging CM users in prevention

The fifth strategy has been aimed at expanding the impact of the program by empowering CM users to become agents of change for their peers and surrounding communities. One way to do this is by involving CM users in the distribution of IEC and other prevention material among their peers and the neighborhood community. Key steps of this strategy are:

i. Recruit volunteers to help with distribution of information. Ideally, such volunteers are from the local CM user community, as they know first-hand what it means to use drugs and they know well the social contexts surrounding the drug. However, it is important to make sure that volunteers have good communication skills, care about HIV and drug related issues, and are respected persons in the area.
ii. Develop partnership with selected local stakeholders to ensure continuity of intervention. Chose stakeholders which are interested and competent to contribute towards the effort.

B. Management of Outreach

The Outreach Guidelines also specify how to manage the implementation of the intervention This section has been prepared to facilitate an evidence-based learning process from the implementation in the field. It has been advised that the implementing partner allocates one dedicated data manager to compile and analyze the daily field reports collected from the outreach workers and presents the results during weekly coordination meetings. This allows the team to adjust strategies where necessary. The following suggestions were made for managing the outreach works:

i. Collect routine field reports to assess the intervention based on evidence from the field. Outreach activities need to be documented daily and compiled by the field coordinator for weekly progress evaluation. A template for the daily field report has been prepared specifically for this operational research (*see Annex 1*).
ii. Routine coordination meetings to be attended by outreach workers, the field coordinator and program manager responsible for the intervention. Some of the key issues to be reviewed and discussed are: the number of client reached, observations of the intervention sites, key findings for further follow up, challenges, plans for the next outreach activities, and strategy adjustment.
iii. Develop follow-up action plan based on the findings, which emerged during the weekly progress evaluation meetings. It is important that each team member understands the plan well and can follow the agreed timeline.

iv. Allow for evaluation of the newly implemented strategies as a valuable activity to understand the process and monitor the quality of the intervention. Any change of strategy needs to be well documented for further analysis;
v. The performance of outreach workers needs to be assessed based on the primary indicators of the implementation, i.e. their progress on reaching new clients, the number of target site visits, their regular attendance in the field, networking initiatives, and number of referrals to support ~~to~~ services.

The implementation design had been evaluated after a four-month trial. Each suggested strategy has been paired with process and output indicators (*see Annex 2* for a complete list of indicators) for monitoring and evaluation purposes. Quantitative indicators were collected by the implementing team based on field report data and submitted to the research team every two weeks for compilation and analysis. In addition, qualitative data related to the process and experiences during the implementation were collected at the end of the trial phase.

SECTION 4: IMPLEMENTATION AND MONITORING

The finalized Outreach Guidelines were tested and implemented at two intervention sites from August – November 2016. The sites chosen for the implementation of the intervention were the same as during the assessment phase, as both locations, *Kebon Bunga* and *Pasar Buah*, were found to have hotspots where CM users congregate and use drugs. The field work had been conducted by four outreach workers and a field coordinator, supervised by a program manager from *Yayasan Karisma*. Monitoring had been conducted simultaneously by the research team, who collected, recorded and analyzed quantitative and qualitative data gathered during the implementation stage. Over the four-month period, a total of 166 field reports had been submitted by the outreach workers. In addition, two coordination meetings involving the research team and implementing partner were held to discuss the implementation process and discuss any adjustments necessary to the implementation design.

Table 1: Number of monitoring data analyzed by month.

Month (2016)	Number of reports (N=166)	Proportion
August	23	13.9
September	38	22.9
October	50	30.1
November	55	33.1

Source: monitoring reports

The description of the implementation of the intervention had been organized along key issues identified in the field and ~~as~~ captured in the collected monitoring reports.

4.1. Strategies to gain trust from CM Community

The intervention has been carried out utilizing various strategies. During the beginning phase, which lasted roughly one month, outreach workers visited the intervention sites to screen and engage with prospective clients. This is generally known as active street outreach. As the characteristic of each location played an important role in determining what kind of strategy had to be used outreach workers spent the first few visits (1-3 visits) canvasing the sites. This activity enabled the outreach workers to better understand the response from the local communities, when would be the most appropriate times to do outreach, common perspectives on drug use and users, as well as identified the hotspots. Subsequently, outreach workers started building relationships with people living and or working around the hotspots. This included asking permission from local community leaders, visiting local shops and conducting small talk with residents. The main purpose of these activities had been to accustom local communities to the presence of the outreach workers in their neighborhoods. This phase of relationship forming resulted in important information regarding the local

crystal-meth situation, including who the persons using CM are, where they usually hang-out, and information on their other characteristics.

> *"We entered [the area] through a person we previously met that had been exposed to information earlier. Also, we can use local stakeholders to find information, whether any locals are known to use crystal-meth. It depends on how skillfully we use the information"* (In-depth interview with outreach worker 01).

> *"First, we tried to gain access to the location by ourselves, but when we do not make any progress after three visits, we will use a different method. Generally, we visit the site individually when we already have solid information. If we fail, we try it by approaching the local community leaders and the community, and if that fails too, we use key informants who are familiar with the location and are known to the prospective client"* (In-depth interview with outreach worker 01).

However, when the networking strategy described above failed, the next strategy would involve the use of key informants, who could help gain access to the hotspots in the area. The involvement of key informants in the intervention proofed to be critical to gain new access in the area. Moreover, their participation had a positive impact on levels of acceptability among new clients. Key informants could originate from various backgrounds, such as respected local leaders, fellow CM users, clients reached by previous interventions, or former injecting drug users and methadone clients. However, to be knowledgeable about the target area and being part of a local network were the main requirements to become a key informant. Generally, persons with a respected position in the area had an advantage and thus there was a higher probability for them to reach new hotspots and introduce new crystal-meth clients. Since key informants have not received any incentives for their contributions, it had been important to build and maintain a good relationship with them throughout the project implementation.

> *"[if we want] to know a new hotspot, we bring the key informants … s/he will explain who we are and what we do, then after that, we will explain fully about our objectives"* (In-depth interview with outreach worker 01).

In addition to key informants, collaborating with other HIV-related civil society organizations (CSOs) can also be utilized as strategy to gain access to a new area. Jakarta being a key target area for the HIV response in Indonesia, the province has numerous CSOs working on HIV related issues targeting various key populations in areas similar to the intervention sites. Many of these CSOs have established longstanding relationships with the communities in their respective areas, which will be critical should this intervention be scaled up later on. Such collaborations can take the form of knowledge and information sharing or joint outreach activities. Once the presence of outreach workers had been accepted by the local community and a complete picture of the targeted sites had been gathered, efforts could be focused on

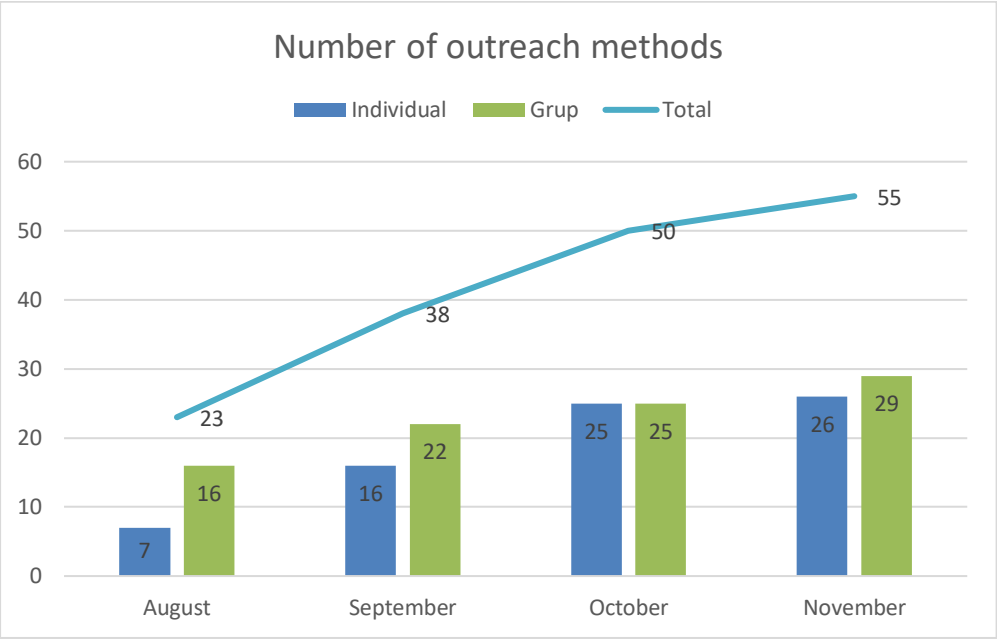
intensifying the relationships with crystal-meth users.

> *"Based on our experience, we collaborated with other NGOs such as YKB, YIM, KIOS and YMM … sometimes we visit the hotspots together and they [the NGO] introduced us to people in the area to smoothen our way"* (In-depth interview with outreach worker 03)

> *"… through other NGOs, although they had programs for injecting drug users, they will tell us about CM users [in the area], yet they cannot bring us to the places, so we need to find it by ourselves"* (In-depth interview with outreach worker 04)

The next step consisted of, conducting "fixed-site outreach", which happens at a specific hotspot and allows for longer discussions with the users. Most of the outreach work had been conducted in the afternoons between 2 p.m. and 6 p.m., a fourth of the visits had been conducted between 6 p.m. and 1 a.m., and one in five field visits had been done around noon time between 10 a.m. and 2 p.m. On average, an outreach worker spent 2.3 hours during each visit at one location. More than half of all outreach activities had been done in groups (97 times), with the rest having been individual outreach (45% or 74 times). Also, the intensity of the outreach activities increased over time. Whether outreach was conducted in groups or individually largely depended on the location and its particular context, such as openness towards outsiders, and the availability of key informants. One of the challenges had been the high mobility of CM users, who frequently changed location and hanged out different hotspots. Thus, it was common that outreach workers failed to meet the intended clients at the previously identified hotspot. Therefore, it was important that outreach workers knew as many hotspots as possible, to increase their changes of meeting the informants.

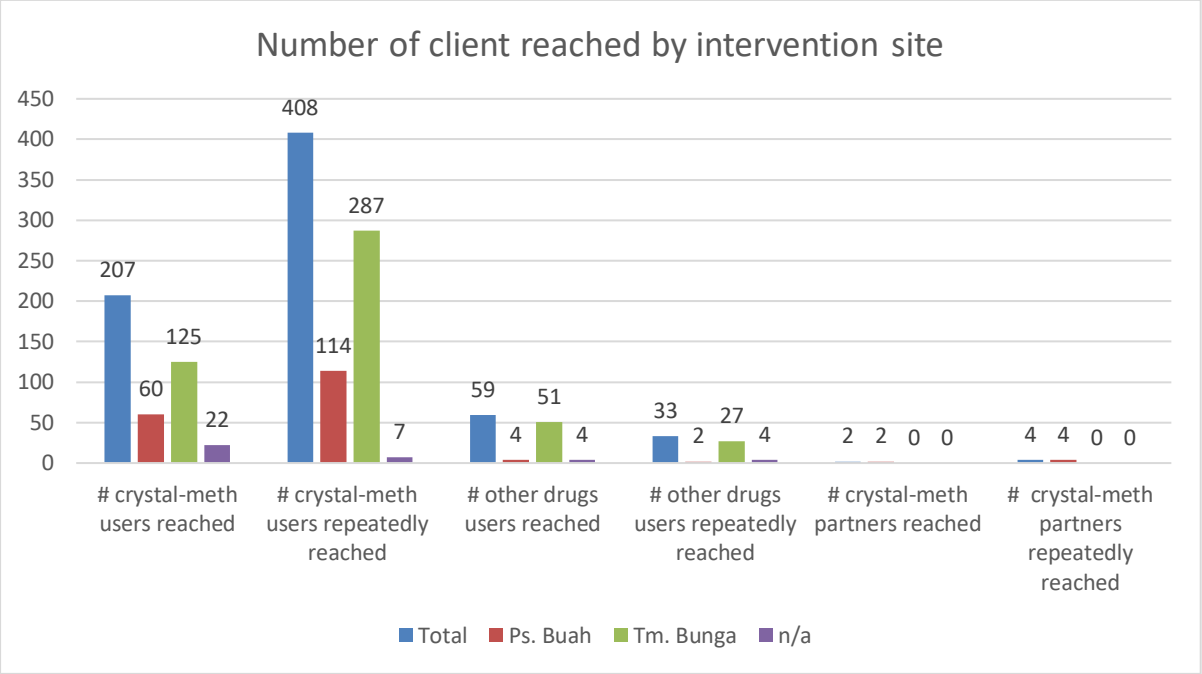
Figure 4: Number of outreach visits conducted each month by method



> *"They may be there or not, even after we made an appointment to visit a house where many CM users hang-out. If he's not there, then we made another appointment. We also need to provide some kind of 'service' like food and cigarettes for them …"* (In-depth interview with outreach worker 03).

The outreach strategies applied during the intervention led to good results. After the four-month implementation period, the number of hotspots identified at both intervention sites increased significantly. In *Pasar Buah*, outreach workers found 8 new crystal-meth hotspots in addition to the 4 hotspots, which had been previously identified during the assessment stage. In the *Kebon Bunga* neighborhood the intervention had been expanded to include 6 more "villages" (previously 2, now 8). The total number of crystal-meth clients reached over the course of the period was 207, as can be seen in *figure 4*. A majority of clients reached were from *Kebon Bunga,* slightly less than a third (30%) originated from *Pasar Buah,* and about 10% were clients from outside the intervention areas. On average, each client had been reached twice during the implementation period, which added up to 408 contacts in total. Clients in *Pasar Buah* were slightly more likely to have been met twice by an outreach worker compared to clients from other locations. Although only in small numbers, the intervention also reached other populations besides CM users. In total, 59 people who use other drugs and 2 partners of crystal-meth users had been reached during the outreach activities.

Figure 5: Number of clients reached by intervention site



Despite these achievements, some challenges were encountered in the field during outreach activities. Reaching out to female CM users proofed difficult due to outreach workers being predominantly male. Although some night clubs and spas had been identified as hotspots where female CM users were present, gaining access to these places had been difficult due to the establishments' restrictions on access. Another challenge had been the limited number of outreach workers in relation to the large number of hotspots. A total of 20 hotspots had to be reached by only four outreach workers. Consequently, not every hotspot had been given the same attention. These challenges thus needed to be addressed prior to continuing the intervention.

4.2. Talking about general matters as a way to increase HIV and drug awareness among CM users

The process of creating a communication platform with the target group could be initiated once access to the intervention sites had been established. Building a good rapport with CM users required multiple approaches and strategies. Outreach workers needed to merge with the community and regularly 'hang-out' together at the hotspots. Prior to any group conversation, careful observation was needed to better understand acceptable and typical discussion topics. General topics, such as football matches, local neighborhood activities, and erotic stories could be used to initiate a conversation. After a couple of meetings, CM users generally felt more comfortable and accepted the presence of outreach workers. The familiarity of clients towards outreach workers determined the extent of their openness to share personal details related to their drug use.

> *"At first we usually just share things. We share about our findings in other areas and what happend in those areas. We make it general and do not focus*

on the program or their behavior. We make sure they are comfortable and our presence is not bothering them." (In depth Interview with Outreach Worker).

This study has documented multiple methods utilized by outreach workers to convey HIV and drug related information at the intervention sites. Intense personal discussions were usually done when there was a need to delve into more personal matters, such as crystal-meth use and sexual behaviour patterns. Sensitive topics were only addressed during one-on-one discussions at a private spot away from the other group members. Sharing sessions were commonly held when more than three CM users gathered at a hotspot. Outreach workers needed to be in charge of guiding the conversation towards the intended topic, by throwing in trigger questions and asking for the informants' opinions. This way, discussions became interactive. The sharing sessions also allowed outreach workers to clarify rumors from suspicious or doubtful participants by using other CM users as messengers.

"For exploring personal issues, it is easier to talk individually, because it will not be focused if we discuss in a group. If we need to discuss something it is more often in a group, but to assess risk behavior and profiling will go individually." (In depth Interview with Outreach Worker)

"For example, in Besar there are some people who talk intensely with me. I persuade them to share the information that they have received to their friends. Otherwise, they will tell us if their friends have a question. It stimulated active conversations among them." (In depth Interview with Outreach Worker)

In addition, outreach workers also conducted FGDs with the target population. Different from the first two methods, for FGDs topics had been preselected prior to the session. Moreover, FGDs had been much more structured, with different people having specific responsibilities. For instance, there had been a main facilitator, co-facilitators, and local contact persons. The FGD method had allowed for larger groups of clients to participate, usually around 8 to 12 CM users attended the discussions. Apart from discussing a specific topic in a systematic way, FGDs also provided an opportunity for meeting with new prospective informants, since clients were asked to bring their peers to the meeting. Finding the right time and a suitable and convenient place for the discussion were crucial, as this largely determined how many participants showed up to the meeting. Public facilities, such as neighborhood offices, district offices, or local youth organizations' common rooms were frequently utilized as convenient meeting places. FGDs allowed for in-depth and more focused discussions about issues commonly experienced by CM users, such as side effects of drug use, drug rehabilitation, and narcotic laws. The decision which method to apply depended on the outreach workers' judgment, depending on the context and situation in the field.

"We make an agreement about the topic before the group discussion, depending on their needs. We try to help by giving a list, like HIV, STIs, harm

reduction. We also asked them what they need for next weeks' meeting. Then they said we need this, so we decide the topic." (Outreach Worker)

"[N1] At night between 8 p.m. ~~to~~ and 9.30 p.m. [N2] At hang out place, in the daytime some people prefer to sleep or work. [N3] The best time is after Isya, we are in our best situation" (Crystal Meth Users, Pasar Buah)

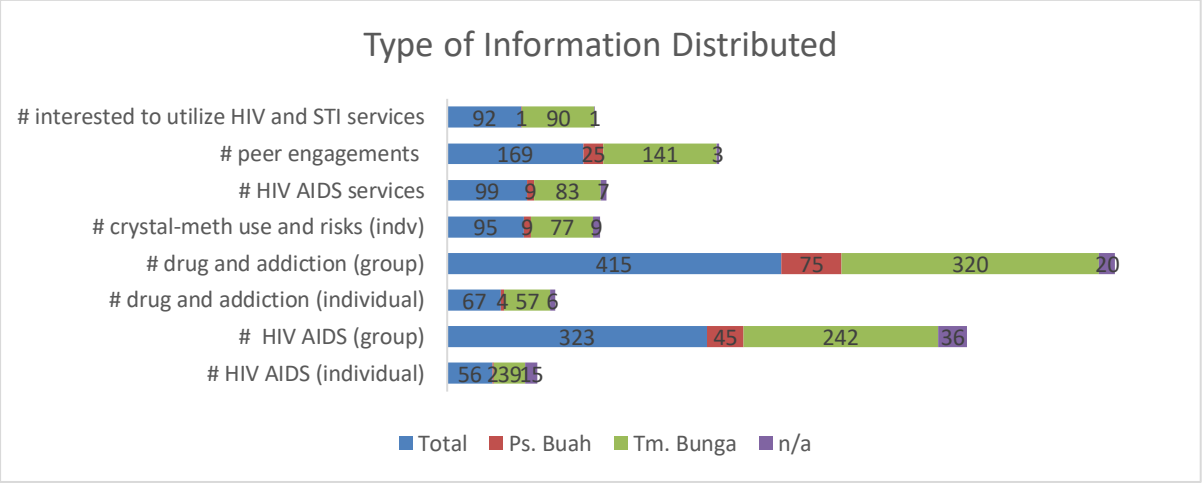
By applying different communication strategies, a variety of topics emerged during field work. CM users tended to be most interested in topics related to their drug habits, such as effects of crystal meth, health and HIV related issues, and drug-related experiences from other locations. However, some topics needed to be avoided during initial meetings, such as individual crystal-meth using patterns, drug dealing, problems with the law, and sexual risk behaviors. Too many questions about these sensitive topics at an early stage of the intervention would have raised suspicion, leading informants to believe that outreach workers were police informants. Outreach workers usually waited to address sensitive topics until the third or subsequent meetings.

"About side effects of crystal meth use, long term and short-term effects." (Key Informant, Kebon Bunga).

"For instance, I asked how many times he uses crystal meth a day. Then, suddenly he doesn't want to tell anymore. Or I asked him whether he had ever been arrested. There are some people who are okay with that, but there are also those who won't accept it. Suspicious. I've been stalked by them when I got home because of this." (Outreach Worker).

As could be seen in figure 5, a majority of outreach activities had been conducted in groups. More information could be distributed during outreach at in *Kebon Bunga* as compared to *Pasar Buah*. This has led to a higher number of clients reached in Kebon Bunga as compared to the other intervention sites. Information related to drug use and addiction were the topics most frequently provided to the target group (31.5%) Topics related to HIV and AIDS made up 24.5% of the total information distributed, thus constituting the second most frequent category. All the other topics concerned less than 8% of the distributed information (see graphic 7), with the exception of the category "information related to peer engagements". The main reason for the distribution of the type of information provided had been the short timeframe of the intervention, which meant that most information distributed had to be suitable for relationship development and trust building, rather than more personal and in-depth information.

Figure 6: Type of information distributed during implementation stage



**source: daily field report analysis

Apart from the target group, outreach workers also engaged with local communities and ~~to~~ involved them in selected activities conducted at both intervention sites. Through the involvement of local communities' outreach workers aimed to gain support and create awareness about the crystal-meth intervention in their neighbourhoods. While local communities had not been the target of the intervention, some activities had been specifically designed and implemented for them (using resources allocated from another project), such as seminars on drug use and HIV and AIDS, as well as free Pap smear testing for female residents. The positive responses from local communities indicated that they considered these activities to be beneficial for themselves. Stakeholders were of the opinion that the program needed to involve *Puskesmas* as local referral health services, encouraging CM users to access these. Another suggestion was to ask permission from and formally engage local neighborhood councils in each area of the intervention, as it had been found that the the intervention had not reached evenly all parts of the neighborhoods. Outreach workers had to cooperate more closely with local stakeholders to involve more people ~~on~~ their activities.

> *"There was a meeting conducted by Karisma in our neighborhood, RW 02, and back then we discussed about the relationship between drugs and HIV… afterwards there was a question about Pap Smear services … basically the community thinks positively about their program" (FGD Stakeholder Pasar Buah)*

> *"It will be better if Karisma conducted again similar activities, like they had before, together with the community, but at the Puskesmas. Also, we only receive patients for treatment, therefore the collaboration needs to be established … not only at district Puskesmas, but also with sub-district Puskesmas, the local government and local law enforcement, because this issue has implications for wider society." (FGD Stakeholder Kebon Bunga)*

Sustained communication with users or local communities had been supported by the distribution of IEC material. Outreach workers distributed HIV information material as an initial step to start a discussion on risk assessment. Data from the daily reports showed that outreach workers distributed 28 pieces of IEC material and 56 condoms in total during outreach. The limited number of IEC and other prevention material distributed was due to the fact that not enough resources had been allocated for this purpose during the implementation. The IEC material, used during the intervention consisted of material developed for the pilot intervention, and condoms were from leftover stocks from other programs. CM users confirmed that the distributed IEC material was beneficial and relevant to their issues. However, most preferred to get information directly from outreach workers as compared to learning it from information material.

> *"It (the material) makes them questioning and discussing about it, for example information about crystal meth use. Even just a copy version, we asked their opinion and it could start a conversation. 'Oh, yes this is so me' or 'I don't feel like this or that'. So, these opinions helped us (to make a better materials)." (In-depth interview with Outreach Worker)*

> *"[N1] I prefer to hear it straight from the outreach worker, so if I have a question I get an instant answer. [N2] I prefer through social media, BBM (BlackBerry Messenger) for example, so anyone can read it. It is easier because we all have cellphones. [N3] It is better straight from outreach workers." (Crystal Meth User, Pasar Buah)*

Being anxious and suspicious toward outsiders, lacking focus, and being unreliable were all character traits of CM users, which proved to be a challenge for outreach workers. Difficulties to build trust with CM users were confirmed by key informants. However, persistence and patience on behalf of the outreach workers usually paid off. Even so, outreach workers voiced the need for capacity building on how to build trust during outreach activities.

> *"[N5] Sometimes, when we look for them, there is none of them. [N3] They feel afraid and have not opened up yet." (Key Informant, Kebon Bunga)*

> *"Until now we have not been trusted by them, they know many of his friends are CM users, but I cannot get in yet. I cannot force him, so just be patient." (Outreach Worker)*

To build effective communication, outreach workers have followed the steps described in the outreach guidelines. However, a number of improvements proposed for future implementations are: more information material specifically on crystal-meth, including with more pictures as opposed to text; collaborate more closely with government at district and sub-district level, include health providers. Moreover, the management needs to make sure outreach workers comprehend the program well. During the intervention, some, outreach workers still seemed to be confused when it came to the final purpose of the program. This led to lack of confidence among outreach workers

when explaining the program to crystal CM users. Thus, the management had been urged to provide capacity building on the purpose of the program, in addition to updating outreach workers knowledge on crystal meth and legal matters.

4.3. Risk assessment among CM users

Once a relationship of trust had been established, the individual risk assessment could be initiated. Choosing a private location was considered important to provide a safe space and ensure confidentiality when discussing informants' risk behavior.

> *"During group discussions, it is hard to talk about risk behavior, it is easier for them to open up during individual discussions. It's not everyday that we talk about risk behavior, but at least once a week we explore issues related to crystal meth use risky sexual behavior, and how often they change sexual partners." (Outreach Worker)*

CM users admitted that discussions on risk behavior were valuable for them. They also recognized the urgency of discussing their risk behaviors. Outreach workers tended to initiate risk assessments by asking users what kind of activities they were doing after using crystal meth and they tested their techniques to use a condom. Enough time needed to be allocated for personal discussions, allowing informants to share their experiences in detail and ask questions.

> *"**[P1] What kind of topic you most often discuss with Karisma?** [N1] Sexuality and the effect of using crystal meth on it [N2] About what we do after we use crystal meth." (Crystal Meth User, Pasar Buah)*

> *"**[P1] Is it important to talk about risk behavior with them (outreach workers)?** [N3] Very important." (Crystal Meth User, Kebon Bunga)*

Another type of risk faced by CM users is that of being arrested. Frequent raids in their neighbourhoods increase the risk of being arrested. CM users were very much aware of this, but they stated that it did not worry them too much. The possibility of being arrested also means there is a need for legal assistance for CM users. The neighbourhood community puts a negative lable on people known to use CM, which sometimes can lead to losing work. Some users become suspicious and paranoid as a result of their drug use, leading them to be frightened and afraid to be lied at or betrayed.

> *"Actually people around us did not know that we use crystal meth, but we feel paranoid if we get caught." (Crystal Meth User, Kebon Bunga)*

The risk assessment component could not be fully implemented during the intervention. Due to time limitations, outreach workers mainly focused on building trust and establishing a good flow of communication, rather than conducting risk assessments.

Different strategies had been applied when conducting risk assessments with CM users. For instance, outreach workers utilized CM users' questions to initiate a discussion on risk behavior. This is one of the strategies highlighted in the guidelines. Moreover, responding to users' questions was also a way of keeping in touch with informants and conducting follow up meetings. However, some informants thought that outreach workers deliberately provided inadequate answers to encourage users to attend follow up sessions.

> *"If he confessed that he had some sexual partners, then I will ask him whether he used a condom or not. If he answered occasionally, then I go further. He said it's not comfortable to use a condom. Then I said you choose comfortable or infection, that is the only option." (Outreach Worker)*

> *"They (outreach workers) thought that if they answer in detail, then we will not come to the next meeting. They must make us curious. It is impossible that they talk completely." (Crystal Meth User, Kebon Bunga)*

In the field, outreach workers tried to build personal relationships first before moving on to the next stage. Outreach workers also asked the CM users to give feedback. This way, both parties benefit from the relationship.

> *"Sometimes it is not only us who assess them, but we also ask CM users to assess us. We try to create conditions that allow~~ed~~ them to assess us. We hope that the relationship between outreach workers and CM users is harmonious, not only a program based relation." (Outreach Worker)*

Outreach workers identified ignorance as an important reason for CM users disinterest in discussing risk behavior. During the assessments, it turned out that many CM users had several sexual partners and did not use condoms. Sharing foil was also listed as an unsafe behavior and most users did not know the related risks. CM users felt that they were at less risk compared to PWIDs since they are not injecting the drug.

> *"At first, they are not interested in HIV and STI related issues, they assume that they are not at risk. They are clean, they are fine. They tend to compare themselves with other communities (PWID), they think PWID have a higher risk than CM users." (Outreach Worker)*

As stated previously, outreach workers had not been able to conduct complete risk assessments with informants, due to limited time available and a stronger focus on building trust. During risk assessment outreach workers provided users with various suggestions and advice, but some stated to be unsure whether their support was enough. Confusion regarding the final purpose of the program caused outreach workers to be insecure. They frequently stated that the purpose of the harm reduction program for PWID was clearer than this program.

Although the risk assessments could not be fully conducted during the implementation phase, it can be argued that the risks assessments have opened the doors to behavior change for some CM users. Also, several risk behaviors had been identified during the risk assessments, proofing that the method was effective. But while the assessment helped some clients to realize their risk behaviors, this did not necessarily translate into behavior change. Most CM users understood the possibility of getting infected by HIV in relation to their sexual behaviors. Yet, they did not see any connection between crystal meth and sexual behavior. Thus, they continued to use crystal meth. However, CM users reported that the use of crystal meth had an impact on their health, which included becoming more vulnerable to infections and loss of appetite.

> *"**[P1] What kind of disease/infection?** [N4] Cough [N5] Easily get colds ... [N2] Back pain. **[P1] Back pain?** [N2] Yes, back pain, hard to breathe." (Crystal Meth Users, Kebon Bunga)*

> *"Yes, there is a possibility (infected by HIV), but if you have many sexual partners." (Crystal Meth Users, Kebon Bunga)*

Outreach workers have the possibility to assess the effectiveness of their outreach efforts by 'testing' the knowledge of their clients. This strategy had been useful to ensure that CM users obtained the intended knowledge from the discussions. Moreover, referrals to health services had been done by outreach workers, however, some CM users ignored the suggestions as they considered themselves healthy.

> *"We asked them whether they have read the information material, if they asked about the issue, it indicates that they have read it. If they read it, then they did not understand they will be asked by us." (Outreach Worker)*

> *"[N3] As I see it, CM users are not afraid of the effects. [N1] But if they get sick badly, maybe they will stop. There are two factors that could make us stop, to get sick badly and got arrested." (Crystal Meth User, Kebon Bunga)*

4.4. I don't have a problem, why should I go to a health service?

After CM users have successfully performed the risk assessment and subsequent risk reduction measures, outreach workers were expected to explore their clients' needs for support and health services. Thus, depending on the problems faced by CM users, outreach workers could link them to an appropriate service.

The Outreach Guidelines also broach the topic of support and health services and under which circumstances referrals are needed. Firstly, outreach workers had to explore the CM users' problems and then define an ideal situation. This had usually been done through an honest talk about common problems experienced by CM users, and then discuss with the clients the ideal situation after the problem had been solved. Based on FGDs with CM users and interviews with field workers it was found that during the

intervention outreach workers had been trying to build confidence and trying various ways to be able to explore and discuss the problems faced by the users.

According to field workers, the topics usually discussed ranged from the users' daily activities to the effects of meth use. Based on field observations during the intervention and several discussion meetings with CM users, outreach workers had been able to identify the problems experienced by CM users and the services they needed in relation to their addiction problems.

> *"From their behavior in general, it is impossible they do not do a risky thing. We do know they do something that is risky, which has an impact on their health." (Field officer)*

> *"One of them used together, the pattern of his life, mix with each other ... drugs, marijuana, alcohol." (Field officer)*

> *"Health services is needed. They assumed that they are not sick but becaus we are aware of their need of services, we say "go check yourself, it is matter with you." (Field officer)*

Frequently, the opinions of CM users and outreach workers differed when it came to the question whether they were in need of health services or not. Most CM users felt no need for accessing health services, as they did not belief to experience any health problems.

> *"There is a need if they already experience any symptoms." (Outreach worker)*

On the other hand, outreach workers had not been able to consistently follow through when it came to linking clients to health services. Individual contacts and in-depth discussions had not been done often enough, despite the fact that this constituted the best method to explore the need for services. The lack of individual contacts ~~is~~ had been recognized by the outreach workers, who tended to wait for CM users to take the initiative.

> *"I talk personally with them but still on the basis of their wishes. So even though it does not happen often, but when it happens, we can have a deep conversation about their problems." (Field officer)*

This is in line with the perception of CM users. Most users found that the discussion on the effects of meth use on their health was very important but they felt there were some obstacles. For instance, they felt that the information provided was still incomplete and the time of the meetings too short to fully discuss and comprehend the information. They also felt that meetings were too short and there were not enough opportunities to meet with the outreach workers one-on-one, which would have allowed them to share their personal issues.

> *"Just a short introduction." (Meth user)*

"We also talked to Karisma for one hour like this ... but not this far ... (compared to the discussions during FGD)" (Meth user)

Furthermore, clients felt that outreach workers did not meet them often enough, with the average number of meetings between CM users and outreach workers having been only 2-3 times, including the seminars held by Karisma.

"I think I rarely see (them)…" (Meth user)

The seminars were considered too crowded so that users felt embarrassed and shy to ask or discuss their personal problems at the seminars. Some CM users also felt that during meetings outreach workers purposely did not provide complete information in order for clients to feel the need to come back to the next meeting.

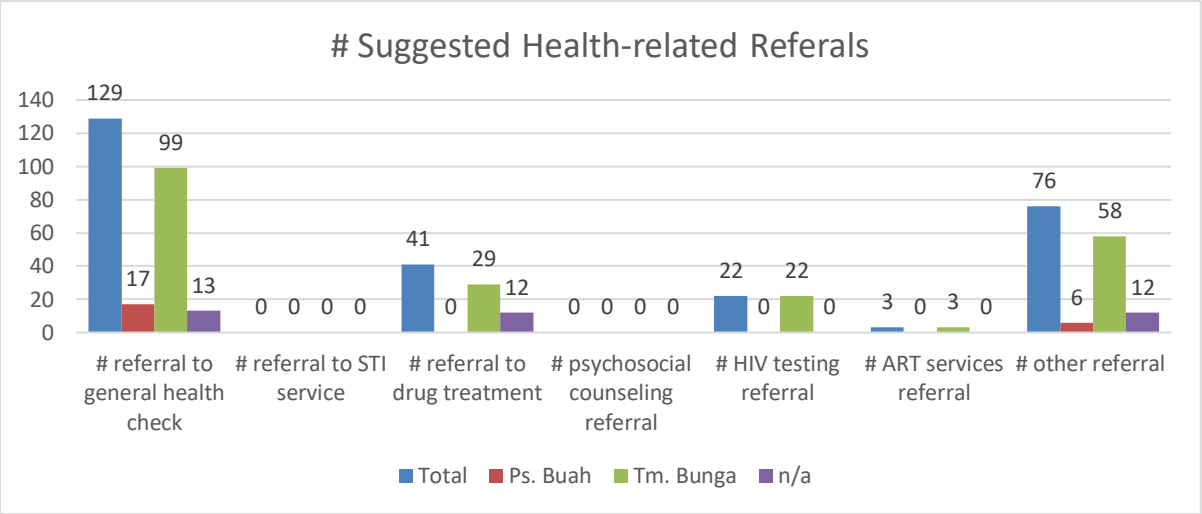
"If they talk this far (like in the FGD), they think we are not going to participate for the next meetings. They for sure make us curious. They may not say anything more ..." (Meth user)

As described above, some of the reasons why issues around the needs for services for CM users had not been properly addressed were the dominant interaction type, which had been group consultations, and time restrictions. And while outreach workers were waiting for their clients to take initiative, CM users felt there were not enough one-on-one situations with outreach workers from Karisma, which would have allowed them to discuss more personal issues, and generally there was a lack of time due to the short duration of the meetings

In the Outreach Guidelines, it has been suggested that outreach workers use a number of different scenarios related to the services needed by CM users. This may include providing information directly during outreach, handing out, prevention material, or compiling lists of referral services tailored to the needs of the clients.

As described above, most CM users do not feel any need for services, except for those who have felt direct health impacts. The chart below provides an overview of the types of referrals suggested to CM users during the intervention.

Figure 7: Suggested Health-related referrals by site



As can be seen in the graphic above, types of referrals offered to users include primary health care, TB, HIV testing and treatment, STIs, psychosocial counseling, and treatment and recovery of drug dependence (rehabilitation). This is consistent with the results obtained from interviews with outreach workers.

> *"Shortness of breath, and easily get tired are the most common complaints we heard from the community." (Outreach worker)*

> *"We always suggest referral for HIV testing, for sex workers we also conduct Pap smear and VCT, in cooperation with YKB." (Outreach worker)*

> *"We give the information about HIV and see their history, if he is PWID he should do VCT and if he ever had sex with someone other than his wife he also should undergo to take VCT." (Outreach worker)*

Although some CM users have been offered HIV testing before, none has accessed such services via Karisma. Users who have previously taken an HIV test stated that they were assisted by another NGO working in the area.

> *"I took VCT but not with Karisma but with another foundation, at health center. The organization's name is Maharani foundation." (Meth user)*

The field officers have also provided information about drug related care and recovery services (rehab) run by Karisma and some CM users have shown interested in knowing more about the rehab procedures. Users' interest in rehabilitation services showed during meetings at the hotspots. In addition, outreach workers also confirmed that they had done referrals to rehabilitation services.

> *"Usually, the list of services that we provide is a list of services that are close to them." (Outreach worker)*

In some cases, outreach workers have done informal referrals to health services, only verbally and without recording it. Some outreach workers perceived the provision of information about services and when and where these could be accessed, to be enough to be counted as referral. However, in reality this did not necessary translate into service visits.

> *"It was right from the beginning that we've explained to the two parties how to understand referrals. Referring and referral are different. So if I let them know that if they're sick they can come to the services, it's one referral information, referring can be different, it means that we drag them to access the services." (Outreach worker)*

The graphic above illustrates the numbers of times that outreach workers provided information on referral services, not actual referrals to services. One of the main problems faced in this regard had been that only a small number of clients actually accessed any type of service, even if the need to access a service had been previously identified. The reasons for this were manifold, but most frequently confusion about how to access services and reluctance to go to the clinic alone, were stated as reasons.

> *"Even if they need health care, the biggest question which is always given to us is at the time of their entry into the health services, what will they say to the health care workers? That is the fundamental question. Do they have to say that they are CM users? They will not say that. So what do they have to do? They think there should be a specific health facility for them that is a little different from the common people." (Outreach worker)*

> *"They want to be accompanied. (P: What is the reason they do not want to come alone?) Because they do not dare to say that they are users." (Outreach worker)*

Another reason users are reluctant to access services was related to the lack of transportation and costs.

> *"I've tried but he said there was no vehicle, there was no BPJS." (Outreach worker)*

> *"Raised questions about payments. So I told him not to think about the cost first rather the benefit when accessing health services. That's what I emphasized." (Outreach worker)*

Another barrier in terms of accessing health services is related to the widespread stigma and discrimination against people living with HIV and AIDS, so that many individuals and their families are still reluctant to check their HIV status or access treatment.

"There are people who got HIV and already got AIDS, but his family is very reluctant to open his status, including to bring him to the health services." (Outreach worker)

To better accommodate the needs of users to accesshealth services, field officers had also provided CM users with a list of different services available in their area. Moreover, health providers had also been approached to discuss the specific needs of CM users, but it turned out that many were still unsure and confused about how to handle such patientsThe harm reduction programs, which they had been handling so far, still focused on PWID, because there had not been any reference model for methamphetamine users for health services.

"Health care workers are also confused. The harm reduction program they handle were still focusing on heroin use. This is also related to the budget, which is mostly for IDUs." (Outreach worker)

"What reference model should be developed? That's what we have not yet done." (Outreach worker)

Apart from health services, there is also a need for legal aid services. For this purpose, Karisma has been cooperating with several other NGOs, which work with PWID and methadone patients. Thus, through this support network, more information has been available and assistance could happen more quickly.

To establish a network of referral services, field officers organized meetings with a variety of health and legal support services, such as community health centers (Puskesmas), legal aid agencies, rehabilitation services, and mobile VCT services provided by Karisma. Nevertheless, field officers have not been able to collect data or track visits to other services within the network, as referrals were made in an informal way and there were no agreements between the various partners.

"We partnered with KanwilKum HAM, which provide recommendations on which legal aid institutions in Jakarta can help for free, so finally, we partnered with legal aid institutions. So we inform CM users if they need legal assistant we will assist them until at the court, whether it should be rehabilitation or something else." (Outreach worker)

As described above, despite the efforts of outreach workers to provide CM users with information related to support services and linking them to these services, many challenges remained. Lack of time and few opportunities to conduct in-depth discussions in a private setting were mentioned as some of the problems. In the end, few clients actually accessed any support services, and it proofed hard to track referrals, because many had been done in an informal way, thus not allowing outreach workers to record them.

4.5. **The use of opinion leaders as a way to engage more CM users in prevention**

At the core of this outreach model lies the active engagement of CM users to broaden the impact of the intervention and help expand prevention activities in the future. Some CM users actively participated during the meetings held by Karisma and voiced their willingness to be involved and introduce fellow users to field officers of Karisma. Most such clients expressed an interest in participating in intervention activities after the first few encounters with field workers.

> *"If I am invited ya (I) am coming." (meth user)*

Based on interviews with outreach workers, CM users' participation in activities conducted by Karisma was quite good, although older users were more involved than younger ones. Also, participation of the target groups differed between locations.

> *"Pretty good because they've been very helpful, showing unconditional care, and they are involved as volunteers." (Outreach worker)*

> *"No, not at all spots, not all the users want to be involved, sometimes they are very reluctant to go to the meetings/events because they are scared." (Outreach worker)*

An important element of the intervention has been to encourage CM users to share their newly gained knowledge about HIV to their friends and acquaintances and ask them to take part in the intervention. This could be done by sharing IEC material, which they had previously received by outreach workers, or just by talking to their friends. Clients acknowledged that field officers have often asked them to invite their friends to participate in meetings. Most seemed to be willing to try and bring friends, but they stated that usually few were interested.

> *"If we as a friend have already been telling them, we cannot prohibit." (Meth user)*

> *"Karisma has tried too, but that resulted in the same thing." (Meth user)*

Various strategies to make clients invite fellow users had been conducted by outreach workers. For instance, they were asked to bring along female CM users, and talk about the intervention in youth organizations. However, this proofed to be difficult

> *"I was told to find a female useer but the bait is very limited." (Meth user)*
> *"Sometimes, if you want a big fish, the fishing bait should also be big." (Meth user)*

> *"At least we get into a community or youth organization in the region. Karang Taruna had already begun to open." (Outreach worker)*

Clients responded in a variety of ways to outreach workers' invitations to become actively involved in the intervention and encouraging friends to join. Firstly, it depended on who asked them, whether it was an outreach worker whom they trusted or not, and secondly, it depended on the particular context and situation in a hotspot. Some locations have been more closed towards outsiders than other locations, which meant that field staff could not freely move in and out of the area. Furthermore, the

threat of police raids has also affected the ways clients interacted with outreach workers and their flexibility to engage with the intervention program.

Based on results from FGDs with CM users, most stated that their friends were still reluctant to hang out with Karisma's outreach workers or join their activities. Most only started to feel at ease after they had met outreach workers several times.

> *"They also do not want to know." (Meth user)*

> *"We also want to tell more to them but they do not want to hear." (Meth user)*

What motivated CM users to invite and bring their friends was that they wanted them to get the same benefits they had received. These benefits included information on health effects and the law.

> *"Let him know the impact of the disease as well." (Meth user)*

> *"So let them know the consequences that may occur (Meth user)*

However, outreach workers stated that their clients were quite successful in referring friends.

> *"Almost 80 to 90 percent." (Outreach workers)*

> *" Once they already know who we are, what we do, finally it flows by itself. Buddy, this is my friend, who I want to introduce." (Outreach workers)*

During FGDs with users, some proposed that information provided by outreach workers should be delivered in a more fun and unconventional way.

> *"Refreshing and interesting information, for example, bringing a lawyer to talk about the law, or bringing the police is also allowed." (Meth user)*

Moreover, activities to provide information or occupational-skills trainings were also considered a necessary distraction from everyday life and the problems of addiction

By the end of the intervention, Karisma field workers had successfully recruited three volunteers, who were formally requested to assist in the outreach activities at the sites. This had also been highlighted in the outreach guidelines, as a strategy to establish a CM key informant.

> *"That's what I told so that they finally introduced their friends. Not only introducing them actually, but also involving them to provide information to their friends." (Outreach worker)*

The recruitment of volunteers was for the purpose of helping the distribution of IEC material and providing information to more users. Through the involvement of volunteers, it was also hoped that more CM users could be reached, especially those who were hard to reach.

"First, we asked them to define their territory, how far it it goes. Well, and then we see to what extent they have opportunities to try and reach their friends." (Outreach worker)

In terms of building partnerships, field officers have also built alliances with other community members. Working closely with community leaders and administrators has been one of the strategies for the program to be accepted by the people in the neighborhoods where the users live. This way, intervention programs are more likely to succeed and develop. Concretely, field officers of Karisma have visited the stakeholders, explained about the intervention and explored with them the possibility of getting some kind of support for the intervention, as well as asking their field activities, showing hope advice on how fieldwork should be conducted in their area.

Based on interviews with field personnel, building good relationships with community members has been the most important thing for the intervention of the program. This process had to be initiated at the beginning of the intervention and continued until the end. It needs to be noted that society is not limited to local stakeholders only, but also includes all inhabitants of the neighborhood, traders, etc.

"It was very high, it was the main thing. The quality is the first. That's because we're living in a social context, so we may not only approach the users but also the community (leaders)." (Outreach worker)

"Before we get to the users we get to the community first. The stakeholders, siomay sellers, porridge sellers. It was every day that I ate porridge there and the CM users finally talked to me because every day I ate porridge there." (Outreach worker)

Ultimately, it is important that the drug issue is understood in a comprehensive way, from the micro (individual) level to the macro (society and government) level.

"At least for the public's understanding, most importantly for the stakeholders. The extent to which meth can affect peoples' lives. Then how to overcome the problems in the family and the surrounding environment." (Outreach worker)

4.6. Program Management

In addition to the five dimensions of outreach, program management had also been evaluated. This included both the management of the organization and the management of the implementation of the intervention, including its planning and reporting. Program management consisted of four components, as outlined in the following section:

4.6.1. Management of Outreach

The management of outreach had been rather flexible. In terms of organizing tasks in the field, various strategies had been tested during the intervention. There had not been

any specific division of tasks and targets for outreach workers. Karisma had been very open to trying out various ways and strategies related to outreach.

> *"The divisions of the tasks? There was not really any. Like I said before, if A went here, B went there, like that. We just coordinated which approach ~~is~~ would be best suited, depending on the situation." (Field coordinator)*

> *"Yes, because from the beginning of the project we just had this one demography, so there is no specific target. How many people we should meet, or anything else. If found any obstacle, lets figure it out." (Program director)*

One of the strategies in the field consisted of dividing the outreach workers into teams of two, one team for each site. Each team consisted of a senior outreach worker, who was more experienced, and junior outreach worker, with little experience. This is turned out to be a good strategy, as seniors had all the experience and know-how needed and could teach the juniors, and juniors had an easier time approaching clients, as they were from a similar age range.

> *"For me, mixed is better. On one side, we want the younger outreach workers to do this, but it will take a long time to learn all by themselves. They must adapt with the overall team ~~in~~ of Karisma, understand the vision and mission and also be capable to respond to the needs in the field. It will take quite a long time." (Program manager)*

In order to monitor field officers, field coordinators sometimes went along during outreach activities in order to observe the officers during their duty. Other strategies were adapting outreach schedules to the clients' needs, individual and group outreach, mapping of stakeholders' needs, and adjusting activities based on the situation in each area.

> *"Yes ... several times I go to the field to see how they work and talk with the users." (Field coordinator)*

> *"The areas' size is also a problem. With only few workers not everything can be done. We have to regularly adjust and find the best approach." (Field coordinator)*

> *"We focus on going as a team, because it is a new area and we have to go there by night. So, it is too risky if they go alone." (Program director)*

Overall, Karisma had done a good job managing the outreach activities. The pairing of senior and junior outreach workers proved to be a good strategy and the high degree of flexibility to adapt and try out new strategies proofed useful, especially during the initial phase of gaining access to the intervention sites. Karisma has been trying to improve the efficiency and effectiveness of its outreach division up until the present.

During the intervention phase, outreach workers have largely followed the steps as outlined in the Outreach Guidelines. By applying these strategies, they have been proofing to be capable to gain access to the local community, including CM users. However, outreach workers still faced difficulties in reaching boarding houses. The

large extent of the intervention sites posed another challenge to the outreach workers, as they numbered only few to reach many different hotspots spread out over a large area

> *"The obstacle is about time, they have many things to do at night, to meet people and do other things. We still struggle to make a schedule for each hotspot." (Field Coordinator)*

Maintaining relationships with key informants ~~is~~ has been another challenge. With the current strategy, outreach workers ~~to~~ had not provided assistance to key informant, who faced legal problems, despite the fact that legal problems were widespread among them. Furthermore, the specific characteristics of some hotspots, in particular night clubs with permit restrictions, also posed a barrier to the intervention.

> *"The easiest is in Pasar Buah. It is harder in Glodok, Pinangsia, and Elok, because for night clubs' permits are needed. Kebon Bunga is a place with a lot of nightlife, thus there is only limited space to do outreach or to approach users in residential areas. When we hang out there, it is not an ideal place, because many people come and go and it is not private. And at boarding houses, they are really suspicious with outsiders." (Field Coordinator)*

4.6.2. Planning & Refining Field Strategies

Before doing any outreach activities in the field, it is important to do thorough planning. Therefore, Karisma has conducted regular coordination meetings with the implementing team (weekly meetings between field officers and the field coordinator, and monthly meetings between the field coordinator, program manager, and director of program). During these meetings findings from previous field visits were presented, barriers and obstacles discussed, and alternative solutions for future visits explored. Based on these discussions, a work plan for the following week was put together, including how to evaluate the work plan on a continuous basis.

During coordination meetings, field data was needed as reference for the discussion. Like this, the planning phase had been continuously informed by data previously collected in the field.

> *"From their reports, actually. If I, as the coordinator, look at their reports like this: "That's tomorrow's plan, so what will we be doing?" "O next week so ..." (Field Coordinator)*

Templates for daily and weekly reports had been developed by Karisma before starting the outreach program for CM users. Therefore, the field officers had been accustomed to create daily reports and action plans.

> *"What is there now ... at Karisma a RKM (Weekly Work Plan) is required, so officer write it every week for one week, like that. So they make plans, this week there, there, with whom, etc." (Field coordinator)*

The daily field reports, which provided a record of daily activities in the field, were compiled by data managers. The compiled data from the field played an important role when it came to the process of planning future activities. This had been in accordance with the guidelines, which stipulate the periodic review of findings and results from the field with the purpose of adjusting and improving future activities. The field coordinator's function has been to ensure that the plans made by the field officers can run well and according to plan.

> *"I should not make the planning, because I want to make sure that they do the planning and that it goes well, you know. Judging from their results, so ... later I follow up." (Field coordinator)*

After reviewing and compiling the weekly reports done by the field officers, the field coordinator had to discuss the results with the program manager. The program manager had then to coordinate with the field coordinator any actions to be undertaken by field officers, and report to the director any relevant issues related to the program. The program director in turn had to oversee the overall progress of the intervention.

> *"For example, what you need or what kind of performance you need to be taken? Is there a problem or not in the field? What needs to be done? What should be the priority?" (Program director)*

The program director was also in charge of the overall design and strategic direction of the intervention, providing guidance throughout the program. This included building a system of good governance, both related to the organizational capacity and the capacity of the team. Moreover, the program director also had to represent the program towards key stakeholders and partners, such as the NNB, government, etc.

> *"He should be designing, building, managing the outreach, including supervising the team, he should have team skills, and the ability to compare officers' skills with the audiences' needs in the field. Keep reviewing, consider other things that happen along the way, compare with the indicators and analyze the possibility of responding it." (Program director)*

> *"Needs to design the grand design of the outreach program. Inversely, for example equal to the scheme by the stakeholders, continue research like what comes up. Update information in the field like nothing out of the program. But related the same external issues." (Program director)*

Planning also included managing the program funds and coordinating with other programs within the organization, which were funded by other donors than Mainline. This was necessary in order to maximize program outputs, for example by joining activities from different programs, such as mobile VCT and rehabilitation.

> *"In Karisma there are many programs. We use the funds to conduct FGD with CM users." (Field coordinator)*

Planning done through regular coordination processes can also be an evaluation tool to measure the success of programs. Nonetheless, the management team felt that the existing indicators could not fully measure the success of the outreach program. During this time, the outreach is done deemed successful if they successfully got access to an area and had contacted the stakeholders and users.

> *"The indicators are written and exist, but if previously we could not have access to an area and later we could gain access to that area, made contacts with the people, I think then it has been a good progress." (Field coordinator)*

4.6.3. Staff Management

It is crucial for the successful development and implementation of an intervention program that the management team and field officers have the same perception and understanding of the overall purpose of the intervention program. Outreach workers may experience confusion if they have not fully understood the purpose of the intervention program. One of the problems had been that outreach workers were not in the clear about the scope of the intervention beyond gaining access to CM users. Similarly, the management team also seemed to be unsure about where the intervention should lead once contact with the clients had been established. The direction of the intervention became unclear once access had been gained to the target population. For example, it was unclear how far the assistance provided by Karisma should go to help crystal CM users who had legal problems. The current intervention design did not include details on this matter.

> *"The existing system is not settled yet. For instance, from step A to D, or first we have to do D and then to B, the step are not clear. Like after doing this, then we do this and so on. There is no system like if we failed, what do we need to do? How to evaluate this? It is not available yet, right?" (Field Coordinator)*

> *"They [outreach workers] did a really good job in gaining access, but the real challenge is what's next? That is the real challenge. This also a new thing for us in the management, we are also confused." (Director)*

In order to bring more clarity to the issues above, more capacity building was needed to improve the field officers and management teams' comprehensive knowledge related to crystal-meth, as well as their analytical skills.

Performance appraisal as a systematic evaluation of the performance of the team is an essential part of staff management. Nonetheless, no systematic performance appraisal had been done in this program. An important tool of staff evaluation is key performance indicators (KPIs), which measure outreach workers performance. During the intervention process, performance evaluation had been limited to weekly meetings to discuss field activities and determine targets related to the duration to gain access to hotspots. However, outreach workers determined their own targets, as they were considered to know best the situation in the field. Concerning problems experienced by

outreach workers, it had been important to communicate and discuss these with the management. The management then provided assistance to solve any possible problems and ensured that outreach workers felt respected and convenient at work.

> *"It is far from an ideal program, it is a trial and error process. Even there are no achievement indicators in this program. This is the process to determine the procedures to achieve the goal of the program." (Program Manager)*

> *"I always discuss and coordinate everything to ensure they [outreach workers] feel convenient. -Each one of them could share their opinion." (Field Coordinator)*

In order to accomplish the program goals successfully, performance appraisal as a systematic evaluation of the program team is needed. Staff evaluation is also necessary in order to determine capacity building needs.

4.6.4. Documentation of strategic information

Data collection constitutes the initial step to assess an evidence based intervention, with field documentation being an important part of this. Two different format types for daily reporting, jointly developed by the ARC and Karisma, had been used for this program. The qualitative and quantitative report format provided by the ARC had been designed to get a detailed description of the situation and context of the intervention location, and the individual profile report format from Karisma had been designed to capture detailed information on the clients' personal profile. All outreach workers had the duty to complete daily activity reports using the two format types described above, which was a bit of a burden for them, as it took quite a bit of time to complete both reporting formats.

Reporting routines at Karisma consisted of, daily reporting by outreach workers to the field coordinator, who compiled the daily reports into a weekly report. These weekly reports were then compiled into monthly reports by monitoring and evaluation staff, supported by data entry staffs. Quality assurance was done by data entry staffs, who validated incomplete weekly reports with the field coordinator. Staff for data processing consisted of two data entry staffs and one monitoring and evaluation staff, which proofed to be sufficient. The only challenge was that Karisma did not have an integrated database system to accommodate the reporting process, which meant that all reports had to be generated manually.

> *"The information system is the obstacle. The current database is from another donor, and we want to integrate it with the Mainline report. This is the only hitch, we can't integrate it, so then we use [microsoft] excel. This is for the outcome database." (Director)*

> *"There is no [database] system yet. We need a better system. If there is no system, planning cannot work properly." (Field Coordinator)*

Concerning to Karisma, individual profile is important aspect to enhance intervention program. Another challenge with the current database system was that double

recording of the same person could easily occur, thus potentially affecting the reporting outcomes and further implementation planning. A further issue of concern had been the outreach workers' capability of making reports. According to the program manager, outreach workers did not fully understand how their reporting had a direct impact on the outputs and further development of the intervention. Hence, capacity building related to analytical skills development should have been considered for outreach workers.

SECTION 5: EVALUATION

The evaluation aimed to assess the acceptability and feasibility of the intervention in terms of technical (outreach) and management (organizational arrangement) aspects. In this study, acceptability has been defined as levels of acceptance towards the intervention to allow smooth program execution in the future. To understand levels of acceptability, the opinions and attitudes of beneficiaries and relevant stakeholders had been gathered and evaluated. Feasibility, on the other hand, had been defined as an assessment of the practicality of the proposed strategies related to the intervention. Key components that contributed towards program achievements during the intervention were highlighted for future program development.

The evaluation of this intervention had been done using a qualitative approach. Data had been collected from 49 informants (44 males, 5 females) through a combination of methods such as in-depth interviews, FGDs, and field observation. To a comprehensive picture of the implemented program, data had been retrieved from both intervention sites and subdivided into three different clusters: [1] Beneficiaries – CM users who resided ~~in~~ at the intervention sites and had been reached by the intervention; [2] Stakeholders – respected figures from the local community and/or officials who had been engaged in the intervention; and [3] Key informants – persons who because of their social position proofed to be a valuable source of information for outreach workers. Furthermore, selected individuals of the implementing team, both from technical and managerial levels, had been included as informants for this evaluation. All the collected data had been transcribed, organized thematically, and analyzed using the qualitative analytical software NVIVO version 11.

Table 2: Demographic characteristic of the participants during evaluation stage

Informants	**Sex**		**Age**	
	Female	*Male*	*Range*	*Average*
CM users	1	11	16-32	21.7
Key informants	4	10	22-61	34.3
Stakeholders	0	16	26-56	41
Implementing partners	0	7		
Total	**5**	**44**		

*source: evaluation stage data analysis

5.1. Is the model acceptable to reach CM communities?

CM users felt that the intervention, including the information provided and the proposed referral services, had been well adapted to their needs and might benefit them in the future.

> *"Yes, they invite people to be a better person, no need to be like this again, because the impact ~~is~~ had already been seen. Helping people too, so people know the impact, the diseases and their transmission."* (FGD CM users)

This is in line with statements from outreach workers, who said that there were mostly positive responses from CM users regarding the intervention, with some even wanting to get involved and contribute towards the program.

> *"Surely he is willing to accept and live, for themselves, their families and communities."* (FGD Key Informant)

Community leaders and key informants were also of the opinion that activities undertaken by Karisma were important, because they directly responded to problems related to drug use in their neighborhoods. The positive response to the program and the ease to gain access are strong indicators of the acceptability of the program. NGOs working in the intervention areas and key figures proofed to be strategic partners in gaining access and building rapport with CM communities.

> *"Very nice, they work with people in the Pasar Buah area as an extended arm. The goes for the RT/RW and the police, who also know the activities of Karisma here. "(Key Informant)*

In terms of gaining access to the community, CM users felt that the role of key figures or "buddies", who were respected and trusted by the CM users, could ease the process of gaining and build trust in the field. Likewise, the role of NGOs in reaching out to communities, especially in places with night clubs/hotspots (in Kebon Bunga), was considered important. Field officers admitted that they had to apply various strategies and that it took them several steps to gain access to clients, including by asking for assistance from stakeholders and local communities. Moreover, due to the different characteristics of each area, strategies also had to be adapted.

> *"So for example, if I want to get into an area it is not rigid. For example, if cannot enter I can reach the stakeholders first. Like when I'm in Besar, I went to the stakeholders before, even if I already knew the users. But there I made my presence known first, so they'll know that I often play here. So local residents, security, and military officer there at least know that I am from Karisma and want to meet the users." (Outreach Worker)*

Acceptability levels regarding the intervention in the local community had been similar to that among CM users. There had been initial resistance, but after a while the presence of outreach workers in the neighborhood had been accepted.

> *"Eh, for example, initially they refused our presence because they thought there was no need for an intervention, or that they already knew everything. Eventually they made some suggestions about what to do in their communities and they also wanted to get involved in some of our activities and another of our programs." (Outreach Worker)*

Part of the process of gaining access to CM users in some areas also involved conducting activities targeting the general population especially in areas where CM users were more secretive. Overall, many positive things could be gained by including local communities in the intervention efforts. The resulting openness and acceptance

towards outreach workers proofed helpful, and some members of the community even wanted to be actively engaged in the program.

> *"Socialization of the program, approaching users, data collection, counseling, information on legal issues, information on HIV transmission, Pap smear testing for 50 women, all these activities had been done with the local community extension in several places in the Pasar Buah neighborhood. We used an approach "per gang", here there are about 45 gangs, and all have been touched by Karisma." (Key Informant)*

This inclusive approach applied by Karisma also received a lot of positive feedback from stakeholders. Outreach workers had not only established good and strong relationships with CM users, but also with local communities and key figures/key informants. This approach also led to more disclosed of CM users.

> *"The way we talk and act is good and we are considered like family so we're comfortable with them." (Key Informant)*

> *"As I said earlier, users tended to disclose with Karisma as they are so open and Karisma has the users' data. That's why I say it. "(Key Informant)*

A high degree of acceptance from stakeholders and key informants enabled outreach workers to easily gain access to the target community. In addition, partnerships with local NGOs had been well established and maintained. This was evident from successful joint activities, for example, joint outreach and counseling night life hotspots (in Kebon Bunga).

In terms of communication and building relationships, CM users stated to be quite comfortable with the outreach workers' approach. They found the topics discussed by the outreach workers appropriate and relevant to them. Communication usually began with 'light' topics relevant to the daily lives of CM users. Most CM users stated that intervention activities were beneficial to them, especially the information provided by outreach workers on the impact of crystal meth use on health, social, and legal issues. Based on results from the FGD with users, although some benefits of the program had already been felt by them, they found that a number of things could still be improved, especially regarding the frequency and quality of the meetings, which were still few and far between with little opportunity to engage in in-depth discussions.

Activities run by Karisma and attended by clients were as follows:

Types of activities attended by users: hanging out together, group discussions, counseling, and FGDs.

a. Topics discussed with the outreach workers: question and answer sessions about meth use and associated risks, sexual behavior, rehabilitation experiences, and sharing of IEC.
b. Duration of meetings: on average 1-3 hours, mostly after sunset.

The provision of information was most effective once a relationship of trust had been established after a few meetings. Likewise, levels of curiosity and attitudes of users

towards activities conducted by Karisma were also of great importance when it came to gaining access to the community. Besides, good relationships with key figures had to be built and maintained so that the provision of information could be continued beyond the intervention.

The types of activities that had been followed by the public and key figures included education about the negative effects of methamphetamine use, medical tests, counseling, and paralegal advocacy training for users. These activities had been jointly implemented with the neighborhood head, youth organizations, the family welfare movement (PKK), NGOs and entertainment places.

These activities had been gaining wide acceptance and positive feedback from the parties involved, but only on micro level. At this stage, no higher instances from the local government had been involved (e.g. district head or PKM). The benefits obtained by the stakeholders thanks to the intervention were improved understanding of the risks of HIV transmission (not limited to but especially related to CM use), effects and side effects of drug use, as well as how to face and support drug users, especially CM users.

The risk assessment component generated plenty of interest from the clients. However, limited time for the discussions and lack of privacy had been an obstacle. Both outreach workers and clients considered IEC material as a helpful tool information tool, but during the intervention IEC material had not been distributed effectively, and stocks were limited. Despite the fact that most clients were aware of the harmful effects of CM use and associated HIV risks, with many having identified such risks during the risk assessments, few seemed to change any of their related behaviors. Overall, stakeholders responded positively regarding the risk assessment activities, as they felt that it benefited the CM users in their respective areas.

> *"We as citizens are very grateful so we know the steps to know the impact of meth use on our children and how to prevent and to monitor our children." (Key Informant)*

> *"So when Karisma is here, they (CM users) realize, 'oh if I use this, it could lead to HIV." (Key Informant)*

In terms of clients' needs for services, most did not have any experience accessing services, due to the absence of obvious ailments and generally feeling healthy. Moreover, users felt reluctant to access health services because they were concerned about discrimination and being stigmatized by health providers because they were meth users. As a result, very few referrals had been made and documented. The only information gathered related to referrals had been anecdotal and by word of mouth, with no confirmations from referral services.

A good indicator of the levels of acceptance among CM users regarding the intervention had been the high degree of their active involvement during activities organized by Karisma. Field officers tried various mechanisms to build up a network of CM users by actively involving local communities and CM users already reached. And while a

majority of CM users had tried to persuade fellow users to engage in the program, few have been successful due to widespread fear among fellow users.

On another level, acceptance of the program could also be seen from the involvement of public figures and key informants in the activities conducted by Karisma. Although community leaders had perceived some barriers to the implementation of the intervention, it was~~,~~ expected that these could be–overcome in the future. Obstacles included the difficulty to assemble participants (CM users) because most were still afraid and not open about their use. To overcome such barriers, public figures suggested more creative dissemination methods to entice CM users, as well as conducting activities on a frequent and ongoing basis.

A high degree of acceptance and support from public figures and key informants could also be seen from their commitment and openness to engage actively in Karisma's program. They were of the opinion that activities should be continued and further improved in order to achieve better results. Moreover, hoped that in the future the intervention can be expanded to other areas in their neighborhoods, which had not yet been reached. Additionally, key informants hoped that future activities can be more diverse, including a stronger emphasize on counselling related to drug use. In order for all this to happen, there will need to be close cooperation with the government at a higher level, such as district heads and public health centers.

In conclusion, the intervention for CM users had been widely accepted by CM users, stakeholders and other partners. However, some overarching considerations will need to be taken into account related to the programs future. Acceptance on the part of CM users happened gradually, usually after 3 or 4 meetings with outreach workers. Adjustment related to the intervention schedule will need to be done, with a main focus on outreach activities during evenings and at night, when most CM users congregated at hotspots. The information provided through the intervention had been considered useful to fill in the knowledge gaps on HIV and addition, two issues which clients had never been exposed to before. The involvement of key informants in the intervention had proven to increase credibility and levels of acceptability of the program in the field. The active involvement of many CM users in during the intervention can be seen as a sign of trust and sense of belonging on behalf of the target group towards the program. Also, levels of curiosity among CM users had increased along with the more frequent presence of outreach workers in the field. These considerations should be taken into account when providing ~~the~~ interventions for CM users to ensure acceptability towards the program.

5.2. Is the model feasible to be implemented?

The results from the implementation of the designed intervention model indicated that most of the strategies utilized were feasible and desirable. However, some practical ways to maximize the results of each strategy had been identified. Gaining access to crystal-meth hotspots had been possible thanks to activities focused on trust building,

introducing the implementing organization and clearly explaining the program objectives to new clients and the local community present around hotspots. Any support services provided by the implementing organization, such as a drug rehabilitation center, health experts, or free health services, could be considered beneficial. Support from local communities to further explore the local situation related to crystal-meth was crucial.

The process of identifying CM users happened gradually, by first gathering and analyzing information provided by key informants, while waiting for potential clients to open up and disclose themselves. In order for this process to be smooth and successful, good communication skills were necessary. In addition, careful observation and consideration of clients' characteristics and daily routines, such as type of language used, gestures, local habits and lifestyle patterns, had been helpful to better interact with the target group.

> *"The most important thing is developing trustworthiness to anyone at ~~in~~ the intervention site that we wish to use as our local contact in the area." (In-depth interview outreach worker)*

Once outreach workers had successfully established contact with CM users and gained trust, the provision of information related to HIV and drug issues could start. In order for such information to be well received, the target group had to feel comfortable with the presence of the outreach workers and the setting. The provision of information happened both during one-on-one (individual) encounters and in group situations, depending on the situation at the hotspots. Individual discussions allowed for more flexibility regarding the discussion topic, while group discussions were more structured and therefore required more preparation. During both individual and group discussions, there had been a gradual shift from more general and "light" topics during the first encounters to more private and sensitive issues, such as HIV and drug use, during subsequent meetings. Regardless of the type of intervention, it had been of utmost importance that outreach workers had good communication skills and were well informed in order to provide accurate information and tackle myths and misconceptions related to HIV, sexual risk-behaviors, crystal-meth use, drug laws and regulations, and addiction.

> *"If it's regarding drug use I know almost everything, but if it [the question] is related to drug laws and regulations, I have to admit that our understanding is still limited, such as evidence for prosecution. Now the situation has already evolved because of the adaptation of a new law, and we need to catch up. So far, we can only share information that we really know." (In-depth interview outreach workers)*

In order for individual risk assessments to be operationally feasible, relationships of trust between outreach workers and clients had to develop first. Only then did clients feel comfortable enough to talk about sensitive issues such as their sexual behavior and experiences with drug use. Once an individual risk assessment had been carried out and

a clients' specific HIV related risks had been identified, the process of developing an individual risk reduction plan for the client could be started. Appropriate information tools to support behavior change and routine follow up by outreach workers were crucial for actual risk reduction to take place.

> *"…the last time I asked about condoms, they said that they were distributed among their peers, I haven't yet asked about condom utilization. And they keep asking about crystal-meth prevention tools since we told them that we're going to provide it." (in depth interview outreach workers)*

Assessments related to the clients' support services needs could be implemented effectively once the clients understood the health implications of unprotected sex and drug use, which ideally was the case after the risk assessment. The need assessments component required outreach workers to have at least basic knowledge and understanding of crystal meth and associated health risks, as well as being attentive and responsive towards clients and their various health conditions. Networking with local primary health centers and private clinics also proofed to be very important in order successfully complete the services needs assessment activity.

> *"I once found out that my client has a genital lesion as he come forward about this. I referred him to the Puskesmas [primary health center] to get medication. First it started to heal but then it reoccurred. They definitely need health services." (in depth interview outreach worker)*

The strategy to expand the scope of the intervention and involve more people in the program could be applied once ideal preconditions had been created. This included the following steps: 1) Program plan developed based on mapping of intervention sites; 2) Relationships with local stakeholders and local communities established and maintained; 3) Role of key informants maximized to reach "hidden" clients; and 4) Frequent and regular visits and engagement in the field. Without these steps, chances of reaching "hidden" CM users were very small.

In a nutshell, all strategies applied during the outreach intervention targeting CM users were feasible to be implemented. Throughout the four-month implementation period, outreach workers had successfully reached 204 CM users through 74 individual and 92 group outreach contacts. In addition, 59 individuals who were using other drugs had also been identified. A variety of information material had been distributed to the target group, covering the following topics: addition (677 times), HIV/AIDS (379 times), and access to HIV services (191 times). Although still limited, based on these collected data we conclude that understanding on risks related to crystal-meth use towards health, legal and social issue, including how to response the risks have been comprehend by some program beneficiaries. Information related to health and support services had also been provided by outreach workers, with general health services discussed (129 times), drug and addiction treatment facilities (117 times), and HIV services (22 times). A total of three individuals agreed to volunteer their time to support the crystal-meth intervention. Volunteers tried to invite peers to take part in the intervention a total of

Thus, the strategies applied in the intervention showed promising results and should therefore be considered for future crystal-meth interventions.

SECTION 6: DISCUSSION

This operational study had been developed in response to the widespread use of CM in the community, and in particular, in an effort to address CM users' elevated HIV risk. (Degenhardt et al., 2010; Nevendorff & Praptoraharjo, 2016; Pinkham, 2010; Strathdee & Stockman, 2010). The outcomes of the intervention were to reduce drug related harms and to reduce HIV risk among CM users. Reducing harms associated with drug use were attained by providing education on the characteristics of drugs, recognizing drug dependency, introducing types of drug treatment and other support services. Reducing HIV risk was intended by promoting safer sex practices, especially the consistent use of condoms, as well as by promoting HIV and STI testing. Hence, the intervention focused more on reducing some of the harms associated with drug use, including risky sexual behavior, rather than preventing drug use in itself. The reason for this approach was based on the understanding that many people cannot or do not want to stop using drugs or engage in sex with multiple partners.

In Indonesia, harm reduction interventions targeting CM users have not been implemented systematically. The main focus of harm reduction interventions has been laid on PWID. Similar like PWID, CM users are hard to reach for health interventions due to the stigma associated with drug use. As a consequence, no data are available about the magnitude and distribution of the problem, except as reported by law enforcement. Without data, it is almost impossible to design and implement a quality program. Therefore, it is of great importance to develop and apply various strategies to reach and study this population so that more about their distribution, characteristics and practices can be learned. This in turn will allow for the development of, or linkage to, appropriate support services. This approach is commonly defined as outreach. Outreach enables health programs to locate, contact and offer services to a hidden or underserved population. (Ford, Miller, Smurzynski, & Leone, 2007). Outreach is an important element of any HIV response and known as an effective strategy to reach and provide information and harm reduction services to PWID (Alliance - CAHR, 2012; Coyle, Needle, & Normand, 1998; WHO, 2004; Wiebel, 1987). Previous studies on interventions for CM users showed that outreach was the preferred strategy to gain access to CM users and provide them with information on HIV and STI prevention, care and treatment, risk reduction strategies, overdose management, or for pharmacological interventions and dexamphetamine maintenance (Corsi & Booth, 2008; Nakamura, Mausbach, Ulibarri, Semple, & Patterson, 2011, Longo et al., 2010).

So far, in Indonesia no intervention targeting CM users had been implemented. Hence, it was not possible to determine the feasibility or acceptability of such an intervention in the Indonesian context. Determined to change this, the ARC Atma Jaya and Karisma Foundation had implemented a pilot study of an outreach intervention targeting CM users at two different locations in Jakarta over the course of 6 months, and

subsequently determined whether such an intervention was feasible and acceptable to be implemented on a larger scale. Evaluation of the pilot intervention focused on three key aspects. Firstly, technical aspects of outreach, which were further subdivided into (a) how to gain access to target population; (b) how to raise awareness about HIV and drug related problems; (c) how to encourage CM users to assess their individual risks related to HIV and drug use; CM, (d) how to support CM users to utilize HIV and drug related support services and (e) how to actively engage CM users in HIV prevention and harm reduction activities in their communities. Secondly, governance aspects of the intervention, which included planning, management of outreach staff, and management of strategic information of the intervention. Thirdly, levels of acceptability of the intervention among local key stakeholders and CM users. This last aspect is considered crucial, as it is an important indicator of whether the intervention could be implemented in the future or expanded to other locations. This is in line with results from a variety of studies, which used similar evaluation approaches (Booth & Wiebel, 1992; Church, Fakudze, Kikuvi, Wringe, & Mayhew, 2011; Dancy & Dutcher, 2007; Ford et al., 2007; Needle et al., 2005; Rhodes, 1994; Swider, 2002).

By looking at three different aspects of outreach, it was expected that the pilot evaluation could provide information on the effectiveness of the outreach intervention, particularly ~~in~~ on the output level, which was measured by numbers of CM users reached, numbers of CM users referred to HIV services, and number of CM users involved in field education sessions. Due to the short duration of the intervention, which only three months, outcome levels related to behavior change could not be measured. However, if more time and resources are available, indicators related to behavior change will need to be considered.

The outreach model applied during a pilot intervention over the course of three months at two different locations in Jakarta had successfully reached almost 300 CM users, all of whom were provided with HIV and drug related information material and information on support services in their area. Both intervention sites were new locations, which had not been targeted previously by any intervention by Karisma Foundation. By using different field strategies and applying an epidemiological and ethnographic approach, the model showed that outreach as a strategy proofed to be successful in reaching a hard to reach population and providing them with relevant information tailored to their needs. Similar results had also been found in a variety of other studies (Anderson et al., 1996; Dancy & Dutcher, 2007; Needle et al., 2005; Rhodes, 1994; Wendell, Cohen, LeSage, & Farley, 2003). Outreach activities had been tailored to the specific characteristics of CM users, such as their language, hang-out times, relevant discussion topics, and social networks, as well as the social context surrounding them. Further, information on referral services (HIV and drug treatment services) had been provided to most of the CM users, but whether or not such services were subsequently accessed, could not be sufficiently tracked.

One of the challenges faced during the pilot was related to the individual risk assessments, which could only be conducted partially. Many CM users turned out to be reluctant to assess their risk. Some of the difficulties related to the risk assessments were likely related to the widespread perception among users that their addiction to CM did not cause any problems. Most reported that they could manage their use (despite the fact that many were almost daily users) and that they could work or conduct their daily activities normally. They perceived addiction to be a situation where the craving for drugs was so overwhelming that nothing else could be thought or done than seeking new drugs, which was a scenario mostly associated with PWID. Yet, despite the outreach workers having delivered information on CM use and associated health risks, including HIV risk, some clients were still reluctant to take part in risk assessment activities. When exploring about these difficulties with outreach workers, they stated that they presented risk reduction as the logical action of someone who has understood a risk, thus wanting to avoid such a risk. However, this does not always seem to be the case for people who live in real life situations, where people have to consider one risk over many other risks and consequences faced in daily life. Therefore, any discussion on risk should consider the dynamic contextual factors of the risk, which is called the risk environment (Fox, 1999; Rhodes, 2002). For instance, using a condom would be the logical step to avoid getting HIV or an STI. But~~,~~ if someone has more than one partner, then proposing to use a condom when having sex with any of the partners would raise suspicion, condoms are perceived as a symbol of unfaithfulness and casual or commercial relationships. Therefore, introducing safer sex behavior may pose a risk to his/her relationships in this context. In order to improve the outcomes of the intervention, outreach workers will need to be provided with capacity building on how to more effectively communicate and counsel on risk reduction practices, so that there will be a shift from acceptable risk to ~~be~~ unacceptable risk, which would then allow a risk reduction plan to be developed and implemented (Booth & Wiebel, 1992; Latkin, Weeks, Glasman, Galletly, & Albarracin, 2011; Wiebel et al., 1996).

Outreach activities also allowed field workers to identify different characteristics of CM users at each target location. Some of the CM users were found to belong to key affected populations, such as sex workers, PWID, and MSM (Morineau et al., 2011; Nevendorff & Praptoraharjo, 2016). However most CM users reached through this intervention had never been reached by any drug or HIV intervention. The CM users' demographic characteristics were diverse in terms of age, socio-economic and educational background. This was similar to the results of a report by the National Narcotics Board (2015).

Modes of CM use were relatively uniform, with most users smoking meth (through inhalation). Only few CM users admitted to injecting the drug, which is similar to other studies on the issue (Corsi et al., 2012; Degenhardt et al., 2010; Strathdee & Stockman, 2010). Consequently, HIV transmission was more likely to happen through unsafe sexual activity than through unsafe injecting practices. Previous studies have indicated that therefore the most relevant intervention measure consisted of the promotion of

safer sexual practices through the consistent usage of condoms and water-based lubricant, including counselling to support this behavior (Molitor, Truax, Ruiz, & Sun, 1998; Semple, Patterson, & Grant, 2004; Zule, Costenbader, Meyer, & Wechsberg, 2007).

Overall, the lessons learned from this outreach intervention targeting CM users had not been very different from similar interventions targeting PWID as part of many HIV responses (Alliance - CAHR, 2012; Booth & Wiebel, 1992; Coyle et al., 1998; Needle et al., 2005; Pinkham, 2010; WHO, 2004). Nevertheless, in the following section some technical lessons learned from the outreach intervention are presented:

a. *Using multiple approaches to gain access to CM users*

   The process of gaining access to hotpots and CM users is gradual and mainly consists of trust building. This involves outreach workers introducing themselves, and the organization they represent, to potential clients in the field. Furthermore, outreach workers need to explain clearly the purpose of the intervention, the target population, as well as the different activities which will be conducted. Different situations require different approaches in order to gain trust and build credibility among clients. Gaining access to CM users who are also sex workers may require a different approach as compared to gaining access to young male CM users. Furthermore, it is important to observe patterns of social interaction and communication among the members of the community. Learning from social interactions and modes of communication can help outreach workers to better understand the culture of a particular community (for instance, who is the vocal person, how to communicate about sensitive topics, what are the social norms in a particular social network, what are beliefs related to drugs, etc.). In doing so, the outreach workers could place herself/himself in certain position (as non-local person) to communicate with the community members. This way, the outreach workers could easily identify key informants, who could help with the process of finding more users in the community In addition, having the support from key informants is key to win trust from community members. Key informants may be respected individuals from the community, former drug users, or community leaders.

b. *Regular field presence*

   Gaining access to the community and building trust needs time and patience. Outreach workers should not force to be accepted during the first or second visit, because this could be counterproductive to their effort to gain trust from the community. Outreach workers should present in the field on a regular basis in order to be easily recognized by community members. Moreover, regular presence in the field attests to a high commitment to help the community to achieve a better health status (as stated in the purpose of the intervention). Outreach workers should go to the location based on a fixed schedule (once or twice a week, always at the same time) and they should keep their promises to visit regularly in the following weeks.

c. *Partnering with local organizations already established in the neighborhood.*

Collaborating with local organizations, which have already been working in the neighborhood is a strategic way to gain access to the local community in less time and more easily. Mapping existing organizations in the area and getting to know their staffs are steps that should be carried out right at the start of the intervention.

d. *Waiting for clients' initiative*

Providing information to individuals who actively ask questions about the intervention is most effective, as this is a good indicator that such individuals are interested in talking further with the outreach worker. There is no point in forcing information on clients in the field who do not show any interest in the intervention, as it is likely that they will not pay any attention to it. The same applies for information related to referral services. To have a 'productive conversation' (conversation related to the intervention and or referral services) patience on behalf of the outreach worker is needed. Discussions should evolve step by step from more general topics towards more personal and private issues. Outreach workers should be careful not to use complicated program language, as this could lead to misunderstandings and miscommunication.

e. *Equip outreach workers with adequate IEC material*

During outreach field workers need good communication skills to deliver the intervention message. Ideally, the communication process is assisted by IEC material, which allows clients to learn the information themselves and get back to the information on a later occasion. IEC material should be simple in terms of language, flow of information and relatively short in length. During education sessions in the field, outreach workers can use IEC material to reinforce the information delivered orally. The material should cover basic information on HIV and STIs, drugs, condom use, hepatitis B and C, drug treatment and referral services available in the neighborhood.

f. *Understand how CM users assess their risk*

Risk assessment is an important step in modifying behavior. People can change their behavior if they perceive their current behavior as harmful to their health. The objective of a risk assessment is to identify risk behavior and to shift perceived acceptable risk to become unacceptable risk, which in the ideal case, should then be followed by behavior change. In reality, things are more complicated, as people may face many risks in their daily life and to avoid one risk can have an effect on another risk. In this case, it may be advisable to assess which risks are most unacceptable. But as long as CM is perceived as an enhancement for daily work, it will be difficult for them to give up this habit, even though he/she knows that CM use is harming their health. For CM users who are also sex workers, the main priority is likely to get

as much money as possible, and refusing a clients' proposition not to use a condom, may mean losing the client. Thus, despite that fact that the sex worker may understand the risks of sex without condom, he/she will still engage in it because of a pressing need for money. Reducing risk is mostly a matter of choice. But choices are constrained by the context of risk. Outreach workers must understand this dilemma in order to be able to work with clients. Small changes and steps towards safer sex practices or drug use should be promoted and appreciated because big changes are unlikely to happen within a short period of time. Risk reduction will only be successful if it is based on the intentions of the users themselves, while at the same time she/he receives support from their environment.

g. Always bring prevention material

Risk reduction is more likely to happen if a person has the means to support his/her efforts. In case of sexual behavior, condoms and lubricant need to be available if a person has multiple sexual partners. For those who inject CM sterile needles need to be available. Therefore, outreach workers should always bring this prevention material whenever they go to the field. Some CM users may have limited access to condoms, lubricant or sterile needles due to a variety of reasons (uncomfortable to buy condoms in a shop, legal restrictions to buy needles, unavailability when they are using drugs, etc.). Prevention material should always be prepared in sufficient numbers prior to going to the field. So far, prevention material–could be obtained from the Provincial AIDS commission or from public health centers in the neighborhood.

h. Establish referral network

One of the main objectives of outreach is to encourage the hard reach populations to independently utilize existing health services in their neighborhood to achieve a better health status. However, due to widespread stigma and discrimination towards drug users, it is important that outreach workers support this process by working with the existing health services in order to reduce discrimination against drug users and other key affected populations. Working both with the demand and supply side of health services is key when trying to build a referral network for CM users.

i. Engage CM users in prevention and care program

Engaging CM users into prevention and care programs is an effective strategy to increase coverage of the program, because peer to peer information provision tends to be faster, reaches more users, and is more acceptable and credible to the community. It is likely that CM users do only want to get involved in an intervention if they see or feel any benefit from it and if their involvement does not lead to any negative consequences (e.g. arrested by police, disclosing their CM use to the public). In order to be effective in reaching the target population, the intervention should be

designed in a way attractive to CM users and involve volunteers, peer educators ~~or~~ and community organizers.

In this operation study, the review on the feasibility of the outreach intervention not limited to technical aspect but also focuses on governance aspects of the intervention. Good governance has been found to lead to better result in the implementation of an intervention (Alliance - CAHR, 2012; Bowen et al., 2009; Ford et al., 2007; Valentine & Wright-De Agüero, 1996; Wendell et al., 2003). Some lessons learned related to the feasibility of the intervention and management aspects are as follows:

a. *Composition of Outreach Team*

   The composition of an outreach team is the key to successfully gaining access to an underserved or hidden community (Ford et al., 2007). The composition of the outreach team for this intervention consisted of a pair of outreach workers at each intervention site, with each pair consisting of an experienced senior outreach worker, often an ex-user, and a less experienced and younger outreach worker. The pairing of outreach workers was done to ensure the safety of the outreach workers in the field, because they were working in areas largely unknown to them, as well as working on the topic of drug use, which is an illegal practice in Indonesia. Combining a more experienced outreach worker with a less experienced one proofed to be a good strategy, as they seemed to complement each other. While the more experienced one could gain access to a new area more easily and faster, the less experienced one tended to be more patient when providing information.

b. *Refining field strategy on an ongoing basis*

   Monitoring and planning of field activities should be carried out on a weekly basis in order to always be in accordance with the situation in the field. The situation in the field is very dynamic and sometimes what had been planned could not (or only partly) be implemented. Sometimes an adjustment is needed or even a change of strategy. Therefore, weekly monitoring and planning enables a team to address problems in the field and develop better and more refined strategies. This way, planning for the following week can be carried out more easily and targets for the the outreach workers can be set on a weekly basis. Through the weekly meetings, the intervention becomes more responsive to the situation in the field, and therefore, also more in accordance with the target population. The field coordinator is responsible for conducting these meetings.

c. *Partner with other programs at the target location*

   Mapping programs or interventions that currently exist at the target location is another strategy to optimize limited resources of the implementing agency. Field experience shows that collaboration with other HIV interventions conducted by NGOs and community health centers targeting FSW, PWID, and MSM enables to reach more CM users, because some may be part of these populations. Working

together with existing programs will not only speed up the process of entring into the community, but also increases the credibility of the program. Furthermore, efficiency related to the limited resources of the program can be achieved.

d. Balancing target coverage with capacity of implementing team

Outreach relies on the number of contacts as proxies to support behavioral change by providing prevention material or doing referrals to support services, including HIV testing and drug treatment services. (Booth & Wiebel, 1992; Valentine & Wright-De Agüero, 1996; Wendell et al., 2003). Therefore, finding the right balance between outreach targets and the number of outreach staff is crucial and will determine the feasibility of the intervention. While no reliable data on numbers of CM users are available, secondary data on numbers of CM users in a particular province or city from the police, NNB, and drug rehabilitation centers can be used. Data from previous outreach programs in Indonesia show that the ratio of outreach workers to clients was 1:100 to115, which is far from ideal and puts a huge burden on outreach workers to support and maintain behavior change activities for their clients.

e. Clear work flow for outreach

Developing a clear work flow for outreach activities is aimed to build a work standard for outreach workers in the field. The standardized work flow enables outreach workers to go through the same steps when doing outreach. Thereby, standardized monitoring and evaluation tools can be developed and the target population receives similar treatment from all outreach workers. The work flow also includes work ethics that cover “do’s” and “don’ts” during outreach. However, the work flow should be developed based on the characteristics of the target population and context of the intervention site.

f. Regular capacity building activities for outreach workers

Field activities demand the full attention and involvement of outreach workers, both on an emotional and physical level. Hence, outreach workers often face high pressure due to the nature of their work and are vulnerable to drop out, or experience burn out. There is also risk for relapse among outreach workers who are recovering addicts. The high pressure may have an impact on the quality of work, perseverance, and adherence to the work flow in outreach. Therefore, it is important that the management recognizes these potential threats to the well-being and performance of outreach workers and takes the necessary steps to to maintain a healthy work environment. This may include knowledge updates, capacity building activities, including team building, and rotating staffs between locations and teams.

g. Documenting field activities

Documenting outreach activities can be complex but there are ways to make it simpler. It all depends on the program management and the set documentation or

reporting standards. There is a general expectation that program documentation is very detailed, as individual records for each person reached are needed have a comprehensive description of all clients. However, one of the challenges faced during this intervention was the risk of duplication, as different outreach workers may have collected data on the same client without being aware, as records are not based on a unique ID or identity card.

Experience from previous interventions has showed that when documentation requirements are very rigid and complex, this may have a negative impact on outreach workers behavior related to data collection and reporting, such as manipulation or making up of data. Therefore, in this intervention, documentation had been focused on capturing the main activities carried out in the field, which locating, contacting, informing and referring. Data collected during this intervention are based on daily reports, which consist of indicators such as: numbers of CM users reached, numbers of new CM users reached, numbers of repeated contacts, numbers of clients who have received prevention and IEC materials, numbers of CM users who have been referred to support services, and numbers of CM users who are involved in field activities.

The likelihood for an intervention to be developed in the future or expanded to other areas depends on the availability of resources the acceptance of the target population (Carver, Douglas, & Tomlinson, 2012; Ford et al., 2007; Tinsman, Bullman, Chen, Burgdorf, & Herrell, 2001). This pilot outreach intervention for CM users has provided solid evidence that an intervention like this can be accepted by CM users. In only three months, the intervention has succeeded in reaching almost 300 CM users multiple times through group or individual outreach. No adverse events occurred during the intervention and no rejection on behalf of CM users had been reported. Lesson learned related to levels of acceptance among CM users are as follows:

a. *Provision of information tailored to the needs of CM users*

The provision of information does not happen instantly, but after a process of establishing contact and gaining trust. This usually happens after 3 or 4 contacts in the field. Hence, outreach workers are not perceived as a threat. The information provided through the intervention must be tailored to the specific needs of CM users. Only then will the information be considered valuable by the target population and accepted.

b. *Frequent contact leads to higher acceptability*

In the evaluation phase of the intervention, finding showed that CM users felt that there had not been enough contact with outreach workers, both in terms of frequency and the duration of each contact. Thus, outreach workers should be present in the field on a frequent basis and the duration of contacts and discussions

should be longer. Overall, it can be said that acceptance of outreach workers equals acceptance of the program. This is similar to what has been found in other populations such as PWID or MSM (Amirkhanian, 2014; Friedman et al., 2007; Jozaghi, Lampkin, & Andresen, 2016; Wiebel, 1987).

c. *Increasing acceptance by establishing contact with key community figures*

Making use of social networks is a good strategy to gain better and quicker access to CM users. Various studies have shown that the social position of a person in a network implies the social role of that person in the community (Latkin et al., 2011; Sherman et al., 2009). With growing importance of a person in a network, their credibility and influence over other community members also grows. Therefore, it is important to identify individuals with a central position within the local community, as such a person can help a program to be more accepted by the community. Winning support from the community leader is a strong indicator for a successful intervention, because the leader can mobilize the community to support it.

d. *Maintaining relations with local key stakeholders*

Understanding the social dynamics of the location where an intervention takes place is important. This includes understanding the social roles of different people, or groups of people. Building communication with individuals or groups who hold an important role in the community will enhance the acceptance of the program. During the pilot intervention, the outreach workers have built communication with local community groups (RT/RW), staffs of community health centers, the local police at a sub-district level, and several NGOs. Good communication and relations with these key stakeholders allowed the outreach workers to visit the neighborhood, including the hotspots, without raising suspicion or being disturbed by the local community. Thanks to smooth communication local leaders sometimes facilitated the program by providing venues to conduct education sessions for CM users. Outreach workers also informed the police about their presence in the neighborhood in order to ensure that they were safe during work. However, at any stage of the intervention outreach workers kept the identity of CM users confidential, including in the presence of the police.

Results from this intervention targeting CM users show many similarities, both related to technical and governance aspects, with other outreach interventions focusing on key affected populations. The difference is high variety of the CM users who have diverse socio-economic and behavioral background. There is also considerable overlap, with many CM users also being MSM, PWID, sex workers, male to female transgenders, or clients of sex workers. They have diverse socio-economic backgrounds, from low to high, reside in different types of neighborhoods, from slum areas to wealthy gated complexes. The diversity of the target population called for different approaches in the field to reach and engage them. And it also meant that outreach workers had to be selected carefully in order to be suitable to reach particular sub-groups of the target

population. This has also been confirmed in other intervention studies outside Indonesia (Alliance - CAHR, 2012; WHO, 2004; Wiebel, 1987).

The diversity of the target population also means that the management of this intervention has been more complex, especially in terms of selecting the intervention sites, organizing the sub-populations, developing field activities, coordinating outreach workers with different backgrounds, and strengthening the capacity of outreach workers due to the diverse characteristics of the target population. Currently, some questions remain, for instance whether a future intervention for CM users should be developed independently, or whether it should be integrated with existing interventions for other key affected populations. The second question is whether the intervention should be categorized as sexual transmission intervention or drug-related transmission. Selection of the options will be heavily depended on availability of resource to support the intervention.

Considering the landscape of the HIV response in Indonesia, integrating interventions targeting CM users into existing interventions, particularly for key affected populations (MSM, PWID, TG, FSW and their clients), would undoubtedly be the best strategy and the most realistic choice to respond to the HIV threat among CM users. Moreover, the intervention should be categorized as focusing on the prevention of HIV through sexual transmission, as HIV transmission among CM users is likely to happen through unprotected sex and not through unsafe injecting practices. However, this does not mean that the manifold issues related to drug addiction should be excluded. Integrating CM specific components into existing interventions will require further training for outreach workers on issues related to CM, drug treatment and harm reduction. Overall, this would require less costs than developing new CM specific interventions. In other words, conducting HIV prevention for CM users would not add a significant strain on the budget of the HIV program. By including a CM user specific component to existing HIV interventions, it is hoped that more people can be encouraged to undergo HIV testing in order to know their HIV status, and if found to be infected, immediately enroll in anti-retroviral therapy. Investing in interventions, which include CM users as one of their target populations, will contribute towards the achievement of the ambitious triple 90 treatment targets, which have been set for 2020. In addition, such interventions will increase the life skills of CM users and help reduce health and social harms related to drug use.

SECTION 7: CONCLUSION AND RECOMMENDATIONS

7.1. Conclusion

This operational research on the feasibility and acceptability of an outreach intervention targeting CM users in Jakarta, which had been jointly implemented by the AIDS Research Center of Atma Jaya Catholic University and Karisma Foundation, has provided empirical evidence to answer the three main research questions: (1) Can the intervention be implemented?; (2) How is the intervention implemented; (3) Can the intervention be implemented in the future and extended to other locations?

To answer the first question, findings from the evaluation have showed that the outreach intervention targeting CM users can be implemented in five steps, namely gaining access to CM users, increasing awareness related to HIV and other harms associated with drug use, encouraging CM users to assess their own risk, providing referral services to enhance risk reduction efforts, and engaging CM users into prevention and care. By applying these steps, the intervention reached almost 300 CM users in two neighborhoods in Jakarta. Outreach was conducted by four outreach workers, who were divided into two teams, one team at each intervention site. Even though the process of gaining access to and trust from CM users took time, efforts paid off after a few weeks with increasing credibility and acceptance. The process of providing information material on HIV and drug use through various field activities also worked well.

However, the risk assessment component proved to be challenging. Most CM users had been exposed to HIV and drug related information for the first time through this intervention. Hence, their understanding of what a risk assessment entails had been very limited. During the pilot intervention, the main focus had been laid on the provision of adequate information, rather than on risk assessment. Consequently, outreach workers had only been able to assist few CM users to assess their risk. Nevertheless, despite the small number of CM users, who conducted a risk assessment, results showed that risk assessments were feasible to be conducted as long as both CM users and outreach workers understood well the risk context of a particular client to develop a risk reduction plan. Increasing intensity of contact with CM users, both in terms of length of contacts and frequency, may have increased the likelihood of CM users conducting a risk assessment, as indicated in the evaluation findings. Involvement of CM users had been active throughout the three months of the intervention period, with many clients actively referring their peers to outreach workers.

The second question can be answered by looking at the process of governing the intervention during the implementation. Karisma Foundation successfully reached CM users in two locations cannot be separated from the governance system that developed to support the outreach. They established mechanisms for monitoring and planning of the field activities, managing the staff, developing referral network, and managing strategic information that covered documentation, analysis and utilization of collected

data from the fields. Even though not all mechanisms were fully operated, the system had resulted in a good performance. However, the system should be evaluated mainly related to documentation of the field activities and coordination among the staff.

The third question is related to the likelihood of the intervention to be expanded to other locations in Jakarta and beyond. The response of CM users at the two intervention sites showed that levels of acceptance were very high, because they felt that the information and referral services provided through the intervention met with their needs. So far, few had been provided with any HIV or drug related information, with the exception of information from online media or newspapers. Thus, the intervention had opened up new opportunities of learning about HIV and CM use. Levels of acceptance among CM users increased throughout the implementation, as none have experienced any adverse effects due to their involvement.

From a programmatic point of view, outreach targeting CM users is not any different from outreach targeting other key affected populations and therefore it should be feasible to expand the intervention to new locations. In any case, program developers will need to consider Consideration about the diversity of CM user's background should be taken seriously by program developer because it will imply the wide range of strategies to cater different sub-population properly. Failing to respond the characteristics of the CM users may lead to be unsuccessful intervention. Given that budget for AIDS response is decreasing in recent years, integrating outreach targeting CM users into existing outreach for key population will be the most realistic option to implement the intervention in the future or in different places compared to develop an independent intervention.

7.2. Recommendations

The objective of this operational research has been to obtain a feasible and acceptable model for HIV prevention and harm reduction targeting crystal methamphetamine users in Indonesia. This operational research has provided evidence that the model is feasible and acceptable to be implemented in a limited setting and in a short period of time. However, before rolling out this intervention in another setting–the following recommendations should be taken into account by the program developers in order to achieve efficacy:

1. A baseline estimation of the magnitude and distribution of CM use and the number of CM users at the targeted locations is important. Existing data from the police, the NNB or from previous surveys, if available, can be used for this purpose. Based on this, resources to be allocated for the intervention can be calculated. Ideally, new interventions build on or are integrated into existing interventions.
2. Ensure that the district health office (DHO) is involved in the process of developing the intervention design, because it is the DHO' responsibility to provide health services to the local community through community health centers. Expanding the

HIV program to include interventions for CM users will improve the performance of the DHO, particularly related to HIV prevention, care and treatment.

3. Some CM users are part of a key affected population group (e.g. MSM, PWID, transgender, FSW or clients of sex workers), therefore it is most strategic to collaborate with existing NGOs, which have been working with these populations. These longstanding NGOs may want to consider adding a new category into their client profile, which would CM users. Consequently, their staff will need to be equipped with the adequate knowledge and skills.
4. CM users from the general population (who are not key affected populations may be reached through local NGOs in the area of the intervention site. With some additional training they could include CM users to become one of their target groups.
5. Related to outreach, the following points need special consideration:
   a Strong emphasis on making new contacts (reaching new clients) and identifying new hotspots.
   b Regular and frequent outreach, with intervention messages that are tailored to the specific contexts and characteristics of CM user at a particular hotspot or area.
   c Regular engagement with local key stakeholders to ensure safety and support, as well as trust and credibility within the neighborhood community.
   ~~d~~ Ensure that the referral network is well established before conducting the first referrals in order to reduce the likelihood of discrimination by health staff.
   ~~e~~ Maintain high commitment and cultivate exemplary behavior among outreach workers in order to give a good example in front of clients.
6. In relation to achieve good governance, implementing agencies should consider to do the following activities:
   a Ensure that all staffs understand about the philosophy, mission, goal and objectives of the intervention.
   b Have a clear scope of work for each staff who is involved in the intervention.
   c Set up outreach standards in the forms of technical guidelines, SOPs, work and data flow charts.
   d Ongoing supervision and capacity development for staffs, including support system for outreach workers.
   e Make sure there is sufficient supply of prevention and IEC material.
   f Regular contact with local key stakeholders in order to obtain positive support.

7. In rolling out the intervention to a wider setting, effectiveness of the intervention should be integrated in the intervention design and should be measured in a systematic monitoring and evaluation framework. (Alliance - CAHR, 2012; Needle et al., 2005; WHO, 2004; Wiebel, 1987). Monitoring and evaluation should be conducted on a regular basis.

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ANNEXES

Annex 1: Daily field report form

Outreach Daily Report

Outreach Worker Name : _____

Day/Date : _____

Time	… to …	… to …	… to …	… to …
Location				

Description of the visited location *(describe how is the characteristic of the location)*

Characteristic of crystal -CM users in the location *[demographic characteristics i.e. sex, occupation, age); using patern; number of users; repeated or new reach]*

Method utilized to access the location, hotspot identification, and supportive key informants

Description on interested and uninterested topics; Any provided IEC material; CM users' response towards the conversation and provided IEC material

Identified issues/problems emerged from discussion and provided responses

Challenges and barriers in approaching CM users; follow up needed

Outreach Worker Activities Report

Name : _____

Day/date : _____

Outreach Activities

Time	… to …	… to …	… to …	… to …
Location				
Number of new CM users reached				
Number of repeat CM users reached				
Number of new drug users reached				
Number of repeat drug users reached				
Number of new drug users' partners reached				
Number of repeat drug user' partners reached				

Education, Information, and Communication

Type of Activity	**Total**
HIV/AIDS individual information	…….. people
HIV/AIDS group information	…….. people
Drugs/addiction individual information	…….. people
Drugs/addiction group information	…….. people
Individual discussion on Crystal-meth uses and risks	…….. people
HIV and STI services information	…….. people
Peer referral	…….. people
Number of client interested to access HIV & STI services	…….. people

Referal suggestion:

- General medical check up : ..... people; referral institution: .....
- STI check up : ..... people; referral institution: .....
- Drug treatment : ..... people; referral institution: .....
- Psychosocial counselling : ..... people; referral institution: .....
- HIV test : ..... people; referral institution: .....
- ART services : ..... people; referral institution: .....
- Others referral: ..... : ..... people; referral institution: .....

Supporting material distributed:

Material	Condoms	Lubricants	Referral sheet	IEC material
Total				

Action Plan:

Issues: Follow up:

Annex 2: Evaluation framework

Strategy	Process indicators	Output indicators	Source of information
Entering the crystal-meth community	- New contacts - New hotspots - Stages to enter crystal-meth community	- Number of hotspots - Number of crystal-meth groups - Number of clients - Number of key informants - Specific strategies for each type of hotspot	- Outreach daily report - Weekly data analysis - Minutes of meeting - Interview OW & PM - FGDs clients & stakeholders
Crystal-meth and HIV-related discussion	- Routine field visit by outreach workers - Follow up meeting by outreach workers - Outreach workers workplan is available - List of communication topics	- Number of topics discussed - Number of IEC material distributed - Communication strategy available - Type of information needed by the clients	- Outreach daily report - Weekly data analysis - Minutes of meeting - Interview OW & PM - FGDs clients & stakeholders
Risks assessment	- Stages to discuss sexual behavior of CM users - Individual risks assessment methods	- Number of condoms distributed - Number of lubricants distributed - Number of clients received condoms - Number of clients received lubricants	- Outreach daily report - Weekly data analysis - Minutes of meeting - Interview OW & PM - FGDs clients & stakeholders
Services need assessment	- List of referral services are available - Discussion on problem and services needed are existed - Documentation of health service experiences	- Number of health service referrals - Number of HIV testing referrals - Number of rehabilitation referrals - Number of community-based treatment referrals - Number of psychological referrals - List of suitable services needed	- Outreach daily report - Weekly data analysis - Minutes of meeting - Interview OW & PM - FGDs clients & stakeholders
Increase prevention awareness	- Peer referral methods - Peer referral mechanism	- Number of volunteer - Number of group activities - Program Acceptance and support	- Outreach daily report - Weekly data analysis - Minutes of meeting - Interview OW & PM - FGDs clients & stakeholders