Productivity Promises, Precarious Realities

Ethnographic Study of Harm Reduction Implementation in Indonesia

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Many other sensitive organisms of the human kind injected heroin in their vein, a substance that deactivates the relation with the speed of the surrounding atmosphere. Then illegal drugs were replaced by those legal substances which the pharmaceutical industry in a white coat made available for its victims and this was the epoch of anti-depressants, of euphoric and or mood regulators.

Fragment from *Precarious Rhapsody* by Franco ‘Bifo’ Berardi

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Abstract

This thesis examines the implementation of harm reduction programs in Indonesia that failed to improve the quality of drug users' lives. The failure is the result of programs that merely provide drug users with instrumental strategy to deal with addiction through substitution therapy. The designation of legal substances such as methadone and subuxone is only to replace illegal drug addiction. In the end, the program fails to provide drug users with sufficient information to manage their dependence and even leads them to uncontrolled poly-substance use. This three months of ethnographic fieldwork focuses on examining Harm Reduction (HR) experiences in both methadone and subuxone users. The users are still stigmatised, although they are no longer illegal drug users. It is caused by the fact that HR only promotes rationalism and pragmatism in the contemporary drug treatment. This stigma results in socioeconomic exclusion which limits the access to lead livable lives for users. It became apparent that instead of improving users' life quality, HR programs continuously reproduce the precariousness of drug users' lives.

List of Acronyms

ARV	: Antiretroviral
AusAID	: Australian Agency for International Development
BNN	: Badan Narkotika National/National Narcotics Board
FHI	: Family Health International
GF ATM	: Global Fund for AIDS, Tuberculosis and Malaria.
HCPI	: HIV Cooperation Program Indonesia
HR	: Harm Reduction
IDUs	: Intravenous Drug Users
IHRA	: International Harm Reduction Association
KPAN	: Komisi Penanggulangan AIDS/National AIDS Commission
MMT	: Methadone Maintenance Treatment
MSM	: Male Sex with Male
NGOs	: Non Governmental Organizations
PCC	: Primary Care Clinics
PKNI	: Persaudaraan Korban Napza Indonesia (Indonesian Brotherhood of Narcotics Victim)
PLWHIVA	: People Living With HIV/AIDS
PPK-UI	: Pusat Penelitian Kesehatan Universitas Indonesia/Center for Health Research Universitas Indonesia
SUM	: Scaling Up for Most-at-risk
THD	: Take Home Doze
USAID	: United States Agency for International Development

Glossary of Indonesian Term

Fresco	: a syringe brand
Kebon	: untidy orchard/yard
Kolong jembatan	: beneath a highway
Makan temen	: an expression meaning betraying a friend
Ngisi	: injecting substance
Putaw	: low quality of Heroin
Sabu-sabu	: Crystal methamphetamine
Sakaw	: withdrawal syndrome
Terumo	: a syringe brand
Wali	: a guardian

Content

Introduction

"Normal people would enjoy their coffee in the morning. For me, I would prefer having methadone. It is not normal... no." Iman, March 20, 2014

"I don't have a job, my marriage is over, I cannot see my kids and my family has given up on me. I am alone and when I try to sleep, my brain would not stop working. I would think about how can I get money to buy subuxone for tomorrow." Taufan, April 18, 2014

What my informants told me in our interviews has really touched me and made me feel their despair. They have no clear sense of what their future will look like. *Productive Promises, Precarious Realities: Ethnographic Study of Harm Reduction Implementation in Indonesia* tells the story of people who are enrolled in Harm Reduction (HR) treatment in Indonesia. It captures critical moments in their everyday lives—struggles born from socio-economic vulnerability and efforts to manage their addiction through drug-substitution therapy. My study reveals that intellectual and institutional challenges of HR treatment can put drug users' lives at stake.

The argument I present here is simple. HR is a globally accepted system of knowledge and practice as a means of dealing with addiction problematic sets of values to become normatively human. For example, when my informants engage in Harm Reduction programs they are expected to refrain from meeting up with their friends to avoid relapse. I argue that in doing so, the programs create mandatory loneliness for users, sowing distrust in friendships, and create tension when they try to sustain their jobs. In this respect, the designation of HR programs to help drug users to continue their lives even puts them in a 'new' precariousness and continuously endangers them.

My thesis begins with a historical analysis of HR programs in Indonesia. It then presents existing funding agencies' efforts to impede transmission of HIV/AIDS from intravenous drug users (IDUs). It also underlines the mechanism of substitution therapy—both from methadone maintenance treatment (MMT) and buprenorphine (subuxone) therapies. It is useful to see the differences between methadone and subuxone therapy and how the two affect users' lives. There is a discrepancy between rhetoric and practice of HR implementation. Substitution therapy in Indonesia stands only on the use of legal substance, neglecting users' aspirations to improve

relationships, engaging in meaningful activities, acquiring material possession and achieving better mental and physical health. Therefore, I argue, the implementation of substitution therapy failed to focus on the actions to improve users' quality of life.

In chapter two, I develop a theoretical framework for the thesis, which draws upon and expands the concepts of *precariousness*. Here, I outline the logic of HR program. This opens up the intricate discourse beyond pragmatic solutions. I introduce the idea of HR to transform drug addicts into more productive persons that in fact makes users' lives stay unlivable (Butler 2004). For me, HR is a practice of normalization where people can be *otherized* to maintain certain exclusions. I argue that HR programs reproduce the stigmatization of addicts, leaving them without capacity to access a better life.

Chapter three offers an overview of the research design and the methods employed in this research. There are descriptions of challenges from the study and explanation of the data analysis process. From chapter four onwards, the data and findings are analyzed and presented. Both chapters four and five focus on the participation of the methadone and subuxone users in community groups. I emphasize the role of community groups and *what* its meaning can be for individual users. Chapter four illustrates the story of methadone patients in Fatmawati National Hospital and Tebet Primary Care Clinics (PCC). The story of methadone users represents how *'life stops moving'*—in contrast with the ideals of HR to transform addicts into more productive citizens.

In chapter five, the story of subuxone users describes the mechanism of substitution therapy in private clinic settings. In this chapter, the narration of buprenorphine therapy patients (subuxone users) who have to face everyday problems such as economic vulnerability and the availability of their subuxone tablets is featured. I found that there are many contradicting factors within suboxone therapy which create dilemmas in the users' lives. With limited access to job security comes limited economic resource for their pills—and inevitably committing crime becomes the only way to survive. Instead of 'healing' addiction, HR through substitution therapies makes people become subject to substances. Inevitably social relation stands on fragile friendships and possession of substances. Lastly, chapter six contains the conclusion of the whole discussion, and some reflection on themes that arise in this research.

Chapter 1

Harm Reduction Programs in Indonesia

1.1 Historical Background

Since the first case of HIV/AIDS was identified in Bali in 1987, Indonesia has started one of Asia's largest HIV/AIDS prevention programs (Spiritia 2008). Since that time, HIV prevalence has increased significantly—especially among Intravenous Drug Users (IDUs), the second largest high-risk group (Directorate General of Communicable Disease and Environmental Health, Ministry of Health 2013).[1] According to statistical data from the Indonesian Ministry of Health, the estimation of the number of people living with HIV/AIDS (PLWHIVA) in 2013 is 842.800, rising up from 293.200 in 2008 (*Ibid*.) Mathematic models for HIV/AIDS epidemic estimation have predicted the increasing new transmission from 2011-2016.

The numbers of drug user increased significantly after the fall of Suharto regime in 1997 (Morrison *et al*. 2012:95). Since 1990s the low-grade quality heroin, or *putau*, took hold in Indonesia as the largest substance use (Davis *et al.* 2009). However BNN and PPK-UI's data suggest that *putau* use has been declining in the past decade. It has been overtaken by cannabis, amphetamines, and psychoactive prescription drugs (BNN and PPK-UI 2011:61). However, the survey says injection use is still the largest administration route for these substances—except for cannabis (*Ibid*). It means, the distribution of *putau* in Indonesia has been declining but drug use by injection has been increasing. This survey also found in 2011 at least 2,2% of the total population of Indonesia, or about 4 million people, have previously used drugs (BNN and PPK-UI 2011:45).

It was a national headline news that the capital city of Jakarta had the highest prevalence of HIV/AIDS cases from 2009-2013 (Tempo 2013).[2] The significant impacts of this statistical data led to the introduction of methadone treatment to prevent the loss of productive members of society (Sarasvita 2009:7). There is a belief that problems of addiction in Jakarta will bring negative impacts on the city's master plan. Thus, in 2003 as a response to HIV and IDUs, the methadone maintenance treatment for replacing

[1] Prior to this, in 2008, the highest number of PLWHIVA came from IDUs—a high-risk group. However, several pieces of literature suggest that sexual contact is the primary means of transmission—especially from high-risk groups such as men who have sex with men (MSM) (*Ibid*.)

[2] http://www.tempo.co/read/news/2013/10/23/083523838/Ini-Pertumbuhan-Kasus-HIVAIDS-di-Jakarta accessed on Wednesday, May 14, 2014.

opioid dependences jointly introduced policies in Jakarta and Bali (Sarasvita *et al.* 2012). A year after, in the new era of President Susilo Bambang Yudhoyono, government agencies embarked on identifying international funding for Indonesia.

In 2006, a decree from Ministry of Health No. 567/MENKES/SK/VIII/2006 became a guide for HR implementation. However, according to BNN and PPK-UI's survey in 2011, Jakarta still ranks as the area with the highest population of people using drugs, with men being 3,6% higher than women (BNN and PPK-UI 2011:47). If HR *is* the only possible approach to defeat addiction then *why* do the numbers of IDUs and HIV transmission steadily increase even after a decade of successfully applied HR in Indonesia? This study intends to identify the gap between the implementation program and the users' lives, who struggle with their dependence on substances to become 'normal' members of society.

1.2 Opioid Substitution Treatment (OST) in Indonesia

HR programs in Indonesia rely largely on the amount of money from international funding agencies to combat HIV transmissions. Therefore, the main focus of HR program is distribution of clean needles for IDUs. In 2010, Indonesia planned that at least 30% of the country's injecting drug users would have access to opiate substitution, and 70% would have access to sterile needle distribution (Morrison *et al.* 2012:96). This goal was a part of the Memorandum of Understanding between BNN and Komisi Penanggulangan AIDS Nasional/KPAN (National AIDS Commission)—witnessed by President Megawati in 2003 (*Ibid*). However, the focus of HR in eliminating HIV transmission among IDUs by distributing clean needles, in fact, is problematic since the Indonesian government emphasize more on the normalization of addiction through methadone treatment.

In Indonesia, substitution therapy is delivered in two ways, methadone[3] and buprenorphine treatment. The government agreed to fully support methadone therapy programs by giving subsidies, and started to establish Primary Care Clinics (PCC) for methadone treatment in 2006 (Sarasvita *et al.* 2012:239). Thus, substances users can access this methadone only for Rp5.000—or less than half Euro for one time consumption—or even for free for those who have Jakarta Citizen Health Insurance

[3] Methadone is a synthetic agent that works by 'occupying' the brain receptor sites affected by heroin or other opiates (Chhabra and Bull 2008).

(*Kartu Jakarta Sehat*). The program has been implemented in hospital clinics, PCC and prison clinics.

Some of my informants who had already enrolled in MMT since 2004 stated that formerly Indonesia had imported methadone from Australia. But just like antiretroviral (ARV) drugs, imported methadone would cost large amounts of money for IDUs (Green and Nagar 2013)[4]. Thus, the regulation changed and Indonesia started to produce methadone through the national drug company, Kimia Farma. However, this affected the quality of methadone the users have access to. According to them, the Indonesian methadone is not as good as the imported one. As they described to me, 'Australian' methadone's efficacy is up to 22 hours, while the locally produced methadone works for only 9-16 hours. Methadone patients said that they were more satisfied with the formerly imported methadone than the local one.

In 2007, Dr. AA stated that buprenorphine therapy was introduced for the first time in Indonesia. In the beginning, buprenorphine therapy used both subutex and subuxone. Both of these substances were imported by private company called Schering Plough Indonesia (SCPI). However, in 2010 the new national narcotics law was in force. In National Policy No. 22, year 1997; buprenorphine was categorized as a psychotropic drug, but in the new regulation, National Policy No. 35 year 2009, it is considered as a narcotic (*Pikiran Rakyat* 2010)[5]. After that, only Kimia Farma had permits to import subutex and subuxone (*Ibid*). At the same time, the government of Indonesia decided only to use subuxone as a prescription drug in the buprenorphine therapy in order to decrease subutex-injecting uses.

While subutex only contains buprenorphine, suboxone contains a combination of buprenorphine and naloxone.[6] Injecting naloxone within the combination drug can precipitate withdrawal symptoms, thus originally, subuxone was choose as a strategy to reducing the potential to be injected. However, this transition affected the availability of buprenorphine therapy. Some users admitted that 2010 was noted as the hardest period for them to get subuxone. Even though subuxone was invented in an effort to dissuade patients from injecting tablets, they still prefer to inject the tablet because the prices are beyond reach for most of them. Also, according to subuxone users, they need a twofold dosage of subuxone if they use the drug orally.

[4] http://spiritia.or.id/art/pdf/a2018.pdf Accessed July 15, 2014, at 1:09 am.
[5] http://www.pikiran-rakyat.com/node/118154 Accessed July 14, 2014, at 9:45am
[6] Naloxone is an antagonist opioid—it is commonly used in the emergency setting for its dramatic ability to reverse the effect of a narcotics overdose (Handal *et al.* 1983).

Since the government of Indonesia does not cover buprenorphine therapy, the patients can only access the pill through private clinics. Consequently, they face varying prices between clinics and depending on the amount of dosage the users need. In Dr. AA's clinic, 2 milligrams of subuxone cost Rp35.000 or almost 3 Euros, and 8 milligrams of subuxone cost Rp104.000 or equal to 7 Euros (figure 1). Two weeks after I left my fieldwork sites, I received an email from one of my informants telling that Dr. AA's clinic had run out of subuxone. Because of that, they could not get their tablets there for weeks. Furthermore, they are suspicious about the motive to increase the price of subuxone that may have come along with this scarcity. It shows that the high price of subuxone muddled the problems between the availability of the substances and users' economic vulnerability.

Figure 1

Package of subuxone from Dr. AA's clinic

Patients in Dr. AA's clinic only come to buy subuxone, and there is no consultation required. One of my informants described how, in his opinion, the mechanism in subuxone clinics was just like that of a 'legal' dealer. In the clinic the patients rarely get a consultation to manage their tablets or reduce their dosage. The relationship between the health care practitioners and the patients in the Dr. AA's clinic—I might say—only stands on the money. My informants said that their dosages of subuxone were subject to change not because of the treatment guidelines but depending on how much money they had to buy the subuxone.

HR programs in Indonesia have been involving many actors that support the implementation. However, I argue, the provision of clean needles to prevent HIV transmission among IDUs is still marginalized as HR in Indonesia concentrates on providing cheap and legal substances to normalize addiction with methadone. Despite a huge price disparity between subuxone and methadone, some users still prefer subuxone to replace their addiction of *putau*.

1.3 The Actors in the Substitutions Therapy

"I don't know where this HR programs will end." This is Khoir's statement when responding to the HR condition in Indonesia, which is also the biggest question during my own research. I know that it may seem that many things are already pursued to seek the best way for addiction problems in Indonesia. Still, in my perception, the users live in a very unpleasant situation, and receive unfair treatment compared to others. The fact is that IDUs correlate with HIV transmission and that so much money has been spent to fight against addiction. So many people have been dedicated their lives to take part in the struggles to against addiction and HIV epidemics scenarios. However, the increasing numbers of both IDUs and HIV transmission remain stable even after a decade since HR has been implemented. Through anthropological frameworks, I am eager to hear the patients' opinions and experiences of HR, and how it influences their lives. It stands on a position to discover users' lives from their own point of view. Only through this that I will be able to grasp an ethnographic understanding that is valuable and often missing in the stories of drug users in Indonesia.

1.3.I From International Funding Agencies to National Commission of AIDS

The fact that 52,4% of injecting drug users in Indonesia represent the highest HIV prevalence level inspired a National HIV and AIDS Strategy and Action Plan 2010-2014 (National AIDS Commission Secretary 2009). During 2007-2009, despite a small amount of domestic funding, the programs in place to impede lethal HIV/AIDS diseases exclusively came from bilateral assistance—mostly USAID and AusAID, Global Fund (GF) and other development partners (National AIDS Commission Secretary 2009:21). As Andriansyah (2010) has clarified, prior to 2010 HIV prevention programs in Indonesia were mainly funded by Family Health International (FHI) which terminated the fund in December 2009 after indication of corruption at the national level. I was part of BNN and PPK-UI's researchers among drug users in Medan, North Sumatra, where

some of my local partners were worried they might lose their job because the NGO could no longer pay their salary due to lack of funding. But I remember that some of the outreach workers in Medan told me that the most significant impact of the termination of the fund would be the users' lives. The distribution of clean needles/syringes would be impossible because local NGOs would find it hard to buy them. Had there still been needles at that moment, nobody couldn't have distributed them because the NGOs couldn't pay the salary for the distributors.

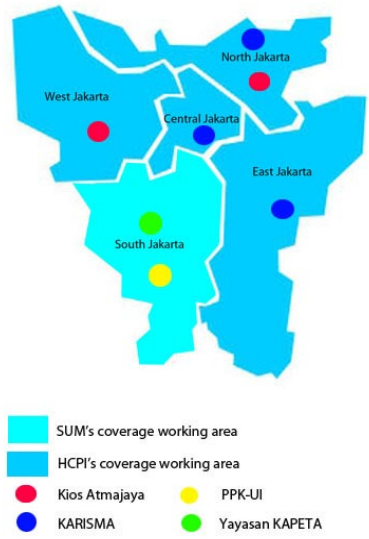
Along with FHI's transition period, a new international funding for Indonesia came from Global Fund for AIDS, Tuberculosis and Malaria/GF ATM. This brought lots of changes—instead of supporting FHI, the GF ATM decided to focus more on the strengthening of government capacity (National AIDS Commission Secretary 2009:41, Andriansyah 2010:7). Therefore, the aid went directly to the government, not to local NGOs. Moreover, since a new financial mechanism came into being, the reporting and evaluating systems are centralized from local NGOs to KPAN (National AIDS Commission Secretary 2009:38). However, the new partnership mechanism made an impact in the national level—local NGOs had mistrusted the government due to the unprofessional commitment of KPAN's staff and also had been suspicion about corruption in the institution. Conversely, KPAN believe that NGOs only criticize government's works without fully understanding what government (KPAN) has done. The changes within the financial mechanisms from funding agencies to KPAN have also brought positive impacts for the reporting system of HR program in Indonesia. For instance, the 'one door' mechanism can be utilized to avoid overlapping implementation programs from other NGOs. Besides, in a practical sense, the availability of clean needles is much safer since both KPAN and local NGOs have the right to purchase the needles. KPAN's stock needles are used in emergency situations as a 'bumper' if the money from funding agency to buy syringes has not come yet to local NGOs.

In carrying out the National Action Plan 2010-2014, the total funding needed to cover the program to impede HIV transmission is equivalent with US$ 1.1 billion (National AIDS Commission Secretary 2009:44). Furthermore, the budget is targeting IDUs as the priority population target. The most recent partnership for HIV/AIDS intervention programs in Indonesia came from HIV Cooperation Program Indonesia (HCPI). HCPI is a support project funded by the Department of Foreign Affairs and

Trade of Australia together with the Government of Indonesia.[7] Started in the 2008, the first goal of HCPI was to support the goal of the Indonesian National HIV and AIDS Strategy and Action Plan for 2007-2010. HCPI fund was extended after the first five-year-program and will end in 2015. The mechanism is similar to GF ATM's works, which focuses on the strengthening of government capacity. Besides HCPI, another funding agency that is supporting HR programs is Scaling Up for Most-at-risk Population (SUM).

The SUM Program is a joint undertaking of two USAID-funded projects: The SUM I Project was implemented by FHI and, when it was over in 2013, the SUM II Project was implemented by the Training Resource Group (TRG), RTI International, Burnet Institute and AIDS Project Management.[8] SUM Projects focuses on short-term financial support, in which the implementation will be more effective because it is straightforward to monitor and evaluate. This funding agency also follows the National HIV and AIDS Strategy and Action Plan 2010-2014 as a guideline to its programs. In Jakarta the main funding source for HR programs is coming from HCPI and SUM II. Although, in this province SUM only focuses in South Jakarta area whereas the other areas become HCPI's working area (figure 2).

Figure 2



Distribution of Local NGOs focusing on HR in Jakarta

[7] https://www.burnet.edu.au/projects/101_hiv_cooperation_program_indonesia_hcpi Accessed July 15th 2014 at 8:35 pm.
[8] http://www.sum.or.id/ Accessed July 15, 2014 at 8:49 pm.

In addition, some NGOs like KARISMA use REMPAH—different local NGOs—as their implementing unit to assist IDUs in North Jakarta. This kind of partnership is common among NGOs in Indonesia. For example, KARISMA may apply for funding support, but sometimes there are certain requirements that have to be met in order to get the aid. For example, since funding agencies work on targeted working areas, the NGOs that want to apply to the programs have to customize partnerships with other NGOs if their working area is not part of the targeted area. In addition, there are other NGOs that work on IDU related issues out of HR programs. Most of them focus on the advocacy for IDUs lives, such as Persaudaraan Korban Napza Indonesia/PKNI (Indonesian Brotherhood of Narcotics Victims), Gerbang, Layak, and Jangkar NGOs.

Strengthening capacity at the government level and improving organizational performances become the main agenda for almost all partnership mechanisms in Indonesia. However, the work of local NGOs as implementing units is highly problematic. Based on my observation in PPK-UI, as one of the local NGOs that are funded by HCPI, the HR programs in Indonesia mainly depend on the local NGOs.

1.3.II The Role of Local NGOs in HR Program: Case Study PPK-UI

Not only the case in Jakarta, most Indonesian people prefer to avoid contact with the government. Erina, one of the outreach workers from PPK-UI, when explaining the most significant factor why KPAN cannot work alone to implement HR programs in Indonesia, says, “For them, government is KPAN and the Police is BNN, basically they are the same… They only give them problems!”. In fact, ”the problems” also get in the way when people try to access health care services (Haliman and Williams 1983). Health-seeking behavior and values are hampered by traditional power structures, rigid bureaucratic restrictions and imbalances of power and authority by (government) health care professionals (Haliman and Williams 1983:1449). Therefore, I found that the role of local NGOs is often to become a bridging partner between the government and the clients.

Starting as a research center in Universitas Indonesia, PPK-UI expanded itself to become one of local NGOs that focus on out-reaching PLWHIV and drug users. In 2014, PPK-UI, which in the beginning concentrated in Southern Jakarta, started to provide HR services for IDUs in Depok, Western Java. Everyday at least 8 outreach workers are operating in different parts of Southern Jakarta. Besides distributing clean needles/syringes, outreach workers are also responsible for advocating users through

monthly IDU meetings. One of outreach workers in PPK-UI even focused on facilitating IDUs who need to access ARV or other health care services, either in hospital clinics or in PCC.

According to Khoir, HR programs in Indonesia provide a facile solution, the only remnant of the medical system for drug users. “We can say that HR provides a practical solution for addiction problems, but, as you know, many things that come in an instant never last forever,” explained Khoir to me about his pessimism on HR programmes. For many local NGOs as HR implementing units, Indonesia does not only need a pragmatic strategy to cope with problems of addiction. As the one and only party who constantly meet and communicate with IDUs, outreach workers witness that many IDUs are back to using illegal drugs only because they do not know *how* to continue their lives after treatment is finished. HR does not provide the users with information on the choices to live abstinent.

I was following some of the PPK-UI outreach workers; the experience told me that as outreach workers they are actually in a difficult position. They know that what they have done for users is not enough, and in their perspective maybe not suitable for the users’ need, but it is the only thing they can do. “Sometimes I feel my job is *bullshit*, no result. I do not make any progress for my client,” more explanation from Veny.

The dilemma that has been faced by outreach workers in PPK-UI is made even more complicated when they need to distribute low-quality clean needles. One key responsibility in HR programs is distributing clean and sterile needles/syringes. Even though local NGOs in Jakarta have their own autonomy to purchase the needles that they want to distribute, they also have to deliver clean needles from Ministry of Health that are dropped off by PCC. The problem is that IDUs do not like the syringe from PCC. PPK-UI always buy syringes with the brand name *Terumo* according to what the IDUs ask for, but PCC buy syringes with the brand name *Fresco* (figure 3). All IDUs in Jakarta get used to using *Terumo,* and they also mention that the syringes are a better quality than the other brand. Sometimes they find that *Fresco’s* needle is not as sharp as the other brand, so they feel pain when they use the needle; worse, they even find that the piston of the syringe is easily broken. One time I found a guy complaining to Veny, “No I don't like *Fresco*, I would prefer to use second-hand *Terumo* than use *Fresco*,” said Ronald one time when Veny was distributing *Fresco*.

Figure 3

Two diferent syringes that are available in PPK-UI

As outreach workers, people in PPK-UI face everyday problems with IDUs. As Veny mentions earlier, she still finds it very hard to accept the fact that HR is only bringing a minimum yet limited impact for IDUs lives. She is quite critical when talking about substitution therapy in Jakarta. In her point of view, the implementations of HR programs in Indonesia are still not being well evaluated. She said that in the subuxone community many users are still injecting the tablets, which according to Indonesian law is fundamentally wrong. However, although the users may use subuxone 'abusively', Veny feels that she cannot blame them because there are never any serious actions to advocating these problems.

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The historical and contextual background of the HR scenario in Indonesia, and in the specific local context of Jakarta, explains that each actor who is involved in the program actually faces institutional insecurity in different settings. In the HR programs, the aim of the program seems problematic both for the implementer (NGOs) and the target group (users). First, as a pragmatic solution to deal with addiction, HR truly fails to promote a comprehensive approach. The government provides inadequate support to improve drug users' lives because their main interest is to normalize addiction. Second, the dependency on the availability of financial support from donors and corrupt government practices has been threatening the sustainability of the programs. The

outreach workers are overwhelmingly devoted but (also) precarious because they are underpaid and the job they have relies on the temporary donation from funding agency. It creates vulnerable lives where people are not only physically dependent on one another, but also physically vulnerable to one another (Butler 2004:27). In the one hand, the implementer is dependent on funding agencies, and on the other hand users are dependent on the implementer. Thus, each of them is physically vulnerable to one another.

Chapter 2
Theoretical Frameworks

2.1 'Harm' Reduction and the Precariousness

To understand and analyse the HR program and its effect to human life, this research begins with an elaboration of HR implementation and its goals. This is followed by a critical analysis on socio-cultural and political factors of HR and the frameworks of precariousness to see HR patients' life. In the last part of this theoretical framework, I present a contextual discussion of precarious conditions for HR patients in Indonesia.

HR was born as a response to the feeling of insecurity towards the number of increasing addiction cases, and more importantly, as a response to addiction, being thought to be affecting the number of productive workers in a country. The International Harm Reduction Association (IHRA) states that "HR programs are used to reduce the adverse health, social, and economic consequences of the use of legal and illegal psychoactive drugs *without necessarily reducing drug consumption,"* (2010, emphasis by the author). Due to a decreasing faith in the government's ability to eliminate drug use, HR was considered a more practical solution (Hathaway 2001; Hawks 1993). According to this perspective, a drug-free life is not possible and therefore there is no life free from harm for drug users. Furthermore, HR approaches rely upon the utilitarian calculations of balancing costs and benefits to the government (Pauly 2007; Hathaway, 2001). Thus, HR implementation, for me, is some kind of an instrumental strategy to deal with addiction by switching from illegal to legal substances.

As a mere instrumental strategy, HR implementation can be drawn to the concept of a precarious life from Butler (2004). Precarious life derives from the *indefinite detention* as repercussion from the strained relation between unlivable and livable lives. Drug users' unlivable lives are caused by negative judgements of drug users, shame and stigmatization of drug users as weak people, and criminalization of drug addicts. According to Butler (2004:130) "…what binds us morally has to do with how we are addressed by others in ways that we cannot avert or avoid…" In this sense, stigma, stereotype, and judgement for substance users have been attributed as their identity—given by the others. Thus, the representation of the 'self' for drug users worsens because the users themselves cannot avoid the others' judgement towards their 'negative' habits to use substances. Drug users are being alienated not only because

they live under the influence of substances, but—even more—because their status is also considered as inappropriate within the social norms where they live. Besides, since the problem of addiction is perceived as an individual problem, the social stigmatization of addicts is "legitimized" as a consequence of their own decision. This makes it difficult for drug users to seek help, leading to justification for drug users to keep on living with their addiction. Thus, drug users live a precarious life in a continuously marginal condition, but the pain they have is considered as their own problem and even *ungrievable.*

Moreover Butler stated "…the assumption that those who gain representation have a better chance of being humanized and those who have no chance to represent themselves run a greater risk of being treated as less than human…" (2004:141). On that account, HR really is an endeavour to gain representation. Towards HR, there is possibility for drug users to transform themselves from living unlivable lives to being rehabilitants with livable lives. Representing a part of the community of HR patients, substance users attempt to be treated as complete human beings. Through HR they can obtain a more productive life, which is understood as an appropriate social standard. Hence, HR revalues their capacity to be involved with the society, and facilitates the chance to become 'normal' members of society.

O'Hare and colleagues (1992) argue that HR programs are a philosophical way to promote rationality, pragmatism and utilitarianism through the development of drug interventions. The aim of HR to eliminate addiction in Indonesia is only based on the provision of legal substance to replace illegal dependences. In that sense, it is not necessary to eradicate dependences on substances. Nevertheless, the maxim of HR programs paradoxically represents a looming image of life for drug users. The vision to become 'normal' members of society in terms of socio-economic progress even creates continuous precarious conditions when rehabilitants remain addicted to those legal substances. Thus HR is naturally open to critique from various points of view. Also, though the program has been medically authorized, it is vulnerable from politicization of the epidemiological drug use aspect.

From the healthcare perspective, the fact that HR treatment simultaneously tries to provide medical solutions and social rehabilitation for drug dependents is deeply problematic. The reason for this is because the concept of 'harm' within HR interventions is itself dilemmatic, since "the nature of harm... [is]… open to interpretation and judgments of harm… contain moral assessment[s]… (Keane,

2002:228, see also Pauly, 2007)." Consequently, several critiques on the fundamental purpose of HR programs have been based on the idea that "harm"—when used as a universal concept—does not take into account the social or cultural factors surrounding drug users as individuals. As an example, many drug users live in difficult conditions and experience homelessness or marginal housing, economical instability or lack of social safety nets (see also McNeil *et al.* 2012). Therefore, according to Pauly (2007), HR is a partial rather than a comprehensive approach in terms of reducing the harm caused by various and multiple inequities.

Drug dependents may encounter common social stigmatization, in which they are viewed as criminals, weak people, or deviants. Gowan and colleagues (2012:1254) argue that in that particular social context, the 'enemy' for the drug user community in HR treatments is not the drug itself, but the shame, stigma, and the sense of powerlessness. Hence, drug users are on the unlivable side of the livable-unlivable dichotomy as described by Butler (Butler 2004). This dichotomy produces and maintains certain exclusionary conceptions of who is normatively human (Butler, 2004:xv). In that sense, the discourse of HR treatment does not regard drug users as normatively human, but instead its logic builds upon the differentiation of people, which reproduces labels and stigma for addicts. Therefore, labelling and stigmatisation are part of HR programs themselves and perpetuate the perception of drug users living unlivable lives. Under these circumstances—the problematic concepts of harm, multiple inequities, and stigma—it is difficult for drug users to transform their unlivable lives to livable ones and become 'normal' people.

A recent article from Zigon (2013:728) illustrates that there are implications of HR programs in Russia which are not only important for the individual users, but much more relevant to the stability, security and the prosperity of the Russian state and economy. In addition, he argues, in terms of making progress on the health of individuals, HR programs would rather result in both reproduction and strengthening state-governing practices. As Zigon asserts, the distribution of methadone and buprenorphine as synthetic opioids in HR treatment is not intended to eradicate addicts' drug use, but rather to decriminalize drug users and to transform users into more productive citizens. Furthermore, he mentions that HR programs, instead of being used as a weapon in the battle against HIV transmission, are "fought on the battlefronts of lifestyles, values, and morals (Zigon 2011:25)."

Lastly, HR in Indonesia focuses less on delivery of a comprehensive method to impede HIV transmission. It is reflected on the decision of the Ministry of Health to use the money from funding agencies to buy low quality needles that IDUs basically are uninterested in using. KPAN and local NGOs decided to distribute different types of needle from the one stipulated in the MoH as a response to it. But the practices of using needles remain highly stigmatised. Substitution therapy in HR programs becomes the means to normalise addiction. Because drug users prefer administering drugs through needles, this puts drug users in a dilemma while doing HR treatment. Besides, with HR being a contemporary medical treatment for addiction, even though it is delivered as a free service, socio-economic factors still hamper users in accessing services. Since there is no such thing as 'free' services (Foster 2010), drug users find it difficult to get financial support to pay for their transportation costs to the hospitals and clinics. All services are run during office hours and mostly during the day when most of the users are still working—while those who work at night spend the day resting. To be absent from their job—or to lose the possibility to get some rest—in order to access the treatment will only cause another 'harm'. It can be easily found that many drug users quit their job to retain the therapy. In that sense, HR's goal to increase users' productivity has failed, because it prevents drug users to achieve their better quality of life. Thus, I claim, HR is not a transformation process from unlivable to livable lives, but a continuous reproduction of precariousness for drug users in Indonesia.

Chapter 3

Research Design and Methodology

3.1 Research Question and Aim

The theoretical framework that I have presented in the previous chapter is needed to shape the main research question of this thesis: *How do people manage to balance the need for substance use with the necessity and desire to have 'normatively human life'?*
The sub-questions are as follows:

a. How is substance use tied to their transitioning from 'unlivable' to 'livable' lives?
b. How do substance users see themselves?
c. How do others see users?

The main aim of this study is to gain an ethnographic understanding of HR as a therapeutic program based on patients' own experiences and feelings towards moral values of productivity. These results may be appurtenant to the re-enhancement of patients' needs and interests within the program of addiction treatment. The empirical data of this study contributes to the discussion on medical anthropology and sociology about the concept of precariousness in the contemporary drug intervention.

3.2 Methodology

Gaining Access and Selection Criteria

After a decade of HR programs implementation in Indonesia, there is still a lack of critical analysis to scrutinize this health development program. It is somewhat difficult to look thoroughly at the implementation of the program when the majority of stakeholders and implementers praise the presence of this 'win-win' solution. PPK-UI arranged an access involving two outreach men and two outreach women. Each person represents a different area and responsibility. Basically, these four people were my gatekeepers and I followed them when they went to the field to meet and deliver services to their clients.

I started to select my informants based on simple criteria. First, I asked my colleagues to introduce me to their clients who have jobs. In the beginning, my definition of 'job' was both formal and informal employment. The research focused on young-adult patients, both male and female. However, after these criteria were applied I

found it difficult to find the appropriate informants that I needed. Until the end of February 2014, I had only succeeded in having two interviews. Hence, I decided to expand my criteria by starting to interview all people in substitution therapies regardless they had a job or not. In the end, this strategy led me to an insight into what exactly a HR patient's life looked like.

Interviews and Participant Observation

In order to record informants' experiences towards HR programs, I relied on both interviews and participant observation among subuxone and methadone users. I began with structured interviews. I developed a list of questions and at the end of the list I put a table as a substance list. The table represented the kind of substances that my informants usually use—from when they wake up in the morning until they go to sleep, the efficacies, and the cost. I found two benefits from this method—on the one hand; the structured interview is useful for me to get the basic information related to substitution therapies and the personal background of my informants. In this stage of research, both my informants and I mutually glean in this new relationship.

Making an effort to gain trust from the informants is common for anthropologists, but trying to trust your informants, especially when dealing with substance users is still the most difficult part for me. I discovered that one of the ways to make sure my data was correct was through discussion with my gatekeepers who work as outreach workers. Confirmation and clarification indeed are highly important and it could only have been possible when I spent time 'hanging out' with them. Therefore, the unstructured interviews from daily conversation became a significant approach in this research.

What cannot be missed is that my data not only comes from the qualitative interviews that I performed during my fieldwork. The whole narration only makes sense through reflective interpretation—gained from 'being there' as ethnographer. Through the intensive relationship that has been built between my informants and I as researcher, we have the chance to break down the personal border that cannot be done only through qualitative interview. In the end, the full image of substance users' lives was pictured through thoughtful story telling and even jokes that we made to each other.

Visual Media

Only with participant observation did my informants and I start to trust each other, and so it goes with the presence of the research equipment I brought to my research sites. I have my notebook, recordings and my camera, and all of those things put me in a certain position in terms of the relationship with my informants. Fortunately, although not on all occasions, my camera gave me the opportunity to open a discussion, which could have otherwise been missing from my research.

One day I was showing my photo-shoots to one of them, and then he realized that his face was pale and looked intoxicated in all of the pictures. After that he was talking reflexively, that he would not be able to have job interviews with that face. From then I discovered that visual media could help me examine subuxone users' opinion about themselves. Through the lens of my camera I could present another interesting rationality—with the moral sentiments that go beyond it. In that sense, the pictures did not only record the moments that happened during my fieldwork, but also helped me to discover how users see themselves through their own images.

3.3 Data Analysis

Coding

The data that has been collected from interview and participant observations was coded, categorized and analysed to develop relevant findings within the informants' experiences. Codes have been structured based on the main research question. Along with the research period and findings that were successfully retrieved, sub-coding was created, focusing on the feelings of insecurity and the conception of vulnerability to capture where the precarious situation are drawn from.

3.4 Ethical Consideration

Ethical Review

All the participants have been treated in accordance with the American Anthropological Association (AAA) Code of Ethics guidelines 2012.[9] Also, the study was granted

[9] American Anthropological Association. 2012. Statement on Ethics: Principles of Professional Responsibilities. Arlington, VA: American Anthropological Association. http://www.aaanet.org/profdev/ethics/upload/Statement-on-Ethics-Principles-of-Professional-Responsibility.pdf

ethical clearance by the institutional board of the University of Amsterdam. In respect to academic consideration in Indonesia, the research proposal of this study has been discussed and examined to gain support from PPK-UI as the local NGOs where this study took place.

Capturing video and images when informants were injecting subuxone meant that I put myself as a witness of crime and might incriminate them as users. Therefore, every pictures and videos created were fully informed, and only for the purpose of this study—although not all of them were willing to have their picture taken and I appreciated their preferences. Those who were documented in the videos and photos are granted security by not fully shown.

Informed Consent and Confidentiality

Due to the awareness that the issue of drug use is sensitive and legally problematic, informed consent is vital. All informants were informed about the consequences that might come from participations in this research. On the substance listing form, the information necessary for informants to understand what the research entailed was also included. It stated that their participation was on a voluntary basis and that everything informants expressed during the interview regarding their opinion, perception dosage, and administration route would be treated as confidential and this was signed as their agreement. All informants—methadone and subuxone users, outreach men, doctors, nurses and NGOs staff—mentioned on this thesis are using pseudonyms to protect their identity.

Chapter 4

Methadone Users: When Life Stops Moving

4.1 Background: Instrumental Programs and Artificial Relationship

This chapter focuses on the discussion about methadone therapy in Fatmawati National Hospital and Tebet Primary Care Clinic (PCC). It entitles narrations about methadone maintenance treatment (MMT) that become the primary means of HR in Indonesia. MMT in terms of helping drug users to improve their quality of life has failed to enhance productivity among methadone users. Instead of envisioning progress in drug users' lives by enrolling in the MMT program, their life stops moving. Drug users may not be addicted to *putau* anymore, but they are now addicted to methadone as the result of instrumental program for addiction.

This ethnographic data departs from the existences of community group among methadone users. This angle—the meaning of community group—is also used in another chapter about subuxone users. It is important to stress that the word community that I use is not a set concept which is based on people's feelings of belonging (Cohen 1985:6-7). Instead, for me, this 'community' is only a term that has been introduced from the NGOs to this group of people in order to ease the HR implementation.

According to the decree from Ministry of Health Republic of Indonesia No. 567/MENKES/SK/VIII/2006, the program might touch upon the social problems on *putau* addiction, but the treatment which has been introduced never mentioned explicitly the role of community groups in the program. The program was designed to be very personal and depend on the individual's decisions. In fact, during the implementation of HR in Indonesia, the term 'community' has overwhelmingly been used as positive connotations for development program implementation—even as a sort of taken-for-granted requirement that has to be fulfilled.

At the policy level, donor agencies and NGOs in recent decades have increasingly been employing the concept of community to link 'sustainable development' or 'community based' and 'participatory' approaches to stress 'harmony', 'equality' and 'tradition' (Li 1996:502). In this sense, the word 'community' for HR is the finest form to distribute and applying the program. It truly accommodated the local NGOs jobs' to be more practical. Through community, the syringes would be easy to be dropped and calculated, and the numbers of the group to be invited to HR workshops

and seminars are easily represented. Besides, measurement of the statistical number of people related to IDUs would be easily recorded—e.g. the number of HIV, new users and so on. In addition, the amount of needles needed per month is counted based on the number of IDUs in one Kelompok Dampingan Sebaya (KDS), or peer-support group. In other words, the term community—even though it provides the common space to use drugs and share information—works well for the HR implementer's side rather than the users'. That is why, among drug users, I argue that community even contributes to and jeopardizes the precariousness of their life.

The division between chapter four and five is not only based on the type of substance that is used in the therapy. Moreover, I would like to present the comparison between substitution therapies that are fully supported by the government of Indonesia and the one which is provided by private agency. My findings show that each of the people experiencing precarious life in different settings. When methadone treatment only provides drug users with instrumental strategy, subuxone users experience artificial relationship as the consequences of the high-priced subuxone tablets. In both chapters, I want to show that the value of HR to make drug users more productive has failed and in the end it shows that drug users' life within HR is not progressively moving.

In the following sub-chapters I present each part as the narratives of the fractured HR schemes. I begin with the explanation of methadone maintenance treatment, in which I argue is the main priority of HR program in Indonesia. As the consequences, in fact it maintains stigma on clean needles.

4.2 Methadone Maintenance Treatments (MMT) in Indonesia

This sub-chapter shows the mechanism of Methadone Maintenance Treatment (MMT) in Indonesia. In 2011, according to national statistics, 2.2 percent of the total population of Indonesia—or about 4 million people—had the experience of using drugs (BNN and PPK-UI 2011:45). Two years later, the Directorate General of Communicable Disease and Environmental Health declared that HIV prevalence had increased significantly, especially among Intravenous Drug Users (IDUs)—the second largest high-risk group (Ministry of Health 2013). As described in chapter 1, the government of Indonesia has responded to the drug use program through the establishment of Methadone Maintenance Treatment (MMT) in public hospitals and primary care clinics all over Indonesia. In the MMT program, the patients are treated to turn away from their dependence on *putau* by consuming methadone syrup. Based on public health

perspectives and the social point of view, this program tries to communicate the problems of addiction and the loss of productive labour for Indonesia (Sarasvita 2009:6). The reliability of the program counts on rational and practical choices such as improving access to jobs, health and other social safety nets that were formerly missing due to the stereotype of the addict (Butler 2004). Those safety nets are only possibly accessed if drug users no longer use illegal drugs, and start to consume legal drugs in the clinics.

With the assumption that the MMT program will bring significant changes to the Indonesian public health condition in general, methadone has been successfully distributed since 2004. In the Indonesian context, HR programs aim to minimize the harm of intravenous drug through the provision of methadone as heroin-substitution. The Harm Reduction decree from Ministry of Health of the Republic of Indonesia No. 567/MENKES/SK/VIII/2006 emphasizes four basic principles:

1. Promoting abstinence for IDUs;
2. If IDUs insist on using substances, then not injecting should be encouraged;
3. If IDUs insist on injecting substances, then they should be encouraged and urged to use disposable and clean needles;
4. If sharing needles remains as practices among IDUs, then they should be persuaded and trained to learn to sterilize the needle and the syringe.

In this policy level, the distribution of clean needles seems equally important with methadone use. In practice however, clean needles and syringes provision is still criminalized. Many drug users are scared to keep their clean needles and also hesitant to take the new ones from their outreach men. This is because the police will use the needles as evidence to arrest drug users. In addition, clean needles are only provided through peer support group—making the role of community group becomes crucial to define drug users' lives.

The underlining assumption of the HR programs is that heroin addiction is the main problem, and methadone treatment is the best solution. Therefore, substance use other than heroin (*putau)* is not the focus of the program. For substance users in Indonesia, there would be no HR programs if there were no intravenous heroin users and no HIV/AIDS epidemic. The HR program in Indonesia is indeed not a comprehensive program to impede the addiction epidemic in Indonesia (Marlatt 1996). In short, methadone treatment is actually giving enduring problems in terms of

delivering ‘positive’ impacts for the user through the complicated THD procedures and imbalance provision between legal substance and clean needles within HR programs.

4.3 Tebet Methadone Clinic

In these following paragraphs, I would like to describe the context of methadone community group. This explanation is useful to understand the pragmatic solution of HR that failed to improve users’ lives.

It was 1 pm Indonesian time, and many people gathered in front of Tebet Primary Care Clinic (PCC)—most of them men, a few women. In Jakarta, almost all PCCs are very crowded in the morning. Thus, this situation was actually quite strange for me even as Indonesian—that I saw a crowd in the afternoon. When I was a child, my mother loved to take me to a PCC to meet the dentist. It was probably because the services given by PCCs are very cheap compared to private clinics, where middle-income family cannot afford it. Though there are some cheaper private clinics in Jakarta, they do not have many facilities other than general practitioner (GP), so PCC is the best choice for the majority of Indonesian people to access their health care.

It’s still vivid in my memory: in the morning, the situation at PCC is usually full of children and their mothers who went there to access vaccines or to see the dentist like my mother and I did. Back to 1 pm that particular day in Tebet PCC, there were no mothers and their children; there was no sound of crying babies after receiving vaccination. Instead, there were a few middle-aged men smoking and drinking coffee, their faces pale. Some of them were enjoying lunch in the small stall outside the service centre. The methadone clinic in the Tebet PCC opens at 1—3 pm every weekday, and opens at 9—12 pm during the weekend. Thus, the guys that I saw smoking in front of the Tebet PCC were not waiting to get vaccinated or to meet the dentist. All of them were waiting for the clinic to open so they could drink their methadone.

Around 30 people gathered as part of KDS in Tebet. Some of them were elderly, maybe around late fifties, but some of them were still in their late twenties. Through Erina, I met Fredy, the leader of this group, a 50-year-old man originally coming from Medan. Every day, he comes to this park using his silver Toyota Fortuner car that he does not drive by himself—a driver always accompanies him. All the members of the group give full respect to Fredy, not only because he is the leader but also because as the leader Fredy expresses kindness and wise perspectives, and also shares his valuable experiences with the other members. Every time he comes to this park he always buys

one black coffee and one iced instant coffee from Fandy—a group member who sells coffee and snacks in Tebet Park. He also always offers something to other people—and yes, he always buys me a drink—after which he buys all the *gorengan*—a typical Indonesian deep-fried snack—for everyone there. My first impression of Fredy was really good; he seems to be the example of how methadone therapy can succeed in giving a new life to the users.

Fredy told me that he was in a very low stage of his life when he found himself HIV positive. He was leaving his family, and after a while he decided to go back to Medan and hoped that he could get a peaceful life there. He was afraid that he would infect his kids and wife. Fredy desperately made a decision to end his life by forgetting his family. Although he was not thinking about committing suicide, his life would end because his HIV status had brought shame on his family—the loved ones in his life. He said that when he was in Medan and stayed at his parent's house he just stayed in his room, refusing to meet his friends and his relatives. If not because his friend's visit, introducing him to GALATEA,[10] he might have stopped looking for a means to help him deal with his addiction to *putau.* People at GALATEA told him that HIV is not the end of the world; there are lots of strategies and health services to deal with the disease. After that day he called his wife and told her that he would return to Jakarta.

When he came back to Jakarta, he started his medication. Firstly he went to one of the private clinics to treat his hepatitis C. He discovered methadone therapy in 2006 after he had tried some alternative therapies. For him, the life that he had imagined has come true—living without being dependent on *putau,* and living happily with his family, "If there was no methadone, I might've been dead now!" he explained. Fredy's story shows the promising successful image of methadone treatment to overcome problems of addiction.

4.3.I Tebet Methadone Users Community: The Pursuit of Happiness?

In Tebet methadone clinic, Fredy played a significant role as the leader of the group. His personal history gave him a strong position as the role model of a successful recovering addict. As I mentioned earlier, Fredy's awful experiences of discovering his HIV status had become a fundamental impetus to change his life. Along with the fact

[10] GALATEA is an NGO that focuses on people living with HIV and IDU in Medan, North Sumatra.

that he has his own successful business and fancy car with a private driver, he is a perfect projection of a methadone user.

Fredy's trajectory has influenced all the group members to live their lives like him. Erina is a 33 year-old lady with two sons. She works as a PPK-UI's outreach woman. The first time that Erina accompanied me to do research in Tebet, she also planned to distribute the clean needles through the guy she had just talked to. Erina and I walked outside the park; she was making a code to one of the guys in the park—giving a sign to go somewhere else. Erina took his motorcycle, I was on her bike too, and we were riding the motorcycles for almost 1 kilometre when suddenly the guy that she had talked to came. He took two boxes of clean needles. I asked Erina "Why didn't you just give him the needles when we were in the park?" - "Naahhh, I can't do that! Bang Fredy was there. It doesn't feel right if you give clean needles where people actually use methadone to live free from *putau*, you know!" It illustrates that within HR programs, only the use of methadone is considered an acceptable way of living. In this sense, the use of clean needles is marginal (Marlatt 1996:779) since methadone becomes the priority in the implementation of HR in Indonesia. It only focused to decriminalize drug users through legal substance use and resulting to the values that distribution of clean needles is stigmatized and considered not right.

At the end of March 2014, Fredy knew that Erina had relapsed - "If he is a good boss (Erina's boss), then he must tell Erina that she cannot work there anymore. She won't be professional, and she won't relapse if she doesn't have money to buy *putau*." According to Fredy, he was upset with Erina not only because she was using *putau*, but also because of the fact that Erina is one of the role models with whom members of this community can ask for health services information. When Erina, being a knowledgeable person, was back using *putau*, Fredy thought that she would not be a good example of how a methadone user's life should be. For Erina, the use of clean needles helped her to avoid HIV transmissions from injecting *putau*—however, her decision to use clean needles seemed unacceptable even when the use of clean needles is also a part of an HR approach.

PPK-UI was doing a urine test not so long after I got the news about Erina from Fredy. Erina and I had not seen each other for two weeks when suddenly she quit her job after her urine test result contained opium and benzodiazepine. Erina felt embarrassed about the fact that she was back to using *putau*, and felt that quitting her job was the best choice for her. As a single parent with two sons, she needed her job to

support her family. One day before I returned to Amsterdam, we met in a coffee shop close to her house. “Yeah, what can I say? It wasn’t that easy not to think about *putau* when you know how it tastes and you know that you have money to buy it…” Erina told me in our last meeting.

Erina’s experience shows that precariousness of life exists between transformative activities from unlivable to livable lives. She tries to change the incomplete stage of the users’ unlivable lives through participation in HR programs in order to become ‘normal’ members of society. She had worked as an outreach worker. However, due to her dependence on substances, the attainment a livable life demands consumption for *putau*. Thus, the precarious life for Erina draws on the ongoing indefinite detention of working to consume (substances) and consuming (substances) to work—a significant illustration in which drug users are alienated from their own bodies in order to fulfil their needs.

Although the role of community among Tebet methadone users seems to give promising positive feedback for the users to reinterpret their lives, the biggest threat for them still comes from the possibility to relapse on *putau* or other illicit drugs—like Erina. As collective members, they would still feel embraced if Fredy knew that they are still using *putau.* Likewise, Erina, as an outreach woman, had responsibilities within her community to stay ‘clean’. But Erina’s decision to use clean needles to inject her *putau* did not gain support from her community. It shows that clean needles supplies and distributions within HR program in Indonesia are still in polemic. This is why even though NGOs and KPAN have stocks of needles, drug users are scared to take it with them and choose to buy it from drugs dealer—when they bought *putau*— or prefer the second-hand needle.

This situation illustrates that HR, as contemporary drug treatment is more instrumental in a sense that drug users merely have to switch their addiction from illegal to legal methadone. It failed to improve drug users’ quality of life. But consequently, if only methadone is considered to be the most ideal approach, it could be possible that the increasing numbers of HIV transmission among IDUs would remain constant—because the decision to use clean needles to use drugs feels incorrect. In the following paragraphs, I would like to address methadone procedures in the mechanism of Take Home Doze (THD). An effort to improve users’ life becomes too difficult when the treatment procedure is really complicated.

4.4 Fatmawati Methadone Centre

The existing community group in Fatmawati Methadone Centre shows huge disparities of socio-economic background of its members. It is significant to see how that background has influenced THD mechanism in Fatmawati Methadone Clinic. Through elaboration on THD mechanism, I can show that the pragmatic methadone treatment has been making the users' life become more unlivable. Instead of transforming methadone users into 'normatively humans' by entering market labour, they are alienated from the therapy.

Fatmawati methadone clinic is a part of the Fatmawati National Hospital. It is located in South Jakarta, near the intersection of Fatmawati Street. This national hospital is quite big—it has complete health services and psychiatry clinic, which is where MMT is delivered. When I was there, this clinic was not so crowded, I wondered if nobody realized that this building beside the motorcycle parking lot was one of the Fatmawati Clinics. This building looked more like a kitchen or an unused building, since there was not much activity in front of it. On March 10, 2014, some guys were talking to each other while Iman, a thirty-year-old guy, blowing out the smoke of his cigarette with a bowed-down face. Across from him, there were two guys who were also sitting with bowed-down face, also smoking their cigarettes. But different from Iman, in their other hands they were holding smartphones. None of them talked to him when I came that day—Iman stood silently, smoking cigarettes.

Most of them were well dressed—the guys wearing shirts and leather shoes. The girl (I met only one) wore nice flat shoes and was holding a paper bag of *Zara* clothing brand. Before talking to Iman, I firstly met Kurnia—a 33-year-old man who is around 170 cm tall, has bright skin, a nice hair cut and was holding a package of Marlboro Red in one hand while the other hand was holding a car key. Kurnia works in his family business. His company is a cleaning-service outsourcing supplier. He dropped out twice from different universities because of using *putau.* Kurnia became a patient in the Fatmawati methadone clinic in December 2003. He was attending the same university as me and, I guess, because of that he was willing to participate in my research. Sitting next to Kurnia was a guy named Akbar. I told Akbar what I was doing there, and asked him if he wanted to participate in an interview with me. He seemed uninterested in talking to me. He smirked at me and returned to paying full attention to his phone.

Iman, Kurnia, Akbar and some of the guys there were waiting for their turn to drink their methadone. Fatmawati methadone clinic opens from 8.30 am to 14.30 pm.

Although this clinic opens longer then the one in Tebet, it did not give me a better chance to have more interviews compared to different research sites. Usually around 3—4 people come in the morning, but mostly this clinic is more crowded during lunch-break time—between 12—13 pm Indonesia time. Perhaps they came to the clinic using their break time from their office hours.

Some of them come to this hospital driving their cars while some others using motorcycles. Unlike in other places, methadone users here have very high-end mobile phones—they often talk to each other, but most of the time they are checking their phones. I had never witnessed something like that in *kolong jembatan* or *kebon* (my other fieldwork sites). So, Kurnia and I were talking when a guy named Ruli showed up. Kurnia introduced me to Ruli, who was the leader of methadone patient group. I knew that Ruli was a model during 1990s in a teen magazine (I confirmed this with Veny). That day he was wearing a t-shirt and blue jeans. An iPhone was in his hand, and he was welcoming me pleasantly when I explained to him that I was doing a research for my thesis. I was about to ask him to have an interview with me when suddenly the clinic opened. Unfortunately, it was Ruli's turn to take his methadone, and after he drank his dose he went away before I couldn't say any word to him that day.

As far as I could remember, this group of people did not spend much time in front of the clinics to hang out with other patients after getting their methadone. There was no sense of belonging among the methadone users in Fatmawati—which is basically a reason for them to become a group. The fact is they do not have the feeling of togetherness as a community group. Some of them are busy with their jobs, whereas the others who have no jobs have no reason to stay at the clinic simply because nobody else will stay there—like Iman, who just smokes his cigarettes and waits for his turn.

4.4.I The *Affliction in Fatmawati Methadone Community Group*

As I mentioned previously, in Fatmawati, methadone users do not have a sense of "the group" when compared to people in Tebet. In this regard, there is no total commitment as the basis of becoming part of the community in the Fatmawati group. For Kurnia, although there is a formal group for them in Fatmawati, this collectivity is not necessarily important for him as a person, especially with the offers of community-based economic program from BNN. However, for Kurnia—he believed that he and his friends in Fatmawati needed more understanding of addiction that they did not receive from MMT. He is trying to stop using methadone and is seeking a life without

substances: “I want to be clean, without methadone, but I do not know how?” explains Kurnia. In this sense, HR that offers a universal therapeutic treatment to overcome addiction as well as rehabilitating socio-economic benefits, does not make sense, since each person has different constraints that they face in life. HR does not consider Kurnia’s need to stay clean and live without methadone. In other words, HR does not accommodate Kurnia’s aspiration to improve his quality of life that may be more livable than methadone users’ life.

Iman threw away his cigarettes when I asked him to talk to me. “Yeah, I have made so many mistakes in my life,” was the first sentence came out of his mouth. I hadn’t really asked him a question, but it was so clear that he needed to talk to someone that day. According to Iman, his family was tired with the troubles he made. They were tired of helping him break free from his problems. But now he was confused because he needed them in order to access his take home dose (THD)[11]. Most of the users take advantage of the THD in order to minimalize time consumed in going to the hospital/clinics. They use time instead for other activities such as working.

However, in Indonesia, THD is only possible if the patients fulfil certain requirements. For instance, they have to be able to show a history of appropriate methadone usage and avoid drug abuse. According to Iman, in the Fatmawati methadone centre, patients can only get a maximum 500 mg as a THD. Besides this, another requirement is that patients must, at least, come to the clinic once a week. Only patients’ families are able take the THD in the clinics, and a parent or a spouse is the priority. Last but not least, urine tests—which costs almost Rp90.000 (4 EUR)—are needed to prove that the patient does not take other substances. If all of the requirements are attained, THD will be given to patients, but they lose this privilege if one day in random urine test the result contains other substance than buprenorphine (Figure 4).

Iman was thinking he would change his life because his wife and his baby needed him to work. “They are all sick of me, I know. I want to change but it is all too late!” Iman lost his THD privilege when he relapsed on *putau* a couple of months ago. But as part of the procedures in Fatmawati clinic, he was required to bring his parents or his wife as the guarantor (*wali*). For him the requirement was too dilemmatic, his wife was still recovering after delivering their baby a week ago, and while his parents did not refuse to come, even if Iman succeeded to persuade them, they were too old to travel to

[11] The THD is the salvation of a patient on methadone maintenance—this privilege is used for patients who cannot come to the clinics to get the methadone on a daily basis.

hospital and take care of their son's problems (again). Iman was too embarrassed to ask his parents, as the procedure was overwhelmingly hard to deal with.

Figure 4

Urine-test package from PPK-UI's random inspection

Yet the enduring agony for Iman to get his THD back comes from a deep pain that was caused by what he saw as an unfair procedural application—Iman knew that some friends in the community never came to the hospital, but still received THD. What Iman's story tries to show us is the violation—by service providers—against technical methadone procedures. Retrospectively, Iman said that he was to get a job from Kurnia as a cleaning service worker. At that time, the clinic had still taken his THD privilege. Iman realized that what Kurnia did for him was a good thing. Kurnia knew that Iman needed money. When Iman proposed to the doctor and the nurse in the clinic that he needed his THD in order to work, they all rejected him. Kurnia, as a friend and a boss, came and explained to the doctor that Iman would work in his company. He talked to the doctor, and said that Iman had to be in the office from 8 am to 5 pm, thus he needed his THD of methadone. The doctor gave Iman's THD back after Kurnia gave his assurance.

Iman gave praise to the doctors, but he was shocked—he could not believe what he had just heard. According to Iman, the doctor asked him to keep the secret that he had just got his THD. Further, he stated, "I mean why they have to tell me that it is a secret, that nobody can know that I got my THD—isn't it strange? Don't they want that

their patients get THD and get a job?!" Iman was completely confused. He was perplexed by the clinics, and the situation he had just faced. Iman was thankful that he got a job and he got his THD, because his friend became his guarantor. But he criticized the situation where a friend who was not his relative could still become his guarantor.

In spite of that, Iman knew that some of his friends in the community had an easy way to get their THD. I am not trying to give subjective judgments towards Iman's statement—maybe the other patients, unlike Iman, had never relapsed on *putau*, or perhaps their urine tests never contained *putau,* benzodiazepine, etc. But this would mean that they still got their THD although they never came to the clinic. Iman argued that, regarding those people who never came to the clinic, it did not mean that their therapy was doing well. It does not mean that they never relapse. Moreover, it is even harder to record and trace their substances use pattern because they would never have a urine test. The fact that they would never experience urine tests but their methadone, especially their THD, never became a problem hurt Iman. Iman believes that a common situation in Indonesia is at play—that his friends bribe the doctors and the nurses in order to bypass the complicated procedures of THD. "You know, right? Here all we have is corrupt government. I know how they play it." Now, with the reality that he is experiencing unfair treatment from the clinic and at the same time pressing economic problems, he is pushed aside to a corner where no one can help him—not even Kurnia, because Iman is not working at Kurnia's office anymore.

What happened to Iman reflects the most painful condition for methadone users in Indonesia. He is a part of the methadone community group in Fatmawati, where most of the users are already secured in their socio-economic condition. Iman has a different condition from the other patients. He has no money, he has no job and he has no iPhone. He travelled to the clinics everyday by public transportation. Moreover, Iman has suffered from a pain by witnessing that the clinics treated him unfairly. He recognizes that his friends in the group have more special rights than him but there is nothing that he can do—even to get his take home dose, as a start to be able to get a job is problematic.

THD is one of the strategies to support the transformation from unproductive drug users into productive methadone rehabilitants. However, this mechanism becomes too difficult when the health care practitioners violate THD procedures. This situation is in line with Zigon's idea (2011:13), Iman cannot live in a normal or sane life because he loose sensibility within a particular range to recognize how THD mechanisms should

work. In addition, HR implementation failed to become a comprehensive strategy to combat addiction. Since methadone therapy becomes the most ideal strategy, it is not eradicating addiction. It has increased users' dependence in this legal substance, without providing information or guide about how to manage their addiction.

4.5 The problem with Methadone Maintenance Treatment

The use of methadone as synthetic opioid, in fact, causes people who use it to become addicted to this substance. There is no possibility for people in HR to be abstinent in order to achieve better mental and physical health (Neale *et al.* 2011). Moreover, MMT does not deal with other addictions. Riri, a methadone patient in Tebet, was not a 'real' *putau* user; she used mostly crystal methamphetamine. She started her treatment by joining the MMT program in 2011, and ever since that day she has never been absent from the Tebet Clinic daily to drink her methadone. Now, according to Riri, she is addicted to methadone and has started to regret her decision to join the MMT.

She wants to quit this therapy, but she cannot do that. Riri has tried to stop drinking methadone, but she experiences huge withdrawals. Her dream to live in abstinence—free from any kind of substance—is simply impossible because now she also needs methadone. Beside, her dependence on methadone lead her to consuming benzodiazepine to overcome her insomnia—a side effect of the methadone used. So the HR program has not diminished her dependence on drugs; it has increased it.

If Riri's physical health is at risk because of being addicted to methadone, Jerry—who has been enrolled in the Tebet methadone clinic since 2003, is a subject to an act of politization to promote methadone treatment. As an old guy, Jerry has been trying to reduce his dosage for five years. He stays in 2-milligram dosage of methadone now. Jerry is planning to be abstinent—he thinks that in his 67-year-old of physical condition, it is not good to keep on consuming strong medicine. Unfortunately, the medical practitioners in Tebet methadone clinic are against Jerry's idea. They want him to stay on methadone, as a role model for other patients. Jerry is considered a good patient because he never relapses and slips (both in terms of *putau* and other substances) during the treatment. Jerry is therefore persuaded to stay on methadone and even spread the 'success' story of HR programs in terms of managing addiction. This program has not only failed to accommodate Jerry's wants, but also threatening his physical condition.

Another problem with methadone is that people who are taking ARVs need higher dosages. This means that patients with HIV—because ARV interacts with and decreases the methadone's effectiveness—need a twofold dosage that of a non-infected HIV patient. If one patient has a 160-milligram dosage of methadone, and is only allowed to reduce it by 2,5-milligram every three weeks—the mechanism is varied, and depends on the individual's doctor—then he/she needs at least 4 years to end the treatment. Hence, if the patient is 38-year-old man then another 4 years means that he will become 42-years old. Regardless of his physical condition after becoming a *putau* user, for a 42-year-old man who has finished his treatment, job opportunities will not remain the same. Job availabilities in Indonesia are limited—especially with the massive increase of freshly graduated students annually—the competition to win the job is harder for methadone users. In the end, the "benefits" of HR in improving employment potential is just simply an irony.

4.6 A Discussion for Methadone Treatment

The stories from the Tebet and Fatmawati methadone users groups represent the vulnerability of substances users' living conditions. If HR programs were intended to give substance users better lives through the implementation of methadone maintenance treatment, their stories would have been different. Since HR only provides drug users with instrumental programs by replacing illegal drugs with legal methadone, it fails to transform users' lives to be more livable. Instead, methadone has created a new addiction in their lives. This continuously replaces a precarious condition with another new precarious situation.

Second, through MMT programs, HR teaches that addicts can participate in productive labour. However, the stories of Iman and Kurnia are the best illustration for this condition. If Iman did not work at Kurnia's company, Kurnia could not help Iman to be his guarantor and thus the story of getting THD for Iman would not be that simple. It means that the vision of living more productively by holding a job is not as simple as what HR and MMT program campaigns have taught. The circumstances at some point feed to the same constraint as when methadone users are still using *putau.*

Third, because the THD mechanism is full of complicated bureaucratic matters, some methadone users in the end decide to stop working and choose to focus on their therapy. On the one hand, methadone treatment is important for their physical condition but on the other hand their treatment (the mechanisms e.g. THD and clinic's working

hours) simultaneously takes away the opportunity to work because of the huge disparity of working time between the patients and the service providers.

In spite of this, methadone side effect affects users' mental health due to chronic sleeping problems and anxiety. Therefore, almost all users cope with this situation by consuming anti-depressant pills. Ironically, a strategy to use 'legal' substance leads the users to consume and becoming addicted to various substances. The HR contributes to the adverse health of users, as they are addicted to different kinds of substances without sufficient information to manage it. Consequently, this also affects the mechanism of MMT program. When they need their THD privilege, for instance, the users need to pass a urine test—but the test will find the other substances used; not only methadone but also benzodiazepine or amphetamines. In the end, the THD will be more difficult to get. Shortly, instead of supporting substance users to become more productive and having better lives, methadone makes users' life stops moving.

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The stories of methadone users representing how life is no longer moving like the idea of HR supposed to be. The substances users will stay in their lives, the ones that tell them to come every day to the clinic and take their methadone—perhaps—until their life ends. In the following chapters, I present the lives of users who enrol in the subuxone therapy. The angle of each story derives from a similar point of view. The community group is the starting point to indicate how subuxone users suffer from severe pain not only from their health, but also from their social and economic conditions.

Chapter 5
The Black and White of Subuxone Users' Life

5.1 Introduction to Subuxone Users' Life

In this chapter, I will discuss three particular issues, the first of which is—what I call as—situated friendship among subuxone users that is based on the possession of substitution drugs availabilities. Second, the agony about productivity in substitution therapy, which makes subuxone users keep on living in difficult condition. Last, a discussion about substitution therapy that is supported only by private agency and its impact on subuxone users' life.

It begins from the story of people in Hitam Putih (Black and White) Community Group. This name was chosen as an illustration of subuxone users' lives. Their lives when they are still using *putau* are represented in black. After using subuxone, they wish that their lives would change as bright as the white colour. Subuxone users wish for a transformation in their life after joining in substitution therapy. My findings are important to show what kind of transformation they experience in subuxone therapy.

Apart from MMT programs, subuxone therapy has become an alternative therapy to overcome *putau* dependency. Users' preference to using subuxone instead of methadone is affected by various discourses. First, many subuxone users believe that methadone's side effects are more harmful than subuxone's. Second, there are a belief that methadone causes a stronger addiction, thus making it more difficult to stop methadone. Last, and most importantly, because methadone is syrup, there is no way for the users to inject it into their veins. For them, injecting subuxone still represents the sensation of the 'pumping ritual' that they miss from using *putau.* But because the price of subuxone is too high for them, injecting subuxone is the best choice for the users to decrease their expenses. However, this 'best' solution prompts other difficulties in subuxone users' lives. Mostly it's because injecting subuxone is recognized as 'abusive' use and illegal. Subuxone users still live in the shadow that stigmatizes them as drug abuse, the same condition when they were still using *putau.*

Since it is an unsubsidized therapy, the users can only access pills through private clinics and the price of the pills is much more expensive for users (see chapter 1). Even though subuxone users come from middle class background, their families often do not financially support them and most of them are reliant on temporary and

informal jobs—occasionally criminal ones. The fact that subuxone users tend to have such a long history of substance use has made them lose their family's empathy and support. In the end, they struggle to fulfil their needs by themselves—such as buying the expensive subuxone tablets or ARVs pill.

This chapter focuses on how the necessity to provide subuxone not covered by the Indonesian government created a market-based treatment coming from private pharmaceutical vendors. Amongst subuxone users, the everyday problems they face are intertwined between the economic vulnerability and the availability of their subuxone tablets. Subuxone users are still socially recognizable as bad people because of crimes they committed and their choice to injecting the substance. Injecting leaves needle marks on their bodies; the marks on their hand are irrevocable; in the end it is difficult for them to get formal jobs with those blemishes. No job security means there are no pills for them. Moreover, subuxone users live in vulnerable and fragile social relationships; these factors put them in dangerous living conditions. And, as I state, their lives do not transform from the dark to the bright condition. Instead, it is still precarious because they are still considered as 'abnormal' persons.

5.2 The Chronic Problem of Hitam Putih Community

These following paragraphs show the social relation that subuxone users have with their community. The high price of subuxone tablets is tied up with the bonds users have with their friends, situating their friendships within the exchange of substances and making the users' lives more precarious. Retrospectively, this community group exists because of—and cannot be separated from—Dr. AA's clinic. The clinic is located in Pondok Pinang Raya. Not so far from the clinic, there is one shopping centre and supermarket in the area. The area is really crowded, especially with a bus station close by, which makes the clinic located in a very hectic zone. Five hundred meters from the clinic there is the TB Simatupang highway. This highway becomes a significant spot where my research about subuxone users began.

Hitam Putih Community was founded in 2006. Since then this community started to develop a formal structural organisation. The Hitam Putih Community serves the most practical solution for the dilemma of injecting subuxone. The community provides a place to use the tablet in a way that—according to them—is 'more efficient'. Thus, with the presence of the 'safe' place and their community group, subuxone users start to enter the ambiguous life between legal subuxone as substitution substance and

the illegal injection administration route. However, the existence of the Hitam Putih Community Group, in fact, failed to adjust the collective aspirations and—furthermore—betrayed the real friendship that the members had between each other.

This group of fifteen people spend their time hanging out across from one of the biggest supermarkets in South Jakarta. Next to the supermarket is a shopping centre. The 'shooting gallery' underneath the highway is not as crowded as the main road—people are maybe too busy with the traffic and with their driving. Therefore, not many people pay attention to this empty space. People cannot see clearly the activity this group does there. It is dark because the highway covers the sunlight. And with so many people hanging out together, all with tattooed bodies, skinny and talking and laughing loudly, it is a scary enough place so that other people prefer to avoid it.

In February 2014, I met some guys there. They were staring at me as I was trying to get closer. They were sitting when I saw them holding their needles, and some of them used the needles to inject something into their hand—I guessed it was subuxone. As a start, I pulled out all of my bravery and willingness and shook one of the closest hands. It wasn't on purpose, but I finally realized that I was shaking the hand of the oldest member in that community. After that moment, they started to talk to me. I told them to finish their 'business' (injecting substance), while I told my friends to buy a cup of coffee in a small coffee stall close by—also to deal with my nervousness.

Figure 5

Kolong Jembatan

Maulana, Veni and I were drinking our coffee when one by one the guys I met beneath the highway came over. In the Hitam Putih Community, there are at least around 30 people who are formally registered as members. However, during my visit there, I met only around 7-8 people regularly—even though in the last meeting (especially after the incident between Ronald and Rafly in early April 2014) the group had 20 people hanging out eventually in *kolong jembatan*. As a subuxone users' community group, Hitam Putih has quite a large number of members. However, this big number of people does not guarantee that the sense of belonging of the group is strong—since the beginning of my research with subuxone users in *kolong jembatan*, I witnessed violence done by the members of the group to their own friends. During my visits there, I argue that that subuxone users' relationship in Hitam Putih community is conditioned on the subuxone availability.

5.2.I Situated Friendship in Hitam Putih Community Group

Wibowo, one of Maulana's clients, usually arrived in *kolong jembatan* earlier than other people. At around 3 pm, some of the subuxone users from Dr. AA's clinic usually came to *kolong jembatan*, while some others decided to wait in front of the clinic. One day, Wibowo was sitting in the small coffee stall where the users buy coffee or asks the seller for hot water—the water they use to dilute subuxone before they inject it. That day—it was 5 pm—I thought that all of them had already taken their subuxone. Ronald was talking to me about his historical experience of how he became really close with a successful mafia-like Indonesian entrepreneur. Ronald was talking to me very excitedly, until I caught my eyes staring at Wibowo's eyes. Wibowo looked pale, and his body was shaking. Nobody talked to him until he finally made a sound—he was begged for attention from people, including me.

Ronald kept on talking to me and gave no attention or response to his friend, who I guess at that time, was feeling pain due to withdrawal symptoms. Eventually Ronald moved closer to Wibowo. Ronald asked Wibowo about his condition. "What is happening to you, *sakaw*—withdrawal symptoms?" I knew that Ronald had enough pills even for a couple of days. Especially as the next day was Sunday, and the clinic is closed during that day, he had bought more pills to use. Ronald lied to Wibowo, "Ah sorry, I do not have *buxone* (short version of subuxone) anymore. I shared my pills with Riyan." I remembered the conversations I had had with Ronald previously; he mentioned that subuxone was the most important thing to him; Ronald said that he

always had enough pills. According to him, he would make sure that he had enough money to buy subuxone although he did not have money to buy food or to give money to his children. In other words, subuxone availability is the main priority in Ronald's life. So when Ronald decided to lie to Wibowo, maybe he just did not want to give it and let him look like a living zombie. Or maybe he thought that if he gave the pills he had, then he would not have spare pill for him self. But that day, nobody helped Wibowo. It shows that the social relation that people dependent on substances have is based on substance. Subuxone is the basic possession that reduces the friendship group meaning into the small size of a tablet.

Beside Wibowo's story, there was a fight between Ronald and Rafly in early April 2014. Ronald punched Rafly after he accompanied his friend—a drug dealer—to buy anti-depressant to sell it again in Bandung. Ronald thought Rafly was a liar and a greedy person and wanted to keep all the pills for himself. The fight that he had with Ronald was not the first problem that Rafly experienced with a friend in this group. It was last year when Rafly had gotten a new motorcycle. It was a brand new motorcycle, and he brought it to *kolong jembatan*. Suddenly, when he wanted to go home he found that his motorcycle was broken. He tried to start the machine, but nothing happened with the engine. After he took his motorcycle to a repair workshop they found that his gasoline tank had been filled with ketchup, salt and water. Rafly needed to replace his new motorcycle's machine with a new one, and this cost him Rp2.000.000 (135 EUR). "It isn't a friendship you know, they come to me if I have money. They only come if I have extra pills!" he told me angrily.

After the fight between Ronald and Rafly I did not see Ronald for a couple of weeks in *kolong jembatan.* Ronald moved to a different gang. But at the end of April 2014, Ronald was with his new gang hanging out in *kolong jembatan,* and I was surprised by his presence. Many people had said that Ronald was an arrogant person, but he was also talkative and easily got people's attention. Ronald would easily share his *Dumolid* (benzodiazepine) sometimes, but only with the people who—according to him—he had a special relationship with, like Riyan. After he was successful in bringing new people to *kolong jembatan*, he never said sorry to Rafly, and even with so many people were on Ronald's side and Rafly became the minority in Hitam Putih Community. It seems that everyone had forgotten Rafly's pain, and the problem he had with Ronald just disappeared. It is ironic that they told me that their friendship in their group would last forever, but they could not help their friends in need and in fact would

steal from and even fights their friends. The object of violence like Rafly, has to forget and suffer from the madness no matter how painful it was.

In addition, friendship within the community has emerged in a pragmatic sense of belonging for the sake of substance availability. Substance has enabled the social relationships within Hitam Putih Community although it does not always determine the base of relation that they have. On the one hand, Hitam Putih as a community has prompted comfort and safe feelings concerning the use of substances through the support system. On the other hand, the proximity of each member depends on the subuxone tablet, and both the community and friendships are fragile enough to make personal life become unlivable. People can easily betray their friends in order to get substances, and it is easy to mistrust someone in the community, which in the end creates continuous individual suffering.

Furthermore, the so-called community in the Hitam Putih group has been reproducing the chronic pain they already have from their addiction and has exacerbated the pain through their fake social ties. If one of the visions of substitution therapy is to bring back ex-drug users to the society, this program shows that the vision has deteriorated. This is because the price of the tablets is so high and at the same time the job availabilities needed in order to survive are limited. People become obsessed with substitution tablets but miss the sensitiveness of social empathy. Subuxone therapy is socially unsuccessful in making users' lives more livable. In the following paragraph, the stories from people who decided to leave Hitam Putih community represent the precariousness of subuxone users who crave productive living conditions.

5.3 Subuxone Users in Kebon

The chronicle tells experiences from the Hitam Putih community—that the expensive alternative substitution therapy has led people to lose their social capacity due to possession of subuxone tablets. Many violent incidents have happened in the name of survival from the severe pain caused by dependence on subuxone. This is exactly the reason that around six people decided to leave the community in *kolong jembatan*—these were Taufan, Mario, Bilal, Ponco, Doni and Ramly, who I met for the first time at Taufan's house. These six people now usually inject subuxone in *kebon*, an orchard, since they no longer hang out in *kolong jembatan*.

Together with Veny and Maulana, I came to this untidy orchard. After they finished *ngisi* (injecting), Taufan asked me to come to his house. When he welcomed

someone like that, from that point on, the most important thing for them in *kebon* would be trust; because they believe that a good strong friendship has to build upon trust. People in *kebon* never declared that they had created a new group. Taufan thought that if they made a formal group they would feel obliged to act collectively—but for him the most important thing was to live with true friends—no cheating and stealing from each other. For them, true friends will happily move on together and change their living condition, "If people who hang out here are not good, then we won't keep them as our friends. Our vision is simple: honesty," Mario explained. Their opinion had been influenced by their experience in Hitam Putih. The lesson learned from that community provided them with a guide for how to maintain not only real friendship, but also real life.

Everybody in *kebon* knew the unhappy experiences of Rizky with people in *kolong jembatan*. The perception of friendship among people in Hitam Putih Community became peculiar for people in *kebon*. They felt unsafe hanging out with people in Hitam Putih Community because they could not trust their friends. Zafar, one of the guys who used to hang out in *kebon*, later told me *"Ah, temen sendiri aja dimakan!"* (this literally means eating your own friend). His opinion was formed by experiences in which Zafar became a victim of violence when one of the guys in *kolong jembatan* stole his money. Thus, according to Zafar, friendship which is legitimised by the formality of community group provides another cause of trouble if it stands only on obsession with subuxone. Zafar's opinion was that relationships among people in *kolong jembatan* were so weak so that he used the expression 'eating their friends' for someone in order to achieve the resource of the substance. As it was, people can easily become victims because they are vulnerable as the object of violence—or, according to Butler, (2004:xii) "subject to death of the whim of another". *Kolong jembatan* was no longer a safe place to spend time using subuxone, and at the same time not a pleasant place to hang out and make friends. This community constituted a source of fear in the life of subuxone users.

Among people in *kebon*, there was the spirit to change their lives together. Moreover, their experiences in *kolong jembatan* had taught them to carefully choose friends when starting new friendship. Since most subuxone users in *kebon* had been 'rejected' by their families, and lost support from them, it was particularly important to have social relations in which they could share their feelings and spirits, "We can change, progress, I believe! Because we all have skills and education, we just need

someone behind us to support us. But we have nobody, that is why we've moved together," said Taufan to me. In their perception, the life they have has broken trajectories. But now they can start to look for a way to make their life 'better'. "I know that people have been seeing us as garbage, maybe we are. We are *junkies*; we are only useless junk for our society and even for our family. But what I am looking forward is to recycle this junk," Taufan told me about his aspirations. Dendi further clarified this opinion by proposing to start a *bengkel* (automotive workshop) between them as their communal income. Thus they saw that the friendship they had now must be better than they had in *kolong jembatan* before, because this friendship would become the basic foundation to change and live as a more productive person.

In HR, the role of substitution therapy is highly emphasized to increase the users' productivity so that they are less likely to use illicit drugs, to be involved in criminal activities or to practice 'risky' behaviours related to HIV transmission (Sarasvita 2009). In fact, what I found among the subuxone users group was that instead of providing subuxone users with assurance of productivity, it was contradictory, since now they are addicted to subuxone. Subuxone users live in a recurrent nightmare in which they still inject substances, even though these are legal now, and remained in the margins, still perceived as not yet 'normatively human'. The stigma as subuxone users is limiting their access to jobs to the same extent as when they were still using *putau.*

5.4 The Agony of Productivity

Subuxone users face discrimination towards their physical appearance, especially when they are trying to apply for a job and people from the company see their hands are full of needle marks. Doni—one of people in *kebon*—also explained that subuxone users are still recognized as drug users because they have skinny bodies: "We are skinny as a part of the impact of injecting the tablets. If we don't, and take it correctly, our bodies will stay big," he told me when we were talking. As a consequence, according to the rehabilitants, the job availabilities are not as high as for people who do not have needle marks and skinny bodies. The jobs that might be available for them are largely informal, and users have to compete with other people who do not use subuxone. And whilst some subuxone users have problems finding a job, other users who do have jobs have trouble maintaining theirs—especially when they have to deal with therapies and their working schedule.

A dilemmatic position between remaining in subuxone therapy in order to have a job on the one hand and maintaining the job by hiding their subuxone-user status on the other hand is a common situation for the users. In essence, this situation is similar to the story of methadone users who have a job. Both groups have no other choice but to keep their status secret from their bosses and colleagues in the office since subuxone and methadone are still stigmatized and full of negative stereotypes. Bilal, a taxi driver who comes to Taufan's house to use subuxone every afternoon, has no other place to use subuxone. His wife does not know that Bilal still injects subuxone. Bilal will never accept clean syringes from Veny, instead he puts syringes in Taufan's room, as he feels insecure if he travels with subuxone and syringes in his taxi.

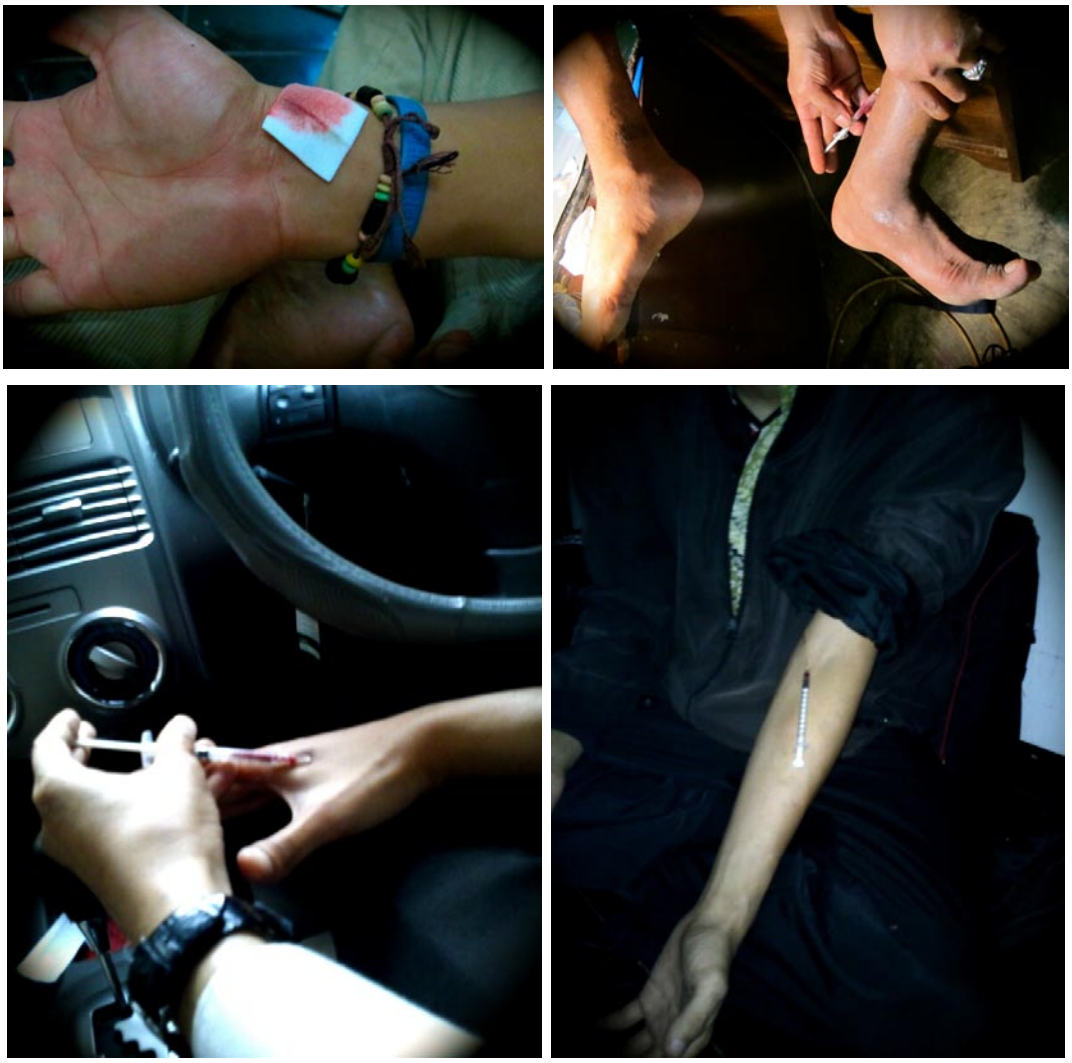
Bilal injects his subuxone into his leg. The only way for him to maintain the job he has is by covering his identity as subuxone user. However, as a consequence of these efforts he cannot work as much as other taxi drivers to get their costumers, because at some point everyday he needs to stop working to go to Taufan's house. He loses at least 2-3 hours of work just to fulfil his dependence, and because the traffic in Jakarta is unpredictable and chaotic, he usually loses more hours still.

Similarly, as a valet, Ramly had a really uptight time schedule because he had to be on time and ready in his office. One day, Ramly asked Taufan to buy him subuxone because he had to work and could not go to the clinic to buy the pills himself. "I would love to help him you know, but I don't have money to buy his subuxone. It is hard for me to buy one for myself!" Taufan explained. The group in *kebon* indeed is trying to change their living conditions, and one of the ways is by helping their friends to maintain their jobs. By helping Ramly to buy subuxone, it means that Taufan does not only support Ramly's life but also attempts to bestow a 'better' life for subuxone users.

It is difficult for Taufan to help his friends, and it's even more complicated because Taufan also loses the capacity to help himself. Taufan told me that every day at 2-3 pm he feels anxious when nobody is in his house. His body starts to crave subuxone, but he usually does not have enough money to buy a little piece of the tablet. In other words, it is basically problematic even for Taufan to help his friend to get subuxone. Mostly, the tablets that Taufan uses are given to him by his friend. Since not all subuxone users can easily inject the subuxone by themselves, Taufan is well known amongst the subuxone users as the 'doctor', as he is able to inject other people smoothly and 'without' pain. For his role, he gets at least 1 milligram subuxone every time he injects his friend. Thus, Taufan's dependence on subuxone also depends on his friends

who come to his house asking for help. Otherwise, it will be impossible for him to have subuxone since he does not have a job. The only choice he has is committing crimes such as stealing helmets with his friend Mario.

Figure 6



Injection locations depend on the job

Subuxone has crashed the users to the ground in agony. Some other subuxone users in *kebon* work as *ojek* drivers—with an income of around Rp50.000 a day (less than 4 Euros). But Taufan stays jobless while Mario is a casual worker who only works in temporary periods. Mario is a thirty one-year-old man. He is married and has one kid from this marriage. He used to work as a barista, but since he had an accident his leg cannot work properly and he has stopped working. Sometimes his family asks Mario to drive them and he gets money from that. Thus, Mario relies on his wife who works at a

mall in Permata Hijau area. As a casual *ojek* driver, Mario does not make enough money to support his family and to buy subuxone—especially since Mario uses both subuxone and anti-depressants three times a day. His expenses—in terms of substance consumption—are much more compared to other subuxone users who do not use anti-depressants. In the end he chose to join the criminals and became an expert in stealing helmets.

Every time Mario comes to Taufan's house he always brings more than one helmets—most of the time he brings three. Doni told me that when Mario brings three, it means that he has just stolen a helmet, or he wants to sell the helmet "…if you go to his place there are lots of helmets in his room, hahaha." Doni was teasing Mario as helmet-stealing expert. One time, when Mario was busted, people brutally beat him.

He was almost sent to jail, until he apologized to the man he stole the helmet from. His family, especially his wife, told Mario to stop stealing helmets—eventually in late April 2014 his wife asked for a divorce. The reason why his wife asked for a divorce was not completely clear to me, but according to Mario, he said that his wife was tired of all that he had done. Subuxone users' lives are not only economically vulnerable, but Mario's relationship with his wife became vulnerable too because of the way he chose to get money to purchase his vice. Before his divorce, Mario secretly used subuxone—he always lied to his wife. He said that he was injecting water to his body as part of the therapy, and that there was no substance in the syringes. Although his wife never complained about his habit of injecting 'water', Mario believes that his wife knew that he was lying. In the end, Mario assumed that the reason that his wife asked for a divorce was because she was tired of seeing Mario steal helmets every day, and tired of him not being honest.

5.6 Poly-substance Use: a Problem of Overcoming Problems

As I mentioned earlier, substitution therapy is not comprehensive enough to give access for drug rehabilitants to improve their quality of life. First, it is inevitable that subuxone users suffer from social hostility caused by artificial friendship within their community groups. Secondly, they do not only struggle to pursue better living conditions through becoming productive citizens, they are also preoccupied with maintaining the therapy at the same time. Thus, I argue, these situations are factors that make it harder for drug rehabilitants to maintain addiction that they have from substitution therapy and tranquilizers.

I found that the use of tranquilizers is well known among both methadone and subuxone users. In Indonesia, it is common to prescribe anti-depressant for drug rehabilitants in methadone treatment. According to Dr. AA, anti-depressants are used to deal with withdrawal symptoms in the beginning of therapy. However, the use of anti-depressant without prescription is prohibited. Methadone users—subuxone users will never get any random urine test—who use anti-depressants will lose their THD if their urine test contains other substances than methadone, because MMT requires only single substance use.

However, Taufan found the use of benzodiazepine helpful to conquer the side effects of subuxone. Ronald swallows a tablet of benzodiazepine before taking subuxone in the morning. He goes on to take another anti-depressant again in the afternoon, injects subuxone at 4 pm in *kolong jembatan* and once more before he sleeps. Sometimes after he takes his second subuxone at *kolong jembatan*, Ronald swallows his third tablet of anti-depressants. But Mario and Taufan prefer to mix subuxone together with benzodiazepine in their syringes. Even though poly-substance use influences the adverse health of drug rehabilitants, there is a lack of solution to help them with these dependences.

From the biomedical point of view, subuxone has side effects that cause sleeping problems, but insomnia is also augmented by the anxiety about social problems. For many drug rehabilitants taking subuxone, the only way to survive is taking benzodiazepine in order to be able to sleep. In this sense, subuxone as a medicine to control addiction problems comes face to face with benzodiazepine to manage subuxone's side effects. This condition is in line with Whyte and colleagues (2002:53). According to them, medicines have an ambiguous role in treating medical problems as well as being a source of power to control their situation.

Since one specific medicine works to overcome a particular illness, and also gives definite side effects, the phenomena of 'mobile medicine' (Whyte *et al.* 2002:8) occurs. It is not only the substance which travels from one place to another, but the use of substance in a person varies—moving from one substance to another. Even for Taufan, besides him needing both subuxone and anti-depressants, he also consumes antibiotic and antifungal medication to treat his opportunistic infections. For drug users, one substance leads to the use of a different substance in order to achieve the absolute 'normal' life. Thus they can no longer live without substances, and only through the use of it they can heal all sickness—physical, physiological and social. This is one of the

discrepancies that I found in substitution therapy. The program fails to provide guidance to manage drug users' dependence on various substances.

The need to turn to illegality for the consumption of anti-depressants among substitution patients finds them caught up in the illegal psychoactive drug dealers network and makes it difficult to guide them in managing consumption in multiple substances since their doctor do not know their poly-substance use—even though in subuxone therapy drug rehabilitants hardly get any consultation. Patients cannot talk about their problems—addicted to both subuxone and benzodiazepine—to their doctors. The lack of trust between patients and health care professionals adds up to the problematic relationship severed by the economic underpinnings already in place because of the price of the privately produced and sold subuxone tablets, making it hard for drug rehabilitants to find a strategy to manage their dependence. Subuxone users cannot get anti-depressants in the subuxone clinics, leading many of them to register in different psychiatric clinics. They spend more money in order to get subuxone and benzodiazepine so they can possibly have a better life. However, their expenses to purchase these substances create a huge gap with their economic condition. As the result, poly-substance use to overcome addiction problems results in another financial problem.

In MMT settings, instead of educating drug users to avoid using benzodiazepine while they are in methadone therapy, the system tends to give punishment by taking patients' THD privilege. The psychiatrists designated to work within the MMT is reluctant to work within the MMT program; users, in turn, are reluctant to confide in them about their poly-subtance use, and prefer to hide it rather than discuss it, in order to keep their THD. In the end, the promise of transformation from unlivable to livable lives through substitution therapy is not fulfilled. The progress to live better is becoming an indefinite detention (Butler 2004), because substitution patients live in the same situation as when they were still using illegal drugs. The patients will still live in this recurrent depressive cycle, because the program to deal with addiction is too instrumental and does not provide the means or support to get them out the situation of precariousness other than giving them legal substances provisions.

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Unlike the name of the Hitam Putih community, the lives its members have in subuxone therapy are not as ‘white’ as their hope to have a brighter future. Since subuxone therapy expresses a business-oriented therapy, the relationship users have with their therapists only depends on money. Consequently, the price subuxone users have to pay is higher and actually beyond the pocket of most. It also inevitably has implications to subuxone users’ social relationships. Their friendship stands on the obsession of substance and it determines *how* the individuals can suffer from severe pain from violence, discrimination and mistrust. Thus, the life they have is as ‘black’ as their condition when they were still illegal drug users. Poly-substance use is common among drug rehabilitants and it dangerously affects their health and increases their economic cost. The pragmatic program of HR does not only hamper health seeking behaviours among rehabilitants by giving punishment to take away THD privilege, but also fails to provide any insights that might be useful to manage their therapy in the subuxone context. In the end, substitution therapy is a shining example of instrumental programs that maintain drug users’ precarious life.

Chapter 6
Conclusion and Reflection

The aim of this study was to seek an ethnographic understanding of HR as therapeutic programs to overcome addiction, based on patients' experiences. I argue that instead of ensuring a productive life and transform drug users into 'normal' persons, HR naturally creates mandatory loneliness because it maintains certain exclusionary socio-economic practices. Furthermore, substitution therapy, such as methadone maintenance treatment (MMT), dominates HR programs in Indonesia. The government of Indonesia is much more interested in normalizing addiction through substitution therapy. Thus the money from international funding agencies for HIV prevention is used to establishing methadone centres and buy low-quality syringes that are useless to users.

Private pharmaceutical companies seize the opportunity to provide buprenorphine therapy through the use of subuxone tablets. Without support from the government, the price of this tablet is higher than methadone, although for some users' subuxone is better in order to improve their quality of life. With the price of subuxone well beyond the pocket of most users, their relationship with doctors and nurses in the clinics is based only on money. This creates the market-based treatment for drug users.

In navigating that context, the question of how people manage to balance the need for substance use with the necessity and desire to have a 'normatively human life' seeks to contribute to improving HR implementation and drug users' quality of life. My findings guide me to the conclusion that first, HR implementation in Indonesia is more instrumental in a sense that drug users merely have to switch their addiction from illegal to legal substances. Since the main aim of HR is to normalize addiction through MMT, the use of clean needles within HR programs is stigmatised. Second, HR's goals to improve drug users' life quality are not met because drug users become addicted to legal substances provided in the clinics. Thus, instead of living productive lives as normatively humans, drug rehabilitants are still experiencing the same precarious life as when they were using illegal drugs.

Moreover, HR programs fail to acknowledge that most drugs users practice poly-drug use and suffer from multiple addictions. Methadone and suboxone are only directed at substituting heroin. They do not address addictions to tranquillizers and other

drugs. In practice, when engaging in substitution therapy, my informants continue to use a spate of other drugs.

HR programs also fail to acknowledge the importance of injecting drugs in their everyday lives. My informants seek the rapid effects and the familiarity that comes with injecting. Many of them prefer to use subuxone, which they can inject. The methadone syrups provided by the government cannot be used in this way. Methadone is free, but the preferred subuxone costs a lot.

The government health policy makers expect drug users to go back to work when using substitution therapy. However, as substance users, the availability of work is limited—not to mention that the therapy mechanisms often disrupt the jobs they have. While some people can focus on their work, substitution patients struggle to deal with their therapy, too. In fact, the findings show that substitution therapy isolates users from having a job.

My findings show that social relations for substitution patients are fragile because the social relationship only stands on the availabilities of substances and the nature of friendship is opportunistic. More important for them is the access to substances that they get by maintaining relationships with people who have substances. Such relationships, based on the supply of substances between substitutions patients, are vulnerable to violence. This interferes with fostering sincere feelings of friendship, hampering the creation of meaningful bonds based on sociability and trust.

My research time for this project was limited, which confined the scope and length of my research. Nonetheless, I hope that with this thesis, I showed that there are significant flaws in HR programs that do not improve drug users' quality of life by enabling a transformation to a more secure life, but instead leaving them in a precarious situation. With this research, I have set foot on the road to comprehensive HR programs guided by empirically informed insights regarding rehabilitants' socio-economic experiences. Research over a longer period of time would contribute to an even greater understanding of the workings of HR programs and the improvements needed to really enable drug users to make their lives livable.

Bibliography:

American Anthropological Association. 2012. Statement on Ethics: Principles of Professional Responsibilities. Arlington, VA: American Anthropological Association. http://www.aaanet.org/profdev/ethics/upload/Statement-on-Ethics-Principles-of-Professional- Responsibility.pdf

Andriansyah, R.
2010 *"Money Talks" A study on the Interaction between Drug Actors and Non-drug Actors within the Community in Bures, Jakarta, Indonesia.* Amsterdam: Amsterdam Master's in Medical Anthropology.

Asad, T.
2000 "Agency and Pain: an Exploration." *Culture and Religion.* 1, 29—60.
2012 "Fear and the Ruptured State: Reflections on Egypt after Mubarak." *Social Research.* 79:2, 271—298.

Berardi, B. F.
2009 *Precarious Rhapsody: Semiocapitalism and the Pathologies of the Post-alpha Generation.* London: Minor Composition.

BNN and PPK-UI
2011 *Laporan Akhir Survei Nasional Perkembangan Penyalahgunaan Narkoba di Indonesia tahun 2011:Kerugian Sosial dan Ekonomi.* (Final Report National Survey on Drug Abuse and Illicit Drug Use in 2011: Social and Economic Cost). Jakarta: Pusat Penelitian Kesehatan Universitas Indonesia.

Butler, J.
2004 *Precarious Life: the Powers of Mourning and Violence*. London: Verso.

Chhabra, S. and J. Bull.
2008 "Methadone" *American Journal of Hospice & Palliative Medicine.* 25:2, 146—150.

Cohen, A. P.
1985 *The Symbolic Construction of Community*. New York: Tavistock Publications.

Davis, S.LM., A. Triwahyuono, and R. Alexander.
2009 "Survey of Abuses Against Injecting Drug Users in Indonesia." *Harm Reduction Journal*. 6:28, 1—6.

Directorate General of Communicable Disease and Environmental Health, Ministry of Health
2013 *Estimasi dan Proyeksi HIV/AIDS di Indonesia tahun 2011-2016.* (HIV/AIDS Estimation and Projection in Indonesia year 2011-2016). Jakarta.

Foster, G. M.
2010 "Medical anthropology and international health planning." in Good, Byron J. (ed) *A Reader in Medical Anthropology: Theoritical trajectory, emergent realities."* London: Blackwell.

Gowan, Teresa, Sarah Whetstone, and Tanja Andic.
2012 "Addiction, Agency, and The Politics of Self-control: Doing Harm Reduction in a Heroin Users' Group." *Social Science and Medicine.* 74: 1251—1260.

Green, C.W., and K. Nagar.
2013 "Care, Support & Treatment for PLHIV in Indonesia." Available at http://spiritia.or.id/art/bacaart.php?artno=2018. Accessed July 15th 2014

Haliman, A., and G. Williams.
1983 "Can People Move Beureaucratic Mountains? Developing Primary Health Care in Rural Indonesia." *Social Science Medicines*. 17:19, 1449— 1455.

Handal, K.A., Schauban J.L., and Salamone, F.R.
1983 "Naloxone." *Annals of Emergency Medicine.* 12, 438—445.

Hathaway, A.D.
2001 "Shortcomings of harm reduction: toward a morally invested drug reform strategy." *International Journal of Drug Policy.* 12, 125—137.

Hawks, D.
1993 "Impediments to the Global Adoption of Harm-reduction Policies". In: Heather N, Wodak A, Nadelmann E, editors. *Psychoactive Drugs and Harm Reduction: From Faith to Science.* London: Whurr Publishers, 1993:93–102.

IHRA
2010 "What is Harm Reduction" A Position Statement from the *International Harm Reduction Association.* London.

Keane, H.
2003 "Critiques of Harm Reduction, Morality, and the Promise of Human Rights." *International Journal of Drug Policy.* 14, 227—232.

Komisi Penanggulangan AIDS Nasional (National AIDS Commission Republic of Indonesia)
2009 "National Strategy and Action Plan 2010-2014" Jakarta.

Li, T.M.
2007 *The Will to Improve: Governmentality, Development, and the Practice of Politics.* Durham: Duke University Press.

Marlatt, G. A.
1996 "Harm Reduction: Come as You Are." *Addictive Behavior.* 21:6, 779—788.

McNeil,R., M. Guirguis-Younger, L. B. Dilley, T. D. Aubry, J. Turnbull, and S. W. Hwang.
2012 "Harm Reduction Services as a point-of-entry to and Source of end-of life Care and Support for Homeless and Marginally Housed Persons Who Use Alcohol and/or Illicit Drugs: A Qualitative Analysis." *BioMed Central.* 12:312, 1—9.

Miller, P.G.
2005 "Scapegoating, Self-confidence, and Risk-comparison: the Functionality of Risk Neutralization and Lay Epidemiology by Injecting Drug Users." *International Journal of Drug Policy.* 16, 246—253.

Ministry of Health Republic Indonesia.
Decree number 567/Menkes/SK/VIII/2006. Guideline for Harm Reduction Implementation on Narcotics, Psychotropic, and Other Addictive Substances.

Morrison, C., Y. Kurniasih, and G. Barton.
2012 "The Landscape of Services for Drug Users in Yogyakarta, Indonesia." *Drug and Alcohol Review.* 31, 95—100.

Neale, J., S. Nettleton, L. Pickering.
2011 "What is the role of harm reduction when drug users say they want abstinence?" *International Journal of Drug Policy.* 22, 189—193.

O'Hare, P. A., Newcombe, R., Matthews, A.. Buning, E. C., & Drucker, E. (Eds.).
1992 "The Reduction of Drug-relared Harm". London: Routledge.

Pauly, B.
2008 "Harm reduction through a social justice lens." *International Journal of Drug Policy. 19,* 4—10.

Pikiran Rakyat 2010 "*Impor Subutex dan Subuxone Dihentikan* (Import Subutex and Subuxone has Stopped" http://www.pikiran-rakyat.com/node/118154 Accesed July 14th 2014.

Sarasvita, R.
2009 "Treatment Retention in Methadone Maintenance Program in Indonesia: towards Evidence-informed Drug Policy." Doctorate Thesis in Doctor of Philosophy. Department of Clinical and Experimental Pharmacology, School of Medicine, Faculty of Health Science, University of Adelaide.

Sarasvita, R., A. Tonkin, B. Utomo, and R. Ali.
2012 "Predictive Factor for Treatment Retention in Methadone Programs in Indonesia." *Journal of Substance Abuse Treatment.* 42, 239—246.

Tempo
2013 *Ini Pertumbuhan Kasus HIV/AIDS di Jakarta.* (Here The Growth of HIV/AIDS Cases in Jakarta.) http://www.tempo.co/read/news/2013/10/23/083523838/Ini. Pertumbuhan Kasus-HIVAIDS-di-Jakarta accesed on Wednesday, May 14 2014.

Undang-undang Republik Indonesia
Nomor 35 tahun 2009 tentang Narkotika. (Indonesian Law on Narcotics Number 35 year 2009).
Nomor 22 tahun 1997 tentang Narkotika. (Indonesian Law on Narcotics Number 22 year 1997).

Whyte, S. R., S. V. Geest, and A. P. Hardon.
2002 *Social Lives of Medicines.* Cambridge: Cambridge University Press.

Yayasan Spiritia (Spiritia Foundation)
n.d. *Sejarah HIV Hingga 1986.* (HIV History up to 1986). Accessed from: http://www.spiritia.or.id/art/bacaart.php?artno=1030 May 20, 2014.

Zigon, Jarret.
2011 *HIV is God's Blessing: Rehabilitating Morality in Neoliberal Russia.* California: University of California Press.
2013 "Human Right as Moral Progress? A Critique." *Cultural Anthropology.* 28:4, 716—736.

HIV Cooperation Program for Indonesia (HCPI)
https://www.burnet.edu.au/projects/101_hiv_cooperation_program_indonesia_hcpi
Accessed July 15th 2014

Annex: Interview Scheme

The original questions were in Bahasa Indonesia.

Introduction. Explain anonymity, recording on tape, allowing to stop at any time during the interview, ask a permit to take pictures.

TURN ON RECORDER

A. History of drug use:

When it began? What kind of substances that you used for the first time? What kind of effect that you feel? What is the difference with the current substances? (in terms of the effect, cost, social impact?) (Cigarettes, alcohol, energy drinks, canabis, vitamin, anti biotic, anti-depressant (Benzodiazepine/Alprazolam/Dumolid/Prohiper)

B. Health problems:

1. Do you have any health problems? What kind of health problems do you have? Where are you going to seek help/health treatment?
2. How much money do you spend to pay the bills for your health treatment? Do you think it is expensive to pay those bills?
3. Do you have any obstacles when trying to access your health treatment?
4. Are you married? If yes, do you use any contraception? For those who not married, do you have any reproduction health problems, explain?

C. Human Capital Development:

1. What is you education background? Are you satisfied with your education?
2. If not, why? What is your expectation for your education? Do you think there is correlation between your education with your substance use practices, explain! Do you want to continue your study? Do you think it is possible as drug users to continue the study?
3. What is your occupation? How long have you been doing this job? Does this job meet your expectation, explain! Have you even been working in other job? What is the comparison you experience between the current job with the previous one?
4. How is the payment system in your job? How much salaray that you get from this job? Do you think it is enough to pay all your expences?
5. For those who have no job. Why you are not working? How can you fulfill your needs? If you work in your own business, what kind of business will you have? Are you satisfied with the money you get?

D. Economic Background:

1. Where do you live right now? Who do you live with, alone or with family? Do you live in your own home? Is there any bill that you pay, if yes how much?

2. Do you have any car or motorcycle? Where did you get that vehicle? Did you bought it cash or credit? If cash, how can you get the money to buy your vehicle?

3. What kind of precious things do you have? Why is it precious?

E. Relationship with Family:

1. How do you describe your relation with your family? Do they know your status as drug user? What is their opinion about that? Do they know what kind of substance do you use? Do they know about methadone/subuxone?

2. How do you describe your relation with your spouse? Is she/he your first spouse? How many times you have been married? Can you tell me how is the process when you met her/him and does she/he know your status as drug user? Have you been married after or before you becoming drug user? Why are you married?

3. For those who are not married, is there is special reason you are not married? Is there any relation with your drug use practices?

4. Do you have any children? How many kids do you have? Do they live with you? Are you involved in raising your kids? What is your role specifically? Do you think as drug user, you cannot play your role as a parent well?

5. Conversely, are you involved to support your parents economic? Are you supporting your extended family economic? Why and since when?

F. Social Life:

1. Who is your friend? Where do you know each other? Are they users like you, school friend, your friend at home? Do you think having a friend is important for your life? Do they help you when you are in difficult situations? To what extent your friend will be able to help you? Will you do the same thing to them?

2. Are you a member of any organization? If yes, are you active in your organization? What kind of role do you have in that organization? If not, why? Do you think it is important to involved in organization, explain!

G. Self and other perceptions:

1. What is your opinion about yourself? What kind of person do you think you are? Do you think you are a trustworthy person? Why? Are you satisfied with all the

things you have in your life? What kind of improvement do you want to experience? Is it related with your methadone/subuxone therapy?

2. How do your family, friends and society think about you? Is their opinion about you important? Do you still feel stigmatized as methadone/subuxone users? Can you open your status publicly as methadone/subuxone user? If not why?
3. What kind of experiences do you feel before and after you use methadone/subuxone? Are there any differences, why?
4. Do still have any problems with the police officers? Have you been arrested? Was it related to substances use? Did you have to pay (do you have any cost) when you have legal problems? How much did you pay?

Fill in the substance list.

Code of Users: Interviewers:
Date: Locations

Previous Product use	Reason to use	Source of Information	Use Time	Place to Buy	Price	Duration of Use	Buy/gifted	Description

Informed consent:

This research is part of Sari Damar Ratri's requirement to gain Master Degree in Medical Anthropology and Sociology at University of Amsterdam. The participation is on a voluntary basis and that everything informants expressed during the interview regarding their opinion, perception dosage, and administration route will be treated as confidential to grant security and safety to all informants. In this research all informants will be interviewed to tell about the experiences in Harm Reduction Programs (Methadone and Subuxone Use) in Jakarta, Indonesia. All information about this research is available for all informants, free to withdraw from this research and the decision will be respected. Every picture will be produced and distributed only for the purpose of this study.

Jakarta, 2014.

(Sari Damar Ratri) (…….……)

STOP RECORDER