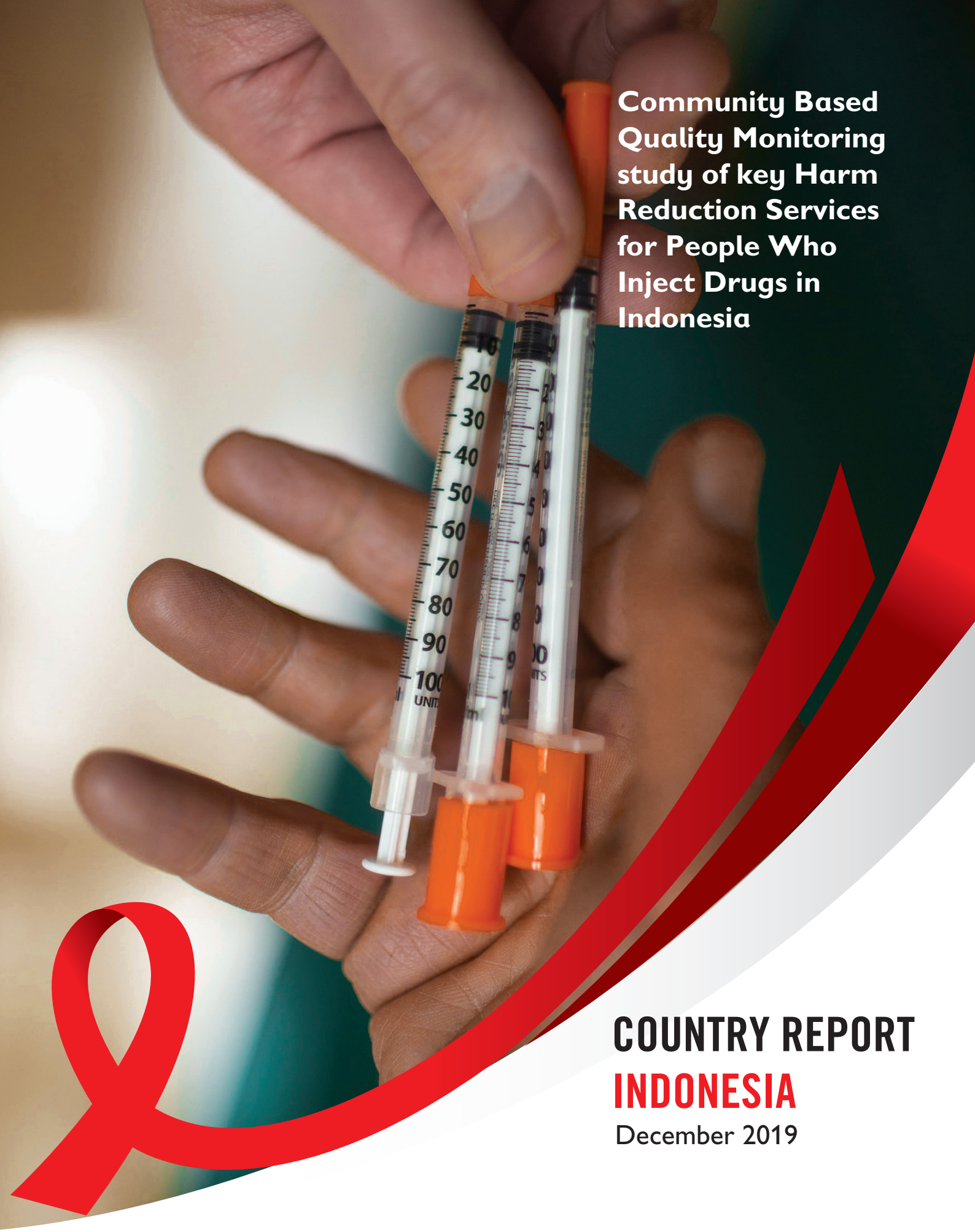

Community Based Quality Monitoring study of key Harm Reduction Services for People Who Inject Drugs in Indonesia

COUNTRY REPORT
INDONESIA

December 2019

KARISMA recovery society

ANPUD 20th Anniversary

KPRA Key Population Research & Advocacy Project

Save the Children

Community Based Quality Monitoring study of key Harm Reduction and other healthcare services for People Who Inject drugs in Indonesia.

This report presents a detailed description, methodology, and findings of the Community Based Quality Monitoring study. This study is the first of its kind in the region, designed, implemented, and analyzed in a peer-to-peer approach and model. The study presents information on the quality of Needle Exchange Services, Opioid Substitution Therapy Services, HIV testing, ART services, and the treatment of Hepatitis C, B, and TB infection. This study has also looked at the current linkage to essential HIV and other healthcare services for people who inject drugs in Indonesia.

The study has been designed and conceived by ANPUD with the active participation and the support from our partners in Indonesia. ANPUD appreciates the support from the data collectors and the community groups who directly and indirectly supported the implementation of this study.

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We hope that this study document will be useful for the development of science, for improving the quality of health services and especially for improving the quality of life of the PWID community in Indonesia.

In solidarity,

Achmad
Director
Yayasan Karitas Sani Madani (Karisma)

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANPUD	Asian Network of People who Use Drugs
APBD	Anggaran Pembelajaan Daerah (Regional Budget Plan)
APBN	Anggaran Pembelajaan Nasional (National Budget Plan)
ART	Antiretroviral Therapy
ARV	Antiretroviral (medicine)
Bappenas	Badan Perencanaan Pembangunan Nasional (National Planning Board)
BMT	Buprenorphine Maintenance Therapy
CCM	Country Coordinating Mechanism
FGD	Focus Group Discussion
FSW	Female Sex Worker
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
Hep	Hepatitis
HIV	Human Immunodeficiency Virus
IBBS	Integrated Behavioral and Biological Survey
KPRA	Key Population Research and Advocacy Project
MMT	Methadone Maintanance Therapy
MoH	Ministry of Health
MSM	Men who have sex with men
NGO	Non Government Organization
NSP	Needle and Syringe Programmes
ORW	Outreach worker
OST	Opiate Substitution Therapy
PE	Peer Educator
PLHIV	People living with HIV
PUD	People who use drugs
Puskesmas	Pusat Kesehatan Masyarakat (Primary Health Care)
PWID	People who inject drugs
RSKO	Rumah Sakit Ketergantungan Obat (Drugs Dependency Hospital)
SOP	Standard Operational Procedure
STI	Sexually transmitted infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime

ABSTRACT

BACKGROUND

Communities are increasingly involved in monitoring access and quality of HIV treatment, care, and support services.

OBJECTIVE

The broader objective of this study is to build evidence for advocacy for improved quality of Harm Reduction, including HIV, TB, HBC, HCV prevention and care services to PWID.

METHOD

The Community Based Quality Monitoring (CBQM) study in Indonesia employed mixed methods. While the community-based survey itself is quantitative, the mixed method is used to effectively review the PWID health services.

KEY RESULTS

To improve the quality of Harm Reduction services, it is necessary to expand NSP services and increase the capacity of OST, Hep B, Hep C and TB resources, integrated within the existing health care systems, aligned with the global strategy of 90-90-90. Harm Reduction saves lives. Provision of Nalox-one to prevent premature drug overdose-related death is important.

1. INTRODUCTION

1.1 Study Background

Due to social and biomedical advances, the responses to HIV have yielded remarkable results. There are better, improved tools for screening, diagnostics, and treatment of HIV. Community responses to HIV are also established as the cornerstone of effective, equitable and sustainable programmes. They play a critical role in demanding and delivering services, supporting health systems and reach those most vulnerable to HIV where state facilities cannot.

Communities are increasingly involved in monitoring access and quality of HIV treatment, care, and support services. They can act as barometers in their watchdog role, tracking what works and what does not with a local, contextualized perspective. Communities give a voice to those who need services, provide feedback as to whether policies and programmes are working and suggest how they can be improved. As service recipients, they are best positioned to evaluate the programs and provide critical feedback to HIV and health programs.

The Asian Network of People who Use Drugs (ANPUD) is a regional network of people who use drugs established to address the obstacles faced by people who use drugs and their families in Asia. The core belief behind the formation of ANPUD is that people who use drugs living in countries of the region coming together with a unified voice can have a greater impact in changing the current punitive laws and strategies. ANPUD believes that drug use as a health issue (and not a law and order issue) can work more effectively towards creating a better environment for people who use drugs and their communities, building from within the community.

In 2014, ANPUD along with other three regional networks applied for a multi-country grant to the Global Fund and was subsequently approved. One of the components of the grant is to conduct a study to monitor the quality of services related to Needle Syringe Programming (NSP), Opioid Substitution Therapy (OST), and; linkage to HIV care for people who inject drugs in Cambodia, Indonesia, Nepal, and Vietnam. For the implementation of this study in Indonesia, the Yayasan Karisma, through a selection mechanism by the Indonesian CCM secretariat, was chosen to be the implementing partner of this study.

1.2 Study Objectives

The broader objective of this study is to build evidence for advocacy for improved quality of Harm Reduction, including HIV, TB, HBC, HCV prevention and care services to PWID in Cambodia, Indonesia, Nepal and Vietnam. The study also aims to expand community-based monitoring in South and South East Asia, moving it out of that which is just related to donor programs and starting to monitor national programs and local services. The evidence generated from the study is expected to help to reshape policy, address bottlenecks and provide an important feedback mechanism for the improvement of the quality of HIV prevention, care, and support programs for the people who inject drugs.

The following are the specific objectives of the study:

1. To improve understanding of policy position, program strategies, legal barriers and the stage of implementation of harm reduction services for PWID in Cambodia, Indonesia, Nepal and Vietnam.
2. To improve understanding of the perceived quality of harm reduction services among PWID in Cambodia, Indonesia, Nepal and Vietnam.

3. To explore the status and the function of referral services, lifesaving care such as the provision of ART, management of TB and Treatment of Hepatitis C and B.

1.3 Expected outcome of the study

The approach used for quality monitoring under this study broadly relates to (with limitation specified in the following section) with the model 1: Downward accountability: Services incorporate mechanisms to allow service users to provide feedback and for feedback to be acted upon (e.g. complaint-handling systems) among the four models of community-based monitoring reported in a review commissioned by the Global Fund. The study which is a significant part of this grant aims for the following outcomes. The following outcomes expected from the study:

Outcome 1: Consolidated report on HIV prevention and care program, legal environment and types of services provided to PWID in Cambodia, Indonesia, Nepal and Vietnam along with country-specific profile and a regional consolidation on HIV prevention and care program, legal environment and types of services provided to PWID in Cambodia, Indonesia, Nepal and Vietnam. The report will include the perceived quality of harm reduction services among service users (PWID).

Outcome 2: A study report each from each study country which will incorporate the policy position, program strategies, legal barriers and implementation of harm reduction services and perceived quality of harm reduction services among service users (PWID) in Cambodia, Indonesia, Nepal, and Vietnam.

1.4 Study Approach

The approach used for the implementation of the study will have the following steps:

Table 1: Stages of the study

Stages	Process
1. Regional desk review and design of country assessment framework	This stage includes desk review and consultation with a technical partner at the regional level. Development of guidance for implementation (tools, and training).
2. Design and implementation of the study at the country	Designed at the regional level, implemented through partner networks at country level using two approaches; Facility-based assessments and community-based survey.
3. Analysis of study and build evidence	Data analyzed at the country level and consolidated at the regional level. Analysis framework and support provided through the regional level
4. Regional and country-level advocacy	Dissemination, engagement and regular advocacy at the country level through respective national networks, regional advocacy by the regional network.

2. INDONESIA CONTEXT

The HIV epidemic in Indonesia continues to be concentrated among three populations defined by high levels of HIV-transmission risk behaviors: people who inject drugs (PWID), female sex workers (FSW), and men who have sex with men (MSM). Decreasing or stabilizing trends in HIV prevalence among PWID and FSW in certain provinces over the past three years suggest that the epidemic is stabilizing.

The implementation of harm reduction services to prevent HIV transmission in Indonesia is approaching 20 years (Stone K, Shirley-Beavan S, Global State of Harm Reduction 2018). There was a time when this service received enormous attention by providing greater resources and policy support for the greater provision. It is estimated that this massive effort has affected the decline in HIV prevalence in people who inject drugs (PWID) from 52.49% in 2007 to 41.2% in 2011, and 28.78% in 2015 (Ministry of Health, 2015 IBBS Report). However, PWID access and adherence to ART remains sub-optimal.

The percentage of people diagnosed with HIV and accessing anti-retroviral treatment (ART) only reached 68.6% (224,471 per 327,282) in late 2018 (Ministry of Health, 2018 4th quarterly report on HIV-AIDS and STI). The dropout rate for ART or cases lost to follow-up reaches 22%. Although national ART-related estimates specifically for PWID are not available, sub-national data suggests that access varies widely among cities.

The cities chosen as study locations in Indonesia are Bandung and Jakarta. Jakarta is the capital city of Indonesia and Bandung is the capital city of West Java province. The distance between the two cities is around 140 km and can be accessed by land. Based on the latest MoH data on the size estimations of key populations (2014), Jakarta is home to 7,245 PWID and Bandung city to 2119 PWID. PWID access to ART services in Jakarta reached 61.23% and in Bandung only 27.61% (Ministry of Health, 2015 IBBS Report).

Table 2: Key HIV related Indicators, Indonesia

SN	Indicators	Total	Remark Source/data year
1.	Total population	266,927,712	Central Bureau of Statistics / 2017
2.	National HIV prevalence among the adult population	0.32	Estimation and Projection of HIV/AIDS in Indonesia 2015-2020, MoH / 2017
3.	Estimated no of PLHIV	632,480	Estimation and Projection of HIV/AIDS in Indonesia 2015-2020, MoH / 2017
4.	The proportion of PLHIV who are PWID	1.27%	Estimation and Projection of HIV/AIDS in Indonesia 2015-2020, MoH / 2017
5.	Estimated number of opioid-dependent people (if available)	N/A	Estimated number of PLHIV is 632,480. 8,034 out of the number is PWID
6.	Estimated number of opioid-dependent people who inject drugs	33,492	
7.	The proportion of MSM who reported using drugs (any drug/ indicate injecting users, if available)	N/A	Indonesia HIV KAP Estimation, MoH/2016

8.	Proportion sex workers who reported using drugs (any drug/ indicate injecting users, if available)	N/A	
9.	The proportion of transgender women who reported using drugs (any drug/ indicate injecting users, if available)	N/A	
10.	HIV prevalence among PWID	28.79%	IBBS, Ministry of Health / 2015
11.	HIV prevalence among PUD	N/A	
12.	HCV prevalence among PWID	63.5%	Integrated Biological and Behavior Rapid Survey, NAC / 2014
13.	HCV prevalence among PUD	N/A	
14.	The proportion of PWID who have been tested for HIV	78%	IBBS, Ministry of Health / 2013
15.	Choice of drugs	NA	There is a rapid shift within PWID to non-injecting practices and a switch from heroin to crystal methamphetamine (locally known as 'Shabu'). Recent evidence suggests increasing trends of shifting to smoking crystal meth in Jakarta, Medan and Makassar. Heroin remains the preferred drug of choice but is not easily affordable for the majority of PWID
16.	Percentage of people who inject drugs reported using sterile injecting equipment the last time they injected	90.04%	IBBS, Ministry of Health / 2015
17.	Number of syringes distributed per person who injects drugs per year by needle and syringe program	44	Global State Report, Regional Overview (Asia), 2016
18.	Program coverage of NSP at the national level	89.98%	IBBS, Ministry of Health / 2015
19.	The proportion of PWID who reported meeting an outreach worker/ peer educator from NSP in the past month	89.98%	IBBS, Ministry of Health / 2015
20.	The proportion of drug users reported purchasing syringes from pharmacies	N/A	
21.	Instances of overdose reported deaths/naloxone treatment provided	N/A	

3. METHODOLOGY

3.1 Study Design

The Community Based Quality Monitoring (CBQM) study in Indonesia employed mixed methods of qualitative and quantitative approaches. While the community-based survey itself is quantitative, the mixed method is used to effectively review the PWID related interventions to contextualize the quality aspect of harm reduction program at the country level.

Data collection from this study uses two approaches, namely qualitative data collection sourced from service facilities and quantitative community surveys. Facility-based information was gathered through structured facility-based observations, focus group discussions and Key Informant interviews. A community-based survey was used to interview PWID through community recruited respondents.

Harm Reduction service outlets were identified for facility assessment. The number of sites was purposi

3.2 Sample Size

The sample size for the community survey is calculated based on the history of utilization of HIV testing for recruitment through a snowball method. The sample size was determined using a proportionate sampling method with error allowance of 0.05% and a target of 307 PWID was set for Indonesia.

The sample size was then distributed based on geographical caseload estimated by the National AIDS Program. Thereafter, a snowball sampling technique was used to enrol study respondents with seeds recommending their peers to the study based on the eligibility criteria

3.3 Data Collection Process

All 307 PWID respondents were recruited from two cities across Bandung (158 PWID) and Jakarta (149 PWID). A structured questionnaire was used to collect data. There were 09 sections in the questionnaire and each section focused on gathering specific information related to personal characteristics, drug use, health services mainly NSP and OST and stigma and discrimination related. Each interview took an average time of 45-60 minutes to complete. A total of 6 data collectors were used for administering these structured interviews. The field-level data collection was carried out between May and July 2019.

An eligibility criterion was set to recruit appropriate respondents for one-on-one structured interviews. The set criteria were to establish a clear confirmation from the respondent that s/he had been injecting drugs until 12 months before the interview. That is, if a person says that he had not injected drugs for more than 12 months (at the time of the interview), the respondents were considered as not eligible for the study. If the first condition was met, then the respondents have to meet any one of the following two conditions: Had used NSP from a service centre/outreach or used OST service within 12 months before the interview. Apart from the aforesaid, the respondent had to be a minimum of 18 years of age to participate in the study.

The results of data analysis are presented descriptively in this document that is added with relevant qualitative data footage. Data analysis was carried out using SPSS and NVIVO.

3.4 Ethical Consideration

Ethical approval was provided by an ethical review panel at Atma Jaya University (No.0522/III/LPPM-PM.10.05/04/2019). All respondents were fully informed about the CBQM study through field data collectors who explained nature of the study, research objectives, confidentiality of the data, potential risk and benefit and their rights to participate/not participate in the study. Written consent was obtained from each study respondent.

3.5 Limitations

The results presented in this report are confined to Bandung and Jakarta, and may not be generalized to other cities or districts or any other part of the country. There may be a possibility of a biased response. Survey participants were expected to provide honest responses to the survey questions asked however, in some circumstances, this assumption may be breached due to factors such as social desirability or recall bias

4. RESULT: OVERVIEW OF CURRENT HEALTH SERVICES

The information provided in this section on the current situation of health services has been obtained through personal visits to service facilities and conducting interviews with program managers who are responsible for successful implementation of these health service facilities that offer NSP and OST to PWID.

4.1 NSP Service

Service providers were visited within three community health centres (Puskesmas), namely Penjaringan, Kebayoran Lama and Tambora in Jakarta.

All of the three NSP services are implemented based on the national guidelines issued from the Ministry of Health and internally they also have a standard operating procedure (SOP) document as well. Documenting client access is done in a manual form which is periodically entered into the online system. However, documentation of the distribution of NSP is still done manually. There is no specific guideline on documentation systems.

Based on the Key Informant's response, it was noted that the NSP package which is offered to PWID contains a sterile syringe package with alcohol swabs and condoms. Total 1 package of sterile syringes given as many as 7 pieces for 1 week. Opening hours and days of NSP services are very limited. Outside this time, PWID can access NSP from outreach workers. According to the Key Informant, those availing NSP do not have access to OST services.

> *"The services provided include the provision of sterile syringes, condoms and alcohol swabs" Key Informant 1*

> *"NSP is specifically for patients who do not have access to methadone while the purpose of both services is behavior change. 1 person gets 7 needles for 1 week" Key Informant 2*

> *"The service on Friday is briefly operated between 13.00-15.00 hours, due to the fear of disturbing other services" Key Informant 3*

The work carried out by NSP service providers is through collaboration with NGOs who conduct outreach. The task of outreach itself is to distribute sterile needles/syringes in the field and encourage clients to access health services.

> *"The outreach service is finding new users and encouraging them to access health services. Outreach is carried out in collaboration with NGOs. Peer educators from Penjaringan Community Health Center are encouraged to influence, invite and refer their peers to access services." Key Informant 2*

Information, Education and Communication (IEC) materials to support behavioral changes in NSP clients are very limited. These materials (posters and brochures) originated from the HIV program several years ago and has not been updated.

Education related to safe sexual behaviors is carried out by promoting the use of condoms. Condoms services are provided in health centres, as well as through outreach workers.

> *"Repeated counselling, provision of condoms, learning by doing." Key Informant 1*

"The strategy is to always provide condoms to patients who access services in the harm reduction unit and to encourage its use." Key Informant 2

NSP is a gateway to access other health care services. Including HIV testing that synergize with ART. PWID are encouraged by the 'Test and Treat' strategy. When it has been found positive, the client will be immediately encouraged to take ART treatment.

"HIV services are separate from Harm Reduction service, so the strategy is to refer PWID to the relevant units. In this case the HIV clinic for testing and access to ART." Key Informant 2

"If the results are positive then ART access must be monitored, if compliance is followed - then early prevention with condom use and periodic preventive follow ups are done." Key Informant 3

"There are brochures and information sheets about ART. But these approaches are less effective, because they like more sophisticated media. They have to look for information via the internet." Key Informant 3

The NSP centre is a separate room in private with limited, uncomfortable conditions and lack of ventilation. The inter-service referral system to meet the needs of clients is running well and quick. In each service, there is already a client satisfaction questionnaire to be used as an internal evaluation.

"We have bi-monthly meetings with the aim is to get feedback from family/friends of PWID. But they rarely express their opinions at the meeting, even though they should. We have a suggestion box too, but none received till now" Key Informant 2

"There is a satisfaction survey held with PWID once a year." Key Informant 3

According to the Key Informant, services provided by the NSP providers have implemented the principle of not stigmatizing and discriminating against drug users and being gender-friendly. The strategies carried out differ.

"Humanizing all PWID and emphasizing upon non-stigma practiced by all officers is basically humanity" Key Informant 1

"The NSP Clinic's entrance is secluded from the main hospital gate. Clients can simply enter by knocking on the door and there is no need to queue. This makes it easier for our friends who face discomfort." Key Informant 2

"Creating a discrimination-free environment has often been discussed by the Head of Puskesmas and other high-ranking officials. Services that are provide must not be discriminating. So, in my opinion, it has become a practice among the staff. It is important to adhere to the principle of not discriminating patients." Key Informant 2

All Key Informants that were interviewed stated that Naloxone was not available in their service centres. Naloxone is only available in hospitals and should only be given by trained doctors.

"There is no naloxone, there has never been a case of overdose." Key Informant 1

"Naloxone is only available in hospitals, those who handle it must be a trained doctor. At the Puskesmas[1] there is no Naloxone. I just agree if provision of Naloxone to PWID to prevent the occurrence of an overdose is needed, but the funding will be very large at the state or provincial level. We don't know when PWID will use substances in excessive ways and end up having overdose." Key Informant 2

"Nothing, refer overdose cases to the nearest hospital, the emergency team needs Naloxone" Key Informant 3

The staffs that run NSP service are partly experienced and have received Harm Reduction training 3 to 10 years ago. According to Key Informants, internal coordination meetings were held regularly to update the field situation once every 3 months.

"There are currently two Officers, one who has joined one month ago. While the other officer who is also in-charge of the clinic, conducted training in 2010. The Health Office should keep providing updated information every three months through team meetings." Key Informant 2

"The last training was conducted in 2017, it should be done at least twice every year." Key Informant 3

4.2 OST Service

For OST services, the service providers visited one community health centre (Tambora) and one drug dependency hospital (RSKO Cibubur).

OST services available at the hospital are divided into Buprenorphine (BMT) and MMT. Whereas, only MMT is available at the Puskesmas. The services provided are not much different, because compulsory and additional counselling is provided. Additional counselling is given, if the client feels the need or found indications of deviant behavior.

The services provided are not only related to OST. But there is a synergy with other services outside the OST. Adherence counselling is given by encouraging patients to analyze the benefits of the behavior carried out and to be productive in their lives.

"The strategy undertaken by doctors and nurses is to provide mandatory and voluntary counselling and additional counselling. The form of counselling is to explore and encourage patients to express problems that bother them. As with the principle of counselling in general, the efforts made do not force patients themselves, but rather seek patients to find some solutions that they are capable of and help reflect them in their daily lives" Key Informant 4

"That is for patients who are addicted to drugs, here is just Methadone. It tells the benefits of quitting from drugs and to analyze the benefits of quitting" Key Informant 7

There is an existing national OST guidelines from the Ministry of Health provided at the OST site and additionally an internal SOP document is available that is more detailed and comprehensive. The OST service flow is displayed on the walls of the clinic. The system for recording and reporting OST access and referral system is well documented. Existing OST services are receiving referral cases and clients come from out of town with easy procedures and also taking a home dose.

1 *Government supported Community Health Centre (CHC) that offers general healthcare services also including NSP, OST, ART, TB treatment*

"We proceed with a urine test, opiates must be tested positive; an agreement is signed with the family to comply, and there are standard pre-requisites such as photocopies of ID cards of client and family has to be submitted." Key Informant 4

"In order to enroll in OST services, they have to be accompanied by a guardian, which is followed by a three day consultation with psychiatrist for dose adjustment. Day 4, clients don't need to come with guardians." Key Informant 5

OST service rooms are following the minimum standards in the OST national guidelines. Communication, documentation and referral system between services are running well. Coordination with outside parties engaged in related fields is rarely done.

Every health care service for PWID has been integrated with HIV services, so for clients who still do not know their HIV status and risk, it is recommended to tested for HIV.

"Internal referrals are standard service guidelines." Key Informant 6

"Same as before, after previously carried out the assessment will be given a referral following the diagnosis" Key Informant 7

Gender-friendly strategies have been implemented in the service facility where the Key Informant is working. No special treatment is given, so it is liked by other patients who access the service.

"There is no specific strategy that we do, we just run according to the existing rules. We carry out according to the given procedures in providing services. It doesn't distinguish any gender, and equal to all" Key Informant 4

"Yes, there is no difference in provision of services and is always for the client. Senior officers attend directly if there are problems with patients" Key Informant 7

Capacity building for staffs is often done internally and externally. Monitoring and technical guidance visits are regularly conducted by the Ministry of Health. Service review and evaluation are conducted internally within 3 months.

Information related to the need for staff sensitivity to OST clients is always provided in the form of training, whether related to key populations of HIV or effective communication.

"Every time a new staff joins, they must be trained first, the training is related to gender or HIV and key populations" Key Informant 4

"The training is focused on effective communication. A discrimination free environment can be seen in the waiting room where all patients gather" Key Informant 6

All procedures in OST services are informed to all patients in advance that includes from nominal fee, service hours and other mandatory requirements. There's a visible decline in patients seen on a yearly basis which makes it difficult for the officers at the OST site.

"It has been explained to all patients about the flexible timings. If someone is working then we accommodate them but insist on exploring OST site close to the work location. The clinic timings are flexible, including the need for take-home dosage" Key Informant 6

A patient satisfaction survey is carried out by the Key Informant along with academicians on the role of PWID for program sustainability.

> *"We have collaborated with academicians to carry out a patient satisfaction survey on the feedback of services provided to them. That becomes the basis of our work and also helps in program planning. Drug user patients fill feedback forms and submit in the suggestion boxes. These forms are then segregated in the evaluation or feedback category" Key Informant 4*

The Key Informant felt that the OST service need to be evaluated for its effectiveness and there was a need of intensive monitoring efforts. Capacity building is also needed for officers in providing services and to maximize the effect therapy provided.

> *"Reviewing the methadone program is it still feasible because at the moment there are a lot of mix drugs use (obtained from the OST client spot-check results)" Key Informant 7*

5. RESULT: STAKEHOLDER PERSPECTIVE

This information was obtained through stakeholder interviews at the national level. These Key Informants were management level personnel and representatives from UNAIDS, UNODC and the Ministry of Health (sub-directorate of HIV and drug use) and the DKI Jakarta Provincial Health Office (MoH).

Most Key Informants were of the opinion that the Harm Reduction program for PWID (NSP and OST services) was effective. The successful factor is noticeable from the evident decline in HIV transmission rates among PWID due to easy access and availability of MMT services. This proves that PWID can be productive (work and re-socialize) after being inducted into the MMT program. But there are still several things that need to be improved, such as the quality of other Harm Reduction services and implementation of policies that are supportive of the program, and the need for an expansion of services.

"There are 3 determinants of success; namely civil society that acts as a bridge between drug users and the government; the government as service providers and the quality of program implementation." UNODC Key Informant

"Theoretically, it is well known that the Harm Reduction program is the most effective. The most important factor for achieving success is its policy. The implementation of the policy and the objectives are certain." UNAIDS Key Informant

"Very effective, proven to have greatly reduced HIV transmission rates among PWID. The main determinants of Harm Reduction success are 2 services, NSP and MMT." MoH Key Informant

All stakeholders agree that drug users should be diverted to rehabilitation services rather than imprisonment. This is a provision actually under the applicable law, but in practice, it is not implemented. This is caused due to a lack of supervision in the implementation of the law. Therefore, the PWID community members are needed to be equipped with knowledge and understanding of the law so that, in case, that they are arrested, they are aware of the basic human rights they can avail under the law.

"If a drug user is arrested, then s/he must be diverted to rehabilitation whilst the drug dealers need to be sent to prison. At present this arrangement exists at the policy level and not implemented due to lack of allocation of budget." UNODC Key Informant

"We have to strengthen the judiciary system on how to supervise the implementation of laws in Indonesia. The PWID community members must also be informed about basic human rights under the law." UNAIDS Key Informant

"My view is to harmonize rules with the law. Is there a plan for harmonizing" MoH Key Informant

Most Key Informants agreed that the Harm Reduction program for PWID must be a national priority in terms of preventing the spread of HIV. However, based on statistics on HIV, budget need to be considered as a national priority.

"Now this is a priority, because the policy exists and because PWID is closely related to HIV." UNODC Key Informant

"This program is a priority because of the relevance of HIV, therefore priority is HIV, not the drug use." UNAIDS Key Informant

"Policy may be depending upon the existing data and according to the priority scale. There are higher trends in the spread of HIV through a sexual transmission so the spread through injecting is not a priority. However, it cannot be ignored." MoH Key Informant

If international donors do not support HIV programs in the country, then the funding responsibility must have to be considered within the national/local budget. Not all provinces in Indonesia have large funding allocations. It cannot be denied that there will be a reduction in several harm reduction programs. Priorities will be adjusted based on the availability of local funding.

"HIV is a national priority and the country must be prepared by diverting funding through local sources such as APBN or APBD through Bappenas[2]." UNODC Key Informant

Some key informants stated that they were unsatisfied with the functioning of the Harm Reduction program and felt that all the components have not done well and needed to be improved. Only one key informant said that he is satisfied with the existing Harm Reduction program because there has been an increase in services for PWID even though it has not reached the target.

"Currently there is progress, but it is not enough and must be improved." UNODC Key Informant

"Not satisfied, because new infections have still been found in injecting drug users." UNAIDS Key Informant

"I will be satisfied if people already know about HIV and how to prevent it." MoH Key Informant

According to the UNAIDS, there is no guideline, that relates to scientific evidence on the quality of Harm Reduction program services whilst according to UNODC the existing program components are the best practices. According to the Ministry of Health Indonesia, the need is regular trainings for health workers in order to increase their knowledge and skills.

"At present, there are no international guidelines that is related to scientific evidence about the quality of service programs that run well." UNAIDS Key Informant

"Even if there are no patients, we still have to be ready. There must be refresher trainings." MoH Key Informant

2 *National Planning Board in Indonesia*

6. RESULT: COMMUNITY PERSPECTIVE

This section is based on information derived from the community survey through one-on-one interviews with PWID in Bandung and Jakarta. The total number of respondents interviewed was 307 people.

6.1 Socio-Demographics

Most of the respondents are male, with the majority of young people among Bandung respondents and adults among Jakarta respondents. The proportion of respondents who have a partner and those who do not have a partner is relatively the same. More than half the respondents have secondary education or above. Only a small proportion (13%) of respondents did not have a job. Average monthly income varies between IDR 125,000 – 40,000,000 and there are a small number of respondents who claim to have sold sex to get money or drugs.

6.1.1 Age

The age of respondents from the two cities ranged between 18 to 54 years, with a median of 32 years. More than one-fourth (28.01%) of these fall into the adolescent age category (18-24 years). In Bandung, nearly half the respondents (48.73%) fall into the same category, with a median age of 25 years. Whereas Jakarta respondents were aged 25 years and over, with a median age of 37 years.

Table 3: Age Category

Age Category	Bandung	% Bandung	Jakarta	% Jakarta	N total	% N total
18-24 years	77	48.73%	9	6.04%	86	28.01%
25-30 years	28	17.72%	17	11.41%	45	14.66%
31-35 years	17	10.76%	39	26.17%	56	18.24%
36-40 years	20	12.66%	49	32.89%	69	22.48%
> 41 years	16	10.13%	35	23.49%	51	16.61%
Grand Total	**158**	**100%**	**149**	**100%**	**307**	**100%**
Median	25		37		32	
Minimal	18		23		18	
Maximal	49		54		54	

6.1.2 Gender

Majority of respondents were males (91.53%). The proportion of female respondents in Bandung (3.8%), is smaller than female respondents in Jakarta (13.42%).

Table 4: Gender Category

Gender Category	Bandung	% Bandung	Jakarta	% Jakarta	N total	% N total
(Male)	152	96.20%	129	86.58%	281	91.53%
(Female)	6	3.80%	20	13.42%	26	8.47%
Grand Total	**158**	**100%**	**149**	**100%**	**307**	**100%**

6.1.3 Marital Status

One-third of respondents (32.57%) are married or living together in a household. Nearly half of the respondents (46.9%) did not have a partner and were single, divorced/separated or widow/widower.

Table 5: Marital Status

Marital Status	Bandung	% Bandung	Jakarta	% Jakarta	N total	% N total
(Married or cohabiting husband/wife/partner is currently living in a household)	37	23.42%	63	42.28%	100	32.57%
(Married or cohabiting but husband/wife/ partner is temporarily living/working away from the household)	1	0.63%	8	5.37%	9	2.93%
(In a relationship but not living together)	39	24.68%	15	10.07%	54	17.59%
(Single)	51	32.28%	35	23.49%	86	28.01%
(Divorced/separated)	25	15.82%	22	14.77%	47	15.31%
(Widow/widower)	5	3.16%	6	4.03%	11	3.58%
Grand Total	**158**	**100%**	**149**	**100%**	**307**	**100%**

6.1.4 Level of Education

More than half the respondents (55.05%) had completed higher secondary education and around 12.05% respondents had studied to college level or higher.

Table 6: Level of Education

Level of Education	Bandung	% Bandung	Jakarta	% Jakarta	N total	% N total
(Primary completed)	18	11.39%	11	7.38%	29	9.45%
(Secondary completed)	41	25.95%	30	20.13%	71	23.13%
(Higher secondary completed)	84	53.16%	85	57.05%	169	55.05%
(College level or higher)	15	9.49%	23	15.44%	37	12.05%
Grand Total	**158**	**100%**	**149**	**100%**	**307**	**100%**

6.1.5 Current Job

Nearly half the total respondents (43.97%) have regular jobs and while the other 43% have irregular jobs such as freelancer, street singer/musician, taxi-bike driver, parking attendant etc. the remaining 13.3% are unemployed.

Table 7: Job Category

Job Category	Bandung	% Bandung	Jakarta	% Jakarta	N total	% N total
(Office employee)	4	2.53%	1	0.67%	6	1.95%
(Self-employed)	45	28.48%	41	27.52%	89	28.99%
(Employed, salaried, work for others)	23	14.56%	17	11.41%	40	13.03%
(Unemployed)	24	15.19%	17	11.41%	40	13.03%
(Other)	62	39.24%	73	48.99%	132	43.00%
Grand Total	**158**	**100%**	**149**	**100%**	**307**	**100%**

6.1.6 Average monthly income

The average income per month is between IDR 125,000 to 40,000,000. The median income among respondent in Bandung is IDR 2,000,000 and Jakarta IDR 3,000,000.

Table 8: Average Income

Average monthly income (IDR)	Bandung	Jakarta
Minimum	200K	125K
Maximum	12000K	40000K
Median	2000K	3000K

6.1.7 Sell sex for money/drugs

The number of respondents who were indulged in selling sex to get money or drugs in the last 12 months is very low (1.63%). Respondents who have sold sex for drugs were male.

Table 9: Sell sex for money/drugs

Sell sex for money/drugs in the last 12 months	Bandung	% Bandung	Jakarta	% Jakarta	N total	% N total
(No)	155	98.10%	145	97.32%	300	97.72%
(Yes)	1	0.63%	4	2.68%	5	1.63%
(Refuse to answer)	2	1.27%	0	0.00%	2	0.65%
Grand Total	**158**	**100%**	**149**	**100%**	**307**	**100%**

6.2 Utilization and quality of NSP services

Almost all the respondents (86.32%) have accessed NSP services at least once in the last 4 weeks.

Table 10: Access NSP

Access NSP in the Last 4 Weeks	Bandung	% Bandung	Jakarta	% Jakarta	N total	% N total
(No)	26	16.46%	16	10.74%	42	13.68%
(Yes)	132	83.54%	133	89.26%	265	86.32%
Grand Total	**158**	**100%**	**149**	**100%**	**307**	**100%**

A large majority of respondents (83%) meet either with Outreach Workers (ORW) or Peer Educators (PE) who provide NSP services in the past 4 weeks. While a few respondents (17%) do not meet the NSP service staffs.

Table 11: Meet Outreach Worker or Peer Educator

Meet ORW or PE from the NSP site in the last 4 weeks.	Bandung	% Bandung	Jakarta	% Jakarta	N total	% N total
(No)	37	23%	15	10%	52	17%
(Yes)	121	77%	134	90%	255	83%
Grand Total	**158**	**100%**	**149**	**100%**	**307**	**100%**

More than half the respondents were satisfied (55.05%) and very satisfied (8.14%) of the overall quality of NSP services. About 14.66% were not satisfied while another 22.15% were neither satisfied nor unsatisfied.

Table 12: Level of Satisfaction of NSP

The level of satisfaction with the overall quality of the NSP	Bandung	% Bandung	Jakarta	% Jakarta	N total	% N total
(Very satisfied)	5	3.16%	20	13.42%	25	8.14%
(Satisfied)	82	51.90%	87	58.39%	169	55.05%
(Neutral)	41	25.95%	27	18.12%	68	22.15%
(Unsatisfied)	30	18.99%	15	10.07%	45	14.66%
Grand Total	**158**	**100%**	**149**	**100%**	**307**	**100%**

6.3 History of utilization of drug treatment services

More than one-third of respondents (37.13%) had received any drug treatment and 33.2% accessed OST in the last 12 months.

Table 13: Received Drug Treatment

Received Any Drug Treatment	Bandung	% Bandung	Jakarta	% Jakarta	N total	% N total
(No)	127	80.38%	66	44.30%	193	62.87%
(Yes)	31	19.62%	83	55.70%	114	37.13%
Grand Total	**158**	**100%**	**149**	**100%**	**307**	**100%**

Most respondents who accessed the OST (81.82%) expressed satisfaction with the dose of OST they receive and 10.91% respondents were not satisfied with their dosages as according to them it was either lower or higher that their required dosage.

Table 14: Satisfaction on OST dose

Satisfaction with the OST dose given	Bandung	% Bandung	Jakarta	% Jakarta	N total	% N total
(Yes)	12	44.44%	78	93.98%	90	81.82%
(No, it is lower than what I need)	7	25.93%	3	3.61%	10	9.09%
(No, it is higher than what I need)	0	0.00%	2	2.41%	2	1.82%
(Refuse to answer)	8	29.63%	0	0.00%	8	7.27%
Grand Total	**27**	**100%**	**83**	**100%**	**110**	**100%**

Adherence counselling and behavior change communication while receiving OST services was availed by 74.51% respondents.

Table 15: Counseling on OST program

Adherence counselling and behavior change communication while in the OST program	Bandung	% Bandung	Jakarta	% Jakarta	N total	% N total
(No)	5	26.32%	19	22.89%	24	23.53%
(Yes)	14	73.68%	62	74.70%	76	74.51%
(Don't know)	0	0.00%	2	2.41%	2	1.96%
Grand Total	**19**	**100%**	**83**	**100%**	**102**	**100%**

OST was introduced in Indonesia in 2007. Till 2014, PWID were provided basic information through peers on the benefits of OST, availability and accessibility. However, this information was not provided through the Puskesmas[3] staff as they did not carry out field level activities. There were no administrative requirements for accessing OST but lately, they are doing urine tests as part of a routine assessment procedure of OST clients. The earlier selection criteria was a health diagnosis to establish opioid dependence; were referred by peers or escorted by a partner/family and had willingness to receive OST along with the economic ability to pay daily administrative costs." FGD OST Jakarta.

6.4 Satisfaction of the OST services

93.14% respondents said the health workers conduct detailed assessments for drug use dependence before induction into the OST program.

The satisfaction of information provided by services providers to respondents availing OST services was established through a scale of 1 to 5. Number 1 being the best and 5 being the worst satisfaction level. The tables below are responses by respondents who avail OST.

3 *Government supported Community Health Centre (CHC) that offers general healthcare services also including NSP, OST, ART, TB treatment*

Table 16: Satisfaction of OST service #1

Service providers explain well about the benefits of OST	Bandung	Jakarta	N total
Minimal	1	1	1
Maximal	3	4	4
Median	2	2	2

Table 17: Satisfaction of OST service #2

The perfection of OST services received	Bandung	Jakarta	N total
Minimal	2	1	1
Maximal	5	4	5
Median	3	2	3

Table 18: Satisfaction of OST service #3

Accessibility to doctors as needed	Bandung	Jakarta	N total
Minimal	1	1	1
Maximal	4	5	5
Median	2	2	2

Table 19: Satisfaction of OST service #4

Hospitality received at OST Service	Bandung	Jakarta	N total
Minimal	1	1	1
Maximal	5	5	5
Median	2	2	2

Table 20: Satisfaction of OST service #5

The ability to get the services needed	Bandung	Jakarta	N total
Minimal	2	1	1
Maximal	5	5	5
Median	3	4	3

Of all the variables, some respondents scored 4 or 5, while the average satisfaction rating was in the range of 2 to 3.

"Officers at the OST site in Tambora[4] are not friendly but are very good with us at Grogol Petamburan[5]. We usually come to take medicine (OST), then hang out. At the beginning of treatment, the procedures are explained to us but not in details, such as to be taken for life time and side effects of OST. We are only told that Methadone is a substitution for Heroin. The place is less private (Tambora), too open and less comfortable. OST services are mixed with other services." FGD OST Jakarta

4 OST site
5 OST site

6.5 Overdose Management

More than one-third of respondents (37.13%) have experienced a drug related overdose. Only 3.51% respondents responded that they had experienced a drug related overdose in the last seven days. However, 71.93% respondents had experienced an overdose more than a year prior to the time of the community survey.

Table 21: Overdose Experience

Drug Overdose Experience	Bandung	% Bandung	Jakarta	% Jakarta	N total	% N total
(No)	98	62.03%	95	63.76%	193	62.87%
(Yes)	60	37.97%	54	36.24%	114	37.13%
Grand Total	**158**	**100%**	**149**	**100%**	**307**	**100%**

Table 22: Last Time Overdosed

When was the last time that you overdosed	Bandung	% Bandung	Jakarta	% Jakarta	N total	% N total
(Within 7 days)	4	6.67%	0	0.00%	4	3.51%
(Between 7 and 30 days)	2	3.33%	0	0.00%	2	1.75%
(Between 1 and 6 months)	4	6.67%	1	1.85%	5	4.39%
(Between 6 and 12 months)	13	21.67%	3	5.56%	16	14.04%
(More than a year ago)	37	61.67%	45	83.33%	82	71.93%
(Don't know)	0	0.00%	5	9.26%	5	4.39%
Grand Total	**60**	**100%**	**54**	**100%**	**114**	**100%**

Almost half the respondents (50.49%) have been educated about overdose. But 68.4% said they did not know what Naloxone is.

Table 23: Overdose Education

Ever Overdosed Education	Bandung	% Bandung	Jakarta	% Jakarta	N total	% N total
(No)	82	51.90%	49	32.89%	131	42.67%
(Yes)	74	46.84%	81	54.36%	155	50.49%
(Don't know)	2	1.27%	19	12.75%	21	6.84%
Grand Total	**158**	**100%**	**149**	**100%**	**307**	**100%**

Table 24: Naloxone

The experience of getting naloxone	Bandung	% Bandung	Jakarta	% Jakarta	N total	% N total
(I get it from an outreach worker (I know))	0	0.00%	47	31.54%	47	15.31%
(I can get it from a service centre/hospital/OST/NSP ite)	4	2.53%	12	8.05%	16	5.21%
(Naloxone is not provided in our area)	20	12.66%	13	8.72%	33	10.75%

(Don't know, what naloxone is)	133	84.18%	77	51.68%	210	68.40%
(Refuse to answer)	1	0.63%	0	0.00%	1	0.33%
Grand Total	**158**	**100%**	**149**	**100%**	**307**	**100%**

"I barely hear information about overdose, let alone the availability of Naloxone." FGD NSP Jakarta

"Never received information on Naloxone." FGD NSP Bandung

6.6 Linkage to HIV testing and ART

Approximately (92.16%) stated that they had been offered HIV testing services. Of these, 95.27% respondents have been tested for HIV. Only a small proportion (4.73%) of respondents from Bandung said that they have never been tested for HIV. The most common reasons given for not getting testing for HIV: "I feel, I'm not at risk for HIV", "Fear of positive results" and "No time to get tested".

Table 25: HIV Testing

HIV testing experience	Bandung	% Bandung	Jakarta	% Jakarta	N total	% N total
(No)	14	8.86%	0	0.00%	14	4.73%
(Yes)	144	91.14%	149	100.00%	293	95.27%
Grand Total	**158**	**100%**	**149**	**100%**	**307**	**100%**

A small number of respondents stated that they had coerced/forced to HIV testing without consent (2.39%) and HIV testing as a mandatory requirement (5.8%).

Table 26: HIV Test Result

HIV test results	Bandung	% Bandung	Jakarta	% Jakarta	N total	% N total
1 (Positive)	19	13.19%	66	44.30%	85	29.01%
2 (Negative)	121	84.03%	79	53.02%	200	68.26%
4 (Did not Receive Result)	4	2.78%	4	2.68%	8	2.73%
Grand Total	**144**	**100%**	**149**	**100%**	**293**	**100%**

Approximately 13.19% respondents in Bandung and 44.3% respondents in Jakarta agreed to disclose their HIV positive status. All Bandung respondents had received CD4 test and access to ART (100%). Whereas Jakarta respondents, 90.91% had had a CD4 test and 86.36% had accessed ART.

"The referral system provided for HIV both testing and treatment has been integrated, so it is very easy for us to avail these services." FGD NSP Jakarta

"For those on OST, prescription drugs are obtained from MMT clinics, they access ART from CST clinics." FGD OST Bandung

6.7 Linkages to Hepatitis B and C, and Tuberculosis diagnosis and treatment

More than half (57.98%) respondents had information on Hep B, but only 7.53% of respondents had had a Hepatitis B vaccine. Less than a quarter (21.82%) of respondents had a Hepatitis B test.

Table 27: Hep B Test Experience

Hep B test experience	Bandung	% Bandung	Jakarta	% Jakarta	N total	% N total
(Yes)	30	18.99%	37	24.83%	67	21.82%
(No)	125	79.11%	112	75.17%	237	77.20%
(Don't know)	3	1.90%	0	0.00%	3	0.98%
Grand Total	**158**	**100%**	**149**	**100%**	**307**	**100%**

76.22% of all respondents had received information about Hep C. Of these (93.29%) respondents were from Jakarta while (60.13%) respondents were from Bandung.

Table 28: Hep C Test Experience

Hep C test experience	Bandung	% Bandung	Jakarta	% Jakarta	N total	% N total
(Yes)	57	36.08%	115	77.18%	172	56.03%
(No)	98	62.03%	33	22.15%	131	42.67%
(Don't know)	3	1.90%	1	0.67%	4	1.30%
Grand Total	**158**	**100%**	**149**	**100%**	**307**	**100%**

Of those who were tested for Hep C, 59.09% respondents said that they got positive results. Only 27.19% respondents have successfully completed Hep C treatment.

Table 29: Hep C Test Result

Hep C test results	Bandung	% Bandung	Jakarta	% Jakarta	N total	% N total
(Positive)	30	50.00%	74	63.79%	104	59.09%
(Negative)	23	38.33%	39	33.62%	62	35.23%
(Don't know)	7	11.67%	3	2.59%	10	5.68%
Grand Total	**60**	**100%**	**116**	**100%**	**176**	**100%**

Table 30: Hep C Therapy Experience

Experience with Hep C therapy	Bandung	% Bandung	Jakarta	% Jakarta	N total	% N total
(Yes, Completed)	11	29.73%	20	25.97%	31	27.19%
(Yes, Currently on Treatment)	1	2.70%	7	9.09%	8	7.02%
(No)	24	64.86%	49	63.64%	73	64.04%
(Refuse to answer)	1	2.70%	1	1.30%	2	1.75%
Grand Total	**37**	**100%**	**77**	**100%**	**114**	**100%**

According to respondents, Hep C services is facilitated through the government (65.12%), private donors (13.95%) and self-purchase (13.93%). The level of satisfaction with Hepatitis C therapy services, 70.73% of respondents said they were satisfied and 19.51% said they were very satisfied.

Table 31: Satisfaction with Hep C Therapy

Satisfaction with Hep C therapy services	Bandung	% Bandung	Jakarta	% Jakarta	N total	% N total
(Very satisfied)	3	23.08%	5	17.86%	8	19.51%
(Satisfied)	8	61.54%	21	75.00%	29	70.73%
(Neutral)	1	7.69%	1	3.57%	2	4.88%
(Unsatisfied)	1	7.69%	1	3.57%	2	4.88%
Grand Total	**13**	**100%**	**28**	**100%**	**41**	**100%**

15.31% respondents were diagnosed with TB infection and 82% of these had received TB treatment. 65.91% were satisfied and 20.45% expressed very satisfied with the TB treatment services.

Table 32: TB Diagnosed Experience

Experience diagnosed with TB	Bandung	% Bandung	Jakarta	% Jakarta	N total	% N total
(No)	142	89.87%	115	77.18%	257	83.71%
(Yes)	14	8.86%	33	22.15%	47	15.31%
(Don't know)	2	1.27%	1	0.67%	3	0.98%
Grand Total	**158**	**100%**	**149**	**100%**	**307**	**100%**

Table 33: TB Therapy Experience

Experience of TB therapy	Bandung	% Bandung	Jakarta	% Jakarta	N total	% N total
(No)	5	31.25%	1	2.94%	6	12.00%
(Yes)	9	56.25%	32	94.12%	41	82.00%
(Don't know)	2	12.50%	1	2.94%	3	6.00%
Grand Total	**16**	**100%**	**34**	**100%**	**50**	**100%**

"Received (all) information when mentoring or counselling, but what is usually provided is an NGO officer, not from the service team." FGD NSP Jakarta

6.8 Stigma and Discrimination

Of the total respondents, 79.48% claimed they were not shunned by their families for using drugs. 72.64% do not feel apprehension in coming for health services.

Table 34: Stigma/Discrimination from Family

Feeling shunned by the family for using drugs	Bandung	% Bandung	Jakarta	% Jakarta	N total	% N total
(No)	135	85.44%	109	73.15%	244	79.48%
(Yes, in the last 6 months)	15	9.49%	32	21.48%	47	15.31%
(Yes but not in the last 6 months)	6	3.80%	7	4.70%	13	4.23%
(Don't know)	2	1.27%	1	0.67%	3	0.98%
Grand Total	**158**	**100%**	**149**	**100%**	**307**	**100%**

In the last 6 months, 2.46% respondents were subject to humiliation by health workers while receiving OST services and 3.26% respondents felt insulted by health workers while receiving NSP services. Almost none (0.98%) were insulted by Outreach Workers / Peer Educators.

Table 35: Stigma/Discrimination from Health Services

Fear comes to health services	Bandung	% Bandung	Jakarta	% Jakarta	N total	% N total
(No)	114	72.15%	109	73.15%	223	72.64%
(Yes, in the last 6 months)	30	18.99%	25	16.78%	55	17.92%
(Yes but not in the last 6 months)	14	8.86%	15	10.07%	29	9.45%
Grand Total	**158**	**100%**	**149**	**100%**	**307**	**100%**

Majority (86.32%) respondents, claimed they have never been defied because of their PWID status. 3.91% respondents have been arrested for using drugs in the last 6 months and 13.03% were arrested more than 6 months.

Table 36: Arrested for Using Drugs

Arrested for using drugs	Bandung	% Bandung	Jakarta	% Jakarta	N total	% N total
(No)	133	84.18%	122	81.88%	255	83.06%
(Yes, in the last 6 months)	5	3.16%	7	4.70%	12	3.91%
(Yes but not in the last 6 months)	20	12.66%	20	13.42%	40	13.03%
Grand Total	**158**	**100%**	**149**	**100%**	**307**	**100%**

Of the respondents who have been imprisoned, there were 25.49% who had been injecting drugs in prison. A small proportion (5.88%) respondents have availed OST inside prisons.

Table 37: Using/Injecting Drugs in Prison

Experience using / injecting drugs in prison	Bandung	% Bandung	Jakarta	% Jakarta	N total	% N total
(No)	15	62.50%	16	59.26%	31	60.78%
(Yes, oral drugs only)	4	16.67%	0	0.00%	4	7.84%
(Yes, injected drugs)	3	12.50%	10	37.04%	13	25.49%
(Don't know)	0	0.00%	1	3.70%	1	1.96%
(other)	2	8.33%	0	0.00%	2	3.92%
Grand Total	**24**	**100%**	**27**	**100%**	**51**	**100%**

"Never had trouble getting a needle. We are smart to clean used needles, there is already a policy, so it's not a problem." FGD NSP Jakarta

"OST service itself is (already) gender friendly. But in other psychiatric services, sometimes there are 10% women who maybe lacking services." FGD OST Bandung

7. CONCLUSIONS

In general, stakeholders and health service providers felt that they have carried out their work according to their respective capacities, the results obtained might not been optimal. They realized that there are still many aspects in the overall harm reduction response needed to be improved. Based on the community perspective, below is a breakdown by the service components.

7.1 NSP: All respondents claimed to have accessed NSP. Approximately 86.32% respondents accessed NSP in the last 4 weeks.

Not all respondents meet with Outreach Workers/Peer Educators when they access NSP services. Only 83% respondents affirmed that they met with Outreach Workers/Peer Educators in the past 4 weeks.

More than half of respondents said they were satisfied (55.05%) and very satisfied (8.14%) of the overall quality of NSP services.

7.2 OST: More than one-third (37.13%) respondents have received drug treatment service. Approximately 33.2% have accessed OST services within the last 12 months.

Most respondents (81.82%) expressed satisfaction with the OST dosing they received. 93.14% said the health workers carry out detailed assessments for drug dependence before inducting into the OST services.

Adherence counselling and behavior change communication while in the OST program was received by 74.51% respondents. Almost all (92.16%) respondents stated that they had been offered HIV testing services.

7.3 Overdose: More than one-third (37.13%) respondents have ever experienced drugs use related overdose. From these, 71.93% of respondents experienced drugs use related overdose more than a year ago. Only 3.51% reported experiencing overdose in the last one week.

Half of the respondents (50.49%) have been educated on drug use related overdose. 68.4% said they did not know what Naloxone is.

7.4 HIV Testing and ART: Almost all respondents (95.2%) have been tested for HIV. Only a small proportion (4.73%) respondents from Bandung said that they had never been tested for HIV. The most common reasons given for not getting tested were: i) "I feel I'm not at risk for HIV", ii) "Fear of positive results", iii) "No time to get tested".

Approximately 13.19% respondents from Bandung and 44.3% respondents from Jakarta agreed to disclose that they were tested positive for HIV. All Bandung respondents who were HIV positive had received a CD4 test and access to ART (100%). Whereas in Jakarta, 90.91% respondents received CD4 test and 86.36% had accessed ART.

7.5 Hepatitis B, Hepatitis C and Tuberculosis: More than half the respondents (57.98%) had received information on Hep B. From these, only 7.53% respondents received Hep B vaccine and 21.82% respondents had undergone a Hepatitis B test.

76.22% respondents stated that they have received information on Hep C. of these, Jakarta respondents were 93.29% as compared to 60.13% respondents from Bandung.

Of those who were tested for Hep C, 59.09% respondents said they were tested positive. 27.19% of these have completed Hep C treatment.

According to the respondents, Hepatitis C treatment services are facilitated through three channels. 65.12% respondents received through government, 13.95% through private donors and 13.93% availed treatment through self. Of these, 70.73% respondents were satisfied and 19.51% were very satisfied with Hepatitis C treatment services.

15.31% respondents have been diagnosed with TB and 82% of them received TB treatment. 65.91% respondents were satisfied and 20.45% were very satisfied with the TB treatment services.

7.6 Stigma and Discrimination: Of the total respondents, 79.48% said that they were not shunned by their families because of their drug use. 72.64% respondents are confident in accessing health services.

In the last 6 months, 2.46% respondents felt humiliated by health workers while receiving OST. Another 3.26% respondents felt insulted by health workers while accessing NSP services. None (0.98%) respondents felt insulted by Outreach Workers/Peer Educators.

Most respondents (86.32%), claimed they had never been harassed because of their drug user status. 3.91% respondents have been arrested for using drugs in the past 6 months and 13.03% have been arrested more than 6 months ago.

Of those who have been imprisoned, 25.49% respondents have injected drugs inside the prison. A small proportion (5.88%) respondents have availed OST in prisons.

8. RECOMMENDATIONS

8.1 To improve the quality of NSP services, it is imperative to scale-up interventions and subsequently increase capacities of Outreach Workers and Peer Educators. Such as assure that needles and syrings available on every NSP services. Start from good documenting inventory, recording and reporting, and longer service operational hours. And for outreach workers and Peer Educators, it should be increasing their knowledge on information (overdose prevention, co-infection, risk assesment and updating regulation related to drugs).

8.2 Although not all PWID need OST services, there is a need for better coordination between referral networks and service providers in order to improve the quality of services. Ideally, in one health service instutution provided to the general public, there are various service units that are also needed by PWID. This services not only for NSP and OST. But also for HIV and STI test, TB treatment, Hepatitis B and C. Built refferal system and coordination between services unit inside the institution or among other institution can run by coordination meeting through technical working group on district/city level.

8.3 In public health perspective, drugs overdose prevention are tertier prevention. Which is a prevention for early death. Increase in avability on IEC materials on prevention and management of overdose, will help outreach workers, peer educators and services staff in health institution in order to giving education for PWID. Besides prevention education, availability of Naloxone is a must.

8.4 HIV testing and treatment strategies for PWID must be aligned with the global strategy 90-90-90 to get more optimal results. Updating SOP on test and treat in Health service institution by socializing for staff regurally. This needs to be done to minimize the impact of employee rotation in health institutions.

8.5 Co-infection is the most comment cause of death in PWID. Examination and treatment of Hep B, Hep C and TB need to be more integrated with existing health care systems. This issue must become a routine discussion topics for services staff and among refferal health institutions.

8.6 Stigma and discrimination among PWID from families and service provider officials, still occur even on a smaller scale. To get a more conducive environment for the implementation of the Harm Reduction program, preventive education and campaigns must scale-up and continue. It can be done by public campaign trough creative media by giving them a massage; *"Drugs dependent issue is public health matters that can be reduce its harm or even it can be stop".*

ANNEXE: ETHICAL CLEARANCE DOCUMENT

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Hal : Persetujuan *Ethical Clearance*

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Dengan hormat,

Setelah melakukan *peer review* terhadap proposal penelitian berjudul:

"Monitoring Berbasis Komunitas terhadap Kualitas Program Layanan Pengurangan Dampak Buruk bagi Pengguna Napza Suntik di Kambodia, India, Indonesia, Thailand dan Vietnam"

dengan ini kami sampaikan bahwa Komisi Etika Penelitian Universitas Katolik Indonesia Atma Jaya menyatakan bahwa proposal laik etik untuk dilaksanakan, sesuai masukan dari Tim Komisi Etika Penelitian terlampir.

Diharapkan setelah pelaksanaan, Saudara dapat memberikan laporan beserta uraian pelaksanaan penjaminan aspek etika penelitian tersebut.

Demikian kami sampaikan, atas perhatian dan kerjasamanya kami ucapkan terima kasih.

Hormat kami,

Dr. Alexander Setiawan, MA
Ketua Komisi Etika Penelitian Unika Atma Jaya

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