HEROIN HARM REDUCTION IN INDONESIA: LESSONS LEARNT FROM OTHER COUNTRIES

Adhi W. Nurhidayat

ABSTRACT

Indonesia has a very significant HIV epidemic among drug injectors. There are 3.2 million drug users with an estimated 580,000 among them injecting drug users (IDUs) and HIV prevalence is very high. Beginning in early 2007, harm reduction approaches were formally approved by the Indonesian government in an attempt to address the HIV problem among IDUs. Indonesia adopted 12 elements of harm reduction from World Health Organization, and Ministry of Health is endorsing it nationwide. However, it is necessary to prioritize some important elements of the harm reduction programs in order for the programs to be successful despite Indonesia’s limited resources. This study aims to describe how harm reduction is implemented in Indonesia, to analyze coverage of harm reduction strategies and determinants of their coverage, to review best practices in harm reduction from other countries and to make contribution towards the harm reduction based on literature review from Indonesia and other countries. This study design is review study in Indonesia and other countries. Data were collected by literature review. The Indonesian government is integrating harm reduction programs into established health systems at 120 sites such as community health center (Puskesmas). Coverage of harm reduction is low. Three main elements (needle exchange, outreach, and substitution therapy) are suggested by experts in developing countries. Shortage of trained service providers and

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1 Sebagian dari tulisan ini adalah kajian penulis untuk memperoleh gelar Master of Public Health dari KIT (Royal Tropical Institute) dan Vrije Universiteit Amsterdam pada tahun 2007
2 MD, MPH
high dependency on external funding agencies will affect sustainability of the programs. Currently, the coverage of harm reduction programs is low with only 2.6% of IDUs participating in needle exchanges and 0.5% of IDUs receiving methadone maintenance treatment nationwide. Lessons learnt for the implementation of harm reduction programs in Indonesia are to prioritize needle exchanges, outreach, and substitution therapy based on local resources, minimize the misuse of substitution therapy, improve readiness of service providers to participate in harm reduction programs, involve key stakeholders (law enforcement authorities, families, drug users, policy makers) in supporting harm reduction, and obtain support from domestic funding agencies to address the problem of sustainability.

**ABSTRAK**

INTRODUCTION

Drug Use situation

National Narcotic Board reported that there are 3.2 million drug users in Indonesia, quarter of them are heavily addicted and injecting drug (NNB, 2005). A national survey in 2003 involving 13,710 respondents aged 16-35 plus in 26 cities, found that 5.8% had been admitted for having used illicit drugs at some point (NNB, 2004).

The National Narcotic Board estimated 520,000 injecting drug users (NNB, 2005), while Pisani (Family Health International) come with estimation number between 145,000-170,000 (Pisani, 2006).

The most popular drugs are marijuana or hypnotic/sedatives, followed by ATS and heroin (Pranata Sosial UI, NNB 2005). Around 60% of IDUs use needles or syringes that someone else had used and share them with other people. A quarter of them also had unsafe sex practices in the year prior to the study. Among 100 respondents with HIV/AIDS, 63 still injected heroin for the last year (Wibowo, 2003).

HIV situation in Indonesia

The first case of AIDS was reported in Indonesian transvestite in 1987, and the first reported AIDS case among IDU was in 1995. Since 2000, HIV epidemic in Indonesia was already concentrated to high-risk sub-population: IDUs, sex workers, and transvestites.
The total number of officially registered HIV/AIDS cases reaching 13,424 HIV/AIDS by the end of 2006 (NAC, 2007).

**Figure 1. Number of AIDS Cases in Indonesia in the last 10 years based on the years when the cases reported until March 31, 2007**

![Graph showing number of AIDS cases in Indonesia from 1998 to 2007]

Source: Ministry of Health, 2007

Estimated number of People Living with HIV/AIDS in Indonesia are between 169,000-217,000. New AIDS cases reported by Ministry of Health is 2,873, injecting drug users are the main (49.6%) cause of this precipitation.

Cumulative AIDS cases (up to March 31, 2007) are collected from 32 provinces and 173 cities/districts. AIDS case cumulative rate is 3.96 per 100,000 population, and cumulative percentage on AIDS cases by mode of transmission are IDU (4,455 cases) 49.6%, heterosexual 41.2%, homosexual 4.3%, perinatal 1.6%, blood transfusion 0.1%, and unknown 3.3%.
Economic cost due to drug dependency is estimated around 23.6 trilium rupiahs or 2.36 billion US dollar (NNB, 2005). Indonesia’s vulnerability to drug problems come from a combination of economy, welfare and political instability. The proportion of people living below poverty line increased from 13% (1997) to more than 35% (after economic crises 1999-2000). Many people can only find jobs in the informal sectors and find selling drugs an interesting option (Irwanto, 2005).

**HIV/AIDS among IDUs**

Health consequences of injecting heroin include increased risk of bloodborne infections such as hepatitis B, C and HIV. IDUs are vulnerable to HIV infection as a result of sharing needles, unsafe sexual contact with other IDUs, and high-risk sexual activity. The chance for IDUs who do not join substitution treatment to become HIV infected is six times higher than IDUs who remain in treatment (WHO, 2004).

60 percent of injecting drug users used needles or syringes that someone else had used and shared them with 2 to 18 other people (Budiutomo, 2003). Sexual transmission also plays an important role among IDUs. Based on behavioral surveillance in 2002, 25% of male IDU had had sex with a female sex worker in the last year. This had a major impact on the epidemic (World Bank, 2005).
There are several institutions related to drugs policy and drug treatment in Indonesia such as National Narcotics Board (BNN), Ministry of Health, Ministry of Justice, and Police Indonesia (Polri).

**Definition of Harm Reduction**

There is no agreement among health professionals as to the definition of harm reduction. Some harm reduction advocate consider the laws reform prohibiting drug possession to be part of harm reduction, while others do not (CCSA, 1996). Others consider the imprisonment of drug users for simple possession to be a form of harm reduction. Health professionals insisting on abstinence may also think of themselves as harm reduction advocates.

*a. Narrow definition*

A policy or programme directed towards decreasing adverse health, social and economic consequences of drug use while the user continues to use drugs (Single, 1997).

*b. Broad definition*

Harm reduction means the employment of any means to reduce the harm resulting from illicit drugs (Wodak, 2005).

*c. IHRA definition*

Comprehensive package of policies and programmes which attempt primarily to reduce the adverse health, social and economic consequences of mood altering substances to individuals, drug users, their families, and their communities (International Harm Reduction Association, 2002).

Definition from IHRA is used in this paper, since it is used worldwide by WHO and elaborate several elements.

**Harm Reduction elements/strategies**

At present, methadone and/or buprenorphine as heroin substitution therapy are available in 59 countries worldwide (Rao, 2007).
According to WHO (2005), harm reduction consists of 12 elements/strategies:

1. **Provision of sterile needles and syringes**
   Providing IDUs with sterile injecting equipment, to ensure that every injection happens with a fresh needle and syringe.

2. **Outreach**
   This activity is organized to reach the optimum number of people in the risky population, to provide drug users with the information to reduce their risk behaviour, and to provide the means to reduce risky behaviour through condoms, bleach, needles and syringes and referrals to a range of health and social services.

3. **Pharmacotherapy services**
   Agonist pharmacotherapy therapy (substitution treatment such as methadone or buprenorphine) usually has two aims: treating drug dependence syndrome and reducing the health risks and negative health effects (such as HIV infection) of drug use.

4. **Information, Education and Communication**
   Specially developed materials that focus on providing explicit information, written in clear and simple language and may focus on the risks of sharing needles and syringes and safer sex.

5. **Risk reduction counseling**
   Usually using information, education and communication materials and aims to educate IDUs about the risks of sharing injecting equipment and unprotected sex, and to help individuals to clarify their feelings and thinking.

6. **Voluntary HIV/AIDS Counseling and Testing**
   These programmes seek to change risky behaviour related to HIV/AIDS among drug users, and can also be used to help prevent injecting-related and sexual transmission of HIV to partners.

7. **Disinfection Programme (bleaching)**
   This programs promotes the cleaning of used needles and syringes with bleach and other disinfection methods.
8. **Safe disposal of used needles and syringes**
Eliminating the possibility of potentially infectious equipment being reused and thus removing a potential source of accidental transmission to non-IDUs, especially children.

9. **Drug treatment and rehabilitation services**
Ranging from institutional short-term and long-term detoxification with or without medication (cold turkey), residential rehabilitation, outpatient detoxification, and community-based detoxification camps.

10. **HIV treatment and care**
Health care for IDUs and their families, both primary health care and support and treatment for HIV-related illness, can be carried out anywhere. In most situations IDUs, and often their families, have poor or little access to health care. They often lack comprehensive treatment for HIV and for AIDS-related conditions.

11. **Primary healthcare**
Primary health care for IDUs attempts to provide health services and/or referrals to appropriate services that suit the needs of drug users and protect the general health of drug-using communities.

12. **Peer education**
Peer educators help to establish trust between IDUs and health services, and increase the reach of HIV prevention services to the most marginalized and hard-to-reach IDUs. In 2004, a MoU was signed between Police Indonesia and Social Welfare Ministries to facilitate multi-sectoral coordination to address HIV/AIDS and drug use. In 2007 the harm reduction approach has been announced formally by the government, with element from Ministry of Health as Chairman, and element from Police Headquarter as Vice chairman (Permenko Kesra, 2007).

The problems in implementing harm reduction are the readiness of Indonesian government to implement harm reduction approaches within health system in Indonesia, and how to scale-up the coverage and improve the quality of services. Indonesia does not have proper national data regarding IDUs, and lack of good documentation and report systems. Harm reduction strategies are still not widely accepted, and then coverage is consequently low.
Method

The study design is review study in Indonesia and other countries. Data were collected by literature review. Data were compiled using journals, reports, published and unpublished documents concerning programs and practices in Indonesia and other countries. Data are obtained from KIT Library, Vrije Universiteit Library, international online data base (such as PubMed) and national/international organizations (NNB-National Narcotics Board Indonesia, MoH-Ministry of Health Indonesia, WHO, UNODC,UNAIDS,IIHRA). In addition, key informants in Indonesia and other countries were interviewed by direct talk or e-mail. Contacts were selected through NIDA (National Institute on Drug Abuse) International Forum members.

Key words used are: heroin, opiates, HIV, AIDS, intravenous, IV, injection, injecting, addicts, drug, drugs, drug use, drug user(s), drug abuse, drug abuser(s), substance, substance abuse, needle, syringe, drug policy, IDU(s), injecting drug user(s), injection drug user(s), harm minimization, harm reduction, Indonesia.

This study will analyze the harm reduction implementation in Indonesia and other countries. Malaysia and the Netherlands are the most frequent to talk about. Malaysia is located in the same region with Indonesia (South East Asia), with the same culture (Malay), and Malaysia is also predominantly Muslim country. We can learn from the Netherlands regarding drug policy, why HIV prevalence is low, and the role of drug users communities in involving with harm reduction programs. Other countries such as Belarus, Russia, Bangladesh, and Ukraine also be discussed due to their high coverage of IDUs on harm reduction programs.

Results

Harm reduction programs in Indonesia were pioneered in 1998 by Yayasan Hati Hati (Bali Province), a non-government organization that ran needle exchange programs. In 2006, the Indonesian Government implemented harm reduction approaches by Permenkes (Ministry of Health Decree) regarding methadone clinics. In 2007, the Indonesian Government established a Working
Group on Harm reduction in national, province and district level (Permenko Kesra, 2007).

In the National Action Plan 2007-2010, the Indonesian Government will prioritize harm reduction strategies in 19 provinces (out of 33 provinces). 17 provinces have a significant problem regarding the HIV/AIDS epidemic, mainly due to high HIV prevalence among injecting drug users. Two provinces (in Papua Island) have problems with HIV epidemic through sexual transmission (NAC, 2007).

Drug policy

The first recorded law to ban opiate use was in 689 in Kingdom of Sriwijaya. In Indonesian modern history, illicit drug became significant problem since 1970s when first heroin case reported. Supply and demand reduction already implemented mainly by law enforcement authority (Police), and harm reduction approach now undertaken by National AIDS Commission (KPA). Ministry of Justice and Human Rights is responsible for intervention inside the prisons nationwide (NAC, 2007).

Law enforcement approaches were previously implemented before using harm reduction approach in 2007. The main body that controls the HIV/AIDS epidemic and responsible for harm reduction is National AIDS Commission (NAC; Komisi Penanggulangan AIDS). This body is not involved in policy implementation, but in formulating policies. Technical support is provided by UNAIDS. The national AIDS Commission has already established a Working Group on Harm Reduction, chaired by representative from Ministry of Health. The vice chairman is from Police Indonesia (Polri) and the Secretary from National AIDS Commission (KPA). Members of this working group are coming from all ministries related to HIV/AIDS prevention program (NAC, 2007).

Community acceptance

The implementation of harm reduction should consider religion, culture, norms and suitable for local condition. Stigmatization on
HIV and drugs is still happens, but in a lower degree compared to several years ago that probably due to better education and HIV prevention campaign on the mass media, and also the role of the two biggest Islamic organizations (such as Muhammadiyah and Nahdlatul Ulama) which are not opposing HIV prevention programs. Since Indonesia is predominantly Muslim, the roles of religious leaders are very important. However, some Indonesian people still have stigmatization on drugs and HIV/AIDS.

In 2007, INTERNA (Indonesia Interfaith Networking on HIV/AIDS), an interfaith forum responses to AIDS problems in Indonesia was founded. This forum consists of LKKNU-Nahdlatul Ulama (Islam), PGI (Christian), Hindu, Buddha, and Konghuchu organizations.

**Sustainability**

Financial sources are allocating a budget from government and local government funds with an increased annual amount, and partnership with international funding agencies and private sectors.

The fourth round of Global Fund gave Indonesia $ 64 million US with a project including a detailed cost study built in the WHO model (Costing Guidelines for HIV/AIDS Intervention Strategy). The budget that is needed by the year 2010 is 2,390 billion rupiahs (US$ 260,151,126), and the estimated lack of funding is 1,800 billion rupiahs (US$ 195,000,000). This shows that Indonesia is very much dependent on external funding agencies.

The case where NEP was supported financially by ASA (USAID) and it froze suddenly due to United States Government policy related to PEPFAR that forbade needle exchange, shows us that Indonesia is prone to interest driven by external funding. Can local resources survive with their programs after contracts with external funding are finish? This question can be answered by strengthening capability on internal funding through community participation (such as corporate social responsibilities) and raise awareness that drugs and HIV/AIDS problems are all Indonesian people’s problems.
Indonesia in the near future will also implement social health insurance nationwide. This will make it easier for IDUs to get services, since they will be covered by social health insurance.

**Harm Reduction in prisons**

At present, HIV prevalence in prisons is 35.54% (Banten Province), 17.84% (Jakarta), and 13.08% (East Java) respectively (MOH, 2007). Harm reduction is already set up in several prisons, with current target is 25,000 inmates. Data in prisons showed that 60 – 70% inmates are drug users, and half of them are injecting drug users (FHI, 2007).

In June 2005, Ministry of Justice and Human Rights announced the National Strategy for Prevention and Control of HIV/AIDS and Drug Abuse in Indonesian Correction and Detention Centers (2005-2009). It will be a framework for the work of prevention, care, support and treatment (CST) of HIV/AIDS inside the prison system. Among 396 prisons nationwide, only a few provide HIV prevention and CST. For example, Kerobokan Prison in Bali provides bleach, condoms, methadone, and ARV. NAC’s strategic plan is to involve 95 prisons by 2010, twenty with comprehensive programs like Kerobokan (Mesquita, 2007).

**Best Practices in Harm Reduction Implementation**

There is evidence that AIDS epidemics among IDUs can be prevented, stopped and even reversed. Effective programs can make a difference. In Dhaka, Bangladesh, prevalence is maintained at less than 5%. Prevalence fell in several Brazilian cities (UNAIDS, 2006).

Regarding shortage of budget and service provider, several developing countries prioritize some elements. An Expert panel in HIV prevention noted the importance of some interventions like NEP, outreach and drug abuse treatment (particularly heroin substitution therapy). Des Jarlais (2005) stated that NEP and outreach might be the first priority in limited resources which is in line with the guidelines of US National Institutes of Health and WHO effective interventions in behavior change among injecting drug users.
Needle exchange programs and Outreach

The goals of Needle Exchange Programs (NEP) are to distribute sterile needles and collect its disposal. These programs mainly distribute needles and other injecting equipment (alcohol swabs, sterile water), as well as IEC materials. NEP can also become contact points for other services, such as counseling, basic health care, drug treatment and as part of referral health systems.

Sharing unsterile needles and other injecting equipments are common behaviour among IDUs. For example, in Dhaka, Bangladesh, over 80% of IDUs had shared needles and other injecting equipment. NEP have shown reductions in these risk behaviours, and no evidence that these programs encourage people to inject drug. The benefits of such programs increase considerably, if provide broader range of services (UNAIDS, 2006).

How to deliver NEP have developed in various settings, can be mobile (through outreach) or fixed sites. Example for this is NEP in Soligorsk, Belarus. Outreach workers service 30-40 sites around the city, covering 30-100 IDUs per site daily. As the result, percentage needles returned is 90.8%. Another example is NEP in Pskov, Russia. In this city, the NEP was established in 1998 and provide a wide range of services, including AIDS clinic and medical services run by doctors and dentists. After four years, HIV prevalence among 741 IDUs participating in the NEP found less than 1% were HIV-positive. (UNAIDS, 2006).

In Sumy, Ukraine all new clients are given with an identification card with a unique numerical identification code. With identification card, they feel safer and hopefully will increase their attendance to NEP sites. Sixty nine percent of them attend NEP sites 1-5 times per month, 21% visit the site 6-10 times per month, and 10% visit more than 10 times per month. This indicates that the utilization of services also depend on the secure feeling of IDUs.

One of the means to record the total number of IDUs is reached by outreach as a specific service. Outreach programs have been successful to motivate and support IDUs who are not in treatment to reduce their risk behaviours (drug use and sexual behaviours) as well as to reduce HIV incidence. In the Netherlands, outreach
work can motivate drug users to participate in harm reduction activities (EMCDDA, 2000).

Several findings indicate that outreach programs that take place outside the conventional social and health care facilities reach out of treatment IDUs and increase drug treatment referrals. In Pskov, Russia, outreach work comprises street-based work and in drug users’ apartments. The program provides social assistance to outreach workers, such as assistance with finding, The outreach team meets regularly to provide daily reports (UNAIDS, 2006).

In Dhaka, Bangladesh the program staff trains active IDUs as peer outreach workers. The training covers a range of topics regarding drugs, sexually transmitted infections (STI), and HIV/AIDS. There are also drop-in centers which provide IDUs with HIV prevention, diagnosis and treatment for STI, and primary health care. The work of these outreach workers is supervised by the field trainers; they are also ensuring that outreach education tasks are being completed correctly. This experience is in line with study which demonstrates the potential of peer outreacher to influence risk behaviors among IDUs (Metzger, 2003).

**Substitution therapy**

High cost in inpatient rehabilitation and high rate of relapse within a year of release makes substitution therapy as pragmatic approach. Agonist pharmacotherapy treatment (substitution therapy) has two aims, to treat drug dependency and to reduce negative health consequences (Metzger, 2003). Engagement and retention in drug dependence treatment also provides opportunities for risk counseling and advice, as well as management of other health and social problems. Substitution therapy assists IDUs to decrease their drug consumption significantly (UNAIDS, 2006). Agonist pharmacotherapy involves treating drug dependent individuals with a drug that has a similar action to the drug they are dependent on, thereby preventing a withdrawal syndrome and craving. Methadone treatment decreases heroin use, injecting behaviour, sharing needles, and rate of HIV prevalence and incidence (Sullivan, 2005).

Regarding accessibility, the protective effects of substitution therapy
can only be achieved when programs are accessible and open to the changing needs of drug users (Metzger, 1998).

Easy access to get services without proper monitoring and evaluation can increased misuse of substitution therapy. Indonesia can learn from Malaysia’s experience. Malaysia has second highest prevalence in Western Pacific (after Viet Nam) among adult populations (0.62%) and the highest proportion of HIV cases resulting from IDUs (76.3%). By the end of 2004, 234,000 heroin users had been registered in government registry, but other estimates exceed 500,000 for heroin users nationwide (Mazlan, 2006).

Over 30,000 heroin users are treated with substitution therapy by more than 500 medical doctors. Substitution therapy is directly dispensed to patients by practitioners in the private sectors, and patients do not need to go to pharmacist to obtain it.

The Ministry of Health Malaysia in 2005 started a pilot project on methadone in the public sector that is planned to treat 1,200 heroin users. Dissemination of MMT has been limited, due partly to the high cost of the medication (40 mg cost US$10). With raw material imported from New Zealand, Malaysia has already produced methadone. The government has targeted 5,000 drug users under 600 private methadone clinics in 2007, but in reality only 3,000 drug users are under treatment. One of the reason is the limitations from the government. For example, only 20 bottles of methadone are given to a private clinic per month (Mahmud Mazlan personal communication, 2007). Methadone is prescribed typically by doctors for patients to self-administer without supervision and outside of medical clinics. There are concerns about misuse of methadone, as well as about the lack of psychosocial counseling provided during treatment. Factors that may help to reduce methadone misuse are the high cost of the medication and the standard practice of converting tablet to liquid before dispensing to patients (Mazlan, 2006).

Another substitution therapy is buprenorphine, it was introduced in 2001. 53% of patients in buprenorphine maintenance treatment remained in treatment for six months, and only 36% avoided heroin relapse (Kasinather, 2007).

Since 2004, the mass media in Malaysia started to report injecting
abuse of buprenorphine. Source obtaining buprenorphine for injection are from private GP (74.1%), from public hospital (2.6%), from public hospital (2.6%), from drug dealer who sells other drugs (13.9%), from middle man who sells buprenorphine only (41.6%), and from other drug users (32.8%) (Mazlan, 2007). General practitioners received little or no training, were not certified, and dispensed buprenorphine in their private clinics, giving additional financial incentives to dispense large supplies. Within a short period, demand for buprenorphine exceeded the 12 kg/year import permit (Kasinather, 2007).

In September 2004, the Ministry of Health delayed the import permit of buprenorphine, to begin investigating doctors who blatantly sold buprenorphine inappropriately. Four of these practitioners were prosecuted. In 2006, it become a social issue when Singapore banned buprenorphine.

The combining of buprenorphine and naltrexone in one tablet may reduce the abuse liability. Suboxon (buprenorphine-naltrexone) is introduced to replace buprenorphine, but the problem is the price. Many drug users could not afford the service. Alas, many IDUs who already joined substitution therapy (Subutex) are injecting heroin again, and those who still under treatment dropped 50% (Mazlan, 2007).

Implementing harm reduction with coverage less than 10% is ineffective and would have little impact in the overall epidemic. The example for this is India and Nepal. In 1996, the coverage of both countries is low and within two years, both countries experienced HIV epidemics with prevalence more than 50% among IDUs (Rao, 2006).

**Drug policy**

Drug policy is a dynamic process, means the position, stance or view a government or organization takes on an issue. Coordination among policy makers regarding drug problems is essential. Indonesia can learn from Brazil in gradually setting up drug policy from local into national level. Drug policy and AIDS policy are also implemented together in practice, resulting in harm reduction approach. Collaboration between outreach workers and community
health (field agents) agents are good. All agents receive at least 60 hours of drug, HIV and STI training; they meet weekly to discuss their work. Another example comes from Soligorsk, Belarus. Harm reduction as a policy were discussed between service providers, City Administration, and the police. They established HIV and AIDS Multi-sectoral Council together, and made written agreement between the police, health provider and program staff regarding needle exchange and outreach activities.

Malaysia has national drug policy since 1983, and then revised in 1996 (Reid, 2005). Current goal of Malaysian Government is a drug free society by 2015, with the lead agency is the National Anti Drug Agency (NADA) under the Ministry of Internal Security (MOIS). Before 2001, Malaysia only used a supply side approach: criminalization of drug users, compulsory two years detention in rehabilitation centers, followed by two years of parole with monthly reporting to the police stations. Death sentence is for moderate amount of drug possession (30 gram of heroin) (Hussin, 2006; Mazlan, 2007). In 2001, The Prime Minister instructed to review drugs policy on treatment for drug users. The major obstacle is that drug policy was the responsibility of the Home Affairs Ministry (responsible for the National Narcotic Agency, Royal Malaysia Police and the Prison Department of Malaysia) and issues related to HIV/AIDS lay with the Ministry of Health (Reid, 2007).

The Netherlands has the revised Opium Act in 1976, that differentiates between Schedule I hard drugs (heroin, cocaine and LSD), and Schedule II soft drugs (marijuana and hashish). This approach is quite liberal, even for some countries in Europe. Someone found in possession of less than 0.5 grams of hard drugs will not prosecuted.

The aim of Dutch drug policy is to separate out the market for soft and hard drugs, Dutch Government believes will reduce the possibility of people progressing to the hard drug use.

The National Drug Monitor served as coordinator between various surveys and registrations in the Netherlands concerning the use of drugs, and collecting data and reporting to national governments and to international organizations.

Six principles of Dutch drug policy (Trimboos Institute, 2006)
are:

- the creation of multifunctional medical network and social services at local and regional level
- accessibility of services
- promotion of the social rehabilitation of drug addicts
- greater and more efficient use of non-specialist services, such as primary care physicians and youth welfare centers
- coordination of aid facilities
- integration of drug education into a general health education campaign

Community acceptance

Community acceptance was generally achieved through advocacy at many level, formal and informal meetings, and public campaigns.

Indonesia can learn on how other countries used social marketing to gain community acceptance on harm reduction programs. In Pskov, Russia the NEP was established in 1998 and advertised on local television. The same means used by service provider in Soligorsk, Belarus. Wide publicity by television, radio and newspaper explain harm reduction programs to get support from the administrative. Another creative meaning also used by Hong Kong SAR. Harm reduction messages were publicized on radio, television, through public transport, street advertisements, and through the internet. These experiences show that by increasing public awareness, drug and HIV-related issues (UNAIDS, 2006).

In Dhaka, neighbors of NEP sites worried that NEP would turn drop-in centers into shooting galleries. Actually, outreach workers use these centers as a base for collecting supplies, holding meetings, and storing used equipment.

A wide range of religious and cultural contexts in cities like Pskov-Russia (predominantly Russian Orthodox), Dhaka-Bangladesh (Islam), and Santos-Brazil (Roman Catholic) show that harm reduction
programs have reached a high coverage among IDUs. It means harm reduction can be accepted across cultures and religions.

In predominantly Muslim countries, harm reduction is underutilized, since drugs, sexuality and HIV/AIDS are taboo topics to be discussed. Being stigmatized by the community is the reason why those with risky behaviors become more vulnerable to HIV infection, for example IDUs, are reluctant to come for VCT or treatment. Hasnain differ religious scholars’ point of view regarding harm reduction (Hasnain, 2005). In countries where HIV/AIDS is spread rapidly, such as Uganda and Indonesia, religious leaders are “taking a more flexible stance” Harm reduction is permissible under a state of emergency. On the other hand, in countries with low HIV prevalence, religious scholars believe that harm reduction approach will encourage promiscuity and drug use. Senegal is also one example regarding HIV/AIDS prevention by involving religious scholars in proactive role through regularly discussed topic in the Friday prayers in mosques. Harm reduction approaches (particularly NEP) were still controversy in Malaysia as they were viewed as encouraging using drug. Religious believes remain to be the strong opposition for the effort of introducing harm reduction into policy debate (Reid, 2005).

**Sustainability-Funding**

Malaysia government allocated funds for HIV prevention 10.3 million US dollar in 2002-2003. The next year, government gave to NGOs around 1.5 million US (Reid, 2005). It shows that government can also collaborate with NGOs in delivering services.

Another issue is regarding payment of services. Even if the service is free, there are many other costs which IDUs have to pay (such as transportation). The Dutch government through Ministry of Health, Welfare and Sport allocate money for funding harm reduction programs, and deliver it by municipalities (IAVs). Substitution therapy is covered by health insurance system, for example funds for methadone have been based on a temporary funding set up by the National Health Insurance Council.

How to deliver harm reduction programs in affordable price is
also challenging. In fact, the WHO mentioned that every dollar invested in treatment may yield a return of between $4 and $7 in reduced criminality. When savings related to health care are included, total savings can exceed costs by a ratio of 12:1 (WHO, 2004).

The strong reliance on external funding can gradually decrease. In 1999, Pskov, Russia received external funding from the Open Society Institute. After three years, the program had reduced its dependence on external donor agency, with 56% of funding being provided by local and national governments as well as local corporate donors (UNAIDS, 2006).

Discussion

Delay in implementing harm reduction permits HIV to spread among IDUs, and it’s more difficult to prevent further transmission among them and their sexual partners. This delay is a common problem in all over the world. In Indonesia itself, HIV prevalence in IDUs is already very high, which is more than 50%; therefore the harm reduction implementation is very urgent to take place.

One of the obstacles in carrying out harm reduction delivering services is that trial and error in its execution is unavoidable and has become a continual process. Trial and error inevitable because harm reduction approaches has to adapt with social and political setting in which they were implemented.

Table 1. Indicator and Target of Harm Reduction Programs in Indonesia

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<tr>
<th>Indicators</th>
<th>Baseline 2006</th>
<th>Target 2007</th>
<th>Target 2008</th>
<th>Target 2009</th>
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<tbody>
<tr>
<td>Percentage of IDUs join NEP</td>
<td>2.6%</td>
<td>12%</td>
<td>32%</td>
<td>56%</td>
</tr>
<tr>
<td>Percentage of IDUs outreach</td>
<td>7.1%</td>
<td>15%</td>
<td>40%</td>
<td>70%</td>
</tr>
<tr>
<td>Percentage of IDUs join MMT</td>
<td>0.5%</td>
<td>4%</td>
<td>10%</td>
<td>17%</td>
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Source: National AIDS Commission Indonesia Coverage
Based on UNAIDS recommendations the coverage of three programs should be more than 10 percent. If below 10 percent, the impact would be too little for reducing HIV epidemic in that area. Des Jarlais et.al suggested that minimum coverage should be between 20 percent up to 30 percent, or 25 percent in average. It means that the coverage in 2006 in Indonesia situation in all of three elements is very poor. Even for the next following years, the target coverage are predicted to be lower than what already been suggested by UNAIDS and Des Jarlais et.al.

If only outreach program in 2008 is on track, it is will be sufficient enough to prevent HIV epidemic. This is quite dangerous regarding HIV transmission among IDUs and to general population since further epidemic explosion will be hardly possible to prevent. So, even for substitution therapy until 2009 the target is still below the experts recommendations.

Costigan et al. (2003) recommends two types of program evaluation:

1. Implementation evaluation

In Indonesia the project is not established successfully yet. The good news is the program is reaching and attracting the target population even though the coverage is still low. The objectives of the programs which are needles exchange, outreach, and substitution therapy are in general successfully done even though the service quality remains in average.

2. Impact evaluation

According to experts consensus, the evaluation will be programmed every three year. If the started year is 2006, we can know the outcome will be in 2009.

The desired change (behaviour change) in the target group (IDUs) is not clear yet, since research and survey regarding that is limited.
The resources devoted to harm reduction intervention could be effective if the puskesmas as harm reduction implementation sites
is selectively chosen. Some of the Puskesmas are already bear excessive burden in their existing programs, therefore the program manager has to choose which puskesmas that has relatively less work load than the others.

Lessons learnt from other countries are as follows:

1. **Start to prioritize NEP and outreach**

   Among all elements of harm reduction, some governments had to make priority due to constraint of funding and human resources. At the same time, the government also has to adapt with socio-political setting.

   Evidence shows that in some developing countries, prioritizing on needle exchange programs, outreach and substitution therapy is a clever choice. In Indonesia, the focus is established on twelve elements of harm reductions while only 17 provinces are prioritized to be handled from 33 provinces that exist. Those 17 provinces have the highest IDUs cases in Indonesia so focusing on them has thus shown to be the right strategy. However, this kind of approach suffers from a resource limitation dilemma. Experts have suggested that developing countries should focus more on emphasizing the three main elements of harm reduction first. This is considered to be the accurate strategy to implement in Indonesia. In addition, the issue of limited resources also adds more importance on implementing programs on public health scale rather than on pilot project.

2. **Substitution therapy must consider accessibility, availability, and affordability of services**

   Issues on coverage and quality of services are always thought about when dealing with harm reduction. Experts have said that coverage should be 20-30% of total population. This is truly a challenge for Indonesia, since IDUs are scattered in many places. Indonesia is such a huge country with thousands of islands. Geographical limitation made implementing harm reduction programs nationwide will acquire high administrative costs.

   **Accessibility**
In Indonesia, IDUs have much difficulty in accessing the sites that provide harm reduction programs since there is only a few numbers of community health centers (Puskesmas) and hospitals that supply the needles and substitution treatment.

How to deliver the services for injecting drug users is a challenge. Since IDUs are hidden community, the services must be reached without fear of being seized by the law enforcement and sometimes need creative means. For example, in Germany and the Netherlands, harm reduction programs are delivered through mobile clinics (methadone bus), so IDUs can access it easily.

Indonesia can carry out the same strategy as Germany by using mobile services that visit the IDUs in their own places. Fortunately, this strategy has been done but only by a few NGOs.

Availability

Availability of human resources and materials are very crucial. Many countries prepare staffs and materials regularly to deliver services. Indonesia has a lack of doctors who have been trained for harm reduction programs. In addition, the materials such as availability of needles and methadone sufficient only for short term horizon.

With 1.5% of total population in Indonesia are drug users, government should pay more attention to educate doctors and other health professionals in treating drug dependency.

Affordability

Methadone treatment can be a good example on how IDUs get therapy with affordable price. With cost payment 5,000 rupiah per day to get methadone treatment in community health center, (s) he will pay 150,000 rupiahs per month. Based on National Survey (NNB, 2005), 60% of drug users have salary between 500,00-1,500,000 rupiahs. With average 1,000,000 rupiahs per month, it means (s) he has to pay 15% of the salary for methadone. It means the cost is still unaffordable for majority drug users.

If the price/cost is affordable, it means more IDUs will be in treatment. It is good from public health perspective, since IDUs
whose under treatment practice lower rate of drug use and related risk behaviors.

Conclusions

Experiences in other countries support current initiatives to improve Indonesia’s response to injecting drug users. Several studies regarding harm reduction in many countries showed some similarity in obstacles and challenges. They are facing limited scope and coverage, and the programs are sporadic. Lack of synchronization between law and health agencies also make a significant problem, due to misunderstanding during delivery of services. Inadequate documentation result in poor report, monitoring and evaluation system. Shortage of resources is common, since it take time to train them in harm reduction programs.

Failure to integrate programmes within existing health system is another obstacle, we can learn from the failure of NGOs to scale up programs due to their incapability to reach whole country.

Substitution drugs at an affordable price is a must, since we can learn from Malaysia’s experience in delivering buprenorphine-naltrexone (Suboxon). Finally, extraordinary dependence on external funding will make sustainability of the programs questionable.

Challenges in the near future are how to deliver a comprehensive program with high-level coverage, how to maintain understanding between service providers and law enforcement authority, and how to choose appropriate monitoring and evaluation system.

In conclusion, Indonesia still has much work to do regarding harm reduction implementation. Successful harm reduction implementation would significantly reduce the spread of HIV/AIDS throughout the injecting drug users.


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