THE TRIP TO NOBODY KNOWS WHERE

Examining The Effectiveness of Indonesia's Compulsory Report Program for Drug Users and Its Compliance to the International Human Rights Standards

PERKUMPULAN LEMBAGA BANTUAN HUKUM MASYARAKAT

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EXECUTIVE SUMMARY

In 2011, the Indonesian Government issued the Government Regulation Number 25 Year 2011 regarding the Implementation of the Compulsory Report of Drug Dependents which regulates the practice of compulsory report and rehabilitation for drug users in Indonesia. By this regulation, Indonesia produced a new institution called the Compulsory Report Institution (Institusi Penerima Wajib Lapor or usually abbreviated as IPWL). This institution is not only the place where drug users can access treatment, but also the place to note, gather, and process the data of drug users.

Looking at its importance, there is a need to understand the implementation of compulsory report and its effect on drug users' life. This research attempts to explore how the compulsory report system has addressed drug users' human rights. Besides that, this research also tries to assess the effectiveness of IPWL according to the client's need.

This research finds that although the program is called compulsory report, many drug users felt that they joined the program voluntarily. There are several exception cases when drug users' family or friends forced the drug users to enter treatment. The information of transition from a rehabilitation center to a compulsory report institution is sometimes inaccessible for drug users, making them feel coerced to join IPWL institution. There are shameful approaches also done by the IPWL institution to get patients, like offering the patients money or tricking potential drug users to become patients.

The issue of voluntarily could not be separated from the issue of accessibility of information. Although many drug users testified that they join the program voluntarily, the majority of them did not know the kind of treatment that is offered. The information that is more accessible for them is the knowledge of the warranty that the program participants will not be prosecuted, therefore some patients joins the IPWL program merely to avoid prosecution.

Relating to other element of accessibility, the majority of drug users said that the compulsory report institutions are physically accessible for them. There is, however, special concern for drug users who live in remote area where do not have drug treatment provider or ARV treatment provider. For some drug users also, the compulsory report institutions are not accessible due to the limited work-hours of the IPWL institution which does not accommodate clients who have regular jobs or educations.

The price of treatment for IPWL patients are different one another. The disparity of price happens between cities, between IPWL institutions in one city, and even between clients in one IPWL institution. The regulation which does not specify

the price of treatment and gives the district government the authority to control the price make the disparity of IPWL payment.

In term of the quality of drug treatment in IPWL, this research finds four problems, which are: some IPWL institution could not give appropriate measure for drug users in withdrawal phase, the problem of medicine supply, the hard mechanism to lower IPWL clients' methadone dosage, and other problems in social IPWL institution. Albeit these problems, the majority of clients were satisfied with the politeness and patience of the doctor or nurse in IPWL institutions.

Since drug users who join IPWL program are clients and in the process of treatment they submit their personal information to IPWL institution, the compulsory report system must then addresses their right to information and right to privacy carefully. In the aspect of right to information and right to privacy, this research finds that some clients did not get or were not explained the treatment plan. Though the clients are relatively comfortable sharing information with the health workers of the IPWL institution, there are cases showing that their personal information has been breached.

Many drug users access IPWL treatment when they still have a job or take education. The working hours of IPWL institution hinder some of them to fulfil their right to work and education. There is also other challenges where IPWL clients are still stigmatized and discriminated in workplace or education institution. The IPWL policy has not been promoted enough to other parties which may have strong influence to the clients' life.

Because it is important for drug users to feel comfortable while get treatment, this research tries to find whether there are violence and discrimination in IPWL program. This research can only finds several examples of violence and discrimination against IPWL clients when accessing IPWL treatment, from either IPWL providers or other IPWL clients. However, this research also finds that IPWL system help some clients in reducing stigma they received from the family or society.

Another serious human right violation found in this research is criminalization of drug use. While many drug user perceived IPWL registration as a guarantee that they would not be prosecuted, many of them still prosecuted in practices. The IPWL institution has small role when a client is arrested, resulting in many clients felt disappointed with both the IPWL institution and IPWL program.

Indonesia's drug policy use the perspective of abstinence to handle drug dependency. This research proves that IPWL program will not be effective if the purpose of treatment is only to achieve abstinence because the majority of IPWL clients use drugs again after they have accessed treatment. Some drug users also believe that the IPWL program would not run effectively if the patient join program involuntarily. Lastly, the IPWL program is not effective because many

IPWL clients are still prosecuted and punished, a way that has been proved damaging drug users' health condition.

The title of this report, "The Trip to Nobody Knows Where", is inspired by the title of Uli M. Schüppel's movie "The Road to God Knows Where", a documentary about Nick Cave and the Bad Seeds' 1989 tour of America. Compulsory report program was designed to overcome Indonesia's drug problem, but in practice all parties that involve in the program see the program's objective in different ways. For example, relating with criminalization of drug use, drug users perceive the IPWL program as a safe card from law enforcement agencies, the law enforcement agencies persistently state that IPWL clients could still be prosecuted, while the IPWL providers want to help drug users in criminalization but their role are limited. This different ways and interests in viewing the objective of IPWL program makes nobody could not predict the end situation that will be created by IPWL policy. Therefore, the researchers find that this title, "The Trip to Nobody Knows Where", suits with the current situation.

BACKGROUND

A. Drug Rehabilitation in Indonesia

The need to rehabilitate drug users has been portrayed in the *Single Convention on Narcotic Drugs of 1961*, though it does not provide sufficient scientific explanation. Along with the measure of treatment, education, after-care, and social reintegration, the act to rehabilitate is meant for 'abusers of drugs', as Article 36 of the aforesaid Convention states. Given that Indonesia has ratified this Convention since 1976, it can be said that Indonesia has known the principle of rehabilitation for drug users for quite some time.

Rehabilitation method that is acknowledged as an effective rehabilitation according to the resolution of the *Single Convention on Narcotic Drugs of 1961* is treatment in hospital institution with a drug-free atmosphere. The same concept of rehabilitation was introduced in Indonesia through its very first Drug Law since independence, which is Law Number 9 Year 1976 regarding Narcotics. Article 32 of this Law stated that only if drug users went to hospital or to see doctors, they could be said undergone rehabilitation.

The development of main legal discourse on narcotics took place in 1997 when the Indonesian House of Representative enacted the Law Number 22 Year 1997 regarding Narcotics. This new legal discourse drastically changed Indonesia's perspective of rehabilitation because the element of coercion was introduced. Article 45 of this Law stated that, "Drug users must undergo treatment and/or rehabilitation."

The concept of compulsory rehabilitation for drug users is then applied until today, even clarified in the present law. In 2009, Indonesia enacted the Law Number 35 Year 2009 regarding Narcotics replacing the previous Narcotics Law. This new law does not only oblige drug users to undergo rehabilitation, but also obliges them to report themselves as drug users to local community health centers, hospitals, medical rehabilitation centers, or social rehabilitation centers which have been accredited by the government. This new obligation raises another concern on the right to privacy and implicitly expresses stigma towards drug users as harmful people for society.

Mandated by the Law Number 35 Year 2009, the Indonesian Government issued a regulation on how to implement the compulsory report and rehabilitation, which is the Government Regulation Number 25 Year 2011 regarding the Implementation of the Compulsory Report of Drug Dependents. By this regulation, Indonesia produced a new institution, which is Compulsory Report Institution (Institusi Penerima Wajib Lapor or usually abbreviated as IPWL). This institution is not only the place where drug users can access treatment, but also the place to note, gather, and process the data of drug users.

B. The Practice of Compulsory Report Policy

According to the Regulation on IPWL, there are several steps to access rehabilitation provided by IPWL facilities. Drug users or the parents of child drug users should request the rehabilitation to the compulsory report institution appointed by the government. The rehabilitation centers will then assess the medical and social condition of drug users by conducting interviews, observation, physical tests, and psychological tests. Afterwards, the IPWL institution will develop plan of rehabilitation, which should be agreed by drug users, parents, guardians, or families, and the manager of the IPWL facilities. Article 10 of the 2011 Government Regulation on IPWL mandates these institutions to provide compulsory report card.

According to the 2009 Narcotics Law there are two models of rehabilitation: the medical and social rehabilitation. Article 4 of the 2011 Government Regulation on IPWL states that the Ministry of Health (MoH) manage the medical rehabilitation while the Ministry of Social Affairs (MoSA) manage the social rehabilitation. The two ministries together with the National Narcotics Board (BNN) have the authority to monitor and evaluate the rehabilitation center or program. The BNN also has the authority to gather the recapitulation data of client.[1] However, in practice, BNN also administers its own compulsory report institutions. According to the 2011 Government Regulation, the National Police (POLRI) may refer drug users to any compulsory report institutions.

The MoH, MoSA, and BNN have different approaches to rehabilitate drug users. The MoH uses harm reduction interventions, drug dependence counseling, and clinical or psychosocial intervention. The MoSA uses case management, after-care programs, self-help group, spiritual counseling, and vocational programs. The BNN uses therapeutic community method in their facilities.[2] All of these rehabilitation methods are available and it is depended on the drug users to report themselves to which kind of institution.

The year of 2015 marks the fourth year of the implementation of the compulsory report policy. In 2012 fiscal year alone, the government has allocated IDR 19 billion for the implementation of the compulsory report program under the budget allocation from the MoH.[3] Only 25% of the allocated budget was, however, absorbed. Another IDR 3.2 billion is allocated by the MoH in 2014 fiscal year, around of which 88% was absorbed. Meanwhile, the MoSA, that is responsible for implementing the social rehabilitation component under the

[1]National Narcotic Agency's Chief Regulation Number 4 Year 2015 on Escalation the Ability of Rehabilitation Institution Conducted by Local Government or Community.
[2]Pascal Tanguay, Claudia Stoicescu, Catherine Cook, 2015, "Community-based drug treatment models for people who use drugs: Six experiences on creating alternatives to compulsory detention centers", *Harm Reduction International Report*.
[3]http://www.antaranews.com/berita/386355/kemenkes-imbau-pemda-optimalkan-ipwl

compulsory report program, has allocated IDR 66 billion in 2015 to build social rehabilitation facilities in seven provinces, which are Jambi, South Sumatera, East Java, West Kalimantan, South Kalimantan, North Sulawesi, and North Maluku. It was expected that, in 2015, 10,000 drug users would be treated under the social rehabilitation facilities.[4]

The BNN itself claims that although government assistance in prevention of drug abuse has already been progressive, there are some problems remain with the compulsory report program.[5] Those problems are lack of referral system, limited number of rehabilitation centers, lack of human resources to manage the implementation of the compulsory report, and lack of socialization and education regarding compulsory report – to name a few.[6]

While progress has been made in providing greater access to rehabilitation, the current drug policy that still criminalizes people who use drugs seems to have failed in decreasing the number of drug users – let alone addressing the problem of drug dependency. The figure of drug users in 2014 was one out of 44 to 48 people in Indonesia.[7] Many of them end up in prisons. In 2014, there are 24,691 drug users who were imprisoned. This enormous number of drug users in prison does not include drug traffickers, which is 31,635 people.[8]

The Indonesia's Narcotic Law still criminalizes and imprisons drug users.[9] Article 128 of the Narcotic Law states that if the drug users are still on treatment (two periods maximum), he/she must be dismissed from criminal prosecution. But in practice this article is rarely used. Therefore there are still many drug users criminalized.[10] For drug users who are not registered under the compulsory report system, they could get compulsory rehabilitation during the legal process if the government assessment team concludes that they are drug users and in need of rehabilitation.[11]However, the implementation of this provision is also under questions because the assessment teams are not working properly.[12]

The objective that the IPWL program will decrease the drug dependency rate has yet to be fulfilled. This regulation also left a question regarding the fulfilment of

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[4]http://www.rmol.co/read/2015/06/26/207890/Kemensos-Alokasikan-Rp-66-Miliar-Bangun-7-Panti-Rehsos-Narkoba-

[5]National Narcotic Board, 2014, "Laporan Akhir Survei Perkembangan Penyalahgunaan Narkoba Tahun Anggaran 2014," pg. 36.

[6]*Ibid.*, pg. 35-36.

[7]*Ibid.*, pg. 16

[8]Prison Department, 2015, "2014 Annual Report", pg. 48.

[9]Article 127 paragraph 1(a) Law Number 35 Year 2009 on Narcotic.

[10]Anang Iskandar, the BNN Chief from 2012-2015, states in his personal blog that the Article 128 has not fully worked. See https://anangiskandar.wordpress.com/2014/02/07/dekriminalisasi-pengguna-narkoba-tidak-sama-dengan-legalisasi/

[11]According to Joint Ministerial Regulation between National Narcotics Board, Ministry of Health, Ministry of Social Affair, National Police Force, Attorney General Office, Supreme Court, Ministry of Law and Human Rights.

[12]http://balikpapan.prokal.co/read/news/174618-optimalisasi-tim-asesmen-terpadu

human rights in the practice of the rehabilitation given the history of human rights violations towards drug users in Indonesia and the experience that other countries have with similar policy.

C. The Problem of Human Rights Violations in Compulsory Rehabilitation

Many non-governmental organizations as well as the United Nations have opposed the compulsory rehabilitation and treatment, looking at what happened in many Asian countries. The Office of High Commissioner of Human Rights made a joint statement with 11 other United Nation bodies that urge all states to close compulsory drug detentions and rehabilitation centers. They demand drug dependency treatment centers to implement voluntary, evidence-informed, right-based health, and social service in the community.[13]

The concept of compulsory rehabilitation and treatment is also implemented in several other countries, such as China, Cambodia, and Laos. Compulsory rehabilitation in these three countries have sent hundreds of thousands of people to detention. In the rehabilitation wards, drug users are forced to work and they get punishment if they violate the institution rules. More ironically, despite declaring themselves as health center, these rehabilitation centers fail to provide proper medical facilities.[14]

The focus of the treatment that are provided in China is forced labor. The only medical method conducted there is detoxification. However, if the detoxification is the only medical treatment offered, it will not successfully bring all of the drug users to reduce their harmful behaviors. The inadequate medical facilities and techniques also resulting in the infection of tuberculosis (TBC) and human immunodeficiency virus (HIV). Instead of helping, this model of rehabilitation leads more stigma and discrimination towards drug users after they return to society.[15]

The compulsory treatment for drug users are futile if there is no support after institutionalization. Many drug users in China were sent back to rehabilitation centers by the Chinese Government because of relapse. There are many factors that make people relapse, such as stigma, discrimination, unemployed, exclusion from family and friends. In China, stigma and discrimination are also raised by

[13]http://www.ohchr.org/en/NewsEvents/Pages/DisplayNews.aspx?NewsID=11941&LangID=E

[14]Amon, J. J., Pearshouse, R., Cohen, J., &Schleifer, R, 2013, "Compulsory drug detention centers in China, Cambodia, Vietnam, and Laos: Health and human rights abuse", *Health and Human Rights Vol. 15(2)*, 124-137.

[15]Human Rights Watch, *Where Darkness Knows No Limits": Incarceration, Ill-Treatment, and Forced Labor as Drug Rehabilitation in China*, (New York: Human Rights Watch, 2010).

identification card system that differentiate between drug users and nondrug users.[16]

When a country determine its citizens to enter compulsory rehabilitation, the country also implies that the drug use for them could no longer be tolerated. This is what happened in China with its detoxification policy which force drug users to not use drugs anymore. However, there are still relapses and the Chinese Government had tried to develop new rehabilitation techniques, such as harm reduction treatment and alternative clinics.[17]

Malaysia also includes forced detention as a part of rehabilitation. It is estimated that there are 6,658 people who are detained in compulsory rehabilitation centers since 2010. These people are detained because they failed to pass urine testing or they got arrested for drug abuse. Drug users in Malaysia can be detained up to two years and after that should be supervised by the community for another two years. The problems in Malaysia's compulsory rehabilitation centers are similar to other countries, which are the unavailability of anti-retroviral (ARV) treatment, shortage of medical facilities, and lacking program to overcome relapse.[18]

Sometimes the compulsory rehabilitation is also enforced by law enforcement agencies, such as police. In Vietnam, police officers who arrest drug users must immediately transfer them to rehabilitation centers. This task burdens the police because every district police office must fulfil the arrest quota of 200 to 300 people per year. Some of the law enforcement agencies still disapprove harm reduction perspective and believe that every person should be free from drug dependency no matter what.[19]

Even though the rehabilitation centers in Indonesia may be different from above mentioned countries', Indonesia shares the same perspective of rehabilitation as a replacement for punishment or as an obligation for every drug dependent. Same with China, the goal of rehabilitation center run by the government is total abstinence from drugs.[20] The practice of compulsory report policy could lead to infringement of human rights as it is happened in many countries.

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[16]Yang, M., Mamy, J., Gao, P., & Xiao, S, 2015, "From Abstinence to Relapse: A Preliminary Qualitative Study of Drug Users in a Compulsory Drug Rehabilitation Center in Changsha, China", *PLoS ONE Vol 10(6)*, 1-17.

[17]Liu, Q., & Gericke, C., 2011, "Yulu Shequ - a unique rehabilitation program for illicit drug users in Kaiyuan in southwest China", *Harm Reduction Journal Vol. 8(26)*, 1-4.

[18]Fu, J., Bazazi, A., Altice, F., Mohamed, M., & Kamarulzaman, A, 2012, "Absence of Antiretroviral Therapy and Other Risk Factors for Morbidity and Mortality in Malaysian Compulsory Drug Detention and Rehabilitation Centers", *PLoS ONE Vol 7(9)*, 1-7.

[19]Khuat, T. H., Nguyen, V., Jardine, M., Moore, T., Bui, T., & Crofts, N, 2012, "Harm reduction and "Clean" community: can Vietnam have both?", *Harm Reduction Vol 9(25),* 1-10.

[20]Pascal Tanguay, Claudia Stoicescu, Catherine Cook, *Op. Cit*., pg. 41.

D. Research Questions

Looking at the aforementioned facts and data, it is crucial to deeply understand the implementation of compulsory report. Human rights standards serve as apt analytical tool for these cases. If the compulsory report system is proved to infringe human rights of drug users, it should not be continued because it obviously brings more harm than good for drug users.

It is also important to assess the effectiveness of IPWL by looking at whether or not the treatment has met the clients' needs and improved patient health. If the IPWL program does not help drug users improving their health conditions and their life, the policy needs to be revised. Therefore this research intends to carefully examine rehabilitation of drug users in IPWL program and provide recommendations to the policy makers so that human rights aspects in drug rehabilitation center are improved.

The research questions are as follows:

1. How have the regulation and the practice of compulsory report addressed drug users' right to health, right to information, right to privacy, right to free from discrimination, right to work, and right to education?
2. How effective is the IPWL provision according to the clients' needs and experiences of relapse?

RESEARCH METHODOLOGY AND DEMOGRAPHIC DATA

A. Methodology

This research combines quantitative and qualitative data. This chosen methodology at least have two purposes which are to seek whether there are any indications of human rights violations taking place in IPWL facilities and whether the system itself violates human rights of drug users. It will also be useful to explain how effective the establishment of compulsory rehabilitation by having a better understanding of the drug users' need and the impact of the program.

For data gathering technique, this research chooses the explanatory sequential mixed methods. With this method, this research first collects and analyzes quantitative data. After that, this research follows up the quantitative data result by analyzing the qualitative data. The quantitative data are gathered through questionnaires and the qualitative data are gathered through in-depth interviews. This research sets the target of 30 people (25 male and 5 female) filling the questionnaire per city. Some of the respondents, maximum 6 people, from the quantitative method will participate again in our qualitative method. The criteria of participants are:

1. drug users (whether regular or recreational user);
2. minimum 18 years old;
3. experienced and/or still undergoing rehabilitation in IPWL facilities.

For balancing the perspective, this research also questioned a health worker who works in compulsory report institution where majority of this research's respondents in that city register.

This research conducted data gathering in six cities which fulfil these criteria:

1. high prevalence of drug use;
2. availability/presence of active drug users/harm reduction organizations;
3. geographical balance between western, eastern, and central regions of Indonesia.

Six cities that we choose are Jakarta, Medan, Batam, Samarinda, Bali, and Makassar.

Researchers corresponded with an active drug users/harm reduction organization for each city. These organizations are People's Movement for Education and Human Rights (GARUDA) in Jakarta, North Sumatera Drug User Network (Jarkons) in Medan, Batam Drug Users Community (Persaudaraan Korban Napza Batam/PKN Batam) in Batam, East Kalimantan Drug Users Community (PKN Kaltim/Perbansakti) in Samarinda, Bali Drug User Association

(Ikatan Korban Napza Bali) in Bali, and Makassar Drug User Association (Persaudaraan Korban Napza Makassar) in Makassar. These organizations gathered drug users who meet the criteria and provided the place to conduct the interview.

This research is conducted from early October 2015 until mid-February 2016. In the first month the researcher collected national and international rules or standard about rehabilitation for drug users. Starting from early November to six weeks after, this research conducted the data collection. In the last three months, data analysis and research report composition took place.

All the names of research participants whom this research interviewed have been disguised for security reasons.

B. Data Collection

Each respondent was asked about their rehabilitation experience and whether it had fulfilled their right to health, right to information, right to privacy, right to free from discrimination, right to work, and right to education by a facilitator with the guidance of a questionnaire. The questionnaire also tries to find out the drug users' needs in rehabilitation process and their experience of relapse. There are also open questions asking drug users' opinion about compulsory rehabilitation and report.

From the quantitative result, this research looked for respondents who show deep or unique experience dealing with compulsory report system. The unique experiences considered worthy to be explored further are violations of drug users' rights, discriminations, disappointments toward compulsory rehabilitation service, and criminalization even after they have IPWL card. The persons who have these experiences were deeply interviewed. Therefore, the research could discover the real situation of the program implementation.

Research teams also came to compulsory report institutions to conduct interview with health workers in that institution. In the analysis section, this research will insert their perspective on the ongoing policy: the weaknesses and the strengths. The research teams contacted Gambir Local Community Center (Puskesmas Gambir) in Jakarta, Adam Malik Public Hospital (RSU Adam Malik) in Medan, Embung Fatimah Public Hospital (RSU Embung Fatimah), Atma Husada Mahakam Mental Hospital (RSJ Atma Husada Mahakam) in Samarinda, Sanglah Public Hospital (RSU Sanglah) in Bali, Jumpandang Baru Local Community Center (Puskesmas Jumpandang Baru). The questionnaire and the guidance of interview of this research could be seen in appendix.

The collection of data was managed by two teams. Each team conducted research in three cities. Each team consisted of three people and is managed by one coordinator. For each city, one team need three to four days for completing data

collection. One until two days is for questionnaire-interviewing for quantitative data, one day is for interviewing for qualitative data, and the one other day is for interviewing the IPWL provider.

C. Research Limitation

This research has several limitations. This research could not achieve the target respondents for female drug users making the proportion of male and female in this research is not balance. Therefore, this research could not analyze deeply the gender aspect that could influence the implementation of compulsory report and rehabilitation.

This research do not have a proportional respondents for each of three models of rehabilitations recognized in Indonesia (the medical rehabilitation, social rehabilitation, and therapeutic community method). The majority of respondents in this research register as medical IPWL clients, therefore it is possible that there are many human rights infringements and problems in the social rehabilitation (managed by the MoSA) or therapeutic community (managed by the BNN) which have not been reviewed.

D. Demographic Data

This research successfully gathered 181 respondents from six cities who met the criteria. From questionnaire-interview process, we acquired demographic data from all of the respondents. This demographic data, consisting of gender, age, ethnic group, occupation, and education, could be seen in the table below.

Table of Demographic Data

Subject	Type/Range	Frequency	Percent
Gender	Male	163	90.1%
	Female	16	8.8%
	Others	2	1.1%
Total		181	100%
Age	Unknown	1	0.6%
	18-25	39	21.5%
	26-35	102	56.4%
	36-45	37	20.4%
	>45	2	1.1%
Total		181	100%
Occupation	Labor	2	1.1%
	Freelance	1	0.6%
	Hairstylist	1	0.6%
	Housewife	9	5.0%
	Addiction Counselor	10	5.5%
	College Student	6	3.3%
	Mechanic	2	1.1.%
	Fisherman	1	0.6%
	Employer	46	25.4%
	Sex Worker	2	1.1%
	Sailor	1	0.6%
	Unemployed	30	16.6%
	Security Guard	3	1.7%
	Artist	1	0.6%
	NGO Staff	5	2.8%
	Driver	4	2.2%
	Tatto Artist	1	0.6%
	Motorcycle Taxi Driver	4	2.2%
	Parking Attendant	4	2.2%
	Entrepreneur	48	26.5%
Total		181	100%
Education	Elementary School	5	2.8%
	Middle School	32	17.7%
	High School	112	61.9%
	College	32	17.7%
Total		181	100%

The result from this table is pretty clear. Although the research had targeted five female participants from each city, which make it 30 females in total target, we could only identify/interview 16. The lack of women participants perhaps caused

by the same problem with many other drug research[21], though this research is not meant to answer about that problem. In Batam, there were two transgender people who agreed to participate in this research. They helped this research to elucidate their specific situation in drug rehabilitation.

The majority of compulsory report clients whom interviewed in this research are ranged from the age of 26-35. All of our respondents are in productive age of working. Their fields of occupations are very varied and it means that each drug user struggles differently in matching the rules of compulsory report institution and their occupation. However, the majority of respondents are entrepreneur (26.5%) therefore they could more easily adjust the obligation to attend treatment with their work. It is important also to note, that 30 people of the compulsory report program clients in this research are unemployed. Moreover, this research could consider the financial strain as obstacle to undergo the treatment.

The majority of respondents are high school graduates (61.9%), followed by middle school and college graduates (17.7%), and followed by elementary school graduates (2.8%). This data show that the respondents of this research are pretty much varied in the context of education level.

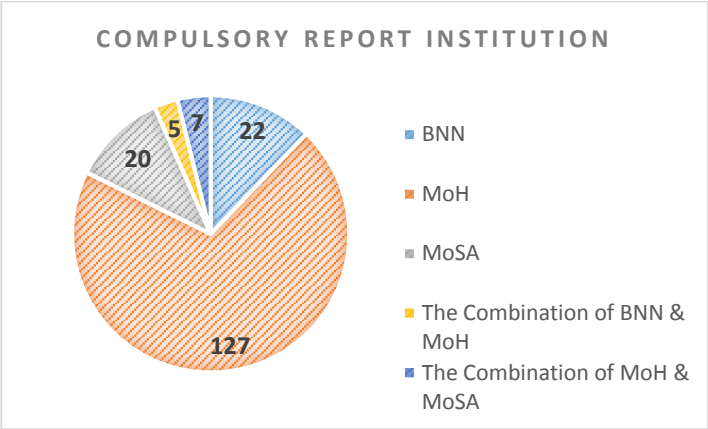
To understand more about respondents' needs, this research also asked the history of drug use from all of respondents. Almost all of the respondents used various drugs in their history. The most common drugs they used are ATS (32.0%), followed by marijuana (26.8%), and followed by heroin (20.5%). Almost 11.0% of our respondents also use drugs other than heroin, ATS, marijuana, and ecstasy. The examples of other drugs they use are LSD, magic mushroom, antidepressants, cocaine, and many more. For complete data, see table below.

History of Drug Use

		Responses		
		N	Percent	Percent of Cases
History of Drug Use	Heroin	104	20.5%	57.5%
	ATS	162	32.0%	89.5%
	Marijuana	136	26.8%	75.1%
	Ecstasy	85	16.8%	47.0%
	Others	20	3.9%	11.0%
Total		507	100.0%	280.1%

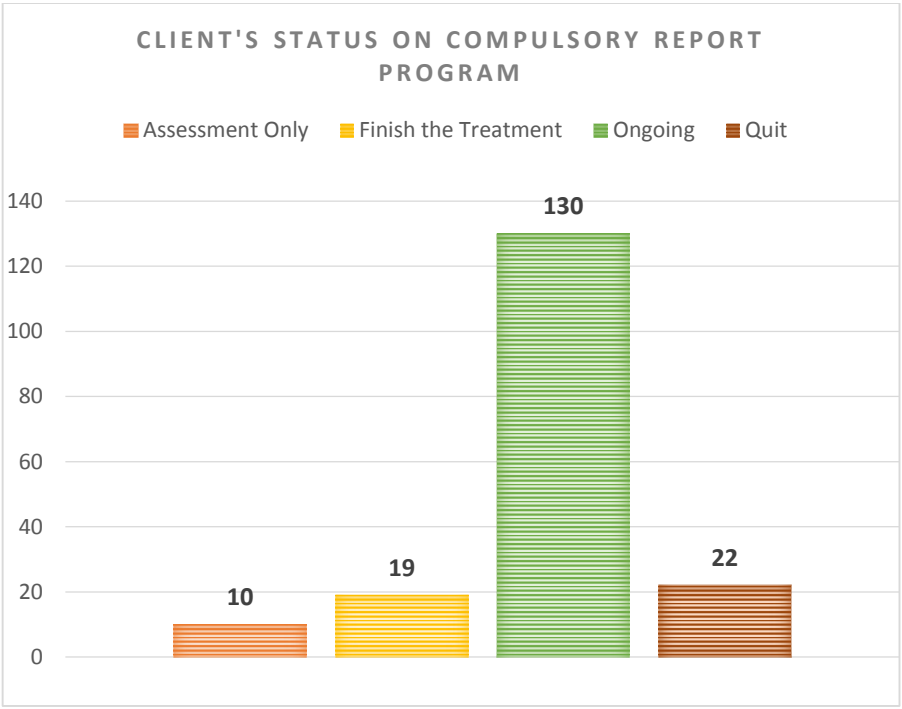
[21]UNODC on study of female drug users in India, conclude that drug abuses impact women dually because male drug users creates enormous burden for the affected women. This conclusion perhaps could elucidate why many female drug users reluctantly search for help from either communities or rehabilitation institution. See completely on ÜNODC, 2008, "Women and Drug Abuse: Substance, Women, High-Risk Assessment Study".

Due to many variance of treatment centers, this research also inquires the type of compulsory report institutions the respondents entered. We divided the type of compulsory report facilities by the national institutions that coordinate them, which are BNN, MoH, MoSA, and the combination between these institutions. Here is the result:



From this result, we could see that there are possibilities of data duplication. Some of the respondents were registered to more than one compulsory report institutions even they only undergo the treatment in one IPWL facility. Some of them completed or stopped treatment in one place and registered to another compulsory report institutions without knowing whether their status of IPWL. This research also finds in one city that some respondents registered themselves in a private clinic which permitted by the BNN to provide compulsory report program. The patients in this private clinic also got IPWL cards. Overall, majority of the respondents are registered in local health community center or hospital (70.1%).

This research also tries to categorize respondents by their IPWL's status. This research categorized IPWL's status by 4 types, which are assessment only, finish the treatment, ongoing treatment, and quit. The result is presented in the bar chart below:

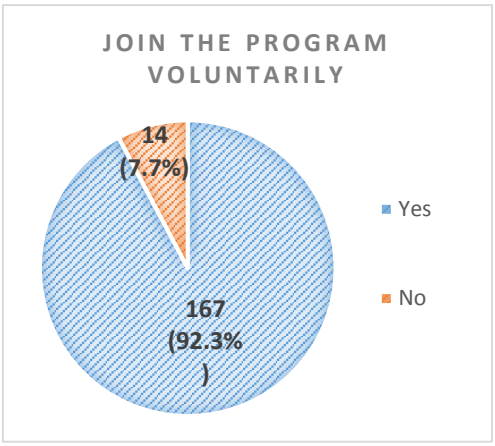


From 181 persons who have been interviewed, 10 persons did not continue the program after assessment, 19 persons finished the treatment, 130 are still undertaking the treatment, and 22 persons quitted the program. Though most of the respondents (71.8%) are still continuing the program, the 12.2% of the participants who quitted the program are numbers which we should not ignore because these are also a measurement unit in terms of effectiveness of the program.

RIGHT TO HEALTH IN IPWL

A. Freedom in Treatment

This research seeks to assess the fulfillment of human rights in compulsory report system implementation. One of the most relevant rights related to drug rehabilitation, in this context, is the right to health. Given that the right to health is not equal to the right to be healthy; this right contains the concept of freedom and entitlement. Freedom means that a person should be able to control one's health and body without any interference.[22] This freedom also relates to the freedom to enter health treatment.



Indonesia's concept of rehabilitation of drug users is compulsory. Drug users must undergo treatment and must report themselves to the government.[23] From this notion only, the policy of rehabilitation in Indonesia has violated the right to health of drug users in the context of freedom. However, in practice, many drug users come to compulsory rehabilitation center and enter the program voluntarily, as shown beside.

Almost all respondents testified to enter the compulsory report institution voluntarily (92.3%). However, there are some drug users who joined the program involuntarily. The questionnaire adds the following question as to why they felt coerced to register to the IPWL program. The result is expressed below:

[22]Committee of Economic, Social, and Cultural Right, *General Comment No. 14: The Right to the Highest Attainable Standard of Health*, E/C.12/2000/4, 11 August 2010, Paragraph 8.
[23]Article 53 and 54 of Law Number 35 Year 2009 About Narcotic.

The Reasons of Involuntarily Joining the Program

	Frequency	Percent	Cumulative Percent
Peer Pressure	2	14.3	14.3
Money Offered by the Indonesian BNN	1	7.1	21.4
Swayed by Parent(s)	6	42.9	64.3
Compelled by the Methadone Treatment Facilities	5	35.7	100.0
Total	14	100.0	

All of these reasons indicate several problem concerning IPWL, there are several problem concerning IPWL that need to be analyzed. We categorized all of the problems in the freedom in treatment into several subsection.

Transition from Rehabilitation Center to Compulsory Report Institution

The latter reason shown in the table above could not be interpreted as a violation of free will to access medical treatment. All of the five people had accessed methadone treatment before the policy of IPWL was started. In the 2011 regulation on IPWL, when entering the program, one must be assessed by the compulsory report institution. According to the 2013 regulation of MoH, the MMT facilities[24] are automatically appointed as compulsory report institution. There is no provision whether MMT facilities must reassess their patient or not. In practice, there are MMT clients who were reassessed and who were not. Some of these patients perhaps rejected only the reassessment or the status of compulsory patient, but not the treatment as a whole.

An interesting experience was felt by a drug user in Makassar, named Usman. He got his IPWL status because one day, a local health center in which he usually hang out with his friends asked them to move to the local health center hall. Although he and his friend did not comprehend enough the explanation at that time, they were still got the assessment one by one.[25]

Drug users might feel that the compulsory report system has the impression of surrendering to the police or the BNN, which is not entirely wrong since the police department and the BNN are categorized as IPWL providers. A doctor in

[24]Far before compulsory report institution policy is introduced, many hospitals and local community health centers had already provided methadone treatment. In 2006, Ministry of Health appointed four hospitals and three local community centers as try-out facilities to provide methadone treatment (see Ministry of Health Decision Number 494 Year 2006). The government regulation of compulsory report centers itself was enacted in 2011.

[25] *Interview with Usman on 3rd November 2015*.

Samarinda, for example, said that many drug users are not comfortable to join the program because IPWL implicitly expresses the presence of police in their rehabilitation program.[26]

The lack of information about compulsory report policy has also made some methadone patients confused on why their rehabilitation center must change its name and what the difference between the previous and the current institution is. One of the informants in this research, Ares, said that he has undertaken methadone for approximately six years and there is nothing changed in the treatment, regardless of IPWL status in the methadone therapy facilities.[27] Take it to the extreme; one of the IPWL patients in Medan expressed his frustration towards compulsory report program. He said:

> "IPWL is merely a slogan, and paper, if mentally ill people use red card, drug users use yellow card, merely a decoration for wallet. From what I see, there isn't any benefit from IPWL."[28]

This remark was made because he had become methadone patient since the first time methadone intervention implemented in Medan and he felt no better change after the IPWL provision is enacted. The IPWL program he had in mind was a program to prevent criminalization for drug users and, according to him, this function had failed.[29] This problem of information about decriminalization will be further explained in the next section. The point that could be learned from his testimony is that the information of IPWL program is unclear in terms of its benefits; driving some patients felt coerced to join the program.

Not only confusing the IPWL's clients, this new program also confuses the health workers working in the IPWL institutions. Many of the health workers interviewed in this research stated that their treatment program had already been established long before the IPWL is introduced, and their work remains the same. Windi, a health worker in Jumpandang Baru Local Community Center (a compulsory report institution in Makassar, South Sulawesi province), was confused with the new policy. She heard from the doctor that the IPWL card can only be used for two periods of treatment, while the length of each treatment is unclear. From her perspective and her experience to date, there should not be any expiration date for methadone treatment.[30] This ambiguous information about the length of treatment could push away drug users to access the

[26]Interview with Mito on 17th November 2015.
[27]Interview with Ares on 17th November 2015.
[28]Interview with Yocki on 17th November 2015.
[29]*Ibid.*
[30]Interview with Windi on 5th November 2015.

compulsory report system. It is safer and more comfortable for drug users if the compulsory report system does not have a time limit.

The problem of transitioning from the previous concept of rehabilitation system to the current one shows that there is a problem on informed consent. To fulfill the principle of informed consent, a patient must make decision voluntarily after comprehending with adequate information about the potential effects, side effects, and the likely results of refraining from treatment.[31] From this definition, the aforementioned problem of transitioning which did not clarify the benefits or the loss of compulsory report system clearly violates the aspect of informed consent.

Swayed by Parents

In Medan, North Sumatera province, the family of drug users can liaise with rehabilitation centers, usually social rehabilitation centers, to place drug users in a rehabilitation center. The family can also liaise with local police or local BNN to force drug users entering compulsory report centers.[32] This kind of practice indicates that it is common for families with the help of IPWL institutions to place drug users in a compulsory report system even without their consent.

One patient of rehabilitation in Medan, Ares[33], was a client in an official IPWL institution; while at the same time he still used illegal substances outside the IPWL treatment. One night, he was suddenly picked up by unknown people to him and then was thrown away into a truck. It was his family decision to do so because they were concerned with Ares's ongoing use of illegal substances. Ares did not consent to his family decision. Ares's experience shows that the consent of drug users to enter a rehabilitation program is often not considered by their family. Ares's case indicates that there may be drug users come into IPWL institutions because compelled by their families. This would not be happening should the government-appointed IPWL institutions reject those drug users if no informed consent is provided when enter the program. Hence, the role of the government is significant to ensure that the principle of informed consent is respected. However, despite the significance of the role of the government, it may be possible that the government itself to undertake inappropriate measures.

Shameful Approach to Obtain Patient

[31]Subcommittee on Prevention Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment, Approach of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading
Treatment or Punishment on the rights of persons institutionalized and medically treated without informed consent, paragraph 12.
[32]Interview with Lutfan on 16th November 2015.
[33]Interview with Ares on 17th November 2015.

There is one client whom the researchers interviewed in the quantitative data gathering felt that his registration to IPWL program was not voluntary because he was offered some money from the IPWL institution. However, he also wanted to end his drug dependency and to live a healthy life, thus accepting the rehabilitation program. The money that was offered added his motivation to register. Therefore, it could be said that he was not completely forced to join the program. In this context, the issue is the way of IPWL institution approaches potential clients rather than the infringement of free will.

In addition to that, during the qualitative data gathering, the researchers also found similar phenomenon. In Batam, there are people from local non-governmental organizations who were 'recruited' by the provincial office of the BNN. These people offered money to drug users to participate in BNN's IPWL institution, with the promise that those drug users will not be prosecuted by the BNN in the future. The practice to ask drug users to bring another drug users to IPWL institution is also pretty common as this research finds that 14.4% of all respondents were asked to bring another drug users in return of money. An informant from Batam explained this kind of practice:

> "National Narcotic Board works together with [name of an NGO]. There are three fieldworkers, if they bring people to BNN for IPWL [registering], [they] will get 250,000 IDR per person they bring."[34]

In Jakarta, the scene is even worse. People working in NGOs who were 'recruited' by the Jakarta's BNN office, offered money to drug users who have been participating in the MoH-appointed IPWL institutions, in particular those who are undergoing the MMT program. Participants of MMT program are generally unemployed and therefore they are more prone to this allure. This situation will lead to duplication of data regarding drug users' participation in IPWL program.

In another case in Makassar, Togar also suffered from similar misconduct committed by the IPWL institution. In 2014, he was invited by his friend to go to a social IPWL institution. Upon their arrival, a staff greeted them and asked them many things concerning their daily life as drug users. Because, Togar had already known this staff, he voluntarily told the staff about his drug condition, including the fact that he relapsed two months before that. He did not know that his answers were used as an assessment for him to join compulsory report program. After the assessment had been done, the staff told him that he would then be registered to be an IPWL client. Knowing that, Togar was surprised and offended because the IPWL institution did not tell him at the first place that he was assessed to join the program. After that assessment, he left the institution and

[34] Interviewed with Ikhsan on 25th November 2015.

never came back. He categorized this manipulation as a kind of psychological violence.[35]

The above cases suggest that the government seems very keen to ensure that their IPWL program is successful. In 2015, the government has declared that they have target of rehabilitating 100,000 drug users.[36] So by definition, it would mean that they need to ensure that there are indeed 100,000 drug users going through treatment under the IPWL program. Whether this target has been achieved or not is of course a separate issue. Nonetheless, even if the government has accomplished their target, their success is contaminated by the above shameful approaches.

B. Accessibility of Treatment

The fulfilment of the right to health also means that the health facilities, goods, and services should be accessible for everyone. The accessibility consists of four principles, which are non-discriminatory, physical accessibility, economic accessibility, and information accessibility.[37] This section will first assess the aspect of information accessibility, followed by physical accessibility, and closed with the analysis of economic accessibility. The analysis of non-discriminatory principle shall be taken into account throughout the discussion.

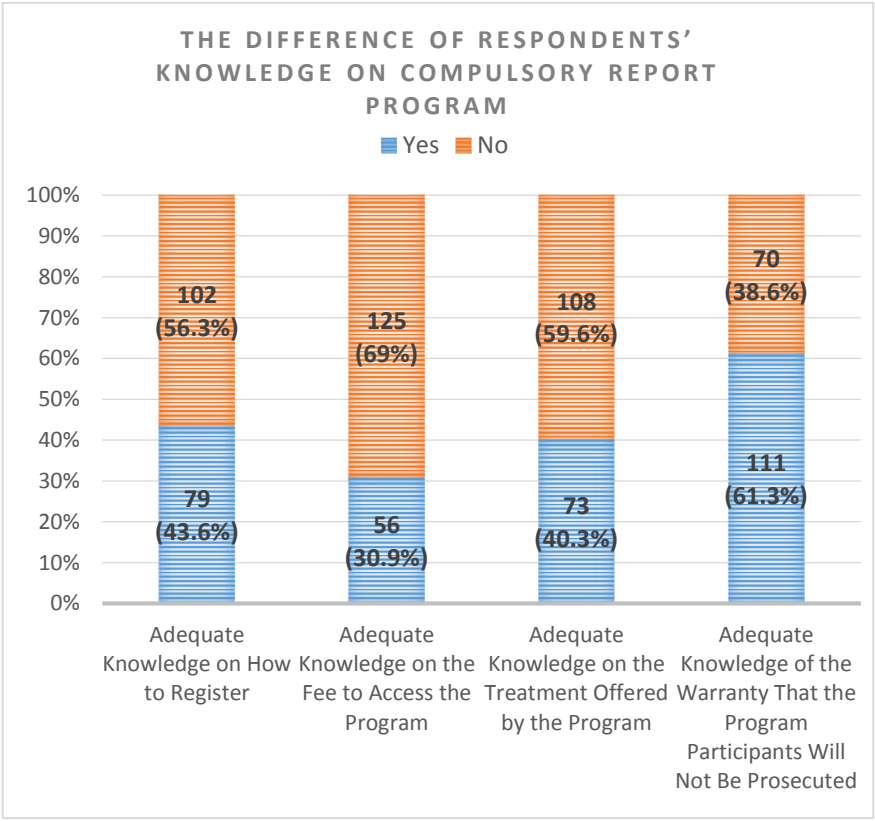
Information Accessibility

As reviewed in the previous section, drug users can make voluntarily decision to join compulsory report system after they are fully informed. The information of compulsory report programs therefore must be accessible for drug users. The right to health dictates that everyone has the freedom to seek, receive and impart information concerning health issue.[38] The majority of respondents perceived that they could easily obtain the information about compulsory report program (79.0%).

However, the kind of information that is accessible for drug users must also be scrutinized. In IPWL program, there is a number of important information that drug users must know if they want to enter the treatment. They must know how to register, the fee to access the program, the treatment offered by the program, and the other benefits of this program which is the warrant not to be prosecuted. This research asked respondents' knowledge on those four issues before they

[35]Interview with Togar on 3rd November 2015.
[36]http://nasional.kompas.com/read/2015/05/17/12583681/BNN.Targetkan.Rehabilitasi.100.000.Pecandu.Narkoba.Tahun.Ini.
[37]Committee of Economic, Social, and Cultural Right, *Op. Cit*., Paragraph 12.
[38]*Ibid.*

registered into the IPWL program. The result of these knowledge is presented below:



In the segment of acknowledging the information of the program, 56.4% of the respondents said that before they accessed the program, they did not have adequate information on how to register as a participant. This research also found that 69% of the participants did not know the fee they should pay to access the program. The 59.7% of the respondents did not have adequate understanding on the treatment offered by the program, while 61.3% of the respondents understood that the participants of the program ideally will not be prosecuted on drug use or small possession[39].

This quantitative data is supported by a testimony from a drug user. He said that at the time of registration, the IPWL providers explain what IPWL program is but did not specify the treatment, like whether there will be detoxification

[39]Article 128 number 3 of Law No. 35 Year 2009 on Narcotics states that drug dependents who are treated medically (max. 2 period(s)) in government appointed sites shall not be prosecuted.

treatment, whether there would be in-patient treatment, or whether there will be referred to undergo social rehabilitation.[40]

The regulation of compulsory report system mentions one objective of IPWL program is to fulfil drug dependents' right to health through medical and social rehabilitation; this regulation does not mention decriminalization as the purpose of this program enacted.[41]It seems understandable that the intention of the government providing IPWL program is to end one's drug dependence, with the stake of criminalization[42]. However, the above data shows that more than 50% of the respondents know that IPWL program will avoid them from prosecution, while less than 50% know the main component of rehabilitation in the IPWL program. This suggests that information readily accessible for most drug users is that when they register the IPWL program, they will not be prosecuted. This leads to the fact that most of the program participants registered into the IPWL program mainly because of fear of being arrest, instead of seeking treatment.

The above phenomenon disappoints one senior drug user, for example. He said,

> "What I am seeing now is, before the '100 thousand drug users program'[43], [drug users] purely intended to report themselves [to access treatment]. But several weeks after the government's program, [the 100,000 program], it is as if they say, "Oh I am still involved in things like this [narcotics], it is better [for me to report to IPWL] than arrested and don't have IPWL [card], and haven't reported myself." As if they only seek for safety."[44]

The fact that the government's expectation to introduce IPWL program does not meet with the intention of the drug users who report themselves to IPWL possess the following risk: drug users may not genuinely undergo their treatment program and thus may further deteriorate their health condition.

This unbalance information accessibility for drug users does not mean that the decriminalization-intended function and consequence in IPWL policy must be erased. This information could suggest that as yet, drug users still face the fear of

[40]Interviewed with Usman on 3rd November 2015

[41]Article 2 Government Regulation Number 25 Year 2011 regarding the Implementation of the Compulsory Report of Drug Dependents.

[42]Article 128 number 3 of Law No. 35 Year 2009 reiterates that people in drug dependence who undergone medical rehabilitation shall not be prosecuted, but the Article 127 of the same Law still criminalizes drug use up to 4 years maximum.

[43]What he mean is BNN program regarding drug rehabilitation in 2015 who targeted 100,000 drug users register to IPWL institution. See footnote number 34.

[44]Interview with Edo on 1st December 2015.

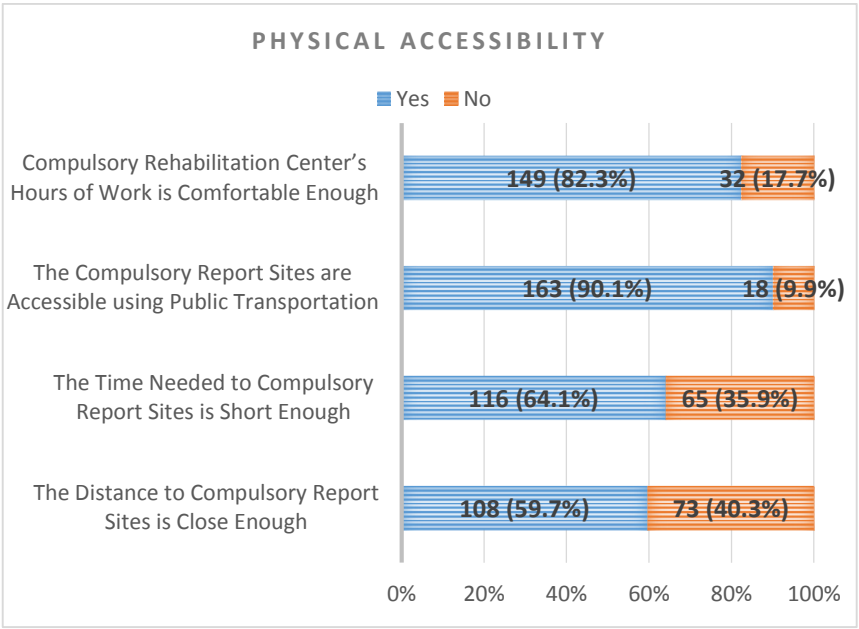
criminalization and the human right violations that follow[45], shown in the high rates of prisoners who are punished due to drug use.[46] Given that the long history of human rights violations in drug users' criminalization, compulsory report program is perceived by many drug users as the only way to stay away from incarceration.

The unbalance accessibility of information could also happen because, between the stakeholders, there are many different perspectives and agenda. For example, between the MoH and the BNN, they differ in viewing the period of treatment and the right to privacy in this program.[47]This dissimilar view between IPWL providers could make the type of information that drug users can obtain are different among them.

Physical Accessibility

Another aspect of accessibility is physical accessibility. TREATNET lists several things that are important regarding availability and accessibility of drug dependence treatment. There are two components that are relevant with the physical accessibility, which are: geographical accessibility, distribution, and linkage; and, timeliness and flexibility of opening hours. The first component means that comprehensive health facility must be situated evenly for everyone in different level of income, including hidden population, to access and also can serve as points of first contact and entry points. The second component means that the treatment must be same-day admission, short waiting time for services, and wide range of opening hours.[48] To assess this physical accessibility from the clients' perspective, this research inquired them with the following questions. The answer could be seen below:

[45]To understand deeply about the infringement of human rights of Drug Users see Ricky Gunawan, et. All (2012), "StudiKasusTerhadapTersangkaKasusNarkotika di Jakarta"
[46]Prison Department, 2015, "2014 Annual Report", pg. 48.
[47]Eunike Tyas Suci, Asmin Fransiska, and Lamtiur Hasianna Tampubolon, 2015, "Long and Winding Road: JalanPanjangPemulihanPecanduNarkotika"
[48]UNODC, 2008, *Principles of Drug Dependence Treatment*, pg. 4.



In terms of accessing the compulsory report sites, this research found that the program participants still experienced difficulties. Though 90.1% of the participants said that the institutions could be accessed using public transportation, 35.9% said that the time that they should spend to get there is not short enough. Further, 40.3% of the respondents said that the institutions are not close enough with their residences. The government must address the issue of accessibility of the IPWL institutions to ensure that there are more people accessing treatment for any drug-related health problem.

This research has a limitation not able to fully analyze how reachable drug facility treatment in remote areas. Since the respondents in this research mostly live in big cities, this research could not give a complete and holistic view on how the distribution of the drug dependence facility in remote areas. However, this research found several respondents who have experience living in remote areas while they need drug dependence treatment.

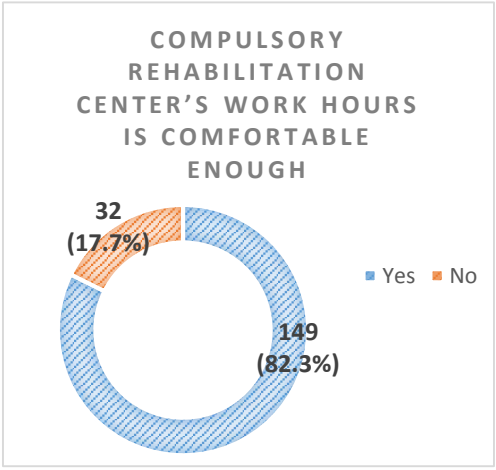
One of the respondents who has obstacle to access treatment due to live in remote area called Stefan. Although at the time of research he lived in Makassar, he had a house in Raha, Kendari. Kendari is located in Southeast Sulawesi (45 minutes flight/approx. 18 hours and 25 minutes car ride of 979km, please see map below), and his house is still quite far from Kendari.

Sometimes he must come back to his parent house in Raha, Kendari. However, there are no drug rehabilitation centers available in his home village, making him

cannot get methadone treatment there. To cope with his drug dependence, he stocked many tramadol[49]pills illegally without doctor prescription. He stocked around 100 pills of tramadol to cope with his craving and this tramadol will run out after one month. After one month consuming tramadol, he would get better and not using any drugs again.[50]

In addition to the absence of methadone treatment in Raha, Kendari, the ARV treatment is also unavailable, thus, inaccessible in his home village. Since Stefan is a person living with HIV/AIDS, he urgently needs ARV treatment. In 2010, for four months he had to come back to his house in Raha and was unable to get any ARV treatment. He did not know whether in Kendari town there are any local health centers that provide ARV treatment. Fortunately, he did not collapse at that time.

It is not suffice to adjust the location of a health service for its clients. It is equally important to ensure that the health service facilities open in various work hours, thereby, the client are comfortable enough to access it. The service for drug dependence treatment should be short in waiting time and have the same day admission. Meaning, people could register and access the treatment in the same day without too much delay.[51] In the case of methadone treatment, it is vital to assure that the facility opens every day. The chart of respondents' opinion on the compulsory rehabilitation center's work hours is presented below.



From this result, majority of respondents said that the work hours of compulsory report institution is comfortable enough (82.3%). However, around 17.7% of the respondents said that it is not comfortable enough. The majority of people who did not feel comfortable for the work hours of the IPWL institutions are clients of institutions registered under the MoH (68.8%). This is related to methadone treatment.

The methadone treatment in every health service centers usually open in the morning until just before lunch time. One of the respondents, Denis, sometimes has to struggle to come to the methadone treatment centers because he must

[49]Tramadol is a narcotic-like pain reliever used to treat moderate severe pain. See the explanation in more detail at http://www.drugs.com/tramadol.html.
[50]Interview with Stefan on 3rd November 2016.
[51]UNODC, 2012, "Quality Standards for Drug Dependence Treatment and Care Services", pg.1

attend lectures in his university. If the lecture scheduled in his university is full in the morning, he should ask for permission to go to toilet and rush over to the hospital and quickly get back to his university. Luckily, his university is located near the hospital.[52]

One time, Denis came late five minutes only to the hospital and the nurse in the methadone clinic did not allow him to get the methadone. He had to beg the nurse to let him drink the methadone but the nurse told him to go cold-turkey (*pasang-badan*) for that day. Because he was unable to get the methadone, Denis must suffer due to this withdrawal.[53]

The difficulty for drug users to adjust their daily activities in conformity with the work hours of the IPWL institutions is also felt by some people who have a 9-to-5 job. Cecep, a respondent in Samarinda, stated that he had work but also must fulfil the treatment in hospital that opens only for two hours, from 10 AM to 12 AM. To cope with this situation, he used the policy of take home dose (THD) that allows him to take methadone dosage up until three days or deliberately absent from his work.[54]

Another IPWL client in Samarinda asserted the same difficulty in complying with the hospital rule. He had to ask permission ten minutes before lunch break (11.50 AM), from his supervisor, to go as quickly as he could to the hospital. He also expressed his dissatisfaction because the hospital was not aware of this accessibility problem. He said:

> "Lunch break is at 12AM, I must go from the office ten minutes before that, rushing, because one minute late I cannot take methadone. I complained that [to the hospital]. What happens if there are drug users who ride motorbike with their children, doesn't the hospital think about it? Does the hospital want to take the responsibility [if something bad happens]? [It] needed few meetings before eventually the hospital loosen their policy."[55]

The strict regulation of opening hours of methadone treatment could lead to the infringement of human rights and could become also a violation of law. According to the MoH Regulation Number 37 Year 2013, it states that the opening hours for drug treatment must accommodate the need of IPWL clients.[56]However, this

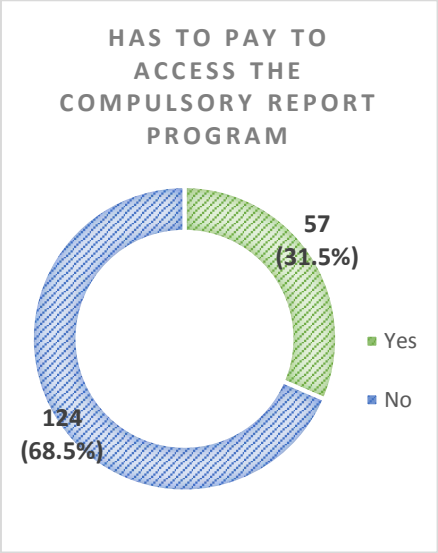
[52]Interview with Denis on 1st December 2015
[53]*Ibid.*
[54]Interview with Cecep on 17th November 2015
[55]Interview with Erwin on 18th November 2015
[56] Ministry of Health Regulation Number 37 Year 2013 About The Procedure of Narcotic Compulsory Report

regulation does not further elaborate what it means in terms of 'accommodating' the needs of the clients.

Affordability

Other factor that could also infringe drug users' right to access treatment is expensive treatment. In the right to health, affordability is considered as a factor of accessibility. It is argued that the payment for health-service must have the principle of equity and affordable for all people, including the socially disadvantaged group.[57]

In the diagram below, there is the result of respondents' opinions regarding the price of drug treatment that they accessed.



Affordability does not necessarily mean that every treatment must be free. By the principle of equity, every drug user, regardless of their social class, must be able to access treatment. Therefore, for people who have to pay for their compulsory report treatment, there are at least two questions that follow: first, how much they have to pay; second, whether such price is affordable for them. The result is presented in the table below with additional information about the type of compulsory report facilities:

[57]Committee of Economic, Social, and Cultural Right, *Op. Cit.*, Paragraph 12.

Crosstab between Type of Compulsory Report Institution and Price

		The Price is Affordable Enough		
		Yes	No	Total
Type of Compulsory Report Institutions	MoH	28	18	46
	MoSA	8	1	9
	Combination between BNN and MoH	1	1	2
Total		37	20	57

As previously explained, there are three main IPWL institutions: those under the MoH; MoSA; and maintained by the BNN. All respondents in this research who participated in the BNN's IPWL treatment do not have to pay for the treatment offered. From the table above, there is a limited example of drug users who could not afford social treatment. There is not any regulation that specifies the price of social rehabilitation in IPWL. Although, in addition to the fees paid by patients, IPWL social rehabilitation facilities can also get funding from central and local government.[58] A bigger sample of social rehabilitation patients is needed to know the exact obstacles of affordability in this regard. From the above data, this research could analyze the questions on how much the IPWL clients in the MoH-appointed IPWL institutions must pay, and if so, whether it is affordable for them.

The MoH is the only institution which specifies the price of compulsory report treatment which includes four activities. First, assessment and composing therapy plan which costs 75,000 IDR per person. Second, Basic Counseling of the Addiction of Narcotics and Psychotropic which costs 50,000 IDR per person. Third, symptomatic therapy which costs 50,000 IDR per person. Fourth, Urinalysis Examination for Three Substances which costs 100,000 IDR per person.[59]This regulation also states that all of the expenditures for compulsory report activities as mentioned above can be reimbursed by the IPWL institutions to the government. Therefore, IPWL clients who do not have to pay for any of the aforementioned activities, the IPWL institutions can claim the expenditure for every client they administer. However, if the IPWL institutions use a ticket payment scheme, then the clients must pay for their own tickets.[60] Reading from this regulation, the assessment in IPWL medical facilities should be free for every client, except in the institutions that have a ticket system.

[58]Article 46 MoSA Regulation Number 22 Year 2014 about Social Rehabilitation Standard with Social Worker Approach and Article 43 MoSA Regulation Number 3 Year 2012 about Social Rehabilitation Standard for Drug, Psychotropic, and Other Addictive Substance Abuse Victim.

[59] Ministry of Health Regulation Number 37 Year 2013 About The Procedure of Narcotic Compulsory Report

[60]*Ibid.*

Another regulation on medical treatment for drug users, Article 2 of the MoH Regulation Number 57 Year 2013 about Technical Guidance of Methadone Maintenance Therapy states that the local government is responsible for the operational costs of methadone therapy. This operational cost consists of the cost of glass, syrup, water, assessment formularies, urine stick, ticket/retribution, and other assessment/therapy needed by the patients, and overtime salary for staff who work in holidays. If the local government cannot cover all of the costs mentioned, patients are then obliged to cover the rest. However, the cost incurred to the patients should be at minimum to ensure the accessibility of treatment.[61]

From these two regulations, the government has acknowledged that in principle drug users do not need to pay for treatment. If the government cannot cover all the costs of treatment, drug users are obliged to pay as long as it is affordable. However, the presence of these two regulations leave disparity in terms of the price of treatment those IPWL clients have to pay in the MoH-appointed IPWL institutions. This research found that 18 of 57 people who had to pay for compulsory rehabilitation admitted that the price is unaffordable for them (31.5%).

This research found that methadone prices vary in each city where this research was conducted. In one IPWL institution in Medan, the price of methadone treatment is 15,000 IDR per person per day; in Batam it cost 10,000 IDR; in Bali it costs 8,000 IDR per person per day; while in Jakarta, Makassar, and Samarinda are free of charge. When we clarified this to the IPWL institution, one doctor in Bali said that 8,000 IDR is not the price of methadone but the price of service. Every day the nurse must treat them, give them water and syrup. The doctor also said that the hospital, not the district government, has the full authority to stipulate the fee of methadone treatment that an IPWL client has to pay.[62]In Jakarta, the national health insurance (BPJS) can cover the treatment expenses of IPWL clients. However, in Medan, the same insurance program (BPJS) cannot cover such expenses. One doctor said that it is drug users' own fault to be dependent to drugs at the first place.[63] This argument risks becoming a justification not to provide better health services for drug users and could be considered as a stigma for drug users.

This research also found that even in one province, the price for treatment in a number of MoH-appointed IPWL institutions that IPWL clients have to pay can be different too. In one hospital in Medan city, IPWL clients have to pay 15,000 IDR per person per day for methadone treatment. While in a community health

[61] Ministry of Health Regulation Number 57 Year 2013 about Technical Guidance of Methadone Maintenance Therapy

[62]Interview with Jumilah on 3rd December 2015.

[63]Interview with Belinda on 19th November 2015.

center, in Deli Serdang municipality, IPWL clients have to pay 8,000 IDR per person per day for the same methadone treatment.

This research further found that even in one MoH-appointed IPWL institution, the price for IPWL treatment is different from one client to another. In one community health center in Jakarta, if an IPWL client has a Jakarta ID card and BPJS card, s/he does not have to pay anything for the methadone treatment, including for the urinal testing. But if an IPWL client does not have those two cards, s/he has to pay 50,000 IDR for urinal testing.

The above findings suggest that clear guidance on financing for IPWL treatment is needed. This is to ensure that the amount of prices that IPWL clients have to pay are clear and alike in many IPWL institutions. Moreover, it is also crucial to ensure that there is an unambiguous provision if IPWL clients have to pay for the treatment and they cannot afford, from which budget allocation or program to cover the shortage. In the accessibility of treatment, the principle of non-discrimination must always be upheld.[64]

C. The Quality of Treatment

Quality IPWL Health workers

To maximize the fulfilment of right to health, the state must also consider the quality of drug dependence treatment. This section will be divided into two sub-categories, the first section examines the quality of IPWL staffs and the second section examines the treatment, including the medicine, aftercare, and the system of treatment.

To ensure that the participation and involvement of IPWL clients, it is important for the IPWL providers to build a comfortable environment for drug users. One way to achieve this is providing training for the staffs as to promote user friendliness and to ensure non-judgmental behavior in treatment settings.[65] This research inquired every respondent whether the doctors and nurse are polite enough, patient enough, and could help them to understand their conditions. The result is presented below.

[64]Committee of Economic, Social, and Cultural Right, *Op. Cit*., Paragraph 12.
[65]UNODC, 2012, "Quality Standards for Drug Dependence Treatment and Care Services", pg.2

The Quality of IPWL Providers

		Count	Percentage
Doctors and Nurses are Polite Enough	Unknown	10	5.5%
	Yes	161	89.0%
	No	10	5.5%
Doctors and Nurses are Patient Enough	Unknown	10	5.5%
	Yes	162	89.5%
	No	9	5.0%
Doctors and Nurses Helped Clients to Understand Their Conditions	Unknown	10	5.5%
	Yes	157	86.7%
	No	14	7.7%

Even though that the majority of respondents said that the quality of doctors and nurses was good enough, this research found a number of points to improve the quality of IPWL staffs. Several respondents still complained about some nurses who were impolite and doctors who are unresponsive.

This research found two examples of refusal of methadone treatment because the IPWL clients were late only for few minutes. The first one happened in Bali when a drug user had difficulty to adjust his therapy and education.[66] The second one happened in Samarinda when a drug user who have tight workplace where is far from his IPWL institution (as mentioned in the previous section).[67] Both of them were late for about five minutes before closing, but they still could not get the medication.

If the methadone therapy is recognized as a crucial treatment to address opioid dependence which must be undertaken regularly by each client, then the insensitiveness of nurses or IPWL staffs is a serious infringement which could harm the practice of rehabilitation and deteriorate clients' condition.

This above problem is not merely an accessibility problem, but it is also a problem of the quality of the IPWL staffs. The IPWL health workers should obviously know more than anybody else about the withdrawal effect on methadone is often severe. A drug user in Samarinda said that the withdrawal effect on methadone, if compared with heroin, is more painful. When he was in withdrawal phrase of methadone, he tried to cope the pain by using heroin again.

> "Whoa it hurts… If heroin [supply] is cut, within three days [the body] is feeling much better… But with methadone, [if the supply is cut] my

[66]Interview with Denis on 1st December 2015.
[67]Interview with Erwin on 18th November 2015.

body will feel sick for two weeks. In the end [I was] relapse and going back to heroin."[68]

The relationship between the patient and doctor in IPWL program also has another weakness. In methadone maintenance therapy, the act to distribute the methadone to the clients are managed by the nurse, but the act to give counselling to the clients is exclusively doctor's authority. The doctor in the IPWL facilities is responsible to increase or decrease the dosage of methadone. Article 11 MoH Regulation Number 57 Year 2013 regarding Technical Guidance of Methadone Maintenance Therapy states that the distribution of methadone to patients can only be carried out based on doctor's recipe. Looking at the importance of doctor's role in drug dependency treatment, the absence of doctor during IPWL working hours will hinder the sustainability of program.

Several respondents, mostly in Samarinda and Medan, complained doctors who often absent during IPWL working hours. David from Samarinda said that the doctor of his IPWL provider has schedule to come once a week but the doctor rarely comes as scheduled.[69]Zulham from Medan said that he had already reviewed the guideline of methadone therapy in his IPWL provider. Such guideline states that the counseling for methadone patients must be done routinely, at least once a month. However, in practice, the initiative should come from the client and the hospital hardly offered the opportunity to counsel. Further, it is often difficult for the IPWL clients to arrange counseling time.[70]

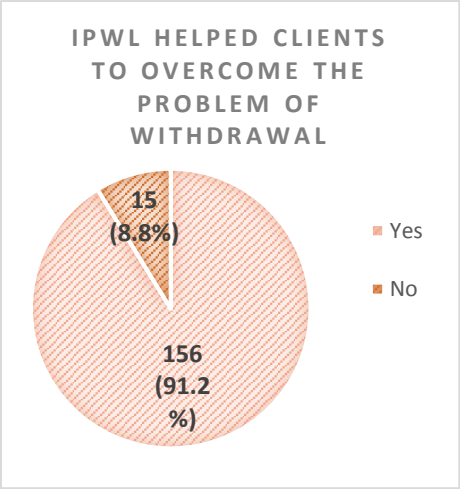
Quality of Medication

This section will examine the quality of treatment, medicine, and other related things. This research found a number of issues on the quality of treatment that recurred in the six cities where this research is conducted.

1) The Problem of Withdrawal Effect

The common medication for treating drug dependence is opioid substitution therapy and painkillers drugs. This two medicine is used to overcome the problem of withdrawal symptoms. This research asked IPWL clients whether the treatment they have received helped them in the withdrawal symptoms. The answer is as described below.

[68]Interview with Erwin on 18th November 2015.
[69]Interview with David on 18th November 2015.
[70]Interview with Zulham on 17th November 2015.



From this diagram it could be understood that most of the patients in the IPWL institution felt that their rehabilitation center has succeeded to help them overcome their problem in withdrawal phrase (91.2%). However, there are several notable cases where the IPWL institutions which have program that require drug users to be inpatient for several months could not give them sufficient amount of drugs.

In Medan, a client dropped out after he could not obtain his methadone in an IPWL social facility. The IPWL institution did not want to give him the methadone because for the institution the purpose of such treatment is to end his dependence on methadone.[71]

2) The Problem of Medicine Supply

Sometimes IPWL institutions have policy that may aggravate drug users' health condition. For example, this research found that an IPWL institution in Samarinda insists drug users to consume subuxone until the stock is run out and then they can change to methadone treatment.[72] This indicates that the IPWL institution ignores the quality of treatment by denying methadone treatment only on the basis of the medicine stock, and not by individual's preference and health condition. It also indicates infringement of the principle of affordability in the context of the right to health because the price of subuxone treatment is more expensive than methadone treatment. The methadone treatment is free, while the subuxone treatment is valued 25,000 IDR per milliliter, which means that IPWL clients must pay more.[73]

Other problem relates to the stock of medicine also took place in Samarinda. One time, the stock of methadone ran out for approximately three months. Due to this condition, the IPWL clients seek another substances, such as heroin and methamphetamine. One respondent described one extreme response to this condition:

[71]Interview with Yocki on 17th November 2015.
[72]Interview with Erwin on 17th November 2015.
[73]Interview with Erwin on 18th November 2015.

> "When the methadone is cut, the client abuse prescription drugs, consume amphetamine, anything… In the end, we robbed subuxone from the hospital."[74]

The reluctance of doctors to give proper medications has also happened in Batam where IPWL patients, who are ATS users, could not get medicine to overcome their withdrawal phase. One patient said that he had already asked his doctor to give him symptomatic medicine. However, the doctor refused to do so. He said,

> "I felt that my need was not fulfilled. I wanted to reduce [using ATS], but I felt pain. I told the doctor [about it]. [He said to me,] "You are the same with anybody else, from what I see, you don't need symptomatic [medicine]." But it was me who felt the pain. I become reluctant to go there ever since."[75]

Since the IPWL institution could not give these clients the medication or drugs that they need, many of them tried to find another substances that are considered illegal according to the Narcotics Law, such as marijuana. Gulam, a patient in Batam, stated that he used marijuana to overcome the ATS craving[76] while Herman stated that he used marijuana – replacing the symptomatic medications that he needed – to relief his headache as a result of ATS consumption[77].

3) Lowering IPWL Clients' Methadone Dosage

In methadone maintenance therapy in Indonesia, doctors have the authority to determine the dose of methadone for IPWL clients. In Samarinda, a patient must undergo urinal testing before the doctor decided whether their dosage of methadone could be reduced. However, because the urinal testing is expensive, around 175,000 IDR, he had difficulty to do the testing. When he finally obtained money to pay for the testing, the result discovered that he was still using amphetamine. Therefore, he could not get his methadone dosage lowered.

[74]Interview with Akhsan on 17th November 2015.
[75]Interview with Herman on 25th November 2015.
[76]Interview with Gulam on 25th November 2015.
[77]Interview with Herman on 25th November 2015.

> "I have done the urine test to lowering the dosage… I testified that I was still actively consuming amphetamine. [But still] I can't lower my dosage [methadone]. What is the purpose of urine testing then?"[78]

In Jakarta, the price for urinal testing is 50,000 IDR. Some of the drug users, especially those who do not work, argue that this price is unaffordable. A patient stated that he had known, through the internet, that the average year to accomplish methadone therapy is three years. But, he has been undergoing this treatment for six years. This grueling treatment and the intricate procedure to lower the dosage made him weary, in his words:

> "I am probably wrong, but I have been undergoing methadone for more than six years. I read from the internet that [methadone treatment usually spends] maximum three years. But it is very hard to lower the dosage. You must undertake urine test first, which mean you must pay for that. [It's not that] I want to be rude against methadone clients [but look] how many of us are employed. If we want to do urine test we have pay 50,000 IDR… Where can we get the money?"

To address the above problems, some drug users tried to find other unusual but still a legitimate way to lower their methadone dosage. Nono, a patient from Jakarta, said that his IPWL institution would cut the dosage into half from the regular one if the patients do not come in three days. He would then deliberately absent for three days and endure the withdrawal effect by himself and by using small methadone dosage from his friends. He successfully cut his methadone dosage from 90 to 65 milliliter by this way.[79]

Other patient, Yocki, said that he had tried to enroll to a social rehabilitation institution to end his dependency to methadone. After a while, he dropped out. He then went to the methadone maintenance therapy again. Years after that, due to the high cost of the treatment, he wished to quit. Since it is hard to ask for lowering dosage, he tried to take methadone once every two days (one day off, one day in). He said:

> "If I'm not doing this, they will make us drink [methadone] forever. It's already a business, it can be said [that the hospital is] a legal 'drug dealer'."[80]

[78]Interview with David on 18th November 2015.
[79]Interview with Nono on 8th December 2015.
[80]Interview with Yocki on 17th November 2015.

Another methadone patient had lose his hope to complete his methadone treatment if the policy in methadone maintenance therapy center do not change. He said:

> "I'm not sure that I can finish the methadone program, because the health workers of the Community Health Center do not give me any target to stop. Instead, they ask "Why do you want to quit [the methadone program], [we worry that] you will use [drugs] again?""

4) Other Problems Related to Social Rehabilitation

An informant who experienced social rehabilitation said that the program was useless for him. He said that he was forced to take English lesson of which he had not mastered until the end of treatment. After the treatment ended the English lesson was off no use.[81] If he did not obey the rule to follow the English lesson, he would be punished with physical labor, such as cleaning the garden or sweeping the floor.[82]

In a BNN-managed IPWL institution, a client explained that this program does not tolerate drop out. Every resident who runs away will be captured and receive severe punishment. He also said that the Therapeutic Community Treatment managed by the BNN, which does not allow any kind of narcotics, has a weakness. The weakness is the patient could yield a feeling of revenge to use narcotics again after the residence program has finished. As he describes,

> "But the weakness of TC is revenge, the feeling of revenge. You know why? [Because] we are confined, confined in a sterile place. Once I am out, I want to revenge, [using drugs again]. [All I can think is] just finish the program."[83]

However, he admitted that therapeutic community has a benefit. He said that TC program provides knowledge to drug users about the negative impact of relapse and how to prevent it.[84]

[81]Interview with Irfan on 3rd November 2015.
[82]*Ibid.*
[83]Interview with Valen on 3rd November 2015.
[84]Ibid.

Based on the above analysis, the majority of respondents said that the quality of doctors and nurses are satisfactory. However, there persist some problems in IPWL medical facilities related with withdrawal effect, supply medicine issue, and lowering methadone dose; and in IPWL social facilities as well as BNN-managed BNN institution.

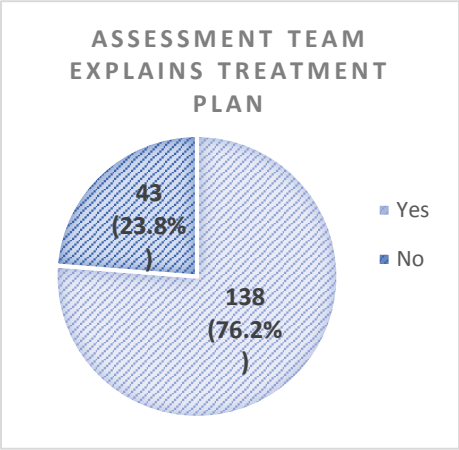
RIGHT TO INFORMATION AND PRIVACY IN IPWL

A. Right to Information

The right to information is very crucial and closely related to the right to health.[85] Compulsory report system in Indonesia should assure the fulfilment of the right to information, by explaining the detail about the treatments and obtain the clients' consent. The right to information that is going to be reviewed in this section is different from previous chapter because this section focuses on the right to information after the assessment phase.

The right of information in this context is mentioned in the Article 9 of the Government Regulation Number 25 Year 2011 which states that the result of assessment is used for constituting rehabilitation plans for drug users. This rehabilitation plan must be approved by the drug users, parents of drug users, families of drug users, or guardians of drug users along with the approval from the manager of compulsory report institutions. This provision could be used to neglect the informed of drug users because it allows parents, families, or guardians to approve the rehabilitation plan by themselves.

This article contradicts with the basic aspects of informed consent like decision made voluntarily, on the basis of comprehensible, sufficient information.[86] Acknowledging that the explanation on rehabilitation plan is a very crucial to the fulfilment of the right to information in IPWL, this research asks whether the respondents had been told about their rehabilitation plan after the assessment. This is the result:

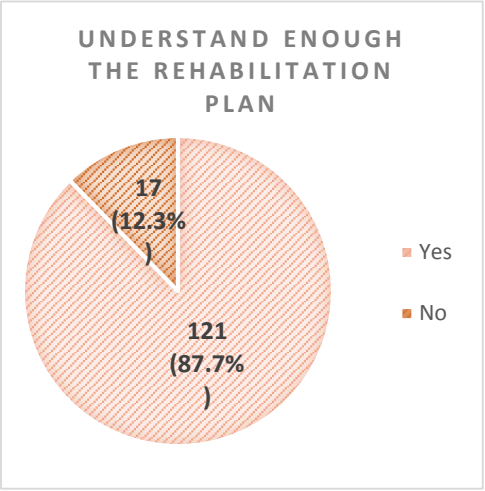


The majority of respondents were explained the treatment plan after the assessment (76.2%). However, the number of drug users who did not get their treatment plan explained are still high (23.8%).

[85]General Comment 14.

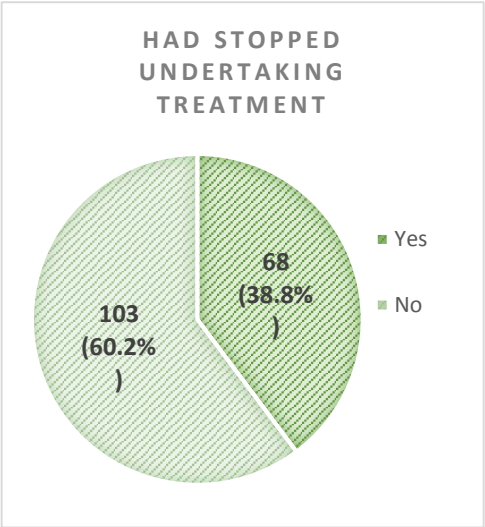
[86]Subcommittee on Prevention Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment, *Approach of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment on the rights of persons institutionalized and medically treated without informed consent*, paragraph 12.

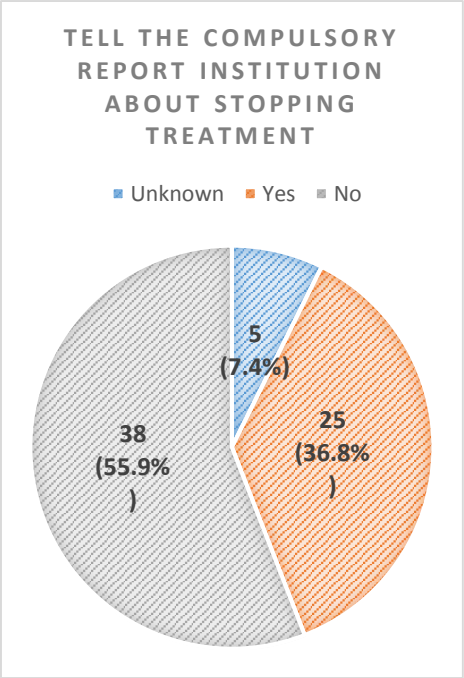
The existence and explanation of the treatment plan alone are not enough to say that the right to information has been fulfilled. The compulsory report institutions must make sure that drug users understand the rehabilitation plan offered. Therefore, for 138 persons who got explanation about the treatment plan, this research asked another question whether they were understood the rehabilitation plan. The result is as follow:



Almost all of the respondents who got explanation about the treatment plan understand the rehabilitation plan (87.7%). However, by understanding and accepting the rehabilitation plans do not mean that the drug users will accept all the action taken by the compulsory report institutions toward them. In the middle of the treatment, there are always possibilities that a client do not agree to undertake a certain kind of treatment offered. The IPWL could not use the clients' consent of rehabilitation plan to insist performing all treatments. This argument is supported by the fact that many respondents had quitted the treatment either temporarily or leading them to drop out (39.8%).

Because informed consent means that the clients should be able to make the decision voluntarily after are given the information, the clients should also have the right to stop attending treatment regardless their reason. In practice, a lot of clients did not tell their compulsory report institutions about their intention to stop undertaking treatments (55.9%).





The drug users could be not comfortable enough or frighten to tell their compulsory report institution about their intention. Whereas, the research finds that only one respondent who get punishment (3.8%) and one respondent (3.8%) who get reprimand from the compulsory report institution because of their intention. The rest responses can be seen in the table below:

Table of Compulsory Report Institution's Responses

Compulsory Report Institution's Responses	Frequency	Percent
Give Counseling	7	26.9%
Give alternative policy/treatment	9	34.6%
No response neither sanction	5	19.2%
Approve	3	11.5%
Reprimand	1	3.8%
Punish	1	3.8%
Total	26	100

This data show that the compulsory report institutions have tried to understand that intention by counseling them, giving another treatment, and even approving it.

Another issue regarding the right to information in Indonesia's compulsory report system is the assurance whether they had really been registered as IPWL clients. Article 10 in the Government Regulation Number 25 Year 2011 states that drug users who have registered to compulsory report system will be given the IPWL card. Several drug users participated in this research admitted that they did not get the IPWL card, which is a proof that a person is really a client of a compulsory report institution.

A drug user testified that the compulsory report institution did not want to give IPWL cards to the clients because the institution feared that it will be used by drug traffickers to avoid prosecution.[87]Meanwhile, a nurse said that:

> "Actually we have the IPWL cards, but we could not give them out because there are people who misuse it. They reprint it for people who are not registered as IPWL clients."[88]

This provision leaves a serious problem to drug users, which is the inability to prove their drug dependence to law enforcement agencies.

Another explanation for inexistence of IPWL card is because the cards are not ready yet. In Bali, the manager of IPWL said that the clients only obtained the cards as patients in a hospital, not the cards as clients of IPWL institution. She said that the hospital had not received the card from the BNN, the institution, according to her understanding, which has the authorization to issue the card.[89] The fast response of IPWL institution in Bali to provide card was praised by Fredrick, an IPWL client. He underlined the need of drug users to have the identification proving themselves as drug users.[90]

There is also another issue that patients from the methadone maintenance therapy (MMT) program, which started earlier than the IPWL program, did not know the transition of rehabilitation/treatment center to IPWL institution (see the analysis in the section of the right to health). This situation making them unaware whether they had already registered as IPWL clients or not.

The absence of the IPWL cards and the unawareness of shifting of the MMT program to IPWL system show that there are violations toward the right to information which the state has to ensure that "every individual should be able to ascertain which public authorities or private individual or bodies control or may control his or her files"[91]. The drug users could not ascertain which governmental institution have their data which they give to the treatment centers.

[87]Interview with Valen on 3rd November 2015.
[88]Interview with Feni on 24th November 2015.
[89]Interview with Jumilah on 3rd December 2015.
[90]Interview with Frederick on 1st December 2015.
[91]Human Right Committee, *General Comment No. 34: Article 19: Freedom of opinion and expression*, CCPR/C/GC/34, 12 September 2011, paragraph 18.

B. Right to Privacy

International Convention on Civil and Political Rights (ICCPR) mandates the protection of somebody's privacy must be in accordance with the aims and objectives of the Covenant. ICCPR requires the state to protect the information of individual from unlawful and arbitrary interferences. The term of unlawful limits the things that could not be interference in the scope of the Law in each States while the term of arbitrary interference also includes the possibility that the interference is governed by the Law.[92]In terms of compulsory report system, the IPWL institution has to protect the clients' privacy such as their status as drug users, their HIV status, their activities related to consume drugs, and any information gathered in the process of assessment and treatment in compulsory report system.

The Government Regulation Number 25 Year 2011 states that drug users' data will be recapitulated. This recapitulation data consists of the number of drug users who get treatment, identity of drug users, the type of narcotics that are used, the period of drug using, the way to use drugs, diagnosis, and history of treatment that have been done.[93] The identity of drug users includes the information about gender, age, religion, marital status, educational background, and occupation. All of this information will be inputted to Information System of Drug User (*Sistem Informasi Pecandu Narkotika*) by the BNN and be used for the evaluation of IPWL program.[94]

The report of drug users' data does not have to include the names and the medical records of compulsory report clients.[95] However, there is a different paradigm between the MoH and the BNN. The MoH is unwilling to share the names and the medical record in the report to the BNN while the BNN still asks for those data.[96]In a regulation that was made by the MoH, information in medical record of a patient can be given in the purpose of law enforcement.[97]Although this regulation protects the privacy of clients from unlawful interferences from third parties, this regulation still give an opportunity for law enforcement agencies to arbitrarily interfere with clients' data.

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[92]Office of the High Commissioner for Human Rights, *CCPR General Comment No. 16: Article 17 (Right to Privacy) The Right to Respect of Privacy, Family, Home and Correspondence, and Protection of Honour and* Reputation, Adopted at the Thirty-second Session of the Human Rights Committee, 8 April 1988, paragraph 3 & 4.

[93]Article 18 Government Regulation Number 25 Year 2011 regarding the Implementation of the Compulsory Report of Drug Dependents.

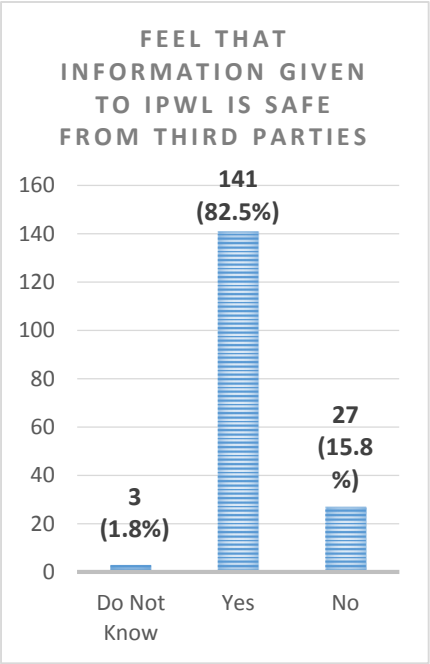
[94]Article 19-20 Government Regulation Number 25 Year 2011 regarding the Implementation of the Compulsory Report of Drug Dependents.

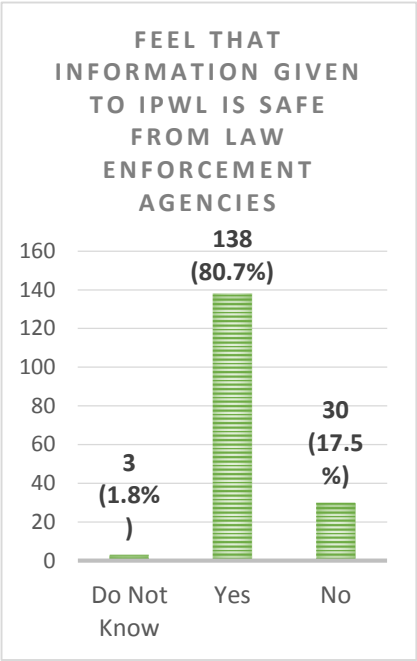
[95]Article 18 Government Regulation Number 25 Year 2011 regarding the Implementation of the Compulsory Report of Drug Dependents.

[96]Suci, Fransiska, and Tampubolon, *Op. Cit*., pg. 183.

[97]Article 5 Ministry of Health Regulation Number 36 Year 2012.

The research could not conclude whether drug users' personal information has been leaked or not by the compulsory report system but the research could seek whether drug users feel comfortable enough to share their personal information to IPWL institutions. This research asked the respondents whether they feel that their personal information in compulsory report centers are secured from law enforcement agencies (which indicates the data is secured from arbitrary interference) and other third parties (which indicates the data is secured from unlawful interference). The result is as follow:





Majority of respondents were sure that their privacy are save from third parties (82.5%) and law enforcement agencies (80.7%). There are several people, though, who said that they could not really trust their compulsory report institution for not leaking their privacy. The number of distrust to law enforcement agencies (17.5%) is slightly higher than the number of distrust to third parties (15.8%).

There are several reasons why drug users did not believe in the security of their data in compulsory report institutions, which shown in the tables below:

Reason Why Feel that Information Given to IPWL is Not Safe from Third Parties

Reason Not to Believe	Frequency	Percentage
Mere Suspicion	17	62.9%
High Discrimination in IPWL	1	3.7%
No Guarantee of the Privacy of Data	4	14.8%
IPWL Working Together with Law Enforcement	4	14.8%
Based on Experiences	1	3.7%
Total	27	100%

Reason Why Feel that Information Given to IPWL is Not Safe from Law Enforcement Agencies

Reason Not to Believe	Frequency	Percentage
Mere Suspicion	13	43.3%
IPWL Working Together with Law Enforcement	7	23.3%
Law Enforcement Agencies Enter Attended IPWL	5	16.6%
Uselessness of IPWL in the Term of Criminalization	5	16.6%
Total	30	100%

Though most of respondents base their distrust, that there will not be any unlawful interferences from other third parties, on mere suspicions (62.9%), there are two experiences that should be examined carefully to understand the situation. The first one happened to a drug user in Samarinda. He is a MMT client and was working for a company. He hid the information about him as a drug user from the company. One day, he requested take home dose (THD) methadone because he had to work outside city for several days. As a policy in the MMT facilities, the patient who requests the THD, must give the evidence explaining the reason why he/she really needs the THD. He had explained the reason and told the MMT facility not to recheck the reason to his workplace because it would harm his position in the office. But the MMT facility still called the workplace and this resulted to discrimination from his coworkers. He said:

> "I had already state, do not call the office concerning this THD… The hospital still called, resulting me to be judged in the office."[98]

[98]Interview with Erwin on 18th November 2015.

Another grave experience also felt by a drug user in Makassar. She is a person living with HIV/AIDS who wanted to deliver a baby. Her compulsory report institution referred her to a bigger hospital and conveyed the information about her as a person living with HIV/AIDS. When she and her husband arrived in the hospital, some journalist had already waiting there and started to ask questions about her status. In anger, her husband took her to another hospital and she delivered her baby there.[99]

The permitted usage of medical record for law enforcement still could be considered as an arbitrary interference if that interference, even allowed by the law, is not in accordance with the provisions, aims and objectives of the Covenant[100]. There is a possibility of arbitrary interference if the BNN or the police use the data to criminalize drug use which is an act that could lead to infringement of the right to health. The Special Rapporteur on the right to health explains in his report that criminalizing drug use is a failed policy and can perpetuated risky forms of drug use[101]. Since in Indonesia, drug use is still criminalized and there is not any clear regulation about into what degree the medical records of drug users can be used for law enforcement, the data of drug users are still risked from arbitrary interference.

A drug user called Usman told his experienced of possible data leaking from an IPWL center to the law enforcement agencies. In 2013, the IPWL center was frisked by the police, but they could not find any evidence. The police insisted that many drug users used this health center as a way to hide and defense against punitive drug law. After that the police were still patrolled in the area making some of the methadone patients report this unusual activity to the director of local compulsory report.

There is an interesting remark from a drug user who said that he could not trust the IPWL institutions because if a client is arrested for drug possession, the IPWL institution could give the patient information to law enforcement without the consent of the client. This kind of proactive conduct by the IPWL institution is actually something that must be done to prevent criminalization for drug use, but it must not breach the right to privacy. The arrested one must give the consent to the IPWL institution before it give his/her personal information to the law enforcement agencies. The privacy of patient data is strictly confidential and for any purpose, the patient must give consent prior to the authorization of data.[102]

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[99]Interview with Riska on 3rd November 2015.

[100]Office of the High Commissioner for Human Rights, *Op. Cit.*, paragraph 4.

[101]Report of the Special Rapporteur on the right of everyoneto the enjoyment of the highest attainable standard of physical and mental health, *Right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, A/65/255, 6 August 2010, paragraph 16.

[102]UNODC, *Op. Cit.*, pg. 10.

The measurable data about drug users is perceived by the government as important information which could be used to identify the demographic of drug users and also the drug using trend. Thus, the government could provide a better drug treatment method and construct further important research. However, the extraction of this data must not infringe the right to privacy. The right to privacy only permits the government to access "information relating to an individual's private life the knowledge of which is essential in the interest of society as understood under the Covenant"[103]. The government must also take effective measures to ensure that the information that have been gathered do not reach the hand of persons who are not authorized by the law to process and use it.[104]

[103]Office of the High Commissioner for Human Rights, *Op. Cit.*, paragraph 7.
[104]Office of the High Commissioner for Human Rights, *Op. Cit.*, paragraph 10.

RIGHT TO WORK AND RIGHT TO EDUCATION IN IPWL

While conducting their treatment, inpatient or outpatient, the clients of Indonesia's Compulsory Report System have to spend some of their time with the health workers. This section will show you how far their involvement with this system affected their daily lives in terms of working and getting education.

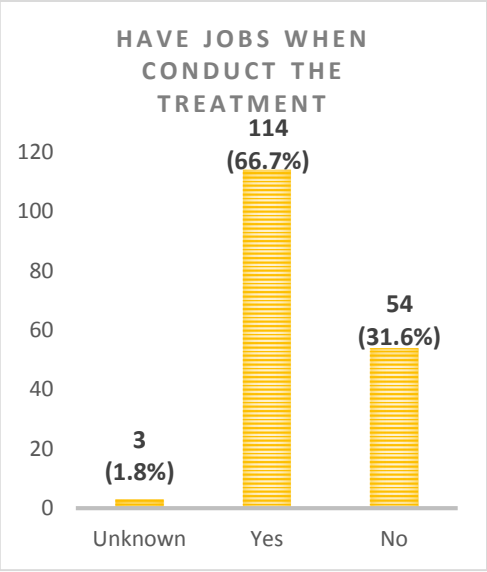
In this section, it's important to bear in the readers' mind that only 171 persons were counted because the other 10 were only underwent the assessments. We see it would be biased if we also include those 10 in these percentages.

This section will be analyzed by the International Convention on Economic, Social, and Cultural Rights (ICESCR) which already ratified by Indonesia by Act No. 11 Year 2005. Besides, we also find the interpretations towards right to work in General Comments No. 18 and the explanations on the right to education in General Comments No. 13.

A. Right to Work

As shown by the bar chart below, we could see that 66.7 percent of the research participants have jobs when they undergo the treatment. Focus on this population we will see the fulfillment of the right to work in the Indonesia's Compulsory Report System.

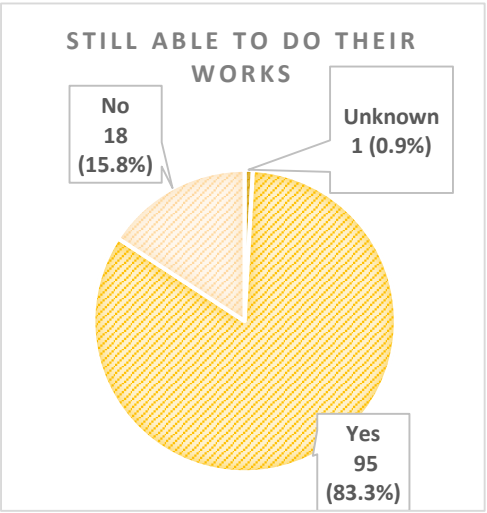
Though, we could see that 31.6 percent of the clients are jobless when they are accessing the treatment. This numbers has not been addressed by the authority. The aspect of development and life quality enhancement have not been embraced enough.



Lack of concerns on those areas has been documented in a statement from an interviewee in Makassar. He undergoes his treatment in social rehabilitation. He said[105]:

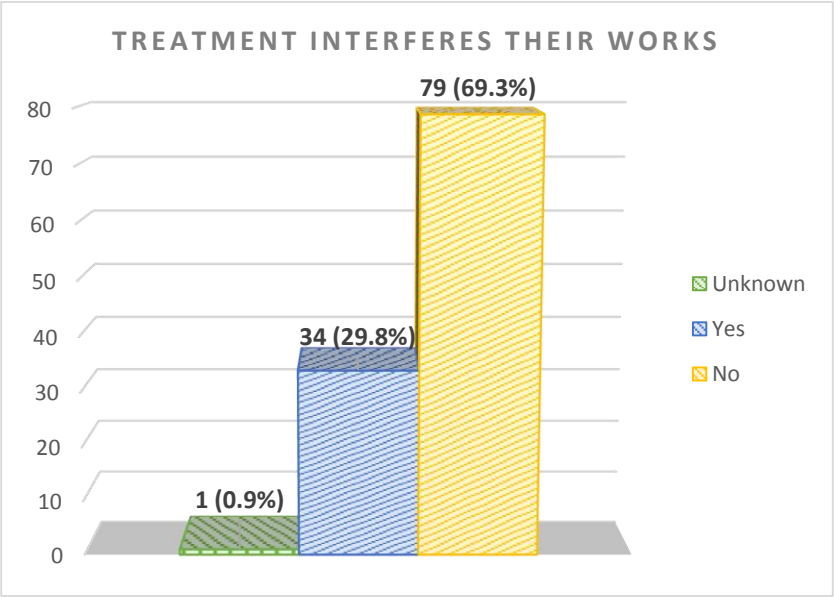
> "I want to be their client in 2011 because they said they will give me a job after three months. In reality, it is not happening. We have just been sold so that rehab center could be a bigger institution. If there was a government representative came, all of us should gather together. They also even call the nearest trishaw drivers. After that, they told us to go home. They did not give us any applicable skill training. They gave us a screen printing job one time. It was happened when there were an election."

From 114 persons who said that they had jobs when they first entered the treatment 83.3 percent said that they still have the time to do their work.



Though, around 30 percent of those 114 the respondents said that conducting the treatment is interfering with their works.

[105]Interview with Padli on 3rd November 2015.



The problems on right to work mostly happened with the people doing the MMT program. The dynamic of the relationship situation between the program provider and the clients, in terms of right to work, is very interesting to see as well. A research participant in Samarinda said[106]:

> "The regulation is so strict. Just imagine that you were working and came a little bit late than the working hours… we could not drink the methadone, whatever your reason is."

This statement is echoed by another Samarinda interviewee[107]:

> "The working hours [of the MMT provider] is started from 10.00 AM to 12.00 AM, while in the same time we have to be in the office. So I could not be there on time. I have to skip work if I want to go to the treatment."

[106]Interview with Akhsan on 17th November 2015.
[107]Interview with Cecep on 17th November 2015.

Another methadone client in Samarinda also said the similar thing that he had to go to the MMT providers 10 minutes before 12.00 AM, the office' lunch break. He wondered if there were a client who rushes his/her way to the MMT providers while brings his/her child would the hospital take the responsibility about it.[108]

The doctors in MMT providers in Jakarta said[109] if there was a client who was working they will give her/him take home dose (THD). Though the policy of take home dose is not less problematic. First of all, the stigma[110]:

> *"If I was a private sector employee, I should get a permission from my boss to take the methadone… [Inevitably] he will judge me [as a drug user]."*

It also summoned up by a MMT client in Samarinda[111]:

> "When my office realized that I am a methadone client, they started to discriminate me. They did not talk with me anymore. They did not involve me in the team as well."

The next problem is the limitation of the take home dose. A MMT client in Samarinda said[112]:

> "THD is limited to 3 days even we asked for 5 days dose. The providers asked for an explanation letter from the office, even though I said that I covered my treatment from the office… After I resigned from that office, the hospital's regulation started to change. You could get THD for 4 days: you drink 1 dose in the MMT provider's place and you can bring 3 doses back home. Though it is pretty rare, I have seen a client who drink 1 dose in the hospital and bring 4 doses back home."

[108] Interview with Erwin on 17th November 2015.
[109] Interview with Toni on 11th December 2015.
[110] Interview with Nono on 8th December 2015.
[111] Interview with Erwin on 17th November 2015.
[112] *Ibid.*

This limitation of THD brought up several complaints in terms of working. Another MMT clients from Samarinda[113] told us that:

> "[I am] tired [so I stop taking it]… I have to drink it every single day for two years… maximum THD is for 3 days, what if we should go to [work in] another city for a week? I feel like I have been imprisoned [by methadone]."

A research participant in Jakarta[114] concluded this problem in a very emotional statement:

> "Before I became a junkie, I was an account officer in a bank. [My money] ran out dry, I had to sleep on the streets. Then I found the methadone treatment, and I now I can work again. But still, I have to face a few obstacles [at work] because it is hard to get THD. I have to go to another city for 5 days and [the providers] only gave us 2 days doses. From a homeless man I could get back on my feet because of methadone, but should I go back to square one because of methadone as well? It does not make sense."

By looking at those data and statements we could put the problems into several categories: inability to work because the program clients have to undergo the rehabilitation process, interference of rehabilitation process to patients' time to work which related to the limited working hours of the program providers, stigma and discrimination towards drug users and compulsory report clients which led to work termination or resignation, and the uncertainty of methadone program completion which inhibits the clients to move forward advancing their quality of life even further.

The ICESCR states[115]:

> "the steps to be taken by a State Party to the present Covenant to achieve the full realization of this right shall include… policies and techniques to achieve steady economic, social and cultural development

[113]Interview with Cecep on 17th November 2015.
[114]Interview with Kifli on 8th December 2015.
[115]Article 6 Point 2 of ICESCR

> and full and productive employment under conditions safeguarding fundamental political and economic freedoms to the individual."

Then by seeing the phenomena stated above, there's a need to reform the policy of compulsory report program in terms of the basic idea and practical basis.

General Comments No. 18 stated that the Article 6 of the ICESCR also implies not to be unfairly deprived of employment.[116] Unfortunately, what we saw in the research is contradictive with that state's obligation. The compulsory report system obliges every single drug user in Indonesia to report to the government then they will be provided with treatment. The problem is the treatment provided often interfere and disturb the work of a client. Then this program unintendedly has violated an aspect of the right to work of some of its clients.

The right to work in ICESCR explains that one dimension of accessibility and fulfilment of this right is anti-discrimination. It prohibits discrimination on the grounds of race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, or civil, political, social or other status, and, in this case, the status of being a drug user and a client of compulsory report system.[117] The tight regulation of compulsory report system creates an unintentional consequences to the right to work because it impedes the clients to do their current jobs or find a decent 9 to 5 jobs. This condition also relates to the State obligatory to ensure employment access for marginalized groups.[118]

When the policy of compulsory report took place, the state also did not explain and disseminate this policy to companies to prevent the discrimination happens. The promotion of the policy to prevent discrimination also pushed by Article 2 of International Labor Organization (ILO) No. 111 which stated that State should:

> "…declare and pursue a national policy designed to promote, by methods appropriate to national conditions and practice, equality of opportunity and treatment in respect of employment and occupation, with a view to eliminating any discrimination in respect thereof."

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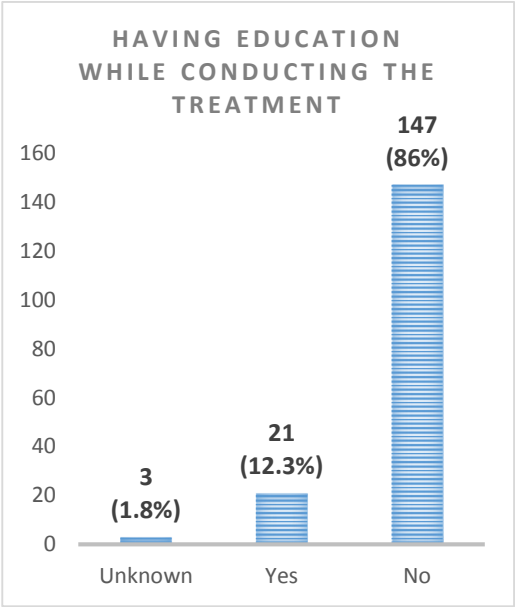
[116]Committee on Economic, Social and Cultural Rights, *The Right to Work: General Comment No. 18 on Article 6 of the International Covenant on Economic, Social and Cultural Rights*, E/C.12/GC/18, Adopted on 24 November 2005, paragraph 4 & 6.
[117]*Ibid.,* paragraph 12 (b) & 31 (b).
[118]*Ibid*., paragraph 31(a).

It's important for the state to promote this policy to prevent further stigma and discrimination towards the drug users and program's clients and for the sake of the program's success.

The program's clients, mainly the MMT participants, also need clarity on the program completion. MMT requires them to drink methadone everyday but the Indonesia's regulation is very tight. It forced the client to come to the providers every single day, except if the client need a take home dose which administratively is hard to obtain. This condition render difficulties for the program clients to do or to find work which are an essential point to enhance their quality of life.

As the General Comment of CESCR stated, the State has to respect, protect and fulfil the right to work.[119] This research find that the State has failed to respect this right by indirectly affecting the ability the drug users chance to do and to find work. This research also find that the state has failed to protect this right by unable to protect the clients of this program from discrimination from their respective companies. The State also failed to fulfil this right because in the implementation of this policy the State have not appropriately promote this right to the companies who employ the compulsory report clients. This failure will lead to relapse and not increase the life quality of the clients. On the other hand, work is a great tool for creating relations with other people. As Johann Hari, in his book "Chasing The Scream: The First and Last Days of the War on Drugs" said that the opposite for addiction is not sobriety, it is connection.

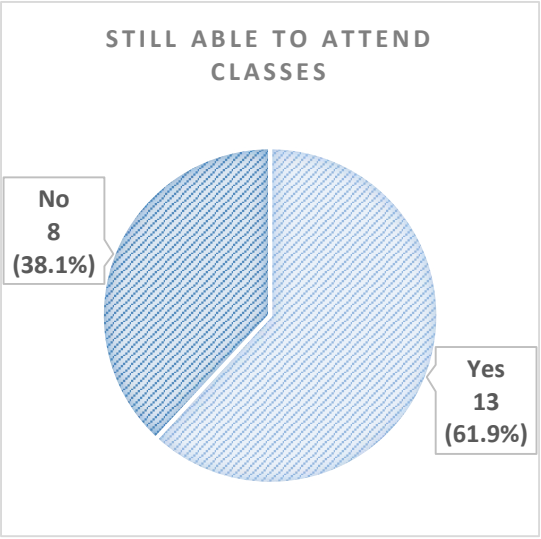


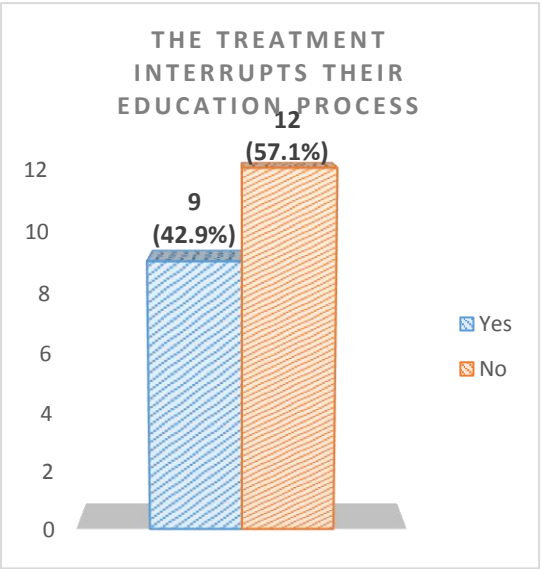
B. Right to Education

Article 13 paragraph (1) of the ICESCR states that everyone has the right to education. Although the Committee of the ESCR differentiates between formal and informal education, what this research meant by education encompasses both the formal education and the informal one.

[119] *Ibid*., paragraph 22.

This research found that 21 persons of 171 research participants were having education while they were undertaking the treatment program (12.3%). The result is presented in diagram above.





This research adds another questions to IPWL clients who study when conduct the treatment whether they were still able to attend their educations. Thirteen of the twenty one persons said that they were still able to attend classes (61.9%) while at the same time eight of thetwenty one persons failed to do the same thing (38.1%), as shown beside. Twelve participants of those twenty one said that the treatment program interrupts their education process.

There are two experiences that this research found which could enrich the discussion on the right to education in the context of IPWL treatment. First, a research participant in Makassar[120] said that he was reluctant to join the IPWL social facility because he was undertaking classes at a university. After he went to the IPWL provider for an assessment, he never came again. There is a need for the government to find a way in providing treatment for drug users who have education or work on going.

[120]Interview with Togar on 8th December 2015

The second case comes from an MMT client in Denpasar.[121] He moved from his previous university in Jakarta because he wanted to start a new life. Back then, there was one lecturer who told his parents to not let him come to the campus. That lecturer feared that this student will bring negative influence to other students. He said that this was a false accusation because he never asked any of his friends in the university to try any drugs whatsoever. He then asked his parents to say to his previous university administration that the reason he moved out was because he got a job in Bali. He did not want to disclose his status to his new university because he was afraid to be judged as he felt at his previous university.

Now, he is taking methadone treatment in an IPWL institution in Bali while at the same time doing his undergraduate study. He struggled, and successfully adapted, with the methadone effect in classes but still he will not open his status to any of his friends or lecturers in university.

Based on the above data, this research found the problems in several main areas: inability to undertake education because the program clients have to undergo the treatment program, interruption of treatment program to patients' time to access education, reluctance of the IPWL clients to commence education which relates to the limited working hours of the IPWL providers, and stigma and discrimination against drug users and IPWL clients often committed by lecturers which led to student's departure from the education institution.

Most of those problems could be seen as unintended consequences of this policy which discriminate the IPWL clients to access education. General Comments No. 13 on the Right to Education states that the aspect of anti-discrimination "…is subject to neither progressive realization nor the availability of resources; it applies fully and immediately to all aspects of education and encompasses all internationally prohibited grounds of discrimination."[122] Therefore, there is a need for the government to review the implementation of this policy so it can also protect the access to education for the IPWL clients. This is also mentioned in paragraph 37:

> "States parties must closely monitor education - including all relevant policies, institutions, programs, spending patterns and other practices - so as to identify and take measures to redress any de facto

[121]Interview with Denis on 1st December 2015.

[122]Committee on Economic, Social and Cultural Rights, *Implementation of the International Covenant on Economic, Social and Cultural Rights: General Comment No. 13: The right to education (article 13 of the Covenant),* E/C.12/1999/10, 8 December 1999, paragraph 31.

discrimination. Educational data should be disaggregated by the prohibited grounds of discrimination."[123]

There is also a need for the government to inform this policy to education institutions so they will be ready and know what measures to take if they have an IPWL client as a student. The stigma and discrimination against students, who are IPWL clients as well, might not happen if the responsible bodies of this policy intervene before and provide appropriate information about this policy and its impacts towards the lives of the IPWL clients. The ICESCR has already mentioned that the state should "guarantee" that the rights mentioned in the covenant or, in this context, the right to education, have to "…exercised without discrimination in any kind"[124]. The state also needs to "take steps" which is "deliberate, concrete, and targeted" headed for the full realization of the right.

Most of all, the realization of human rights, including the right to education, required three level of State's obligation: to respect, to protect, and to fulfil. This research found that the government was unsuccessful to respect the right to education. In terms of the creation and implementation of IPWL policy, it has failed to "avoid measures that hinder or prevent the enjoyment of the right to education" as mentioned in the aforementioned the General Comment.[125]

[123]Ibid., paragraph 37.
[124]Article 2 of *International Convention on Economic, Social, and Cultural Rights*.
[125]Committee on Economic, Social and Cultural Rights*, Implementation of the International Covenant on Economic, Social and Cultural Rights: General Comment No. 13: The right to education (article 13 of the Covenant),* E/C.12/1999/10, 8 December 1999, paragraph 47.

STIGMA, DISCRIMINATION, VIOLENCE AND CRIMINALIZATION OF DRUG USE

A. Stigma, Discrimination, and Violence

Drug users' intention to access IPWL program relies heavily on whether or not stigma and discrimination against them exist. As explained in the following passage:

> "In the past decades, drug dependence has been considered, depending on the different beliefs or ideological points of view: only a social problem, only an educational or spiritual issue, only a guilty behavior to be punished, only a pharmacological problem. The notion that drug dependence could be considered a "self-acquired disease", based on individual free choice leading to the first experimentation with illicit drugs, has contributed to stigma and discrimination associated with drug dependence."[126]

Drug users who face humiliation, punishment, and cruelty every day also suffered from stigmatization.[127] Stigma leads to violence and discrimination. This research seeks to establish whether violence and discrimination took place in IPWL system.

Violence and Discrimination from IPWL Providers

This first section will assess whether IPWL clients experienced any kinds of violations or discrimination committed by IPWL providers.

Numbers of IPWL Clients Experienced Violence From IPWL Staffs

	Frequency	Percent	Cumulative Percent
Yes	9	5.3	5.3
No	162	94.7	100.0
Total	171	100.0	

[126]UNODC & WHO, "Discussion Paper - Principles of Drug Dependency Treatment", Pg. 1.
[127] Human Rights Council, *Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez*, A/HRC/22/53, 1 February 2013, Paragraph 72.

Types of Violences Committed by Compulsory Report Institution Staffs

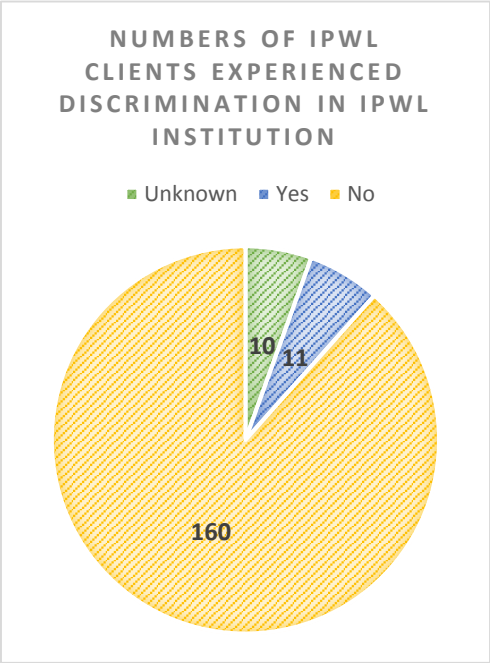
		Responses		Percent of Cases
		N	Percent	
Types of Violence	Physical	2	13.3%	22.2%
	Verbal	9	60.0%	100.0%
	Psychology resulted from physical and verbal violence	3	20.0%	33.3%
	Psychological not resulted from physical and verbal violence	1	6.7%	11.1%
Total		15	100.0%	166.7%

The two tables above show that from total of 181 respondents, only nine had experienced violence from IPWL providers. From these nine people, this research obtains fifteen responses which explain the types of violence experienced by them. All of them admitted that the providers had insulted, yelled, or committed other variety of verbal aggression against them. There were two people who had experienced physical violence from IPWL providers. Though this number is small, their experiences are still valuable in understanding the situation of IPWL system.

There was a drug user who underwent a harsh rehabilitation method in a rehabilitation center managed by the BNN before it was legitimized to be an IPWL institution. There, he and other clients experienced verbal abuse as a part of treatment. However, as long as he knew, this kind of treatment has been now prohibited. He said:

> "Today, harsh words are prohibited, but in my period, [we] still must crawl under the chair [to move around] and we were fed like dogs. "Here, take this." [*Valen gestured an act of throwing food plates to the floor.*]"[128]

[128]Interview with Valen on 3rd November 2015.



In addition to violence, IPWL clients may have to face discrimination routinely. Therefore, this research also includes the experience of discrimination in thequestionnaire. The result can be seen from the pie chart beside.

There were 11 people who felt discrimination when undergoing the treatment. The types of discrimination that IPWL clients experienced are vary. For example, one IPWL client in Medan shared his experience of stigma and discrimination against methadone patients in small kiosks within hospital area that refused to serve them and dismissed them. He testified:

> "This statement came from shopkeeper, "Methadone clients are prohibited to sit here, because if methadone clients sit here, our shop will not get any profits." It is clear an example of discrimination and stigma towards drug users."[129]

Also in the kiosk, people living with HIV are sometimes prohibited to drink from any glass owned by the kiosk. Those who created the environment in the hospital was not conducive were not only the owner of the kiosk, but also the security staffs. Due to the prior case of motorcycle helmet burglary, security staffs have given an extra concern towards methadone patients, thus stigmatize them as public offenders.[130] The stigma and discrimination taking place in the IPWL

[129]Interview with Zulham on 17th November 2015.
[130]*Ibid*.

institutions will discourage IPWL clients to access treatment. This would increase health risk of a drug user.[131]

The discrimination for methadone patients also happened in Batam. Joni, a methadone client, said that he felt discrimination in treatment. As a patient, he has the need to counsel with doctor. He has asked the IPWL institution to give him counseling but the institution did not give it. He said:

> "I am a methadone user, which means I must enter IPWL. I should get first, second, and third counseling. But I don't get that… just because I am a methadone user. There is a difference, [because] for other substances users, there are counseling."[132]

A drug user in Makassar also felt discriminated by an IPWL institution. The IPWL institution released a special card for clients who are infected with HIV, which is a red card as a patient card while other patients get blue card. This condition makes other people could easily know one's HIV status even though one do not intend to open it.[133]

Violence and Discrimination from Other IPWL Clients

Next, this research will analyze the violence and discrimination that IPWL clients get from other clients in the IPWL institution. First, this research asked the participants whether they have experienced violence or not, and also the types of violence they received. This is shown in tables below:

Have Experienced Violence From Another IPWL Clients

	Frequency	Percent	Cumulative Percent
Yes	11	6.4	6.4
No	160	93.6	100.0
Total	171	100.0	

[131]Report of the Special Rapporteur on the right of everyoneto the enjoyment of the highest attainable standard of physical and mental health, *Op. Cit*., paragraph 7.
[132]Interview with Joni on 25th November 2015.
[133]*Ibid*.

Types of Violence by Another IPWL Clients

		Responses		Percent of Cases
		N	Percent	
Types of Violence	Physical	4	30.8%	36.4%
	Verbal	8	61.5%	72.7%
	Sexual	1	7.7%	9.1%
Total		13	100.0%	118.2%

The majority of our respondents had not received any kind of violence from another patient (93.6%). However, there areeleven people (6.4%) who said that they suffered violence done by other clients in IPWL institutions. From these eleven people, this research records eight experience of verbal abuse (61.5%), four experience of physical abuse (30.8%), and one experience of sexual abuse (7.7%).

It could be seen in the table that there is one experience of sexual abuse in the IPWL treatment by other clients. This experience belongs to a female drug user in Bali. She testified that she sometimes get sexual harassment, either verbally or physically.[134]This data could indicate that there is different violence received between female and male drug users, though further research is needed to understand this problem since this research is lack of female respondents.

Besides violence, several drug users told their experience about discrimination againts people living with HIV by other IPWL clients. One of the IPWL in Bali pointed out that there are several methadone patients that were reluctant to join conversation with another IPWL clients in the hospital and immediately leave after finishing their business. Those clients also discriminate other clients whom they know as people living with HIV/AIDS, with the gesture of closing their mouth when talking, staying away, and bringing their own glass to drink methadone. Because those clients rarely involve in discussion and community activities, it is understandable, a client said, that they did not get sufficient education about HIV and feel threaten by people living with HIV/AIDS.[135]

[134]Interview with Yanti on 1st December 2015.
[135]Interview with Carlos on 1st December 2015.

In Medan, a client testified that injecting drug users (IDU) sometimes get discrimination from clients who use non-injecting methods of consuming drugs. Other drug users, who did not have sufficient information about HIV infection, stigmatize that every IDU has to be people living with HIV. This situation segregated the population of drug users to IDU community and other substance users' community.

> ""You have infected with HIV", [some clients say], for example. Because [we are] identic with HIV, because injecting drug users have already perceived as people living with HIV/AIDS. [This] becomes negative thinking."[136]

Stigma and Discrimination Reduction as a Result of IPWL Treatment

Despite there were cases related with discrimination in IPWL institution this does not mean that it does not have positive impact on stigma and discrimination reduction at all. Some of drug users appraised IPWL institutions, because these institutions help drug users to reduce stigma and discrimination in their families. Edo, a IPWL client from Bali, said that attending methadone treatment could give positive assurance to drug users' family.[137] This testimony is similar to the experience of a drug user in Bali who said the following statement:

> "From the start I reported myself, my families, especially my father… this is his statement at that time, "It's great, it means you have intention to report yourself about the substance that you use, that you consume.""[138]

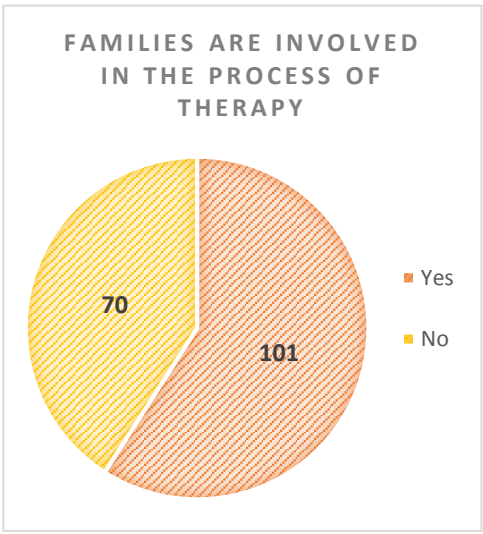
Since compulsory report system is considered as a legitimate way to deal with drug dependence, many families feel secure if their family members register to compulsory report institution. Moreover, Edo himself was willing to register and follow the rehabilitation plan in an IPWL institution. This condition addressed the stigma that Edo had received before from his family.[139]

According to the Government Regulation Number 25 Year 2011, the role of family is mentioned only in the case of children who use drugs. Parents or legal guardians must report the drug dependencies of a child to IPWL institutions.

[136]Interview with Zulham on 17th November 2015.
[137]Interview with Kris on 3rd November 2015.
[138]Interview with Edo on 1st December 2015.
[139]*Ibid.*

However, in many cases, adult drug users must also be accompanied with their guardians when accessing treatment. In methadone treatment, the first registration must be done by the adult drug users with their family. The family becomes some kind of guarantee to prevent drug users from dropping out.

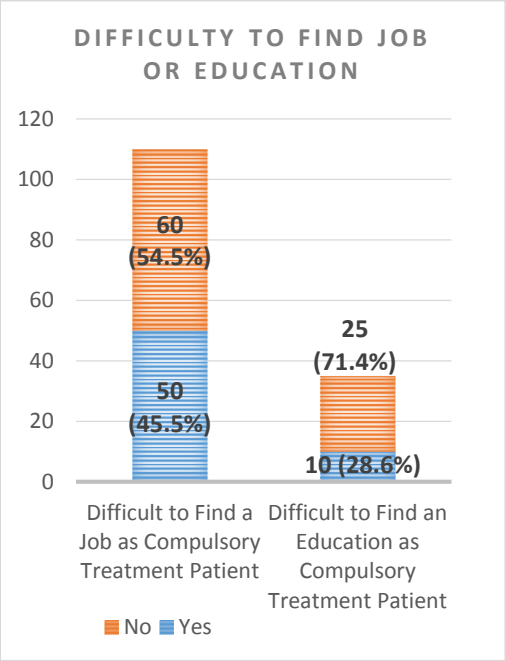
Many researches have already mentioned the important role of family in terms of drug users' treatment programs. The role of family has also been recognized in the compulsory report provision, and made as one of the main purposes of compulsory rehabilitation[140]. Since the role of family in the Government Regulation on IPWL is mentioned only for parents of children who use drug who must report their children to IPWL institution, this research tries to understand how far the families is involved in the treatment. It is crucial if the family know the treatment and the development of the patient's health in order to support and motivate them to keep continue treatment. The diagram below presents the result of family involvement in IPWL program.



From 171 respondents who get the treatment in IPWL, seventy of them admitted that their families are not involved in any kind of treatment. If, from the start the family is well informed with the kind of treatment the drug users get in the rehabilitation center, it will likely to help drug users cope the stigma, violence, and discrimination that they routinely face.

The diminishment of stigma also has the purpose to restore drug users' life condition after treatment. The real practice of this purpose is to give drug users skills and suitable environment to continue their live without depending on drugs, either with giving them jobs or educations. These two aspects are crucial because the right to work and the right to education are closely inter-dependent with the right to health.

[140]Article 2 of PP 25/2011 states one of compulsory report policy function is involving parents, guardians, families, and society in increasing responsibility of drug dependents whose under their guard.



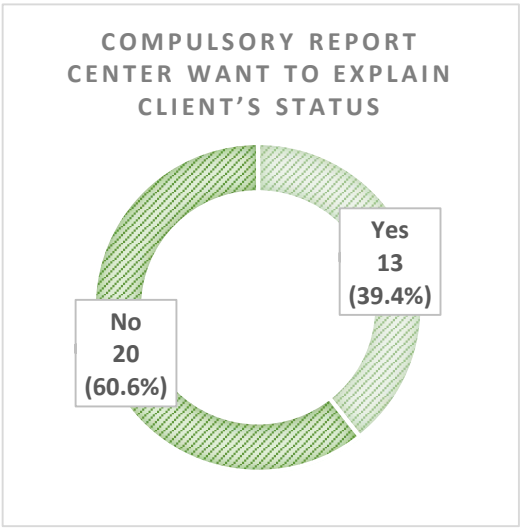
To know the impact of compulsory treatment to drug users' skill and opportunity, this research asked all respondents who follow treatment whether after treatment or in treatment, they have tried to search for job or education. From all of 171 respondents who follow treatment, 110 persons had tried to find jobs and 37 persons had tried to find educations after they have accessed treatment. This research asked whether they find difficulty to find jobs or education as IPWL patients. The result is presented beside.

We found that a lot of persons hardly find a new job after they have accessed IPWL treatment (45.5%). Unfortunately, the questions that the questionnaire ask do not include the reason why many drug users still felt burdened by their compulsory report status to look for a job. The difficulties could be caused by their mere status as drug users, the rules of IPWL that hinder them to find a decent job, or unrelated drug user things. The same condition could happen to many drug users who are unable to find higher education after accessed treatment, though the number is smaller (28.6%).

B. Criminalization

As analyzed in the section of the right to health, many drug users intend to join IPWL for the sake to not get criminalized. Indonesia Narcotic Law states that, "Drug users who have undergone two period of treatment in doctors or medical rehabilitation appointed by the government are not prosecuted" [141], thus creating the legal argument for this belief. To elucidate this provision further, the Government of Indonesia enacted IPWL system as a way to decriminalize drug use.

[141]Article 128 Law Number 35 Year 2009 about Narcotics.



From 181 respondents who involved in this research, 33 persons are still criminalized after they have acquired IPWL status. Arrestment and detainment by the police or BNN investigator are already consider as a part of criminalization, though it does not mean that every arrest ends up in imprisonment. In this process, drug user could already get human rights infringement and discrimination, as showed by a research that finds around 60% drug abuse convicts get physical abuses by the police[142].

To analyze deeper about kinds of prosecution experienced by IPWL clients, the research questionnaire also asked whether IPWL providers were willing to help them to face prosecution. Beside is the diagram of the answer.

From the above diagram, many compulsory report clients did not experience any help from IPWL institution centers regarding their prosecution (60.6%). However, drug users could perceived no presence of IPWL institution in their process of criminalization, though the IPWL institution has already tried to help them by their limited role.

The reason that many of IPWL institution did not help their clients is their role in the criminalization process is very little. The doctors or nurse in IPWL institution can only provide information about their client's status, but cannot involve in the treatment that drug users will get after they have been arrested. A doctor in Samarinda expressed his concern about this role problem:

> "When our client is arrested, if s/he ask for letter, we will give it. Is it useful? We don't know. It's a legal matter. Sometimes there is an X factor, such as closeness (with law enforcement agencies). Now, there is the Assessment Team. (For example) we have given treatment for 3 months, but the verdict is 3 years… we do not know… whether it is in

[142]Sara LM Davis, Agus Triwahyuono, and Risa Alexander, 2009, "Survey of abuses against injecting drug users in Indonesia", *Harm Reduction Journal 6:28*

accordance with its technical guidance… since it is still in grey area between Law No. 35/2009 and the certainty of law."[143]

One of the staff in IPWL institution in Makassar said that the role of compulsory report institution in a drug case involving their patient is only by sending a letter that confirms that he/she is a methadone patient in this facility.[144] The same procedure is applied in an IPWL institution in Medan. This institution will publish an explanation letter regarding their clients. However, this letter could only be made if the request come from the law enforcement agencies. The client's family could not make this request because the IPWL institution feared that there will be a misuse of this letter.[145] Some explanation could also be made orally, as it happened in Bali when a law enforcement agency telephones an IPWL institution to ask about a drug user who is just being arrested, the hospital will confirm the client's status by phone as well.[146]

From the description above, it is clear that the role of physicians and medical experts are very limited. This policy is far from the ideal role of physicians, which could be seen in the drug policy of another country, such as Portugal. In Portugal, law enforcement can send drug user who possess up to 10 days' worth of an average daily doses of drugs for personal uses to dissuasion commission (CDT). This commission is a panel of three person, who are medical experts, social workers, and legal professionals.[147] The role of medical professionals and harm reduction program is very crucial in the decriminalization of drug users along with roles of the judiciary and police who must promote human rights and harm reduction.[148]

In the prosecution of an IPWL client, the demand for an explanation about a client's status must come from the law enforcement agency, making the situation is hard for the family, friends, communities or drug user's attorney to help. This situation has a downside if the law enforcement agencies do not ask the IPWL institution about a client's status. The law enforcement agencies may not ask the IPWL institution because they might not understand the provision of IPWL, their perspective toward drug users is still criminalization, or they are merely unmotivated to seek the background of a drug user.

A veteran in drug rehabilitation, Valen, said that police in Makassar do not comprehend the IPWL policy so he thought it could be better if in every police

[143]Interview with Mito on 17th November 2015.
[144]Interview with Windi on 5th November 2015.
[145]Interview with Belinda on 19th February 2015.
[146]Interview with Jumilah and Ivan on 3rd December 2015.
[147]Ari Rosmarin and Niamh Eastwood, 2012, *A Quiet Revolution: Drug Decriminalisation Policies in Practice Across the Globe*, Relapse, pg. 28.
[148]*Ibid*., pg. 10.

station there is either a community member or public health expert that could help elucidate the IPWL policy to the police.[149] This suggestion can perhaps become useful for the police in Samarinda, since one drug user testified:

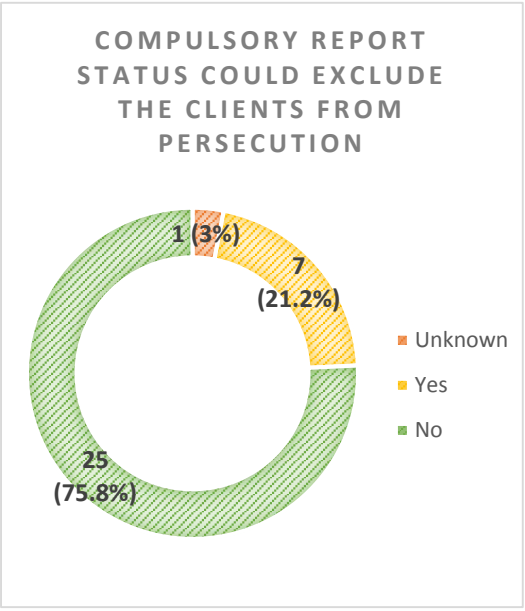
> "My friend showed the yellow card from hospital… the police tore it… said it is useless."[150]

Beside the roles of medical expert and social workers who are often unable to influence the legal process, another reason why compulsory report institution hardly helps to explain their clients' status is because they could not help their client if the confiscated narcotics are higher than the quantity of narcotics that are regulated for one week use. However, the threshold for one week use itself is problematic, since the regulation about threshold is issued in the form of Supreme Court Circular Decree, not a governmental law, making it could only impact the judge not the police and persecutors.[151] Even the judges are not legally bind to judge as the circular decree says.

A nurse of a local health community center in Makassar stated that they could not help the drug user who arrested with narcotics that are different from the type of narcotics that is revealed in their assessment. For example, if the assessment process found that a drug user only use marijuana and later s/he get caught using amphetamine, his IPWL card cannot be used. Regarding this regulation, this nurse often reminds the drug users:

> "In the process of compulsory report, s/he say, "I also use marijuana, also drink alcohol, also used amphetamine. So OK, we list it. When s/he is arrested by the police for using marijuana, s/he automatically identified as a marijuana user. So, the card is still useful and we still can help. But, if s/he is arrested with any narcotics that are different from what we found in [the assessment of] IPWL, we give up. We have already said it in the beginning, "Be honest, what are all substances that you use?" His/her answer [on that question] is what we input [into the data]."[152]

[149]Interview with Valen on 3rd November 2015.
[150]Interview with Cecep on 17th November 2015.
[151]Supreme Court Circular Degree Number 4 Year 2010.
[152]Interview with Windi on 5th November 2015.



This provision which condemns the IPWL clients, who arrested for different substances from what the assessment has found, has a disadvantage. Firstly, this provision does not consider the possibility of multi drug use after the treatment, though it is very possible for drug users to feel that their treatment unsuitable for his dependency and need extra substance. Not to mention that multi drug use is a common thing between drug users. Secondly, this provision can lead drug users to lie by including all the substance though they have never used before, thus resulting in they might get the treatment that they do not need.

This research also asks whether IPWL status could avoid the clients from prosecution. From the diagram above, it is revealed that, in practice, the IPWL status cannot guarantee the clients to get away from prosecution. Around 75.8% of the research participants, who had been arrested, still got punishment, either with imprisonment or rehabilitation through the judges' verdict. Another problem appears when an IPWL client is punished by undertaking rehabilitation. It is hard to match their on-going treatment in IPWL institution with the treatment that the client will get in the rehabilitation center appointed by the judges' verdict. The judges also could decide the period of treatment more or less than what the client actually needed. It is hard for the judges to categorize the addiction level, therefore the judges should summon an expert on health or addiction, but usually they do not.[153]

Many of IPWL clients also had difficulties to prove their status to law enforcement agencies which happened because in several cities, the clients do not get their IPWL cards. A nurse in Batam stated that the cards are exist but could not be taken by the IPWL clients. [154] A similar situation also happened in Makassar. [155]

[153]Eunike Tyas Suci, Asmin Fransiska, and Lamtiur Hasianna Tampubolon, *Op. Cit.*, pg. 155-157.
[154]Interview with Feni on 24th November 2015.
[155]Interview with Valen on 3rd November 2015.

However, it is worth to mention that there is 7 people who were able to avoid prosecution. This research asks further in what stage they are released, leaving the answer to 3 types which are in the stage of investigation, prosecution, and interlocutory decision. These answer is combined with the IPWL status that they have, and the result is as follow:

Crosstab Between IPWL Status and Stage IPWL Users Released

		Stage IPWL Users are Released		
		Unknown	Investigation Process	Total
IPWL Status	Finished	0	1	1
	Ongoing	0	4	4
	Drop Out	1	1	2
Total		1	6	7

As can be seen above, six of the respondents were released in the investigation process or by the investigator such as police or BNN. There is one person who admitted that he bribed the law enforcement agency to release him, therefore this research did not consider it as a legitimate way of exclusion from prosecution.

From this table also, we could see that the IPWL clients who have finish or drop out from the treatment still get a chance to avoid persecution. This is a good example which should be followed by law enforcement agencies, because drug dependencies is a long-life disorder that have the symptoms of relapse.

OTHER FACTORS OF THE IPWL PROGRAM EFFECTIVENESS

The rehabilitation model provided by the Government of Indonesia sets the abstinence from drug use as a target of treatment.[156] This purpose is shown by several regulations which implicitly say that point, which are:

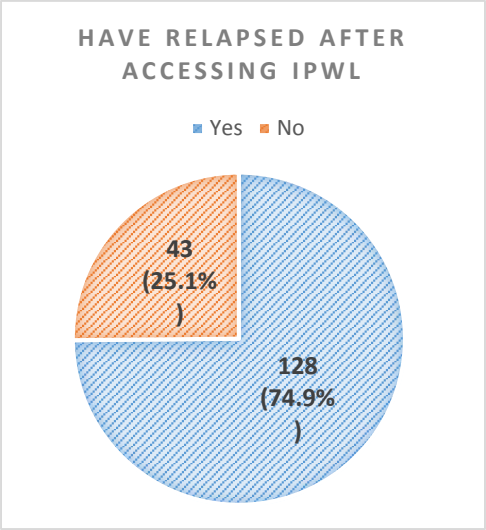
1. Narcotics Law still criminalizes drug use. Article 127 of Narcotics Law states that drug use could be punished maximum 4 year of imprisonment. This regulation, which leads to mass incarceration for people who use drugs, shows the perspective State which does not allow drug use.
2. Article 128 of Narcotics Law states if a drug user still undergo a treatment program for two periods, s/he could not be prosecuted. In the context of IPWL, Article 10 from the Government Regulation Number 25 Year 2011 states that the IPWL card could be used only for two periods of treatment. With this provision, drug users only have two chances to complete or drop out from the treatment. After that, there is no explanation on whether they are able to get treatment again or not, whether they could be an IPWL client once more or not, and, the most important thing, whether they could avoid prosecution on drug use/possession or not.

These regulations implicitly said that drug users are expected to use drugs no more. Since this perspective is also shared by the responsible government bodies on drug policy, then the IPWL institutions are demanded to turn their clients to abstinent.

Though abstinence is the soul of Indonesia's drug policy, MoH also has programs for drug users which based on harm reduction approach. Harm reduction itself has not been a meaningful essence for Indonesia's drug policy. It is a great challenge for the civil society to convince the public and also the officials that harm reduction works. Besides, harm reduction is never mentioned in the main legal instruments that formed Indonesia's drug policy.

To look on how the abstinence perspective has been achieved by the IPWL institutions, the respondents in this research were asked whether they have relapsed after accessing the compulsory rehabilitation center. These are the answer:

[156] Pascal Tanguay, Claudia Stoicescu, Catherine Cook, *Op. Cit.*



This research does not include drug users who only conducted the assessment phase. Therefore, the total respondents, on this question, is 171 persons. The majority of the respondents have relapsed after they accessed treatment (74.9%). Hence, if the purpose of compulsory report system is to prevent drug users to relapse, the program has been failed.

Though the scheme of IPWL system in the regulation is abstinence, the stakeholders in the IPWL system may have different perspective. In another research, an informant from MoSA said that the social rehabilitation under the MoSA cannot accept drug users who relapse. The clients who relapse must be transferred to IPWL institution appointed by the MoH.[157] By this perspective, the staff thought it is better if the IPWL system could be integrated from one institution to the others. Therefore, the social IPWL institutions which deal only with drug users who are clean can easily transfer the clients who relapse to medical IPWL institutions. However, still according to Suci, Fransiska, and Tampubolon research, a staff in a social rehabilitation institution under the MoSA administration did not agree with the abstinence perspective offered by the MoSA and the budget allocation for IPWL card that can be used only for two times treatment. The staff perceived drug dependence as chronicle relapse disease which means that drug users could relapse anytime.[158]

The research also find a health worker in Bali who said that relapse is an ordinary problem for drug users. She have a perspective that drug dependence is a serious mental health problem, therefore it is completely natural for drug users to relapse. She said:

> "Relapse, in terms of addiction, is natural. It is something natural and humanly, because it is a chronic brain dysfunction. The main point is we have to hold them closely."[159]

[157] Eunike Tyas Suci, Asmin Fransiska, and Lamtiur Hasianna Tampubolon, *Op. Cit*., pg. 206.
[158] *Ibid*., pg. 236.
[159] Interview with Jumilah on 3rd December 2015.

If the effectiveness of this program is valued by the abstinence perspective, then many of IPWL institutions have failed. However, this does not mean that the IPWL program is totally unsuccessful. Many clients still feel that IPWL program help them get healthier and enable them to continue working, but not with the lifestyle of abstinence. A drug user stated that methadone treatment, compared with other treatments, is the most advance because it enable him to have normal activity and deaden the craving.[160] A drug users in another city feel that marijuana help him to relieve the headache pain from amphetamine dependence.[161]

A drug treatment could also not worked effectively if IPWL clients are not willing to enter the rehabilitation program. Many of clients are still relapsed because they feel coerced to enter the IPWL center. In the previous section about right to health, this research already analyzes the freedom aspect of the program enrollment. This research found that a lot of drug users feel voluntarily enter the treatment which could happened because the Indonesia's drug policy situation does not give any alternative for drug users.

This coercive situation could exacerbate the recovery of patients and thus initiate their relapse. A drug user in Bali, Doni, who have stopped using drugs from several years ago said that compulsory treatment can be a backlash for the purpose of stopping someone from using drugs. Drug users who enroll the treatment involuntarily have the tendency to make revenge by using drugs outside the treatment. Looking back at his experiences in several different treatment place, he said:

"Recovery depends on drug users' own will, not coercion."[162]

The same notion is also given by Novian, an addiction counselor from Bali. He has a principle not to start a treatment or counseling for drug users who still want to use drugs. He said that the treatment would be futile if the drug users themselves do not have the will to be free from their dependence.[163]

A nurse in IPWL institution in Batam also said a similar notion when asked about the biggest challenge in her work:

[160] Interview with Valen on 3rd November 2015.
[161] Interview with Gulam on 25th November 2015.
[162] Interview with Geri on 1st December 2015.
[163] Interview with Novian on 1st December 2015.

> "The biggest challenge is that most of the clients come here because of the will of his/her family, not from himself/herself…"

These testimonies that underline the importance of voluntary treatment reaffirm many prior research that conclude compulsory treatments do not give positive impact on drug use.[164] This notion also echoed by paragraph 74 of the Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment in 2013 which stated:

> "By denying effective drug treatment, State drug policies intentionally subject a large group of people to severe physical pain, suffering and humiliation, effectively punishing them for using drugs and trying to coerce them into abstinence, in complete disregard of the chronic nature of dependency and of the scientific evidence pointing to the ineffectiveness of punitive measures."

The abstinence purpose is also very unlikely to be achieved because IPWL clients enrolled into the program for the sake not to be criminalized. Meanwhile, the IPWL policy's goal of, somehow, decriminalize drug users is perceived to be failed as well. A drug user in Makassar shared his friends' experiences:

> "When our friend [a drug user] is arrested, [IPWL policy] is not implemented."

This testimony is also strengthened with the findings in this research that show many of IPWL clients, who were arrested, were still punished. Many IPWL clients are imprisoned or prosecuted which happened because the criminalization policy is still in force as well.

[164]D. Werb, et.all., "The Effectiveness of Compulsory Drug Treatment: A Systematic Review", *International Journal of Drug Policy 28 (2016) 1–9.*

CONCLUSION AND RECOMMENDATION

A. Conclusions

1. The policy of compulsory report system (IPWL) has largely expanded treatment access for drug users. However, there are human rights violations with the concept of the policy itself and in its implementation.
2. In right to health aspect, there is an issue on informed consent where an MMT client is automatically registered under the compulsory report system since the policy was enacted in 2011. There is also a problem where children are coerced by their parents to join the rehabilitation program. This research also finds that the IPWL institutions are using shameful approaches like manipulation and offering money to fulfill their targets of the IPWL clients.
3. Although most of the clients are satisfied with the accessibility of the treatment facilities, there are still some complaints in this regard. The information that most clients can access is that they will not be prosecuted, instead of getting treatment. There is also a disparity on payment of the treatment between one IPWL institution and another, or worse, between patients within the same facility. In terms of physical accessibility, there are several clients who complained that the facilities are far from their residence. They also complained that the working hours of the IPWL institutions are short which resulted in difficulties to access the treatment.
4. In terms of the treatment quality, most of the clients said that the health workers are quite patient and friendly to them, although there are some cases that indicate otherwise. This research also finds that some of the MMT clients expressed their tiresome and exhaustion when following the program because it is hard for them to lower their dose and the IPWL institution does not set out an end for their treatment program.
5. In the aspect of right to information and right to privacy, this research finds that some clients did not get or were not explained the treatment plan. Though the clients are relatively comfortable sharing information with the health workers of the IPWL institution, there are cases showing that their personal information has been breached.
6. In the aspect of right to work and right to education, the issue of short working hours are also raised because it hinders the drug users to get decent jobs or access formal education. While at the same time, the relevant authorities have not been promoting the IPWL policy to educational institutions and employers. This is important to minimize

stigma and discrimination against IPWL clients who have work or are still studying.

7. This research finds several examples of violence and discrimination against IPWL clients when accessing IPWL treatment, from either IPWL providers or other IPWL clients. There are cases where the discrimination relates to the issue of HIV/AIDS. However, some of the clients said that the IPWL system help reducing stigma they received from the family or society.
8. Even when equipped with the IPWL status, many drug users are still criminalized by the law enforcement agencies. Many clients said that their IPWL institutions did not help them when they are criminalized and their IPWL status meant nothing in the face of the law enforcement agencies.
9. Finally, on its objective for abstinence, the compulsory report system has not been effective as this research still finds high relapse rates. For some drug users, IPWL program is not effective because involuntarily participation did not result in adequate recovery. Additionally, the IPWL program is not effective because there are many IPWL clients who are still prosecuted which worsen their life condition.

B. Recommendations

Based on the above findings and analysis, the research team is of the view that the policy and practices of drug treatment for people who use drugs must be based on evidence and human rights. It should promote the health of drug users and respect their dignity and human rights.

The research team further formulates the following recommendations.

GOVERNMENT

1. To improve the quality of treatment:
    a. The government must ensure that those who access IPWL treatment shall not be coerced and participate in a voluntarily manner.
    b. The government must develop the capacity of the health workers in IPWL institutions on many aspects, including human rights, drug and HIV treatment, and communication skills.
    c. Given the recent widespread of Amphetamine-Type-Substances (ATS) use, the government must carry out

evidence-based research, grounding on human rights standards, to identify suitable treatments for ATS-users.

2. To ensure accessibility of treatment by: developing more treatment facilities, including in remote areas; adjusting the working hours of IPWL facilities to accommodate drug users' condition, particularly those who have regular occupation or in study.

3. As this research finds, there are payment disparity between one IPWL institution and another, as well as among IPWL clients. Therefore, the government must address this problem by clarifying the financing source of the IPWL program and ensuring the transparency and accountability on the use of such budget, developing national standardized payment for IPWL clients, ensuring under-privileged IPWL clients can still access the treatment in the same quality as those who pay for the treatment.

4. To minimize stigma and discrimination against IPWL clients who have work or in study, the government must widely promote the IPWL policy to educational institutions and employer.

GOVERNMENT AND HOUSE OF REPRESENTATIVES

1. Decriminalize drug use, small drug possession, and buying small amount of drugs for personal use. The IPWL policy cannot be claimed and relied as a way to avoid prosecution for people who use drugs because the 2009 Narcotics Law still criminalize drug use. Criminalization of drug use discourages drug users to access treatment. Therefore, to ensure wider access to treatment for drug users, drug use itself must be decriminalized.

2. The abstinence perspective must not be the sole purpose of drug treatment. As an alternative, harm reduction program must be recognized as an effective way to address drug dependence. With this diverse perspectives on drug treatment, there would be more drug users willing to join the IPWL program.

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Lembaga Bantuan Hukum Masyarakat (LBHMasyarakat/Community Legal Aid Institute) is a not-for-profit non-governmental organization that provides free legal services for the poor and victims of human rights abuses; undertakes community legal empowerment for marginalized groups; and advocates for law reform and human rights protection through campaigns, strategic litigation, policy advocacy, research and analysis.

LBH Masyarakat focuses its works in the following areas: legal aid, legal empowerment, legal reform, criminal justice reform, fair trial, torture, death penalty, right to health, human rights and drug policy reform, human rights and HIV/AIDS. Throughout its work, LBH Masyarakat has evolved to be a leading legal aid organization/human rights organization which has expertise on the intersections between drug policy and human rights as well as HIV and human rights. LBH Masyarakat also defends human rights of those who are forgotten and at the margins of the society such as sex workers; lesbian, gay, bisexual, transgender, and intersex; people who use drugs; people living with HIV, and people facing the death penalty/execution.

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