

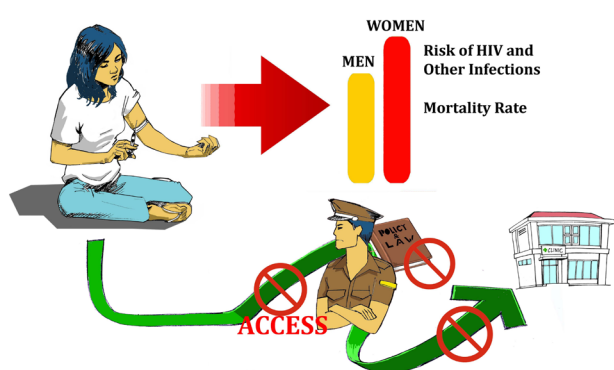
## **Women who use drugs in Indonesia: The harmful impacts of drug control**

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## Executive summary

Women who inject drugs experience the impacts of drug use and dependence differently than men. They are at higher risk of HIV and other infections, face higher mortality rates, and experience inadequate access to HIV prevention and treatment. Women's health and access to care are shaped and constrained by criminalising laws and policies, with the police playing a key role in the practical enforcement of these laws.



The “Women Speak Out” research study, conducted in 2015 through a collaboration between Oxford University and Indonesian Drug User Network researchers, used community-based participatory approaches and peer-driven methods to explore the impacts of police enforcement practices on the physical and mental health of women who inject drugs in Indonesia. This briefing paper presents a new analysis from this study to describe the public health impact of the so-called ‘war on drugs’, a set of punitive law enforcement strategies that define the dominant approach to drugs around the world.

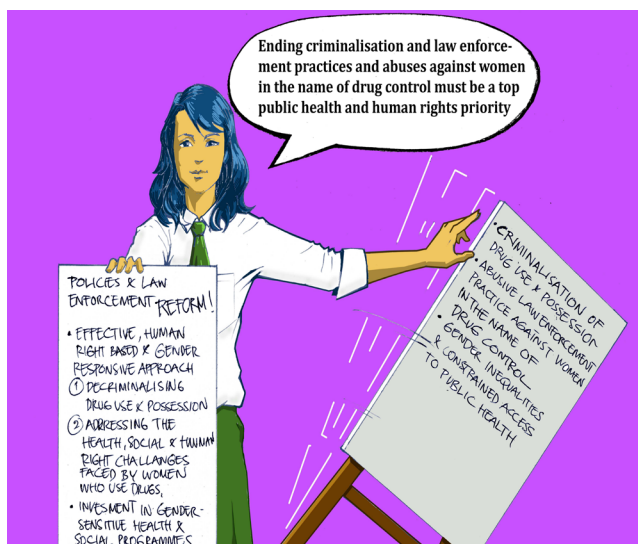
The paper aims to inform advocacy efforts toward improving the quality of life and expanding healthcare access for women who use drugs. It examines how police enforcement activities impact the physical and mental health of women who inject drugs in Indonesia and offers a set of policy recommendations for an evidence-informed and gender-sensitive response to drug use and HIV.

Survey responses from 731 women who inject drugs generated four key findings:

- 1. Women who inject drugs in Indonesia face heavily punitive police enforcement.** The criminalisation of drug use is pervasive, with nearly half (48%) of the women reporting being arrested at least once in their lifetime, mostly for drug use and possession. Approximately 9 in 10 of the women who have come into contact with the police in this way also experienced police violence, including extortion, physical and sexual violence.
- 2. Overdoses and other drug-related harms increase with arrest, incarceration and police violence.** Women with a history of arrest or incarceration are significantly more likely to be exposed to HIV risks (sharing non-sterile needles and syringes and engaging in unprotected sex). They are also more likely to experience overdose, than women who have never been in contact with the criminal justice system. Having a history of arrest and being exposed to police violence has even more harmful effects: women who experienced both types of punitive practices faced a 19.2% increase in overdose incidents, compared with women who experienced neither.
- 3. Criminalising women who inject drugs is associated with poorer mental health outcomes.** A history of arrest and incarceration was associated with greater mental health challenges among women who inject drugs. Experiencing arrest or incarceration was linked to a 10% increase in the prevalence of women's mental health problems. Experiencing additional police violence was associated with a 15.3% increase in mental health problems, from 58% among women who have never been exposed to such abuses to 73% among women who have.
- 4. Drug law enforcement is associated with increases in HIV risk and disruptions to HIV prevention and treatment.** Being exposed to street-level policing and arrest was linked to a 29.6% reduction in women's past-month access to a needle and syringe programme (NSP). Experiencing police violence, including extortion, physical or sexual violence, made it 15.4% less likely that women would access sterile needles or syringes. Incarceration is also a significant barrier to accessing and adhering to anti-retroviral treatment (ART).

Among women living with HIV, going to prison for a drug offence increased the likelihood of interrupting antiretroviral treatment by 42.3%.

Systemic reforms are urgently required to mitigate the harmful effects of punitive laws and practices on the health of women who inject drugs. Ending criminalisation and law enforcement practices and abuses against women in the name of drug control must be a top public health and human rights priority. An effective, human rights-based and gender-responsive approach would require firstly decriminalising drug use and possession, and secondly addressing the health, social and human rights challenges faced by women who use drugs, including via investments in gender-sensitive health and social programmes.



## Introduction: women, drugs and criminalisation

### Indonesia's punitive drug control response

Since the 1970s, Indonesia's response to drug use has heavily relied on criminalising people who use drugs.<sup>3</sup> In practice, punitive drug policies are enforced through street policing, along with arrests, corporal punishment and extrajudicial killings. Drug offences extend from use and possession to the sale, distribution, export, import, delivery, planting, and manufacture of narcotics. The 2009 Narcotics Law No. 35 imposes criminal penalties for these offences that include fines,

mandatory drug treatment, incarceration, and, in cases of drug trafficking, even the death penalty. Although the legislation introduced mechanisms for diverting people who use drugs away from prison and towards drug dependence treatment, its implementation is inconsistent. An ongoing government-led 'war on drugs' launched in 2015 has resulted in aggressive street-level drug law enforcement, including police raids, sweeps and crackdowns, numerous arrests and reports of unlawful abuses.<sup>4</sup>

Despite comprising a relatively small proportion (approximately 5%) of the total prison population in Indonesia, women are being incarcerated overall at a higher annual rate than men.<sup>5</sup> As of February 2020, 14,204 prisoners in Indonesia were women, among whom more than half were imprisoned for drug offences.<sup>6</sup>

### Disproportionate impact on women who use drugs



Women who use drugs are among the most marginalised communities in Indonesia. Although they are at increased risk of facing negative health outcomes, including HIV, they have low access to health services. Women also face additional structural challenges including gender-based violence, pervasive gender inequalities, economic disadvantage and misogyny. As a result, women often become the collateral victims of drug poli-

## Box 1. Criminalisation, drug law enforcement and police violence

For over six decades, people who use drugs have incurred criminal sanctions, either directly for drug use or indirectly for possession of drugs or paraphernalia for drug use. The imposition of punishment has been the central pillar of the international drug control framework established under the three United Nations drug control conventions.<sup>7</sup> Depending on a country's interpretation of the conventions, drug enforcement practices permitted by nations' laws may include street-level policing, arrest for drug use and possession for personal use, police crackdowns, incarceration, and the death penalty. In addition, several countries, including Indonesia, implement compulsory drug treatment and rehabilitation programmes where people who use drugs are

held for months or years.<sup>8</sup>

These forms of criminalisation may be accompanied by punitive practices and abuses outside the lawful authority of government authorities such as the police and other law enforcement agencies. Such practices may encompass physical and sexual violence, extortion for money or sexual services, and extrajudicial killings perpetrated by the police and other law enforcement officers in the name of drug control. Such practices are often enabled by a broader criminalisation framework. The distinction between drug law enforcement and unlawful police violence is often blurred and both can lead to grave human rights violations.<sup>9</sup>

cies which focus narrowly on reducing drug supply and demand through aggressive enforcement.

Aggressive tactics by law enforcement agencies are a serious threat to public health for all people who use drugs, but women in particular.<sup>10</sup> Women are more likely to be targeted by law enforcement and experience harsher treatment than men, particularly with unlawful abuses such as gender-based violence and extortion for money and sexual favours.<sup>11</sup> Treating women who use drugs like criminals marginalises them further by pushing them into high risk, often violent environments where they have limited ability to negotiate safer sexual or drug-using behaviours.<sup>12</sup> Since criminalisation also stigmatises drug use, it results in widespread discrimination against women who use drugs in community and healthcare settings, which exacerbates the risks they face.<sup>13</sup> Although women are less likely to use, possess or sell drugs, they face higher rates of conviction and incarceration for drug-related offences than men – 35% globally compared to 19%, respectively.<sup>14</sup>

### What is 'Women Speak Out'?

Until recently, the criminalisation of drug use has made it challenging to reach women who inject drugs for public health research. When they have been reached, women often comprised much



smaller proportions of sample sizes than men did, and tended to be folded into mixed analyses or excluded from estimates altogether. The lack of reliable data on women who use drugs has contributed to rendering these women invisible in policy and programmatic decision-making.

The Women Speak Out study aims to bridge this evidence gap. The study is the first to explore the links between criminalisation and the health outcomes of women who use drugs in Indonesia. Women Speak Out is a research collaboration between the UK's Oxford University, the Indonesian Drug User Network, Atma Jaya University's HIV and AIDS Research Centre and several Indonesian community-based organisations working with

people who use drugs: Kios Atma Jaya, Karitas Sani Madani (Karisma) Foundation, Stigma Foundation, Rumah Cemara, Grapiks Foundation, Rumah Singga Peka and Rumah Sebaya. Underpinning the research is a commitment to community-based participatory approaches (see Box 2).

## Box 2. The importance of meaningful community engagement

The meaningful participation of people who use drugs in research, programmes, and policies that affect them is an ethical imperative that directly contributes to a human rights-based HIV response. Underpinning the Women Speak Out research study is a profound commitment to community-based participatory approaches. The study sought to provide women with lived experience of drug use a meaningful role at every step of the research process, from design to dissemination.



For example, the community of women who use drugs and academic partners co-developed grant proposals, made joint decisions regarding budgets and allocated equitable division of funds based on actual contributions to the project. Most members of the all-female research team were women who use drugs, which provided added opportunities for knowledge exchange and personal development. Once the study was completed, the community of women who use drugs and the researchers devised and implemented dissemination plans, co-authored reports, and co-presented jointly at national and international conferences. Women

were provided with support and training to participate in these activities (e.g., training and mentoring in abstract writing and presentation skills).

*'I chose to work on this study to help other women like me. I was sad to hear how many of the women I interviewed had experienced the same things I had. My hope is that this work will change policy and facilitate easier access to health and support services for women'.* Merry, peer researcher.

The active involvement of women with lived experience ultimately improved the quality of the research findings and deepened community ownership of the research. Women who were previously suspicious of health and social services came forward and shared their personal experiences when referred to, and interviewed by, trusted peers. The participatory process also strengthened research capacity among the women involved. Women gained skills in grant proposal development, interviewing, and project management, which led to further employment opportunities, opportunities for community members to present at international high-level events and conferences, and seed funding for a new women-focused advocacy programme at the Indonesian Drug User Network.

*'It's been extremely inspiring to see the women who participated in the study use the information generated as a key ingredient in their advocacy, to fight for their human rights, rights for basic health and legal protection'.* Rima, field coordinator.

The study used respondent-driven sampling, a recruitment method that has been widely used to engage individuals involved in illegal and highly stigmatised activities. 731 women who inject drugs from areas with high rates of HIV and injecting drug use (the capital Jakarta and its adjacent suburbs Bogor, Tangerang, Depok, Bekasi, and Bandung, the provincial capital of West Java province) shared their experiences. A detailed description of the study methodology, measures and constructs is provided in Annex 1.

## Findings

The Women Speak Out study generated extensive information on the punitive drug law enforcement practices that women who inject drugs in Indonesia experience, and the implications of criminalisation for the HIV response.

A total of 731 women who were actively using drugs at the time of the study completed the survey (see Annex 1 for full methodology). The research participants came from diverse backgrounds: nearly half (46.7%) of the women who took part were living with HIV. Others included women who traded sex; women whose partners also injected drugs; lesbian and bisexual women; women who

had experienced homelessness and economic hardship; and women who had been incarcerated. As the findings below show, nearly all of these women had been targeted by law enforcement at some point in their lives.

### *Women who inject drugs in Indonesia face heavily punitive police enforcement*

As a result of criminalisation, women who inject drugs lead risky and precarious lives. Their treatment by the criminal justice system and law enforcement agencies severely compounds this, increasing their insecurity and vulnerability.

Nearly half (48%) of research participants had previously been arrested. On average, women reported three arrests in their lifetime, with 93.2% reporting that their last arrest was for a drug-related offence. The last time they were arrested, 77% of the women were charged with use or possession of drugs for personal use. By law, those charged with drug use or possession should have the right to access drug dependence treatment, but most participants with this charge were sent to prison instead and many became victims of police violence.

## Experience of Arrests by Research Participants

Previously Arrested

**48%**



Last Arrested for Drug Offence

**93%**

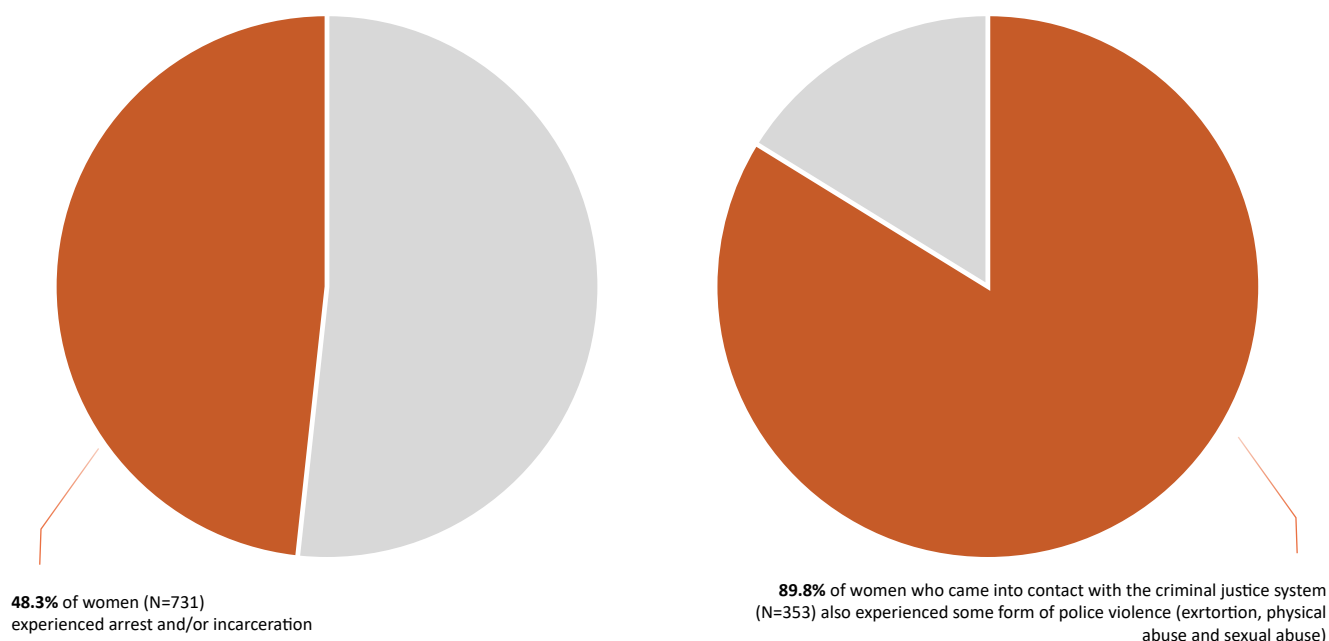


Charged With Use or Possession for Personal Use

**77%**



**Figure 1. Contact with the criminal justice system and exposure to police violence among women inject drugs**



22.7% of women spent time in prison, in most cases for a drug use or possession charge. Almost half of these women (42%) continued to inject drugs while in prison or pre-trial detention. This puts them at high risk of transmitting and acquiring HIV and hepatitis C, given the lack of access to sterile needles and harm reduction programmes in Indonesian prisons and detention centres.

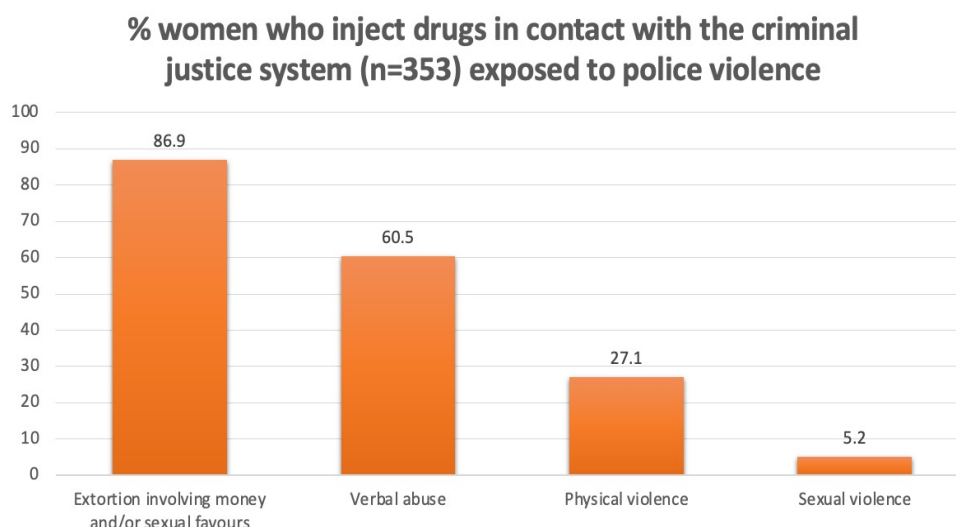
The Women Speak Out study exposed **high levels of police violence against women who inject drugs** (see Figure 2). Nine in 10 (89.8%) of the women in contact with the criminal justice system experienced some form of police violence. Among women in contact with the criminal justice system (n=353), the overwhelming majority, almost 87%, faced extortion in the form of being asked to pay a bribe or provide sexual favours in exchange for freedom, a reduced sentence

or a referral to drug dependence treatment. Open-ended qualitative responses included examples where women were forced to provide the names and addresses of other drug-using peers in exchange for having their charge reduced. 60.5% experienced verbal abuse by the police, including being insulted, called names, or berated. 27.1% of women were exposed to physical violence, including being slapped, punched, electrocuted, kicked, beaten or otherwise hurt physically by the police. 5.2% of women experienced sexual violence, including rape. Sexual violence perpetrated by law enforcement officers in particular tends to be severely under-reported due to fear of further abuse and the acute stigma and shame it carries. Sexual violence by the police also deters women from using health services and taking up treatment due to fear of being reported to the authorities or facing further abuse.

**“Almost half (42%) of the women with a history of incarceration continued to inject drugs while in prison or pre-trial detention.”**

**“9 in 10 women who came into contact with the criminal justice system experienced some form of police violence.”**

**Figure 2. Exposure to different forms of police violence among women who inject drugs in contact with the criminal justice system**

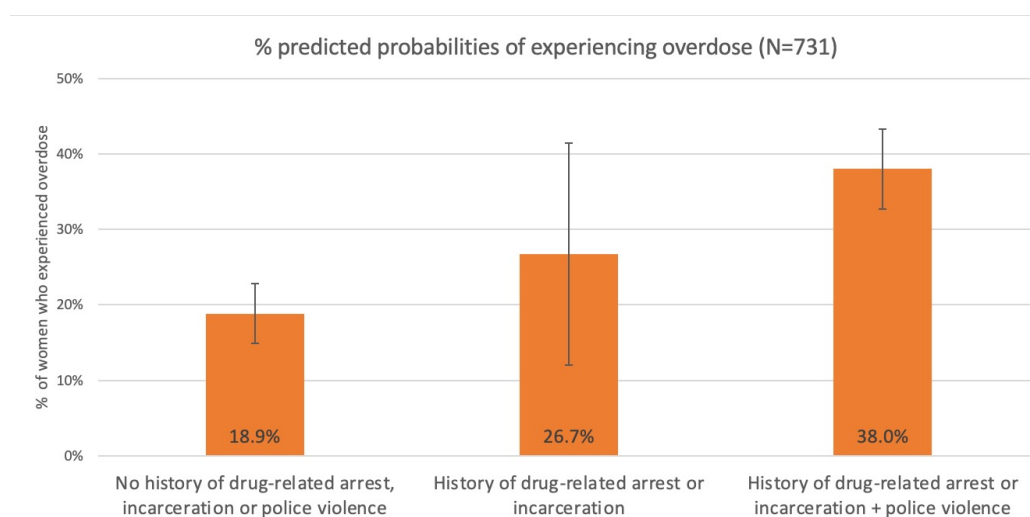


***Overdoses and other drug-related harms increase with arrest and unlawful punishment***

**Women targeted by drug law enforcement activities were more likely to experience drug-related harm** (see Figure 3). Overall, nearly one in three women (27.8%) had experienced at least one overdose incident in their lifetime, and 39% witnessed a friend or acquaintance overdosing fatally. Women with a history of drug-related arrest were nearly three times more likely to overdose than women who didn't come into

contact with the criminal justice system in this way. Being a target of arrest or incarceration and being a victim of police violence had cumulative negative effects: 38% of women who experienced both forms of criminalisation reported overdosing, compared with 18.9% of women who experienced neither arrest nor police violence – almost a two-fold increase in the probability of experiencing overdose. Fear of arrest, persecution and violence can compel women to engage in rushed, high-risk injections and push them further into marginal spaces where they are more likely to engage in unsafe behaviours.

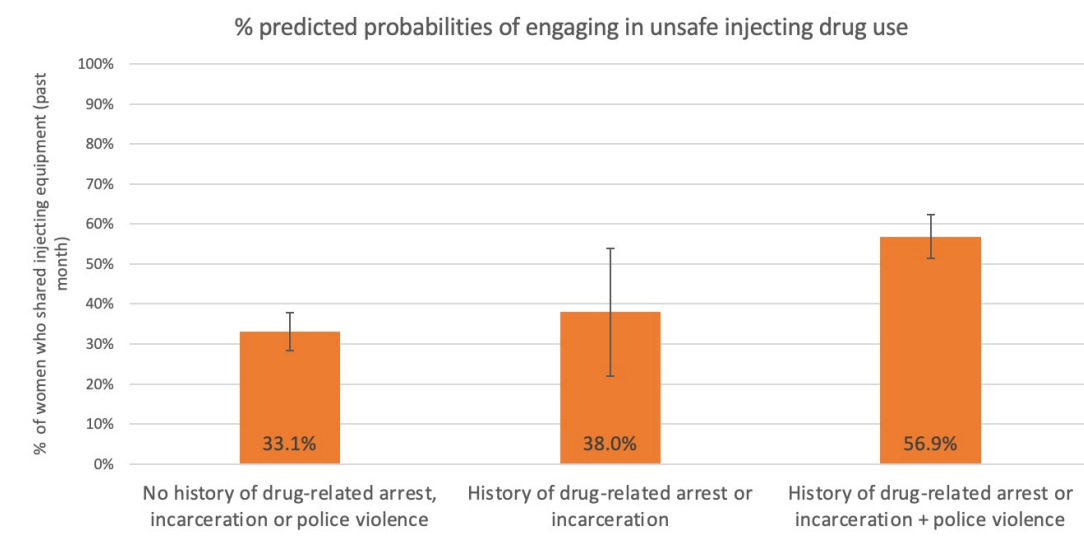
**Figure 3. The effects of drug law enforcement activities and police violence on non-fatal overdose among women who inject drugs<sup>15</sup>**



Participants experienced a high risk of contracting HIV via drug injection. More than one in five women (21%) had shared a needle or syringe, and nearly half of the participants (44%) had engaged in unsafe injecting practices such as sharing injecting paraphernalia used to prepare drugs (i.e., cookers, filters, tourniquets and water) in the past month, a significant risk factor for infections, including HIV and hepatitis C.<sup>16</sup>

**Punitive law enforcement practices appear to play a key role in shaping drug-related health risks.** Contact with the criminal justice system via street-level policing, arrest, or being incarcerated increased women's likelihood of sharing injecting equipment. Specifically, having a history of arrest or incarceration was linked to a 23.8% increase in women's odds of engaging in unsafe injecting practices, from 33.1% among women who had never been arrested or incarcerated to 56.9% among women who had (see Figure 4).

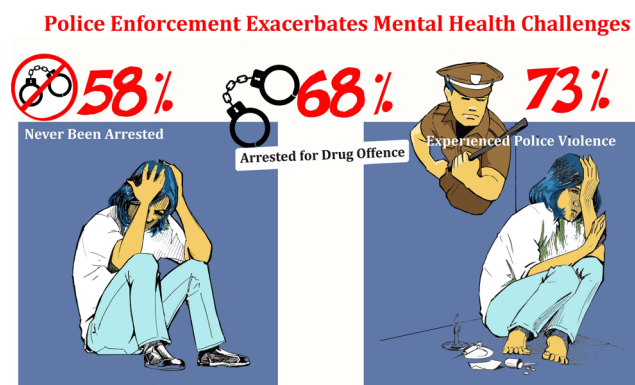
**Figure 4. The effects of drug law enforcement activities and police violence on women's unsafe injecting practices<sup>17</sup>**



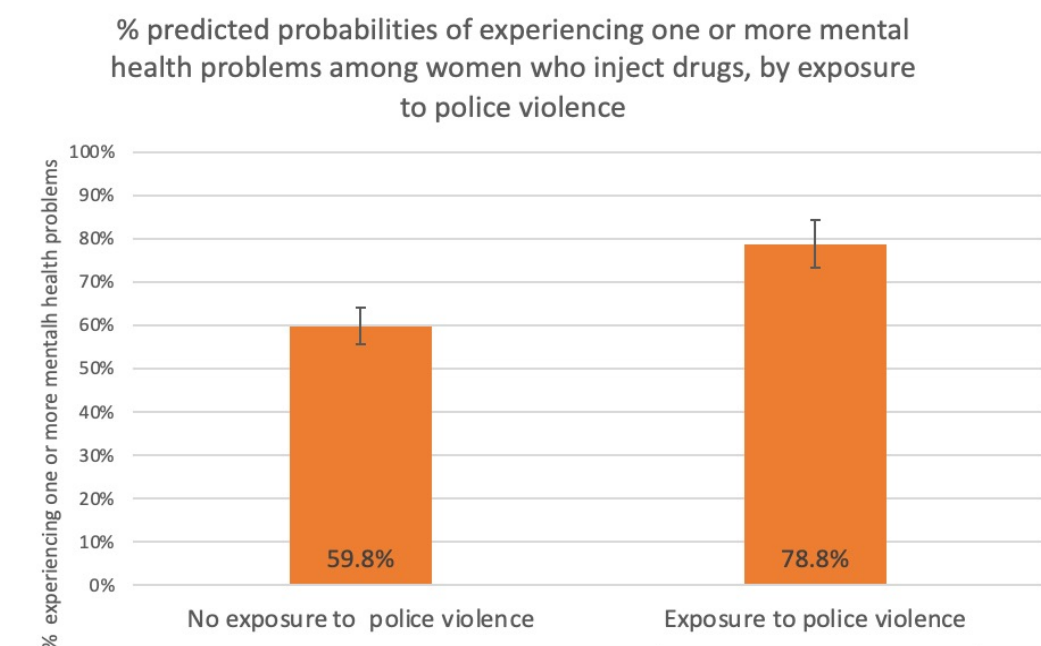
### ***Criminalising women who inject drugs worsens their mental health***

The study found high levels of mental health challenges among women who inject drugs. 65.4% of the participants reported symptoms of clinical depression. Mental health challenges appear to intensify after exposure to punitive police enforcement. For example, depression and/or post-traumatic stress disorder (PTSD) were prevalent in 58.2% of women who had never been arrested or incarcerated, but the prevalence of these mental health difficulties rose to 68.2% among women who had faced drug-related arrest and/or incarceration. Experiencing police violence further worsened women's mental health, with mental health problems reported by 73.4% of women exposed to such practices (Figure 5). Depression and PTSD also play a role in increasing

women's drug use and in inhibiting their ability to discern and navigate risky situations.<sup>18</sup>



**Figure 5. The effects of drug law enforcement activities and police violence on mental health among women who inject drugs<sup>19</sup>**



### ***Drug law enforcement increases HIV risk and undermines HIV prevention and treatment***

Most research participants (65%) reported currently having sexually transmitted infection (STI) symptoms, yet only 39.9% used a condom the last time they had sex. This suggests they are at high risk of contracting HIV and transmitting it to their sexual and injecting partners. Women who experienced police physical or sexual violence were twice as likely to have current STI symptoms, and three times more likely to be diagnosed with an STI in the previous year, compared with women that did not experience such abuse.

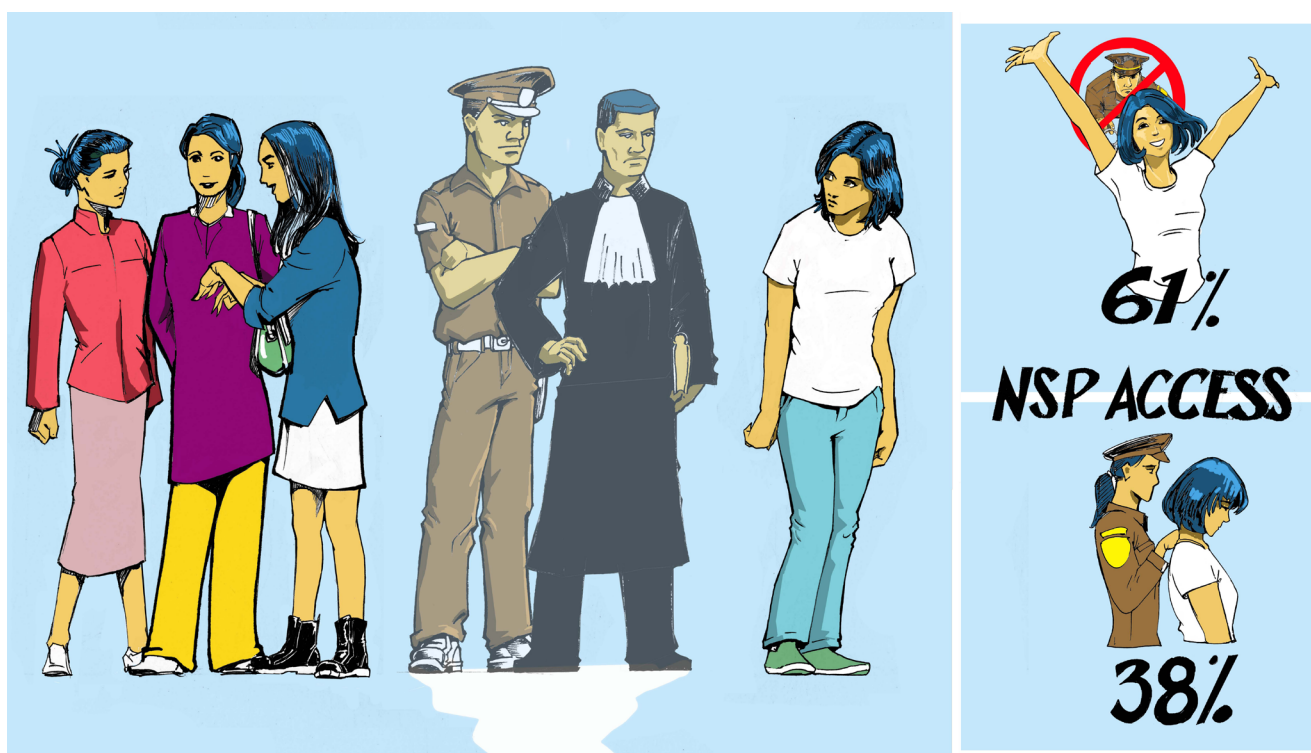
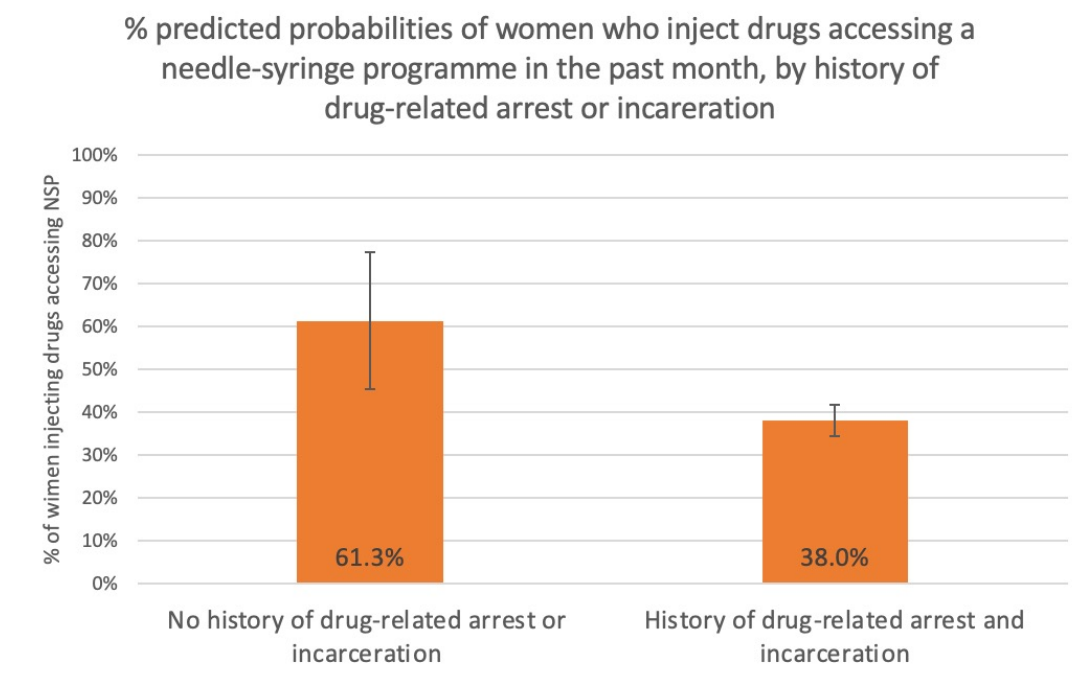
Nearly half the women reported living with HIV. Although 84% of the 731 participants in the study had been tested for HIV, approximately 20% of the women were unaware of their HIV status. Among women living with HIV who knew their status, about half (52%) initiated life-saving antiretroviral treatment (ART) in the past, but 21% of these women had stopped taking ART at the time of the survey. These numbers are grossly inadequate in the context of the UNAIDS 95-95-95 targets, which aim to increase access to HIV testing and treatment to 95% among people living with HIV and end AIDS by 2030.<sup>20</sup>

The research revealed that police enforcement activities and police violence significantly undermined HIV prevention and harm reduction efforts. Overall, 16% of study participants were enrolled in Opioid Agonist Therapy (OAT) and about half of the women had accessed sterile needles in the past year: 44% via a fixed NSP site at a community health centre and 59% via outreach workers. As with access to treatment, the scale and reach of harm reduction services for women who inject drugs is insufficient to reverse HIV incidence and mortality trends.<sup>21</sup>



Women who inject drugs are already socially isolated and find it hard to access healthcare, but drug law enforcement compounds this marginalisation. The data revealed that 61.3% of women who did not come into contact with law enforcement had accessed NSP in the past month, but this percentage dropped to 37.9% among women with a history of arrest and incarceration – a reduction of 23.4% (see Figure 6).

**Figure 6. The effects of drug law enforcement on past-month access to sterile needles and syringes among women injecting drugs (N=731)**



**“72.3% of women with a history of incarceration had stopped ART, compared with 30% of women who had never been to prison.”**

Incarceration has a negative effect on ART adherence. Among women who inject drugs living with HIV, incarceration may interrupt access to life-saving ART. Among this sample of women, 30% of women who had never been incarcerated reported stopping ART treatment, but this proportion surged to 72.3% among women who had been incarcerated.

## Recommendations

As the findings in this briefing paper have shown, punitive drug policy has had detrimental impacts of crisis proportions on women in Indonesia. Punitive drug control approaches have undermined women's access to health, exposed them to violence, and compromised their human rights.

Systemic policy reforms centred on public health and human rights are urgently needed to create an enabling environment for women to access services and seek support. Ending AIDS and realising universal human rights and gender equality for women can only be achieved within an enabling policy environment. This requires governments to urgently address the consequences of drug criminalisation for women. The following recommendations, aimed at policy-

and decision-makers in Indonesia, are essential to achieving a more effective health-focused response for women who inject drugs and a more just criminal justice system:

### Health and harm reduction services

- Engage women who inject drugs directly in the design and implementation of policies and programmes that affect them.
- Expand the scale, quality and gender-responsiveness of existing harm reduction programmes, drug dependence treatment, sexual and reproductive health and rights services, services tackling gender-based violence and mental health services in the community and in closed settings, including prisons, in line with the UNODC Practical Guide for service providers on gender-responsive HIV services<sup>22</sup> and the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the “Bangkok Rules”).<sup>23</sup>

### Criminal justice system and drug law enforcement

- Decriminalise<sup>24</sup> drug use, possession for personal use, and other activities relating to personal use such as possession of drug use paraphernalia.
- Develop national sentencing guidelines that distinguish between different drug offences as part of broader national drug law reform efforts. For example, where drug offences involve personal use or possession, voluntary community-based drug dependence treatment, psychosocial support, and harm reduction services should be offered as more humane and effective alternatives to arrest, conviction, imprisonment and any other form of punishment.
- Promote collaboration between criminal justice systems and civil society, especially networks of people who use drugs, including by training and sensitising law enforcement officials such as judges, the police and other drug enforcement officers to the needs and rights of women who use drugs.
- Design and implement alternatives to the criminal justice system that integrate a harm reduction approach, with arrest, conviction, detention

Systemic policy reforms centred on public health and human rights and gender equality



and incarceration being used only as measures of very last resort. This could include offering people who use drugs voluntary referrals to a broad menu of evidence-informed, community-based and gender-sensitive drug treatment programmes, including OAT, counselling on drug dependence and other voluntary, client-centred options based on their individual needs, as recommended by international guidance.<sup>25</sup>

- Increase the salaries and improve the working conditions of lower-level police and other drug enforcement officers in an effort to reduce the incidence of bribery and extortion.
- Implement police training to increase knowledge of drug laws, particularly provisions for the diversion of people who use drugs away from the criminal justice system and toward gender-sensitive health and social support services, improve attitudes toward harm reduction services, and address stereotypes, stigma and discrimination against people who use drugs.

## Acknowledgements

The Women Speak Out project would not have been possible without the active participation and courage of every woman who shared her experiences with us. We gratefully acknowledge the contributions of the Women Speak Out research team: Rima Ameilia, Rika Nasution, Merry Christina, Ratu Tatiek, Mumpuni, Dwi Surya, Mira Febryanti, Putty Sekar Melati, and Putri Tanjung. We thank the Indonesian Drug User Network for their leadership and for hosting the research team throughout study implementation, the HIV and AIDS Research Centre at Atma Jaya University (Indonesia) and the Centre for Evidence-Based Intervention at Oxford University (United Kingdom) for acting as academic hosts for the study. Funding was provided by Canadian Institutes of Health Research, Pierre Elliott Trudeau Foundation, Asian Network of People Living with HIV, Australian Injecting and Illicit Drug Users' League, UNAIDS Indonesia, and Rumah Cemara.

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## Annex 1: Methods

This supplementary file describes the methods employed in the study and the analyses conducted for this briefing paper.

### Study design, sampling and procedures

Details of the study design and sampling methods have previously been explained in detail elsewhere.<sup>26</sup> A cross-sectional design was employed to recruit women who inject drugs from urban areas with large numbers of people who inject drugs and high prevalence of HIV: Jakarta and adjacent suburbs Bogor, Tangerang, Depok and Bekasi, and Bandung, the provincial capital of West Java. Between September 2014 and June 2015, 731 women were recruited using respondent-driven sampling (RDS). RDS, a modified chain referral sampling method, is known to be effective for the recruitment of populations that are highly stigmatized and marginalized.<sup>27</sup> Participant eligibility criteria included: being  $\geq 18$  years of age, residing in one of the study catchment areas, injecting drugs in the preceding 12 months, and possessing a valid recruitment referral.

A diverse group of 20 initial recruits (“seeds”) was selected by the research team. Seed selection was informed by extensive formative research, including mapping of hotspots where people inject drugs, key informant interviews with local harm reduction service providers, and community consultations. To increase the representativeness of the sample, selected seeds were diverse in relation to age, education, levels of risk behaviour and known HIV status. Each initial recruit was asked to refer up to three peers to the study, who in turn enlisted others in a chain-referral fashion until the desired sample size was reached.

Questionnaires were translated into Bahasa Indonesia by bilingual health workers and pre-tested with women representative of the target sample, as recommended by World Health Organisation guidelines.<sup>28</sup> Seven female peer fieldworkers were trained by senior researchers in mobile-assisted interviewing, ethics, health and safety. Face-to-face interviews lasted approximately 1 h and were conducted in the local language at locations deemed safe by participants, such as offices of

non-governmental organisations or participants’ homes. Information was collected using tablets equipped with Open Data Kit, an open-source application for data collection and management on mobile devices. The study used mobile-site interviewing to enable more women the opportunity to participate and share their experiences. As part of the recruitment process, participants received a primary incentive of 75,000 Indonesian Rupiah (~ USD \$5) for participating in the interview and a secondary incentive of 25,000 Indonesian Rupiah (~ USD \$2) per eligible peer recruited.

### Ethical considerations

The study was anonymous, and all participants were encouraged to use a pseudonym. Verbal and written voluntary informed consent was obtained from each participant. Consent forms were worded in plain language and included clear explanations of the nature and purpose of the research, limits to confidentiality in the context of illegal activities, and explicit statements regarding participants’ rights to opt-out at any point. Consent forms were read and discussed verbally by the interviewers to ensure that participants had the necessary information to be able to provide informed consent, regardless of literacy level. Ethical protocols were approved by the Central University Research Ethics Committee at Oxford University (ref no: SSD/CUREC2/ 13-23) and the Ethics Board of Atma Jaya University (ref no: 1114/III/LPPM-PM.10.05/11/2013).

### Measurement of drug law enforcement and health constructs

Measures and indicators were divided into two broad categories, comprising (1) policies, activities and behaviours permitted under existing drug laws, and (2) unlawful punitive practices outside the remit of existing drug laws.

#### *Drug law enforcement*

**History of arrest** was assessed using the following dichotomous item: “Have you ever been arrested by law enforcement (for any reason)?” Lifetime drug-related arrest history was evaluated using a follow-up question to participants who responded in the affirmative: “Have you ever been arrested

on a drug-related offence (e.g. use, possession, buying, selling, courier, trafficking)?”

**History of incarceration** was measured using the following dichotomous item: “Have you ever been incarcerated?” Participants who responded in the affirmative were asked the following questions: “Have you ever been incarcerated on a drug-related charge?” Participants with a history of incarceration were further asked, “Think of the last time you went to prison. Did you inject drugs while you were incarcerated?”

#### *Police violence*

Different forms of **police violence** were assessed using the following multiple-choice item, asked of the sub-sample of participants who had previously come into contact with the criminal justice system via arrest, detention or incarceration: “Have you experienced the following in the process of arrest and detention?” Response options included: “(a) I / my family were asked to pay bribes in the form of money and/or sexual services in exchange for a lesser charge and/or access to drug dependence treatment; (b) I was verbally insulted / abused by law enforcement officials; (c) I was dragged / slapped / beaten / punched / electrocuted (or otherwise hurt physically) by law enforcement officials; (d) I was forcibly touched in private areas (i.e. sexual organs) by law enforcement officers against my will; (e) I was asked to perform oral sex by law enforcement officers against my will; (e) I was forced to have vaginal and/or anal sex by law enforcement officials against my will; (f) Other (specify). A dichotomous variable indicating **extortion** was created by coding all responses to option (a) “1 = experienced extortion” vs “0 = no extortion”. Separate dichotomous items were generated for police verbal abuse by the police (response option (b) only), police physical abuse (response option (c) only), and police sexual abuse (response options (d), (e), (f)). A composite police violence measure was ascertained by coding a composite dichotomous variable to reflect “any police violence” (experience of extortion, verbal, physical or sexual violence) vs “no police violence” (no experience of extortion, verbal, physical or sexual violence).

#### *Health outcomes*

Health outcomes comprise measures related to physical health, including HIV outcomes and drug-related risks, sexual health and mental health.

**Depressive symptoms** was measured using the Revised Center for Epidemiologic Studies Depression (CESD-R) scale.<sup>29</sup> The CESD-R is validated and has been used widely across a range of settings and with diverse populations, including samples of people who inject drugs in Indonesia.<sup>30</sup> The scale measures symptoms of depression in the previous two weeks, as defined by the American Psychiatric Association Diagnostic and Statistical Manual, 5<sup>th</sup> edition. Possible scores for the 20-item scale range from 0 to 60, with a cut-off score of 16 or above indicating the presence of clinically significant depressive symptoms. Responses to the 20 questions were summed, combined, and dichotomized as either below or above 16. For this sample, the reliability of the CESD-R was  $\alpha = 0.90$ .

**Post-traumatic stress disorder** (PTSD) was measured using The PTSD Checklist (PCL) Scale.<sup>31</sup> The PCL is a self-report scale which asks the respondent how often they have been bothered by each symptom in the last month on a 5-point scale. For the analyses presented in this briefing, this measure was dichotomised following Diagnostic and Statistical Manual of Mental Disorders, 4<sup>th</sup> edition (DSM-IV) criteria for clinical PTSD. This was done by first determining whether a respondent met DSM-IV symptom criteria as defined by at least 1 B item (questions 1-5), 3 C items (questions 6-12), and at least 2 D items (questions 13-17). Symptoms rated as “Moderately” or above (responses 3 through 5 on individual items) were counted as present PTSD and dichotomised.

Questions related to **antiretroviral treatment (ART) access, uptake, interruption and adherence** were asked of the sub-sample of women living with HIV and aware of their status (n=341). Participants were first asked whether they ever initiated ART, followed by whether they were still adhering to ART at the time of the survey. Women who had previously initiated ART but had interrupted treatment at the time of the survey were coded into a separate dichotomous variable where “1=ART

interruption” and “0=continuous ART adherence.”

**Overdose** was assessed using a dichotomous item asking, “Have you ever experienced an overdose?” The meaning of “overdose” was explained to participants by the interviewers and defined using the World Health Organization definition, “An opioid overdose can be identified by a combination of three signs and symptoms, including pinpoint pupils, unconsciousness, and respiratory depression.”

**Injecting equipment sharing** was measured using the Blood-Borne Virus Transmission Risk Assessment Questionnaire (BBV-TRAQ), a validated instrument that captures the frequency of injecting, sexual and other skin penetration risk practices in the previous 30 days.<sup>32</sup> The BBV-TRAQ has been used extensively by governmental and community-based harm reduction and drug treatment programs<sup>33</sup> and research studies in Indonesia.<sup>34</sup> Items assessed as part of the injecting risk sub-scale included: “In the last month, how many times have you injected with another person’s used needle/syringe?”; “In the last month, how many times have you injected with a needle/syringe after another person has already injected some of its contents?”; “In the last month, how many times have you received a needle-stick/prick from another person’s used needle/syringe?” and “In the last month, how many times have you re-used a needle/syringe taken out of a shared disposal/sharps container?” To achieve a higher sensitivity of the measure, affirmative responses (i.e., never, once, twice, 3–5 times, 6–10 times, >10 times) were dichotomised to “any” or “no past-month injecting equipment sharing”.

**Sexually transmitted infection (STI) symptomatology** was measured using a multiple-choice checklist of six easily recognised symptoms (i.e. “burning sensation and/or discomfort when urinating,” “itching, irritation and/or discomfort in the genital area,” “discomfort and/or pain during sexual intercourse,” “sores, blisters and/or ulcers on or in the vagina,” “unusual vaginal discharge, such as pus or a thick and/or sticky liquid from the genital area,” and/or “lower abdominal pain”).<sup>35</sup> STI symptomatology was ascertained if participants reported experiencing ≥2 symptoms.

Guided by literature review and formative research, selected socio-economic and background information was collected as basis for a confounder analysis. Using items modelled on the Indonesia Population Census (Statistics Indonesia) and Integrated Biological and Behavioural Surveillance (Ministry of Health), women were asked their age, relationship status, employment status, level of education, individual monthly income, and whether they had any dependent children in the household or other dependents for whom they were responsible. Participants were also asked whether they had knowledge of their HIV status.

All measures are based on self-report.

### Statistical analysis

Statistical analyses were conducted in Stata 14 (StataCorp, College Station, TX) in three stages:

1. Frequencies for all predictor and outcome variables were calculated using the merged, unweighted dataset.
2. Multivariate logistic regressions controlling for potentially confounding sociodemographic characteristics (i.e., age, education level, and relationship status) were conducted to explore the associations between drug law enforcement predictors and health-related outcomes.
3. We tested whether the women’s adverse health effects were greater if they experienced cumulative exposure to drug law enforcement practices and police violence. To enable the measurement of additive effects of these practices on women’s health outcomes, all variables from the multivariate logistic regressions in step 2 were entered into a marginal effects model (one model for each outcome), adjusting for key sociodemographic confounders.

### Limitations

The findings presented in this briefing paper are based on the largest dataset of women who inject drugs in Indonesia (N=731) and, to our knowledge, represent the first quantitative analysis of

the health impacts of drug law enforcement and police violence among women who use drugs in Asia. However, results may not be generalizable to other settings and should be interpreted with caution in light of several limitations.

First, the cross-sectional nature of the data precludes causal interpretation and highlights the need for longitudinal research to confirm the associations observed here. Data were collected at a single point in time and thus only provide a snapshot of characteristics within a population. All analyses presented in this briefing paper are descriptive (i.e., assessing the burden and prevalence of a given outcome). While significant associations between risk factors and health outcomes provide indications of areas where future longitudinal and intervention research could be focused, study design characteristics limit the ability to determine temporality or causality.

Second, all measures are based on self-report, which may be subject to recall and reporting bias. To address this limitation, the Women Speak Out study used a peer-driven recruitment strategy and interviewers with lived experience of drug use,<sup>36</sup> which has been shown to improve the validity and reliability of data by improving rapport and trust between interviewers and participants.<sup>37</sup>

Third, findings should be interpreted with caution considering potential biases resulting from the use of the unweighted dataset for the computation of statistical analyses presented in this briefing paper. Given that estimates do not fulfill RDS theoretical assumptions, findings from the regression and marginal effects analyses are not generalizable to other settings or populations.

# Endnotes

1. School of Public Health and Preventive Medicine, Monash University; Columbia School of Social Work, Columbia University; Centre for Criminology, University of Oxford
2. Brighton and Sussex Medical School, University of Sussex
3. Republic of Indonesia (2009), Narcotics Law No. 35. Jakarta (Indonesia Ministry of Internal Affairs)
4. Stoicescu, C. & Amelila, R. (2015), 'Impact of punitive drug policies and policing on public health research among injecting drug users in Indonesia: A Qualitative Perspective', 24th International Harm Reduction Conference. Kuala Lumpur, Malaysia; Institute for Criminal Justice Reform (2018), Usut Tuntas Extra Judicial Killing dalam Operasi Kewilayahan Mandiri 2018 Polda Metro Jaya (Jakarta, Indonesia); Indonesian Drug User Network (2017), The War on Drugs in Indonesia: A Documentation (Jakarta, Indonesia)
5. Lembaga Bantuan Hukum Masyarakat (2019), Yang Terabaikan: Potret Situasi Perempuan Yang Dipenjara Akibat Tindak Pidana Narkotika (Jakarta: LBHM)
6. LBH Masyarakat, ICJR & Harm Reduction International (2020), Submission to the UN Working Group on Arbitrary Detention on detention in the context of drug policies, pursuant to Human Rights Council Resolution 42/22, [https://www.ohchr.org/Documents/Issues/Detention/Call/CSOs/LBHM\\_ICJR\\_and\\_HRI.pdf](https://www.ohchr.org/Documents/Issues/Detention/Call/CSOs/LBHM_ICJR_and_HRI.pdf)
7. Institute for Criminal Justice Reform (2018), Usut Tuntas Extra Judicial Killing dalam Operasi Kewilayahan Mandiri 2018 Polda Metro Jaya (Jakarta, Indonesia)
8. UNODC Regional Office for Southeast Asia and the Pacific & UNAIDS (2022), *Booklet 2: Regional overview of compulsory drug treatment and rehabilitation in East and Southeast Asia*, [https://www.unodc.org/documents/southeastasiaandpacific/Publications/2022/Booklet\\_2\\_12th\\_Jan\\_2022.pdf](https://www.unodc.org/documents/southeastasiaandpacific/Publications/2022/Booklet_2_12th_Jan_2022.pdf)
9. United Nations (1979), *The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)*, <https://www.ohchr.org/en/professionalinterest/pages/cedaw.aspx>; United Nations (1965), *International Convention on the Elimination of All Forms of Racial Discrimination*, <https://www.ohchr.org/en/professionalinterest/pages/icerd.aspx>; Indonesian Drug User Network (2017), *The War on Drugs in Indonesia: A Documentation* (Jakarta, Indonesia)
10. DeBeck, K., Cheng, T., Montaner, J.S., et al. (2017), 'HIV and the criminalisation of drug use among people who inject drugs: A systematic review'. *Lancet HIV*, 4: e357–374; Werb, D., Rowell, G., Guyatt, G., Kerr, T., Montaner, J. & Wood, E. (2010), *Effect of drug law enforcement on drug-related violence: Evidence from a scientific review* (Vancouver, Canada: International Centre for Science in Drug Policy), [https://cdpe.org/wp-content/uploads/2018/04/Effects-of-Drug-Law-Enforcement-on-Drug-Related-Violence-Report\\_ENG.pdf](https://cdpe.org/wp-content/uploads/2018/04/Effects-of-Drug-Law-Enforcement-on-Drug-Related-Violence-Report_ENG.pdf)
11. Lunze, K., Raj, A., Cheng, D.M., et al. (2016), 'Sexual violence from police and HIV risk behaviours among HIV-positive women who inject drugs in St. Petersburg, Russia - a mixed methods study', *Journal of the International AIDS Society*, 19(4 Suppl 3): 20877; United Nations Office on Drugs and Crime, UN Women, World Health Organization & International Network of People Who Use Drugs (2014), *Policy Brief: Women who inject drugs and HIV: Addressing specific needs*, [https://www.unodc.org/documents/hiv-aids/publications/WOMEN\\_POLICY\\_BRIEF2014.pdf](https://www.unodc.org/documents/hiv-aids/publications/WOMEN_POLICY_BRIEF2014.pdf)
12. El-Bassel, N., Shaw, S.A., Dasgupta, A. & Strathdee, S.A. (2014), 'Drug use as a driver of HIV risks: Re-emerging and emerging issues', *Current Opinion on HIV/AIDS*, 9(2): 150-155
13. Harm Reduction International (2019), *Women and harm reduction: Global state of harm reduction 2018 briefing*, <https://www.hri.global/files/2019/03/06/women-harm-reduction-2018.pdf>
14. UNAIDS (2019), Health, rights and drugs: Harm reduction, decriminalization, and zero discrimination for people who use drugs (Geneva, Switzerland)
15. Figure based on a marginal effects model testing for additive effects of drug law enforcement activities (i.e., arrest and incarceration) and police violence on self-reported non-fatal overdose among women who inject drugs. Model adjusted for age, relationship status and education level
16. Pouget, E.R., Hagan, H. & Des Jarlais, D.C. (2012), 'Meta-analysis of hepatitis C seroconversion in relation to shared syringes and drug preparation equipment', *Addiction*, 107(6): 1057-1065
17. Figure based on a marginal effects model testing for additive effects of drug law enforcement activities (i.e., arrest and incarceration) and police violence on mental health outcomes among women who inject drugs. Model adjusted for age, relationship status and education level
18. Devries, K.M., Mak, J.Y., Bacchus, L.J., et al. (2013), 'Intimate partner violence and incident depressive symptoms and suicide attempts: A systematic review of longitudinal studies', *PLoS Medicine*, 10(5): e1001439
19. Figure based on a marginal effects model testing for additive effects of drug law enforcement activities (i.e., arrest and incarceration) and police violence on mental health challenges among women who inject drugs. Model adjusted for age, relationship status and education level
20. UNAIDS (2021), *Global AIDS Strategy 2021-2026 - End Inequalities*. End AIDS (Geneva, Switzerland), <https://www.unaids.org/en/resources/documents/2021/2021-2026-global-AIDS-strategy>
21. World Health Organization, United Nations Office on Drugs and Crime & UNAIDS (2012), *Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users* (Geneva, Switzerland), <https://www.who.int/publications/i/item/978924150437>
22. United Nations Office on Drugs and Crime (2016), *Addressing the specific needs of women who inject drugs: Practical guide for service providers on gender-responsive HIV services*, [https://www.unodc.org/documents/hiv-aids/2016/Addressing\\_the\\_specific\\_needs\\_of\\_women\\_who\\_inject\\_drugs\\_Practical\\_guide\\_for\\_service\\_providers\\_on\\_gender-responsive\\_HIV\\_services.pdf](https://www.unodc.org/documents/hiv-aids/2016/Addressing_the_specific_needs_of_women_who_inject_drugs_Practical_guide_for_service_providers_on_gender-responsive_HIV_services.pdf)
23. United Nations Office on Drugs and Crime (2021), *The Bangkok Rules: United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders with their Commentary*, [https://www.unodc.org/documents/justice-and-prison-reform/Bangkok\\_Rules\\_ENG\\_22032015.pdf](https://www.unodc.org/documents/justice-and-prison-reform/Bangkok_Rules_ENG_22032015.pdf)
24. Decriminalisation refers to the removal of all criminal sanctions for drug use, possession and other activities related to drug use, and the provision of voluntary health and social services, including harm reduction responses and evidence-based drug dependence treatment programmes. Over 50 jurisdictions in more than 30 countries have already decriminalised such activities: <https://www.talkingdrugs.org/drug-decriminalisation>
25. United Nations Office on Drugs and Crime (2014). *Guidance for Community-Based Treatment and Care Services for People Affected by Drug Use and Dependence in Southeast Asia*, [https://www.unodc.org/documents/drug-treatment/UNODC\\_cbtg\\_guidance\\_EN.pdf](https://www.unodc.org/documents/drug-treatment/UNODC_cbtg_guidance_EN.pdf)
26. Stoicescu, C., Cluver, L.D., Spreckelsen, T.F., Mahanani, M.M. Amelila, R. (2018), 'Intimate partner violence and receptive syringe sharing among women who inject drugs in Indonesia: A respondent-driven sampling study', *International Journal on Drug Policy*, 63: 1-11
27. Heckathorn, D. (1997), 'Respondent-driven sampling: A new approach to the study of hidden populations', *Social Problems*, 44(2): 174-199
28. World Health Organization (2017), *Management of substance abuse: Process of translation and adaptation of instruments*, [http://www.who.int/substance\\_abuse/research\\_tools/translation/en/](http://www.who.int/substance_abuse/research_tools/translation/en/)
29. Radloff, L.S. (1977), 'The CES-D scale: A self-report depression scale for research in the general population', *Applied Psychological Measurement*, 1: 385-401
30. Li, Y., Hershov, R., Irwanto, Praptoraharjo, I., Setiawan, M. & Levy, J. (2014), 'Factors associated with symptoms of depression among injection drug users receiving antiretroviral treatment in Indonesia', *Journal of AIDS Clinical Research*, 5(5): 303; Van Dam, N.T. & Earleywine, M. (2011), 'Validation of the Center for Epidemiologic Studies Depression Scale - Revised (CESD-R): Pragmatic depression assessment in the general population', *Psychiatry Research*, 186(1)
31. Blanchard, E.B., Jones-Alexander, J., Buckley, T.C. & Forneris, C.A. (1996), 'Psychometric properties of the PTSD Checklist (PCL)', *Behavioural Research Therapies*, 34(8): 669-673
32. Fry, C.L. & Lintzeris, N. (2002), 'Psychometric properties of the Blood-borne Virus Transmission Risk Assessment Questionnaire (BBV-TRAQ)', *Addiction*, 98: 171-178
33. Wijoyo, E., Sarasvita, R. & Rachman, A. (2014), 'Evaluation process for community-based drug treatment program in Indonesia', *National Institute on Drug Abuse International Forum* (San Juan, Puerto Rico)
34. Iskandar, S., Basar, D., Hidayat, T., et al. (2010), 'High risk behavior for HIV transmission among former injecting drug users: A survey from Indonesia', *BMC Public Health*, 10(472): 1-7
35. World Health Organization (2003), *Guidelines for the management of sexually transmitted infections* (Geneva, Switzerland), <https://www.who.int/publications/i/item/9789240024168>
36. Broadhead, R.S., Heckathorn, D., Weakliem, D.L., et al. (1998), 'Harnessing peer networking as an instrument for AIDS prevention:

Results from a peer-driven intervention', *Public Health Reports*, **113**(1): 42-57

37. Goodson, L. & Phillimore, J., 'Recruitment and capacity-building challenges in participatory research involving young people in Northern Ireland'. In: MacCartan, C., Burns, S. & Schubotz, D., eds. (2012), *Community Research for Participation: From theory to method* (Bristol, United Kingdom: Policy Press)

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### About this advocacy note

The paper aims to inform advocacy efforts toward improving the quality of life and expanding healthcare access for women who use drugs. It examines how police enforcement activities impact the physical and mental health of women who inject drugs in Indonesia and offers a set of policy recommendations for an evidence-informed and gender-sensitive response to drug use and HIV.

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The International Drug Policy Consortium is a global network of non-government organisations that specialise in issues related to illegal drug production and use. The Consortium aims to promote objective and open debate on the effectiveness, direction and content of drug policies at national and international level, and supports evidence-based policies that are effective in reducing drug-related harm. It produces briefing papers, disseminates the reports of its member organisations, and offers expert advice to policy makers and officials around the world.

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