



Multiple burdens of stigma for prisoners participating in Opioid Antagonist Treatment (OAT) programmes in Indonesian prisons: A qualitative study

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Introduction

After South Africa, Southeast Asian countries have the second highest burden of HIV infection globally with around 5.8 million people living with HIV (PLWH) in 2019 (Avert 2020). Twenty percent of this total (WHO 2016) live in Indonesia, an archipelago and Muslim-majority nation, where there are concentrated epidemics in key populations including among people who inject drugs (PWID) (UNAIDS DATA 2019). UNAIDS (2019) reported an HIV prevalence figure of 28.8% for PWID in Indonesia. Despite these figures, only 13% of PLWH in the country receive treatment (UNAIDS 2017). Studies in Eastern Europe and Central Asia, as well as in Indonesia, indicate that injecting drugs is the primary cause of HIV infection, and that many injectors are incarcerated (Altice et al. 2016; Morineau et al. 2012).

According to the Directorate of Corrections (2017), 224,032 people are imprisoned in Indonesia, 40% of whom (90,606 people) are drug-offending prisoners. Of these 964 are known to be HIV-positive. The 2016 Indonesian country report (UNAIDS 2017) indicated that the prevalence of HIV in prisons was 2.6%. No records are kept of the number of drug injecting prisoners. However, a study in Kerobokan Prison (Bali) reported 7.4 % of 230 prisoner participants had injected drugs while in prison, of whom 47% had also shared needles with between two and ten other prisoners (Sawitri et al. 2016).

Opioid agonist treatment (OAT) programmes are regarded as the gold standard for treating people with opioid dependence and for preventing HIV transmission among injecting drug users (IDUs) (UNAIDS and UNODC 2004). It is estimated that globally, HIV prevention programmes have helped to reduce new HIV infection by 9% (Avert 2020).

Studies have reported benefits from prison-based OAT programmes including reductions in illicit opioid use and in injecting drug use and sharing of injecting equipment. Furthermore, OAT programmes have been linked to increased entry into community-based treatment and retention in these programmes post-release (Moore et al. 2019; Hedrich et al. 2012). Despite these benefits, only 12 out of the 412

prisons in Indonesia provided OAT programmes in 2016 (Directorate of Corrections 2017) and, even more strikingly, the total number of prisoners receiving OAT programmes was only around 795 by 2016 (UNAIDS 2017).

Studies conducted in the Kyrgyz Republic, Iran, and Malaysia have reported that moral biases and stigma constitute significant barriers to the delivery of OAT programmes in prisons, leading to low enrollment and retention rates (Rhodes et al. 2019; Zamani et al. 2010; Moradi et al. 2015). In the Indonesian context, stigmatisation of Methadone maintenance treatment (MMT) programme participants has been found to result in the continuation of HIV risk behaviours in prison (Culbert et al. 2015b). However, while a few studies have explored some aspects of the stigmatisation of drug users in Indonesian prisons, there have been no detailed qualitative explorations of stigma in relation to MMT programme participation. Given the very low uptake of both programmes by prisons and MMT by prisoners, an in-depth qualitative study of how prison staff (including healthcare and security staff and prison managers) and prisoners perceive and experience stigma related to OAT programmes, was urgently required to develop a better understanding and design potential strategies to alleviate stigma-related OAT in prison settings.

Setting

Indonesia has the fastest growing HIV epidemic in Asia with 620,000 people living with HIV in 2016 (UNAIDS 2017). It is predicted that around two million people will be living with HIV by 2025 (Karts 2006). The rise will be mainly influenced by the high risk of HIV transmission among key populations including PWID, men who have sex with men (MSM), and clients of sex workers. It has been estimated that 0.01% of a total 264 million Indonesian people are illicit opioids users (ISSP 2020), many frequently administering drugs by injection. Therefore, Indonesia was selected as a case study.

Prison structures and OAT programmes in Indonesia

In Indonesia, prisons are classified by security levels – ranging from low to maximum security. Within each of these levels, prisons are further classified as narcotics or

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4 non-narcotics (general) prisons. Narcotics prisons are specifically designed for drug
5 offenders. However, due to the increasing numbers of drug offenders, many are
6 detained in general prisons. At the time of this study, only 33 out of 412 Indonesian
7 prisons were narcotics prisons, with many experiencing overcrowding by as much as
8 260% (Directorate of Corrections 2016).
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15 In Indonesia, OAT programmes take the form of MMT programmes. Following the
16 establishment of the first MMT programme in a community hospital in Bali in 2003
17 (National AIDS Commission 2009), an MMT programme was also introduced in a
18 Kerobokan Prison (Bali) in 2005 (Ministry of Health Indonesia 2008). By 2016, 12
19 prisons across the country were providing MMT programmes. However, the number
20 of MMT participants was very low compared to the total number of drug users in
21 prison. Across the Indonesian prison estate, the greatest number of prisoners
22 recorded in any one prison as receiving methadone in a prison was 45 (1.7%) out of
23 2649 drug using prisoners, while the lowest number was 2 (0.3%) out of 734 drug
24 using prisoners.
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34 While Indonesian prisons set addiction criteria based on DSM IV for opioid
35 dependence, programme eligibility requirements vary between prisons. No other
36 treatment options are available apart from Therapeutic Community (TC)
37 programmes. TCs were established in Indonesian prisons in 2013 under the
38 supervision of National Anti-Narcotics Agency of the Republic of Indonesia (BNN).
39 They provide psychosocial and cognitive-behavioural support to drug dependent
40 prisoners, but require participants to be free from drugs (including prescribed drugs
41 such as methadone). By 2017, there were 60 TC programmes in prison, as well as 6
42 community-based TCs. However in December 2017, the BNN suspended provision
43 of TCs in Indonesian prisons temporarily on the basis that they were 'ineffective'
44 and, given the persistently high levels of illicit drug use in prisons, wasted
45 resources (Sukmana 2017).
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Methodology

Research design

We employed a qualitative case study design to allow for the development of an in-depth and contextualised understanding of the perspectives and experiences of study participants, that also took on board the complexities of the issues that emerged (Yin 2014). This design is regarded as being suitable for the exploration of how institutional programmes are implemented and function (Denscombe 2014).

Sampling strategy

Prisons: The selection of prisons for this case study was based on their relevance to the research questions and, more pragmatically, the feasibility of obtaining access, given the different administrative approval processes for research projects in the different provinces of Indonesia. Prisons were selected in a three-stage process. First, prisons known to have the largest numbers of drug users were identified. Second, prisons were classified as either having or not having MMT programmes. In the final stage, three different types of prisons were selected for study - a narcotics prison with an MMT programme, a general prison with an MMT programme, and a general prison, with no MMT programme – based on having the highest number of HIV infected prisoners. The multiple perspectives of the prisoners and of the diverse range of staff involved in the implementation of programmes were then explored in each prison.

Study participants: Purposive sampling was used to recruit study participants, including both prison staff and prisoners, to obtain a variety of key perspectives (Bryman 2012). Snowball sampling was also employed to collect data from harder-to-reach groups (Noy 2008). Face-to-face semi-structured interviews were conducted to allow interviewees to answer questions in their own words and to express their own feelings (Patton 2015).

Selection criteria for study participants

Four groups of study participants were included: prison governors, prison officers, healthcare staff, and prisoners including both those participating in MMT

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4 programmes (referred to as methadone prisoners from here on) and those who were
5 not (referred to as non-methadone prisoners from here on). The selection criteria for
6 prison staff was based on their roles and responsibilities. In each prison, participants
7 were selected with the help of the prison doctor, prison manager and the chief of
8 prison security.
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15 Methadone prisoners were eligible for inclusion if they had participated in prison
16 MMT programmes for more than six months, while non-methadone prisoners were
17 eligible for inclusion if they were current injecting drug users, or had been injecting
18 drugs for more than six months before imprisonment. The methadone prisoners
19 recruited may or may not have been participating in other prison HIV programmes.
20 Methadone and non-methadone prisoners were excluded if they had significant
21 mental health disorders or might be released before the completion of data
22 collection. In each prison, healthcare staff provided a list of potential prisoners for
23 inclusion in the study. The researcher then selected potential participants based on
24 the study criteria. As discussed, in addition to purposive sampling, snowball
25 sampling was used to help the researcher to minimise participant selection bias and
26 to recruit potential participants who might provide valuable insights (both methadone
27 and non-methadone prisoners). In this way, the researcher avoided relying
28 exclusively on the chief of security and healthcare staff to identify potential
29 participants.
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42 Sample structure

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44 In qualitative research, the richness, complexity, and detail of the data produced and
45 analysed are prioritised above the size of the sample (Mason 2002). However, for
46 practical reasons, the proposed number of participants was decided upon in the
47 planning stage of the study. Creswell and Miller (2000) suggest a minimum of 3 to 5
48 interviews per case study, while Leech and Onwuegbuzie (2007c) suggest a
49 minimum of 3 participants per sub-group. Given the fact that there were five types of
50 sub-group participants across three types of prisons, a minimum sample size of 45
51 participants was planned. In the selection of sample members, the criteria were not
52 always fully applied. For example, a psychologist who was responsible for
53 Therapeutic Community (TC) programmes in the narcotics methadone prison was
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also recruited on the assumption that her role might enrich understanding of the study context. In total, there were 57 participants in this study. Table 1 below summarises the sample structure.

Table 1. Sample structure

Prison name	Prison Governor	Healthcare staff		Prison officers	Prisoners			
		Planned =Actual	Planned		Actual	Methadone		Non-methadone
	Planned			Actual		Planned	Actual	
Narcotics methadone	1	3	4	3	6	10	3	7
General methadone	1	3	3	3	6	6	3	6
General non-methadone	1	3	3	3	-	-	6	6
Total	3	9	10	9	12	16	12	19
Minimum number of participants required: 45								
Total number of participants achieved: 57								

Ethical approval

There are no procedures for gaining ethical approval from the Indonesian prison service. Ethical approval was granted by the University Research Ethics Committee of the University of Stirling. Additionally, a letter of recommendation from the Ministry of Justice Indonesia was sent to each prison selected as a potential study site. The outcome was an approval letter signed by each of the three prison governors to access their prison.

Data collection

Data were collected between December 2015 and March 2016. A topic guide for each professional group and for prisoners was developed in English and translated to Bahasa Indonesia (the Indonesian national language), to ensure that key themes were addressed consistently and to allow comparison across sub-groups and prisons. All interviews were conducted in Bahasa Indonesia, a language spoken by both the researcher and the participants. Participants were informed about the

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4 voluntary nature of study participation and the anonymity of data collection. A
5 private room was made available in the study prisons. Most semi-structured
6 interviews lasted for 45-60 minutes. The shortest lasted 30 minutes (interrupted by a
7 regular security check), and the longest took 120 minutes.
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13 Both written and verbal consent were obtained from each participant regarding their
14 willingness to participate in the study. Monetary incentives were not given to ensure
15 that prisoners took part voluntarily, although a small snack was offered. No incentive,
16 monetary or snack, was offered to prison staff participants, as this could have been
17 construed as bribery.
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23 **Data analysis**

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27 Interview recordings were transcribed and analyzed using Nvivo 11 (Brandão 2015).
28 The researcher translated and coded these transcripts from Indonesian to English
29 and conducted back translation from English to Indonesian. Coding of data began
30 with a review of every line and paragraph of the contextual data guided by the
31 research questions. The similarities and differences between the codes were
32 compared. Themes that were found to be conceptually related were grouped into
33 categories leading to the development of central themes emerging from the
34 transcribed interviews. The data analysis was based on constructing a thematic
35 framework (Braun and Clarke 2006).
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44 **Findings**

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47 Intersectional stigma takes place when multiple identities co-occur and are linked
48 together. When this happens the experience of stigma is often amplified, (Swan et al.
49 2016) preventing people living with these conditions accessing both individual and
50 structural support (Jackson-Best et al. 2018). In this study injecting drug use and
51 associated characteristics, HIV positive status, and participation in MMT
52 programmes were linked in discussions of stigma and found to amplify the stigma
53 experienced.
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4 Stigma towards MMT programme participants is driven by generalised negative
5 perceptions of both prison staff (prison governors, prison officers and healthcare
6 staff) and other prisoners. Organisational factors that reinforced the stigmatisation
7 relating to MMT programmes ranged from a lack of confidentiality in delivering the
8 programmes to the absence of family and institutional support.
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15 **Negative perceptions of people participating in MMT programmes as a driver** 16 **of stigma** 17 18 19

20 Methadone prisoners were perceived by both non-methadone prisoners and prison
21 staff alike in similar ways to those taking illicit drugs. They were also seen as lazy
22 and poor. A non-methadone prisoner from the general prison said:
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27 "I think cameras highlight those kind of people (methadone-prisoners).
28 There are cameras (CCTV) here (in the clinic) and throughout the
29 prison. It is easy to identify them as they are lethargic" (General
30 methadone prison, Non-methadone prisoner, late 20s).
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35 A non-methadone prisoner from the general non-methadone prison also suggested
36 that:
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39 "Drug dealers and those (drug users) who have money would not take
40 methadone; methadone is only for prisoners who have no financial
41 support from their family" (General non-methadone prison, Non-
42 methadone prisoner, early 30s).
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47 Thus, poverty was also a source of stigma rather than compassion. Methadone
48 prisoners were also assumed to be HIV-positive, as suggested by a non-methadone
49 prisoner from the general non-methadone prison:
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54 "There is some stigma towards people who are injecting drugs in the
55 prison - they are a dirty people and a source of disease. Fellow
56 prisoners and prison staff think those prisoners in the methadone
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4 programmes are HIV-positive prisoners" (General non-methadone
5 prison, Non-methadone prisoner, late 30s).
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10 However, as one methadone-prisoner from the narcotics methadone prison pointed
11 out:
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13 "People say that methadone-prisoners are HIV-positive people, even
14 though not all methadone-prisoners have HIV infection" (Narcotics
15 methadone prison, Methadone-prisoner, early 40s).
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20 Another concern relating to the MMT programme participants was their low
21 productivity. Prisoners receiving methadone were often perceived as being
22 physically slow and lazy:
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26 "Many methadone-prisoners do not get involved in the prison activities
27 such as sports and only a few of them joined the educational session.
28 They just go back directly to their unit to sleep after taking their
29 methadone, so the staff think we are unproductive " (Narcotics
30 methadone prison, methadone-prisoner, early 30s).
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38 Many prisoners linked the high levels of stigma and discrimination in prisons with a
39 lack of education and awareness about HIV prevention, as indicated by one non-
40 methadone prisoner:
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44 "I think stigma is a normal thing in the prison and everywhere. I think
45 because people do not know what HIV is and how it could be
46 transmitted" (General non-methadone prison, Non-methadone prisoner,
47 late 30s).
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54 In sharp contrast to views held about the methadone programmes and their
55 participants, many prison staff and both groups of prisoners appreciated the TC
56 programmes because they are drug-free. They were perceived to be more
57 acceptable in prison settings and provided nutritious meals and emotional support for
58 their participants. A non-methadone prisoner said:
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4 "I like the TC programmes since their participants can talk and discuss
5 all their problems in prison with the experts (psychologists) (Narcotics
6 methadone prison, Non-methadone prisoner, early 30s).
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11 Another emphasised:
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15 "TC is a good programme since it is making their members healthy.
16 They fulfilled our needs by giving nice regular meals. It is because they
17 have their funding. Frequently I saw them get snacks, curry chicken rice
18 that sort of healthy nice food" (Narcotics methadone prison, Non-
19 methadone prisoner, late 20s).
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25 However, although TC programmes were perceived positively by prison staff and
26 prisoners, many prisoners considered these programmes to be unsuitable for
27 injecting drug use, as it was believed that injecting drug users found it more difficult
28 to be drug free, a pre-requisite for joining a TC programme. As one non-methadone
29 prisoner put it:
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35 "We are injecting drug users, while many of TC participants are non-
36 injecting users. So, although TC programmes have many benefits we
37 could not join the TC programme" (Narcotics methadone prison, Non-
38 methadone prisoner, early 30s).
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44 **Understanding intersectional stigma and its impact on MMT programme** 45 **participants in prisons** 46 47

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49 According to a member of the healthcare staff from the general methadone prison, 12
50 of the 17 MMT programme participants were also HIV-positive. The connection
51 made between MMT programme participation and having a positive HIV status was
52 a concern for many prisoners in both methadone prisons. As one programme
53 participant put it:
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4 "I felt quite different since being infected with HIV but joining the
5 methadone programmes make things even worse (additional layer of
6 stigma)" (Narcotics methadone prison, Methadone-prisoner, mid 30s).
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11 However, healthcare staff in this study often failed to recognise the intersectionality
12 of stigma, believing that stigma was simply attached to a known HIV positive status
13 rather than also to participation in MMT:
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18 "I think the methadone-prisoners do not mind even when we have no
19 private clinic, but I think it might be that some of HIV patients do not
20 want to be known as HIV-patients. I know that some of them were not
21 ready to disclose their (HIV) status afraid of being stigmatised by other
22 prisoners" (Narcotics methadone prison, Doctor, female).
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29 This intersectionality and the amplification of stigma can have a devastating impact
30 on mental health and well-being leading to greater levels of depression and suicide.
31 As one methadone-prisoner from the narcotics methadone prison explained:
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35 "Being ostracised, separated, and mocked are common practice, but
36 not everyone can handle on their stress. You know that some people
37 turned to depression and chose to commit suicide here" (Narcotics
38 methadone prison, Methadone-prisoner, early 40s).
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44 The stigmatising attitudes of prison staff may also reduce methadone prisoners'
45 opportunity to get parole and therefore their chance of an early release. In the
46 narcotics prison with a MMT programme, many prisoners apply to participate in a
47 work programme with the aim of obtaining a recommendation to join the parole
48 programme. However, methadone prisoners have difficulty accessing work
49 programmes since they were assumed not to be able to work as hard as other
50 prisoners. As one prison officer observed:
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58 "All prisoners are equal here since they can join any work programmes
59 with no prohibition, but physically they should be able to perform well,
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4 and they should know their capacities at work (physically demanding
5 job)" (Narcotics methadone prison, Prison officer, late 20s).
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10 Similarly, some methadone prisoners linked this limitation of their work options
11 directly to stigma associated with their participation on methadone programmes and
12 their HIV status:
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16 "It was a shame that I could not join the work programmes. [A] prison
17 officer said [this was] because of my participation in the methadone
18 programmes and my health status (HIV-positive). I wanted to work so
19 that I did not feel lonely. I know people see us as failures" (General
20 methadone prison, Methadone prisoner, early 40s).
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27 Many methadone prisoners also associated the uncaring behaviour of healthcare
28 staff at the methadone clinic with their HIV-positive status. A methadone-prisoner
29 from the general methadone prison said:
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33 "All the healthcare staff must have also known our HIV status, so when
34 we stand in the clinic corridor waiting for the methadone, they walk
35 cautiously because they feel disgusted by being close to us. I think it
36 was not a good example from the healthcare staff to others, so the
37 prison officers also acted like that" (General methadone prison,
38 Methadone-prisoner, early 30s).
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46 Indeed, some healthcare staff from the general methadone prison believed that such
47 actions were justified and not discriminatory, indicating a lack of empathy for prisoner
48 concerns:
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52 "I do not think there is a discrimination problem. It is just the matter of
53 health concerns. Their hygiene was lacking so we liked to stay away
54 from them" (General methadone prison, Doctor, male).
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4 Rather than addressing stigma, senior prison staff suggested that HIV-positive
5 prisoners should be segregated:
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9 "I think if we find HIV-positive prisoners we should separate them, but
10 the doctors said HIV-positive prisoners could not be separated.
11 Honestly, if I [had the] space, I [would] separate them, but according to
12 the law, it is not allowed" (Prison Governor).
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18 Regardless of their experiences of stigma, some methadone prisoners also used
19 prison officers' fear of HIV infection to their advantage as a way of hindering security
20 procedures. A methadone-prisoner from the narcotics methadone prison described
21 the following scenario, while indicating by his aside to the researcher, that such
22 discrimination was common knowledge:
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28 "I just pretended to use a mask and to cough, so they did not enter our
29 cell. Mobile phones (prohibited in prison) and that sort kind of thing
30 were possessed by most of the people here. Once they wanted to take
31 our rice cooker, but we said, 'sorry sir, it belongs to the methadone-
32 prisoners, and we are all sick here (HIV positive)'. Thus, they took other
33 peoples' rice cookers, but they gave us ours back. You must already
34 have known there is that kind of discrimination here" (Narcotics
35 methadone prison, Methadone-prisoner, early 40s).
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44 Such interpersonal stigmatisation was further reflected in and reinforced by
45 organisational factors.
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49 **Organisational factors that promote stigmatisation of MMT programme** 50 **participants** 51

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54 In addition to individual attitudes amongst staff and prisoners, a range of
55 organisational factors were found to reinforce and promote the stigmatisation of
56 prisoners attending MMT programmes.
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Lack of confidentiality

Prisoners in both the methadone prisons expressed concerns about a lack of confidentiality linked to their attendance at the methadone clinic at weekends. At the weekend, other prisoners were locked up, but methadone prisoners were allowed to go to the clinic to receive their methadone. Therefore, security staff knew that a prisoner who passed the security post to access the clinic was likely to be a methadone-prisoner (and prisoners deciding whether to use the clinic had to consider this).

For other prisoners, the fear of being identified as a methadone prisoner stemmed from a specific methadone uniform, a coloured T-shirt. The methadone uniform was intended to inspire togetherness and methadone prisoners were encouraged to wear it when visiting the methadone clinic, especially at the weekend. While prisoners were free to choose whether to wear their methadone or prison uniform, the methadone uniform was the only alternative when their prison uniform was being washed. Although many prisoners feared being recognised as a participant in the MMT programme by the methadone uniform, prison officers on the other hand appreciated it for security reasons:

"It is important for methadone participants to use their (methadone) uniform, so we can differentiate them from non-methadone prisoners for security reasons. So, we (prison officers) will open the gates and they can access the methadone clinic" (Narcotics methadone prison, Prison officer, mid 40s).

The location of methadone clinics was another important factor. In the general methadone prison, the methadone clinic was located within the health workers' staff room, while in the narcotics methadone prison, the methadone clinic was in a single long corridor alongside other health clinics. A methadone-prisoner from the narcotics methadone prison raised the issue of clinic location, and offered a potential solution:

"I felt very uncomfortable when my friends who are from the same village saw me in that methadone clinic. I think they should put the

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4 methadone clinic at the end of corridor (away from the other health
5 clinics)" (Narcotics methadone prison, Methadone-prisoner, early 40s).
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9 One healthcare staff member from the general methadone prison, recognised that
10 MMT programme participants experienced stigma but identified spatial constraints as
11 a reason why nothing could be done to remedy the situation:
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16 "I know the methadone clinic should be in a separate place, and the
17 recent clinic arrangement might make the prisoner uncomfortable, but
18 we have no other space" (General methadone prison, Healthcare staff,
19 female, mid 30s).
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25 Even the size of prisoners' medical records could betray participation in MMT
26 programmes. As a non-methadone prisoner from the narcotics methadone prison
27 described:
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32 "People can spot the difference from their records. A methadone-
33 prisoner has a big medical record while others have small ones"
34 (Narcotics methadone prison, Non-methadone prisoner, early 40s).
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39 Lack of family and institutional support for methadone prisoners

40 Many prisoners had already experienced stigma from their families. The importance
41 of this stigmatisation is exacerbated in the Indonesian prison context by the fact that
42 family members play an essential role in supporting prisoners. For example, at the
43 time of the study, prisoners' families were expected to pay for X-rays and for
44 medication for opportunistic infections because of limited financial resources in
45 prisons. Prisoners also rely on family money to buy extra food to supplement the
46 poor prison diet, as well as soap, toothpaste and other hygiene products.
47 Consequently, the many HIV-positive prisoners, who have been rejected by their
48 families face problems. As a prisoner from the general methadone prison explained,
49 this has implications for HIV-positive prisoners:
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57 "I feel a lack of vitamin and fruit intake while in prison. Methadone is a
58 hard drug, so it should be consumed with vitamins and fruits. I am afraid
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4 my health would deteriorate dramatically without those supplements"
5 (General methadone prison, Non-methadone prisoner, mid 20s).
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9 These prisoners also often lacked emotional support from their families:
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13 "I want the doctors to provide emotional support to boost our motivation
14 to take ART (antiretroviral treatment) or to join the methadone
15 programmes, since we have no families to support us" (General
16 methadone prison, Methadone prisoner, mid 20s).
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21 A member of healthcare staff from the general non-methadone prison seemed
22 unaware of this problem of family stigma. She encouraged the disclosure of the
23 prisoners' HIV-status to their family members to get support, seemingly unaware that
24 it might not be forthcoming:
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30 "Being open about their HIV status to their family members is important
31 because this is a long-life treatment and their health condition may
32 deteriorate at any time here. We encourage them to disclose their HIV
33 status at some point, so their family will be aware of their conditions and
34 then give them support" (General non-methadone prison, Healthcare
35 staff, female, mid 30s).
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42 However, some health workers did recognise that there was a problem of trust.
43 Some services for HIV-infected prisoners were provided, including a peer support
44 group. However, some staff were aware of feelings of insecurity among prisoners
45 when talking about sensitive issues, such as HIV, with them:
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51 "I used to ask psychology students who had an internship programme
52 here to talk to the HIV-positive prisoners. I realised there would be
53 some barrier when we talked to them because we wear this uniform.
54 They were afraid that if they were honest with us that they would
55 receive the consequences from the prison authority, but they would feel
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4 safe talking with those students" (General non-methadone prison,
5 Doctor, female).
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10 **Discussion**

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13 This study confirms that prisoners participating in MMT programmes experience
14 considerable stigma from both prison staff and other prisoners. Furthermore,
15 healthcare and other prison staff often failed to understand the intersectionality of
16 stigma that linked MMT programme participation with HIV positive status and
17 negative stereotypes of drug users; or how individual attitudes or institutional
18 practices contributed to this. This not only had a profound effect on prisoners' lives
19 while in prison, adversely affecting mental health and driving some to suicide, but
20 also limited their access to the parole system and therefore the possibility of early
21 release.
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30 To our knowledge, this is the first focused qualitative exploration of stigma and MMT
31 programme participation involving prison stakeholders, prison officers, healthcare
32 staff, and prisoners. The results provide empirical insights about perceived and
33 experienced stigma related to MMT programmes in Indonesian prison settings.
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39 In both of the study prisons with MMT programmes, many prisoners indicated that
40 they had experienced stigma associated with their participation in these programmes
41 as indicated by previous study (Komalasari et al. 2020). This was confirmed by some
42 healthcare staff in the general methadone prison and has also been recognised in
43 studies in other locations (Woo et al. 2017; Carlin 2005; Mitchell et al. 2009). The
44 findings also point to many organisational factors including policies, culture and
45 practices that suggested negative beliefs and attitudes with regard to MMT
46 programme participation. Such factors have been described as 'institutional stigma'.
47 Harris and McEwan (2012) argue that such stigma leads to low levels of accessibility
48 to participation in methadone programmes, as well as the development of general
49 and mental health problems.
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4 As in previous studies conducted in prison settings (Zaman et al. 2010; Moradi et al.
5 2015), negative perceptions of participants in MMT programmes were often
6 associated with drug use, being lazy and poor and having a positive HIV status.
7 Similarly, studies in the community (Nong et al. 2017) found that MMT programme
8 participants were also perceived to be lazy. Both prison staff and prisoners linked
9 these perceptions to the side effects of methadone. However, at the appropriate,
10 therapeutic dose, methadone does not cause sleepiness or interfere with normal
11 activity, but rather has a positive effect on overall physical health (Kheradmand et al.
12 2010). Stigmatisation was also linked mainly to negative perceptions of drug use as
13 dangerous and integrally linked to violence and illegality (Ahern et al. 2007). Many
14 prisoners, particularly in the general methadone prison, reported hurtful comments
15 such as being told that they were 'dirty people' by healthcare staff.
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27 This study supports previous studies on MMT programmes in community settings,
28 which found that healthcare staff did not fully appreciate the associations made
29 between MMT programme participation and a positive HIV status, or the breadth and
30 scope of the intersectional stigmatisation of opioid-dependent clients (Medina-
31 Perucha et al. 2019; Kuesza et al. 2016). Indeed, healthcare staff in the narcotics
32 methadone prison thought that there was less stigma attached to methadone status
33 compared to HIV status, even though other prisoners and prison staff automatically
34 assumed methadone participants to be HIV-positive. The stigmatisation of people
35 with HIV infection (Iskandar 2014) is matched by the stigmatisation of injecting drug
36 use compared with other means of drug administration (Brener et al. 2017). Notably,
37 some methadone prisoners in the narcotics prison linked the limitation of their work
38 options, and therefore their reduced eligibility for parole, to such intersectional
39 stigma.
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51 Difficulties in maintaining privacy in prison settings, together with lack of a support
52 system for additional health expenses, nutritious food, and hygiene products
53 independent of family support, fuelled the stigmatisation of prisoners in the MMT
54 programmes. The links between drug use and mental health problems have been
55 identified in community settings (Park-Lee et al. 2017). However, prisoners are
56 usually members of vulnerable groups that are particularly unlikely to receive
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4 emotional support. This, together with overcrowding and insular prison environments
5 in limited resource prison contexts, can provoke strong adverse emotional reactions
6 to the stigma identified in this paper. For example, prisoners in the narcotics prison
7 reported that some MMT programme participants had committed suicide because of
8 stigma they experienced from their participation.
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15 In the context of the limited resources of the Indonesian prison system, family plays
16 a significant role in supporting prisoners by providing financial support. However in
17 Indonesia, as in many countries (Fotopoulou et al. 2014; Yu, et al. 2018; Salter et al.
18 2010), drug use by a family member is considered a family disgrace that should be
19 concealed to maintain 'family honour' (Ritanti 2017). Stigma associated with HIV also
20 prevents family disclosure (Culbert et al. 2015a). As a result, although healthcare
21 staff encouraged prisoners to disclose their HIV status to their families to get
22 support, many prisoners declined to do this. Consequently, many methadone
23 prisoners were unable to pay additional medical expenses, provide for their personal
24 hygiene or purchase additional food to supplement inadequate prison food.
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34 Education for prisoners and training for prison staff can both play an essential role in
35 reducing stigma in prison settings (Tavakoli et al. 2019; Woo et al. 2017).
36 Challenging specific misconceptions, such as all methadone participants are HIV
37 positive, must be included to ensure that any strategy aiming to reduce stigma is
38 effective. In particular, lack of understanding of how attitudes of healthcare staff can
39 stigmatise methadone participants, which, in turn can negatively affect the attitudes
40 of other prison staff and prisoners towards programme participants, needs to be
41 addressed. Healthcare and other prison staff would benefit from training in: harm
42 reduction and the provision of MMT programmes in prison; the intersectionality of
43 stigma and guidance on working with drug users in a prison setting. In addition,
44 where possible, encouraging prisoners' family members to participate in MMT
45 programmes will help ensure that more methadone prisoners receive the emotional
46 and financial support they need to succeed in their treatment efforts while in prisons.
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58 One limitation of the study was that it did not include female prisoners. This was
59 because female only and mixed gender prisons were excluded during the prison
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4 selection stage as HIV prevalence in these prisons is much lower. However, it is
5 likely that the stigmatisation of male and female prisoners may manifest itself
6 differently because of expectations associated with traditional gender roles. For
7 example, women in MMT programmes may face greater stigma, as they are likely to
8 be seen as failing in their family responsibilities. This remains an important area for
9 further research. In addition, selection bias resulting from the reliance in part on
10 prison managers to nominate study participants may have restricted disclosure or
11 discussion of barriers to MMT programme implementation. The use of snowball
12 sampling to recruit some study participants, however, overcame this to some degree
13 and, in practice, there appeared to be open discussion of a wide range of issues
14 during the interviews. In spite of these limitations, this study provides an in-depth
15 exploration of stigma towards MMT programme participant and OAT programme
16 participants more generally, and has revealed new and important consequences of
17 stigma in prisons such as preventing access to parole programmes.
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30 **Conclusion**

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33 This qualitative study highlights the need for the development of prison policies and
34 related guidance aimed at reducing the stigma associated with methadone
35 programmes and discrimination by prison staff and prisoners in Indonesia. In
36 particular, specific education programmes and information for prisoners and training
37 for prison staff (including those working in security, healthcare and prison
38 management) is required. This should focus on improving understandings of: i) the
39 principles of harm reduction and how this relates to the provision of MMT
40 programmes in prison; and ii) how institutional and individual practices of both prison
41 staff and other prisoners promote the multi-layered and intersectional stigmatisation
42 of MMT programme participants and deter others from participation.
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52 The study also highlights the importance of education for prisoners' family members
53 to alleviate stigma. Furthermore, incorporating prisoners' family members within
54 programmes to ensure participants receive support might be an effective strategy to
55 increase participation in and improve the quality of programmes in prison settings.
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