Drug Addiction Policies and Practices: Access to Health Services in Indonesia[1]

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Abstract

Issues on drug use/abuse are not new in Indonesia, as the country experiences to have a long history of it as early as 17th century. The development of drug use/abuse follows the international trend from opium, narcotics, cannabis, to heroin dan psychotropic substances. Recent reports indicate a dramatic increase in the use of illicit drugs among young people in Indonesia. The high demand leads the distribution and production to increase and Indonesia becomes a big market as well as a producer of illicit drugs that incorporate international cartels. The most recent regulation on narcotics, the Law no. 35/2009 treats narcotic addicts as patients and not criminals. The regulation requires them (or parents of under age) to register to the assigned institutions that they are narcotic addicts and therefore have access to health through medical and social rehabilitations. This compulsory regulation tries to avoid narcotic addicts from criminalization. If they do not refgister and are caught by the police, they have to go to the court as criminals.

The purpose of this study was to investigate the implementation of the compulsory regulation on the self registration and the access to health services. We did in-depth interview (individual and group) as the method of investigations. The stake holders included Ministry of Health (MOH), Ministry of Social Affair (MOSA), Ministry of Law and Human Rights, Community based Social Organizations (CSO), Legislators, and the National Narcotic Board (NNB). Because the recent law No. 35/2009 on narcotics distinguishes medical and social rehabilitations, the MOH is responsible for the medical rehabilitation, while the MOSA is responsible for the social rehabilitation. Content analysis was used to understand the implementation of the regulation and the procedure of access to health services.

Both medical and social rehabilitations are in fact provided together in one program rehabilitation. The MOH reported it as a comprehensive rehabilitation. We found that both ministries have difficulties in developing an agreement in implementing the regulation. At the grass root level, it is obvious that narcotic addicts are reluctant to register. Most are afraid of being arrested and stigmatized. Furthermore, they do not get benefit from the program because the compulsory tends to merely record for the government to have comprehensive data.

Since the law and government regulation mention only about narcotic addicts, those who use psychotropic substances and are not addicted might not need to register but take the risks to be arrested. At the mezo level, we investigated the institutions assigned to receive the drug addicts who want to register them selves voluntarily. We found that in the medical institutions none of the addicts register voluntarily. Yet, they reported to the MOH the number of those who are taking metadone maintenance treatment as self registrants. As for the social institutions, they seem not to know what to do. One institution reported that they provide medical assessment/treatment in addition to the after care services.

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[1] Presented at the Seventh Annual Conference of the *International Society for the Study of Drug Policy*. May 15- 17, 2013. Bogota, Colombia.

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Background
The history of drug use/abuse in Indonesia has long been recorded when Arabic traders came to Indonesia trading goods (Rush, 1985). Since opium cannot grow here, the roles of foreign traders became important as they were the ones who were able to bring it to the country. When the Dutch traders came to Indonesia in the 17th century to find spices, they found that trading opium was very profitable. They introduced opium from Bengal, India, to the Java not as a part of medication, but as way to get relaxed (Simanungkalit, 2011). In 1677 the Dutch East India Company (*Vereenigde Oostindische Compagnie* or VOC) developed an agreement with King Amangkurat II of Java to guarantee VOC had the monopoly in supplying the opium throughout his kingdom, which was the most part of the Java.

For centuries VOC traded the opium by franchising it to local traders, many are Chinese. There are several opium warehouse in Java, such as Batavia (now Jakarta), Semarang, and Surabaya. Some other warehouses were built in other islands. Besides, hundreds of opium houses were established for farmers and local people to enjoy after working hours. By making them addicted, the Dutch was able to control West India as well as to get more profit out of it. Due to the significant profit from trading in the East India, opium and other spices, VOC transformed itself from commercial to territorial power in order to get more profit in the long run (Rush, 1985). When the VOC collapsed in 1799, the Royal Dutch government took over the monopoly of opium in Java and other islands in Indonesia. The government launched a number of opium regulations (*opium regie*) to control the import, preparation, and distribution of opium across the country. A number of regulations (*ordonantie*) were developed according to the island the government needed to control, for example *Aceh Regie Ordonantie, Bali Regie Ordonantie, Borneo Regie Ordonantie, and Celebes Regie Ordonantie.* In 1927 the government unified about 44 *ordonantie*s and established a new drug law called *Verdoovende Middelen Ordonantie,* Stb 1927, no. 278 jo 536 (Suci et al., 2010). When Indonesia got its independence in 1945, the government continued using this *ordonantie* for decades until the country has it's own in 1976.

It is important to note that at the end of 19th century, when the Dutch government had monopolized the importation and distribution of opium successfully, they tried to cultivate coca bushes in Java. Different from opium that needs special temperature, altitude, and terrain, coca plant is easier to grow. The government started to cultivate coca leaves in 1880 in East Java comprising 6,000 acres of area. They planted coca together with cacao, coffee, and rubber as supplemental. Java coca has quality similar to the Peruvian product (Journal of the Royal Society of Arts, 1922). In early 20th century the exports of coca leaves from Java boomed. In 1912 Java exported more than 1,000 tons of leaves to Amsterdam to be processed. In 1920 the export increased to be 1,600 tons or about 25 ton of cocaine. About the same time, Peru only exported about 22 tons of cocaine, while Bolivia never reached 5 tons (Jakarta Post, 2000). This shows that Java had been once the biggest producer of cocaine in the world.

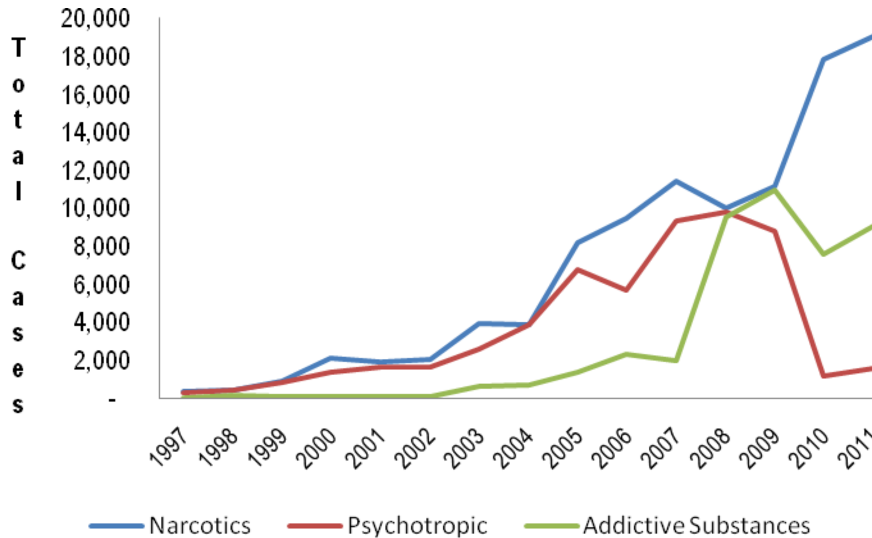
Due to the international concern on drug use, the production of cocaine decreased significantly worldwide. In 1935 the export of cocaine from Java fell to less than 2 tons with the worldwide production of under 10 tons (Jakarta Post, 2000). This is partly because the Netherlands actively participated and signed the 1912 Hague International Opium Convention that took place in the Hague. By 1920 there were 60 countries had signed and ratified the Hague treaty, during which the Netherlands prepared to unified 44 *ordonantie* in the Dutch East India. It is likely that the single *ordonantie* was established to incorporate the Opium Convention that has six chapters and 25 articles on opium, morphine, cocaine, and heroin. The two latter were actually new substances during that time and still in debate ("The 1912 Hague International Opium Convention.")

After Indonesia got its independence, the regulation on drugs did not change much for many years until 1976 when the government thought that the 1927 *Ordonantie* could not incorporate the new issues on drugs, especially on the development of cocaine, heroin, and the new type of psychotropic drug namely *Lyserg Diathylamid Saeure* (LSD). The latter was actually developed in about 1940s as a medication for psychiatric patients. In 1960s it has been mass produced and people could get it easily, although it was illegal. In the United States LSD was used by young people who were frustrated with the situation at that time. The US was in turbulence due to the Vietnam War, the human rights movements, and other political problems. The use of LSD, marijuana, and other types of drugs was the way of young people protested to the US government (Simanungkalit, 2011). The situation in Indonesia in 1960s was not better either. The elimination of communist party and its followers in 1965 took millions of the citizens to death, and this movement was partly supported by CIA. The New Order Era was started with the close relationship with the US government, where many western lifestyles were adopted by Indonesians, including the trend of consuming marijuana, heroin, and LSD.

When the United Nations (UN) established the Single Convention on Narcotic Drugs in 1961, Indonesia ratified it in 1976 under the Law No. 8/1976. The ratification was announced after establishing the Law No. 3/1976 on drugs because the colonial *ordonantie* was outdated. When the UN established the Convention on Psychotropic Substances in 1971, the government did not ratify it until 1996 through the Law No. 8/1996. A year later, the Indonesian government also ratified the 1988 UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances through the Law No. 7/1997. During the same time, the government also established the Law No. 5/1997 on Psychotropic and the Law No. 22/1997 on Narcotics. These facts imply that the government took very long times to ratify the UN conventions. When they ratified the conventions, they were likely to also establish new laws on narcotic and psychotropic substances.

In order to control the supply and demand of narcotics and psychotropic substances, the government established the new National Narcotic Board (NNB) in 2002 through the Presidential Decree. This means that the board is directly responsible to the president in order to control the circulation such substances in the country. Since then, the cases of drug users in the country were better recorded. Chart 1 below shows the increase reported

cases on narcotics, psychotropic substances, and other addictive substances since the NNB was established. The chart indicates a decrease in psychotropic substances in the few years. However, it might not represent the actual cases, because psychotropic substances are commonly consumed by middle class people for recreational events. This is different from narcotics, because these people are usually not addictive and can perform their social roles normally. In contrast, narcotic users are more likely to be addictive and they tend to commit crimes when they run out of money. In other words, narcotic users are more vulnerable to be arrested (and reported) than psychotropic users.



(Source: NNB Dit IV/Drugs, Janary 2009; NNB Directorate Drugs Crimes, March 2012)

Chart 1. Estimated cases of drug users in Indonesia by types (1997 – 2011)

Based on the chart above, one might note that the year 2009 was the point when psychotropic and addictive substances started to decrease. It is the same year when the Indonesian government launched the new Law No. 35/2009 on Narcotics that replaced the previous Law No. 22/1997. Some reasons for replacing the previous law are: 1) the increase of HIV/AIDS infection; 2) the need to handle drug crime at the national, regional, and international levels due to the fact that drug trafficking covers a wide rage from home industry to transnational business; 3) the need to have a clear regulation on who are responsible for controlling, preventing, and eradicating drug trafficking, and 4) the increase of drug users that need to be treated as victims (Suci et al., 2010).

The new law on narcotics has significant improvements on strengthening NNB roles. Previously NNB functioned as the coordinating board. In the new law, it becomes a public organization beyond the president's cabinets that has more power in doing investigation on drug trafficking. Furthermore, the 2009 law has 17 chapters and 152 verses, while the 1997 law has 15 chapters and 104 verses. This means that the new law

incorporates more issues that are relevant to be integrated. The penalties for drug crimes are heavier so that they do not commit the same crime in the future.

The new narcotic law uses more public health approach than crime approach. Chapter VII, articles 44 – 51 of the previous 1997 law mention that narcotic addicts are required to take medication and/or care through rehabilitation facilities, both medical and/or social rehabilitations. They or their parents are to register to the assigned officer in order to get medication and/or care. Furthermore, the implementation of the access to health services is supposed to be regulated by the Ministry of Health (MOH) (Article 46.3). However, there was no regulation or anything about this from the MOH until the new 2009 law was established. One can conclude that Indonesia could produce a good law on narcotics and access to health services, but cannot be implemented.

The new 2009 one has actually similar statements on the access to health services as the previous ones, yet clearer. They are in Chapter IX, articles 53 – 59. It mentions that narcotic addicts or their parents are required to take medical and social rehabilitations. While the old law mentions that they are to register to "the assigned officer," the 2009 law mentions that they are to register to public health centers (*Puskesmas*), hospitals, and/or medical and social rehabilitation institutions. All these should have been assigned by the government. The implementation of the compulsory registration is regulated through the Government Regulation (Article 55.3 of the 2009 Law on Narcotics).

In 2011 the Indonesian government established the Government Regulation No. 25/2011 on the Implementation of the Compulsory Registration for Narcotic Addicts. This demonstrates that the new 2009 narcotic law are to be implemented. The offices that are responsible for the implementation of the access to health services are Ministry of Health (MOH) and Ministry of Social Affair (MOSA) because: 1) the law mentions about medical and social rehabilitations separately, and 2) it mentions clearly about the role of social rehabilitation institutions as one of the institutions that register narcotic addicts.

We attempt to investigate the implementation of the compulsory regulation on the self registration and the access to health services according to the Government Regulation No. 25/2011.

Method

We used qualitative approach by interviewing in-deeply to the relevant stake holders, individually or collectively according to the availability of the participants (representatives of the office). Our stake holders were the Ministry of Health (MOH), Ministry of Social Affair (MOSA), Ministry of Law and Human Rights, National Narcotic Board (NNB), Legislators, and some Community based Social Organizations (CSO). Because the new Law No. 35/2009 distinguishes medical and social rehabilitations, the MOH is responsible for the medical rehabilitation, while the MOSA is responsible for the social rehabilitation. Secondary data about the documentation of the work progress of our stake holders were collected as well. Content analysis was used to

understand the implementation of the regulation and the procedure of access to health services.

Results

It is important to note that although the Law No. 35/2009 is about narcotics and uses "narcotic addicts" to refer the users, the attachment pages of the Law listed non-narcotic substances as narcotics group 1, such as DET, DMT, LSD, mescaline, amphetamine, phenmetrazine, and phencyclidine.

This could be due to the definition of narcotics that is stated in Chapter 1, Article 1 as follow:

> " *Narcotic is a substance or a drug that is originally from plant or non-plant, synthetic or non-synthetic, that can cause a decrease or a change of awareness (cognition), a lack of sense, a decrease or a lack of pain. Narcotic can cause dependency, and it is divided into groups as stated in the attachments of this law*."

Based on this definition, the law and the regulation under this law (the Government Regulation No. 25/2011) use the term "narcotic addicts" (*pecandu narkotika*) instead of drug users/abusers or drug addicts. Indeed, the implementation of the law tends to apply for drug users in general because the regulation actually accounts for non-narcotic substances. Therefore the following explanation of our study, we use "drug addicts" and "narcotic addicts" to refer the same persons who consume narcotic and/or psychotropic substances.

As mentioned previously, the new law uses public health approach in which the government wants to treat narcotic addicts as victim instead of criminals. To avoid from being arrested, those who use substances should have a proof that they are under medication. This could be taken if they register them selves to an institution assigned for this (*Institusi Penerima Wajib Lapor*, or IPWL). When they come to the institution, an assessment will be performed to measure their condition. The assessment includes interview, observation, physical and mental tests. The interview consists of medical history, narcotic history, the history of treatment and care, psychiatric history, criminal history, and also family history of the patient/client. There are two types of institutions: medical and social. We will use the term patient if an individual comes to a medical institution, such as community health centers (*puskesmas*) and hospitals. If the individual comes to a social institution, we will call them client.

The results of the assessment will be recorded in the medical record or behavioral change record. When an assessment is completed, the patient/client receives a self-register card (*Kartu Lapor Diri* or KLD) that can be used twice. When a drug addict is caught by a police officer, he/she needs to show the card as a proof that the individual is under a medical treatment. In this case, he/she will be released and continue the treatment/rehabilitation. The third time the individual get caught, the police will arrest him/her and do the investigation as a law case. This regulation is still in a big debate because, based on our interviews to our stake holders and discussions with some experts

and activists, the regulation should take into account that drug addicts suffer from "chronic personality disorder" (head of RSKO), or "chronically relapse disease" (coordinator of PEKA). Both mean that the person is very likely to get relapse easily, and therefore allowing two times is not enough. This is confirmed by our previous study (Suci et al. 2010) that some drug addicts get relapsed many times, although the persons have been treated and rehabilitated several time. One went to various types of rehabilitations (medical, social, traditional, and religious) and still relapsed.

When an individual goes to the court and the judge concludes that the individual is not a criminal, the judge could decide that he/she needs medical and/or social rehabilitation and therefore recommend him/her to go to the assigned rehab center. According to this issue, the Head of the Supreme Court has made a circulated letter (*Surat Edaran Mahkamah Agung* or SEMA) stating that if an addict could prove that he/she is a victim of a substance, is under medication, and does not commit to drug trafficking, the judge could decide a penalty to the person for taking a rehabilitation program for a certain period of time accordingly. To get a clearer scheme of the self-register procedure vs. the law case, Chart 2 below is presented.

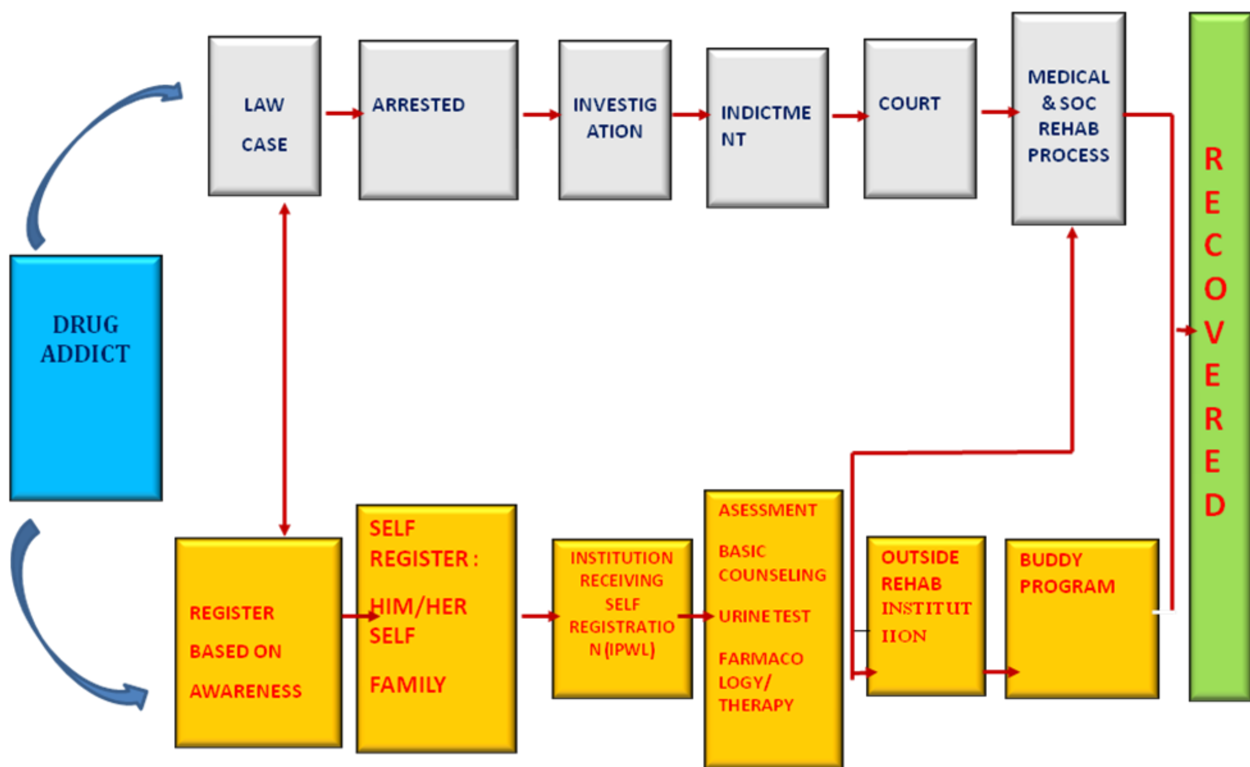


Chart 2. Procedure of Self Registration vs. Law Case

The law case procedure takes more public health approach to deal with drug issues, because at the end the addict is hopefully recovered. The problem is that the SEMA is not a regulation; it is only a type of recommendation and does not have strong power to push

judges to send addicted people to a rehabilitation center. It depends on how the judges perceive the issue on drug/narcotic addiction.

As mentioned earlier, the Ministry of Health (MOH) is responsible for medical rehabilitation, while the Ministry of Social Affair (MOSA) is responsible for the social rehabilitation. Chart 3 shows the scheme of Compulsory Self Registration between the two. To understand the implementation of self registration of drug/narcotic addicts to the assigned institution (*Institusi Penerima Wajib Lapor* or IPWL), we investigated the medical and social IPWL.

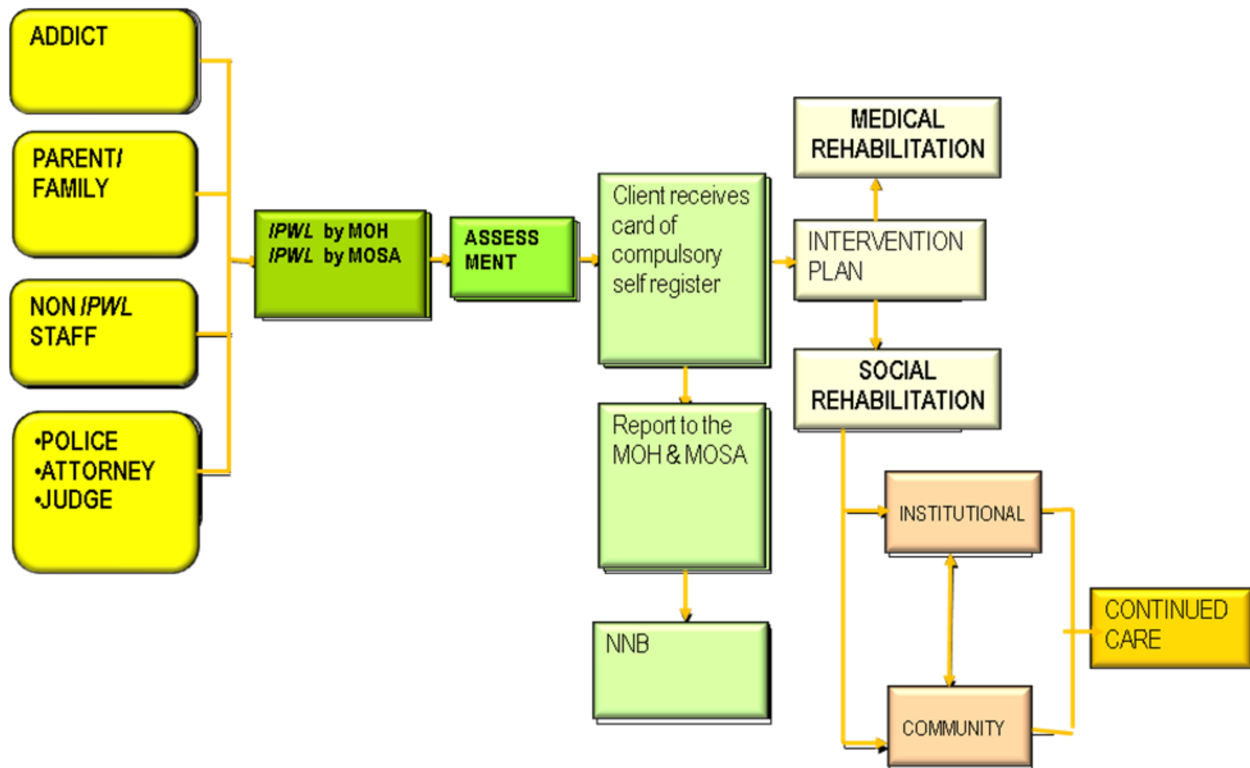


Chart 3. Scheme of Self Registration between Medical and Social IPWL

As for the medical IPWL, we visited three community health centers (*puskesmas*) and the Drug Dependence Hospital (*Rumah Sakit Ketergantuangan Obat* or RSKO) that are listed as four of 129 IPWL assigned by the MOH to provide assessment to drug/narcotic addicts who want to register them selves and get access to health services. All three *puskesmas* are located in Jakarta that can be visited easily; they are *Jatinegara Puskesmas*, *Kramatjati Puskesmas*, and *Rawamangun Puskesmas*. We interviewed the medical doctors who are responsible for the implementation of the compulsory self-register program for drug addicts.

Based on the in-depth interviews, we found that none of all three *puskesmas* had received a new patient coming to the health center for registering him/her self voluntarily as a drug

addict. What they reported to the MOH about the number of cases of the compulsory self-register program was actually the number of narcotic addicts who had registered to the *puskesmas* to take the methadone maintenance treatment (MMT). To these patients, they did assessments (again) and tests for the compulsory program. The zero or minimum number of new registrant was also reported by other *puskesmas.* During a meeting held in Atma Jaya Catholic University, the medical professional of Koja *Puskesmas* reported that out of 91 drug addicts they reported to the MOH, only two were new patients who voluntarily register their selves. Based on our interviews and discussions with other parties (mostly are activists from CSOs), we found that the reluctance for registering them-selves to the compulsory program was the worries of being caught by the police and get arrested. The second reason, and more crucial thing, is that the drug addicts do not get any benefit from the program. The third reason, there is not guarantee that they will be free from court, and that they will get rehabilitation for free. The last, some question about the compulsory program that requires them come to the center voluntarily. How can it be voluntary if it is compulsory?

Furthermore, the medical professionals complained that the government put so many programs to the *puskesmas* that they are overburdened with all the programs. Indeed, they acknowledged that the compulsory program is actually a good program if the government could prepare all the instruments, infrastructures, and sources well. They also thought that the compulsory program does not have a clear scheme on how to monitor and evaluate it.

As stated in the Government Regulation No. 25/2011 Article 18.2, an assigned *puskesmas* is to report information about the number of narcotic addicts they are dealing with, their identities, type of drugs they consumed, duration of taking the drugs, the way they consume, the diagnoses, and the rehabilitation they had taken. The *puskesmas* should report the information to the MOH. Based on our interviews, the medical professionals claimed that the compulsory program tends to merely collecting data from *puskesmas* about drug addicts. As for the rehabilitation, since the reported registering patients were actually those who were taking MMT and this was recognized as a medical treatment, therefore the health professionals did not need to refer them to a special medical or social rehabilitation.

One important issue is about the self-register card or *Kartu Lapor Diri* (KLD). As mentioned earlier, the Article 10.2 of the Government Regulation mentions that the card can only be used two times of cares or rehabilitations. This allows to some potential problems. First, up to the data collection, there was no single national card issued by the government. This means that each institution could issue a card to the addicted patients. The implication is that when they have taken two times of treatments or rehabilitation, they could register them selves to other institution as a new registrant and get a new card. This way they could avoid of being arrested by the police. Second, assuming that MOH attempts to have statistic data on drug addicts in Indonesia, the total statistics will not represents the real number as there are probably some addicts registered in more than one *puskesmas*. Third, it is possible that drug addicts also register to the assigned social IPWL

institutions under the MOSA to get social rehabilitation. The statistical data will be more complicated due to the duplications between the two departments.

As for the medical and social rehabilitations, we found that these two cannot be separated as instructed by the regulation. On the one hand, the representative of the MOH claimed that the medical rehabilitation they provided is not merely medical but also social, and she calls this as a "comprehensive rehabilitation." On the other hand, the representative of MOSA stated that the social IPWL institutions have the same assessment as the medical IPWL do. Moreover the coordinator of a community based social organization (CSO) that is assigned as a social IPWL reported that he, as medical doctor, also provided medical treatment to the addicts coming to his institution. Based on our observations, interview, and discussion with the representatives of both ministries, they seem to have difficulties in getting along together in developing a single program that can clearly distinguish the responsibilities of each of them. For example, if the assessment is more medical, how to arrange that a client coming to a social IPWL can be referred to the nearest medical IPWL (*puskesmas*), so that they do not need to do by them selves. Or, if the medical IPWL assessment shows that a patient needs social rehabilitation, how could they refer him/her to the social IPWL. The head of RSKO stated that departmental arrogances make the two cannot get along together, especially of the department perceives this is a "project" (=money).

The RSKO is located in Cibubur, Jakarta greater area. This is the only hospital, a national referral hospital focusing on drug users/abusers. We were able to interview the head of the hospital who is very well informed about the program.[3] The hospital occupies a large area and has an independent social rehabilitation in the back wing of the hospital. The hospital uses the name of islands in Indonesia to the hospital wings. The social rehabilitation is called *Halmahera,* an island in North Moluccas province. This is one IPWL under the MOH that provides medical and social rehabilitations, the comprehensive rehabilitation. Furthermore, as a drug dependence hospital, RSKO has done what is instructed by the Government Regulation on being an IPWL. All patients who took medical program by the end of 2011[4] were automatically registered in the compulsory program. Different from *puskesmas*, drug addicts who come to the hospital were commonly referred by the Provincial Police Department (POLDA) because the individual has been found to have certain drug problems. In this case, the person will have to follow the judicial procedure as a law case after the assessment is completed. For those who come to the hospital accompanied by their family (parents), they can take rehabilitation program based on the family request. In this case, the head of the hospital claimed that there is no standard procedure for the registration and rehabilitation.

[3] She is now the director of the mental health unit, under the directorate general of health maintenance, Ministry of Health.

[4] Interview was taken on February 2012

One important issue on the rehabilitation is about who pays the cost of rehabilitation. It is known that the monthly fee for taking a rehabilitation program is not cheap and not many families can afford it, especially because the program needs at least 6-7 months duration. Based on the SEMA, a detox and stabilization program needs one month, followed by a primary program that takes 6 months. If the person performs good progress, he/she then needs to take re-entry program for 6 months. For the medical assessment and care, the RSKO receives funding directly from the national budget (APBN) so that they could state that no patient coming to the hospital without being cared. When an assessment is completed, the health provider should evaluate it to develop an intervention plan that has two options: medical or social rehabilitation. This time the hospital has to discuss it with the parents about the plan and the budget.

The implementation of social IPWL, as previously stated, is under the Ministry of Social Affair (MOSA). We were able to visit several community based social organizations (SCO) to observe and interview the persons in charge of the implementation of the compulsory self-registration to the social IPWL. Based on the interview with the officials at the MOSA, we learned that the procedure after the assessment is slightly different from the medical one. As shown in Chart 3, when the assessment concludes that the drug addict needs social rehabilitation, there are two types: institutional and community based. After the client completed either of the two, he/she will need to take continued care.

We visited several community based organizations (CSOs), including the ones recommended by the MOSA as their pilot projects. For example, we visited one MOSA's pilot project on community-based rehabilitation (*Rehabilitasi Berbasis Masyarakat* or RBM) in Cimahi, Bandung. This rehabilitation is under the CSO Siliwangi, so they called RBM Siliwanti as well for the MOSA's project. This place located about 3 hour drive from Jakarta. We found out a misperception about RBM between local people who were in charge in the organization and the officers of MOSA. The fact that this CSO has existed long before the MOSA developed the idea of RBM. Since the this CSO has a number of activities that were what the MOSA think are good to be developed, MOSA provided funding to the CSO Siliwangi for the activities, and then claim it was their pilot project. The CSO did not reject to this claim because they received money form MOSA to support their activities. Some of the activities included trash recycling, motor cycle services, and printing services. All services were done by the ex. drug addicts who want to get normal job and regular income. We also noted that these activities were fully supported by a local key person who paid close attention to them and monitor the sustainability of the services.

As mentioned earlier that MOSA has also social IPWL. Based on the MOSA's regulation (Peraturan Menteri Sosial or Permensos), in 2012 there were 30 social IPWL under MOSA consisting 7 public social organization, 4 religious organization providing social rehabilitation, and the rest were community-based social organizations (CSO) focusing on drug issues and providing social rehabilitation. As mentioned earlier, one of the SCO claimed that they provide medical services, while others refer to the nearest *puskesmas* or a medical doctor to do medical treatments. We tried very hard to visit one of the seven

public social organizations and failed, even after we reported to the officials at MOSA and got help from them to contact the institution. One officer at MOSA noted that this social organization might not receive any drug addict and therefore they started to open people with any problem, such as elderly who need housing. Therefore this organization made us so difficult to visit and see the activities because they do not want us finds the real activities that are not according to the MOSA instruction. Interestingly, the officer at MOSA was unable to monitor and evaluate the organization because these seven public social organizations are directly under the local government, and not under MOSA. Indeed MOSA keeps including them as parts of the social IPWL for the next term. The officer at MOSA claimed that she cannot exclude such public organization because this is part of the governmental joint work.

Conclusion

There are many problems in the implementation of the compulsory self register program and the access to health services for drug addicts. Many claimed that this program is [almost] failed, because the program does not provide clear benefits to the addicts. The join work between the Ministry of Health (MOH) and Ministry of Social Affair (MOSA) is a big challenge and need to find the way to get along together in order to implement the government regulation on the compulsory program. There is a need to clarify the term of narcotic addict along the law and the regulation, because those who take medical treatments and need medical/social rehabilitation mostly were heroin addicts. Those who do not take heroin should not be neglected. Also, those who are not addicted (i.e., drug user for social purpose or for increasing their working stamina) should have the same right to access health services.

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