UNIVERSITY OF INDONESIA

SOCIAL FACTORS ASSOCIATED WITH INJECTING DRUG USE JAKARTA INDONESIA

THESIS

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FACULTY OF PUBLIC HEALTH

PROGRAM MASTER OF PUBLIC HEALTH

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SOCIAL FACTORS ASSOCIATED WITH INJECTING DRUG USE

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THESIS

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STATEMENT OF ORIGINALITY

Thesis is the result of my own work, and all good resources quoted or referenced I stated correctly.

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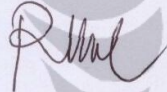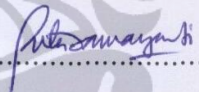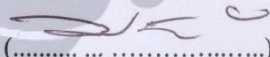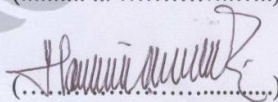
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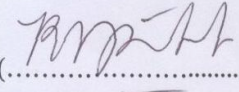
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ABSTRACT

Name   :   Abdul Subor Momand

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Title   :   Social factors associated with injecting drug use_Jakarta

Objective of the study to identify Social and drug related factors associated with injecting drug use among drug users' in Jakarta.

Method the design of the study was cross sectional total respondents were 135 drug users (72 IDUs and 63 None-IDUs) personal, family Social factors, and drug related factors are included in the analysis.

Result Multivariate analysis showed that student are at low risk (AOR=0.09) of using injection than those who are working, also those whose family don't know about his/her drug using habit are at low risk (AOR=0.07) of injection than those whose family member aware, and those who use tranquilizer as first drug are at higher risk (AOR=3.89) of using injection than who use marijuana.

Conclusion Primary prevention activities focusing on improving social conditions, controlling black market of tranquilizers and improving family knowledge and skills to detect drug use in family as early as possible would help drug users to prevent them from indulging in injecting drug use, according to this study job, family and type of drug should be considered in the designing and planning of addicts' treatment and harm reduction activities.

Keywords:

Injecting drug use, Social Factors, Tranquilizers, Jakarta.

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LIST OF ABBREVIATIONS

MoH	Ministry of Health
NNB	National Narcotic Board
UNODC	United Nation Office on Drug and Crime
UNDCP	United Nation office on Drug and Crime Prevention
WHO	World Health Organization
NIDA	National Institute on Drug Abuse of America
IDUs	Injecting Drug Users
DUs	Drug Users
TB	Tuberculosis
HIV	Human Immunosuppressive virus
AIDS	Acquired Immune Deficiency Syndrome
STI	Sexually Transmitted Infection
HCV	Hepatitis C Virus
HBV	Hepatitis B Virus
FSWs	Female Sex Workers
ATS	Amphetamine Type Stimulants
LSD	d-Lysergic acid diethylamide

CHAPTER 1

INTRODUCTION

1.1. Background

Drug Abuse is a worldwide phenomenon, and drug use occurs in almost every country. The specific drug or drugs used varies from country to country and from region to region. Worldwide, the three main drugs of use are cannabis (such as marijuana), opiates (such as heroin), and cocaine. Although individual countries have their own drug laws, in general, drug possession, sale, and use are illegal. The problems associated with drug abuse are 1. Socioeconomic problem: because most of the drug abusers are young people who are more proactive economically and are the back bone of family and society and they become burden on family and society 2. Health care cost increased due to drug abuse, because of overdose, accidents and vulnerability for serious infections such as HIV/AIDS, Hepatitis B&C and TB 3. Crimes: drug abuse increases the crimes in the community.

Estimation made by UNODC suggest that there were between 18 and 38 millions problem drug users aged 15-64 years in 2007 in the world, and among them 11-21 millions are Injecting problem Drug Users. (UNODC, World Drug Report, 2009)

Regarding the global trends in drug use throughout the 1990s, the use of amphetamine-type stimulants (ATS) increased dramatically worldwide. The main regions of use of ATS are in North America, Western Europe, and Asia. By the end of the 1990s, ATS use had stabilized or declined in North America and Western Europe. By contrast, use has continued to increase in Asia. Worldwide, cocaine use has been reported in more than twothirds of all countries. Although the use of cocaine is declining in North America, In Western Europe, cocaine use has continued to rise since 1980. The lowest rates of cocaine use are found in Asia. Law-enforcement efforts have brought down the rate of production in cocaine-producing nations in recent years.

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The use of opiates has been increasing worldwide at an alarming rate, with more than two-thirds of the countries in the world reporting increases. Opiate use is highest in developing nations and nations in transition, while use in developed nations is stable or declining. One possible reason for the increase in use worldwide is that production of opium has increased dramatically. Production of opium has been shifting from Southeast Asia to Southwest Asia. Afghanistan leads the world in opium production, producing 79 percent of the total. Cannabis remains the most widespread drug in use worldwide. The use of cannabis is increasing overall, but in some regions, notably North America, Russia, China, and parts of Asia, use has stabilized or decreased in recent years. Cannabis will probably remain the most widely used drug because the crop is easily grown in many different climates and requires no processing for use as drugs. Opium and opiate drugs are most widely used in Asia. Cocaine use is highest in the United States, but use is also high in other countries throughout the Americas and Europe. In general, rates of cocaine use are higher in more affluent countries. The use of amphetamine-type stimulants is highest in Europe and significant in selected other countries in the Americas. Africa has the lowest overall use of opium, and African rates of cocaine use are low. African countries generally show more amphetamine-type stimulant use than use of opium and cocaine. (Drug Use Around the world, 2000)

Drug abuse is the main and growing problem in Asia, because the main producers of opium are located in Asia due to easy availability the drug user are increasing day by day, the Golden triangle (today the focal point of illicit drug production and trade is known as the 'Golden Triangle') of opium production is located in south east Asia the triangle include Myanmar, Thailand and Laos, Myanmar is the second biggest opium producer after Afghanistan, and the Myanmar opium is imported to Laos and Thailand and other contries, The evidence suggest that drug trafficking, injecting drug use, and HIV infection are woven closely together and that HIV follows drug trafficking routes. Asia had an estimated 7.2 million HIV cases in 2000 making it the world leader in HIV infection after Africa.

Also the Golden crescent of opium producer is located in Asia, the Golden crescent includes Afghanistan, Pakistan, Iran and India, Afghanistan has the highest record of opium production in the world and these opium are transited to neighboring countries Pakistan and Iran, in 1993 Pakistan had 3 million heroin addicts which is the one of the highest addiction rate in the world, India is one of the world's top producers of licit opium. Heroin use has effectively replaced opium and cannabis use. A growing number of people are also using licitly manufactured drugs, in particular codeine based cough syrups and benzodiazepines, which are ingested, snorted and injected, often in combination with illicit drugs like heroin. The main reason for this increase seems to be the lack of uniformity in monitoring compliance with prescription requirements.

Drug abuse in Indonesia the Republic of Indonesia with a 238 million population is the fourth populated country in the world, 3.2 million people in Indonesia use illicit drug with 15,000 dying each year from illegal drug usage, besides 2 out of 10 drug users are involve in small scale drug dealing, 1.5% of the Indonesian population ever abused drug, the 26% experimental users, 27% regular users, 40% of the addicts' are non IDU and 7% are IDU, 60% non student abusers, 40% student abusers, 88% male and 12% are female. 90% of the experimental users are students while regular users and addicts are non student (Drug Abuse survey Indonesia , 2008).

According to the type of drug abused cannabis use by 92% of drug users, shabu (Methamphetamine) 64%, ecstasy 54%, tranquillizers 52%, heroin 32%. Pattern of abuse is poly drug user. Also the same research shows that injecting drug use was the cause of HIV in 49%. (Drug Abuse survey Indonesia , 2008)

Government estimated that there is 200,000 injecting drug users in the country, but the grassroots NGOs estimated that the number to be high, currently 170,000 people are living with HIV in Indonesia, low grade heroin hold in Indonesia in 1990, the rapid in injecting drug user in Indonesia since that time has

led to an increase HIV prevalence over half of those living with HIV are people who inject drugs. (Sara LM Davis et al, 2009)

Fiqure 1 Map of Indonesia

Tabel 1(Comparison of drug abuse between Afghanistan and Indonesia)

Drug user characteristics	Afghanistan	Indonesia	Comments
Prevalence of drug users	920,000 (3.8% of the total population and 8% 0f adult population 14-64)	3.2millions (1.5% of the population)	Afghanistan is the highest opium producer in the world
Cannabis user	520,000 (2.2 % of total population) 56% of drug user	92%	Cannabis or hashish is the main drug used in both countries
Opium user	150,000 (0.6% of total population) 16% of drug users	x	Opium is prevalent in Afghanistan because of availability but not in Indonesia
Heroin user	50,000 (0.2%) 5% of drug users	32%	Heroin user are growing in Afghanistan
Pharmaceuticals	180,000 (0.8%) 19% of drug users	52%	Pharmaceuticals or tranquilizers is prevalent in both countries
Alcohol user	160,000(0.7%) 17% of drug users	x	Alcohol is considered as a problem in Afghanistan
Other drug user	200,000 (0.9%) 21% of drug users	x	Other drug may contain many such as methamphetamine and so on
Methamphetamine	x	64%	Methamphetamine is prevalent in Indonesia but not in Afghanistan.
Ecstasy	x	54%	Ecstasy is not prevalent in Afghanistan, but it is in Indonesia
Injecting drug users	19,000 (2% of drug users)	5.3% (170,000)	

Profile of Indonesia, officially the Republic of Indonesia is a country in Southeast Asia and Oceania. Indonesia comprises 17,508 islands. With a population of around 238 million people, it is the world's fourth most populous country, and has the world's largest population of Muslims. Indonesia is a republic, with an elected legislature and president. The nation's capital city is Jakarta. The country shares land borders with Papua New Guinea, East Timor, and Malaysia. Other neighboring countries include Singapore, Philippines, Australia, and the Indian territory of the Andaman and Nicobar Islands. Indonesia is a founding member of ASEAN and a member of the G-20 major economies. (wiklipedia)

The urban population is 52%, life expectancy is 67years, healthy life expectancy at birth 60y, Adult mortality rate 206/1000, under five mortality rate 41/1000, HIV prevalence (15-49) 2%, prevalence of TB 210/100,000. (WHO, 2010)

Average annual population growth rate is 1.7%, youth literacy rate 98%, area of the country 1,860,360 sq km, Gross National Income(GNI) per capita 1280$, total fertility rate 2.2, Maternal Mortality Rate (MMR) 307/100,000 (11 Health question about SEAR contries).

1.2. Problem statement

As Injecting drug use is the main cause of HIV in Indonesia, half of the people living with HIV are injecting drug users and the IDUs are rapidly growing in the country and the behavior of drug users are changing easily from none injecting to injecting with an alarming rate. In the space of 3 years, IDUs in Jakarta have gone from no reported HIV cases in 1998 to having a prevalence rate of 50% in 2001. Seroprevalence figures for drug users published in June 2005 by WHO, show that prevalence had reached 48% in Jakarta, 53% in Denpasar, Bali, and 24% in West Java (Monica Karst et al, 2006)

Since the number of injecting drug users are increasing and injecting is associated with other serious problems such as HIV, Hepatitis and TB, and drug abuse is a social phenomenon, it is crucial to find the social factors associated with injecting drug use.

1.3. Research question

What are the Social factors (personal, family and drug related) associated with injecting drug use?

1.4. Objectives

1.4.1. General Objective

To explor the Social and drug related factors associated with injecting drug use in Jakarta.

1.4.2. Specifc objectives

o   To determine the association of personal factors (gender, Age, level of education, living condition, job and income) and injecting drug use.

o   To determine the association of family factors (Marital status, having children, parent education level, parent job, awareness of family member and drug use among family) and injecting drug use.

o   To determine the association of drug related factors (Age of first drug use, way of starting, type of first drug use) and injecting drug use.

1.5. Benefit of the Research

- Finding Social factors associated with injecting drug use.
- Evidence based recommendations for HIV and Drug Demand Reduction programs
- Design of evidence based interventions for prevention of injecting drug use in order to prevent HIV and Hepatitis B & C.

1.6. Study Justification

Dependence on drugs has enormous costs for society in terms of direct and indirect health and social consequences human and financial resources lost due to the workplace, road and domestic accidents related to drug abuse, health care costs increases related to diseases that develop in relation to drug dependence (HIV, Hepatitis and other diseases including mental disorders); and social problems including drug-related crimes and deaths due to overdose. The majority of these costs are difficult to quantify, but the few available studies indicate that a direct correlation exists.In the last 25 years, one of the most visible negative consequences of drug dependence has been the spread of HIV/AIDS and it is estimated that more than 10% of all HIV infections worldwide are due to the use of contaminated drug injecting equipments. If Sub-Saharan Africa and the Caribbean are excluded, this rate of injecting drug users rises as high as 30- 40% among those with HIV infection. Among injecting drug users, the rate of hepatitis infection in some places is even higher than HIV. Despite the size of the problem and the enormous costs related to drug abuse, as the number of HIV infection is high in Indonesia and its main cause is injecting drug and control of HIV is one of the MDGs goals indeed to reach this goal one of the invaluable step is to find the causes of injecting drug use and design programs to ameliorate this problem.

CHAPTER 2
LITERATURE REVIEW

The purpose of this section is to review literature related to the study to provide supportive information to the proposed research, in this section it will be explain that what is Narcotic drug, types of drug, Risk factors for drug abuse, Protective factor of drug abuse, route of using drugs, risk associated with drug abuse, prevalence of drug abuse, origin of heroin, complication of persistent heroin usage, related study conducted on social determinants of injecting drug use and transition to injection.

2.1.1   What is Drug?

"For over 13000 years, human used psychoactive drugs for religious, cultural, recreational and medicinal purposes. The rise of illicit drugs as a problem is central to the history of capitalism and colonialism in the nineteenth century when drug notably opium, morphine and heroin become global commodities linked to the power of modern nation" (Campbell et al, 2001, p. 374)

"A psychoactive substance is any substance people take to change either the way they feel, think, or behave. This description covers alcohol and tobacco as well as other natural and manufactured drugs. (Slime et al, 2002).

"Drugs are any chemical substances that effect a physical, mental, emotional, or behavioral change in an individual. " (CIA, 2010)

2.1.2. Types of drugs

Narcotic drugs are of two types natural and synthetics in the past most of the drug were natural but now human is able to make synthetic drugs. (Slime et al, 2002)

a. Natural drugs: these drugs originally have herbal origin and are converted to addictive substances this group includes opium, Heroin, Cocaine, cannabis,

b. Synthetic or man- made drugs: this group includes Ecstasy, LSD,

Drug can be classified according to their psychotropic effects:

a) Depressants they suppress, decrease or inhibit the CNS(Central Nervous System) activity, this group include: alcohol, anesthetic, Sleeping pills, and opioid such as morphine, heroin and methadone (UNODC, 2009)

b) Stimulant**:** agents that activate enhance or increase neural activity in CNS, Amphetamines, cocaine, caffeine, nicotine, and synthetic appetite suppressants fall into this group. (UNODC, 2009)

c) Hallucinogen: are chemical agents that alter our perceptions, thinking, feelings, and sense of time and place. They induce delusions, hallucinations, and paranoia. Hallucinogenic drugs include mescaline (the hallucinogenic substance of the peyote cactus), ketamine, LSD, and psilocybin (the hallucinogenic substance of the psilocybe mushroom), phencyclidine (PCP), some hallucinogenic amphetamines, and marijuana and hashish. (UNODC, 2009)

2.1.3. Epidemiology of drug abuse

According to the world drug report 2010 of UNODC, 155-250 million people in the world using drugs, it consist of 3.5-7.5% of the world population aged 15-64 years, at first the cannabis has been used in large number (129-190 millions), 2nd Amphetamine type stimulants, and 3rd opiate and cocaine. In term of harms associated with used opiate would be ranked at the top. (Chawla et al, 2010)

Figure 2 Global drug users (2008)

Number of People who inject drugs, age 15-64 years: 11-21 million persons

Number of "problem drug users" aged 15-64 years : 16-38 million

Number of people who have used drugs at least once in the past year age 15-64 years: 155-250 million persons

Total number of people aged 15-64 years in 2008: 4,396 million persons
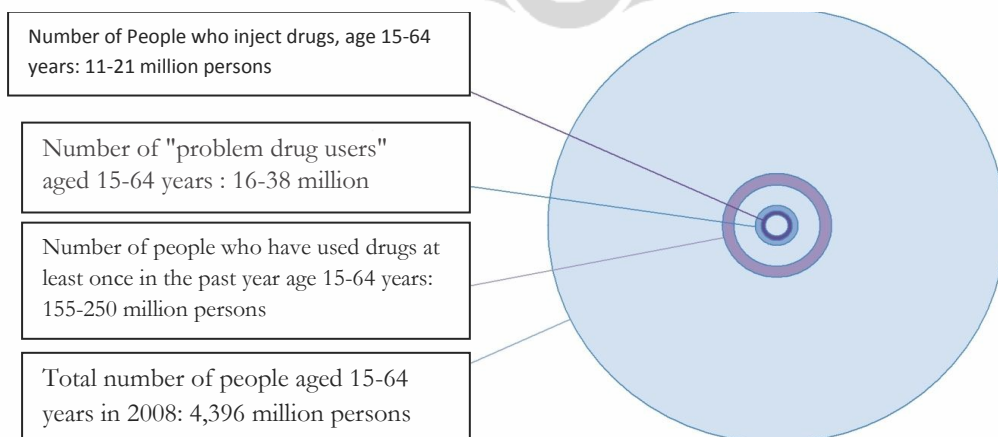
(Chawla et al, 2010)

"In Europe, the prevalence rate of problem drug users varies between 2.7 in Greece and 9.0 in UK as rate per 1,000 population aged 15-64. The United Kingdom, Italy and Spain are on the higher end of the range, whereas Greece, Germany and Hungary are countries with low rates of problem drug use. In the United States, 7 million people - or 2.8% of the population aged 12 and older - were considered substance dependent, abusing illicit substances in 2008. Cannabis was the illicit substance with the highest rate of past year dependence, followed by pain relievers (opioids) and cocaine. In Canada, 2.7% of the population aged 15 and older were reported to have experienced at least one type of harm in the past year due to illicit drug use. 'Harm' in the Canadian reports is classified as harm to physical health, or in the social, employment and legal spheres." (Chawla et al, 2010)

2.1.4. The History of Drug Use

Drugs have played a part in every culture throughout history, whether used for medical, religious, or recreational purposes. Records of cannabis use date back thousands of years; opium use dates back to the beginning of civilization; and the chewing of coca leaves by laborers extends back thousands of years. Drug abuse most certainly occurred in the past, but it was not until people learned how to process and refine drugs that abuse rose dramatically. During the past 100 years, advances in chemistry and pharmacology(the science of drugs) have allowed new drugs to be created from old sources. Opium was processed and refined into morphine and heroin. Coca leaves were processed and refined into cocaine and crack. Amphetamines, a new class of stimulants, were synthesized in the laboratory, as were new hallucinogenic drugs such as LSD, ecstasy, and MDA. These new drugs and refined old drugs are more powerful and addictive than any drugs in the past. While great advances have been made in the creation and use of drugs for medical purposes,use for pleasure has increased sharply. (Drug Use Around the world, 2000)

2.1.5. Common terminology used in the field of drug abuse:

"Drug abuse is the use of any licit or illicit chemical substance that results in physical, mental, emotional, or behavioral impairment in an individual." (CIA, 2010)

Dependency: State of physical and psychological need to continue taking substances dependency is of two types.

Psychological dependency: Continuous desire to take substance

Physical dependency: need to take substance to prevent withdrawal syndrome

Tolerance: The need to use more and more of the substance to experience effects.

Withdrawal syndrome: specific physical symptoms that follow the ending of the heavy use of a substance.

Craving: is an intense desire to reexperience the effects of a psychoactive substance. Craving is the cause of relapse after long periods of abstinence.

Lapse: is the use of drug for some occasions, after abstinence.

Relapse: is a resumption of drug-seeking or drug-taking behavior after a period of abstinence. Priming, environmental cues (people, places, or things associated with past drug use), and stress can trigger intense craving and cause a relapse.

Detoxification: "The process by which an individual is withdrawn from the effects of a sychoactive substance.Detoxification may or may not involve the administration of medication." (Walsh et al, 2008)

2.1.6. Route of using drugs

Drugs can be used in many different ways such as smoking, eating, drinking, chewing, sniffing and Injecting. People can change the route of drug using from one method to another for e.g. from smoking to injecting. Or they can consume drug in different mode in the same time for e.g. Injecting heroin, drinking alcohol and smoking cannabis in poly drug users.

• "Drugs that are commonly smoked or inhaled include tobacco, marijuana,opium, heroin, ATS and glue.

• Drugs that are "chased" include heroin – it is placed on foil and heated and turns into a sticky liquid which wriggles around like a Chinese dragon.Fumes are given off and inhaled through a tube, rolled up newspaper or magazine.

• Drugs that are commonly ingested or swallowed (as in drinking) include alcohol, opium, marijuana, sedatives (e.g. diazepam), ATS and heroin (rarely).

• Cocaine is commonly snorted (inhaling into the nostril).

• Drugs that are commonly injected include heroin, sedatives, ATS (less commonly) and buprenorphine." (Kuma et al, 2008)

2.1.7. Drug abuse and Addiction

Drug abuse is excessive use of drug that is not medically acceptable resulting in repeated problem with work, friendship, family relation, law and mental status.

Dependence syndrome has been defined in ICD10 as "A cluster of physiological, behavioural and cognitive phenomena in which use of a substance or a class of substances takes on a much higher priority for a given individual than other behaviours that once had greater value" The ICD 10 criteria specifies dependence as three or more experiences exhibited at some time during a one year period:

a) **Tolerance** there is a need for significantly increased amounts of the substance to achieve intoxication or the desired effect, or a markedly diminished effect with continued use of the same amount of the substance.

b) **Physiological withdrawal state:** characteristic symptoms experienced on stoppage/reduction of a substace after prolonged use.The patient uses the same (or closely re-lated) substance to relieve or avoid withdrawal symptoms.

C) **Impaired capacity to control substance** use behavior in terms of its onset, termination or level of use as evidenced by the substance being often taken in larger amounts or over a longer period than intended; or by a per-sistent desire or unsuccessful efforts to re-duce or control substance use.

Thus, an individual may find it difficult to avoid using substances at particular place or time or also to limit himself to a par-ticular predetermined amount. Some researchers are of the view that loss of control is the most important criterion determining substance use.

D)   **Preoccupation with substance use**, as manifested by important alternative pleasures or interests being given up or reduced because of substance use; or a great deal of time spent in activities necessary to obtain, take or recover from the effects of the substance.

E) **Continued use inspite of clear evidence of harmful consequences**, as evidenced by continued use when the individual is actually aware, or may be expected to be aware, of the nature and extent of harm.

F) **Strong desire to use substance (craving).**This craving may occur spontaneously or induced by the presence of particular stimuli. Exposure to stimuli where or with whom the individual would have used the substance would lead to a strong desire to consume the substance.

Criteria (a) and (b) are physiological, whilecriteria (c), (d) and (f) are psychological in nature. (Lal et al, 2005)

2.1.8. Harmful use

a) A pattern of substance use that is causing damage to health. The damage may be physical or mental. The diagnosis requires that actual damage should have been caused to the mental or physical health of the user.

b) No concurrent diagnosis of the substance dependence syndrome for the same class of the substance. (Lal et al, 2005)

2.2. Risk and protective factors for drug abuse

A. Risk factors for drug Abuse

The risk factors for using drug is different in different societies, the common risk factors are mentioned as below:

Personal Factors

o **Young age:** young age especially the period of teenage is itself a risk factor, young people are in a constant struggle to establish their identities, and answer questions like, "Who am I? What is my role in society? What do I want to be?" Finding answers to these questions is never an easy thing and it takes some time. Often, during this period, you can start doubting yourself, your ability to achieve and to do things. It is then that you may try to "forget about the world" or "drown your sorrows by abusing different substances. (UNDCP, 2002)

o **Mental Problems:** if a person has mental problem he/she is at risk of using drug, also the using drug also precipitate for mental problems.

o **Undeveloped or underdeveloped personal skills** like the inability to take decisions, to express what (s)he feels, to assert themselves, to solve problems, etc. also put an individual at greater risk of succumbing to substance abuse. (UNDCP, 2002)

o **Personality disorders**

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3. Environmental Factors

Environmental factors that have role or encourage substance abuse are:

o The young person's parents do not know how to look after him/her emotionally, physically or in terms of providing the right kind of support and guidance. (UNDCP, 2002)

o The person does not have a family

o The person's parents, brothers or sisters abuse drugs of any kind

o The young person is being mentally, physically, sexually or verbally abused

o The young person is moving around with a group of people who abuse drugs

o The society that the person is part of has cultural and/or religious values that encourage substance abuse or the media, advertising and attitudes in the society condone abuse.

o The person is homeless and is living with or without his/her family on the streets

o There are few/no opportunities for education

o There is a lot of free unstructured time in which there are no constructive imaginative and challenging activities to take part in

o There are no job opportunities or even the hope of getting a fulfilling job

o Health services are not provided or if they are provided, they are not youth friendly

o There is widespread availability of licit and illicit substances, since laws and regulations that are supposed to discourage or prevent abuse are not stringent or are not enforced. (UNDCP, 2002)

A. Protective factors for drug abuse

1. Personal protective factors

"Well developed personal skills to deal with difficult situations such as an ability to analyse situations, to take quick decisions, to communicate with others, to relax, to negotiate and enter into compromises etc". (UNDCP, 2002)

2. **Environmental Protective factors:**

o **"Good personal connections to people** including family members and friends, animals and things that encourage caring, sharing and bonding. For example, having a friend who is willing to help them out in difficult situations, who has good personal skills, or having a pet that they must look after. In both these cases, one has to learn to be responsible not only for something/one else but for your own self.

o **Adequate resources to meet physical and emotional needs of the person**, e.g. schools, youth friendly health services, social centres with recreational activities, sport facilities, employment opportunities etc.

o **Cultural norms that discourage substance abuse.** For example, Gujarat in India, the State where Gandhi came from, has a long tradition of temperance. Alcohol is prohibited and the community at large does not tolerate intoxication. The extent of drug abuse in this state is much smaller than in other parts of the India.

o **The laws that regulate substance use** are stringent and well enforced and access to licit and illicit drugs is limited or difficult". (UNDCP, 2002)

2.3. Treatment options for drug addiction

To identify drug abuse as earlier and starting treatment is effective both behavioral and pharmacological treatment are effective in order to be most effective both of those treatment should applied. Most of the pharmacological drugs used in the treatment of addictions are as follow:

1. Methadone: methadone join the same receptors as opiate, its sustain release and the patient daily activities are not interrupted.

2. Buprenorphine:

3. Naloxone and Nalotrexone

4. Lefoxidine

Generally the treatment process is divided into three stages/ phases as follow

- o Initial Phase: initial phase is detoxification which usually last 2-4 weeks in this phase the person becomes free from intoxicants.
- o Middle Phase: maintaining the drug free status and initiation of re-integration in to the society this phase lasts 3-6 months.
- o Late phase: healthy life style and alternate coping strategies are thought it last >6 months.

Common modalities used are:

- Agonist
- Antagonist
- Deterrent

Relapse prevention:

"Relapse Prevention is helping patients to:

- Identify high-risk relapse factors and develop strategies to deal with them
- Understand relapse as a process
- Understand and deal with cues related to drug and alcohol use and craving
- Deal with social pressure that causese drugs and alcohol use.
- Develop and enhance a supportive social network
- Develop methods of coping with negative emotional states
- Learn methods to cope with cognitive distortion
- Work towards a balanced lifestyle

In addition, the patients should be assessed for presence of psychiatric disorder and the need for regular follow-up is emphasised." (Lal et al, 2005)

Network therapy: in which friends and family member are in listed to provide continuous support and promote attitude change. (Lal et al, 2005)

Self help group: in these group people with the same problems unite to provide mutual approach.

Social correctional approach: in this type drug abuse is thought as a social deviance and residential programs are offered as correctional approach, such as TC (therapeutic community). (Lal et al, 2005)

Harm Reduction: Harm reduction is the most useful treatment now days because of the high relapse rate in detoxification methods. (Lal et al, 2005)

As the addiction is a chronic and relapsing disorders the main focused should be on prevention aspect of the problem, prevention is more cost effective than cure.

In order to apply a prevention program a comprehensive strategic plan would be develop and the main focus of the prevention program should be young adult, whose are open to more information and they should be prevented from using drugs, we should have school based and street based program to raise the awareness of young people about the drug harms.

2.4.   INJECTING DRUG USE (IDU)
2.2.1. Epidemiology of IDU

  "Among the most problematic drug users are those who inject drugs. The last available estimate of the global number of IDU remains the one developed by the UNODC/UNAIDS reference group in 2008, which estimated that there are 15.9 million people who inject drugs (between 11 – 21.2 million). Of these, 3 million may be living with HIV (range 0.5-5.5 million). EastEurope (1.5%) and Australia and New Zealand (1.03%) have a high prevalence of injecting drug use. In absolute numbers, East Europe has one of the highest numbers of injecting drug users. In East Europe most of the injectors are using opiates, while in Australia and New Zealand, methamphetamine is the main substance being injected." (Chawla et al, 2010)

Drug abuse is one of the top 20 risk factors to health globally, and among the top 10 in developed countries, problems associated with drug use are getting infection such as HIV, Hepatitis and TB and crime, annually 100,000 people losing their lives because of drug use. Along with that drug users can be treated, recovered

and while recover they can contribute to their community. There is need for treatment and prevention programs and decreased the supply of drugs, the real crimes are drug traffickers not users. (UNODC, Promoting Health,Security and Justice, 2010)

2.5. Complication of Injecting Drug Use

Using of drug is associated with higher infection rate, the types of infection related to the route a person has been using his drug.

Tabel 2 Complication of IDU

Injection-related injuries and infections	
Injection-related injuries	• Bruising • Scarring • Swelling and inflammation including urticaria • Venous injury • Arterial injury
Injection-related infections	• Cellulitis and abscess • Thrombophlebitis
Complications of injection-related infections	• Bacteraemia and septicaemia • Musculoskeletal infections • Endovascular complications • Tetanus
Infectious diseases	
	• Sexually transmitted infections • Viral hepatitis (hepatitis B and C) • Respiratory tract infections • Tuberculosis (TB) • HIV/AIDS
Non-infectious disorders	
	• Psychiatric disorders • Substance dependence and substance use- related disorders
Other common health problems	
	• Pain • Constipation • Poor dental condition/hygiene

(UNDCP, 2002)

2.6.   Heroin

*   **Origin**

Heroin is an opioid, a term which refers to all natural, semi synthetic and synthetic substances with chemical structures and pharmacological effects similar to the drug morphine. The production of heroin begins with the extraction of opium from the opium poppy. Shallow incisions are around the center of the poppy pod, and immediately after this liquid opium forms in milky droplets around the cuts the droplets coagulate slowly in contact with the air thickening and turning brown. Liquid opium is generally allowed to dry for 10 or 12 hours before being scraped from the pods. As the raw opium collects on the scraping device, it is removed and placed in an open container so that it may dry further it is then processed in a washing or cooking process from which powder or rock is made.

Opium contains two painkiller alkaloids, codeine and morphine. Morphine that has been extracted from opium can be further refined to create diamorphine or heroin. Heroin is approximately 40 times more powerful than raw opium.
Injection or "mainlining" is favored because the effects of the hit or rush are felt immediately (7-8 seconds), as the heroin rapidly penetrate the blood brain barrier. Heroin can be injected under the skin into the fat muscle subcutaneous (skin popping) or deep into the muscle intramuscularly (IM) although this is not a proffered method of administration as the rush is less intense. The most common injecting site is the forearm and inside elbow, where the veins are closets to the skin and surface.

Heroin users may develop physical and psychological dependence within 14 days, especially if the drug is used daily, after which a withdrawal syndrome begins but remain mild for some time. The body chemistry of the user changes through tolerance (neuro adaptation) and the user may increasingly use the drug to feel normal. (Campbell et al, 2001)

- **Production**

The production and usage of opium and drug back many centuries, according to some references opium production transited from America to Europe and then from Europe it reach to the Asia, in Asia it reach to China and India.

Short History of Opium War: two wars time 1839-1842, 1856-1860.

The first war was between china and British on the trade of opium that China wanted to ban the trade of opium but British want to open it finally British win the war.

The British and French again defeated China in a second opium war in 1856. By the terms of the Treaty of Tientsin (1858) the Chinese opened new ports to trading and allowed foreigners with passports to travel in the interior. Christians gained the right to spread their faith and hold property, thus opening up another means of western penetration. The United States and Russia gained the same privileges in separate treaties. (Wallbank et al)

Shanghai Conference

The international conference on opium trade was conducted in February 1909, in Shanghai of china, in the beginning of twenty century china was the largest opium producer in the world it produced 85% of global opium, the 2nd largest opium producer was India which produce 12% of the world opium, the 3rd was Persia (Today's Islamic Republic of Iran) who produced 1.5% of world opium, Turkey, Laos, Vietnam were in lower level of opium production. (Chawla et al, 2007)

Opium production of Afghanistan was not discussed in Shanghai conference because the production was thought low in Afghanistan. The largest exporter of opium was India, then Honking and in 3rd level Singapore. (Chawla et al, 2007)

"The Shanghai conference revealed the value of approaching drug control multilaterally. India, which was still the world's largest opium exporter, agreed to

end all opium exports to restriction that prohibited its import, thus ending the trade to Philippine ports. Of particular importance was the agreement between the United Kingdom and China negotiated during the preparatory phase of the Shanghai conference, on the basis of which the last chest of Indian opium was publicly burned in Shanghai in January 1919—ending the 300-year Indian-Chinese opium trade". (Chawla et al, 2007)

Hague Conference

The conference took place in the Hague from 1 December 1911 to 23 January 1912, the conference agreed on first international drug control treaty, in addition of opium and morphine Hague added heroin and Cocaine to the list of substance to be controlled. (Chawla et al, 2007)

Heroin, originally known under its chemical name, diacetylmorphine, was first synthesized in **1874** by an English chemist, C. R. Alder Wright, who was experimentally combining morphine with various acids. The drug was rediscovered by the German pharmaceutical company Bayer in 1895 and marketed as a cough suppressant under the name of heroin as from 1898 , quickly gaining market shares around the globe and emerging as the world's most dangerous drug in the twentieth century. (Chawla et al, 2007)

But unfortunately due to the outbreak of First World War the implementation of first drug control treaty had less chance.
In 1st world war the level of drug use in several countries increased also limitation on alcohol also prompted people to use opiate as alternatives.

Thereafter many conventions have conducted such as:

o Drug control under the league of the nation 1920-1945
o The 1925 convention
o The 1931 convention
o The 1936 convention

During the 2nd world war a number of new synthetic drugs of narcotic developed like methadone by Germany in 1973, and pethidine.

From 1946 the United Nation assumed the drug control functions, in 1948 protocol 14 new substance were place under international control by 1951 and a further 6 by 1954. (Chawla et al, 2007)

2.7. Impact of Heroin use

Opium comes from poppy plant and its converted to morphine and morphine is then converted to heroin, heroin can be used in the routes of Injecting, smoking, snorting/snoring, the effects of heroin will occur in injecting after 5-8 seconds, while in smoking it will occur in 10-15 seconds.

Soon after using heroin it crosses the blood brain barrier and heroin is converted to morphine and binds rapidly to the opioid receptors, in the nervous system heroin/morphine has the following effects:

o Opiate can depress breathing by changing neuro chemical activity in the brain system where automatic body functions are controlled.
o Opiate can change the limbic system which controls emotions to increase the feeling of pleasure.
o Opiate can block pain messages transmitted through the spinal cord from the body.

Short term effects of Heroin

- Feeling of pleasure
- Rush
- Warm flushing in the skin
- Drug mouth
- Heavy feeling in extremities
- Nausea, vomiting and sever itching
- Drowsiness
- Clouded of mental functions

- Slow breathing and cardiac functions

Long term effects

- Addiction
- Infectious diseases, for example, HIV/AIDS and hepatitis B and C
- Collapsed veins
- Bacterial infections
- Abscesses
- Infection of heart lining and valves
- Arthritis and other rheumatologic problems

Medical Complications associated with heroin usage:

o Collapse vein
o Bacterial infections of blood vessels and heart valves
o Abscess
o Liver and kidney disease
o Pneumonia and TB
o Hepatitis B & C
o HIV
o STI

(NIDA, 2005)

2.8. Socioeconomic factor and Drug Abuse

Socio demographic

"Statistical socio-economic characteristics or variables of a population, such as age, sex, education level, income level, marital status, occupation, religion, birth rate, death rate, average size of a family, average age at marriage. A census is a collection of the demographic factors associated with every member of a population" (Bussinessdictionary.com)

socioeconomic factors

Social and economic are factors that characterise the individual or group within the social structure.

Socioeconomic factors include income, ethnicity, sense of community and other such factors. (envirohealthhouston.org)

Socio economic factors and drug abuse

General health and well-being, drug-use behaviours and drug-related outcomes are affected in a number of ways by individual socio-economic status and environmental socio-economic factors at both the family and community levels.

☐ Individual socio-economic status: is a determinant of health and of drug-use behaviours. However, this is not a purely individual risk factor. The impacts of individual socio-economic status are related more to relative socioeconomic position than to absolute poverty, and are affected by social and structural variables such as social attitudes towards disadvantaged people and the degree to which supports and services are available.

☐ Family socio-economic status: being raised in a family characterised by low socioeconomic status has been found to contribute to negative outcomes during childhood and later in adulthood. Family disadvantage particularly when combined with other factors such as community disadvantage and/or drug-dependent parents . can result in inter-generational disadvantage and associated negative outcomes.

☐ Community disadvantage: growing up or living in a socio-economically disadvantaged community can contribute to negative outcomes for child development as well as contributing to drug use in adolescence and adult life.

☐ Income inequality: there is ongoing debate about the impact of income inequality at the national, state or local level on health and social outcomes. The evidence is somewhat mixed, and limited in relation to drug-use behaviours and outcomes.

Socio-economic factors can interact or accumulate. The effects of each can be difficult to isolate, particularly as the mechanisms by which socio-economic factors influence druguse behaviours and outcomes can be common to multiple socio-economic factors.

Definitions and indicators

Socio-economic status (or socio-economic position describes a person position in society using criteria such as income, level of education, occupation, value of property owned and so on.

Poverty is defined in both absolute and relative terms. Absolute poverty refers to a state of lacking the most basic requirements of life. Relative poverty refers to lacking the resources required to participate in the lifestyle and consumption patterns enjoyed by others in society. As such, poverty is a multidimensional concept that can include material deprivation, exclusion from social networks and isolation from community life.

Some argue that definitions of poverty should also encompass the notion that poverty is forced onto people, not chosen. Poverty is measured in a number of ways and each method results in markedly different results. As summarised by the Senate Community Affairs References Committee, these include:

☐ income-based poverty lines to measure income poverty, for example, the Henderson poverty line

☐ budget standards to measure the income level needed to afford a clearly defined basket of goods' that is required to maintain a minimum acceptable lifestyle.

☐ consensual approaches using what members of the community think is a minimum necessary income and drawing a poverty line at this point

☐ living standards which attempt to directly measure the living standards of low-income people and compare them to those in the wider community.

Inequality refers to a condition in which separate groups differ in terms of a defined variable. The defined variable can relate to socio-economic status (hence terms such as socio-economic inequality, economic inequality and income inequality)..

Inequity is distinct from inequality, and refers to a situation where inequality is deemed unfair or unjust. The concept of inequity is thus value-laden, as what is considered or essentially influenced by norms and values.

INDIVIDUAL SOCIO-ECONOMIC STATUS

It is now widely accepted that, at this time of history, higher socio-economic status is generally associated with better health. On the basis of reviews of the literature and original research, Lynch and colleagues have drawn the following conclusions:

o   Research has demonstrated a relationship between socio-economic status and many (but not all) disease and mortality outcomes. The relationship between individual-level health outcomes and socio-economic status can vary: This relationship is found for many but not all disease and morbidity outcomes and across many but not all places and over many but not all time period. The heterogeneity in relationships might provide insight into the mechanisms by which socio-economic status and health are related.

o   The relationship between individual-level income and health is an incremental one. That is, with each increment in socio-economic status, there is generally an increment in health status. This is referred to as the social gradient. However, this relationship is not linear: the health benefits of increased socio-economic status become smaller as socio-economic status increases.

o   While the relationship is two-way, in that socio-economic status can contribute to health outcomes and health outcomes can contribute to socio-economic status (for example, poor health can impede the ability to work), longitudinal research has demonstrated that the bulk of the association between socio-economic status and health is in the direction of socio-economic status affecting health.

o   Income at the national level (gross domestic product) has also been found to influence health. For example, data from the World Bank have demonstrated that a national average life expectancy is related to gross domestic product. This relationship is also curvilinear, such that the improvement in health outcomes for

every unit of increase in gross domestic product decreases at higher levels of gross domestic product.

o   Poverty shows a dosenresponse relationship with health as long-term poverty has a greater impact on the health of children and adults than do short periods of poverty.

Conceptual models often include health behaviours such as drug use as one of the mediating factors in the relationship between socio-economic status and health outcomes. That is, socio-economic status is thought to influence health risk factors such as stress, access to resources (healthy food, health services, recreation), and health risk behaviours such as exercise, diet and drug use, which in turn affect health.   Socio- economic status differentials in drug use and drug problems add credibility to these conceptualisations.

Smoking is more prevalent and more frequent, and quitting less successful among people from lower socio-economic backgrounds. A study demonstrates a reduction in the rate of smoking from the lowest (26 per cent) to the highest (18 per cent) socio-economic groups. In addition to being more likely to smoke cigarettes, low socio-economic status smokers tend to smoke more cigarettes per week than higher socio-economic status smokers. This is reflected in comparisons of smokers with no post-school qualifications (114 cigarettes) compared with smokers who do have post-school qualifications (103 cigarettes) or smokers who are unemployed (120 cigarettes) compared with smokers who are employed (106 cigarettes).   Furthermore, the differential socio-economic impacts on smoking commence early in life, as pregnant women are more likely to smoke when they are from low socio- economic status backgrounds than from high socio-economic status backgrounds. While smokers from low socio-economic status backgrounds are just as likely to try to quit smoking, they are less likely to succeed than smokers from higher socio-economic status backgrounds.

Socio-economic status has also been associated with drug-related harms such as foetal alcohol syndrome,   alcohol and drug disorders,   hospital discharges due to diagnoses related to alcoholism (alcohol psychosis,

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alcoholism and alcohol intoxication), alcohol- related deaths, lung cancer, drug overdose and alcohol-related assault.

As discussed by Room, the relationships between socio-economic status and drug use and drug outcomes are neither simple, unidirectional, nor consistent. He described possible complications in any analysis:

1.   Patterns of use or problems by socio-economic status can vary with the measure of drug use (for example, frequency or quantity) or problem. Indeed the socio- economic status relation can be reversed.

2.   Patterns of use or problems by socio-economic status can vary with the measure of socio-economic status used. Room concluded that, all else being equal, income tends to have the strongest positive relation of any inequality indicator to consumption variables, particularly to volume of consumption.

3.   The relation between socio-economic status and substance use pattern can vary within the same country across, for example, age, gender and ethnic groups.

4. The relationship can be mediated by factors such as the social and policy environment.

5. For serious substance-related consequences such as mortality, the effects of different components of socio-economic status may be additive.

 Frequency of drinking

o Frequency of drinking was most clearly related to income for both males and females across all three ages, with more frequent drinking associated with higher income.

o Educational achievement was related to drinking frequency only for men at age 18, such that males with less educational achievement consumed alcohol more frequently than males with higher educational achievement at age 18. This difference did not remain at ages 21 and 26. Educational achievement did not affect drinking frequency among the women studied.

o Occupational activity did not significantly affect drinking frequency among men, but did have an impact among women. Among women two patterns of frequency of use over time emerged. Among the employed, drinking

frequency rose steadily, while among the unemployed and other groups drinking frequency decreased at age 21, then increased at age 26. At all ages, the unemployed group drank more frequently than the other group, while the group with low-status employment drank more frequently than the group with high-status employment.

Quantity consumed per typical occasion of drinking:

o   Quantity of use was not affected by income.

o   Of all of the socio-economic status indicators, educational achievement had   the clearest relationship with quantity of alcohol consumed. The better-educated men and women drank smaller amounts when they drank alcohol than the less-well educated. This difference was found at all three ages.

o   Relationships between the quantity of alcohol consumed and occupation were inconsistent. Occupational activity had no effect on the quantity of alcohol consumed by men. Among women, changes in the quantity of alcohol consumed over time differed between the occupational groups For example, unemployed women drank the most alcohol at age 18 and the least at age 26. Women with lower- status jobs consistently drank more when they drank than women with higher-status jobs.

FAMILY SOCIO-ECONOMIC STATUS

There is a strong body of research demonstrating that child development and health behaviours are affected by socio-economic status in childhood, and that these have impacts on socio-economic status and health in adulthood. Access to material and social resources or reactions to stress-inducing conditions by both the children and their parents are posited as mediating variables. Davey Smith and Lynch described how socio-economic conditions affect health across the life course, and how social circumstances can increase exposure to a variety of risks over the life course, thereby accumulating risk.   They noted that the relationship with socio-economic status varies with the health outcome and with how the relationships between risk factors for health are linked to socio-economic status over the life course, which can depend upon place, time and group:

o   place for example, countries have different social conditions in terms of political systems, economic systems, culture, and so on

o   historical time period for example, in the 1700s location close to sources of infection was a more important indicator of life expectancy than income

o   population subgroup for example, gender.

  With regard to specific outcomes, Davey Smith and Lynch identified that there is a substantial body of literature to demonstrate that childhood socio-economic status (parental occupation and/or education) affects (among other outcomes):

o   child abuse and neglect (Bremne and Vermetten, 2001)

o   psychosocial characteristics such as hostility, hopelessness and depression (Harper et al, 2002; Gilman et al, 2002)

o   psychiatric outcomes (Power and Manor, 1992; Fan and Eaton, 2001; Eaton et al, 2001; Ritsher et al, 2001)

o   health behaviours such as smoking and alcohol consumption.

    That is, socio-economic status contributes to exposure to risk factors (for example, child abuse) for drug abuse and related problems (for example, depression) across the life course. Davey Smith and Lynch suggested that some caution is warranted in asserting this relationship as childhood experience can be mediated by adult experience

COMMUNITY DISADVANTAGE

    Community disadvantage has been associated with numerous health, social and other problems.   Vinson mapped local area disadvantage (unemployment, income) and a range of problems (for example, low birth weight, child abuse, early school leaving, criminal offences, imprisonment, mortality) in Victoria and New South Wales in 1999 and 2003.   Unfortunately, neither drug use nor drug problems were included in the study. However, the study did describe how socio-economic status, health and social problems cluster. Vinson found that low income, disability/sickness, early school leaving, court convictions, long-term unemployment, low skills, unemployment and non- completion of Year 12 were highly intercorrelated and clustered geographically: about 5 per cent of the postcode areas accounted for about 25

per cent of each measure of disadvantage.

There is evidence of increased drug use in disadvantaged communities. For example, Galea and colleguesí review of the social contributors to drug use and misuse (above) identified that neighbourhood socio-economic status contributed to the initiation of illicit drug use and use patterns of alcohol, tobacco and illicit drugs. The United Kingdom Advisory Council on the Misuse of Drugs noted how post-war research in the United States of America and the United Kingdom identified that areas marked by a concentration of economic disadvantage tend to include a multitude of risk factors for drug abuse and social problems. Consequently, they noted, the problems associated with drug misuse and drug markets become problems for the whole neighbourhood. Furthermore, children growing up in such neighbourhoods face disadvantage and incentives to be involved in the drug market: In poor neighbourhoods where young people suffer exclusion from formal opportunities in terms of education and the job market, drugs and crime can offer an alternative means by which to demonstrate status and achievement. Where low level drug dealing is concerned, this can involve significant monetary gains .

INCOME INEQUALITY

The impact of income inequality on health and well-being has been a subject of considerable debate and research in the past decade. In the 1990s the evidence seemed quite convincing that income inequality at a national, state or area level was a significant cause of harm to psychosocial and physical health. However, since then a great deal more sophisticated research has been conducted and it has become apparent that the effects of income inequality are not as robust as first thought. the evidence on the impact of income inequality on drug use is insufficient for firm conclusions at this time.

As a conclusion Socio-economic factors at multiple levels have an association with the aetiology of drug use and exacerbation of problems among drug users. (wales)

3.3. Related studies on Injecting Drug use

1. A study conducted in 1996 in the city of Karachi Pakistan with objective to identify the association of Scio-economic and demographic factors with injecting drug use the total sample of the study were 474 including 242 IDUs and 231 non-IDUs and from the result of the study its concluded that Illegal mode of income, sharing income with family and presence of suicidal thoughts are significantly associated with injecting drug use (A.Agha, 2003).

2. A review of GALEA in 2002 on social determinants and health of drug users concluded that Scio-economic status, Homelessness and incarceration are determinants of injecting drug use (GALEA et al, 2002).

3. A cross sectional survey conducted in Chang Mai of Thailand the total sample of the study was 2,231 drug users admitted to the Northern Drug Treatment Center in Mae Rim, Chiang Mai, Thailand, between February 1, 1999 and December 31, 2000 the objective of the study was risk factors associated with injection initiation from the result of the study its concluded that Young age of starting, single, ever receiving education, urban residence, and having a history of smoking or incarceration were significantly associated with higher likelihood of injection initiation,. those whose first drug was heroin as their initiation drug had greater risk of injection initiation; conversely, those taking amphetamine as their first drug had less risk of injection initiation (Cheng et al, 2006).

4. A case control study conducted in Lahore Pakistan which is published in 2006 the objective of the study was to assess the various correlates of injection of synthetic drugs among drug users in Pakistan, the sample of the study was 141 cases (IDUs synthetics) and 272 control (IDUs using heroin) and its concluded that Young age, living arrangement and presence of friend who inject drug, are associated with IDU, cost of current drug and poly drug use is strongly predictor of IDU of synthetic preparation (Faran et al, 2006).

5. A study conducted mid 2006 in Manipur, Nagaland, north-east India the study was cross sectional and total sample was 200 IDUs the finding of the study

showed that the first injection occurred in the age of 20, and the drug first injected were SP and heroin and all participants know other IDUs, they were unemployed, had drop out of school and living with their parents or other relative (Kermode et al, 2007).

6. a prospective cohort study conducted from march 1996-march 2003 in the New York city on transition to injecting drug use among non injecting and former injector the author investigate the social net work influence and individual susceptibility: the total eligible participant was 579 and 369 (64%) of them are followed among these 369, 160 (43%) were former injector and 209 (57%) were never injectors, the study result conclude that the risk of initiating injection were lower than the risk of resuming injection and social network influence facilitates transition to injection among those susceptible (Alan Neaigus et al, 2006).

7. A cross sectional study conducted from 1999-mid 2000 in Melbourne of Australia, the respondents were 200 heroin users both injectors and non injectors, more than half of the participants switch to injection from smoking and the risk factors for this transition were a longer duration of using heroin, using in public places and being male (Higgs et al, 2008).

8. the study conducted in San Antonio, in Texas the sample of the study were 300 Mexican American, 79% (n=88) never injector and 21% (n=62) former injectors, mean age was 22 years (SD=4.9) the mean age of never injector was 21 years (SD=4.4) lower than former injector (24y, SD=6.2) the mean number of year for education was 9.7, 67% unemployed, 39% of income was from job and the remaining was from other illegal activities. Overall finding of the study support that none injecting users with history of injecting are at greater risk of resuming injection. (Valdez et al, 2007)

9. a study conducted from June 2005 to January 2008 in four cities of Afghanistan Jalalabad, Mazari sharif, Heart and Kabul the sample size of the study was 1078 IDUs and the purpose of the study was to assess prevalence and correlates of syphilis and condom use with female sex workers (FSWs) among male IDUs, the study found that the prevalence of syphilis and condom

use varied significantly by site, high levels of risky sexual behavior were common, and consistent condom use was rare among IDUs in Afghanistan.also its mentioned in the study report that marijuana and smoking has been described for centuries and the administration was eating and smoking, but now the injecting practice is increasing which is a recent trend Dynamic population shifts in the region, largely driven by conflict and drought, have introduced injection use to some Afghans while they were refugees in neighboring countries. Other Afghans in Kabul described reasons for changing from smoking to injecting, including police or social pressure to have a fast, hidden route of drug administration,relative economy of injecting, or peer influence, in a qualitative study. These reasons may not be identical across the country and further study is needed to better elucidate transitions to injecting. (Todd et al, 2010)

10. The studies conducted in the different parts of India realized the following causes for transition from non injecting to injecting heroin use:
    o When heroin is scarce
    o The cost of heroin increased
    o Reduction in purity
    o When police enforcement is vigilant
    o Easy availability of pharmaceuticals in lower cost(pentazosin and Buprenorphine)
    o Peer pressure
    o Quick high
    o Unavailability of heroin
    o Cheaper to produce the same effects as smoking
    o Instantaneous effect of injecting
    o Reduce the frequency of using drugs
    o Increased quantity required for chasing drug
    o Allay withdrawal of brown sugar
    o To reduce time taken in administering (Injecting take less time than chasing)

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o Convenience- injection is easier to administer anywhere

o Chance of kick(rush) from injecting

o Higher euphoria

o Non availability of secure place for chasing

o The immediate relief from withdrawal

(Injecting drug and HIV in India an emerging concern)

11. A study conducted in Baltimore in 1997-1999 the total participants were 276 IDUs between the age of 15-30 years and 144 of these participants were included in the analysis the result of the study conclude that Neighborhood, minority composition and education level are important in explaining the association between age at initiation of injection drug use and race and ethnicity. (Fuller et al, 1999)
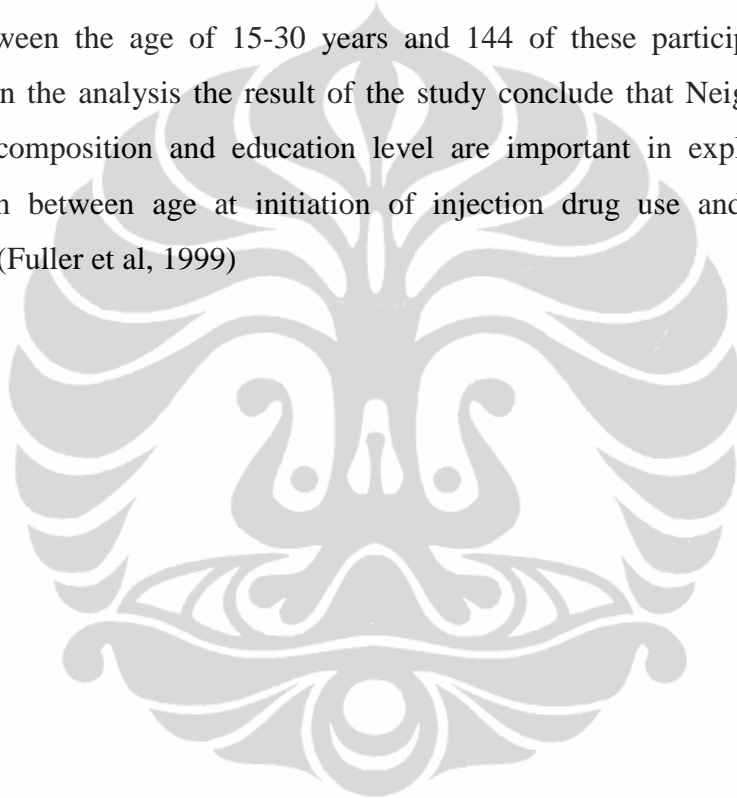
3.4.   Theoretical Model

There are several factors that are related to drug abuse. The model for this study was guided by the Bio-Psycho-Social model. Bio psycho social is general model which insists that biological, psychological and social factors all play a significant role in human functioning in the context of disease or illness. Indeed, health is best understood in terms of a combination of biological, psychological, and social factors rather than purely in biological terms. The biopsychosocial paradigm is also a technical term for the popular concept of the mind–body connection, which addresses more philosophical arguments between the biopsychosocial and biomedical models, rather than their empirical exploration and clinical application.

History of the bio psycho social model

The model was theorized by psychiatrist George L. Engel at the University of Rochester, and putatively discussed in a 1977 article in Science, where he posited "the need for a new medical model"; however no single definitive, irreducible model has been published. However, the general BPS model has guided formulation and testing of models within each professional field. Interestingly, evidence for the application of the biopsychosocial model was found in ancient Asian (2600 B.C.) and Greek (500 B.C.) civilizations prior to Engel's introduction of the theory in 1977. The novelty, acceptance, and prevalence of the biopsychosocial model varies across cultures.

Components of the bio psycho social model

The bio psycho social model/ frame have three main components, Biological, Psychological and Social.

A.   Biological component

Biology is a natural science concerned with the study of life and living organisms, including their structure, function, growth, origin, evolution, distribution, and taxonomy.

The biological component of the biopsychosocial model seeks to understand how the cause of the illness stems from the functioning of the individual's body,

B. Psychological component:

Psychology is a science, an academic, and applied discipline that involves the scientific study of human or animal mental functions and behaviors. The psychological component of the biopsychosocial model looks for potential psychological causes for a health problem such lack of self-control, emotional turmoil, and negative thinking.

C. Social Component:

The term Social refers to a characteristic of living organisms (humans in particular, though biologists also apply the term to populations of other animals). It always refers to the interaction of organisms with other organisms and to their collective co-existence, irrespective of whether they are aware of it or not, and irrespective of whether the interaction is voluntary or involuntary.

The social part of the biopsychosocial model investigates how different social factors such as socioeconomic status, culture, poverty, technology, and religion can influence health.

All the above three components are interrelated to one another, it means that one component can cause the other, for e.g. biological factors can pose psychological or social problem or vice versa, In a philosophical sense, the biopsychosocial model states that the workings of the body can affect the mind, and the workings of the mind can affect the body This means both a direct interaction between mind and body as well as indirect effects through intermediate factors.

The biopsychosocial model presumes that it is important to handle the three together as a growing body of empirical literature suggests that patient perceptions of health and threat of disease, as well as barriers in a patient's social or cultural environment, appear to influence the likelihood that a patient will engage in health-promoting or treatment behaviors, such as medication taking, proper diet, and engaging in physical activity.

While operating from a BPS framework requires that more information be gathered during a consultation, a growing trend in US healthcare (and already well-established in Europe such as in the U.K. & Germany) includes the integration of professional services through integrated disciplinary teams, to provide better care and address the patient's needs at all three levels. As seen, for example in integrated primary care clinics, such as used in the U.K., Germany, U.S. Veteran's Administration, U.S. military, Kaiser Permanente, integrated teams may comprise of physicians, nurses, health psychologists, social workers, and other specialties to address all three aspects of the BPS framework, allowing the physician to focus on predominantly biological mechanisms of the patient's complaints.

Psychosocial factors can cause a biological effect by predisposing the patient to risk factors. An example is that depression by itself may not cause liver problems, but a depressed person may be more likely to have alcohol problems, and therefore liver damage. Perhaps it is this increased risk-taking that leads to an increased likelihood of disease. Most diseases in BPS discussion are such behaviourally-moderated illnesses, with known high risk factors, or so-called "biopsychosocial illnesses/disorders". An example of this is type 2 diabetes, which with the growing prevalence of obesity and physical inactivity, is on course to become a worldwide pandemic.

3.5.   Social Cognitive Theory

As the Biopsychosocial model is based on the social cognitive theory which is mostly used in the field of psychology and Social cognitive theory provides a framework for understanding, predicting, and changing human behavior. The theory identifies human behavior as an interaction of personal factors, behavior, and the environment (Bandura 1977; Bandura 1986).

The interaction between the person and the environment involves human beliefs and cognitive competencies that are developed and modified by social influences and structures within the environment. The third interaction, between the environment and behavior, involves a person's behavior determining the

aspects of their environment and in turn their behavior is modified by that environment.

According to Jones (1989) "the fact that behavior varies from situation to situation may not necessarily mean that behavior is controlled by situations but rather that the person is construing the situations differently and thus the same set of stimuli may provoke different responses from different people or from the same person at different times."

In conclusion, social cognitive theory is helpful for understanding and predicting both individual and group behavior and identifying methods in which behavior can be modified or changed.
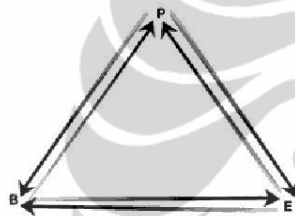
Fiqure 3 Cognitive theory image

Diagram/schematic of theory

Social Cognitive Theory: B represents behavior, P represents personal factors in the form of cognitive, affective, and biological events, and E represents the external environment. Source: Bandura (1986)

CAPTER 3

THERORETICAL FRAMEWORK

Fiqure 4 Theoretical framework

```
┌─────────────────────────────┐
│        Biological           │
│                             │
│  • Neurology                │
│  • Genetics                 │
│  • Physical condition       │
│  • Personality              │
│  • Function of the individual of │
│    the body                 │
└─────────────────────────────┘

┌─────────────────────────────┐
│       Psychological         │
│                             │
│  • Emotion                  │
│  • Violation                │
│  • Thought                  │       ┌──────────────────┐
│  • Defense                  │──────▶│  Mental Problem  │
│  • Copying                  │       └──────────────────┘
│  • Self control             │
│  • Negative thinking        │
└─────────────────────────────┘

┌─────────────────────────────┐
│          Social             │
│                             │
│  • Childhood                │
│  • Family life              │
│  • Social trauma            │
│  • Stress                   │
│  • Socioeconomic status     │
│  • Culture                  │
│  • Poverty                  │
│  • Technology               │
│  • Religion                 │
└─────────────────────────────┘
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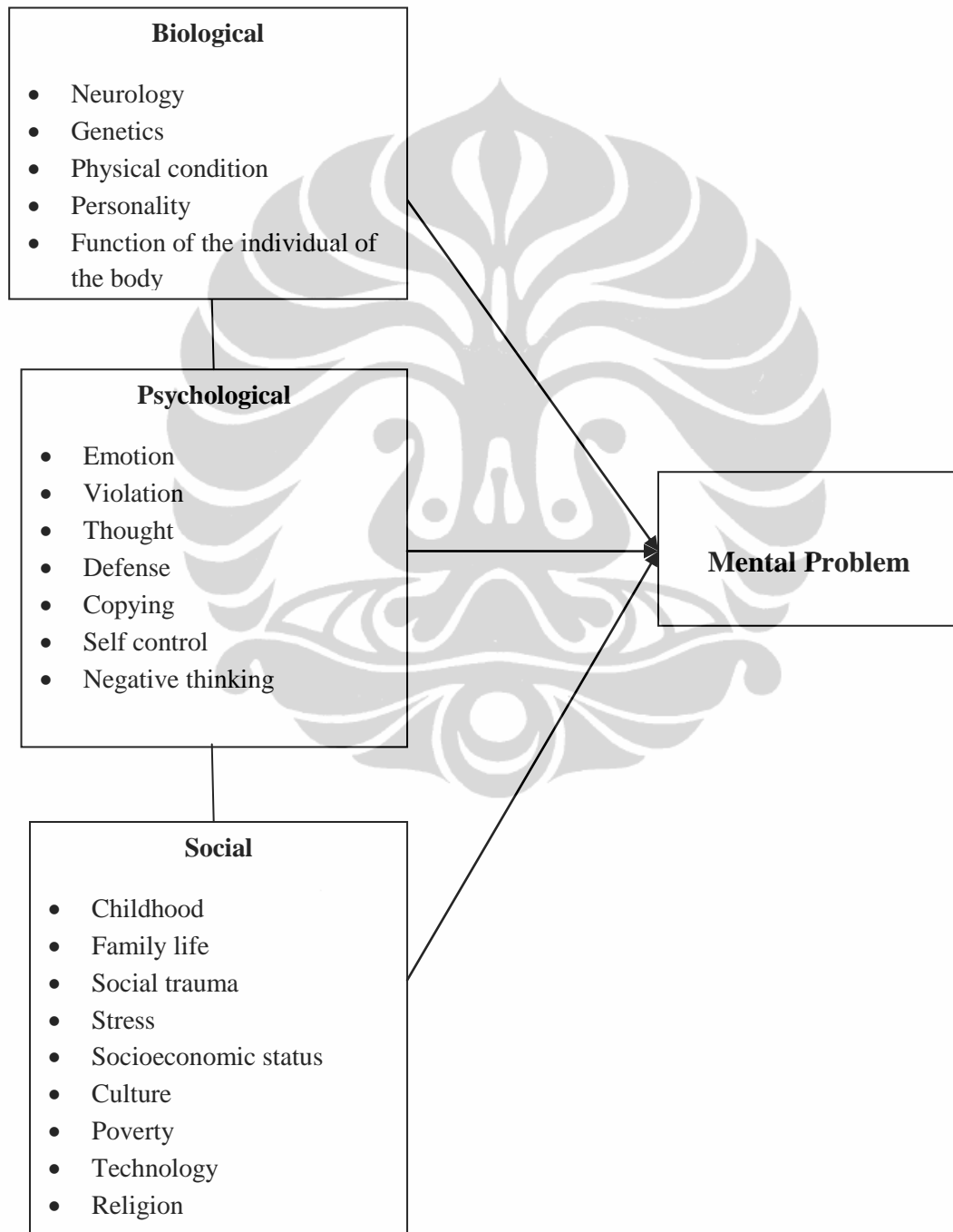
As drug abuse is one of the mental health problems and most mental problems are comprehensively described by the bio-psycho-social model, the initiation of drug by non-injecting or injecting route are related to bio-psycho-social factors that these factors are interrelated and interconnected, which are predisposing for each others for instance a patient with psychiatric disorder may initiate drug after the psychiatric disorder or the drug may cause the psychiatric disorder in patient.

The bio-psycho-social factors might cause non injecting or injecting drug use, or these factors might cause non-injecting drug use and as by starting drug the problem will not solve but will deteriorate then later on the patient may not able to cope with these increasing problem and he will start more risky behaviors such starting drug by injecting route.
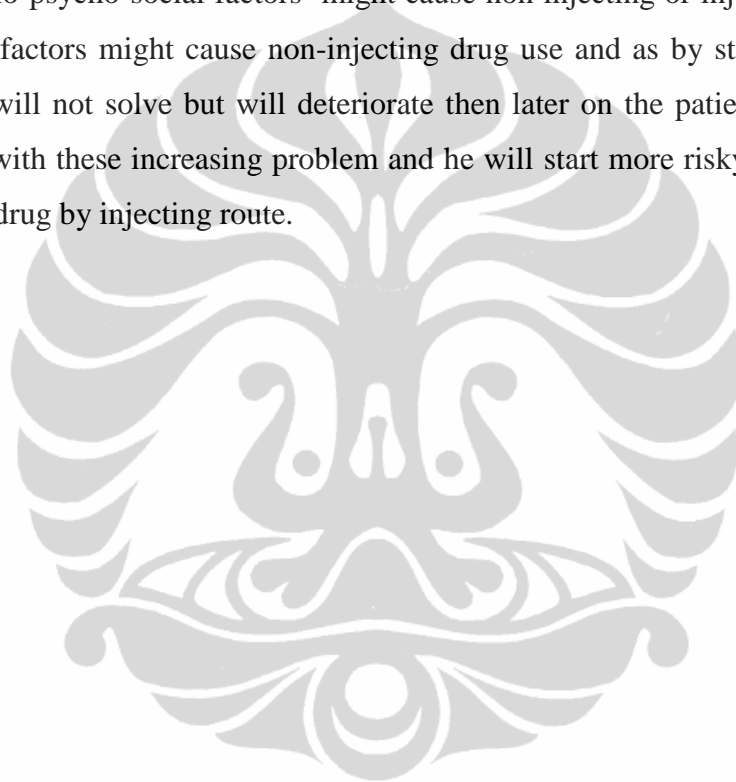
3.2 Conceptual framework

Fiqure 5 Conceptual framework

Social Factors

Personal:

- Gender
- Age
- Level of education
- Living condition
- Income/Job

Social Factors

Family:

- Marital status
- Having children
- Parents education level
- Parents job
- Knowing of family member
- Drug use among family member

Injecting drug use (Yes/NO)

Drug related Factors

- Age of first drug use
- Way of starting drug(smoking/Drinking)
- Type of drug used first
- History of drug use

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The conceptual framework is based on the Social part of the biopsychosocial model and it shows that personal social factors, Family social factors and drug related factors have influence on the route of drug use.

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3.3 Variables

3.3.1 Independent Variable

1. Personal factors   2. Family Factors   3. Drug related

o **Gender**	**- having children**	**- Way of starting drug**
o **Age**	**- Parent education level**	**- Age of first drug use**
o **Level of education**	**- Parent job**	**- Type of first drug use**
o **Living condition**	**- knowing of family members**	**- History of drug used**
o **Income**	**- drug use among family members**	
o **Main Job**	**- Marital status**	

3.3.2 Dependent Variable

Dependent variable in this study is ever used drug by injection (Yes/No).

3.3.3 Operational definition of variables

Tabel 3 Operational definition of variables

Conceptual definition of variable	Operational definition	scale	Scale of measurement	
Dependent variable:				
P2.17 Use of injection	used drug by injection	Yes No	Categorical	
Independent variables:				
P1.1 Age	Age of respondent	• <20 • 20-30 • >30	Categorical	ordinal
P1.2 Sex	Sex of the respondent	• Male • Female	Categorical	Nominal
P1.4 Education level	latest educational background of respondent	• Low • High	Categorical	Ordinal
P1.5 Marital status	Marital status at the moment	• unmarried • Married	Categorical	Nominal

		• Divorced		
P1.6 Children	Having children	Yes No	Categorical	Nominal
P1.9 Living place	living place	• Own , parent • Rented and others	Categorical	Ordinal
P1.12 Parents education level	parents educational background	• Low • High	Categorical	Ordinal
P1.13 Parent job	Parents job	• Not working • working	Categorical	ordinal
P1.14 Type of Job	current job and income	• Not • Student • Working	Categorical	Ordinal
P2.1 Smoking	smoke and time of smoking	Yes No	Categorical	Ordinal
P2.5 Drinking	Ever drink alcohols and age of consuming	Yes No	Categorical	Ordinal
P2.8 Experience of drug	Experiences of drug used from the first time up to now	• Marijuana • Sedative • others	Categorical	Nominal
P2.14 Knowing of family member	Knowing of family member about drug use within family	• Yes • No	Categorical	Nominal
P2.16 Family member use drug	Family member who ever used drugs.	Father Mother Children Brother/sister	Categorical	Nominal
P2.22 Time of injection	Time of started injection	• <=2000 • >2000	Numerical	Discrete

3.3.4. Hypothesis

1.   There is association between personal social factors (Gender, Age, Education level, living condition, income and Job) and injecting drug use.

2.   There is association between Family factors (Marital status, having children, parent education level, parent job, awareness of family from the drug using habit and drug use among family) and injecting drug use.

3.   There is association between drug related factors (Age of first drug use, way of starting drug, and type of first drug use) and injecting drug use.

CHAPTER 4

METHODOLOGY

This chapter describe the methodology of the study, including research design, selection method, study population, sample description, sample size and calculation technique, site of the study and instruments involved in data collection and procedure of data analysis.

4.1. Research Design

The study design is cross sectional and secondary data is used from the research conducted in 2008 by the health research center of the University of Indonesia and National Narcotic Board of Indonesia.

4.1.1 Study Site

The study place is the Jakarta city of Indonesia, which is the most populated city in the country.

Fiqure 6 Map of Jakarta

4.1.2 Target population

The target population is the drug users both injecting and none injecting who are interviewed for the drug abuse survey Indonesia 2008.

4.2 Study population and Sample

4.2.1 Sample specification:

The selected sample from the previous survey is used, which consists of 135 respondents both IDUs and none IDUs.

4.2.2. Sample size calculation and technique

Simple size is calculated based on below formula:

The Baltimore prospective study conducted between July 1997 – May 1999 shows that the education level has influence on injection initiation and its shows that drug user with less than high school were 60% IDUs and high school and more than high school were 40% IDUs.

Formula for Sample Size calculation

$$ n = \frac{\left\{ z_{1-\alpha/2}\sqrt{2\overline{P}(1-\overline{P})} + z_{1-\beta}\sqrt{P_1(1-P_1) + P_2(1-P_2)} \right\}^2}{\left(P_1 - P_2\right)^2} $$

P1 (Anticipated population proportion-1) = 0.40   (IDUs among high school and more education group-Baltimore)

P2 (Anticipated population proportion-2) = 0.60   (IDUs among less than high school group- Baltimore)

a (level of significance %) = 5

1-β (Power of the test) = 90

Z 1-a/2 (critical value) = 1.960

n (sample size) = 130

The required sample size for the study is 130, but for more precision of the study all 135 respondents of the primary study will included in the analysis.

4.2.3. Ethical consideration:

The survey already certified by the health research center of the University of Indonesia.

4.3 Data collection

4.3.1 Method

The method of data collection was the interview technique the structure questionnaire is used; the respondents are drug users who are selected by sample random sampling.

4.3.2 Research Instruments

The instrument used for data collection is the structured questionnaire the questionnaire consist of 11 parts including respondent identity, respondent characteristics, drug using pattern, sex and drug abuse, the impact of drug abuse, medical treatment, criminality and circulation (questionnaire is attached in appendix-2)

Part-1: Respondent identity & characteristics

This part include information about personal, demographic and social situation of the respondent such as age, living situation of the respondent, marital status, having children and their arrangement, education level and job status.

Part-2: Drug using pattern

This part include information about drug use, smoking and drinking behavior, experience of different drugs, price of drug, drug use among family member, drug used by injection, types of drug used by injection, average injections used per day and sharing of injection equipment.

Part-3: Sex and drug abuse

Sexual behaviors and risks, type of drug arouse sex and preventive measure taken for sexual risk such as condom use.

Part-4: The impact of drug abuse

This part of the questionnaire collect information about the symptoms the user has had, the treatment seeking behavior, financial support for treatment, result of diagnosis, accompanied by someone, and overdose time and treatment.

Part-5: Medical treatment:

This part assesses information about the detoxification & rehabilitation treatment method that patient ever attend these sort of treatment and what was the result, who accompanied him, and the self treatment struggle by himself by using traditional medicines or recipe.

Part-6: criminality and circulation:

In this part of the questionnaire most of the questions are related to involving in drug selling and offer of drug to others and the role of drug use in the crash accident.

4.3   Data management and analysis

After coding and cleaning the data analysis is done by SPSS soft ware-version-13 and the statistics used for analysis are describing frequencies, cross tabulation, chi square, and logistic regression.

Chi-square is a statistical test commonly used to compare observed data with data we would expect to obtain according to a specific hypothesis

Logistic regression (sometimes called the logistic model or logit model) is used for prediction of the probability of occurrence of an event by fitting data to a logit function logistic curve.

Odd ratio is a relative measure of risk, telling us how much more likely it is that someone who is exposed to the factor under study will develop the outcome as compared to someone who is not exposed.

CHAPTER 5
RESULTS OF THE STUDY

The cross sectional study was conducted in 17 provinces of Indonesia by the health research center of the University of Indonesia supported by the National Narcotic Board of Indonesia in 2008, the data of the Jakarta city collected from 135 drug users by face to face interview and structure questionnaire has been used as a secondary data for this study in order to identify the influence of social factors on injecting drug use.

5.1 Descriptive Information

This part of the results presented by the form of tables using descriptive statistics (frequency and percentage distribution, mean, and standard deviation) about personal characteristics, Family factors, drug related factors, drug using pattern and history of drug use of the respondents.

5.1.1   Description of Personal Social factors

Table 5 shows that regarding to gender most of the respondents were male (84.4%), the mean age was 25.7 years with SD of 5.6 years, minimum age was 16 and maximum 45 years, most of them (67.4%) were between 20-30 years old. Regarding the education level, three quarter of them (75.7%) have had the education of high school and university which is considered as high education level. More than three quarter (77.8%) of them were living in their own, parents or relative houses. With income variable, half of the drug users (52.6%) answered that they have no income, and half of them declared that they are receiving money on regular basis from someone (53.3%). According to the main job of the respondents less than half (47.4%) had job and the remaining were not working or students.

Tabel 4 Description of the respondents by personal Social factors (n=135)

Personal Social factors	n	%
Gender		
Male	114	84.4
Female	21	15.6
Age group in year		
<20	16	11.9
20-30	91	67.4
>30	28	20.7
Mean &SD=25.7 $\pm$ 5.6		
Education level of the respondent		
Low	33	24.4
High	102	75.6
Living place		
Rented and other house	30	22.2
Own and relative house	105	77.8
Income from main job		
No income	71	52.6
Low income	20	14.8
High income	44	32.6
Receiving money from someone		
Yes	72	53.3
No	63	46.7
Main Job of the respondent		
Not working	37	27.4
Student	34	25.2
Working	64	47.4

5.1.2 **Description of Family Social factors**

Table 6 shows that 65.2% of the respondents were unmarried, 26.7% were married and only one quarter (24.4%) had children.

Around 69% of fathers had high education level and more than half (58.5%) of the mothers had high education level consisted of high school and university. With respect to parent job two third of the drug users' fathers were working (77%) while only 31.9% of the mothers had employment.

Three quarter of the respondents (74.1%) answered that their family knows that they are using drug, more than half (57%) of the respondents' father knows that his child is using drug while 72% of the mother knows about her child drug using habit, most of the younger brother/sister were aware about the respondents drug using habit (76%).

Regarding relative most of the respondents answered that their relative don't know about their drug using habit (65%)

With drug use among family member most of them (65.2%) answered that their family member are not using drug, and only 33.3% answered that their family member are also using drug and most of them were younger brother and sister.

Tabel 5 Description of family factors (n=135)

Family Social factors	n	%
Marital status		
Divorce	11	8.1
Married	36	26.7
Unmarried	88	65.2
Having children		
Yes	33	24.4
No	102	75.6
Father educational level		
Low	37	27.4
High	93	68.9
Mother Educational level		
Low	52	38.5
High	79	58.5
Father Job		
Not working	31	23
Working	104	77
Mother Job		
Not working	92	68.1
Working	43	31.9
Family member knows about the respondent drug use		
Yes	100	74.1
No	34	25.2
Father knows		
Yes	57	57
No	43	43
Mother knows		
Yes	72	72
No	28	28
Younger brother/sister knows		
Yes	76	76
No	24	24
Relative knows		
Yes	35	35
No	65	65
Other family member use drug		
Yes	45	33.3
No	88	65.2
Younger Brother and sister also use drug		
Yes	30	66.7
No	15	33.3
Brother/ relative also used drug		
Yes	15	33.3
No	30	66.7

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5.1.3 Description of drug related factors

Table 7 shows regarding the history of smoking all the drug users (100%) were smokers. Half of them (51.9%) started smoking in the stage of early adolescent between the ages of 12-14 years; the mean age of starting smoking was 12.8 years with SD 2.3 years.

Almost all (97.8%) answered that they drink alcohol, and most of them (68.1%) has used alcohol before the age of 16 years and the mean age of first alcohol use was 14.7 years with SD of 3.0 years. also most of them 87.4% used alcohol in the last 6-8 months.

Regarding the type of first drug use most of them (68.1%) started drug from using Ganja.

Tabel 6 . Description of drug related factors (n=135)

Drug related factors	n	%
History of smoking		
Yes	135	100
No	0	0
Age of first smoking		
<12	36	26.7
12-14	70	51.9
15+	29	21.5
Mean & SD = 12.8 $\pm$ 2.3		
Use of alcohol		
Yes	132	97.8
No	3	2.2
Age of first use Alcohol		
<16	92	70.8
>=16	38	29.2
Mean & SD = 14.7 $\pm$ 3.0		
Last month use alcohol		
>6	11	8.1
6-8	118	87.4
<8	6	4.4
Type of first drug use		
Ganja	92	68.1
Tranquilizer	28	20.7
Others	15	11.1

5.1.4 Description of drug using pattern

Among the sample of 135 drug users more than half (53.3%) were ever used drug by the route of injection, consist of 72 drug users and among these 72 most of them (68%) has shared needle with others, and 64.8% of them started injection prior 8 years, the mean age of starting injection was 18.1 years with SD 3.2 years and most of them were between 15-18 years. Also three quarter of them was using injection between 1-3 times per day.

Tabel 7 Description of drug using pattern

Drug using pattern	n	%
Ever used drug by injection		
Yes	72	53.3
No	63	46.7
n = 72 ever used drug by injection		
Ever shared needle		
Yes	49	68
No	23	32
Length of started injection		
>8 years	46	64.8
<=8 years	25	35.2
Age of starting injection (year)		
<15	6	8.5
15-18	38	53.5
>18	27	38
Mean &SD = 18.1 ± 3.2		
Times of using injection/day		
1-3	29	74.3
4-6	7	17.9
7-9	3	7.7

5.1.5 History of Drug Experience

Reference to table 9 the respondents are asked about the experience of drug they used from first time up to now, in other word the drug they used in their life time. Almost all (94.8%) has used marijuana; hashish is only used by 8.9%. Cocaine was also used by less number of respondents (8.9%); most of them (71.9%) have the experience of methamphetamine.

Also more than half of them (53.3%) have used ecstasy; however the heroin was used by less number of them (11.1%). Most of them had the experience of using heroin powder (60%), meantime heroin liquid only used by 2.2%, tranquilizers user were also more (63%), while LSD was used by 7.4%, and 9.6% used mushroom, and number of respondents who experienced the type of other drug were 5.2%, and among the sample only 4.4% had the experience of drug inhalation.

Tabel 8 Description of history of drug use

History of drug used	n	%
Ever used Marijuana		
Yes	128	94.8
No	7	5.2
Ever used Hashish		
Yes	12	8.9
No	123	91.1
Ever used cocaine		
Yes	12	8.9
No	123	91.1
Ever used Methamphetamine		
Yes	97	71.9
No	38	28.1
Ever used Ecstasy		
Yes	72	53.3
No	63	46.7
Ever used Heroin		
Yes	15	11.1
No	120	88.9
Ever used Heroin power		
Yes	81	60
No	54	40
Ever used liquid Heroin		
Yes	3	2.2
No	123	97.8
Ever used Tranquilizer		
Yes	85	63
No	50	37
Ever used LSD		
Yes	10	7.4
No	125	92.6
Ever used Mushroom		
Yes	13	9.6
No	122	90.4
Ever inhaled/ breathe		
Yes	6	4.4
No	129	95.6
Ever used drugs other type		
Yes	7	5.2
No	128	94.8

5.2 Association between Social, drug related factors and IDUs

This part of the result presents the association between personal, family Social factors, Drug related factors, Drug using pattern, experience of drug and injecting drug use, chi-square test (Pearson and fisher exact tests) are used to describe the association between independents and dependent variables.

5.2.1 . Association between personal Social factors and IDUs

Table 10 shows that with respect to gender however there was no any association (p-value=0.236) between the gender and injecting drug use, but the injection use was higher among female (66.7%).

Regarding to age there was association (p-value=0.000) between age and injecting drug use. 71.4% of drug users more than 30 years old has used the drug mostly by the route of injection, half (51%) of the drug user were between 20-30 years old use the drug by injection, the drug user less than 20 years old were only 6.3% IDUs, the risk of IDUs is higher in the old age group those who were more than 30 years.

According to education level from fisher exact test analysis there was no association (P=0.074) between education level and route of drug use, however among the high educated drug users more than half (57.8%) were IDUs and in low educated drug users around 40% were IDUs.

Also there was no association between living place and injecting drug use (P= 0.416), injecting drug use were higher among those who live in their own, parent or relative houses (55.2%). According to the job also there was association (p=0.000) between injecting drug use and job, among the not working group more than three quarter (78.4%) were IDUs.

Regarding to respondents income IDUs were higher in the low income group (60%). Also the respondents are asked about receiving money from someone those who didn't receive were more IDUs (63.3%).

Tabel 9 Association of personal Social factors and injecting drug use

Personal Social Factors	Total Sample	IDUs		Non IDUs		P-Value
		n	%	n	%	
Gender						**0.236**
Male	114	58	50.9	56	49.1	
Female	21	14	66.7	7	33.3	
Age group in years						**0.000**
<20	16	1	6.3	15	93.8	
20-30	91	51	56	40	44	
>30	28	20	71.4	8	28.6	
Level of Education						**0.074**
Low	33	13	39.4	20	60.6	
High	102	59	57.8	43	42.2	
Still in school today						**0.000**
Yes	34	4	11.8	30	88.2	
No	101	68	67.3	33	32.7	
Living place						**0.416**
Rented house and other	30	14	46.7	16	53.3	
Own, parent, relative	105	58	55.2	47	44.8	
Main Job						**0.000**
Not working	37	29	78.4	8	21.6	
Student	34	5	14.7	29	85.3	
Working	64	38	59.4	26	40.6	
Income						**0.409**
No	71	34	47.9	37	52.1	
Low	20	12	60	8	40	
High	44	26	59.1	18	40.9	
Receive money from someone						**0.167**
Yes	72	34	47.2	38	52.8	
No	63	38	63.3	25	39.7	

5.2.2 Association between Family Social factors and IDUs

Table 11 shows with respect to the marital status from Pearson chi-square analysis there was association between marital status and injecting drug use (p=0.000) and the prevalence of IDUs were higher among the divorce group. There was association (P=0.005) between having children and IDUs those who had children were three quarter IDUs (75.8%). Also there was association (P=0.000) between the family member knows about the respondent drug using habit and Injecting Drug Use (IDU), the injection used more by the respondents whose family member know that he is using drug (79.2%).

From fisher exact test analysis there was no association (P-value = 0.583) between drug use among family members and injecting drug use, however among those whose family member also use drug 57.8% were IDUs.

Also there was no association between parents' education level and injecting drug use. It was also found that parents' current job has no association with injecting drug use among their children while IDUs were more among those whose father were not working (67.7%).

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Tabel 10 Association of family Social factors and injecting drug use

Family Social Factors	Total Sample	IDUs		Non IDUS		P-Value
		n	%	n	%	
Marital Status						**0.000**
Unmarried	87	36	41.9	52	59.1	
Married	36	25	69.4	11	30.6	
Divorce	11	11	100	0	0	
Having children						**0.005**
Yes	33	25	75.8	8	24.2	
No	102	47	46.1	55	53.9	
Family member knows						**0.000**
Yes	100	67	67	33	33	
No	34	5	14.3	29	85.7	
Other family member also use drug						**0.583**
Yes	45	26	57.8	19	42.2	
No	88	45	51.1	43	48.9	
Younger brother/sister use drug						**0.347**
Yes	30	19	63.3	11	36.7	
No	15	7	46.7	8	53.3	
Brother/relative use drug						**0.116**
Yes	15	6	40	9	60	
No	30	20	66.7	10	33.3	
Father education level						**0.100**
Low	37	20	54.1	17	45.9	
High	93	51	54.8	42	45.2	
Mother education level						**0.858**
Low	52	29	55.8	23	44.2	
High	79	42	53.2	37	46.8	
Father current job						**0.100**
Not working	31	21	67.7	10	23.3	
Working	104	51	49	53	51	
Mother current job						**1.000**
Not working	92	49	53.3	43	46.7	
Working	43	23	53.5	20	46.5	

5.2.3 Drug related factors and its association with IDU

Table 12 regarding to the age of first smoking those who start smoking between the age of 12-14 years old were more IDUs (58.6%) however the finding is not significant (p-value = 0.295).

There was no association between drinking alcohol and injecting drug use (P-value=1.000). Regarding to the Age of first drinking those who start drinking after the age of 16 years old were more IDUs (57.9%) the finding is not significant (P-value=0.583).

There was association (P-value=0.001) between the last time drinking alcohol and injecting drug use those who drank alcohol before 2008 were more using injection 83.3%.

According to the type of first drug used among those who used tranquilizers were more IDUs (71.4%) P-value = 0.062.

Tabel 11 Association between drugs related factors and injecting drug use

Drug related factors	Total Sample	IDUs		Non IDUs		P-Value
		n	%	n	%	
Age of first smoking						**0.295**
<12	36	19	52.8	17	47.2	
12-14	70	41	58.6	29	41.14	
15+	29	12	41.4	17	58.6	
Ever drink alcohol						**1.00**
Yes	132	70	53	62	47	
No	3	2	66.7	1	33.3	
Age of first drinking						**0.563**
<16	92	47	51.1	45	48.9	
16+	38	22	57.9	16	42.1	
Last time drink alcohol						**0.001**
<2008	24	20	83.3	4	16.7	
2008+	105	49	46.7	56	53.3	
Type of first drug used						**0.062**
Ganja	92	43	46.7	49	53.3	
Sedatives	28	20	71.4	8	28.6	
Others	15	9	60	6	40	

5.2.4 **Associations between history of type of drug use and IDUs**

In the P2.8 section of the questionnaire the respondents are asked about the use of drugs they experience form first time up to now, and in cross tabulation analysis and fisher exact test it's explored that there is no association (p-value=0.448) between usage of marijuana and injecting drug use those who use marijuana 52.3% become IDUs and those who don't use marijuana 71.4% were IDUs. There was association (0.000) between using hashish and IDUs, also those who used cocaine were 91.7% IDUs (P-value = 0.005).

Those who use methamphetamine were more IDUs (P-value=0.000), also there was association between IDUs and use of Ecstasy, Heroin, heroin powder, LSD, and there was no association between heroin liquid, tranquilizer, Mushroom, and use of other drugs with using injecting drug use.
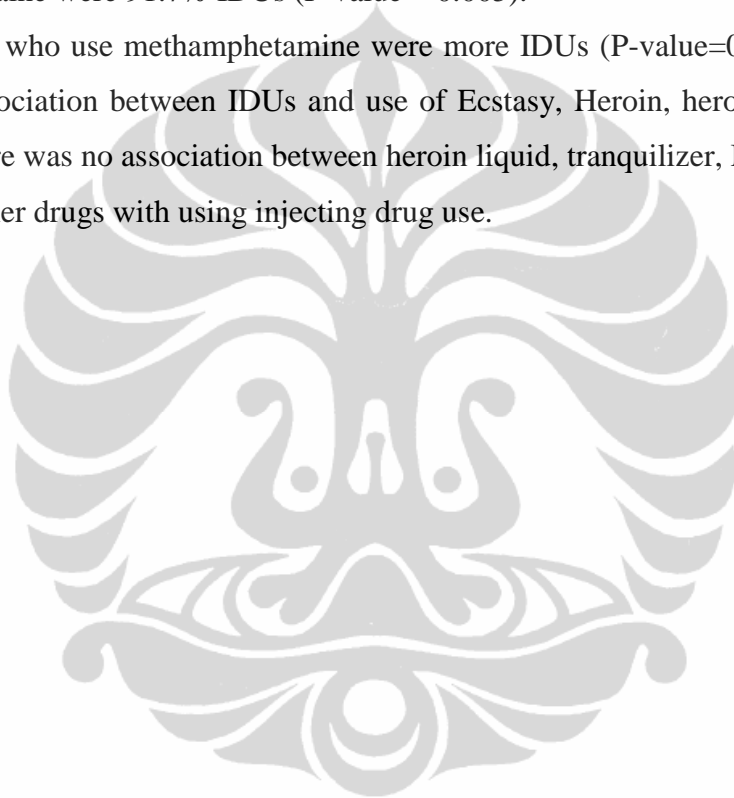
Tabel 12 . History of drug use and its association with injecting drug use

Type of Drug used	Total	IDUs		Non IDU		
	Sample	n	%	n	%	P-Value
Ever use marijuana						**0.448**
Yes	128	67	52.3	61	47.7	
No	7	5	71.4	2	28.6	
Ever used hashish						**0.000**
Yes	12	12	100	0	0	
No	123	60	48.8	63	51.2	
Ever use cocaine						**0.005**
Yes	12	11	91.7	1	8.3	
No	123	61	49.6	62	50.4	
Ever use Methamphetamine						**0.000**
Yes	97	63	64.9	34	35.1	
No	38	9	23.7	29	76.3	
Ever use ectasy						**0.000**
Yes	72	49	68.1	23	31.9	
No	63	23	36.5	40	63.5	
Ever use heroin						**0.001**
Yes	15	14	93.3	1	6.7	
No	120	58	48.3	62	51.7	
Ever use heroin powder						**0.000**
Yes	81	71	87.7	10	12.3	
No	54	1	1.9	53	98.1	
Ever used heroin liquid						**1.000**
Yes	3	2	66.7	1	33.3	
No	132	70	53	62	47	
Ever used tranquilizer						**0.375**
Yes	85	48	56.5	37	43.5	
No	50	24	48	26	52	
Ever used LSD						**0.002**
Yes	10	10	100	0	0	
No	125	62	49.6	63	50.4	
Ever used mushroom						**0.574**
Yes	13	8	61.5	5	38.5	
No	122	64	52.5	58	47.5	
Ever use other drug						**0.448**
Yes	7	5	71.4	2	28.6	
No	128	67	52.3	61	47.7	

5.3   Determinants of injecting drug use

After the bi-variate analysis (cross tabulation) all the variables which had the p-value 0.25 and less than 0.25 are shifted to the binary logistic regression. Thereafter by the enter method they are further analyzed with eight stages in the final model three variables are remained significant which are main job, family member know about the respondent drug using habit and type of first drug use.

1.   Main job: there is association between being student and injecting drug use those who are student are at low risk (AOR=0.09) of using injection than those who are working.

While those who are not working are two times more at risk (AOR=1.98) of using injection than those who are working but the last finding is not significant (p-value=0.212).

2.   Family member don't know: there is association (P-value = 0.000) between Family member don't know about the drug using habit of the respondents and injecting drug use, and those whose family don't knowing are at low risk of using injection (AOR = 0.07).

3.   Type of first drug used: there is association (p-value= 0.027) between using tranquilizer and injecting drug use those who use tranquilizers are about four times more at risk (AOR=3.89) of using injection than those who use Marijuana.

Also those who use other types of drugs without tranqulizers are at high risk of using injection (AOR=1.38) than those who use Marijuana but this finding is not significant (P-value=0.668).

Tabel 13 Determinants of injecting drug use (Logistic regression)

Determinants of Injecting drug use	n (%)	COR (95% CI)	AOR (95% CI)	P-Value
Main Job				
Working	64 (47.4)	Ref.		
Student	34 (25.2)	0.12(0.04-0.35)	0.09 (0.03-0.32)	0.000
Not working	37 (27.4)	2.48(0.98-6.28)	1.98 (0.68-5.77)	0.212
Family member know				
Yes	100 (74.8)	Ref.		
No	34 (25.4)	0.09(0.03-0.24)	0.07(0.02-0.24)	0.000
Type of first drug used				
Ganja	92 (68.1)	Ref.		
Tranquilizer	28 (20.7)	2.85(1.14-7.12)	3.89(1.17-12.95)	0.027
Other	15 (11.1)	1.71(0.56-5.19)	1.38 (0.32-5.98)	0.668

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CHAPTER 6

DISCUSSION

Injecting drug use is one of the main public health problems and second main factor of HIV epidemic in the world and it's the number one cause of HIV transmission in Indonesia besides HIV, Injecting drug use is associated with Hepatitis B & C, worldwide 16 millions IDUs are available and 3 million of them are living with HIV, the estimated number of IDUs are about 170,000 in Indonesia which is increasing year by year, and as injecting drug use is a social problem there is need for research to identify the social determinants of this phenomenon.

A study conducted in 2008 by the health research center University of Indonesia and National Narcotic Board of Indonesia the study was conducted in 17 provinces of the country with the objective to find the prevalence of drug users in the country the data collected in the Jakarta city is used as a secondary data for this study as the data is secondary and the objective of the primary study is different and the study was cross sectional which can't identify the cause effect relationship these are limitations of the study however we can generalize the findings of the result to the drug users in Jakarta city because the descriptive information and general characteristics of the study respondents are similar to the finding of other studies has been conducted in Jakarta.

Jakarta is the capital of the Republic of Indonesia and one of the crowded cities in the country, Jakarta is the home for more than 10 million inhabitants.

Total sample of this study is 135 drug users among them 72 (53.3%) were Injecting Drug Users and 63 (46.7%) were non injecting drug users, in order to describe the personal Social factors, Family factors, Drug related factors and Drug using pattern, and to identify the association between personal, Family, Drug related factors towards injecting drug use .

6.1. Personal Social factors

As illustrated in table 5. Distribution of the gender in the sample is 1:5 female for male and it could be explain that most of the drug users are male in the city.

The mean age of the respondent is 25.7 years with standard deviation of 5.6 years the minimum age was 16 and maximum 45 years and most of them (67.4%) are between 20-30 years old these findings are the same with study of 3 cities of Indonesia most of the respondent in that study were also between 20-30 years with median age of 23 years (Pisani et al, 2003), also a study conducted in India mention that mean age of IDUs was 24.5 years with SD 2.7 years (Kermode et al, 2007).

Three quarter (75.6%) of them had the education of high school and university this finding is similar to the study conducted in Jakarta which reported that 72.9 % of male and 77.4% of female HIV patients had high school education and most of them were between the age of 16-30 years old (Sahbandar et al, 2009), 77.8% of them living in own, parent or relative houses this finding is similar to the study conducted in 3 cities of Indonesia which stated that 79.5% of drug users in Jakarta are living with parents (Pisani et al, 2003).

More than half (52.6%) doesn't have income because 25.2% of them were students and it could be explain that they are supported by family the study in India shows that 83.8% source of income of drug user was from family (Kermode et al, 2007).

6.2. Family Social factors

Most (65.2%) of the respondent are unmarried this finding is similar to the study of Karachi Pakistan which mention that 66% of drug users were un married in Karachi too (A.Agha, 2003).

Regarding children 24.4% had children because only 26.7% of the respondents were married this finding is the same with the study in Karachi which mention that three quarter of the respondents were unmarried and only about 30% had children (A.Agha, 2003).

according to parent education and job most of the fathers had higher education than mother and most of the father had job than mother, among the family member who knows about the respondent drug using habit mother know more than father and younger brother/sister know more than relative.

Regarding the drug use among family member 33.3% said that their family member also used drug and most of them were younger brother and sister.

6.3. Drug related factors

All the respondents were smokers and the mean age of starting smoking was 12.8years with standard deviation of 2.3 years most of them started smoking between 12-14 years, the study conducted in Thailand also show that both smoking (93%) and drinking (80.9%) were very common (Cheng et al, 2006).

Almost all of them (97.8%) has used alcohol the mean age of starting alcohol was 14.7 years with Standard deviation of 3 years and most of them started alcohol use before the age of 16 years this finding of using alcohol is contradictory to the study conducted in Karachi-Pakistan which show that 23.1% of IDUs were using alcohol in Karachi (A.Agha et al, 2003) the culture and social differences can be explain as the cause of this difference also 87.4 % of them used alcohol in the last 6-8 months in Jakarta.

Ganja was the drug which used first by most (68.1%) of the respondents in Jakarta, the study conducted in Thailand show that the first ever used drug was opium and second was Marijuana (Kermode et al, 2007).

6.4.   Drug using pattern

More than half of the respondents 72 (53.3%) were IDUs and among them 68% said that they ever shared needle this finding is supported by the study conducted in 3 cities of Indonesia including Jakarta which show that 85.7% shared needle in the last week (Pisani et al, 2003). Most of them started injection before the year of 2000, which can be explain that the longer they use drug they will be heavily addicted and more prone for using injection and the mean age of starting injection was 18.1 years old with the standard deviation of 3.2 years and mostly started injection between the age of 15-18 years, and two quarter (74.3%) of them were using injection 1-3 times a day supported by previous study which shows that drug user in Jakarta are using drug 2 times a day while in Surabaya and Bandung the times of injection is 1.1 and 1 respectively (Pisani et al, 2003).

10. Determinant of injecting drug use (logistic regression)

After the bi-variate analysis all the variables which had the p-value less than 0.26 these variables were gender, Age, Educational level, marital status, main job, having children, father job, family member know about respondent drug using habit, relative also use drug, and type of first drug used are shifted to the logistic regression analysis as table 14 Shows that after the logistic regression the three variables become significant, which are significantly associated with injecting drug use these three variables are main job of the drug users, family member know about drug using habit and type of first drug used.

The remaining variables such as age, education level, living place and marital status are significant towards injecting drug use in other studies the Baltimore study revealed that education is significant towards age of initiation of injection   (Fuller et al, 2005), the study conducted in Chang Mai of Thailand show that young age of starting drug, ever receive education, single and having

history of smoking were significantly associated with initiation of injection (Cheng et al, 2006).

The reason for this difference between Baltimore, Thailand and this study are that the design of Baltimore study was prospective and the selection criteria of the respondents were also different from this study, in Baltimore study they select the IDUs whose uuse injection for last 3-5 years, also in Thailand study the sample size was very large (2,231 DU) and the study conducted in treatment center not in community.

In the present study one of the main significant findings is the main job of the drug users, as table 14 shows that students are at low risk (AOR=0.09 P-value=0.000) of using injection versus those who are working. The reason for this will be that students are at young age, new drug users and not heavily addicted and they are under the supervision of family and which shows the cohesion of drug user in the family, and being in family which is supportive environment may avoid the drug user from more stress and injecting drug use.

Those drug users who are not working are two times more at risk (AOR=1.98) of using injection versus those who are working this finding is important but not significant (p-value=0.212) in this study however it was significant in some other studies.

literature revealed that using injection incurred low cost compare to other routes and producing quick rush and when the cost of narcotics increased or the income of the drug user is low they prefer to use injection than other routes (A.Agha et al, 2003), also the study conducted in Manipur, Nagaland north east India in 2007 identified that most of the drug users who initiated injection were unemployed (Kermode et al, 2007) and the reason for this might be that unemployed drug users has low income, more stress and need more drug to use and to fulfill the desire they are using the drug by the route of injection.

The second main finding of this study is that those drug user whose family member don't know about his/her drug using habit are at lower risk (AOR=0.07,

P-value=0.000) of using injection than those whose family member know about the drug using habit of the drug user.

The reason for this will be that these are new drug user and still living inside family and while the family and community knows that he/she is drug user then he will be isolated and in that time he will be vulnerable for using injection because of stress and Scio-economic problems. Also family detects the drug using habit while he becomes addict not in early stages of starting drug.

The study conducted in Karachi Pakistan revealed that those drug user who share income with family depict cohesion of drug user with family and close family network may help drug user to keep away from using injection and those drug user who not share income with family which show isolated life style are 1.7 times more at risk of using injection versus those who sharing income (A.Agha et al, 2003).

Also the third finding of this study is that those drug users who started drug from using tranquilizer are about four (AOR=3.89) times more at risk (P-value=0.000) of using injection than those who started drug using from Ganja or Marijuana.

Those who used the first drug other than marijuana and tranquilizers are 1.38 times more at risk of using injection versus those who start from marijuana the last finding is not significant (P-value= 0.668) .

The reason for this might be the high prevalence of dual diagnosis in drug users, and as mental problem can cause drug uses or drug use precipate mental disorders these are interconnected, a review paper form the addiction journal and online library.wiley.com had explain about sedative "that studies in the US, Europe and Australia indicate that benzodiazepine is extremely common among IDUs, at the entry into treatment 73% of heroin users in US Treatment Outcome Prospective Study (TOPS) reported benzodiazepine use in the preceding year, with a quarter of the benzodiazepine-using clients reporting daily at some stage in that year, Extensive benzodiazepine use among British IDUs has been reported in a number of studies, Clinical lore typically describes benzodiazepine-using clients

as more psychologically and socially impaired, and difficult to treat than other clients.

The ability of benzodiazepines to impair the acquisition of new information after drug administration (i.e. produce anterograde amnesia) has been clearly documented (Curran 1991; Woods et al. 1992). Because this effect was correlated with sedation, and because tolerance to the sedative effects of benzodiazepines was well known, it was often assumed that tolerance developed to these memory impairing effects as well (Ghoneim and Mewaldt 1990; Curran 1991). However, studies in patients (Golombok et al. 1988; Lucki and Rickels 1988; Curran 1991, 1992; Tata et al. 1994; Gorenstein et al. 1995; Tönne et al. 1995) and healthy volunteers (Ghoniem et al. 1981) have now demonstrated that complete tolerance does not occur to the amnestic and other cognitive effects of benzodiazepines, even after years of chronic use. Since loss of memory has sometimes been a concern of benzodiazepine-using patients (Busto et al. 1986), a persuasive case can be made for considering impaired memory as a risk in both acute and chronic use of benzodiazepine drugs. The case is particularly strong for the elderly (Foy et al. 1995), particularly those who already have reduced levels of cognitive functioning. For example, a single-blind study of elderly nursing home residents showed that those who discontinued chronic benzodiazepines improved on measures of memory and cognitive functioning compared to a group that continued use (Salzman et al. 1992). Two studies observed that discontinuation of chronic benzodiazepine use among elderly nursing home residents resulted in an improved sense of well-being, energy and cognitive functioning that was apparent to family members as well as nursing home staff (Larson et al. 1987; Salzman et al. 1992). The memory impairment phenomenon of transient global amnesia refers to a period of several hours or longer in which individuals report complete memory loss after taking a benzodiazepine hypnotic. Transient global amnesia has been well documented in case reports (usually with triazolam or midazolam); however the phenomenon occurs at very low frequency and has not been characterized experimentally (Woods et al. 1992)". (Griffiths et al, 1997).

Some finding of this study need more investigations such as family member don't know and the association of first drug use and initiation of injection

and also recalls bias is a main obstacle so there is need for more studies to confirm the finding and minimize the chance of recall bias.

11. Implication for program

The major findings of this study are important to be considered during designing of primary, secondary or tertiary drug demand reduction programs:

a. Vocational training as the drug users who are not working are at greater risk of using injection, so if vocational training become part of the treatment and harm reduction programs then besides receiving treatment and harm reduction services they will become proactive member of the family which will improve the family network, which is supportive environment .

b. Improving the knowledge and skills of family to detect drug use earlier because in early stages the family don't know about the drug using habit and the drug user is not addict later on while the drug user become addict then family usually aware from it which is too late and its difficult in this stage to avoid him from using drug so, there is need to improve both knowledge and skills of family to detect the drug use as early as possible before the stage of addiction and provide the appropriate support.it is crucial to design intervention to improve family and community knowledge and skills to detect drug user in early stages.

c. As tranquilizer users are more prone for using injection, so the medical staff has to be more cautious about prescribing tranqilizers and the staff has to be train in this regards. Regulation to control black market of tranquilizers and limit its free access without prescription.

d. Street based/out reach program as those drug users who are not in school/not working are at greater risk of using injection in order to reach the drug users there is need for street based/out reach program to increase the awareness and prevent them from using injection.

e. School based program as the study shows that students are using drug in Jakarta which will decline the school performance and will increase school dropout and this will increase injecting drug use so, there is need for school

based program to increase the awareness and prevent students from using drugs.

f. **Implication for future studies:** There is need for more researches on social factors associated with injecting drug use and if the study design is prospective/retrospective cohort or qualitative to lessen the affect of recall bias and include some other variables such as incarceration, cost of drug, fear of police and HIV knowledge and investigate its association with injecting drug use.

CHAPTER 7
CONCLUSION

The study conducted in 17 provinces of Indonesia with goal of determining the prevalence of drug users in Indonesia the data collected in Jakarta city of mentioned study used as secondary data for this study, the total sample of the study was 135 drug users including 114 male and 21 female from 16 to 45 years old the mean age was 25.7 with SD of 5.6, majority of the respondents were single living in their own or relative houses more than half were exposed to using injection.

The objective of this study was to explore the influences of Social and drug related factors on injecting drug use, also the purpose of the study was to assess the association of personal characteristics, main job/income and type of drug use towards injecting drug use.

The main findings of study was that the main job of drug user, family member don't know about the respondent drug using habit, and type of first drug use are significantly associated with injecting drug use or initiation of injection.

One of the finding was that student are at low risk of using injection versus working group, which indicate that they are new drug user not heavily addicted and that family usually not detect drug use in early stages, it also show that isolation from family is risk than cohesion.

The second main finding of the study was that not knowing of family member from the respondent drug using habit is significantly associated with injecting drug use and those whose family members don't know from their drug using are at lower risk of using injection than those whose family member know, which show that family don't aware in early stages they usually aware in late stages while the user become addict.

The third finding of this study is that type of first drug use is significantly associated with using injection and those who use tranquilizer are more at risk of using injection than marijuana and other drugs.

So, primary prevention activities focusing on improving social conditions, controlling black market of tranquilizers and improving family knowledge and skills to detect drug use in family as early as possible would help IDUs to prevent them from indulging in injecting drug use, according to this study job status, family and type of drug should be considered in the designing and planning of addicts' treatment and harm reduction activities.

RECOMMONDATIONS

This part includes recommendations based on the finding of the presented study. The following recommendations are suggested to improve the situation and promote the preventive behaviors to avoid injecting drug use among drug users in Jakarta.

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1. Regulation to control black market of tranquilizers and people will not have access to tranqulizer without prescription and train all medical staff regarding tranquilizers and addiction, to be cautious during writing of prescription.

2. Among none injecting drug users pay more attention to the drug users who start drug use from tranquilizer because this group is more vulnerable for using injection.

3. Designing interventions to improve the knowledge and skills of family to detect drug use in family as early as possible to prevent the drug users from addiction and using injection.

4. Providing vocational training besides treatment program for drug user, to enhance the social status of the ex-addict and improve family and social network.

5. Comprehensive school based program to increase the awareness among student in order to prevent them from using drugs. And insist on the life skill curriculum in primary school to improve the life skills in early life and enable puple to say no to drug.

6. Outreach program to reach drug users who are not in school/not working because they are more vulnerable for using drug via the route of injection

7. Conducting studies on social determinants of injecting drug use and design to minimize the recall bias, or qualitative study to find in depth information about tranquilizer use and its association with injecting drug use.

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FORM-3

CONFIDENTIAL

QUESTIONNAIRE
The Survey of Drug Abuse in Indonesia, 2008
Pusat Penelitian Kesehatan Universitas Indonesia

Respondent Identity

RI1. City

Kalbar (Pontianak)	01	D.I. Yogyakarta	10
North Sumatra(Medan)	02	East Java (Surabaya)	11
Kepulauan Riau (Batam)	03	Bali (Denpasar)	12
South Sumatra (Palembang)	04	NTB (Mataram)	13
Lampung (Bandar Lampung)	05	South Sulawesi (Makasar)	14
East Kalimantan (Samarinda)	06	North Sulawesi(Manado)	15
DKI Jakarta	07	Central Sulawesi (Palu)	16
West Java (Bandung)	08	Papua (Jayapura)	17
Central Java (Semarang)	09		

RI2. The region of respondent sampling

Central	1	West	4
North	2	East	5
South	3		

RI3. Group of respondent (based on entry point at the first time)

Student/ College Student	1
Unemployed (out of work/seeking work, parking man, street singer, etc)	2
Worker	3

RI4. Respondent's number

[   ]

RI5. Wave of respondent on sampling RDS

1	2	3	4	5	6

RI6. Hang out place/sentinel

Street	01	Campus	05	Friend's house	09
Park	02	School	06	Empty house	10
Parking Place	03	Rent house	07	Other, mention it	11
Mall	04	Respondent's house	08	....	

The Interview : To be a respondent

TI1. Have you used any drugs?

YES	1
NO	2 STOP INTERVIEWING

TI2. Has it been 5 times drugs consuming since you used it at the first time?

YES	1
NO	2 STOP INTERVIEWING

TI3. When did the last time you use it? month....................year.. type:

Yes, in period of Augt'07 – present (in the last one year)	1	Read " informed consent", if you willing to Then go to the next question	
Yes, before Aug'07	2	STOP INTERVIEWING	

Result and Completion of Interview:

RI1. Result of Interview:

Questionnaire completely filled	1	Death end: the same person	5
Incompletely filled (The interview is not finished)	2	Refuse the interview	6
Incompletely filled (cannot be met on the next visit)	3	Other, _____	7
No respondent/address cannot be found	4		

RI2. Name and interviewer code

Name :Code :   [|]

RI3. Date of interview :__ __ / __ __ / 2008 (dd/mm/yy)

RI4. This result has been checked for its validity and also its completion by:

NameStatusDate of checkedSignature

Interviewer I	__ __ / __ __ /2008	
Interviewer II	__ __ / __ __ /2008	
Korlap		

Social factors , Abdul Subor Momand, FKM UI, 2011

Informed Consent

Read

Good morning/ afternoon/ evening. My name is ……………………………….......................................(Interviewer)

I am from Health Reaearch Center of Indonesia University who is gathering data for health survey.
The data we are gathering is about the drug using behavior and its impact in Indonesia. We are going to give you questionnaires which are very personal and related to drug using. We are not going to ask for your name or address so it will not be recognized and your statement will be used for the purpose of study only.The purpose of this study is, as a refference for drafting the policy, regarding to the prevention programme of drug using in Indonesia. We hope that you can participate in this study and willing to answer all the questions. If you agree, we will conduct an hour interview session, and in case, during the interview you feel discomfort with the question, you are allowed to not answer it.

All the answers are welcome. There is no correct or incorrect answer in this session.We only want to know your opinion about this topic. We really appreciate if you answer the questions to the best of your knowledge honestly. If you are bored, tired, or you have any other appointments during the interview, you can have a break or reschedule the time to continue the interview.
Do you agree to participate in this survey? If yes, can we start the interview?

"Have you been interviewed for this kind of survey in the last three weeks"?
    1. YES, I have. Then, STOP
    2. NO.

If the respondent has been interviewed for this study, don't interview him for the second time. Say thank you and end the interview. If NO, continue to interview.

I comprehend the content of the information and the agreement sheet, and am under my awareness to participate in this survey and understand that all the information I give are confidentially guaranteed.

I agree to participate in this survey.
Date : ____ / _____ / 2008

Respondent   Interviewer
Signature   Signature

If the respondent is not willing to give a sign then the interviewer's signature is enough.

Part 1 : Respondent Characteristic

P1.1   How old are you? (based on his last birthday)

	SA
Age month :_____ year :_____	....
Do not know/ Do not remember	98
Not answering	99

P1.2   Sex?

	SA
Male	1
Female	2

P1.3   Do you go to school now?

	SA
Yes	1
No	2
Not answering	9

P1.4   What is your latest educational background?

	SA
Never go to school	1
Have not finished elementary school	2
Elementary School	3
Junior High School	4
Senior High School	5
Academy/University	6
Not answering	9

P1.5   What is your marital status?

	SA
Single	1
Married	2
Divorced by death	3
Divorced	4
Live together without marriage status	5
Other, mention it ………..	7
Not answering	9

P1.6   Do you have any children? (including adopted child)

	SA	Go to
Yes	1	
No	2	P1.8
No answering	9	P1.8

P1.7   How many children do you have who are still alive?

	SA
Number of children: …....... (persons)	....
Do not know/ Do not remember	98
Not answering	99

P1.8   How often do you pray, based on your faith, in the last one year?

Read your options:	SA
Always/routine	1
Sometimes	2
Just do it on holiday	3
Seldom	4
Never	9

P1.9 Where do you live now (house belonging)?

If the respondent stay in more than one home, choose one which is stayed the most in the last one year.

	SA		SA
Respondent's own house	01	Friend's house/ neighbour's house	05
Parent's house	02	Rent house	06
Brother's house	03	Nomaden	07
Aunt's house/grandparents's house/ cousin's house	04	Other, mention it	97
		Not answering	99

P1.10 Who stays with you in your house in the last one year (Agst'07- present)?

MA			MA		
	Yes	No		Yes	No
Alone	1	2	husband/wife/kids	1	2
Parent	1	2	Lover/fiancee	1	2
Brother/sister	1	2	Friend	1	2
Grandparents/other relatives	1	2	Other, mention it	1	2

P1.11 Do you have these belongings in your parent's house/your house? (can choose more than one)

Read it

1. Household belongings	MA			MA	
	Yes	No		Yes	No
a. Television	1	2	g. Gas stove	1	2
b. Computer/laptop	1	2	h. Refrigerator	1	2
c. Telephone/mobile phone	1	2	i. Water pomp	1	2
d. Video/VCD/CD player	1	2	j. Air Conditoner (AC)	1	2
e. Radio/tape	1	2	k. Rice cooker	1	2
f. Fan	1	2	l. TV satelite	1	2
2. Vehicle belongings					
a. Car	1	2	d. bycicle	1	2
b. Motor cycle	1	2	e. Other, mention:	1	2
c. Boat	1	2	_____		

P1.12 What is your parent's educational background?

	Father(SA)	Mother (SA)
Never go to school	1	1
Have not finished elementary school	2	2
Elementary school	3	3
Junior High School	4	4
Senor High School	5	5
Academy/ University	6	6
Do not know	8	8
Not answering	9	9

P1.13 What is your parents job now?

	Father (SA)	Mother(SA)
Not working/a housewife mother	01	01
Civil servants	02	02
Private employee	03	03
TNI/ POLRI	04	04
Enterpreneur/ seller	05	05
Pension	06	06
Farmer	07	07
Fisherman	08	08
Labour	09	09
Under contract labour	10	10
Driver	11	11
Ojek	12	12
Passed away	13	13
Other, mention: _____	97	97
Do not know		

P1.14 What is your current job? And how much you earn?

	P1.14.A Type of job			P1.14.B The salary		P1.14.C Notes
	a. Main (SA)	b. Side job (MA)		a. Main/monthly	b. Side job/annually (in the last one year)	
a. Not working	Yes/no			go to P1.15	go to P1.15	
b. College student	01 Loncat P1.15			go to P1.15	Rp	
c. Student	02	12		go to P1.15	Rp	
d. Civil Servant	03	12			Rp	
e. Private employee	04	12		Rp	Rp	
f. TNI/ POLRI	05	12		Rp	Rp	
g. Pension	06	12		Rp	Rp	
h. Enterpreneur/seller	07	12		Rp	Rp	
i. farmer	08	12		Rp	Rp	
j. Fisherman	09	12		Rp	Rp	
k. Labour	10	12		Rp	Rp	
l. Under contract labour	11	12		Rp	Rp	
m. Driver	12	12		Rp	Rp	
n. Ojek	13	12		Rp	Rp	
o. Other, mention..........	14	12		Rp	Rp	
o1..................................	97	12		Rp	Rp	
o2..................................		12		Rp	Rp	
Not answering		12		Rp	Rp	
	99 go to P1.15			Rp	Rp	
				Rp	Rp	
p.						

P1.15 Does somebody send you some money regularly in the last one year (Agst'07- present)?
(including : scholarship, parents, guardian, or children at the last one year)

	SA	Go to	The amount of money	Regularly received			Who send the moneyi	How many times have been Received in a year
Yes	1		Rp	1	2	3		
No	2	P2.1						
Not answering	9	P2.1						

* Notes, The time when regularly receive the money : 1=Weekl, 2=Month, and 3=Year

FORM-3

Part 2: Drug Using Pattern

READ IT TO THE RESPONDENT

In this part, we will ask you about your habitual activities, like smoking, drinking and drug using. Some questions will be very sensitive and might discomfort you. We hope you willing to give the answer to the best of your knowledge honestly.

There is no correct or incorrect answer, we really appreciate your statements. You have rights to not answer if you mind the question.

Are you ready? If yes, we will start giving you questions.

A. SMOKING

P2.1　Have you smoked before? How old were you when you smoked for the first time?

	SA	Go to	Age when smoked for The first time
Yes	1		………. year
No	2	P2.5	
Do not know/ Do not remember	8	P2.5	98
Not answering	9	P2.5	99

P2.2　When did the last time you smoke? Month _____ Year _____

	SA	Go to
Yes, in period of Aug'07 – present (in the last one year)	1	
Yes, before Aug'07	2	P2.5
Not answering	9	P2.5

P2.3　Have you stopped smoking in the last one year (Aug'07-present) and how long was it?

	SA	Period of Not smoking	Time standardization*
Yes1		……….	1….2….3
Never stop smoking2			
Not answering9			
* Note: choose the time standardization: (1=day, 2=week, 3=month)			

P2.4　How many cigarrettes did you smoke? How much money did you spend to buy it in average?

	SA	Time Standardi zation*	Average cost per Time standardi zation
Number of cigarrettes…….		1　2　3	Rp …………….
Do not know/ Do not remember 98			9998
Not answering99			9999
* note: choose the time standardization: (1=day, 2=week, 3=month)			

B. DRINKING

P2.5　Have you consumed any alcoholic drinking? And how old were you when the first time you drank it??

	SA	Go to	Age when the first Time drank the Alcoholic drinking
Yes	1		………. tahun
No	2	P2.8	
Do not know/ Do not remember	8	P2.8	98
Not answering	9	P2.8	99

P2.6　When did the last time you consume alcoholic drinking?Month _____ Year _____

	SA	Go to
Yes, in period of Augt'07 – present (in the last one year)	1	
Yes, before Aug'07	2	P2.8
Not answering	9	P2.8

P2.7   Mention the type, the amount and the price of alcoholic drinking that you have consumed in the last one year (Agst'07-present)?

Time period	Type of Alcoholic drinking	Amount of consuming	Satuan konsumsi*	The price	Average cost spent for al- soholic drinking
1. Weekly	1.			Rp.	
	2.			Rp.	
	3.			Rp.	
	4.			Rp.	
2. Monthly	1.			Rp.	
	2.			Rp.	
	3.			Rp.	
	4.			Rp.	
3. Annually	1.			Rp.	
	2.			Rp.	
	3.			Rp.	
	4.			Rp.	

* Keterangan satuan konsumsi : 1=Gelas, 2=sloki, 3=botol, 4=liter

Coloumn for taking notes and alcoholic consuming calcuation:

C. DRUG Abuse

P2.8 We would like to ask about your experience in using drugs since the first time you used it until now?

Frekuensi pakai adalah jumlah narkoba yang dipakai sendiri oleh responden BUKAN banyaknya barang yang dibeli. Dalam beberapa kasus seringkali responden membeli secara patungan.

		Seumur hidup		Setahun terakhir Agst'07-sekarang						Ya	Tidak	hr	mg	bl	th		waktu
Jenis narkoba yang pertama kali dipakai	Cara pakai Jenis narkoba terakhir dipakai	Umur:riil yang sesuai kebiasaan pakai narkoba*	Biaya yang dikeluar per jenis	Frekuensi pakai dalam satuan waktu (kali) pilih waktu yg tidak pakai narkoba (MA)		Status dalam setahun terakhir pakai narkoba*	Jenis narkoba yang pernah dipakai (MA)	Kapan pertama jenis#	Umur pertama pakai per jenis satuan (MA)@	Frekuensi jarang&ter aktif pakai jenis#							
1		2 (hari)	(SA)	pakai (SA)(MA)	(MA)	per jenis satuan (MA)@		jenis#	7		8		9			10	11	12
a. Ganja (cannabis,gele,cimeng,marijuana)	01	1	2		1 2 3					1	2							
b. Hashish (getah ganja)	02	1	2		1 2 3					1	2							
c. Kokain	03	1	2		1 2 3					1	2							
d. Shabu	04	1	2		1 2 3					1	2							
e. Ekstasi (inex, i, XTC)	05	1	2		1 2 3					1	2							
f. Heroin	06	1	2		1 2 3					1	2							
g. Putau bubuk	07	1	2		1 2 3					1	2							
h. Putau cair	08	1	2		1 2 3					1	2							
i. Metadhon	09	1	2		1 2 3					1	2							
j. Subutex (buprenorphine)	10	1	2		1 2 3					1	2							
k. Obat penenang/barbiturat (valium, lexo/lexotan, nipam, BK, rohypnol, sanax)	11	1	2		1 2 3					1	2							
l. LSD (acid)	12	1	2		1 2 3					1	2							
m. Kecubung, jamur di kotoran Sapi (mushroom)	13	1	2		1 2 3					1	2							
n. Inhalan/dihirup (ngelem, bensin)	14	1	2		1 2 3					1	2							
o. Lainnya, sebutkan	97	1	2		1 2 3					1	2							
o1. …………………		1	2		1 2 3					1	2							
o2. …………………		1	2		1 2 3					1	2							

* Keterangan: 1=Coba pakai, 2=Jarang pakai, 3=Teratur/rutin pakai
# Keterangan : sesuaikan umur kategori pakai narkoba pada kolom sebelumnya.
$ Keterangan satuan pakai : 1=paket, 2=linting, 3=gram, 4=tablet/butir, 5=mililiter (ml), 6=amplop/amp, 7=Lainnya, _ _ _

@Cara pakai per jenis narkoba: 1=disuntikkan, 2=dihisap seperti rokok, 3=dihirup(snip), 4=di-drag, 5=ditempel di langit-langit rongga mulut, 6=melalui goresan luka, 7=ditelan, 8=dimakan(dicampur dengan makanan), 9=lainnya (diisi sesuai jawaban responden)

P2.9   Table of drug using history and period of time in the last one year (Agst'07-present)?
      Give the check list code (√) based on type of drug and the month of using.Make sure the drug type in P2.8 is the same with drug type in this table (in the last one year).

Jenis Narkoba	Agst'07	Sept'07	Okt'07	Nop'07	Des'07	Jan'08	Feb'08	Mart'08	April'08	Mei'08	Juni'08	Jul'08	Agst'08	Total
	1	2	3	4	5	6	7	8	9	10	11	12	13	
a. Ganja (cannabis,gele,cimeng,marijuana)														
b. Hashish (getah ganja)														
c. Kokain														
d. Shabu														
e. Ekstasi (inex, i, XTC)														
f. Heroin														
g. Putau bubuk														
h. Putau cair														
i. Metadhon														
j. Subutex (buprenorphine)														
k. Obat penenang (valium, lexo/lexotan, nipam, BK, rohypnol, sanax)														
l. LSD (acid)														
m. Kecubung, jamur di kotoran Sapi (mushroom)														
n. Inhalan/dihirup (ngelem, bensin)														
o. Lainnya, sebutkan														
o1.														
o2.														

P2.10 Based on your knowledge how much is the price of drugs in market demand and for how many times it can be used? (Match the answer on P2.8 (in the last one year)?

Type of Drugs	Market Buy (MA)		Amount	Tulis Satuan pakai	The price	For how many Times it can be used
	Yes	No				
a. Ganja (cannabis,gele,cimeng,marijuana)	1	2			Rp..	
b. Hashish (getah ganja)	1	2			Rp..	
c. Kokain	1	2			Rp..	
d. Shabu	1	2			Rp..	
e. Ekstasi (inex, i, XTC)	1	2			Rp..	
f. Heroin	1	2			Rp..	
g. Putau bubuk	1	2			Rp..	
h. Putau cair	1	2			Rp..	
i. Metadhon	1	2			Rp..	
j. Subutex (buprenorphine)	1	2				
k. Obat penenang (valium, lexo/lexotan, nipam, BK, rohypnol, sanax)	1	2			Rp..	
l.LSD (acid)	1	2			Rp..	
m. Kecubung, jamur di kotoran Sapi (mushroom)	1	2			Rp..	
n. Inhalan/dihirup (ngelem, bensin)						
o. Lainnya, sebutkan 12Rp..						
12o1. ……………………….Rp..						
12o2. ……………………….Rp..						

Keterangan satuan pakai : 1=paket, 2=linting, 3=gram, 4=tablet/butir, 5=mililiter (ml), 6=amplop/amp, 7=Lainnya, _ _ _

P2.11 How many times did you buy drugs in the last few month?

	SA	Go to	The purchase that Needs extra budget (transportation)	The average cost of trans-portation in once drugs purchasing
Total amount of purchasing	…….		…….	Rp. ……………………
Do not know/Do not remember	98	P2.13	98	9998
Not answering	99	P2.13	99	9999

If there is no purchasing: give 0 (zero)   Go to P2.13

P2.12 From question no. P2.11, how many times did you buy drugs directly to the distributor in the last few months?

	SA
Amount	………
Do not remember	98
Not answering	99

P2.13 Where do you get the budget to buy drugs in the last one year (Agst'07- present)?

		Yes	MA No			Yes	MA No
a.	Monthly salary	1	2	h. Sell oneself's belongings		1	2
b.	Side job	1	2	i. Sell drugs		1	2
c.	Pocket money	1	2	j. Drugs courier		1	2
d.	School fee	1	2	k. Other, mention ……		1	2
e.	Exchange your own belongings/family's	1	2	…………………………………..		1	2
f.	Exchange oneself's belongings	1	2			1	2
g.	Sell your own belongings/family's	1	2			1	2

P2.14 Does anyone of your family member know that you are a drug user?

SA		Go to
Yes	1	
No	2	P2.16
Not answering	9	P2.16

P2.15 Who, in your family, knows that you are a drug user ?

		MA				MA	
		Yes	No			Yes	No
a.	Father	12		e.	Cousin/relatives	1	2
b.	Mother	12		f.	Other, ...	1	2
c.	Children	12		g.	Not answering	1	2
d.	Brother/sister	12					

P2.16 Beside you, is there any family member who also becomes a drug user?

SA		Go to
Yes	1	
No	2	P2.18
Not answering	9	P2.18

P2.17 Who, in your family, has ever used drugs?

		MA				MA	
		Yes	No			Yes	No
a.	Father	12		e.	Cousin/relatives	1	2
b.	Mother	12		f.	Other, ...	1	2
c.	Children	12		g.	Not answering	1	2
d.	Brother/sister	12					

D. Drug abuse (injection)

P2.18 Have used drugs by injecting?

	SA	Go to
Yes	1	
No	2	P3.1
Not answering	9	P3.1

P2.19 Did you share the needle or use the ex-used needle?

	SA	Amount of people you shared the needle with
Yes	1	_____ ppl
No	2	
Not answering	9	

P2.20 Do you inject the drugs regularly? How long has it been done?

	SA	Period of injecting (in months)
Yes	1	....
Not regularly, just couple times	2	
Do not remember	98	
Not answering	99	

P2.21 What are the kinds of drug that have been injected into your body?

	MA			MA	
	Yes	No		Yes	No
a. Kokain	1	2	g. Metadhon	1	2
b. Shabu	1	2	h. Subutex (buprenorphine)	1	2
c. Ekstasi (inex, i, XTC)	1	2	i. Obat penenang (valium, lexo/lexotan, nipam, BK, rohypnol, sanax)	1	2
d. Heroin	1	2	j. Lainnya............................	1	2
e. Putau bubuk	1	2	k. Tidak tahu	1	2
f. Putau cair	1	2			

P2.22 When did you inject drugs for the first time?

	SA
Age of the first time injecting month : _____ Year : _____	..........Year
Do not know/ Do not remember	98
Not answering	99

P2.23   Do you still inject drugs in the last one year (Agst'07- present)?

	SA	Go to	The last time of injecting
Yes	1		......., days ago
No	2	P3.1	......., weeks ago
Do not remember	8	P3.1	
Not answering	9	P3.1	......., months ago

P2.24   How many times do you inject drugs in average?
(sesuaikan waktu pemakaian dengan kebiasaan responden, dan isi pada kolom yang disediakan)

SA Go To		
Amount of using in a day………times		
Amount of using in a week………times		
Amount of using in a month………times		
Amount of using in a year………times P3.1		
Do not remember 98		
Not answering 99		

P2.25   During this month, how many times do you use a new needle?

	Total of needles	free needles	Bought needles	Needles that need Extra budget for trans portation	The average cost to get a new needle
Amount	....	....	....	………times transport	Rp. ....
Don't know/Don't remember	98	98	98	98	9998
Not answering	99	99	99	99	9999

Part 3. Sex in Drug Abuse

Now, I am going to ask about sex in drug abuse. I appology if there any dicomfort questions appear. I don't mean to despise you, but this experience is commonly happened among the drug users in some big cities in Indonesia. If you mind the question, you are allowed to not answer it.

P3.1   Have you had sex before?

	SA	Go to
Yes	1	
No	2	P4.1
Not answering	9	P4.1

P3.2   When did you have sex for the first time?

	SA
Age of first having sex month :_____ Year :_____	Age:.........years
Do not know/do not remember	98
Not answering	99

P3.3   When did the last time you have sex? month_____ year _____

	SA	Go to
Yes, in period of Agst'07 – present (a year)	1	
Yes, before Agst'07	2	P4.1
Do not know/ Do not remember	8	P4.1
Not answering	9	P4.1

P3.4   How many times you had sex in the last one year (Agst'07- present)?

	SA	Time set
Frequent of having sex	.... times	1 2 3
Do not know/ do not remember	998	
Not answering	999	

* note: Time set options: (1=days, 2=weeks, 3=months)

P3.5   Whom did you have a sex with in the last one year?

	MA	
	Yes	No
a. Wife/husband	1	2
b. Lover	1	2
c. Friend	1	2
d. Acquintance	1	2
e. Sex workers	1	2

	MA	
	Yes	No
f. Drugs distributor	1	2
g. Homo/Lesbi	1	2
h. Other, mention _____	1	2

P3.6   Have you ever asked for a date or having sex for a money?

	SA	Go to	How many times in a year
Yes, I have. In the last one year	1		....
Yes, I have but nit in the last one year	1	P3.8	
Never	2	P3.8	
Do not know/ Do not remember	8	P3.8	
Not answering	9	P3.8	

P3.7   How much do you get from your sex transaction in the last one year (Agst'07- present)? (If you are paid by getting drugs instead of money, convert it into rupiah)

	Average amount in Rp
How much you got per transaction	Rp ....
Do not know/ Do not remember	9998
Not answering	9999

P3.8   How often did you use condoms in the last one year (Aug'07 – present) ?

	SA
Never	1
Seldom	2
Often	3
Always	4
Do not know/Do not remember	8
Not answering	9

P3.9   Based on your experience, what is kind of drugs that can arouse you to have sex?

	MA				MA	
	Yes	No			Yes	No
a. Ganja (cannabis,gele,cimeng,marijuana)	1	2	i. Metadhon		1	2
b. Hasish (getah ganja)	1	2	j. Subutex (buprenorphine)		1	2
c. Kokain	1	2	k. Obat penenang (valium, lexo/lexotan, nipam, BK, rohypnol, sanax)		1	2
d. Shabu	1	2	l. LSD (acid)		1	2
e. Ekstasi (inex, i, XTC)	1	2	m. Kecubung, jamur di kotoran Sapi (mushroom) Inhalan/dihirup (ngelem, bensin)		1	2
f. Heroin	1	2	n. Lainnya:..........................		1	2
g. Putau bubuk	1	2	o.		1	2
h. Putau cair	1	2			1	2

Part 4: The Impact of Drug Abuse

READ IT TO RESPONDENT: In this section you will find some informations that related to the impact of drug abuse. The information is a respondent's experience, so there will not be no wrong statement. We hope, you will be honest in answering all the questions and all the informations will be kept very well.

___

A.   History of Disease

P4.1   In the last one year (Agst'07-present), do you feel any symptomps like these:

Read these symptomps from a s/d q	MA	
	Ya	Tidak
a. Nauseous	1	2
b. No appetite	1	2
c. Rasa sakit pada ulu hati	1	2
d. Rasa perih/nyeri saat menelan makanan	1	2
e. Warna putih menebal (jamuran) di mulut/tenggorokan		
Rasa sesak pada dada	1	2
f. Rasa sakit pada saat bernafas	1	2
g. Batuk berdahak lebih dari 2 minggu	1	2
h. Diare lebih dari 2 minggu	1	2
i. Rasa lelah (fatique) berkepanjangan	1	2
j. Keluar keringat di malam hari secara	1	2
k. berlebih	1	2

Bacakan keluhan berikut mulai dari a s/d q	MA	
	Ya	Tidak
l. Demam tinggi lebih dari 2 minggu	1	2
m. Kulit dan kuku berwarna kuning	1	2
n. Peradangan di kulit (luka yg sulit sembuh)	1	2
o. Rasa gatal/panas dan ruam/memerah di kulit	1	2
p. Munculnya bercak berwarna merah/putih/hitam di kulit	1	2
q. Penurunan berat badan lebih dari 10% dalam 2 minggu	1	2

Apabila tidak ada keluhan sama sekali (kodenya 2 semua)Loncat ke P4.12

P4.2   Was there any symptomps that maim your activities(cannot go to school/work/college) in the last one year (Aug'07-present)?

	SA	Go to
Yes	1	
No	2	P4.4
Do not know/ do not remember	9	P4.4

P4.3   How long did it happen / maim your activities: _ _ _ _ days

P4.4   Did you try to cure it yourself in the last one year (Agst'07- present)?

	SA	Go to
Yes	1	
No	2	P4.6

P4.5   What was the method of your treatment? - And how much did it cost?

	Total amount In a year		(Rp)The method	(MA) The treatment (in a year)
	Yes	No		
a. traditional treatment	1	2		
b. modern treatment	1	2		
c. Other:_____	1	2		

P4.6   Did you go to any medical / non medical places for a treatment in the last one year (Agst'07- present)?

	Rawat Jalan (SA)	Rawat Inap (SA)
Yes	1	1
No	2	2
Do not remember	9	9

If you never have any medical treatment, what is the reason: _
_ _
_ go to P4.12)

P4.7   Where did you go to get medical treatment in the last one year to cure the symptomps? (Agst'07- present)?

Medical Places	Rawat Jalan*			Rawat Inap		
	Done (MA)	Amount of visiting	Total of cost In a year(Rp)	Done (MA)	The period	Total of cost (Rp) in a day
	Yes	No			Yes	No		
a. Government Hospital	1	2	…….. times		1	2	…….. times	
b. Private Hospital	1	2	…….. times		1	2	…….. times	
c. Practitioner	1	2	…….. times		1	2	…….. times	
d. Puskesmas	1	2	…….. times		1	2	…….. times	
e. Puskesmas Pembantu	1	2	…….. times		1	2	…….. times	
f. Polyclinic	1	2	…….. times		1	2	…….. times	
g. Praktek petugas kesehatan	1	2	…….. times		1	2	…….. times	
h. Traditional treatment	1	2	…….. times		1	2	…….. times	
i. Other. mention …………………….	1	2	…….. times		1	2	…….. times	
	1	2	…….. times		1	2	…….. times	

* Untuk responden yang saat ini sedang dalam terapi subutex/metadon   termasuk dalam terapi rawat jalan untuk biaya
konsul dokter

P4.8   Do you know the result of your diagnosis?

	SA
Yes, Mention	1
No	2

P4.9   Who supports you in financial to buy medicines or all kind of treatments?

	MA	
	Yes	No
a. Askes	1	2
b. Astek jamsostek	1	2
c. Company	1	2
d. Other assurance/private assurance	1	2
e. Kartu sehat/SKTM/jamkesmas/Gakin	1	2
f. Family/relatives	1	2
g. Yourself (respondent)	1	2
h. Other	1	2

P4.10 Did anyone accompany you in doing the treatment in the last one year? (Agst'07- present)?

	Rawat Jalan (SA)	Rawat Inap (SA)
Yes1		1
No 2		2
Do not remember 9		9

Jika jawaban responden tidak atau tidak ingat, untuk rawat jalan dan rawat inap (keduanya=2)   Loncat P4.12

P4.11 Based on your visits, how many times were you accompanied? Then how long did it take in average (in hour)? And how much did it cost?

Kind of treatment	Total of visits/ days of hospitalized	Jumlah orang yg sering menunggu/ menemani	Rata-rata lama menunggu per-hari (jam)	Rata-rata biaya pengeluaran per hari (Rupiah)		
				Makan/Trans-portasi minumportasi	Lain-lain	
Rawat jalan			………….			
Rawat inap			………….			

		-		-		-		

IR1   IR2 IR3   IR4

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B.   Over dose

P4.12   Have you been in too much of a drug taken at one time?

	SA	Go to
Yes	1	
No	2	P5.1
Do not know / Do not remember	8	P5.1
Not answering	9	P5.1

P4.13   When was the last time you were overdose (OD)? month __ __ Year __ __ __ __

	SA	Go to
Yes, in period of Agst'07 – present (in a year)	1	
Yes, before Agst'07	2	P5.1
Do not know / Do not remember	8	P5.1
Not answering	9	P5.1

P4.14   How many times were you overdose (OD)in the last one year (Aug '07 – present)?

	SA
Total of OD in a year	.... times
Do not know/Do not remember	998
Not answering	999

P4.15   What was the aid when you were overdose last time?

	MA Yes	No	Go To
a. Nothing	12		P5.1
b. With the aid of friend	12		P5.1
c. Medical treatment	12		
d. Non medical treatment	12		
e. Other, mention	12		
f. Do not know/ Do not remember	12		P5.1
g. Not answering	12		P5.1

P4.16 If you were taken care in a Hospital or Clinic, in your last time overdose, what was the name of the hospital/clinic and how much did it cost for the treatment in the last one year (Agst'07- present)?

Place	Days of being hospitalized	The cost (Rp)
1.	....	Rp. ....
2.	....	Rp. ....
3.	....	Rp. ....

P4.17   Was there anyone who supported you/accompanied you when you were overdose in the las one year? (Agst'07- prresent)?

	SA	Go to
Yes	1	
No	2	P5.1
Not answering	9	P5.1

P4.18 How many people were there to accompany you when you were overdose and how long did they accompany you ? How much di dit cost(in the last one year ?

Place	Total of ppl who accompanied	Period of Accompanying In a day (hour)	Average cost per day (Rupiah)	
			Meal/drink	Transportation/other
1.		....		
2.		....		
3.		....		

Bagian 5. Medical Treatment

A. Detocsification and rehabilitation treatment

P5.1   Have you had these kind of treatments below:

Kind of treatment	Done (MA)		Age of the First time treatment	Done in the last One year (MA)		The frequences In the last one year
	Yes	No		Yes	No	
a. Detoksifikasi	1	2		1	2	
b. Rehabilitasi	1	2		1	2	
c. Detoksifikasi & Rehabilitasi	1	2		1	2	

If Never Done or Never Done in the last one year   Go to P5.5

P5.2   Related to the treatment, mention the institution, category, type of institution, the period, and the cost in the last one Year (Agst'07- present)

Name of the institution	Category (MA)		Type of institution (LSM,RS,PONPES, rehabilitasi, dll)	The period	The cost (Rp)
	1. Medical	2.Non medical			
Detoksifikasi	Yes	No			
1.	1		....	....	Rp. ....
2.	1		....	....	Rp. ....
Rehabilitasi					
1.	1	2	....	.... Rp.	
2.	1	2	....	.... Rp.	
Detoksifikasi & Rehabilitasi					
1.	1	2	....	.... Rp.	
2.	1	2	....	.... Rp.	

P5.3   Were you accompanied during the Detocsification and Rehabilitation treatment?

SA	Go To		
Yes1			
	P5.5No2		
	P5.5 Not answering9		

P5.4   If yes, how many people were there, period of accompanying, and the cost for detocsification !

Nama institusi tempat penanganan	Jumlah orang yang menunggu/menunggu menemani/ X per perawatan	Total lama menunggu pasien Makan/ minum	Biaya Pengeluaran per hari (Rupiah)			
		Trans-	Lain-lain portasi	menjenguk selama bulan	jam	
1.						
2.						

Rehabilitasi jika responden tidak bisa membedakan detoksifikasi atau rehahabilitasi (seperti pengobatan di pesantren/ponpes)masukkan sebagai rehabilitasi

Nama institusi tempat penanganan	Jumlah orang yang menunggu/menunggu menemani/ X per perawatan	Total lama menunggu pasien Makan/ minum	Biaya Pengeluaran per hari (Rupiah)			
		Trans-	Lain-lain portasi	menjenguk selama bulan	jam	
1.						
2.						

B. Self Treatment for Curing Drug Abuse

Did you cure yourself from drug addiction by taking traditional recipe, like jamu, etc?

P5.5

	SA	Go to
Yes	1	
No	2	P6.1
Do not know/ Do not remember	8	P6.1
Not answering	9	P6.1

P5.6 When did the last time you did self treatment from drug addiction? month._____ year _____

	SA	Go to
Yes, in period of Agst'07 – present (in a year)	1	
Yes, before Agst'07	2	P6.1
Do not know/ Do not remember	8	P6.1
Not answering	9	P6.1

P5.7 How many times did you do the self treatment in the last oe year (Agst'07-present)?

	SA
The frequence of treatment	.........times
Do not know/ Do not remember	998
Not answering	999

P5.8 Did you spend some money in self treatment to cure your drug addiction?

	SA	Go To
Yes	1	
No	2	P6.1

P5.9 Mention the type of treatment, period of treatment, and the cost spent during your self curing in the last one year (Aug'07 – present) :

If there is not any cost, fill 0(zero) in The Cost coloumn.

Type of treatment	Period of Treatment	The Cost	Notes
1.	....	Rp.	....
2.	....	Rp.	....
3.	....	Rp.	....

Bagian 6. Criminality and Circulation

A. Drug Circulation History

P6.1 Did you sell drug before?

	SA	Go To
Yes	1	
No	2	P6.6
Do not know/ Do not remember	8	P6.6
Not answering	9	P6.6

P6.2 When did the last time you sell drug? month_____ year _____

	SA	Go to
Yes, in period of Agst'07 – present (in a year)	1	
Yes, before Agst'07	2	P6.6
Do not know/ Do not Remember	8	P6.6

P6.3 As you remember, How many transactions in drug selling that you had done in the last one year?
(Agst'07-present

Type of drug	Pernah transaksi		Jumlah transaksi penjualan narkoba	Rata-rata Total keuntungan hasil penjualan dalam	Jumlah orangnarkoba yang yang membelidijual per
	Ya	Tidak		setahun	
a. Ganja (cannabis,gele,cimeng,marijuana)	1	2		Rp.	
b. Hashish (getah ganja)	1	2		transaksi *	Rp. ....
c. Kokain	1	2			Rp. ....
d. Shabu	1	2			Rp. ....
e. Ekstasi (inex, i, XTC)	1	2			Rp. ....
f. Heroin	1	2			Rp. ....
g. Putau bubuk	1	2			Rp. ....
h. Putau cair	1	2			Rp. ....
i. Metadhon	1	2			Rp. ....
j. Subutex (buprenorphine)	1	2			Rp. ....
k. Obat penenang (valium, lexo/lexotan, nipam, BK, rohypnol, sanax)	1	2			Rp. ....
l. LSD (acid)	1	2			Rp. ....
m. Kecubung, jamur di kotoran Sapi (mushroom)	1	2			Rp. ....
n. Inhalan/dihirup (ngelem, bensin)	1	2			Rp. ....
o. Lainnya, sebutkan					

* Keterangan satuan pakai : 1=paket, 2=linting, 3=gram, 4=tablet/butir, 5=mililiter (ml), 6=amplop/amp, 7=Lainnya, _ _ _

P6.4 Have you been a courier for drug circulation?

	SA	How much did you get (Rp) per delivering
Yes, in period of Agst'07 – present (in a year)	1	Rp.
Yes, before Agst'07	2	
Do not know/ Do not remember	8	

P6.5 Did you offer to someone else to use drug?

	SA
Yes	1
No	2

B. Criminal Act History

Before we go to the next section, we would like to inform you that the questions will be very personal and sensitive, yet we still have to ask them to you to count the estimation of cost that might harmful due to drug abuse. Your answer will be kept well and there is not any purpose which is not related to this study.

P6.6   Did you ever do such criminal actions, like stealing or robbery to buy drug?

	SA	Go to
Yes	1	
No	2	P6.9
Do not know/ Do not remember	8	P6.9
Not answering	9	P6.9

P6.7   When did the last time you steal?month. _____ year _____

	SA	Go to
Less than a year (since Agst'07- present)	1	
More than the last one year (before Agst'07)	2	P6.9
Do not know / Do not remember	8	P6.9
Not answering	9	P6.9

P6.8   What are the goods that you stole in period of Aug '07 – present?

Time Period (month/year)	The goods (including money)	Belongings*	Total items	The exchange amount when the goods were resold	
1.				Rp.	Rp. ....
2.				Rp.	Rp. ....
3.			....	Rp.	Rp. ....
4.			....	Rp.	Rp. ....
5.			....	Rp.	Rp. ....
6.			....	Rp.	Rp. ....
7.			....	Rp.	Rp. ....
8.			....	Rp.	Rp. ....
9.			....	Rp.	Rp. ....
10.			....	Rp.	

*   Notes:Belongings: 1= parent's, yours or relatives, 2= friend's or someone else's

C. TRAFFIC ACCIDENT HISTORY

P6.9   Have you ever had any crash accident due to drug using?

	SA	Go to
Yes	1	
No	2	P6.14
Do not know/Do not remember	8	P6.14
Not answering	9	P6.14

P6.10   Have you ever had any crash accident due to drug using in the last one year (Aug '07 – present)?

	SA	Go to	How many times did you have crash accident
Yes	1		.... times
No	2	P6.14	
Not answering	9	P6.14	999

P6.11 How much did you spend due to crash accident in the last one year (Aug'07-present)?

Jenis Pengeluaran :	MA Ya	MA Tidak	Biaya Pengeluaran (Rupiah) Kejadian-1	Kejadian-2	Kejadian-3
a. Biaya perawatan/Pengobatan responden	1	2	Rp.	Rp.	Rp. ....
b. Pengobatan si korban	1	2	Rp.	Rp.	Rp. ....
c. Perbaikan sepeda/motor/mobil milik sendiri	1	2	Rp.	Rp.	Rp. ....
d. Perbaikan sepeda/motor/mobil milik korban	1	2	Rp.	Rp.	Rp. ....
e. Biaya ganti rugi bagi si korban	1	2	Rp.	Rp.	Rp. ....
f. Urusan Kepolisian	1	2	Rp.	Rp.	Rp. ....
g. Lainnya, sebutkan	1	2			
g.1	1	2			
g.2	1	2			
Tidak tahu/ tidak ingat	1	2	Rp.	Rp.	Rp. ....
	1	2	Rp.	Rp.	Rp. ....
h.					
i. Tidak menjawab					
TOTAL BIAYA KECELAKAAN			Rp.	Rp.	Rp. ....

Jika tidak dapat merinci per jenis pengeluaran maka tuliskan total biaya kecelakaan
Jika kejadian lebih dari 3 kalitulis/catat pada lembar terpisah

P6.12 Related to the budget spent for crash accident, was there any relatives/ family who accompanied you while handling the accident?

	SA	Go to
Yes	1	
No	2	P6.14
Do not know / Do not remember	8	P6.14
Not answering	9	P6.14

P6.13 If yes, fill the field of people based on the spending, total of people, period of time during handling the accident!

	Total of ppl During the accident	Berapa hari menunggu	Rata-rata lama menunggu per hari (jam)	Biaya Pengeluaran per hari (Rupiah)		
				Makan/Trans-portasi	Lain-lain minum	
1. First accident			....			
2. Second accident			....			
3. Third accident			....			

D. Riwayat Penangkapan Oleh Pihak Kepolisian

P6.14 Apakah Anda pernah ditangkap oleh pihak kepolisian karena kasus narkoba ataupun kasus kriminal terkait dengan narkoba?

Termasuk semua kasus kriminal yang disebabkan oleh narkoba, baik pengaruh akibat pemakaian narkoba, tindak kriminal untuk memperoleh uang dengan tujuan untuk membeli narkoba.

SA	Loncat ke	
Ya	1	
Tidak	2	P6.20
Tidak tahu/ tidak ingat	8	P6.20
Tidak menjawab	9	P6.20

P6.15 Apakah Anda pernah ditangkap oleh pihak kepolisian karena kasus narkoba ataupun kasus kriminal terkait dengan narkoba dalam setahun terakhir (Agst'07-sekarang)?

	SA	Jumlah penangkapan	Loncat ke
Ya	1	.... kali	
Tidak	2		P6.20
Tidak tahu/ tidak ingat	8		P6.20
Tidak menjawab	9		P6.20

P6.16 Apakah Anda mengeluarkan biaya supaya bisa terbebas dari tangkapan kepolisian tersebut dalam setahun terakhir (Agst'07-sekarang)

	SA	Loncat ke
Ya	1	
Tidak	2	P6.18
Tidak tahu/ tidak ingat	8	P6.18
Tidak menjawab	9	P6.18

P6.17 Berapa besar biaya yang telah Anda atau keluarga Anda keluarkan selama berurusan dengan pihak kepolisian dalam setahun terakhir (Agst'07-sekarang)

Penangkapan Polisi	Biaya Pengeluaran (Rupiah)
1. Kejadian 1	Rp. ....
2. Kejadian 2	Rp. ....
3. Kejadian 3	Rp. ....

P6.18 Terkait dengan urusan di kepolisian tersebut, apakah ada anggota keluarga/orang lain yang membantu/mengurus sehingga waktu kerjanya hilang?

	SA	Loncat ke
Ya	1	
Tidak	2	P6.20
Tidak tahu/ tidak ingat	8	P6.20
Tidak menjawab	9	P6.20

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| | | - | | - | | - | | |

IR1   IR2   IR3   IR4

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P6.19 Jika Ya, isilah orang-orang yang dimaksud sesuai dengan jenis pengeluaran menurut jenis, jumlah orang, total lama menunggu dan biaya selama pengurusan dengan kepolisian?

Penangkapan oleh kepolisian	Jumlah orang yang menunggu selama kejadian	Berapa hari menunggu	Rata-rata lama menunggu per hari (jam)	Biaya Pengeluaran per hari (Rupiah)		
				Makan/ minum	Trans-portasi	Lain-lain
1. Kejadian pertama			…………			
2. Kejadian kedua			…………			
3. Kejadian ketiga			…………			

E. Riwayat Pengalaman di Penjara

P6.20 Apakah Anda pernah dipenjara karena penyalahgunaan narkoba ataupun kasus kriminal terkait dengan narkoba?

	SA	Loncat ke
Ya	1	
Tidak	2	P7.1
Tidak tahu/ tidak ingat	8	P7.1
Tidak menjawab	9	P7.1

P6.21 Apakah Anda pernah dipenjara karena penyalahgunaan narkoba ataupun kasus kriminal terkait dengan narkoba dalam setahun terakhir (Agst'07-sekarang)?

	SA	Loncat ke
Ya	1	
Tidak	2	P7.1
Tidak tahu/ tidak ingat	8	P7.1
Tidak menjawab	9	P7.1

P6.22 Berapa kali Anda pernah di penjara dalam setahun terakhir (Agst'07-sekarang)

	SA	Loncat ke
Jumlah di Penjara	……… kali	
Tidak tahu/ tidak ingat	998	
Tidak menjawab	999	

P6.23 Apakah Anda mengeluarkan biaya terkait urusan penjara yang pernah Anda alami dalam setahun terakhir (Agst'07-sekarang)?

	SA	Loncat ke
Ya, berapa kali........................	1	
Tidak	2	P6.25
Tidak tahu/ tidak ingat	8	P6.25
Tidak menjawab	9	P6.25

P6.24 Berapa besar biaya yang telah Anda atau keluarga Anda keluarkan terkait dengan urusan penjara yang pernah Anda alami dalam setahun terakhir (Agst'07-sekarang)?

Urusan penjara	Biaya yang dikeluarkan (Rupiah)
1. Kejadian 1	Rp. …………
2. Kejadian 2	Rp. …………
3. Kejadian 3	Rp. …………

P6.25 Terkait dengan urusan di penjaran tersebut, apakah ada angota keluarga/orang lain yang membantu atau mengurus selama Anda di penjara?

	SA	Loncat ke
Ya, siapa saja:	1	
Tidak	2	P7.1
Tidak tahu/ tidak ingat	8	P7.1
Tidak menjawab	9	P7.1

P6.26 Jika Ya, isilah orang-orang yang dimaksud sesuai dengan penjara yang pernah dialami, lama di penjara, jumlah orang yang menjenguk, total lama menjenguk dan besar biaya yang keluarga Anda keluarkan selama di penjara dalam setahun terakhir (Agst'07-sekarang)?

| Nama Penjara | Lama di penjara (hari) | Jumlah orang yang mejenguk rutin selama di penjara | Rata-rata lama menjenguk | | Biaya Pengeluaran per hari (Rupiah) | | |
			X per bulan	Jam	Makan/ minum	Trans-portasi	Lain-lain
1.							
2.							
3.							

Bagian 7. Riwayat Aktivitas Terganggu

Pertanyaan riwayat aktivitas terganggu hanya untuk yang status kerja pelajar atau mahasiswa dan pekerja.

P7.1 Setelah pakai narkoba, apakah Anda pernah tidak masuk sekolah/kerja karena pengaruh narkoba?

	SA	Loncat ke
Ya	1	
Tidak	2	P8.1
Tidak tahu/ tidak ingat	8	P8.1
Tidak menjawab	9	P8.1

P7.2 Kapan terakhir kali Anda pernah tidak masuk sekolah/kerja karena pengaruh narkoba?
Bulan _____ Tahun _____

	SA	Loncat ke
Ya, dalam periode Agst'07 – sekarang (setahun terakhir)	1	
Ya, sebelum bulan Agst'07	2	P8.1
Tidak menjawab	9	P8.1

P7.3 Riwayat terganggunya aktivitas akibat pengaruh pakai narkoba dalam setahun terakhir (Agst'07-sekarang)?

| Aktivitas | MA | | Lama Tidak Masuk (hari) | Catatan |
	Ya	Tidak		
a. Sekolah	1	2	....	
b. Kuliah	1	2	....	
c. Bekerja	1	2	....	
d. Lainnya,sebutkan……	1	2	....	
e. Tidak tahu/ tidak ingat	1	2	....	
f. Tidak menjawab	1	2	....	

Bagian 8. Teman Responden yang Pakai Narkoba (teman sepermainan/gang)

P8.1 Berapa jumlah teman Anda yang pakai narkoba dalam setahun terakhir dan masih tinggal di kota ini (minimal tinggal dalam 3 bulan terakhir dan masih hidup)?

	SA	Loncat ke
Jumlah teman	.......orang	
Tidak tahu/ tidak ingat	98	P9.1
Tidak menjawab	99	P9.1

P8.2 Berapa jumlah teman Anda yang meninggal dalam setahun terakhir?

	SA	Jumlah	Loncat ke
Ya	1	.........org	
Tidak	2		P9.1

P8.3   Mohon sebutkan siapa saja yang meninggal karena pemakaian narkoba dalam setahun terakhir (Agst'07-sekarang)?

No	Nama	Jenis kelamin		Umur dan tahun meninggal		Penyebab Kematian	Lokasi	
		Laki-laki	Perempuan	Umur	Tahun		Rumah tinggal	Kematian
Contoh:	Mr. X	(1)	2	23 th	2007	OD	Kel. Pondok Jaya	RS. Swasta
1	....	1	2				....	....
2	....	1	2				....	....
3	....	1	2				....	....
4	....	1	2				....	....
5	....	1	2				....	....
6	....	1	2				....	....
7	....	1	2				....	....
8	....	1	2				....	....
9	....	1	2				....	....
10	....	1	2				....	....

Bagian 9. Program Intervensi

P9.1   Apakah Anda pernah mengetahui/mendengar institusi/lembaga berikut ini?

Bacakan nama institusi/lembaga berikut:	MA	
	Ya	Tidak
Badan Narkotika Nasional	1	2
Badan Narkotika Propinsi	1	2
Badan Narkotika Kabupaten	1	2

Apabila tidak pernah mengetahui/mendengar ke 3 lembaga diatas   Loncat ke P9.6

P9.2   Darimana Anda mengetahui/mendengar institusi/lembaga tersebut?

	MA	
	Ya	Tidak
Televisi	1	2
Radio	1	2
Buku/Surat kabar/majalah	1	2
Stiker/pamflet/selebaran/poster/billboard/baliho	1	2
Orang tua/Anda/kakak	1	2
Teman	1	2
Tetangga	1	2
Tempat kerja	1	2
Posyandu/RS/petugas kesehatan	1	2
Perkumpulan keagamaan	1	2
LSM	1	2
Sekolah/kampus/guru/dosen	1	2
Lainnya_____	1	2

P9.3   Apakah Anda pernah terlibat dalam kegiatan program pencegahan narkoba yang dilakukan oleh institusi/lembaga berikut?

Bacakan	MA	
	Ya	Tidak
Badan Narkotika Nasional	1	2
Badan Narkotika Propinsi	1	2
Badan Narkotika Kabupaten	1	2

Apabila tidak pernah terlibat di semua kegiatan (kode 2)   Loncat ke P9.6

P9.4   Jika pernah terlibat, jenis kegiatan apa yang pernah diikuti terkait program pencegahan narkoba?

	MA	
	Ya	Tidak
Penyuluhan/penerangan/CERAMAH	1	2
Panggung hiburan/konser musik	1	2
Dialog interaktif/DISKUSI	1	2
Kegiatan olah raga/gerak jalan	1	2
Pembuatan Spanduk/Pamflet/Brosur	1	2
Pembuatan Buku /Majalah	1	2
Detoksifikasi dan rehabilitasi	1	2
Kegiatan hari anti madat	1	2
Pelatihan/workshop tentang narkoba	1	2
Lainnya , sebutkan_____	1	2

P9.5   Menurut Anda apakah kegiatan BNN/BNP/BNK terkait dengan pencegahan narkoba tersebut dapat
meningkatkan kesadaran ANDA untuk tidak menggunakan narkoba?

	SA
Ya	1
Tidak	2
Tidak pernah ikut/melihat kegiatan promosi mengenai bahaya narkoba	3
Tidak menjawab	9

P9.6   Apakah Anda pernah/sedang ikut program dampingan yang dilakukan LSM atau Puskesmas untuk
pengurangan dampak buruk (Harm Reduction) penggunaan narkoba?

	SA
Ya	1
Tidak	2
Tidak menjawab	9

Bagian 10. Kualitas Hidup

Berikan tanda cek list (√) pada [ ] di depan setiap pernyataan di bawah ini. Apabila mengalami kesulitan, pilihlah yang paling menggambarkan kondisi diri Anda.

P10.1 Mobilitas
    a. Apakah sebelum mengkonsumsi narkoba Anda mempunyai gangguan dalam berjalan? (bukan karena cacat)
        [ ] Ya
        [ ] Tidak
    b. Pilihlah salah satu yang paling menggambarkan diri Anda saat ini. (Bacakan)
        [ ] Saya dapat berjalan dengan normal (tanpa ada keluhan)
        [ ] Saya mempunyai masalah dalam berjalan, tapi masih bisa berjalan tanpa menggunakan alat bantu/orang lain
        [ ] Saya bisa berjalan dengan menggunakan alat bantu/orang lain
        [ ] Saya tidak bisa berjalan (terbaring di tempat tidur)

P10.2 Aktivitas pribadi
    a. Apakah sebelum mengkonsumsi narkoba Anda mempunyai gangguan dalam melakukan aktivitas pribadi (mengenakan pakaian sendiri, mandi, BAB, BAK, dll)?
        [ ] Ya
        [ ] Tidak
    b. Pilihlah salah satu yang paling menggambarkan diri Anda saat ini.
        [ ] Saya tidak mempunyai masalah apapun dalam melakukan aktivitas pribadi
        [ ] Saya mempunyai masalah dalam melakukan aktivitas pribadi, tapi masih bisa beraktivitas tanpa menggunakan alat bantu/orang lain
        [ ] Saya bisa melakukan aktivitas pribadi dengan menggunakan alat bantu/orang lain
        [ ] Saya tidak mampu melakukan aktivitas pribadi

P10.3 Aktivitas sehari-hari (bekerja, belajar, mengurus keluarga, dll)
    a. Apakah sebelum mengkonsumsi narkoba Anda mempunyai masalah dalam melakukan aktivitas sehari-hari? (sulit konsentrasi kerja, sulit konsentrasi belajar, dsb)
        [ ] Ya
        [ ] Tidak
    b. Pilihlah salah satu yang paling menggambarkan diri Anda saat ini.
        [ ] Saya tidak mempunyai masalah apapun dalam melakukan aktivitas sehari-hari
        [ ] Saya mempunyai masalah dalam melakukan aktivitas sehari-hari, tapi masih bisa beraktivitas tanpa menggunakan alat bantu/orang lain
        [ ] Saya bisa melakukan aktivitas sehari-hari dengan menggunakan alat bantu/orang lain
        [ ] Saya tidak mampu melakukan aktivitas sehari-hari

P10.4 Kegiatan sosial (kegiatan umum, masyarakat atau sosial, berorganisasi, dll)
    a. Apakah sebelum mengkonsumsi narkoba Anda aktif berorganisasi dalam kegiatan sosial?
        [ ] Ya
        [ ] Tidak
    b. Pilihlah salah satu yang paling menggambarkan diri Anda saat ini.
        [ ] Saya masih aktif melakukan kegiatan sosial.
        [ ] Saya hanya mau datang ke kegiatan sosial, bila ada orang lain yang menemani.
        [ ] Saya bisa melakukan kegiatan sosial tanpa ditemani oleh orang lain.
        [ ] Saya sama sekali tidak mau melakukan kegiatan sosial.

P10.5 Nyeri/rasa sakit
    a. Apakah sebelum mengkonsumsi narkoba Anda mempunyai rasa sakit/nyeri pada tubuh Anda?
        [ ] Ya
        [ ] Tidak
    b. Pilihlah salah satu yang paling menggambarkan diri Anda saat ini.
        [ ] Tidak pernah
        [ ] Kadang-kadang
        [ ] Sering
        [ ] Selalu

P10.6 Gangguan Tidur (tidak bisa tidur pulas atau sulit tidur, misalkan sering terbangun di tengah malam)
    a. Apakah sebelum mengkonsumsi narkoba Anda mengalami gangguan tidur?
        [ ] Ya
        [ ] Tidak
    b. Pilihlah salah satu yang paling menggambarkan diri Anda saat ini.
        [ ] Saya tidak pernah mengalami gangguan tidur
        [ ] Saya kadang-kadang mengalami gangguan tidur
        [ ] Saya sering mengalami gangguan tidur
        [ ] Saya selalu mengalami gangguan tidur

P10.7 Gelisah
    a. Apakah sebelum mengkonsumsi narkoba Anda mengalami kegelisahan atau depresi?
        [ ] Ya
        [ ] Tidak
    b. Pilihlah salah satu yang paling menggambarkan diri Anda saat ini.
        [ ] Saya tidak pernah gelisah atau depresi
        [ ] Saya kadang-kadang gelisah atau depresi
        [ ] Saya sering gelisah dan depresi
        [ ] Saya selalu gelisah dan depresi

P10.8 Emosi atau Mood
    a. Apakah sebelum pakai narkoba Anda mudah emosi (mis. marah/sedih) dan berubah mood?
        [ ] Ya
        [ ] Tidak
    b. Pilihlah salah satu yang paling menggambarkan diri Anda saat ini.
        [ ] Saya tidak pernah emosi atau berubah mood
        [ ] Saya kadang-kadang emosi atau berubah mood
        [ ] Saya sering emosi atau berubah mood
        [ ] Saya selalu emosi dan berubah mood

P10.9 Merasa Aneh dan berbeda
    a. Apakah sebelum mengkonsumsi Anda merasa ingin aneh dan berbeda dengan orang lain?
        [ ] Ya
        [ ] Tidak
    b. Pilihlah salah satu yang paling menggambarkan diri Anda saat ini.
        [ ] Saya tidak pernah merasa aneh dan berbeda dengan orang lain
        [ ] Saya kadang-kadang merasa aneh dan berbeda dengan orang lain
        [ ] Saya sering merasa aneh dan berbeda dengan orang lain
        [ ] Saya selalu aneh dan berbeda dengan orang lain

P10.10 Menghindari orang lain selain teman pengguna narkoba
    a. Apakah sebelum mengkonsumsi Anda merasa ingin menghindari orang lain?
        [ ] Ya
        [ ] Tidak
    b. Pilihlah salah satu yang paling menggambarkan diri Anda saat ini.
        [ ] Saya tidak pernah ingin menghindar dari orang lain
        [ ] Saya kadang-kadang ingin menghindari orang lain
        [ ] Saya sering menghindari orang lain
        [ ] Saya selalu menghindari orang lain

P10.11 Dijauhi orang lain selain teman pengguna narkoba
    a. Apakah sebelum mengkonsumsi Anda merasa dijauhi/dikucilkan oleh orang lain?
        [ ] Ya
        [ ] Tidak
    b. Pilihlah salah satu yang paling menggambarkan diri Anda saat ini.
        [ ] Saya tidak pernah ingin dijauhi/dikucilkan oleh orang lain
        [ ] Saya kadang-kadang dijauhi/dikucilkan oleh orang lain
        [ ] Saya sering dijauhi oleh orang lain
        [ ] Saya selalu dijauhi orang lain

P10.12 Keluarga

a. Apakah sebelum pakai narkoba Anda merasa keluarga Anda sangat menyayangi, hangat dan akrab dengan Anda?

[ ] Ya
[ ] Tidak

b. Pilihlah salah satu yang paling menggambarkan hubungan anda dengan keluarga saat ini.

[ ] Saya tidak pernah merasa disayangi atau akrab dengan keluarga
[ ] Saya kadang-kadang merasa disayangi atau akrab dengan keluarga
[ ] Saya sering merasa disayangi atau akrab dengan keluarga
[ ] Saya selalu merasa disayangi atau akrab dengan keluarga

P10.13 Untuk menyatakan seberapa baik atau buruk kondisi kesehatan, kami membuat gambar skala (seperti termometer), dimana kondisi kesehatan paling baik pada tanda 100 dan kondisi kesehatan terburuk pada skala 0.

Kami menginginkan Anda untuk menandai pada skala ini seberapa baik atau buruk kondisi kesehatan Anda hari ini, menurut pendapat Anda. Lakukan dengan cara menghubungkan sebuah garis dari kotak di bawah ini ke titik pada skala di samping untuk menentukan seberapa baik atau buruk kondisi kesehatan Anda.

Tingkat kesehatan
paling baik
100

90

80

70

60

50

Kondisi
kesehatan
anda saat ini

40

30

20

10

0
Tingkat Kesehatan
paling buruk

P10.14 Apakah Anda tahu akibat dari pakai narkoba?

	SA	Loncat ke
Ya, sebutkan	1	
Tidak	2	P10.16
Tidak tahu/ tidak ingat	8	P10.16
Tidak menjawab	9	P10.16

P10.15 Jika Ya sebutkan akibat dari pakai narkoba?

	MA	
	Ya	Tidak
Dapat tertular virus HIV/AIDS	1	2
Dapat tertular virus hepatitis C	1	2
Dapat tertular penyakit menular seksual	1	2
Merusak fisik (kesehatan,kecelakaan)	1	2
Merusak mental,emosi dan spiritual	1	2
Merugikan ekonomi individu/keluarga	1	2
Ketagihan	1	2
OD/kematian	1	2
Penjara/ditangkap polisi	1	2
Lainnya _____	1	2

P10.16 Bila ada seseorang pengguna narkoba yang tingkat pemakaiannya seperti Anda, maka berapa
tahun kira-kira berkurang harapan hidupnya? (isilah skala di bawah ini)
Perkiraan berkurangnya harapan hidup

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | Dst (dlm tahun)…… |

P10.17 Bila ada seseorang pengguna narkoba yang tingkat pemakaiannya seperti Anda, dan mendapatkan
pengobatan atau rehabilitasi, berapa kira-kira tambahan harapan hidup orang tersebut? (isilah
skala di bawah ini)
Perkiraan bertambahnya harapan hidup

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | Dst (dlm tahun)…… |

P10.18 Apakah Anda setuju bahwa dengan pemakaian narkoba akan mengurangi masa hidup?

	SA
Setuju	1
Tidak	2
Tidak tahu/ tidak ingat	8
Tidak menjawab	9

Social factors..., Abdul Subor Momand, FKM UI, 2011

	|-| |-| |-|	
IR1	IR2	IR3	IR4

Bagian 11. DSM - 4

A.   SUBSTANCE ABUSE (Penyalahguna Teratur belum Pecandu)   dalam setahun terakhir

PERNYATAAN	Ya	Tidak	Tidak relevan
P11.1 Kegagalan dalam melaksanakan pekerjaan, tugas sekolah, tugas di rumah			
• Bila Anda masih sekolah, Apakah pencapaian nilai sekolah/ulangan/ujian selama setahun ini mengalami penurunan?	1	2	3
• Bila Anda masih bekerja, Apakah kinerja Anda dinilai oleh bos/pimpinan tempat kerja mengalami penurunan?	1	2	3
• Apakah Anda pernah dikeluarkan dari sekolah atau tempat kerja dalam setahun terakhir?	1	2	3
• Apakah Anda merasa bahwa keluarga memperhatikan/ mendukung kegiatan-kegiatan yang Anda lakukan?	1	2	3
P11.2 Pernah dihukum (ditahan, dipenjara, dihukum di sekolah/tempat kerja/di rumah) berkaitan dengan pemakaian narkoba			
• Apakah pernah dihukum atau di skors di sekolah/tempat kerja akibat pakai narkoba?	1	2	3
P11.3 Tetap pakai narkoba walaupun ada masalah social atau interpersonal akibat pakai narkoba			
• Apakah Anda pernah mengalami ketidakharmonisan hubungan/konflik dengan sesama anggota keluarga di rumah?	1	2	3
• Apakah Anda pernah konflik dengan sesama teman sekolah atau teman sekerja?	1	2	3
• Bila pernah konflik, apakah setelah konflik Anda masih tetap memakai narkoba?	1	2	3
P11.4 Risiko pengaruh pakai narkoba			
• Apakah Anda pernah menyetir kendaraan dalam kondisi masih pengaruh narkoba	1	2	3
• Apakah Anda pernah melakukan pengrusakan fasilitas umum (telpon, halte, taman, dsb) dalam kondisi masih pengaruh narkoba	1	2	3

B   SUBSTANCE DEPENDENCE / ADDICT (Pecandu)   dalam setahun terakhir

PERNYATAAN	Ya	Tidak	Tidak relevan
P11.5 Dosis Narkoba (Tolerance)			
• Apakah Anda mengkonsumsi narkoba dengan dosis yang sama atau tetap, selama setahun terakhir,?	1	2	3
• Apakah dengan dosis narkoba yang sama akan berefek sesuai harapan Anda?	1	2	3
• Apakah Anda membutuhkan dosis yang lebih besar untuk mencapai efek yang diinginkan?	1	2	3
P11.6 Putus Obat (Withdrawal)			
• Apakah Anda pernah mengalami sakau? (sakau adalah mengalami gejala gelisah, cemas, dan rasa sakit luar biasa)	1	2	3
• Apakah gejala sakau tersebut dapat hilang bila Anda pakai narkoba?	1	2	3
P11.7 Keinginan untuk pakai narkoba yg terus menerus, atau kegagalan untuk menurunkan atau mengendalikan dosis pemakaian narkoba			
• Ketika bangun tidur dipagi hari, Apakah Anda ingin segera pakai narkoba?	1	2	3
• Apakah Anda pernah berusaha mengurangi dosis narkoba yang Anda pakai?	1	2	3
• Jika Anda tidak pakai narkoba dalam 2 hari, apakah memberikan efek sakau?	1	2	3
P11.8 Pemakaian narkoba dilakukan dengan dosis yang lebih besar atau dalam waktu yg lebih lama dari yg diinginkan awalnya			
• Apakah Anda ingin meningkatkan dosis narkoba yang dipakai saat ini?	1	2	3
• Apakah Anda ingin tetap memakai dosis narkoba dengan dosis yang sama untuk satu tahun ke depan?	1	2	3
• Apakah Anda pernah mengalami perubahan dosis pakai narkoba dalam satu tahun terakhir?	1	2	3

FORM-3

PERNYATAAN	Ya	Tidak	Tidak relevan
P11.9 Berbagai usaha dilakukan untuk mendapatkan narkoba			
• Apakah Anda pernah berusaha tidak mendapatkan narkoba?	1	2	3
• Apakah Anda pernah berkeinginan mengorbankan apapun untuk mendapatkan narkoba, termasuk menjual diri atau memberikan layanan seks untuk dapat narkoba?	1	2	3
• Apakah Anda merasa sebagian waktu sehari-hari dipergunakan untuk mendapatkan dan mengkonsumsi narkoba dalam setahun terakhir	1	2	3
P11.10 Berbagai usaha dilakukan untuk pulih dari pakai narkoba			
• Apakah Anda pernah berusaha untuk berhenti pakai narkoba?	1	2	3
• Apakah Anda pernah berhenti pakai narkoba?	1	2	3
• Jika pernah berhenti narkoba, apakah pernah relaps/kambuh lagi pakai narkoba?	1	2	3
P11.11 Berkurangnya kegiatan sosial, pekerjaan, kegiatan rekreasi, karena pemakaian narkoba			
• Dalam tiga bulan terakhir, Apakah Anda pernah melakukan kegiatan rekreasi (tidak berkaitan dengan narkoba), seperti bertamasya, berolahraga, kesenian, berkumpul bersama anggota keluarga lain?	1	2	3
• Apakah kegiatan rekreasi tersebut sesering tiga bulan sebelumnya?	1	2	3
• Apakah Anda masih bekerja di tempat pekerjaan yang sama seperti setahun yang lalu	1	2	3
• Apakah hubungan dengan teman sekerja memburuk dalam setahun ini	1	2	3
• Apakah hubungan dengan anggota keluarga memburuk dalam setahun ini	1	2	3
P11.12 Terus memakai narkoba walaupun sudah tahu bahwa ada gejala fisik atau psikologis akibat kambuhnya pakai narkoba			
• Apakah Anda tahu efek narkoba itu berbahaya terhadap diri Anda	1	2	3
• Apakah ada efek buruk yang dirasakan oleh tubuh Anda akibat pakai narkoba?	1	2	3
• Apakah ada efek buruk terhadap pikiran/perasaan Anda akibat pakai narkoba?	1	2	3
• Apakah Anda akan tetap pakai narkoba walaupun terdapat efek/dampak buruk terhadap fisik/tubuh atau psikologis/pikiran Anda?	1	2	3
• Apakah Anda pernah merasa sakit atau tidak enak badan ketika menggunakan narkoba	1	2	3

Akhir Wawancara
Terima kasih atas kesediaan Anda meluangkan waktu menjawab kuesioner
Kami sangat menghargai bantuan yang Anda berikan.