Prosperity for One, For All, But Not for Some: Deconstructing “harm” in the Indonesian harm reduction program

by

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# TABLE OF CONTENTS

**ACKNOWLEDGMENTS**  
3

**INTRODUCTION: CONFLICT AND COLLABORATION**  
4

I. CONTEXTUALIZING THE CONFLICT  
II. HARM REDUCTION AND THE PROGRAM IN INDONESIA  
III. BIOPower IN THE NEW HUMANITARIAN ORDER  
IV. GETTING TO KNOW KIOS  
V. DEFINING HARM REDUCTION AND IDENTIFYING A TRAJECTORY  

**CHAPTER ONE: GOVERNMENT EXTENDED**  
26

I. REFORMASI: A DEVELOPMENT NOT A SHOCK TO THE SYSTEM  
II. A THEORY OF GOVERNMENT  
III. DECENTRALIZATION AND INCLUSION  
   a. KIOS LEGITIMATED  
   b. THE NGO EXTENDED FROM THE GOVERNMENT  
IV. WHY OPPOSITION?  

**CHAPTER TWO: HARM REDUCTION AND THE EMERGENCY**  
45

I. EXCEPTION AND EXTENSION  
II. A THEORY OF EXCEPTION  
   a. THE STATE OF GLOBAL GOVERNANCE  
III. THE INDONESIAN WAR ON DRUGS  
   a. HARM REDUCTION IN THE WAR ON DRUGS  
   b. INSTITUTIONAL CHANGE  
IV. THE GLOBAL FIGHT AGAINST HIV/AIDS  
V. HARM REDUCTION AS AN EXCEPTION  
VI. HARM REDUCTION THE HUMANITARIAN  

**CHAPTER THREE: A CRUSADE OF COMPASSION**  
70

I. CARING HERE AND NOW  
II. A TWIN BIRTH  
III. HUMANITARIAN AID FOR KIOS  
IV. WHAT IS LOST  
   a. CONTEXT  
   b. INDIVIDUATION  
   c. MULTILATERAL PROVISION OF AID  

**CHAPTER FOUR: WHAT IS DEATH IN HARM REDUCTION**  
90

I. THEORY IN DIALOGUE  
II. THE ADMINISTRATION OF THE DEATH PENALTY  
III. PRISON FOR DRUG USERS  
IV. REHABILITATION  
V. FORCES OF LIFE AND DEATH IN HARM REDUCTION  
   a. THE CRIMINAL BEFORE THE CRIME  
   b. MEDICALIZING THE DRUG USER  
   c. MEDICATING THE DRUG USER  
   d. INITIATING A CHAIN REACTION OF INVOLVEMENT  

**CONCLUSION**  
112

**BIBLIOGRAPHY**  
114
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INTRODUCTION: Conflict and Collaboration

The harsh, punitive approach to drug use in Asia stands in stark contrast with the health approach in many Western countries, where programs for ‘harm reduction’ of drug use—such as access to clean needles and methadone substitution treatment—are the norm.¹

■ THE DIPLOMAT May 2016

The drug policy of our nation, starting from 1961, has been modeled after the UN basis for drug policy, not from Indonesia. It is time that we hear the Indonesian point of view, and mold our legislation accordingly.²

■ DiCERNA June 2016

Language surrounding drug policy is often oppositional. Enemy forces are constructed through rhetoric and the people must unite against these forces to conquer. But in the 21st century, the people read articles from online news sources, like The Diplomat, between meetings or classes or bites of cereal in the morning. The people attend policy meetings, like the one hosted in June in Jakarta, that reify their own beliefs, which they assert passionately during the Q&A sessions that follow, but usually fail to express outside of the community of advocates. Constructing enemy forces is a simple task in drug policy because there are so many enemies to be created. There is the drug, the drug dealer, the drug user, the foreign policy influence, the state policy influence, the list goes on.

In a feature on “Asia’s War on Drugs,” The Diplomat, a Japanese international news magazine, makes an enemy of the punitive approach that many Asian states take

¹ Mangai Balasegaram. “Asia’s War on Drugs,” The Diplomat, May 12, 2016.
to drug policy. The article’s tone matches that taken by The New York Times, Reuters, Aljazeera and even The Jakarta Post, a news source geared toward the English-speaking expat community in Indonesia, when they write about drug policy. It hierarchically positions the Western public health concern above and against draconian state policy. In contrast, at a panel hosted in Jakarta by the Lembaga Bantuan Hukum Masyarakat (LBHM), a community-based paralegal organization that facilitates access to justice for people who use drugs, a panelist made an enemy of UN drug policy. The meeting was called to invite the public to petition to the government concerning the upcoming revision to Narcotics Law no. 35. The panelist said that the UN’s dominant influence on Indonesian drug policy over the past 50 years had suppressed the Indonesian perspective and contributed to policy failures. It was time to let the Indonesian people write their own policy. This criticism is prevalent among activists, NGOs and legislators: the international influence contributes negatively to issues associated with Indonesian drug policy. Now, if state policy is the enemy according to international news, and global governance is the enemy according to local activists, and the great change-makers being called to action are hunkered behind computer screens or slumped in the audience of a twenty-person policy meeting somewhere in a city of 13 million people...who is supposed to act and what action must be taken?

At Soekarno Hatta Airport, the largest international airport in Indonesia, there is a sign after immigration that reads:
Selamat Datang di Jakarta
Hukuman Mati Bagi Pendgedar Narkoba!

Welcome to Jakarta
Death Penalty for Drug Traffickers!

And another:

NARKOBA...
Jalan Sesat Untuk Nikmat Sesat!

DRUGS! is a bad decision to have such satisfaction.

While some⁢ have cited these banners as indicators that Indonesia’s drug policy is among the harshest in the world, I see a different message. The presentation of anti-drug propaganda as a featured image at the country’s most traveled border illustrates a fundamental element of the politics surrounding this issue: the drug problem in Indonesia is everywhere and nowhere at the same time.

A different image set in the same location was painted through a conversation I had with a man I met through Kios named Marcos.⁶ He had spent two years in his father’s hometown outside of Medan in Sumatra getting clean after his parents had found him overdosed in his bed in Jakarta. He did not go through rehabilitation or take withdrawal medication, he recounted with pride. He just swam in the lake near his father’s house every morning at 5AM and prayed every evening at 5PM. After a week, he no longer felt physically addicted and for two years he stayed and worked in that

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⁴ “12 Years of Travel: Drugs Warning, Jakarta Airport, Indonesia,” Travel Happy2005
⁶ All names of interviewees have been changed.
town without using drugs once. “From 2005 to 2007 I stopped using,” he told me, “but when I got back in Jakarta, the first time I stepped my feet in Soekarno Hatta...just heroin, heroin, heroin. The smell. I couldn’t control it. For the first time in so long.”

For Marcos, the drugs banner was invisible. The moment that associations of heroin were back, the posted threat paled in comparison to the flaming desire.

In his book *Pleasure Consuming Medicine*, Kane Race writes, “The effects of a drug can alter significantly depending on how, where and when it is used.” While Race writes about the literal effects of drugs from a harm reduction standpoint, I find this quote applicable to the consideration of drug-related stigma. Drugs are often inflated through rhetoric and rumor. Symbols of drug use are often polarizing. In the case of Indonesia, drug-related stigma exacerbates opposition between the foreign and the national, the state and the NGO, the user and the abstinent, the disease victim and the criminal threat. Attachment to this two-dimensional framework oversimplifies the multifarious relationships that exist within each one of these pairs.

Crucial messages fatten the drug problem. President Joko Widodo announced in December 2014 that up to 50 Indonesians were dying from drug-related causes per day. A public health article published in 2011 quoted 2007 statistics to say that Indonesia has one of the fastest growing AIDS epidemics in the world. A quick Google search of Indonesian drug policy shows that three of the ten articles appearing on the first page reference the death penalty in the title. Eight out of ten use words like,

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7 Marcos (suboxone injection) a personal discussion, July 22, 2016.
“crackdown,” “harsh,” “crime,” and “strict” between the title and two-sentence article description. But these urgent messages are mysteriously empty. President Widodo’s statistics are disclaimed by international news sources for being notoriously exaggerated.¹¹ Studies conducted by Atma Jaya University’s AIDS Research Center (ARC) in Jakarta show that the prevalence of HIV/AIDS has dropped significantly among injecting drug users in Indonesia and, moreover, injection drug use is also becoming decreasingly popular.¹² The articles that problematize Indonesian drug policy by taking issue with the death penalty, which has been exercised 20 times in the past three years in Indonesia¹³ and 28 times in the United States in 2015 alone,¹⁴ focus on a marginal portion of policy that generally calls for rehabilitation of drug users. With these facts deflated, I ask what is all the fuss and where is the actual drug problem? This question calls for a brief background of drug use and policy in Indonesia to help identify currently perceived drug-related problems from state and global governance perspectives.

CONTEXTUALIZING THE CONFLICT

The program manager at ARC Atma Jaya once described to me that traditionally in Indonesian and especially in Javanese culture, there were four permitted vices: sex, alcohol, food, and drugs.¹⁵ In the early and mid-1900s, drugs were part of

¹² “Community Based Drug Dependence Treatment in Indonesia: Documentation of Best Practice,” Komisi Penanggulangan AIDS, August 2015, 9.
¹⁴ Tracy Connor, “Year of Extremes: America is one of the World’s Top 5 Executioners,” NBC News April 5, 2016.
¹⁵ Gambit (Project Manager at ARC), discussion about drug policy, August 2, 2016.
culture; marijuana was used in food, opium was smoked socially. During the early 1900s, there were large influxes of opium due to Dutch colonial imports and policy, but drug use was not problematized among Indonesians until the 1960s and 1970s. Nick Crofts published a different story in the *International Journal of Drug Policy*, claiming that due to forcible expansion of the opium trade by the Dutch, the trade was central to Java’s economy by 1929. In an event called the Opium Regie, the Dutch banned the production of opium in Indonesia in 1894 and established current-day Jakarta as a center for processing opium that was purchased from abroad, distributing it to people through government shops that peaked in number and activity the 1930s.

While Crofts linked the Dutch intervention directly to the existence of widespread drug use and the risk of HIV transmission among users in Indonesia at the turn of the 21st century, a conversation with another administrator at ARC indicated that the problematizing of Indonesian drug use began later. He said that the influx of morphine that occurred during the Vietnam War was what first expanded and intensified drug use in Indonesia. Morphine first became popular in expat communities during the war and spread among the Indonesian youths from there. As a response both to the rising availability of morphine and the United Nations 1961 Single Convention on Narcotic Drugs, the Indonesian government issued its first drug policy initiative in 1971, by which the National Intelligence Coordination Agency was to

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16 Gambit (Project Manager at ARC), discussion about drug policy, August 2, 2016.
19 Irwanto (President of ARC), discussion about history of drug policy, July 24, 2016.
take counterfeit money out of circulation, conduct surveillance of foreigners, and prevent illicit drug use and smuggling. In a continued effort to compile an oral history of drugs in Indonesia from the perspective of drug policy experts and advocates, I asked a leader of the Indonesian Network of People Who Use Drugs (PKNI) about the implementation of this 1971 legislation. He told me that the policy implementation included the establishment of rehabilitation centers, which I was quite surprised to hear. How had such a tolerant response arisen so early and why did the government turn to more criminalizing measures later? Doubting the information, I asked him how he knew about the rehabilitation centers, to which he responded wryly, “They put one in the neighborhood I grew up in, near Tebet. I used to shoot up across the street from it. They weren’t very effective.”

Drug policy in Indonesia was first seriously enforced when HIV was identified among injecting drug users in the mid-1990s. This landmark was consistent between personal accounts from Indonesian drug policy experts and reports from international news and journals. Following the first discovery of an HIV positive drug user in 1996, the first Anti-Narcotics Agency (BKNN) was established in 1997 as a subset of the National Police and was headed by the Chief of Indonesian police. The BKNN earned its status as an independent ministry (called the BNN) in 2002 shortly after President Megawati’s declaration of a War on Drugs. The BNN was granted its own chief in 2009 with the release of a new narcotic law, Narcotics Law no. 35. Law no. 35 introduced methods for diverting drug users from incarceration and toward rehabilitation. The

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22 Sugihendo (Administrative Member of PKNI) discussion about advocacy, August 4, 2016.
foundation of the current drug policy, Law no. 35 was developed as a strict interpretation of policies promoted by UN drug conventions.

This brief history reveals that drug use was not always synonymous with a drug problem in Indonesia. It also reveals that foreign influence has historically played a dominant role in policy and experience. The incongruences between the two storylines, that of international publications and that of the Indonesian people, are subtle but important for exemplifying and reminding the analyst of the space between researched fact and lived experience. The shared analysis that drug policy in Indonesia was first strictly enforced when HIV entered the scene indicates two things.

The first is that drug use, on a macro level, becomes a problem when it is called a problem and the proposed solution often indicates the nature of the issue. According to Indonesian policy experts, drug use first was considered problematic with the introduction of the morphine in the 1960s. The primary focus in the proposed solution was to inhibit the drug trade to reduce drug use, which implies that the problem at hand was a concern for foreign influence that made its mark through the popularization of morphine. When the risk of HIV transmission became associated with drug use in the 1990s, drug use was problematized with new vigor by both state and global governance structures. The state solution was to declare a War on Drugs to protect the Indonesian people from widespread drug “abuse”\textsuperscript{24} while the global governance solution was to provide donor dollar through foreign aid organizations to support the Indonesians who were most at risk of contracting HIV. This implies that the problem at hand was a perceived threat to the population of interest.

The second follows from the first and is that the perceived threat to the population became an incentive for political action. With the introduction of HIV came the notion that the effects of drug use could spread beyond the drug using population. Without specifically targeting HIV or disease at all, the Indonesian government adopted this disease-oriented rhetoric and spoke of drug use as if it were an epidemic plaguing the nation. By framing drug policy as action taken in defense of the innocent and for the betterment of the population at large, both global governance and state drug policies were framed in the language of humanitarianism and biopower, two concepts that I will soon define.

Through this brief analysis of two perspectives on the history of Indonesian drug use and policy, we arrive at the birth of harm reduction in Indonesia. We have arrived not through a framework that focuses strictly on the opposition between the domestic lived experience and the international theory, but rather through one that traces the similarities and differences between the two to arrive at a point of conjunction that precedes the birth of harm reduction in Indonesia. Moving forward, I will introduce the central object of this thesis, harm reduction in Indonesia, and then use it to frame the response to drug policy within a framework of biopower in the new humanitarian order.

HARM REDUCTION AND THE PROGRAM IN INDONESIA

According to the Harm Reduction Coalition, harm reduction can be defined as, “A set of practical strategies and ideas aimed at reducing negative consequences
associated with drug use.” Comparably, Harm Reduction International writes, “Harm reduction refers to policies, programs and practices that aim to reduce the harms associated with the use of psychoactive drugs in people unable or unwilling to stop.”

These definitions leave abundant room for normative conjecture, the most significant of which are questions of harm. What is harm? Who defines harm? Who enacts harm upon whom? It is a far simpler task to describe the implementation of harm reduction than it is to define harm reduction. For example, UN applications of harm reduction strategy traditionally are rooted in disease prevention among low income drug users. The interventions often involve sharing information about and providing materials for “safe” drug use and providing a network of resources to enable paths to abstinence and/or treatment. In this case “harm” is exposure to disease namely HIV. This harm is defined by the UN and identified by doctors at local community health centers.

To consider that the discovery of HIV in the drug using community was what first initiated increased state and global activity relating to Indonesian drug policy is to acknowledge that harm reduction is far more central to Indonesian drug policy than it initially seems. As was indicated in the opening quote, harm reduction is often pictured as a Western technique that is brought and applied to non-Western contexts, in this case Indonesia. However, the previous analysis illustrates that the disease mentality was adopted by the Indonesian government and applied to the state’s portrayal of the drug problem in Indonesia. As harm reduction is the dominant implementer of HIV prevention in Indonesia, the government’s adoption of disease mentality indicates the

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influence that was channeled through harm reduction at an early stage.

Harm reduction was first introduced to Indonesia in Bali in 1998 before it moved to Jakarta in 2001. Kios, the first harm reduction center in Jakarta, began operating in 2001 as an outreach branch of the urban center for health at Atma Jaya Catholic University. The organization was not funded by an international NGO until late in 2001 and was not legalized or formally recognized by the Indonesian government until 2003. In its first years, the most important responsibility of the center was to circulate information about the risks of HIV/AIDS in drug using communities. Needle sharing was a cultural norm among injecting drug users in the 1990s and knowledge about the dangers associated with this practice was scarce. Although this is still a responsibility of the center today, the main priority currently is the distribution of materials such as needles and condoms, and the provision of resources including access to counseling, disease testing, opioid substitution therapy, provision of antiretroviral treatment for HIV positive users and the facilitation of links to rehabilitation centers for clients interested in abstinence. These responsibilities centered on reducing exposure to disease and promoting abstinence make up the day-to-day work at harm reduction centers like Kios.

Harm reduction is recognized by the Indonesian government as a legitimate form of drug policy. In 2006, the Ministry of Health declared that it was legal for harm reduction workers to carry clean needles for distribution, whereas this had been considered promotion of drug use. In 2009, Law no. 35, which is still practiced today, was the first to revert certain people who use drugs away from prison. This law still criminalizes drug use, however, because only users defined as addicts are rehabilitated
rather than incarcerated. Distinctions between users and addicts are made officially according to conservative quantification of possession, but in practice this distinction usually involves a monetary negotiation between the officer and the suspect. The Indonesian government is making slow legislative progress in treating drug use as a public health problem.

Also in 2009, the National Narcotics Board (BNN), which oversees both criminal and public-health related narcotic drug policy, began operating under its own chief rather than under the chief of the National Police, further distancing drug policy from criminal surveillance of the state. Still, the state remains attentive to drug use and vocal about the threat it poses to the entire Indonesian population. Though moving away from criminalization, drug use has remained a highly stigmatized problem in Indonesian society. It exacerbates tensions between internal groups and also between the Indonesian government and global governance structures. Before exploring how harm reduction fits into the relationship between the Indonesian state and global governance, I will introduce some critical theory.

BIOPOWER IN THE NEW HUMANITARIAN ORDER

Michael Foucault’s theory of biopower establishes a framework between governing structures and populations in the modern state and asserts that the former exists to perpetuate the latter. His notions of biopower and governmentality are similar, differing only in that governmentality incorporates sovereignty as well. I will use these

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terms interchangeably to refer chiefly to biopower but acknowledge the role of sovereignty in the modern state.

Foucault’s most widely known formulation of governmentality is derived from his lecture, “Security, territory and population” first delivered in 1978. His most widely known formulation of biopower is in, “Right of Death and Power over Life,” 1978. The main difference between the two theories, outside of some minor terminological distinctions, is the governmentality accounts for the continuation of sovereignty in modernity within the biopolitical framework.

According to Foucault, biopower began in the seventeenth century as the art of government overtook the theory of sovereignty.29 The pre-existing mode of government, sovereignty, was characterized by the juridical theory that the sovereign ruled in singularity and externality over his principality.30 The object of the state according to the theory of sovereignty was to reinforce and protect this principality, comprised of territory and the people of a state, in terms of the sovereign’s relation to it.31 Therefore, in the theory of sovereignty, the state was an end unto itself; it existed for its own perpetuation, drawing a line between the power of the sovereign and any other form of power and reinforcing that line by mandating that citizens obey the law. In the words of Foucault, “What characterizes the end of sovereignty, this common and general good, is in sum nothing other than submission to sovereignty...the good is obedience to the law, hence the good for sovereignty is that people should obey it.”32

30 Ibid., 204.
31 Ibid., 205.
32 Ibid.,210.
With the development of the art of government in the seventeenth century, first attempted through mercantilism and further enabled by demographic expansion, surplus of money and the expansion of agricultural production, the state assumed the responsibility to strategize to provide for its citizens. The reason for the government was no longer government itself, rather it was to enhance the wellbeing of the population using the knowledge of political economy and the means of security forces not to threaten the citizens into lawful behavior, but rather to enhance life in society. Through the development of the art of government there arises a new form of discipline: discipline of the body as a machine, the simultaneous enhancement of utility and docility of the human body defined by as anatomo-politics. Following the development of anatomo-politics but still wrapped within the development of the art of government is the appearance of bio-politics, the supervision of the population through regulatory controls, the quantifications of biological processes, the knowledge that is used as a tool for the promotion of the wellbeing of the population.

In this new framework through which governmentality arises, sovereignty is not eliminated or moved beyond, only the theory of sovereignty is. Foucault explains, "given that such an art [of government] now existed and was spreading, it involved an attempt to see what juridical and institutional form, what foundation in the law, could be given to the sovereignty that characterizes a state."

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33 Ibid., 215.
34 Ibid., 222.
36 Ibid., 262.
38 Ibid., 218.
sovereignty using knowledge of the political economy and the means of indoctrinating docility. Through this system, governmentality is produced and exercised. Biopower was theorized as having begun before the global rise of humanitarianism. The theory has been integrated into critiques of humanitarianism by social scientists before, however its application in the realm of humanitarian health politics in Indonesia has not been widely explored.

When the diffusion of government power occurred in Indonesia during Reformasi, the nation became increasingly open to the influence of global government. New NGOs were enabled through an influx of humanitarian aid, which resulted from a global political shift that had occurred in the years when Indonesia’s strong central government dictated its relative closure to foreign influence. This shift was called the “new humanitarian order.”39 The term was born in 1990 during the Gulf War when the UN extended aid to the Kurds after they were heavily supported by a coalition of allied states during an Iraqi attack. Larry Minear and Thomas Watson paraphrased Resolution 668 of the 1991 UN Security Council when they wrote, “No longer would governments be allowed to abuse their people with impunity. Outside forces would be used, if necessary, in defense of helpless civilians.”40 Elizabeth Bernstein deconstructs this rosy image of humanitarianism and exposes it as militarized humanitarianism,41 but

41 See Elizabeth Bernstein’s, “Militarized humanitarianism meets carceral feminism: the politics of sex, rights, and freedom in contemporary anti-trafficking campaigns,” for critique of militarized humanitarianism, illustrated by UN intervention in the Gulf War.
I will focus on the “new humanitarian order” to mark the time -- 1990 until the present -- of the increasing power and presence of global humanitarianism.

Though initially employed to defend intervention in times of war, the new humanitarian order expanded to defend the extension of global governance to local communities around the world through the development of international networks of NGOs. Through these networks, global government extended, cultivating the authority to define concepts such as “need” and “harm” in daily life and on the local level. With compassion as the ambiguous underlying principle for involvement, the UN took charge in identifying widespread trends of displacement, strategizing responses and extending humanitarian aid to high-risk locations around the world. On the one hand, providing this kind of global quality control for the protection of human rights is one of the key tasks the UN is put in place to do. By setting an international standard, the UN promises to defend civilians both against the government and through the government. On the other hand, structural challenges of the new humanitarian order have become apparent through these interventions.

Didier Fassin writes about contemporary humanitarian government, which he defines as, “the deployment of moral sentiments in contemporary politics.” He considers government in the broad sense, the way it is conceptualized by thinkers like Nikolas Rose and Louis Althusser, to include institutions (local, state, international) more generally. Fassin identifies the presence of a tension between inequality and solidarity within humanitarian intervention, and asks why humanitarianism works so well as a government program. I use Minear and Watson’s term, the new humanitarian

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state and Fassin’s definition of contemporary humanitarianism to explore the ways in which biopower is dominant in this new humanitarian order and in contemporary strategies of governance. I consider the ways in which harm reduction in Indonesia extends state power in the name of biopower and enables an intervention on the part of global governance in the name of humanitarianism. I explore how the two governing structures interact with the harm reduction center as a conjoining point. In doing this, I use Kios Harm Reduction Center as the focal point of my research.

GETTING TO KNOW KIOS

Kios Harm Reduction Center sits in West Jakarta across the street from the famously spicy Abang Adek noodle restaurant and next to a constantly empty math tutoring center. The area is quiet and residential. There are about ten mosques in a 50-yard radius and the closest bus station is an eight-minute walk north. Bonjos, the neighborhood in which the heroin trade flourishes most, is about a fifteen-minute walk away and it is the primary reason that the drop-in center relocated to this site during the spring of 2015. The tall green gate at Kios opens to a wide concrete driveway that is always packed with scooters and beyond them in the welcome area, there sits a crowd of people regardless of the time of day. In the morning, most people smoke or drink coffee, greet newcomers and settle in. In the afternoon, people smoke, fiddle on their phones, gather for group counseling sessions, dip in and out of the offices and complete outreach reports. At night, people smoke, drink black wine, a kind of moonshine, from a plastic and hypothesize about the future of the center and the future of drug use.
Through the summer of 2016, I spent three to four days per week at Kios. On my off days, I acted as a research assistant at Atma Jaya University’s AIDS Research Center (ARC), ventured downtown to policy advocacy meetings or visited other harm reduction and rehabilitation centers. But days at Kios were my favorite. I mainly shadowed outreach workers for my first two months and then began attending funding meetings with the director and attending group counseling sessions with the staff counselor. I recorded field notes each day and conducted my research through a combination of observations, casual conversations, and more formal interviews. Each Sunday I met with Mas Very Kamil, a PhD candidate and former associate of both Kios and Atma Jaya. Very became my mentor for the summer. Having worked in harm reduction since it was first introduced to Indonesia, Very was then and remains now a resource for my many questions ranging from basic structural elements of Indonesian drug policy to specific client-specific inquiries.

These were my tools for my study and I both realize their limitations and marvel at the exposure I had. I conducted my fieldwork over an extremely short time, two and a half months, and I spent the first few weeks discovering what it was that I thought I was learning about. I wrote my grant proposal to travel to Indonesia and study criminal drug policy; having read about the death penalty in the news and broadly and briefly studied Indonesian law and government while studying for a semester at the School of Oriental and African Studies in London, I became curious about Indonesian criminal drug policy. Why it was the chosen form of policy when it seemed that a punitive response to drug use missed the center of the problem? While I do not revoke this initial object of my curiosity, it took traveling to Indonesia to begin to see that criminal
drug policy is far from the only response to drug use in Jakarta alone, forget the whole of Indonesia. Nuances in both the legislation and its application continued to cultivate my interest in Indonesian drug policy. I located my research at Kios and found that I learned most through observation, simply by asking for translations and explanations of what was going on around me. Spending time at the center gave me the opportunity to speak to various institutions and individuals who could help me better understand the relationship between the drug user and the drug policy. It took me a long time to look at Kios and consider the role of this institution and the role of institutions in drug policy more broadly.

In a way, my experience in arriving at my research topic is reflective of a central element of my critique of humanitarianism: the humanitarian institution obscures the role and veils presence of governing structures, while also extending their influence in a way that can be deceivingly polarizing and ill fit to developing lasting solutions to identified problems. My research is unique because it is drawn largely from personal experience and fills a gap in the literature. Most research relating to drug use in Indonesia considers it in relation to the spread of disease and the small amount of literature produced on Indonesian drug policy highlights its punitive nature, either to support it or to compare it against (superior) Western drug policy. Kios is not purely a product of Western aid and global governance but it is also not directly a product of Indonesian culture and government. I use Foucault and Fassin to analyze my personal encounters at Kios and the site-specific data I collected in an effort to understand these encounters. Through this project, I make a significant contribution to the literature on Indonesian drug policy as I examine the workings of biopower and humanitarianism in
a setting where their influence is felt but hardly critically analyzed. By separating the rhetoric of drug policy and humanitarian intervention from the activities of the center and the lived experiences of employees and clients, I hope to examine the definition of harm reduction and the governance of the drug user through institutions like Kios.

DEFINING HARM REDUCTION AND IDENTIFYING A TRAJECTORY

The most telling indicators of the relationship between governance and harm reduction revolve around the definition of harm itself. The term is carried by the normative connotations it evokes, which makes it an extremely powerful tool for the person or governing body with the authority to define it. Who has this authority? Whose definition of harm determines the activities of the harm reduction center? Whose definition of harm is determined by the activities of the harm reduction center? I do not think that there is a simple answer to these questions. I will use an anecdote to say more.

Molded from harm reduction strategies promoted by foreign aid organizations, programs in Jakarta distribute needles and condoms to drug users in harm reduction kits. Three years ago, a number of harm reduction centers in Jakarta began distributing a new brand of condoms when they learned that clients would often throw away the ones distributed in harm reduction kits. The cheap brand provided was too uncomfortable, they said.再次在2016年夏天，客户开始抱怨新品牌的不舒服，Kios, 其他一些机构中，毒贩, 其中一些机构的定义
reduction centers, petitioned to the National AIDS Committee to approve distribution of a higher-rate brand.\footnote{The organizations petitioned to the National AIDS Committee because they would use money from the budget provided by a foreign aid organization called Global Fund when making this transition to the more expensive condoms, and the primary recipient for Global Fund in Indonesia was the National AIDS Committee in 2016.} The National AIDS Committee has not yet approved this second upgrade request with the justification that, while mid-grade condoms increase effectiveness of harm reduction activity, handing out high-quality condoms might incentivize sex among drug users, who are potentially unmarried and potentially HIV positive.\footnote{Very Kamil (PhD candidate, drug policy activist), Mentoring session, July 30.} This would both upset cultural norms of the sanctity of marriage and open the risk of increasing HIV transmission. In this instance, global governance, drug users and the Indonesian government all influence program policy and it is impossible to locate authority unequivocally from one source.

The definition of harm reduction is therefore a complex and shifting, but it is still one that must be considered when grappling with the role of global and state at and through the harm reduction center. The question of the government’s definition of and relation to harm reduction is the starting point for Chapter One. The introduction of neoliberalism in Indonesia in the late 1990s enabled the expansion of civil society and the diffusion of the strong central government. Chapter One parses developments that became considered extensions of government power from those that were considered the expansion of civil society, questioning what contributes to the distinction between the two. As harm reduction was binned into the latter category, Chapter One uses critical theory to determine how it could also be considered an extension of government power and theorize why it is not considered to be such. Finally, Chapter
One re-identifies harm reduction as an extension of state power.

Chapter Two builds from this re-identification of the harm reduction center in terms of the Indonesian state to analyze the role of harm reduction in two states of emergency, one declared by global governance and the other declared by the Indonesian state. Drawing from Didier Fassin’s notion of the contemporary state of emergency, Chapter Two modifies the theory and uses it to articulate the nature of the two states of emergency in which the harm reduction program in Indonesia is wrapped. Chapter Two uses this analysis to make a claim about the nature of the humanitarian intervention and the influence it has on the activities of the harm reduction center when humanitarianism is the governing tool through which harm reduction is carried out. Chapter Three builds on this critique of humanitarianism and challenges the top-down structure of humanitarian aid. It draws from challenges identified through case studies in existing literature, supplementing this evidence with original challenges presented by the top-down structure of humanitarian aid. Finally, Chapter Four illustrates how harm reduction influences the relationship that the government has with the life and death of the drug user, showing how this program enhances the use of politics of biopower in Indonesia. In Chapter 4, I include conversation of necropolitics. Together, these chapter fill a gap in the literature by highlighting the interrelations, rather than functioning within the assumption of oppositions, that surround and define the harm reduction program in Indonesia.
CHAPTER ONE: Government Extended

One knows that all these institutions are made to elaborate and to transmit a certain number of decisions, in the name of the nation or of the state, to have them applied and to punish those who don’t obey. But I believe that political power also exercises itself through the mediation of a certain number of institutions which look as if they have nothing in common with the political power, and as if they are independent of it, while they are not.47

■ MICHEL FOUCAULT Reflexive Water

For Marco, it started with his basketball coach. He shuffled his feet and brought his hand to his temple as he told me. He stood as I sat on the two-foot tall cement wall that lined a large pit, about six feet in depth. At the bottom of the pit there was a bed of dirty needles all mingled in with browning fallen leaves. We were hanging out with his friends under a bridge in South Jakarta, comically close to a building labeled “POLISI” (police) and around the corner from the private practitioner who used to write prescriptions for most of these young men’s buprenorphine orders.48 This was the place where they met each day to crush the pills, mix them with water in a plastic bag and shoot up buprenorphine, which the others were doing as Marco and I spoke.

Marco had grown up in a rough area in North Jakarta, a port district. At the beginning of our conversation, he had painted this environment as his entry into heroin use. “There’s easy access at the port.” He shared nonchalantly, “The police there are blind or they pretend they don’t know. And money talks.”

48 Buprenorphine is a type of opioid often used as a treatment drug in opioid substitution therapy. The doctor only “used to” write this prescription because the chain of distribution had changed for buprenorphine that summer; it was no longer provided by the private practitioner, only by the government referral hospital for opioid substitution therapy.
His dad had been a low-ranking manager at one of the docks and Marco had grown up making pocket money by helping to unload the ships. When there were drugs on board, the dock workers would sell him some at a discounted price. “It was like buying peanuts,” he said. So cheap, so simple. He wove through his personal cycles of use, overdose and abstinence and shared with me his perceptions regarding the drug market and the regulation of the drug trade. He verified my understanding that heroin started coming to Jakarta in large quantities for the first time in 1993, but said he was only thirteen at that point. He had heard of this drug called “putau” (the Bahasa word for heroin) but it didn’t mean anything to him.

He was only thirteen, he repeated. Only thirteen. He began muttering and fidgeting. “I was a basketball athlete,” he said. “My school – ” through the garbled words and repetition his statements were running over one another but also were punctuated with choked silences. “I really, really disappointed my mom,” he released. “They supported me as an athlete but even my coach was using the…he gave it to me for free. ‘You can use this, it gives you good stamina.’ In 1996, the school gave me money, 500,000 ruppiah which was big at the time for a student like me.” He paused and watched his friends for a moment as they stood in laughing conversation. “It’s very shameful. I wasn’t using like the other athletes anymore, I was using for myself. And

49 This was led, he shared with me, by one of former President Suharto’s grandchildren who was an important figure in the car import industry. He notoriously smuggled heroin in with his shipments, Marco told me. No one questioned or punished him because he was a Suharto. His business flourished until the end of his grandfather’s leadership. I tried to cross-check the story with a member of ARC, but he waved it off without saying much. While I cannot speculate the accuracy of Marco’s claim, I can at least acknowledge that it coincides with the historical narrative, presented in Jeffrey Winters’ Oligarchy and other political texts involving the New Order. President Suharto’s familial oligarchy became increasingly immune to the law in the final years of his leadership and the negative popular opinion surrounding this fact contributed to his forced resignation.

50 The equivalent of about $40 USD today.
my mom and dad, they were so proud. They always used to come see me play basketball…”

Marco trailed off, caught in the memory. After a few moments, he started muttering again, promising aloud to himself that he would make his mom proud again. He would do that at the very least.

The ride back to Kios that evening was a long one; we were traveling five miles during rush hour through the center of one of the most congested traffic cities in the world." From the back of Hendra’s scooter, I thought of Marco. I thought about how he only saw his own faults in his story. He had accepted the drugs, he had let his use get out of hand. All I saw was the coach. The coach offering methamphetamine to a thirteen-year-old boy so that the kid could perform better in a basketball game. Did the coach know the power he had over these young boys? Did he know how much this basketball league probably meant to them or what they would do to please him, their leader? Maybe even their role model? If he had grasped the power that he held, the extent to which these pre-teens were compelled to obey him, maybe he would have thought twice about his offer. The kids blindly believed that he had their best interest in mind, but he couldn’t have. He was probably as blind as they were if he failed to see these boys as part of the basketball league, part of the neighborhood, part of the port district surveilled by a police force that punished drugs users and looked the other way in the face of a drug deal as long as they could secure a cut of the money. For this blindness, Marco still pays the price.

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REFORMASI: A DEVELOPMENT NOT A SHOCK TO THE SYSTEM

The fall of the New Order, President Suharto’s 32-year dictatorship, in 1998 and 1999 marked a dramatic political and societal shift for Indonesia. Indonesians and the international community alike tend to fondly remember Reformasi, the period that followed his resignation, as a symbol of liberation, a move toward democracy. However, when it was occurring, people around the world spoke of the Balkanization of the Indonesian nation state and doubtfully speculated its chance of survival. The strong central government, held together by the leadership of President Suharto, had collapsed. With few structures in place to fill the void, religious groups, student groups and interest groups collected more formally to produce new political parties, nongovernment organizations and advocacy groups. The Prosperous Justice Party (Partai Keadilan Sejatera, PKS), for example was born at this time. PKS was rooted in the Jemaah Tarbiyah (Education Movement) that began in the 1970s when the New Order repressed political activism among university students and supported social activities and religious movements in its place. The leaders of Jemaah Tarbiyah took the opportunity presented by Reformasi to create the Justice Party in 1998 that became the PKS in 2003. PKS is now the dominant Islamic party in Indonesia. ²²

As is evidenced by PKS, many of the institutions that developed through Reformasi were rooted in societal stirrings that began before the fall of the New Order, but were repressed until Reformasi. While this was a time of liberation and great growth, it also was a time of unpunished lawlessness and civil unrest. To conceptualize

²² Sunny Tanuwidjaja, "PKS in Post-Reformasi Indonesia: Catching the Catch-all and Moderation Wave." South East Asia Research 20, no. 4 (2012), 536.
the situation in the language of biopower, it was governmentality without enough sovereignty; there was an explosive diversification of governing structures that sought to promote the wellbeing of the population using discipline and knowledge, but the institutions were not strong enough to inspire order. There were no institutions that could claim the sovereignty that characterizes a state. The structures that were arising had been suppressed and minimized for so long that they struggled to take the shape of institutional forms and motivate obedience by law. Thus ensued a period of unpunished lawlessness that developed into a process of government diffusion, characterized by the strengthening of institutions. Through this subsequent period of diffusion, often mistakenly considered reduction, of the Indonesian state, emerged the decentralized government.

Was this decentralized state a neoliberal state? Let us refer to David Harvey’s definition of neoliberalism:

A theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets, and free trade. The role of the state is to create a preserve an institutional framework appropriate to such practices.

Bob Jessop links this definition of neoliberalism to biopower and the diffusion of government. He considers the hollowing out of the nation state, a process that occurs globally through the introduction of neoliberalism. It began in the 1970s as previously

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53 In reference to a statement that Foucault makes about how sovereignty operates in the context of governmentality. Governmentality, 218.

54 Ibid
held state responsibilities were delegated to groups and individuals that possessed authority on a lower geographic scale. During the New Order Indonesia, through its relative self-containment and the strong central state, resisted this global trend of neoliberalism until the late 1990s. In the 1990s, however, through the localization of government and the emergence of numerous institutions, certain neoliberal governing strategies were increasingly integrated into Indonesian government and politics. It was through the imposition of these neoliberal strategies that the Indonesian government was able to harness the opportunity for diversity under newfound unity and continue forward as a nation governed true to the roots of Pancasila: Unity and Diversity.

It is important to note here that neoliberalism, as defined by Harvey, both necessitates the precondition and enables the expansion of governmentality. For the state to maintain (not necessarily unilateral) sovereignty in a free market economy, it must both have knowledge of political economy and means for controlling and surveilling it. By inviting neoliberalism, the state indicates that it is secure in its ability to promote the wellbeing of the population and that it can use its knowledge of political economy even when it does not have full control over it. Biopower and governmentality are thus preconditions to neoliberalism.

In neoliberalism, the state does not contract, rather it becomes diffuse and operates through some clearly governmental institutions, like political parties, and some seemingly neutral institutions, like NGOs and schools. Through the concepts of state and civil society, the clearly governmental and seemingly neutral institutions of the state

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57 Bob Jessop, “Hollowing Out the Nation-State and Multi-Level Governance.” In Kenneth, P. A Handbook of Comparative Social Policy. (Cheltenham: Edward Elgar.)
are often posed in opposition. A comparison between the harm reduction center and the *preman*, a recognized institutional extension of state power that transforms through *Reformasi*, illustrates the false opposition that is cultivated between the two. An analysis of the harm reduction center and its bio-political power shows that the harm reduction center can act as an extension of the state. In drawing these new considerations of government according to governmentality in a neoliberal framework, this chapter deconstructs a false line of opposition between the government and civil society.

**A THEORY OF GOVERNMENT**

Non-governmental organizations (NGOs) began to appear in numbers with the rise of international neoliberalism in the 1970s and have continued to do so up through today. David Harvey critically acknowledges that this development is, “giving rise to the belief that opposition mobilized outside the state apparatus and within some separate entity called ‘civil society’ is the powerhouse of oppositional politics and social transformation.”59 This popular belief bears some relation to the sentiments of Alexis de Tocqueville, who writes that civil society represents the sovereignty of the people and that, for this reason it belongs at the center of government because it checks government power.60 In both conceptions, civil society is glorified as it represents civilian freedom against state power. Harvey acknowledges that this viewpoint is overtaking the Gramscian notion that the state and civil society operate as a coherent unit.

Lamia Karim aligns herself with Harvey as she notes that the NGO and other structures, are perceived to operate outside of and contrary to government forces, but she argues that the NGO and government forces are still, if not more than ever, deeply intertwined. The NGO has overtaken certain roles traditionally occupied by the state for many rural and marginalized communities. By representing morality in development and operating in the name of humanitarianism, the NGO has a uniquely far reach in its ability to promote state agendas.61

Using this concept of the NGO as an extension of state power, I argue in this chapter that the spread of government power through neoliberalism covertly enables the extension of state power, while it simultaneously highlights that power is diffuse. I introduce Reformasi, a period of decentralization in Indonesia and consider the preman system, surveillance using thugs, a legitimated form of extension of state power. I then introduce Kios Harm Reduction Center, an NGO that earns trust among clients and support from foreign aid organizations because they perceive that it works in opposition to criminal drug policy of the state. I question this common understanding of Kios as I trace how the organization was constructed as an extension of the government and how it operates currently as an extension of the government. Finally, I propose potential explanations for its classification as a civil society force rather than as a government instrument of discipline and control. While the harm reduction center is popularly considered a force that stands in opposition to the seemingly contracted state, I argue that this perceived contraction is in fact diffusion of the state, enabled by

institutions like NGOs, which highlight that power itself is diffuse as they promote both the extension of state power and the introduction of new institutions of influence.

DECENTRALIZATION AND INCLUSION

President Muhammad Suharto, the second president of Indonesia, held office for just under 32 years, a period that began with a power seizure from President Sukarno 1967 and ended with his forced resignation in 1998. He played a prominent role in the communist purge of 1965 and 1966, eliminating leftist politics and setting a foundation for the suppression of grassroots movements and non-state community engagement that he maintained throughout his dictatorship. His leadership was military-dominated and intensely authoritarian. Operating a strong central government was no easy task on the world’s largest archipelago and President Suharto was necessarily resourceful in his maintenance of power and authority. One component of his policing was the use of preman, or thugs, who acted as local police with responsibilities such as tax collection. He employed two semi-official preman groups, Pemuda Pancasila and Pemuda Panca Marga, that adopted national organizational structures to mirror those of the state. The members of the preman groups enjoyed privileges akin to those shared by state officials and, because they had the support of the state, faced little competition from other preman groups.

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62 This communist purge included the genocide of between 500,000 to one million Indonesians. This tragic incident set the tone for authoritarian leadership by President Suharto.

With the collapse of Suharto’s regime in 1998, a period of Indonesian history known as Reformasi, the strong central government experienced rapid decentralization. Government ministries and allies were greatly altered during this period and for the preman this meant that the two sub-franchises of state power faced a sudden onslaught of competition. The preman groups gained manpower through unemployment that followed the 1997-1998 economic crisis. The great number of preman recruits coincided with the unsure leadership that followed the collapse of the New Order. This motivated further integration between politics and the preman. Political theorist Jun Honna identifies that politicians began to see benefits in tapping the coercive power of ‘popular’ protests led by the preman, and this alliance began to blur the boundary between political and criminal societies. This, he says, has evolved into the criminalization of local politics that we see in many Indonesian cities today. As the government continues to blame international crime networks for domestic incivility, the preman networks fly under the radar as the undiscovered cause of government mismanagement of criminal security. He believes,

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specifically regarding the anti-drug campaign, that the emphasis that the Indonesian government has put on the development of grassroots movements over the past two decades focuses on the symptoms rather than the cause of the drug problem. According to Honna, the focus need not be on the international crime community nor the development of grassroots movements, but on domestic management of crime.  

Honna reduces the NGO to a docile and inadequate substitute for “real” (criminal) law enforcement. The NGO network, like the preman, must be considered as a government outsourcing mechanism. Without contesting that the reconfiguration of preman groups enabled the government to extend its power by outsourcing certain surveillance responsibilities, I ask why certain institutions that similarly arose or transformed through Reformasi are considered to act in opposition to the government rather than as an extension of it.  

Although Honna does not consider the NGO an extension of government power, he does identify that the diversification of preman was an imitation of the rapid increase in NGOs in Indonesia that occurred a decade earlier. This acknowledgment is implicitly fortified by the parallel imagery used by Ian Wilson, who describes the preman as a “mirror” of the state and Lamia Karim, who depicts the NGO as the “shadow-state.” In the 1990s, Indonesia faced a surge of NGO diversification as Suharto’s power began to decline. His authoritative government was increasingly exposed for corruption and the strong middleclass that had developed through his

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policies for economic growth in the 1970s began collecting and mobilizing in peaceful opposition through the development of interest groups and NGOs. International NGOs supported these movements ideologically and fiscally as they advocated for an Indonesian transition toward democracy. It was these interest groups, young NGOs and student rallies that mobilized opposition that led to Suharto’s resignation in 1998. In this context, the NGO seems to directly oppose state power, but decentralization shows how government influences the growth and operation of the NGO. An analysis of the development and current operation of Kios Harm Reduction Center illustrates that the NGO in enables the diffusion of government power and the infiltration of other influences and illustrates that power itself is diffuse.

**KIOS LEGITIMATED**

Kios was legitimated through a ministry of the government called the Badan Narkotika Nasional (BNN), or National Narcotics Board of Indonesia. The BNN, established in 2001, first appeared as a new program on the agenda of the national police force. Fueled by international attention brought forth by a large illicit drug bust that had occurred in Tangerang, Banten in April 2002, the BNN was committed to asserting its position as an indispensable new feature of the Indonesian government. It developed a plan to fight drug crime and promised a “drug-free Indonesia in 2015.”

The BNN proposed that the central government provide an increased budget, international cooperation in law enforcement and program development for drug users in order to achieve this goal. In 2003, the BNN was granted 150 billion Indonesian

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70 Badan Narkotika Nasional 2003: 5-6, 14-15
rupiah, about $170,000 USD, as an annual budget for its project: Preventing and Combating Illicit Drug Trafficking and Abuse P4GN.\textsuperscript{71}

Correspondingly, Kios, the first harm reduction center in Jakarta, was first recognized by the Indonesian government in 2003. Though it began operating in 2001 as an outreach branch of the urban center for health at Atma Jaya Catholic University, the organization was not funded by an international NGO until late in 2001 and was not legalized or formally recognized by the Indonesian government until 2003. Legitimizing Kios allowed the government to mark the development of a new program “through” P4GN. In practicality, the government’s recognition of Kios had little impact on the organization’s operational capacity because the possession of needles, by users and employees of organizations alike, remained illegal until 2006. This meant that the primary activity of the harm reduction center, needle exchange, was only tacitly allowed by the government for the first five years of its functional and first three years of its formal operation.

Even though Kios’ harm reduction philosophy did not fit the mold for the P4GN vision of a drug free Indonesia by 2015, it fit the quota as a program developed for drug users and helped the government win favor with donor countries by indicating that it was beginning to treat drug use as a public health issue. By recognizing Kios in 2003, the government set a precedent for harm reduction to operate in the interest of expanding political power and facilitate the outsourcing of government responsibility when deemed it necessary.

THE NGO EXTENDED FROM THE GOVERNMENT

Part of an NGO’s power to extend government ideals and surveillance lies in the fact that it is popularly considered to stand in opposition to the government. Foucault warns of organizations like this: the institution that appears neutral, but acts as an avenue through which political violence can be exercised while remaining obscured. By appearing neutral, or even in opposition to government policy, NGOs make themselves far more useful as tools for extending government ideals and surveillance to communities that usually hide from authorities out of fear of being criminalized.

When I was shadowing at Kios during the summer of 2016, I periodically asked the employees about the purpose of their work. What was the end goal for the client? They often responded by saying that abstinence through rehabilitation is ideal, but it is not for everybody. Kios, though not based in abstinence theory, is informed by Indonesian cultural and governmental biases regarding drug use. Though it does not demonize the drug user as other forms of Indonesian drug policy do, it still establishes a hierarchy between clients who achieve abstinence and those who moderate their using habits. In this case, Kios extends ideals of abstinence-based drug policy through a public health-related approach.

Similarly, Rumah Singgah PEKA, a rehabilitation center that is a partner to Kios, is one of the many organizations that extends the previously introduced compulsory self-reporting law, wajib lapor to its clients. Wajib lapor mandates that the

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user or the family of the user reports to the BNN for registration. The user and or family members can be fined or imprisoned\(^7\) for failing to do so. This law, though it is written to impose standards of a relationship between the national police and the drug user, in practice is often carried out through NGOs. PEKA registers the user with a number rather than a name and gives the user a registration card, which ensures the user a three-strike warning system if they are found in possession of drugs. The center gains good favor with the government and monetary compensation for the extension of user registration. The user gains security through the three-strike system and does not surrender much, it seems, if only a number rather than a name is recorded as identification. Both parties see the benefits in this system that ultimately contributes to a pretty extreme extension of government power over drug users and their families.

The extension of government legislation through the NGO network is a lucrative method for spreading government power, but sometimes subtle modes of extension of power are best suited to these institutions. The home base of Kios is a drop-in center in West Jakarta that is about a ten-minute ride from the most densely populated community of “street drug users,” meaning people who use heroin and methamphetamine, in the city of 13 million people. Kios’ positioning allows the center to maintain close contact with the users in this area and serve as a practical resource for clients to drop in for needle exchange, counseling, group information sessions, or provision of antiretroviral treatment drugs for users who are HIV positive. Though the center is strategically positioned for the convenience of members of this high-density

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\(^7\) The maximum sentence for failing to report as a drug user is a five-year sentence for a user and a three-year sentence for a family member.
drug using community, the organization’s reach is not limited to this tight geographical area.

Kios’ outreach workers split into three geographical teams: one pair for South Jakarta, one for North Jakarta and one for West Jakarta. South Jakarta has a reputation for being the wealthiest district, North Jakarta for being gang-ridden and West Jakarta for being the poorest.\textsuperscript{74} Outreach workers are trained and assigned to a district according to their strengths. The center is geographically positioned and the employees are systematically trained to track drug use in impoverished communities characterized by drug use. While these features of harm reduction enable the center to conduct thorough outreach and provide extensive care, they also extend the government eye to certain areas and communities that are traditionally difficult for the state to access.

Kios also extends government surveillance by acting as one of the satellite centers for distribution of antiretroviral (ARV) treatment drugs among HIV positive users. Before the satellite system was developed, referral hospitals were generally understaffed and overwhelmed by the demand they received for ARV medication. Even with these satellites, the central referral hospitals see between 70 to 100 patients per day.\textsuperscript{75} Outsourcing ARV distribution to NGOs like Kios helps the government extend medicine to more clients.

One morning, I accompanied two Kios outreach workers, Jonna and Mani, to a community health center that provided methadone maintenance therapy (MMT), a

\textsuperscript{74} Husen, Basalamah. Interviewed by Alyssa Domino. Personal Interview. West Jakarta, June 14, 2016.

form of opioid substitution therapy (OST) in West Jakarta. Though the purpose of the visit was to accompany clients to MMT, we spent very little time inside the methadone center. It was a small room with a little window that had an eerie resemblance to the divider in a confessional. The government employee at the health center lifted the screen and passed a small cup with a serving of methadone to the next customer in line. In the room, there was a chair with a notebook for record keeping. On a small counter to the right there was an enormous bottle labeled “methadone.” It was mixed with grenadine and looked like cherry cough syrup.

MMT centers are open for about six hours per day in Jakarta and most patients must take their medicine onsite each day. They earn take-home doses if they regularly pass urine tests to show that they are not taking any other drugs while they are on methadone. With a maximum of three days away from the center at a time, this system chains users to the treatment dock. There is no strong treatment plan in place to bring a patient off methadone and many users have been visiting these clinics every three days for the past ten years.

We spent most of our time just outside of the walls of the center. We walked around one side, speaking to various Kios clients. Jonna pointed down at a gutter where there were tens of needles resting along the bottom. He said that Kios hadn’t been around for a needle cleanup for a few weeks. They were overdue. I was confused. Why would people use needles here, right outside the government-run community health center? Jonna laughed as if I had missed the punchline of a simple joke, “Of course

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76 Substitution drugs provided through OST activate the dopamine receptors just like opioids do, but they are much more difficult to overdose from than heroin or morphine. OST drugs largely satisfy the craving that a habitual user feels for an opioid and are far less pleasurable than recreational opioids (National Drug Court Institute, Module 2 Online)
they sell here! It’s easy, so many people come here. You see the ones in the hats? They’re the dealers.” I looked around and saw five or six young men wearing black hats talking to people in various circles. I tried to stay attentive for any hand-to-hand contact, any transfers, but I only saw conversation. I looked around for police or health center employees coming to break up the gathering - *they must have known it was happening!* - but no one came and the users and dealers both appeared at ease. It was not until later that it dawned on me: why would the government break up this hotspot for drug use and dealing? Just like shantytowns with known shooting galleries and open exchanges, this was a contained and surveyed site of drug use and exchange. Both the users and the dealers were quarantined to this spot as the government eye looked on, satisfied.

Before closing, I must add that the NGO’s ability to extend government power is not necessarily bad. One positive aspect of this system is that the NGO can extend resources to citizens who are otherwise not reached by the government. I do not intend to demonize the government or present the NGO as a tool for spying, rather I aim to draw out non-oppositional features of the government-NGO relationship.

**WHY OPPOSITION?**

If Kios is an avenue through which the state exercises its power to intervene in the lives of drug users, why is it popularly considered to stand in opposition to the state? Framing the NGO against the state strengthens the government’s ability to extend ideals and surveillance to communities that otherwise distance themselves from or reject certain government policies. It contributes to the notion that the client has a loyal
friend in the NGO, that the NGO’s intention lies with the interest of the client. With this shield, the NGO, and the state through the NGO, effectively dodges fundamental questions. For Kios, these could be questions like, why is abstinence superior to moderated drug use? Why is “harm reduction” situated around controlling disease? Why does the organization channel its services toward geographically isolated communities of drug users rather than toward those who use at school or after work, and are generally within the social strata of the regular population?

Because power is diffuse, Kios can stand both alongside and in opposition to the government in the same moment. Even as power is extended from the state through Kios, other streams of power move through the harm reduction center, sometimes driving it to oppose governance of the state. The alternative to an abstinence-based model, adapted from the West, is a perfect example of this. By offering this resource, Kios appeals to portions of the drug using population that are unreachable to treatment centers. When Kios provides this resource, the center is opposing a government regulation in the interest of reducing harm, or mitigating the spread of disease, or something other than abstinence. In this case, Kios is, “the powerhouse of oppositional politics and social transformation,” but it does not act independently. In this case, the power of the harm reduction ideology, backed by international NGO and Western aid networks, wins out over government regulation. Power constantly moves on and through the harm reduction center and the diffusion of government power enables us to more clearly see power that moves from other influencers and reminds us to remember that the government, though less centralized, still exerts power over the identified user.
CHAPTER 2: Harm Reduction the Emergency

Power (and not necessarily state power) continuously refers and appeals to exception, emergency, and a fictionalized notion of the enemy. It also labors to produce that same exception, emergency, and fictionalized enemy.\footnote{Achille Mbembe, “Necropolitics,” (Duke University Press, 2003), 17.}

ACHILLE MBEMBE Necropolitics

Although Kios has grown in independence from Atma Jaya University over time, it is still connected to the university through the AIDS Research Center (ARC) and sometimes works in tandem with students, particularly through the AIDS Care Group, a student-run organization to promote knowledge about HIV/AIDS and other diseases. I attended a program jointly run by Kios and AIDS Care Group in June of 2016 at Sanggar Akar, a center in East Jakarta that provides alternative education for street children between age six and sixteen. Perhaps “intervention” is a better word than “program” to describe the activities that occurred that day. The university students from AIDS Care Group were the MCs for the event and two representatives from Kios led lectures with PowerPoints for a group of children between ages six and ten. They presented lessons on drug use through a “user, abuser, addict” model to speak to the children about the stages of use. The lecture and discussion were meant to be part of a preventative program for students who, through the communities they were born into, are highly exposed to drugs from a young age. The presentation, however was a bit over the heads of these young kids. When AIDS Care Group opened the floor for students...
to share personal experiences and struggles regarding the subject matter presented,” the first student to raise his hand politely shared, “My friend sometimes sniffs glue when we play arts and crafts and I tell him that it’s bad but he does it anyway.”

This adorable, innocent response to the weighty presentation was a perfect representation of the key issues in this intervention. First, the session was treated not as part of a program, but as an emergency information session. There was no relationship established between the children and the presenters, which made it difficult for the latter group to deliver its message. Second, the presentation used language of disease and urgency to scare the children out of trying drugs, when the closest issues to potential drug use on their radars were incidents of glue sniffing and cigarette bumming. Because they used the format and language of an emergency, Kios and AIDS Care Group were minimally effective in delivering the humanitarian message they sought to share with the students at Sanggar Akar.

This story presents a microcosm of the issues that this chapter will address. I will begin the chapter by establishing a theory of the contemporary state of emergency, modified from the conception of emergency provided by Didier Fassin in *Humanitarian Reason*. Fassin says that the contemporary state of emergency responds to a threat and acts by limiting the freedoms of civilians to expand the power of government. After modifying this definition to make it applicable to health-related states of emergency, I will revisit this scene of Kios, AIDS Care Group and Sanggar

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78 Participation was incentivized through distribution of candy. Had it not been, I do not think that many people would have participated in the post-lecture discussion.

79 Another student told a similar story to that of the first participant, where she – the hero – was unable to persuade a misguided friend out of sneaking out of class to smoke cigarettes.
Akar as I explore the two states of emergency that directly influence harm reduction programs in Indonesia.

EXCEPTION AND EXTENSION

The idea that the government, in times of necessity, might extend its power in order to ensure the protection of sovereignty has been in circulation for millennia, reaching back to the imposition of Cincinnatus’ dictatorship to save Ancient Rome. In the seventeenth century, there was a shift in mentality from the state whose duty it is to protect sovereignty of the state to one whose duty it is to deliver on its fundamental promise to protect the people. European Enlightenment thinker John Locke instituted this as a tenet of Western theory of government when he wrote that the social contract for the creation of government included the surrender of certain liberties in exchange for protection by the state. Michel Foucault cites this shift as, “a sort of theoretical matrix for deriving the general principles of an art of government.” Though the framework for implementation was not yet in place, this moment indicated a shift toward biopower.

When Abraham Lincoln, a great hero of the American political system, was criticized for suspending the writ of habeas corpus through an executive order during the Civil War, he defended his action by saying that acts illegal in peacetime might be

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80 At this point in time, the purpose of the state according to Foucault was to protect the sovereign, and therefore the ideals of the state of emergency and the theory of the state were aligned.


82 Although the government reoriented its purpose around the wellbeing of the people, the state of emergency remained geared toward the protection of state sovereignty for some time.
necessary “in case of rebellion” when the state is threatened. He justified the suspension of freedom of speech by declaring a state of emergency as the nation underwent a civil war that could have been the end of the United States. This state of emergency allowed the US government to take sanctions against its own people in the interest of protecting the state. Lincoln’s administration arrested peaceful citizens who criticized the US government and censored the newspapers, thus employing sanctions that are considered fundamentally undemocratic. Lincoln’s declared state of emergency is an example of what social theorist Didier Fassin would call a traditional state of exception: the suspension of certain constitutional rights to give full power to the sovereign to protect the state in a time when public order is in danger of being compromised.

Carl Schmitt questions the bounds of the role of the state in the declaration of and exception, “The Sovereign is he who decides on the exception.” If the government has the authority to declare a state of emergency, it also has the authority to extend its own power and suspend the rights of the citizens. Does this framework compromise democracy? To bring biopower back into play, a Foucauldian response would highlight that, because the art of government has been developed, the government aims to serve the population, but a rebuttal in the spirit of Fassin might state that the traditional state of emergency aims to protect the state, and therefore the theory of sovereignty governs in the traditional state of emergency. This means that the

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perpetuation of a traditional state of emergency presents a legitimate threat to democracy, as what occurred in Nazi Germany.

In this chapter, I modify Didier Fassin’s definition of the contemporary state of emergency by expanding on the nature of the “threat” to which he says the state responds and by distinguishing that the extension of state power through the state of emergency can, but need not always, limit the freedom of civilians. Instead it is characterized by the cultivation of urgency that enables rapid legislative action. I use Fassin’s modified theory as a baseline to argue that the Indonesian War on Drugs and the UN declaration of a global HIV/AIDS emergency use the rhetoric and tactics of a state of emergency to respond to two issues that are not, in fact, emergencies.

Harm reduction in Indonesia and at Kios specifically, was born and legitimated through states of exception, and therefore has a relationship with each and informs the relationship between the two. While harm reduction does not mitigate certain oppositional features of the two movements, it does provide a neutral zone where the agenda of each is enabled. Woven throughout these applications of theory and analysis is the opening scene of the chapter. I equally use the analysis from this chapter to interpret that day at Sanggar Akar, and use the day to ground the analysis in this chapter. This leads to my final task in the chapter, which is to test the harm reduction center against Fassin’s definition of a humanitarian actor.

**A THEORY OF EXCEPTION**

Giorgio Agamben wrote that in recent history, the use of periods of emergency rule has continued on an upward trend: “The state of exception tends increasingly to
appear as the dominant paradigm of government in contemporary politics.” There is a fundamental paradox in the normalization of the state of exception, at least rhetorically. Didier Fassin confronts this paradigm in his book *Humanitarian Reason* and argues that the rise of humanitarianism marks a new stage of development in precisely this trend: the state of exception as the normal, or the rule of government. If this is the case, there must be shifts between traditional and contemporary politics and traditional and contemporary states of exception. Fassin identifies some of these shifts and I use his examples and my own examples to defend the modifications I make to his theory.

Fassin argues that, while states of exception are still used by the government today, they are justified and executed differently in the contemporary world. In contrast to traditional reasons for declaring a state of exception, contemporary states today declare them because of a threat, but not necessarily one of war, and nowadays states of emergency limit certain freedoms but do not abolish or set aside the rule of law. He believes that humanitarianism is now often used to justify a state of exception. It is the contemporary catalyst for action, enabling the extension of government power in times of need. He uses the 1999 Venezuelan natural disaster, *Tragedia*, as his case in point. *Tragedia* brought the death of thousands and the displacement of tens of thousands of Venezuelans, drawing the Venezuelan government to call a state of emergency to mobilize relief efforts. Fassin illustrates, through his analysis of the two-fold

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government response to this disaster, his theory of the contemporary state of exception and how it is both validated by and validates humanitarian reason.89

Though I agree with Didier Fassin’s theory that the grounds for declaring a state of exception have changed, his distinction is not clear. He writes that in the traditional, “the state of exception is instituted in response to a danger to public order (particularly war)” whereas in the contemporary world, “it does not necessarily respond to war per se, but rather to the presence of a threat,”90 but these phrases are hardly distinct. I would like to suggest that there has been a shift not in the nature of the threat to which the state of emergency responds, but rather in the subject that is threatened. Foucault’s theory of governmentality says that the theory of sovereignty gives way the art of government through the sixteenth to eighteenth centuries. Applying this transition to the state of emergency, the subject threatened in the traditional state of emergency is the power of the sovereign. Conversely, in contemporary society, it is a threat to the wellbeing of the general population to which a state of emergency responds. This is logical because as the wellbeing of the people continues to grow as a primary concern of the government, it follows that a threat to the wellbeing of the people, rather than a threat to state power, acts as the justification91 for urgent government response signaled by the declaration of a state of emergency.

89 “Humanitarian reason” is defined by Didier Fassin on page 2 of his book, *Humanitarian Reason*, as follows: “On both national and international levels, the vocabulary of suffering, compassion, assistance, and responsibility to protect forms part of our political life: it serves to qualify the issues involved and to the reason about choices made. This is the definition I consider when using this term.


91 Sometimes urgent government action justified in the name of defense against a threat to the wellbeing of the population is in fact primarily a response to a perceived threat to the state.
While the first element of Didier Fassin’s distinction between traditional and contemporary states of emergency can be clarified by defining the subject of the threat, the second element is theoretically sound but practically challenging. Fassin says that, in the traditional state of emergency, the government will often suspend constitutional rights by ceding full power to the sovereign, frequently through the military, whereas in the contemporary state of emergency, the government revokes certain freedoms but does not abolish law. The distinction here seems relatively clear; in the traditional case, the people cede full power to the sovereign during the state of emergency whereas in the contemporary case they lose certain freedoms but the laws protecting their other rights are not abolished. I argue, however, that in practice these two seemingly distinct characteristics are not so different.

Fassin uses Nazi Germany to exemplify the traditional state of emergency. Adolf Hitler’s administration declared a state of emergency in response to an arson attack on the Reichstag building in Berlin in 1933, through which the Nazis defended the suspension of due process of law for the duration of the Third Reich, paving the way for the consolidation of power by the Nazi police force. Fassin cites this as the abolition of constitutional rights to eliminate constraints on government power. While Lincoln’s decision to suspend habeas corpus may seem far removed from my current discussion on Fassin’s definition of the contemporary state of emergency, it is nonetheless relevant because of a point that I will return to below.

I believe that the Nazi case is a unique example of the traditional state of emergency and while it followed Fassin’s framework by suspending constitutional rights

and nullifying due process of law for the entirety of the regime, this behavior was not
typical even in the traditional state of emergency. The example of Abraham Lincoln’s
suspension of habeas corpus presents an alternative picture of the traditional state of
emergency. The government limited freedom of speech, but did not abolish it entirely.
This behavior seems to align more closely to Fassin’s depiction of the contemporary
state of emergency, which limits but does not abolish certain freedoms of civilians.”
In contemporary cases, governments expand their powers but do not necessarily claim
unlimited power. On October 9, 2016, the Ethiopian government declared a state of
emergency in response to nearly a year of ethnically divided anti-government protests.
The protests were often violent and at least 500 people were killed by government
security forces. The declaration of the state of emergency was followed by curfews,
social media blocks, and domestic travel bans of oppositional party members, justified
by a desire to protect the innocent.” Similar to Lincoln’s traditional state of emergency,
the government imposed limits on freedom of speech and limits on freedom of
assembly.

In a quite different case, on January 16, 2016 President Obama declared a state
of emergency in Flint, Michigan responding to toxic lead contamination in residents’
drinking water. The contamination began in 2014 when Flint began sourcing water
from Flint River instead of Lake Huron to save money as a new pipeline was being
built. The state of emergency was called because the general population of Flint was
threatened by this contaminated drinking water. When the state of emergency was

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95 “Ethiopia extends state of emergency by months,” *Aljazeera*
http://www.aljazeera.com/news/2017/03/ethiopia-extends-state-emergency-months-
called, the Federal Emergency Management Agency (FEMA) was authorized to provide disaster relief funds and the local government was pressured to improve drinking water conditions for the people of Flint. In the first example of a contemporary state of emergency, the government limited the freedom of its citizens by functionally suspending rights to free speech and assembly just as Abraham Lincoln did during the Civil War. In the second example, however, a state of emergency was called and the government did not revoke freedoms of the general population. In both cases, the government used the state of emergency to provide urgent humanitarian aid and push government action. I argue that consolidation of government power in the contemporary state of emergency occurs in defense of promoting general well-being of the population and is executed through the mobilization of resources.

In *Tragedia*, Fassin’s example of a contemporary state of emergency, the situation is two-fold: first, the Venezuelan government declared a state of emergency following a natural disaster; second, the Venezuelan government did not declare, but it implied, a state of emergency to respond to “looters, rapists or thieves” who appeared in the aftermath of the disaster. On the one hand, the solidarity that arose in the immediate wake of natural disaster was seen as miraculous in a country that was otherwise riddled with corruption and inequality. In this respect the state of emergency was not characterized by the government limiting the rights of the people, rather it arranged an influx of resources to help the victims. On the other hand, the Venezuelan

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97 It is worth noting that the state of emergency in Flint, Michigan and the two states of emergency I will present regarding drug use in Indonesia claim that they respond to public health-related emergencies.

government imposed curfews on citizens, limiting the freedom of the public so that military could more easily identify the looters, rapists and thieves. Effectively, this curfew allowed the military to open fire on those out after hours, as the surveillance forces operated under the assumption that those who did not follow government sanctioned curfews were the looters, rapists and thieves.∗∗ Fassin aptly uses this case to show that the contemporary state of emergency involves the government limiting civilian freedom. However, I believe that when considered in conjunction with the Ethiopia and Flint cases, it is more accurate to say that the contemporary state of emergency does not always involve the limitation of civilian freedom; rather it is characterized by the pooling of resources and cultivation of support for rapid legislative action. The government still uses the state of exception to extend its power, but this does not always occur at the expense of freedom of the citizens. This modified contemporary model illustrates the centrality of biopower to the modern state, which no longer only justifies its actions in relation the wellbeing of the population in regular time, but also in states of exception. The increasing variety of applications of the contemporary model shows that the rhetorically powerful state of emergency is extended in response to a wide range of humanitarian concerns today.

To summarize my alterations to Fassin’s identification of the traditional versus the contemporary state of emergency are twofold. First, I state what he seems to indicate: that the traditional state of emergency responds to a threat against power of the sovereign while the contemporary state of emergency responds to a threat against the wellbeing of the general population. Second, I agree that the traditional state of

emergency expands government power by justifying the limitation of citizen freedoms, but distinguish that the contemporary state of emergency expands government power by mobilizing resources and pushing for rapid legislative action, which sometimes but not always involves the limitation of citizen freedoms. As a footnote, I want to reiterate that Nazi Germany exemplifies Fassin’s definition of the traditional state of emergency, but was historically unique in its severity. In the words of Hannah Arendt, “There are no parallels to the life in the concentration camps. Its horror can never be fully embraced by the imagination for the very reason that it stands outside of life and death.”

Through these slight changes, Fassin’s theory of the contemporary state of emergency becomes applicable to perceived public health problem. I will briefly consider this theory in the context of a state of emergency declared by a structure of global governance, as Fassin only speaks about a state of emergency declared by a state. I then will apply the theory to the two states of emergency declared in relation to harm reduction programs in Indonesia: the Indonesian War on Drugs and the UN’s declaration of an emergency regarding the global spread of HIV/AIDS.

THE STATE OF GLOBAL GOVERNANCE

Though Fassin acknowledges both the importance of global governance structures in the “new humanitarian order” and the growing role of humanitarianism in contemporary states of emergency, he does not state whether global structures of governance can declare a state of emergency. If they have such power, the challenge

becomes how to define the general population whose threat indicates emergency. An analysis of the United Nations’ Standards of Human Rights and Humanitarian Law indicates that the United Nations does reserve the right to intervene to defend either a national population or certain sub-groups that are discriminated against on the national level if they are denied human rights.

Though these standards do not explicitly state the UN’s power to call a state of emergency, they detail expectations for human rights protections for all individuals in member states and additional expectations for certain sub-communities and special circumstances. The UN reserves the right to intervene when member states vote to agree that these expectations have not been met. This indicates a particularly close alignment between the state of emergency and humanitarian reason. The general population in this case is not defined by nationhood, rather it is defined according to whose rights are being violated. Having identified this link, I will use Fassin’s modified theory to consider whether the rise and spread of HIV and AIDS may be considered a state of emergency.

One final consideration regarding the state of emergency declared by a global governance structure is that of multilateral sovereignty. If both global governance and national government structures have the authority to declare states of emergency, Schmitt’s model of exception is confounded. While his model presupposes a concept of sovereignty that is unitary, here we see the potential for conflict if two governing bodies declare states of emergency. While in Fassin’s case study, the state of emergency in response to a natural disaster compounds into one against criminal activity, in my

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case study, a global state of emergency against HIV and AIDS stands in partial opposition to the Indonesian state of emergency against drugs. The harm reduction center, as a player in both, may thus be placed in a compromising position if it must mediate the relationship between the two.

THE INDONESIAN WAR ON DRUGS

On February 4, 2015, President Joko Widodo announced at a national coordination meeting for 2015 drug policy, “There is an emergency situation [of rampant drug abuse cases in the country] that requires everyone work together [in handling it].”104 This call to action echoed the sentiment voiced by President Megawati during her speech at the State Palace in 2001, “For me, it is better to have a person suffer capital punishment than to see the whole community become addicted to drugs.”105 In both cases, the presidential justification for the War on Drugs was a biopolitical concern that drug use, characterized as addiction and abuse, was becoming a threat to the population.

As she declared a state of emergency, Megawati called for a War on Drugs and elevated the status of the BKNN (the predecessor to the BNN) from an administrative agency to a ministry with the authority to enforce the law against drug offenders. She criticized the authorities for failing to punish drug offenders according to the law. At the time, Indonesian drug law officially treated those convicted of narcotic or psychotropic drug possession with up to 20 years of prison and narcotics offenders with the death

penalty; however, in practice most possession cases involving ecstasy, methamphetamine and heroin reportedly resulted in one to five years of imprisonment for the offender. Calling for change, Megawati advised, “I would urge the chief justice and all other legal officials to reflect on the dangers of drugs for our children and grandchildren when handing down verdicts.”

President Widodo’s 2015 War on Drugs also identified drug use as a threat to the wellbeing of the general population. The president took action by signing off on the execution of fourteen drug offenders in 2015, twelve of whom were foreigners. The BNN pledged to rehabilitate 100,000 drug users that year and double their numbers in each subsequent year. Carrying the spirit of emergency into 2016, President Widodo passed a decree in 2016 that guaranteed the government the right to shut down any organization that provided drug information that was not directly approved by the government. Buddi Waseso, the leader of the BNN, held a press conference at which he promised to build special prisons for drug offenders that would be guarded by man-eating crocodiles. Of all these promises (or maybe threats), the only one delivered was the execution of fourteen convicted drug traffickers.

The states of emergency enabled quick legislative action by fostering a sense of urgency and motivating increased allocation of funds to the issues at hand. The two administrations justified these states of emergency by highlighting the threat that drug

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106 Ibid.
use poses to the present and future population of Indonesia. According to this analysis, the Indonesian War on Drugs was a state of emergency in both cases. I argue that they were states of emergency declared in response to non-emergency issues. For this reason, they were not carried out to serve the best interest of the population. Megawati campaigned for increased incarceration and Widodo exercised the death penalty. Both presidents rhetorically medicalized the drug user by using terms like “abuser” and “addict” to refer to those who use, thus further isolating stigmatized communities of drug users rather than providing treatment or preventing use. On that day at Sanggar Akar, I saw Kios echo the War on Drugs, not through divisive action, but through divisive rhetoric.

Although Kios and other liberal NGOs often criticize the use of terms like “abuser” and “addict” in reference to people who use drugs, intriguingly, when they presented to the youth at Sanggar Akar Kios representatives used precisely this terminology when they provided a framework of use, abuse, and addiction. By using medicalizing language and cringe-inducing pictures, they distanced the drug user from the normal so that these students saw no hints of themselves in the depictions provided. While the younger children, in pursuit of candy and applause, tried to bridge this gap, the ten-year-old children, to whom the message was far more relevant, sat in the back and snickered as they watched this occur. After the presentation, a group of these ten-year-olds retreated outside to smoke cigarettes.

Kios did not declare a state of emergency, but this intervention echoed the divisive, medicalizing rhetoric of the War on Drugs. Though Kios sought to foster urgency among the audience, the presenters failed to deliver a unifying message. At
Soekarna Hatta airport, the “No Drugs!” sign is presented as an urgent message to all Indonesian and foreign travelers, most of whom find it off-putting, but irrelevant to them personally. People like Marco, however, who associate drug use with the culture of Jakarta, hardly see the sign because memories evoked by re-entry into the city provide far more meaningful associations and sometimes trigger relapse. At Sanggar Akar, the ten-year-old students were deaf to the message delivered by Kios and AIDS Care Group because they only saw it for the distance that existed between themselves and this medicalized individuals projected onto the wall. By using fear-inducing terminology and images of drug use to scare the kids away from drugs, the presenters incidentally provided a false sense of security and distance among the students for whom this information could be most useful. Parallels with the War on Drugs at the national level are plentiful.

HARM REDUCTION IN THE WAR ON DRUGS

Extending from the historical background that joined Kios and the Indonesian government in the previous chapter, President Megawati’s declaration of a National War on Drugs indirectly facilitated government legitimation of Kios. The state of emergency provided the government the freedom to enact swift legislative action, which they did when they elevated the status of the BKNN and expanded its funding. This expanded budget enabled the P4GN project, by which Kios was legally legitimated. Ironically, through a state of emergency called in the name of a National War on Drugs, Megawati opened the door to Indonesia’s first non-abstinence-based form of drug policy.
Harm reduction centers have not experienced many benefits from President Widodo’s War on Drugs, but they have been influenced. The focus on mandatory rehabilitation has pushed users further underground as they are drawn to distrust organizations that they fear may try to round them up.\footnote{111} The harm reduction center remains useful to the government as it continues to act as both an extension of government surveillance and outsourcing of government responsibility, but the War on Drugs makes the center less effective in achieving both of these tasks. This War on Drugs makes an example of the drug user through subjecting rhetoric and the foreign drug trafficker through punitive action.

While Carl Schmitt claims that the sovereign defines the exception, in the case of the drug war in Indonesia, it is safe to say that the sovereign invents the exception. The drug problem in Indonesia is hyperbolized by the government. The government stated in 2015 that about 4.5 million Indonesians were addicted to drugs\footnote{112} while the National AIDS Commission conducted a study in 2015 that showed that about 3.8 million Indonesians use drugs,\footnote{113} which is about .015% of the entire population. The campaigns built upon false statistics that warn against the dangers of rampant drug abuse serves, more than anything, to help the general population unite behind the common enemy of “the drug.” Prosecution of the foreign drug trafficker and

\footnote{111} Contrarily, clients of harm reduction centers are often treated more leniently than unassociated individuals found in possession of drugs. The police hold an attitude of tolerance for harm reduction. Users who fear that there has been or may be a shift in this relationship through the War on Drugs make themselves scarce, a challenge that outreach workers frequently troubled over at Kios.


\footnote{113} Community Based Drug Dependence Treatment in Indonesia: Documentation of Best Practice,” Komisi Penanggulangan AIDS, August 2015, 9.
demonization of the drug user help the government fill in the figure of this enemy. These two emergencies do not influence the harm reduction center in the same way, but it is influenced through both.

Fassin defines exception by calling it, “a political gesture that involves and cuts through the whole of society.”114 In the case of the Indonesian drug war, the declared exception is a political gesture that does not motivate political action toward the population as a whole. This is because the state of exception in this case is inappropriately extended to a humanitarian concern that is not episodic, rather it involves long-term conditions that require sustained and institutionalized management. The contrived emergency of a drug problem is a political gesture that unifies the general population of Indonesia against a problem that they do not see as affecting them. While the projected threat of drug use creates anxiety about the well-being of the Indonesian population, the drug war fosters a sense of purity and collective resistance among the abstinent.

INSTITUTIONAL CHANGE

During the Sanggar Akar intervention day, I met a girl named Yuse who was an eighteen-year-old student mentor at the program. The center taught arts and music to street children and she told me about how talented some of them were, that the elites being considered for sponsorship to travel to Norway and participate in a dance competition there. She showed me around the center, to the bunkrooms of the student mentors and the activity rooms for the children, and introduced me to the director.115 I

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115 When I became aware that the program director of Sanggar Akar was onsite, I was surprised that he did not greet the visitors or participate in the intervention at all. This read
was taken by the contrast between the facilities, which were meager, and the community, which seemed to excel. Though the center had nothing to do with drug education or prevention, it seemed to do a better job of showing the students opportunities outside of drug use, showing them ways in which their lives needed not be stifled by the environments they were born into. Sanggar Akar shows a counter-example to the misappropriated state of emergency. Certain humanitarian interests should be carried out through institutions that are managed and maintained, rather than through emergency interventions that create urgency and enable quick fixes, but do not build long-term solutions.

THE GLOBAL FIGHT AGAINST HIV/AIDS

Megawati’s War on Drugs was not the only state of emergency influencing Indonesian harm reduction centers at the turn of the century. In June of 2001, the UN General Assembly convened in “as a matter of urgency” to address the global issue of HIV/AIDS. In the resultant declaration of global action, the UN affirmed that it was:

Deeply concerned that the global HIV/AIDS epidemic through its devastating scale and impact constitutes a global emergency and one of the most formidable challenges to human life and dignity, as well as to the effective enjoyment of human rights, which undermines social and economic development throughout the world and affects all levels of society.\(^\text{116}\)

The declaration went on to detail a plan of action for promoting national, regional and international efforts to fight HIV/AIDS. In the same year, FHI, partially funded by

UNAIDS, became the first international donor to support Kios. The United Nations 2001 Declaration of Commitment on HIV/AIDS responded to perceived “challenges to human life and dignity” experienced by those living with HIV and AIDS. The state of emergency responded to threats to the wellbeing of people around the world who were especially exposed to risks of contracting HIV. Similarly to the War on Drugs, this state of emergency responded not by limiting freedoms of the majority of the relevant population,\(^{117}\) but by motivating revisions to global guidelines for governance and mobilizing resources for those living with or at a high risk of contracting HIV.

Addressing drug users in Indonesia, the UN’s declaration motivated foreign aid organizations to invest in local NGOs that considered drug use a public health issue. These organizations achieved this through the introduction of Western models and strategies. Before harm reduction was introduced to Indonesia, culturally normalized habits of needle-sharing indicated that there was a lack of information circulating through drug-using communities regarding the risks associated with drug use and the spread of HIV. These indications were quickly verified by VCT testing results reported by Kios in its first years of operation. For these first years, about 75% of injection drug users were HIV positive. This verified threats anticipated by the International Community’s War on HIV: there was limited access to materials and information regarding safe drug use relative to the spread of HIV and the war waged by the Indonesian government against drugs was not identifying or addressing this issue. On the contrary, the War on Drugs, conducted without concern for understanding the position or needs of the user, motivated users to withdraw further into hiding. This was

\(^{117}\) The relevant population for the state is the general population.
part of what made distribution of harm reduction resources for drug users especially
difficult in its first years of operation.

Harm reduction programs have been quite successful in mitigating legitimate
health risks associated with drug use, especially those regarding the spread of HIV.
While about 75% of injection drug users tested HIV positive in the first few years of
Kios’ operation, in 2015 and 2016, this number was down near 50% with a mere 25% rate among first-time testers. These statistics indicate that a harm reduction program
can be effective in distributing information and resources for HIV prevention and
information and resources regarding ARV adherence.  

By providing an alternative to abstinence, harm reduction provides a safe avenue for people who want to continue using drugs to ask questions about HIV. The harm reduction center also reflects an interest in and understanding of the position of the drug user and grants its clients a certain degree of protection from the War on Drugs, as harm reduction centers are tolerated by and useful to the Indonesian government.

The UN’s involvement in harm reduction and rehabilitation in Indonesia relates to global need and the Indonesian situation in respect to that global need. It does not correspond, necessarily, to the War on Drugs. International NGOs and global governance structures with an interest in the reduction of the HIV/AIDS crisis on the global scale no longer see such a crisis in Indonesia. The progress achieved through harm reduction coupled with the rising economic status of Indonesia on the global scale (it is now a lower-middle income country) has led the UN to encourage international NGOs to allocate HIV/AIDS prevention funding to other nations in

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118 Community Based Drug Dependence Treatment in Indonesia: Documentation of Best Practice,” Komisi Penanggulangan AIDS, August 2015, 9.
need. Such is the challenge with humanitarian aid and the state of emergency; when the status of the situation appears to improve or a new emergency arises elsewhere, funds and attention are diverted as quickly as they appeared. As government investment in mandatory rehabilitation replaces international funding for harm reduction, the drug user’s ability to choose between abstinence and drug use begins to fade.

HIV relief was the decree instituted by the international community, justified by the sentiment that the government would not provide the relief otherwise. In this case, the political gesture was to help the sub-communities around the world that are most vulnerable to HIV/AIDS to develop tactics to reduce these risks. The temporal nature of a state of emergency lends itself to short-term fixes rather than institutional management of a sustained issue. Invoking the idea of an emergency generates a wave of action, but one that recedes quickly, just as a true emergency does. Promising initiatives founder, but the problems are left to foster. The UN imposes new strategies for addressing drug use as a public health issue, but by calling a state of emergency and initiating short-term intervention, it fails to support a long-term solution to public health issues associated with drug use in the Indonesian context.

**HARM REDUCTION AS AN EXCEPTION**

Fundamentally, the Indonesian War on Drugs and the UN Declaration of Commitment of HIV/AIDS stand partially at odds. The former demonizes the foreigner drug trafficker and the domestic drug user and enacts policy in the fashion of militarized humanitarianism. The latter, in the interest of disease prevention, temporarily validates the drug user through the introduction of tolerance-based drug
policy, but only acts as a temporary protector against abstinence-based policy. Though this relationship of partial opposition is not eliminated by the harm reduction center, the center cultivates a temporary neutral zone by making itself useful to both movements, but drug users suffer because they don’t need emergency assistance, they need long-term change.

HARM REDUCTION THE HUMANITARIAN

While many social scientists consider nation-states and global governing structures enactors of humanitarian policy, the local NGO is often subverted to being seen as an extension of global governance rather than being considered an independent entity with its own mission and political interests and constraints. As the example of Kios’ influence at Sanggar Akar illustrates, the harm reduction center can shadow the structures of governance that shape it. In doing so, the harm reduction center sometimes makes similar errors to those made by the state and global governance structures when presenting and implementing a humanitarian or biopolitical mission through a state of emergency framework. Kios does a more thorough job, however, with its own clients, with whom it takes on an institutional, rather than an emergency role.

After what had been a particularly tough day for the most senior staff member at Kios, I asked him why he has been involved for so long. He told me, “It’s addicting. It wears you down, but it’s also the best thing in the world.” I believe he was talking about the powerful attraction of saving lives. He did not consider these lives as evidence of the gradually reduced risk of HIV among drug users or proof that there could be life
without abstinence. Those who are served by the program were just people, clients and friends and family, who, through the development of interpersonal relationships predicated on tolerance and optimism, found a way to live, making it “the best thing in the world.”
CHAPTER 3: A Crusade of Compassion

The perspective of government draws our attention to all those multitudinous programs, proposals, and policies that have attempted to shape the conduct of individuals - not just to control, subdue, discipline, normalize or reform them, but also to make them more intelligent, wise, happy, virtuous, healthy, productive, docile, enterprising, fulfilled, self-esteeming, empowered, or whatever.

NIKOLAS ROSE, Inventing Our Selves

Tina and I sat at a table for two at a café in downtown Seminyak, Bali. I had just met her. She was kind, comfortable in her skin, and beautiful, the kind of person whose natural state seems to be summer. To my right, over the rail, was a small rice patty terrace between two rows of three-story buildings, an odd blend of urban and rural. Two doors down was the soon-to-open Manik Organik; a restaurant that Tina managed in Denpasar, Bali and was expanding to this new, tourist-friendly location. I had left Kios for a week to interview some employees that used to work at Hati Hati, the first harm reduction in Indonesia that had since closed. Though she was now in the food industry, Tina had been one of the first members of the Hati Hati team.

She ordered a soy latte when we sat and occasionally picked fries off the plate of a nearby Australian friend as we spoke. This all was in great contrast to the way my Kios friends and I interacted, and to no discredit to the beautifully eager hilariously quirky relationships we shared, I found this relaxed familiarity refreshing and curiosity inducing. “There’s a social construction that people who did drugs are not going to do their jobs,” Tina began after we had spoken for a while about Manik Organik. “But there’s a lot of opportunity to build up basic skills in rehabilitation. $70 per month is
the average income for the Indonesian. If you are working three hours a day as a housekeeper, cleaning a pool, practicing your English, the opportunities are out there for people who are unable to continue their education.”

Her words brought me back to a conversation I’d had with Husen, the director of Kios. When we first met, he outlined the five goals of Kios: mapping, increase knowledge/skills of drug users, provide risk reduction counseling, support change/provide referrals and help the clients get involved.119 This institutionalized framework of the program implicitly fails the client in that it never provides, or even advocates for, the opportunity to move away from drugs. If “getting involved” with harm reduction is the final step of the program, then even if the client manages her use or stops using all together, the program guides her success to still be defined by her continued relationship to drugs and drug using communities. This final step of “get involved” was institutionalized to help the program grow and help information regarding safe drug use spread, but by failing to advocate alternative options, it grows the program at the cost of confining the client.

Though she would have never traded her time at Hati Hati, though it was a crucial step for her movement away from drug use, Tina took issue with the notion that all clients who come up through these programs were implicitly expected to then work as employees within harm reduction and rehabilitation. “A few years ago, when I was still in the harm reduction environment, I would see my old self in my clients and sometimes it would drive me nuts. The choice is still there [to use drugs again] but there was more of a chance for me to go back then.”

119 Husen Basalahma (Director of Kios) Introductory Conversation Record, Tuesday June 14.
In reflecting on these challenges, Tina spoke about two things. She spoke most directly about her personal need to get away from the program over time because she wanted to maintain abstinence from drug use and found it too difficult there. She more implicitly provided a critique of harm reduction; by advocating “involvement in the program” as the final step for the client, harm reduction contributes to the social construction that Nita identified: people who used to do drugs will not do their jobs. Harm reduction inadvertently shapes its clients by telling them what is empowering, what is success. This is a small-scale example of limitations felt by recipients of top-down structures of humanitarianism. It shows how, by defining notions of failure and success for individuals, these programs often fail to deliver on the actually needs of the client. Foucault writes, “The new noso-politics inscribes the specific question of sickness of the poor within the general problem of the health of populations.”

Through disease-politics, the individual poor person is considered as a sample of the population. In global humanitarian aid, local organizations are often treated as part of a whole rather than as individual institutions, an issue exacerbated by the top-down structure of humanitarian aid.

CARING HERE AND NOW

Didier Fassin examines the extension of humanitarian aid to children living with HIV/AIDS in South Africa and criticizes that, because the problem is defined by a foreign body as part of an international trend, the solution does not properly consider

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the aid recipients in their social realities.\textsuperscript{121} Lamia Karim raises a comparable issue in her research regarding microfinance networks in Bangladesh; she identifies the contradiction between the perception shared by many lenders at microfinance organizations, who consider their clients to be autonomous and rational participants in the free market, and the lived realities of the borrowers, whose social and familial obligations dictate their economic activity.\textsuperscript{122} While Fassin’s example illustrates how context can be lost when local issues are fixed into the mold of a global problem, Karim’s shows how calculating human action is often an inadequate solution to understanding and improving the human condition. A third issue that I add to these shortcoming of aid is the assumption that aid is unilateral, a generalization that arises as global humanitarianism focuses on the longitudinal relationship between the global (INGO network) and the local (NGO). These three issues – lost context, miscalculated human action and assumptions of unilateral aid – are structural challenges that arise from the top-down structure of humanitarian aid.

In this chapter, I will link the birth of harm reduction theory to the rise of the new humanitarian order. I will identify the correspondence between global governance’s push to address disease control and the introduction of the balance approach in Indonesia. After identifying disease control as the global mission and harm reduction as part of this structure, I will evaluate the success of harm reduction in Indonesia according to this mission. I will then highlight challenges that remain for people who use drugs in Indonesia. Some of these challenges are not addressed because they do not fit the agenda of disease control; others still reflect the assumption

\textsuperscript{121} Didier Fassin, \textit{Humanitarian Reason}. (University of California Press 2011), 180.
that all aid is equal. By highlighting these outstanding challenges, I aim to contrast the harm reduction center as an extension of global humanitarianism against the harm reduction center in relation to its clients. While this chapter acknowledges the positive aspects of global humanitarian intervention, it also examines fundamental challenges produced by the top-down structure of need identification in the new humanitarian order.

A TWIN BIRTH

The inspiration for harm reduction theory is widely cited as the American liberal “Responsible Use” strategy, first employed by the Office of Substance Abuse Prevention, which released a proposal in the early 1970s for less risky methods for snorting solvent drugs.123 About a decade later, the term “harm reduction” first entered circulation in Liverpool, England, where the rise of tolerance-based drug policy corresponded with the sudden appearance of HIV, a disease that was most commonly spread through unprotected sexual activity and needle sharing. Though these two programs addressed different issues that arose through different styles of drug use, the early American and early British versions of harm reduction shared a quality that is a trademark of harm reduction today; they focused on preventing drug-related harm, but did not necessarily focus on preventing drug use.124 These two models continued to grow in their own spheres until 1990, when Liverpool, England hosted the first International Conference on the Reduction of Drug Related Harm.

This conference was first held just a year before the UN declared a new humanitarian order. Aided by these sentiments of global humanitarianism arm reduction and it gained immediate traction. The conferences began to serve as an annual opportunity for early harm reduction activists to share their methods and findings. Through these gatherings came the first scientific research supporting harm reduction methodology. Harm reduction was best received as a method of disease prevention. The global AIDS epidemic was still growing in 1991\textsuperscript{125} and harm reduction provided an inlet for researchers, activists and public health professionals to sharpen their understandings of behavior surrounding the spread of HIV and AIDS in communities of drug users. This in turn enabled the distribution of materials and information to drug users in a time when the reputation of HIV/AIDS was shrouded by myth. The globalization of harm reduction promoted education of professionals, users, and finally of the general population. Even though harm reduction was not oriented toward prevention of drug use, the rise in drug experts that accompanied the expansion of the harm reduction provided new opportunities for drug education.

Before harm reduction, there were hardly any professional drug educators. For example, when harm reduction was introduced to England and Wales, a drug education force of about 100 people served the two countries, which had a joint population of about 50 million people.\textsuperscript{126} These individuals were often teachers who had learned about drug education through supplementary courses. It was with the rise of global harm reduction activism that drug education became widespread.

Today, even as the international network of harm reduction is well established, its

\footnotesize{\textsuperscript{125} Ibid.  
\textsuperscript{126} Ibid.}
position in global governance and international drug policy continues to shift. UNAIDS, UNODC (UN Office of Drug and Crime) and the WHO (World Health Organization) first began discussing the overlap between drug use and HIV/AIDS transmission in the 1990s. The United Nations General Assembly Special Session special (UNGASS) conferred for the first time in 1998 to discuss the global status of drugs use. This provided a center point for global activism to initiate a shift in the world’s attitude toward drug use and drug policy. One focus of UNGASS-inspired activism was to shift UNODC leadership. By proposing a move away from American leadership and toward Western European leadership, UNGASS sought a transition from rather conservative to rather liberal drug policy. This initiative was finally successful in 2006. In 2008, the newly liberalized UNODC produced a guide in tandem with UNAIDS and the WHO, releasing a recommendation that governments around the world should take a public health approach, rather than a criminal approach, to the drug user.\textsuperscript{127}

Though the UN’s ability to enforce law is limited, the influence of this policy shift was felt around the world, as was illustrated by Indonesia’s release of a new, progressive narcotics law in 2009. This short history of the birth of harm reduction and the corresponding policy path for concerning drug user treatment illustrates how the journey to a balanced approach has been carved in the interest of promoting disease control. It is logical then, that the institutions that deal with drug users and are funded by foreign aid organizations, Kios Harm Reduction Center being one of them, are structured to address the globally identified problem of HIV transmission among

\textsuperscript{127} Very Kamil (PhD Candidate, drug policy advocate) Mentoring Session, April 8, 2017.
people who use drugs.

HUMANITARIAN AID FOR KIOS

While global governance structures develop recommendations for drug policy, international aid organizations provide direct funding and impose interventions at local NGOs around the world. An introduction to Family Health International (FHI), AusAID and the Global Fund, the three organizations that have funded Kios over the past fifteen years, shows how their funding and interventions have aligned with disease control more than they have aligned with a balanced approach to drug policy.

Family Health International (FHI) was the first international organization to fund Kios and for this reason, FHI contributed greatly to the ideological structure upon which Kios was built. At the time, there was only one other harm reduction center operating in Indonesia. It was called Hati Hati and had opened in 1998 in Bali with funding support from an Australian organization. With almost no domestic precedent for harm reduction, FHI informed Kios’ structural focus on reducing HIV/AIDS among drug users. With guidance from FHI, Kios set out to provide outreach for users. In response to the lack of data on rates of HIV/AIDS in communities of injecting drug users, Kios began recruiting for voluntary counseling and testing sessions at community health centers. Users were tested for HIV, hepatitis A and B and tuberculosis and counseled accordingly. Kios pioneered data on HIV/AIDS prevalence among the injection drug users in Indonesia and worked with Hati Hati, and later others, to extend their data outside of the Jakarta area. Kios also was an early satellite provider of antiretroviral treatment medication, drugs that stabilize the effects of HIV
on the inhabitant’s body and can reduce the likelihood of transmission from the HIV-positive individual.\textsuperscript{128} FHI specifically allocated funds for Kios to have a doctor on staff who could approve new and council existing ARV treatment recipients.\textsuperscript{129}

The American organization also provided significant funds for the printing and distribution of booklets to brief users on the risks associated with injecting drugs and guide them to inject more safely. These booklets spoke chiefly to the medical risks associated with drug use and situated “safe injection” around cleaning needles and cleaning the skin around the injection site. The main role of outreach, outside of recruitment, was the distribution of these booklets, the distribution of condoms to prevent sexual transmission of HIV among drug users, and bleaching needles or rinsing them with water. Globally, the predominant concern in harm reduction for people who use drugs is preventing HIV, but harm reduction normatively need not be confined to this. An analysis of the client needs that are not met by harm reduction programs in Indonesia may indicate non-HIV-related harm reduction programs could be used in Indonesia.

AusAID, the international aid department of the Australian government, followed suit in its parameters for funding Kios between 2011 and 2016. A few years prior to this, AusAID took a turn away from providing direct aid in favor of facilitating private investment and domestic finance. AusAID collaborated with the Indonesian government to run a program called HIV Cooperation Program for Indonesia (HCPI) from 2008 – 2016. HCPI partnered with the National AIDS Commission of Indonesia.

\textsuperscript{129} Dr. Turgu. Interviewed by Alyssa Domino. Personal Interview. Jakarta, July 29, 2016
to develop “sustainable responses”\textsuperscript{130} to rising rates of HIV on Java and Papua islands. HCPI eagerly funded Kios, whose primary interest of operation was to address HIV among people who use drugs. HCPI assumed the role of primary donor for Kios in 2011 and Kios’ model of harm reduction continued to respond exposure to disease through drug use. Although HCPI marked a transition in leadership because the program was run collaboratively between the Indonesian government and the Australian government, it maintained the trend of using harm reduction to respond to a globally identified issue of HIV transmission.

The third, and currently the primary, international donor to partner with Kios is the Global Fund to Fight AIDS, Tuberculosis and Malaria. Global Fund, founded in 2001, has been credited for establishing a new era of international financial support for HIV.\textsuperscript{131} Alongside the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), which was initiated by President George W. Bush in 2003, Global Fund was the first organization to provide free antiretroviral (ARV) treatment in countries with low economic standings, a service that had previously only been available in wealthy countries.\textsuperscript{132} Global Fund partnered with local NGOs around the world with a focus on Eastern Europe, Southeast Asia and sub-Saharan Africa. Global Fund developed clinics and providing free low-grade ARV treatment plans. When PEPFAR’s spending capacity contracted in 2010 as President Obama redirected global health dollars to programs for women and children, Global Fund solidified its position as the largest


\textsuperscript{131} Ibid.

financier of anti-AIDS, TB and malaria programs in the world. 95\% of this large spending capacity comes from donor governments, chiefly the United States, France, Japan and Germany, and the remaining 5\% is provided by private donors, with the Bill and Melinda Gates Foundation as the primary contributor.\footnote{133}{“Financials,” \textit{The Global Fund}, https://www.theglobalfund.org/en/financials/}

Global Fund is different from FHI and HCPI in that it is not an implementing agency; it is a funding agency. The Global Fund Secretariat is small in comparison to other international bureaucracies and focuses on financial distribution. Funds are implemented through principal recipients in each country. It is common that these Principal Recipients allocate spending money through a network of sub-recipients.\footnote{134}{Ibid.} In Indonesia, Kios is a sub-sub-recipient (SSR) of Global Fund. As was the case for HCPI, Kios is an attractive partner for Global Fund, as the organization was established for the primary purpose of reducing the spread of HIV/AIDS among drug users. The history of Global Fund’s influence and a brief profile of its financial supporters indicates the breadth of support that has developed, privately and publically, to address HIV/AIDS on the global level and the conative influence of Global Fund involvement in local organizations.

THE STATISTICS

Through FHI, HCPI and Global Fund, foreign investment in Kios has almost exclusively pointed toward the reduction of HIV/AIDS among drug users. These organizations have made progress in achieving this goal. Inspired by the cultivation of

\footnote{134}{Ibid.}
\footnote{135}{Ibid.}
research first enabled by Kios and Hati Hati, there are now HIV/AIDS research centers in Indonesia that work closely with drug using communities and harm reduction centers. The HIV epidemic in Indonesia is still expanding, with injecting drug use accounting for most new cases each year until the height of the epidemic in 2008. In 2008, 52.4% of all people who inject drugs were living with HIV.\textsuperscript{136} The expansion of the harm reduction program between 2008 and 2011 led to the decrease from 52.4% of injecting drug users living with HIV to 36.4%.\textsuperscript{137} As of July, 2014, harm reduction centers in Indonesia have provided clean injection equipment to 9,302 people across 194 government-managed community health centers and methadone treatment to 2,515 drug users across 17 provinces and through 87 health facilities.\textsuperscript{138} Harm reduction has been extremely active in reaching people who use, particularly people who inject, drugs, but still has much work to do in an effort to make the HIV epidemic contract.

WHAT IS LOST

When global governance structures and international networks of humanitarian aid work in tandem to define and address global trends of need, elements of a local issue such as context, individuation, collaboration with local solutions, and recognized variance between aid providers are often lost at the level of implementation. In this section I explore shortfalls of humanitarian intervention recognized by Didier Fassin and Lamia Karim, contextualizing them as results of the top-down structure of global

\textsuperscript{136} Community Based Drug Dependence Treatment in Indonesia: Documentation of Best Practice,” \textit{Komisi Penanggulangan AIDS}, August 2015, 9.
\textsuperscript{137} Ibid.
\textsuperscript{138} Ibid.
humanitarianism. I relate each challenge to a similar challenge in harm reduction in
Indonesia in the interest of exploring locally significant elements of harm reduction as a
way to critique the structure of humanitarian aid and intervention.

CONTEXT

Bonjos once was the largest center for heroin exchange in Jakarta area. It was an
entire neighborhood of homes that leaned into and sagged over one another,
connected by narrow winding streets and backed up against a tall concrete wall behind
which was an open yard. Before I visited, I saw a video that Kios had made, City of
Happiness, about its harm reduction activity in Bonjos.

Mire, an outreach worker I have since come to know, climbed over the
concrete wall to meet her satellite client who was waiting to distribute
needles to friends. The camera panned over a thin layer of used needles
that polluted the ground. The scene was not the picture of prosperity, but
the shantytown bustled and there was something beautiful about that.

It was an odd sensation to visit the location myself during an eight-month heroin
draught. The place looked almost ironically destitute; like an American industrial town
in the age of globalization; business was gone and it was unclear if it would be gone for
good.

My time at Bonjos was brief because Mire saw some police officers and grew
nervous that they would see me – I did not exactly blend in – and assume I was buying.
Tourists did that sometimes, she said. Though Bonjos was not what I had anticipated, I
had been excited to visit, so I made a point to engage with someone before it was time
to go. Her name was Gracie and we arranged to get lunch the following day.

When compassion is blanketeted as the driving force behind humanitarian
intervention, aid recipients can become quickly reduced to victims and removed from
their social realities. Didier Fassin raises this issue in the context of HIV/AIDS relief in South Africa. Through depictions of need, HIV positive children become caricatures of victims of disease and power; HIV positive men become brutes, the women are judged as foolish, but pitied because they are subverted to the power of the men.\textsuperscript{139} The orphaned HIV positive child is the ultimate picture of pity and therefore attracts generosity from foreign aid organizations. The enormous outpouring of support for the HIV positive orphan seems to imply a successful intervention, but a lack of consideration for cultural context has led issues to arise in the implementation of aid for these children. Fassin writes, according to literature and his personal experience, that a long history of orphaned children in South Africa, owed mainly to labor migrations, has led to the institutionalization of informal adoption customs.\textsuperscript{140} Traditionally, some relative, most frequently the aunt of the grandmother, would take the orphan in.

Following the introduction of large scale international aid, relatives still frequently accommodated the children, however conflict over custody arose. Through foreign aid contributions, the government instituted “foster family grants” that paid more than the average worker’s wage to parents who adopted.\textsuperscript{141} This acted as a shock to the traditional system in place and instigated a new conflict between the family members. Though foreign aid was well-intentioned, it failed to account for context and therefore victimized the orphan and, by ignoring, meddled with, the social context. Fassin writes in evaluation, “The exaggeration of both compassion for current suffering and anxiety about future disorder adds to the confusion of emotions surrounding a

\textsuperscript{139} Didier Fassin, \textit{Humanitarian Reason}. (University of California Press 2011), 167.
\textsuperscript{140} Didier Fassin, \textit{Humanitarian Reason}. (University of California Press 2011),, 178
\textsuperscript{141} Ibid.
tragedy of which neither the historical nor the political aspects are being taken into consideration.\textsuperscript{142} The humanitarian drive overtakes rational consideration of the problem and context is disregarded as urgency is cultivated.

\begin{quote}
“I used to carry around about 400 needles with me, but now I carry 15.”\textsuperscript{143} Mire, told me one day as I rode on the back of her scooter to a hotspot in South Jakarta. “People do not use them as much anymore.” Well, they did use them, but not to always to inject. An increasing proportion of Kios clients use methamphetamine. Many of these clients are scared to carry paraphernalia in case they are frisked. While harm reduction has championed the decriminalization of needle possession, pipes and bongs are not treated with the same tolerance. To get around this issue, people who use methamphetamine often ask for harm reduction kits, which they disassemble and use the metal piece of the needle as the mouthpiece to a water bottle bong. Although Mire and the other outreach workers warn their clients about the risks of injecting fumes from burning plastic, they often disregard these cautions, so Mire strategically keeps her stocks low. Even with the rising popularity of methamphetamine and fading popularity of heroin,\textsuperscript{144} drug-related stigma and harm reduction initiatives remain geared toward injecting drug use, namely heroin use because of its association with HIV/AIDS.

“Do you carry something else in place of the needles?” I asked Mire. “Extra condoms? Pamphlets?” But the booklets spoke mainly about injection drug use and the condoms were disappointingly unpopular. By continuing to respond issues relevant to injection drug use even as non-injection drug use becomes increasingly prevalent,

\textsuperscript{142} Didier Fassin, \textit{Humanitarian Reason}. (University of California Press 2011), 179

\textsuperscript{143} Mire (Kios outreach worker) recorded conversation on way back from outreach, July 17.

\textsuperscript{144} Community Based Drug Dependence Treatment in Indonesia: Documentation of Best Practice,” \textit{Komisi Penanggulangan AIDS}, August 2015, 9.
international aid ignores shifts in the field in Indonesia. They miss the context and instead continue to address the issue that they first identified: the high prevalence of disease among drug users. Like Fassin’s example, this illustrates the challenge of lost context that arises through the implementation of top-down humanitarian intervention.

INDIVIDUATION

While Fassin criticizes context lost in humanitarian intervention, Lamia Karim responds to a similar, but separate issue: the quantification of the recipient of aid. She describes an interaction she had with a borrower from Grameen Bank, a large microfinance organizations in Bangladesh, who described how she had struggled to pay back her most recent loan because her nephew, knowing that she was receiving loans from the bank, had borrowed money from her with no return. As his aunt, it was her duty culturally to provide for him in this moment. Karim contrasts this interaction with a conversation she had with one of the bankers at Grameen, who considered the borrowers to be rational participants in the free market. Karim believes that the two conversations illustrate how the aid providers misunderstand the situation of the aid recipients when they quantify the recipients and consider them to be isolated from intricate webs of social and familial responsibilities into which they were woven. Foucault calls this quantification of human life, “the entry of life into history.” It is the point at which the unique human experience becomes calculable in the interest of developing political techniques to promote the wellbeing of the general population. Though this quantification is exercised in the interest of enhancing life for the general population, miscalculations can lead aid organizations to have a negative rather than a

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positive impact through intervention. Just as Grameen Bank failed to consider the social constraints that limited their borrowers’ capacity to operate as independent participants in the free market, Kios donors fail to acknowledge that sometimes stopping the spread of HIV is not the top priority for all people.

Gracie arrived early for lunch the following day. We ate on the roof of the Kios drop-in center and stumbled through conversation. She told me that she worked at a club downtown, that she would bring the party. We laughed and I asked a few times which drugs she brought to the club but she kept insisting she didn’t bring drugs; it was too risky. After minutes of confusion, I finally understood “the party.” Gracie was a sex worker. “I used to inject heroin, but now, buprenorphine because heroin is too expensive,” she scowled. I’d been hearing a lot of that. She didn’t do drugs with her clients, but she did date some of them on and off. She told me she had tried rehabilitation, VCT, OST, ARV...

“ARV?” I asked. Gracie verified, but said that she did not stick with it. It turned her skin a weird color and that was bad for business. “Are you HIV positive, Gracie?”

“Yes.”

“What do your clients say?”

“I don’t tell them! Bad for business. And I need business.” We spoke for a little while longer and then we just sat. “My baby was seven months old and I tried not to use at all. I really tried, but when I was pregnant I –” she shook her head. “She died from withdrawal, but I’m still here. I leave things to chance now.” We sat a while longer and then she got up and walked downstairs, out the door, and straight back to Bonjos.
I have come to see that I do not understand Gracie’s actions. This is not to say I do or do not sympathize, but I cannot quite relate or configure them logically in my head. Her life and her decisions are lived experiences and these things, sometimes mundane sometimes crushing, cannot always be quantified. When international aid networks rely too heavily on the rationality of individuals, miscalculations will occur, especially when these judgments are made at the international level and applied to the local.

MULTILATERAL PROVISION OF AID

One final challenge that results from the top-down structure of humanitarian government is the assumption that provision of aid is unilateral when it is, in fact, multilateral. At Kios, international donors invest through three-to-five year contracts that they usually renew once before terminating the partnership. This means that the primary donor for Kios changes periodically. These shifts often add unforeseen challenges to Kios’ operational capacity. FHI brought American interest and influence to Kios during its formative years. As per a conversation with my advisor and friend, Very Kamil, American organizations have a reputation for technical strategy implementation and are criticized for slow movement on big progressive ideas.146 In 2001, FHI provided Kios with funding for needle sanitation programs because needle exchange was not yet legalized by the Indonesian government. When Indonesia formally recognized Kios, it tacitly softened its outlook on possession of needles. Kios approached FHI to discuss plans for purchasing disposable needles, but to the NGO’s surprise, America did not condone distribution of needles through international aid at

146 Very Kamil (PhD Candidate, drug policy advocate) Mentoring Session, June 19, 2016.
that time." As the Indonesian government began to tolerate harm reduction increasingly, they relaxed their policies on needle exchange. FHI was ready to begin supplying disposable needles for Kios to distribute, but in 2004, President Bush passed a law to forbid federal money from contributing to syringe exchange.

Very, who worked for FHI through its partnership with Kios recalled, “At the time, people would laugh at us. It was messy and outreach workers complained that this bleach was ruining their clothing. So, part of our job at this point was finding a better container for the bleach.” He laughed at the ridiculousness. “But bleach was important to make the harm reduction exist. We were working hard from 2001 to 2004 and then the US funding became a kind of chicken in front of the Indonesian community saying, ‘we can support harm reduction but not with needles.’ I was new at the time but I could see how someone like Wayne [the American project coordinator for FHI in Jakarta] would feel coming from a country that is very big and powerful but sometimes acts like a chicken.”

FHI brought the American influence of conservative bureaucracy, a technical approach to solving problems and the ability to see a project through. Australian aid organizations brought progressive attitudes, tolerant leadership, and a focus on starting, but not finishing projects. In this vein, FHI was more situated toward developing client loyalty while AusAID primarily wanted Kios to attract new clients. These differences between the two foreign influences, though seemingly minimal, were hugely influential in determining types of projects to which Kios could commit.

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147 Very Kamil (PhD Candidate, drug policy advocate) Mentoring Session, April 8, 2017.
148 Ibid.
149 Husen Basalahma (Director of Kios) Introductory Conversation Record, Tuesday June 14.
Tracing the birth and development of international harm reduction grounds the Indonesian harm reduction program historically and globally. It illustrates that controlling HIV/AIDS is not only a primary function of harm reduction in Indonesia; this trend is global in harm reduction. Although the harm reduction program in Indonesia is making progress in reducing the prevalence of HIV/AIDS among drug users, HIV is not the potential harm Indonesian drug users face. Drawing from Didier Fassin and Lamia Karim, I found that the top-down structure of humanitarian aid fails to meet many needs of drug users as it discounts context of their social realities, relies too heavily on the notion of the quantified, rationalized aid recipient and fails to consider the implications that multilateral aid has on the operational capacity of the harm reduction center. These three challenges do not exhaust the structural deficiencies present in top-down global humanitarian aid, but they do provide adequate material for considering the implications of this problem.
CHAPTER 4: What is Death in Harm Reduction

He was henceforth no longer like a leaf in the wind, a plaything of nonsense, “without-sense,” now he could will something – no matter for the moment in what direction, to what end, with what he willed: the will itself was saved.

- FREIDRICH NIETZSCHE On the Genealogy of Morality

Instead of considering reason as the truth of the subject, we can look to other foundational categories that are less abstract and more tactile, such as life and death.

- ACHILLE MBEMBE Necropolitics

When I first noticed a client wearing a BNN pin to a group counseling session at Kios, I was sure that either BNN was giving away free merchandise or that they had planted someone at the center to supervise the session. I asked the Kios director what the meaning of this was and he said that these clients were either current counselors or had been past counselors at the BNN rehabilitation centers. One of the Kios clients that I spoke to explained her situation to me, which helped me gain a better understanding of the client/counselor role.

In 2008, she was caught by a plainclothes policeman while buying heroin. She was imprisoned for possession for just under two years. She was released early for good behavior but her experience still left her scared of continuing drug use outside of prison. After trying for a couple of years to manage her use independently, she checked into rehabilitation at BNN in 2013. Upon completing the program, she was recruited as a counselor, as many former clients are, and began working at a rehabilitation center in South Sumatra. She was clean for a while and then began using again when she visited
her home of Jakarta and encountered an old friend, to whom she referred as her PIC (Partner in Crime.) During this relapse, she did not use heroin, only methamphetamine, because she found that the latter increased her working capacity while the former interfered with it. For a while, she was using as she counseled at the rehabilitation center, but eventually she failed a urine test and was let go from her position; she now exclusively uses the harm reduction center as a resource, attempting abstinence now and again, but also growing more comfortable with moderated use.

She was far from the only person to tell me about her experiences cycling through the different facilities put in place for (or at least predominately occupied by) drug users. Stories of harm reduction clients who double as counselors for abstinence-based treatment facilities speak to the depth of interconnectedness of these institutions. While policy shifts over time have moved away from criminalization and toward consideration of drug use as a public health problem, the death penalty for drug dealers, criminalization of drug users and mandatory rehabilitation for drug “abusers” are all in place and operate alongside harm reduction programs. These responses to the perceived drug problem in Indonesia institute elements of Michel Foucault’s theory of governmentality and Achille Mbembe’s concept of necropolitics. I will present the relevant aspects of these two theories before engaging in an analysis of how they are applied by government forces in response to the perceived threat that drugs present on the wellbeing of society. Through this exploration, I will identify how each of these responses influences the relationship between the government and the life and death of the drug user, a progression that reifies the increasing prevalence of politics of biopower in the Indonesian response to drugs use.
THEORY IN DIALOGUE

I will begin by revisiting Foucault’s theory of governmentality before putting it in conversation with Mbembe’s necropolitics and considering how they are present in the government’s relationship with the life and death of the drug user. This analysis uses the term, “pre-modern” in reference to times before the origin of multiple concepts of sovereignty, before the bio-political, and “modern” in reference the time between the introduction of the bio-political and the present.

Foucault states in his essay, “Governmentality” that pre-modern society was governed by the theory of sovereignty;

The objective of the exercise of power is to reinforce, strengthen, and protect the principality, but with this last understood to mean not the objective ensemble of its subjects and the territory but, rather, the prince’s relation with what he owns, with the territory he has inherited or acquired, and with his subjects.

The pre-modern government must protect the singularity of the sovereign and secure his control in relation to his territory and subjects. This means that the purpose of government by the theory of sovereignty is perpetuation of government itself. This changes with the cultivation of the art of government, through which concepts of biopower are introduced. According to politics of biopower, modern government

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150 Achille Mbembe uses the same distinction in his essay, “Necropolitics,” stated on page 12: “The entire process of the cultivation of the art of government, unfolding between the sixteenth and eighteenth centuries, is what brings about the “modern,” but the bio-political, as the final development to enable the practice of this new system of governmentality, is the marker of the complete transition into the modern.”


152 I use the term “politics of biopower” instead of “bio-politics” as a means to include concepts of anatomo-politics, which works with bio-politics one of the two poles driving biopower.
uses policing\textsuperscript{153} and statistical knowledge about the population\textsuperscript{154} as factors of power to the end of promoting the wellbeing of the general population.\textsuperscript{155} This policing, centered on the body as a machine, Foucault calls anatomo-politics and the statistical knowledge, strategic cultivation of knowledge of biological processes, is the bio-politics.\textsuperscript{156}

The relationship between the government and life and death of its citizens fundamentally changed through this transition. According to the pre-modern concept of sovereignty, the state has the power to kill, but lacks the power to regulate the private life of the individual.\textsuperscript{157} In this setting, condemning legal subjects to death is gave the sovereign ultimate dominion over them.\textsuperscript{158} Conversely, the modern state regulates the day-to-day lives of its citizens (through the imposition of minimum wage, childcare laws and handicap parking spots for example) but far less frequently exercises its power to kill. It still reserves this power, but it goes against the very purpose of the state through biopower: prosperous life.

When the biopolitical state does exercise power to kill, the action is justified in the interest of the wellbeing of the population, not in the preservation of state power.\textsuperscript{159} Through the rise of biopower, government administration of death became increasingly contradictory as the purpose of government became increasingly oriented on promoting the welfare of its citizens. Before continuing forward to introduce Mbembe’s theory of necropolitics, I want to make the distinction that the rise of biopower did not mean the end of sovereignty. Though the theory of sovereignty was replaced by the art

\textsuperscript{153} Foucault, Michel. “Governmentality,” *Power*. (The New Press), 207.
\textsuperscript{154} Ibid., 212.
\textsuperscript{155} Ibid., 220.
\textsuperscript{157} Ibid., 260.
\textsuperscript{158} Ibid., 265.
\textsuperscript{159} Ibid., 261.
of government, the problem of sovereignty continued, and according to Foucault even strengthened, as the unilateral nature of the sovereign gave way to the multitude of institutions that arose with biopower.

Achille Mbembe coined the term, “necropolitics” in his 2003 essay aptly titled, “Necropolitics.” He defines the term as, “subjugation of life to the power of death,” and states that contemporary forms of necropolitics have changed and blurred the relationship between resistance, sacrifice and terror. He puts biopower in conversation with sovereignty and the state of exception and finds that biopower takes an important step in identifying developments in the relationship between the government and the life and death of citizens. Biopower does not, however sufficiently account for contemporary forms of subjugation of life. Necropower and necropolitics introduce the concept of death-worlds, populations that are subjected to conditions of life that give them the status of the living dead. The theory adds to biopower by stating that contemporary politics administers death infrequently through bullet or poison, but frequently and subtly through the creation of death-worlds. Mbembe chiefly uses examples of racialized political action to ground his work.

Mbembe built on Foucault’s critique of sovereignty in relation to war and biopower. His interpretation of biopower is, “The ultimate expression of sovereignty resides, to a large degree, in the power and capacity to dictate who may live and who must die. Hence, to kill or to allow to live constitute the limits of sovereignty, its

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162 Mbembe 39.
163 Ibid., 12.
164 Ibid., 40.
165 Ibid., 11.
fundamental attributes.”¹⁶⁶ This is Mbembe’s interpretation¹⁶⁷ of Foucault’s concept, “One might say that the ancient right to take life or let live was replaced by a power to foster life or disallow it to the point of death.”¹⁶⁸ Upon first read, it seems that Mbembe’s conception of the government’s relationship with life and death of its citizens is trapped within the framework of the theory of sovereignty. However, when considering that, for Mbembe, the citizen that “must die” is the citizen that is subjected to social death, there arises a clear equality between Foucault’s biopower and Mbembe’s interpretation of it, which he uses as a foundation upon which he builds to necropolitics. Disallowed life to the point of death is precisely the concept that Mbembe draws on to develop his theory of necropolitics.

Mbembe draws on the sovereign power to administer death and highlights its implicit continuation through biopower, as sovereignty continues through biopower. Foucault presents the opposition between the pre-modern government responsibility to administer death and let live and the modern responsibility to enable life and let die. Mbembe takes up the notion of a government that disallows life to the point of death, and extends it to develop necropolitics. He draws on Georges Bataille to say that death is the principle of excess, an anti-economy.¹⁶⁹ Promoting the anti-economy is, of course, ill-suited to the framework of modern governmentality, which takes knowledge of the economy as one of the key tools for fostering the wellbeing of the general population. By instead promoting death-in-life, electing certain populations who can become

¹⁶⁶ Ibid., 11.
¹⁶⁷ There is a passage better suited to Mbembe’s application in “Society Must Be Defended,” but the passage from “Right of Death and Power over Life aligns better with my theory application.
shadows of people, their humanity discounted, the government is able to administer a kind of death that is not unproductive. Built from this understanding of the conversation between Foucault and Mbembe, I will use the framework of necropolitics when considering social death administered by the state and the framework of biopolitics when considering how the government enables life and distances itself from the literal death of the drug user.

THE ADMINISTRATION OF THE DEATH PENALTY

The administration of the death penalty, a state power that has been discontinued in most contemporary governments, is the final remaining avenue through which a state can condemn its own citizen to literal death. Under the theory of sovereignty, the death penalty aligned tightly with the ideals of the state. The sovereign exercised power by condemning to death those who opposed his will, which scared the people into adhering to the law and defined the line between the sovereign and his principality, both of which were central goals of pre-modern government. Today, however, when the chief responsibility of the state is not only to foster life, but also to be globally competitive in its ability sustain and improve the quality of life for its citizens, Foucault states that the traditional application of the death penalty is contradictory, or, in the words of Bataille, anti-economic. As an indication of the

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171 In Mbembe’s example of the slave experience of death-in-life, this population is in fact productive because slaves were used for labor. I am not sure, however, that populations that make up death-worlds are always productive and so I will, for now, call them “not unproductive.”

biopower structure and importance of humanitarianism in the modern state, use of the death penalty is justified by stating that the executed criminal poses a threat to society; “one had the right to kill those who represented a kind of biological harm to others.”

In certain countries, the United States and Indonesia included, drug traffickers are classified as members of this group.

Between 1998 and 2016, narcotic and psychotropic drug cases accounted for more executions on death row in Indonesia than any other offense. It was a drug charge that reopened the use of the death sentence in Indonesia in 2013 when Adami Wilson, citizen of Malawi, was the first person in nearly five years to face the firing squad. In 2015, fourteen drug offenders, twelve of whom were foreigners, faced similar fates. In alignment with the modern justification for the death penalty, President Widodo defended these executions by claiming that the international drug trafficking network was the reason that the Indonesian people were exposed to drugs in the first place and the executions were necessary measures to protect the general health of the population against the risks presented by infiltration of drugs. Although the wellbeing of the population served to justify these executions, hints of a desire to protect Indonesian sovereignty also ring through this action. The opium trade had been central Dutch colonial occupation of Indonesia, morphine entered Indonesia in large quantities during the Vietnam War and more recently, heroin first entered the Indonesia through Bali, an island sometimes colloquially referred to as Australia’s backyard. Although not all elements of the drug trade or drug use involved foreigners,

173 Ibid., 261.
time and time again drugs entered Indonesia through foreign influence. A symbol of colonialism and neo-colonialism, foreign influence on the Indonesian drug trade was a perceived threat to the state. This shows that, though the humanitarian interest is the modern justification for enactment of the death penalty, it still is often partially motivated by perceived threats to the sovereign. The fact that the death penalty has been used majorly for drug-related cases – but never in response to mere drug use – in the past three years in Indonesia symbolizes the enemy status that drugs have in the eye of the Indonesian government.

**PRISON FOR DRUG USERS**

In February of 2016, Cipinang, Indonesia’s largest jail, stretched its maximum capacity of 1,000 inmates to house 2,933 inmates.176 About 1,000 prisoners attended mandatory prison rehabilitation classes through the prison treatment center, which indicates that at least 1,000 of the inmates were in jail for drug use. The prisoners at Cipinang lack access to basic accommodations such as clean water and sanitary bathrooms. At Cipinang, personal space is a figment of the imagination.177 In addition to these deplorable conditions, Cipinang also exemplifies a trend consistent through prisons in Indonesia at large in that it acts as a festering ground for drug cartels.178 Trade within and between prisons was not always so lucrative. Tina the manager of Manik Organik in Bali, recalled that the neighborhood with the largest number of drug dealers in Denpasar was no longer the center for that kind of business; “Kampung Flores is

177 Ibid.
178 Ibid.,
shut down now,” she recalled. “You can buy drugs in prison. It’s all organized by phone.” According to Tina, this transition happened gradually through the early 2000s and now the prisons in Indonesia act as the center point for trade. These prison cartels are enabled depend by institutionalized bribery and are largely untouched by the state or any police apparatus.

It is with these realities in mind that I assert that the prisons act chiefly as necropolitical structures for people convicted of using drugs in Indonesia. Though the government does not overtly condemn citizens to death in sentencing them to prison, it disallows life. Under normal circumstances of imprisonment, it is accurate to say that the prisoner is temporarily removed from social existence, but they are not necessarily subjects of necropolitical action. In this case, however, these individuals are subjected to torturous conditions and are denied even the most basic amenities. From the pool of convicted drug users that I interviewed over those two months, approximately 70% of them had been in jail more than once, which indicates that there is, as is often the case with prisons, frequent re-incarceration of targetted criminals. Clearly, the wellbeing of these individuals is not considered a contributing factor to the wellbeing of the population when they are subjected to these conditions repeatedly.

The extent to which the prisons are overcrowded, as indicated by the description of the situation at Cipinang, physicalizes the tight control that the government administers over their bodies. Additionally, by targeting geographically specific communities of drug users for incarceration, the government demonstrates the presupposition that the human species is distributed into groups of who can live

179 Tina (Manik Organik Employee), personal interview, July 2, 2016.
180 Calculation made through reviewing 14 conversations from summer of 2016.
181 By rounding up individuals from slums like Bonjos that are characterized by drug use.
and who cannot. These elements of the prison system in Indonesia are proof of the bio-political factors at play in this response to drug use.

I do not liken this prison system to slavery or colonization, two of the examples cited by Mbembe. I do, however, suggest that there are strong threads of necropolitics at play in the prison system in Indonesia. Drug users make up the majority of incarcerated individuals, which indicates that the government uses the prison system to condemn the drug user to social death. Though this condemnation is not lifelong and does not implicitly apply to all people who use drugs in the way that slavery once applied to, more or less, all black Americans, the concepts introduced through Mbembe’s example of necropolitics are also present in the government relationship with the drug user in the Indonesian prison system.

**REHABILITATION**

All rehabilitation programs considered in this section operate according to the logic that drug use can lead to addiction, which can lead to death. In an effort to foster life and prevent death for someone who uses drugs, the main goal of the rehabilitation center is to help its clients achieve abstinence. Though methods vary between programs, they all provide care through temporary institutionalization of the user in a drug free environment. Markers of success in the rehabilitation process are often oriented around eligibility to work for pay.

The use of rehabilitation in response to drug use in Indonesia illustrates the government’s increasing orientation toward biopower in this response. The client is

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physically disciplined to not use drugs by being placed in a drug-free environment. Psychological disciplines are reinforced as information regarding the dangers presented by drug use is reiterated. Bio-political tools are used in rehabilitation when the government releases statistics of national drug use to support goals for increased rehabilitation. Although these statistics were reportedly faulty and the logic behind mandatory rehabilitation has been widely criticized, the partnership between government ministries (namely the BNN, the Ministry of Health and the Ministry of Social Affairs) and universities such as Atma Jaya University and University of Indonesia show that the government increasingly promotes knowledge of biological processes in its response to national drug use.

Through medicalization and victimization, certain drug users fall under a category that Foucault calls “the good poor.” The good poor is a form of functional discrimination that developed with the rise of biopower, as the previously generalized “pauper” was analyzed and subdivided according to use value of the individual. If a person can be disciplined and transformed to become useful in the labor force, they are considered good poor.\footnote{Foucault, Michel. *The Foucault Reader.* Editor Paul Rabinow. New York: Vintage Books, 2010. 276.} Their health is considered a worthwhile investment.\footnote{It is fitting, then, that in practice, the distinction between the user and the addict is not related to the health of the user, but rather to the correlation between the quantity of drugs found in their possession and the degree to which they could pay off the officer at the time of seizure.} Policy developments that distinguish those sent to mandatory rehabilitation from those sent to prison for drug use demonstrates the rising importance of medicalization of the individual and demonstrates how this tool is used to promote the well-being of the population at large.

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\footnote{It is fitting, then, that in practice, the distinction between the user and the addict is not related to the health of the user, but rather to the correlation between the quantity of drugs found in their possession and the degree to which they could pay off the officer at the time of seizure.}
Rehabilitation is not necropolitical because the patients, while they are temporarily removed from their contexts of social existence, remain a part of the general population whose wellbeing is of interest to the government. By taking interest in the rehabilitation of these individuals, the government’s concern is to save the individual from drug use, rather than save society from the individual as it does tries to do through incarceration of the user. According to the logic of rehabilitation, the drug is the enemy, but the drug user medicalized as the addict is not the enemy. In this way, the government does not contribute to the person’s social death, but rather it fact fosters social life. The acquisition of social life is still contingent on the patient’s ability to achieve abstinence. It is only with the introduction of harm reduction that the government begins to foster life for a person who uses drugs, not just those who once used drugs.

FORCES OF LIFE AND DEATH IN HARM REDUCTION

When the government instituted rehabilitation for drug use, the user was no longer the enemy and the life of the user was fostered through rehabilitation. Through harm reduction, the government promotes life for the drug user without renouncing drug use, but also subjects the user to some features of necropolitics as it ostracizes and subordinates the drug using population to the general population. Harm reduction does not, however, expose users to necropolitics entirely because the program exists to promote the wellbeing of people who use drugs. I will analyze the anatomo-political, bio-political and potential necropolitical features of three features of harm reduction:
reification of the delinquent,\textsuperscript{185} medicalization of the drug user and medication of the drug user. Through this analysis, I will determine how harm reduction helps the government make advances in fostering life and how it disallows life to the point of death.

**THE CRIMINAL BEFORE THE CRIME**

Foucault states that the delinquent stands behind the offender, and the delinquent is born through the government’s establishment of, “The criminal as existing before the crime and even outside of it.”\textsuperscript{186} The concept of this pre-delinquent, the criminal before the crime, is both pivotal to and constantly reinforced by the operation of the Indonesian harm reduction center. It is through this concept that the identification “drug user” does not hinge entirely on a person’s consumption of drugs. Allow me for a moment to return to my Balinese friend, Tina.

Tina told me that when she was growing up in Denpasar, the big center for drugs was Sudirman, “Which was weird,” she noted, “Because it was an army area. But people would buy drugs from there because it was a safe area, one that the police could not regularly patrol.”

The military men did not really use, she told me. It was just the army kids and she was one of them. Police knew about the drug use in this area and targeted Sudirman despite the tension that this would sometimes foster between them and the military men that lived there. Tina remembered her mother’s understanding attitude with appreciation as she recalled her mother supplying clean needles for her and her

\textsuperscript{185} A term, defined by Foucault as a pathologized subject builds the mode for the criminal type. (Foucault Reader, Illegalities and Delinquency,” 231.)

friends before harm reduction was institutionalized. If the police came to search the house, Tina’s mother would hide the needles and have Tina tell her friends to stay away. Even a strong network of friends and even some parental allies, many of Tina’s friends, including her brother, were arrested but she never was.

Years after leaving home, she told me, when she was clean, Tina was waiting for her friend at the police station and there was a man in plainclothes sitting there too. He commented that she looked healthy. “You’re clean.” He said. She understood what he meant and suddenly also understood that he was an officer and, because old habits die hard, she denied having ever used. He responded by reciting to her who her supplier had been, where she had gone for pickups, where she went to school. “You were my target.” He said. In that moment, Tina told me, she realized how lucky, and how close to incarceration, she had been.187

When mapping outreach, Kios concentrates its resources in areas have proven to have high concentrations of drug users. As is evidenced by Tina’s story, the police do the same when mapping their surveillance strategies. Pre-exposed to tight surveillance, Tina was extremely lucky to have never been arrested. The students who shared the room next to mine in the boarding house I stayed at in Jakarta painted a different picture rooted in the same principles through a story about a girl they went to school with. I asked them, when we were talking one night, if they knew people at their school that used drugs. Though they firmly denied at first, they eventually started telling me about a girl they knew. “She was so fat!” They began, giggling. “Ya! Ya, she was so fat and then all the suddenly, doop! And then we heard that it was,” the girls rallied

187 Tina (Manik Organik Employee), personal interview, July 2, 2016.
back and forth looking for the word “amphetamine” for a while and finally found it. “Ya! Ya! Amphetamine...girls at our school smoke it to get skinny sometimes. She looks good now, ya, but she doesn’t smile because of her teeth...”

These two examples, when considered in conjunction, illustrate that drug use is not always the best indicator of who gets attention from authorities or harm reduction centers in drug related surveillance. Tina was a target of surveillance, as were her friends, because of the area she lived in. The classmate of my neighbors, according to their story, was not the target of drug-related surveillance in this same way because their school was not a notorious drug-centric community. While the bio-political logic behind Kios’ mapping strategy helps harm reduction foster life by extending resources to as many clients as possible, it also helps perpetuate social divisions that have led these areas to become prominent locations for injecting drug use in the first place, disciplining the users from these communities to consider themselves as such.

While harm reduction strategy relies on the concept of the pre-crime criminal, the program also makes progress in destigmatizing life that involves drug use. Harm reduction focuses its involvement on improving the personal wellbeing of the client. For some, this means abstinence and for others this means moderated drug use. This philosophical shift from abstinence-based treatment allows harm reduction to promote life not only beyond drug use, but also through drug use if this better suits the preferences and abilities of the client. As the enemy-status of the drug is weakened through harm reduction, the community in which drug use is a feature of communal identity is able to promote life for community members without renouncing itself.

188 Cindy Neighbor (high school student) personal interview, August 8, 2016.
comparison to abstinence-based models, harm reduction is more effective in mobilizing resources and fostering opportunities for life that includes drug use for its clients.

**MEDICALIZING THE DRUG USER**

The harm reduction center extends medicalization of drug use beyond the institution and the role of the professional beyond the expert. In doing so, it blurs the status of both the patient and the doctor. According to Foucault, the institutionalization of the sick and the unruly began to grow obsolete during the eighteenth century and has become increasingly so ever since. He says of the hospital, “The hospital is more the seat of death for the cities where it is sited than a therapeutic agent for the population as a whole.”

He says that domestic forms of hospitalization and the method of dispensaries have begun to take the place of the hospital as the institution. The harm reduction center is a prime example of this replacement in the area of drug use. The majority of harm reduction activity is mobile and involves outreach workers entering the domestic spheres of the clients they reach. The harm reduction drop-in center acts as a dispensary in that it maintains some technical advantages of the hospital – it can distribute ARV and conduct medical counseling – without incurring medical and economical costs that the hospital faces. In making this shift, harm reduction fosters life by making resources more accessible and sustainable.

In exemplifying a shift away from the institution in modern medicine, the harm reduction center also illustrates advancement in the developing relationship between the government and the life and death of a drug user. Harm reduction allows for the enhancement of life because the person using drugs need not relocate to an isolated

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institution to receive help in altering their using habits. This occurs through the deployment of outreach workers who establish “satellite clients” to amplify the message within the community. This illustrates harm reduction’s implementation of a system of discipline within a community that is executed according to an understanding of biopolitical tendencies. This subtle and diffuse form of discipline allows the government to use harm reduction to reach further into drug using communities rather than having its influence confined to institutions.

When medicalized intervention in the lives of drug users is extended from the institution, expertise to carry out this work must also be extended. Harm reduction promotes the extension of the expertise beyond the realm of the professional by granting outreach workers a certain level of authority as they deliver information to the communities that they medicalize. Nikolas Rose writes about the social authority that accompanies the notion of expertise. Being an expert gives someone the power to define problems, diagnose them and claim technical efficacy regarding this diagnostic. Specifically, he writes about the power of expertise in psychology, “Those who enter such arrangements with psychology are those engaged in all the proliferating practices that have to deal with the vagaries of human conduct and human pathology, all those who seek to act upon it in a reasoned and calculated form.” The harm reduction center extends the authority of expertise to the outreach worker because this is the person that has the greatest amount of direct contact with the drug user. It is the responsibility of the outreach worker not only to anatomo-politically monitor the

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behavior of the client, but also to provide semi-professional advice, through which process they ideally instruct the clients according to bio-political knowledge.

MEDICATING THE DRUG USER

While the rehabilitation center introduced the medication of the drug user as a government response to the perceived drug problem, harm reduction changed the nature of medical surveillance and therefore changed the power that the government has over the drug user to ensure medication. The harm reduction center is involved in the administration of antiretroviral (ARV) treatment for HIV-positive people who use drugs and opiate substitution treatment (OST) for people interested in abstaining from drug use but struggling with withdrawal.

Harm reduction centers in Jakarta provide ARV treatment at their drop-in centers, making the drugs more accessible for many HIV-positive users. Access to ARV drugs can be challenging at referral hospitals because they are over-crowded and can be difficult to reach because there are only a few throughout the city. Kios clients have also reported cases of discrimination and refusal to provide medication at the referral hospitals, especially among unwed mothers.191 Because studies show that adherence to strict schedules of ARV consumption is key to the effectiveness of the medication,192 these uncontrolled variables leave HIV positive individuals eager for better access to treatment. By extending the provision of ARV treatment, the harm reduction center helps the government foster life among drug users because the medication makes HIV chronic rather than fatal. The centers monetarily incentivize their clients to get tested

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191 Dial (Kios Outreach worker), conversation at community health center, July 27, 2016.
regularly for HIV, Hepatitis A and B and tuberculosis and provide networks through which the clients can learn more about ARV treatment with an emphasis on the way that ARV drugs interact with various opioids and amphetamines.

Incentivizing substitution therapy (OST) is another avenue through which the harm reduction center alters the way that a drug user is medicated. Opiate substitution therapy happens most commonly through methadone maintenance treatment (MMT) at a community health center. Another form of opiate substitution is buprenorphine, which is a pill that can be acquired at referral hospitals. While the rehabilitation center can monitor the client’s adherence to OST through their time at the institution, a harm reduction center stays involved in the community of the drug user and is able to prolong this relationship. By incentivizing OST maintenance, harm reduction helps enable the user to reintegrate into the work world. According to norms accepted and reinforced through harm reduction, people tend to maintain greater degrees of functionality on methadone and buprenorphine in comparison to when they are on heroin. Similarly and not entirely separately, OST drugs are less stigmatized in the general population than recreational drugs. Anthropologist Kane Race states that this is linked to the fact that less pleasure is associated with these treatment drugs, and therefore they are more socially acceptable to use.\(^{193}\)

There are also limiting features of OST that are neither caused nor solved by the harm reduction program. A user can become a prisoner to the community health center through methadone treatment, as MMT requires that a person visits the community health center at a minimum rate of once every three days during a short

time window. Buprenorphine does not present this issue, but the drug can be inaccessible because it is expensive while MMT is free and because it is only available at referral hospitals.

INITIATING A CHAIN REACTION OF INVOLVEMENT

Philosophically, the most dramatic difference between harm reduction and other responses to drug use employed in Indonesia is the non-abstinence-based nature of harm reduction. In theory this should allow harm reduction to liberate users because of government validation of life that includes drug use. However because tolerance of drug use is marginally practiced in Indonesia, a client who moderates drug use according to tolerance-based underpinnings of harm reduction will likely not be accepted by the general population.

Perhaps the most revolutionary and metacognitive tool of biopower made possible through harm reduction is the development of a group of drug users to discipline other drug users to accept their social death together. Through this cycle of isolation from the general population, but cultivation of community, the community around the harm reduction center is able to disciplines itself to accept its necropolitical state. While life is fostered in these environments, within limits, that life is neither validated nor enabled by the government. This situation is maybe best illustrated by a post-counseling ritual.

At the end of every of every group counseling session at Kios, the counselor leads the group in the Serenity Prayer: “God give me the serenity to accept the things I cannot change; the courage to change the things I can; and the wisdom to know the difference.” I always found this funny because if there was any official religion in these
counseling session, it was definitely Islam and here was this prayer that originated in a Christian context to bring it all together at the end. But looking past the religious connotations, when I see these words and how they apply both to the realities of the center and its clients and think of how they are incredibly aligned.
CONCLUSION

A study of Kios harm reduction center helps to shed light on the increasingly prominent links between humanitarianism and biopower. By recognizing that the harm reduction center is a feature of government structure, we are able to consider the ways in which its activities are influenced by and in service to both state governance and global governance. By considering the ways that the harm reduction center works with state and global government, we open the opportunity to examine the definition of “harm” according to the state, global governance, and the harm reduction center. While humanitarian logic is the primary driver for global governance intervention, the logic of biopower is the primary drive for Indonesian state action. In this paper, I acknowledge that both governing structures use harm reduction in emergency interventions regarding drug use and I critique the application of “emergency” interventions to solve deeply rooted public health problems. I then address the issues with the top-down structure of international humanitarian aid that emerge in the Indonesian harm reduction program before I consider the challenges in the relationship between the Indonesian government and the life and death of the drug user. I acknowledge how harm reduction influences this relationship and consider what this influence means for the drug user’s ability to live as a member of Indonesian society.

By focusing on experiences of people at Kios and considering these in conjunction with the studies of social scientists like Lamia Karim, Angela Garcia and Didier Fassin, I was able to gain a more holistic and comparative understanding of issues that seemed like they must have been unique to Kios when I was first exposed to
them. The harm reduction center, like the drug itself, is a curious thing. It attracts attention in international news articles and referendums by international drug policy consortiums. I’ve hardly ever felt as almost-famous as I did upon arriving home from Indonesia to read news articles on harm reduction and see friends and coworkers in almost every one. But unlike the stigma that surrounds drugs, I do not believe that the conversation that surrounds harm reduction is negative. Conceptually, it is a uniting institution as it validates controlled drug use. Practically, however, there is still progress to be made in uniting the drug user with the general population. Harm reduction illustrates how politics of both biopower and humanitarianism are embedded in drug policy and drug use. While it is important to criticize the program and remain aware of the governmental structures that influence it, it is equally important to pay it due respect and appreciate the lives that are saved by, defined by and devoted to this work.


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Dial (Kios Outreach worker), conversation at community health center, July 27, 2016.

Dr. Chakka (doctor at referral hospital), personal interview. Jakarta, July 29, 2016.

Dr. Turgu (staff doctor for Kios and doctor at referral hospital), personal interview. Jakarta, July 29, 2016.

Gabi (Researcher at ARC Atma Jaya), policy and research interview, August 3, 2016.

Gracie (Kios Client), personal interview, July 18, 2016.

Husen Basalahma (Director of Kios) introductory conversation recorded, Tuesday June 14, 2016.

Husen Basalahma (Director of Kios) personal interview, Tuesday July 20, 2016.

Irwanto (President of ARC), discussion about history of drug policy, July 24, 2016.

Mire (Kios outreach worker) recorded conversation on way back from outreach, July 17, 2016.

Marcos (suboxone injection) a personal discussion, July 22, 2016.


Sugihendro (Administrative Member of PKNI) discussion about advocacy, August 4, 2016.

Tina (Manik Organik Employee), personal interview, July 2, 2016.

Very Kamil (PhD Candidate, drug policy advocate) Mentoring Session, June 19, 2016.
Very Kamil (PhD Candidate, drug policy advocate) Mentoring Session, June 10, 2016.

Very Kamil (PhD Candidate, drug policy advocate) Mentoring Session, June 12, 2016.

Very Kamil (PhD Candidate, drug policy advocate) Mentoring Session, June 27, 2016.

Very Kamil (PhD Candidate, drug policy advocate) Mentoring Session, July 16, 2016.

Very Kamil (PhD Candidate, drug policy advocate) Mentoring Session, July 24, 2016.

Very Kamil (PhD Candidate, drug policy advocate) Mentoring Session, July 30, 2016.

Very Kamil (PhD Candidate, drug policy advocate) Mentoring Session, April 8, 2017.