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

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Introduction

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

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

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

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

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

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

Setting

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

Prison structures and OAT programmes in Indonesia

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

non-narcotics (general) prisons. Narcotics prisons are specifically designed for drug offenders. However, due to the increasing numbers of drug offenders, many are detained in general prisons. At the time of this study, only 33 out of 412 Indonesian prisons were narcotics prisons, with many experiencing overcrowding by as much as 260% (Directorate of Corrections 2016).

In Indonesia, OAT programmes take the form of MMT programmes. Following the establishment of the first MMT programme in a community hospital in Bali in 2003 (National AIDS Commission 2009), an MMT programme was also introduced in a Kerobokan Prison (Bali) in 2005 (Ministry of Health Indonesia 2008). By 2016, 12 prisons across the country were providing MMT programmes. However, the number of MMT participants was very low compared to the total number of drug users in prison. Across the Indonesian prison estate, the greatest number of prisoners recorded in any one prison as receiving methadone in a prison was 45 (1.7%) out of 2649 drug using prisoners, while the lowest number was 2 (0.3%) out of 734 drug using prisoners.

While Indonesian prisons set addiction criteria based on DSM IV for opioid dependence, programme eligibility requirements vary between prisons. No other treatment options are available apart from Therapeutic Community (TC) programmes. TCs were established in Indonesian prisons in 2013 under the supervision of National Anti-Narcotics Agency of the Republic of Indonesia (BNN). They provide psychosocial and cognitive-behavioural support to drug dependent prisons, but require participants to be free from drugs (including prescribed drugs such as methadone). By 2017, there were 60 TC programmes in prison, as well as 6 community-based TCs. However in December 2017, the BNN suspended provision of TCs in Indonesian prisons temporarily on the basis that they were 'ineffective' and, given the persistently high levels of illicit drug use in prisons, wasted resources (Sukmana 2017).

Methodology

Research design

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

Sampling strategy

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

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

Selection criteria for study participants

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

programmes (referred to as methadone prisoners from here on) and those who were not (referred to as non-methadone prisoners from here on). The selection criteria for prison staff was based on their roles and responsibilities. In each prison, participants were selected with the help of the prison doctor, prison manager and the chief of prison security.

Methadone prisoners were eligible for inclusion if they had participated in prison MMT programmes for more than six months, while non-methadone prisoners were eligible for inclusion if they were current injecting drug users, or had been injecting drugs for more than six months before imprisonment. The methadone prisoners recruited may or may not have been participating in other prison HIV programmes. Methadone and non-methadone prisoners were excluded if they had significant mental health disorders or might be released before the completion of data collection. In each prison, healthcare staff provided a list of potential prisoners for inclusion in the study. The researcher then selected potential participants based on the study criteria. As discussed, in addition to purposive sampling, snowball sampling was used to help the researcher to minimise participant selection bias and to recruit potential participants who might provide valuable insights (both methadone and non-methadone prisoners). In this way, the researcher avoided relying exclusively on the chief of security and healthcare staff to identify potential participants.

Sample structure

In qualitative research, the richness, complexity, and detail of the data produced and analysed are prioritised above the size of the sample (Mason 2002). However, for practical reasons, the proposed number of participants was decided upon in the planning stage of the study. Creswell and Miller (2000) suggest a minimum of 3 to 5 interviews per case study, while Leech and Onwuegbuzie (2007c) suggest a minimum of 3 participants per sub-group. Given the fact that there were five types of sub-group participants across three types of prisons, a minimum sample size of 45 participants was planned. In the selection of sample members, the criteria were not always fully applied. For example, a psychologist who was responsible for Therapeutic Community (TC) programmes in the narcotics methadone prison was

also recruited on the assumption that her role might enrich understanding of the study context. In total, there were 57 participants in this study. Table 1 below summarises the sample structure.

Table 1. Sample structure

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

Ethical approval

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

Data collection

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

voluntary nature of study participation and the annonymity of data collection. A private room was made available in the study prisons. Most semi-structured interviews lasted for 45-60 minutes. The shortest lasted 30 minutes (interrupted by a regular security check), and the longest took 120 minutes.

Both written and verbal consent were obtained from each participant regarding their willingness to participate in the study. Monetary incentives were not given to ensure that prisoners took part voluntarily, although a small snack was offered. No incentive, monetary or snack, was offered to prison staff participants, as this could have been construed as bribery.

Data analysis

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

Findings

Intersectional stigma takes place when multiple identities co-occur and are linked together. When this happens the experience of stigma is often amplified, (Swan et al. 2016) preventing people living with these conditions accessing both individual and structural support (Jackson-Best et al. 2018). In this study injecting drug use and associated characteristics, HIV positive status, and participation in MMT programmes were linked in discussions of stigma and found to amplify the stigma experienced.

Stigma towards MMT programme participants is driven by generalised negative perceptions of both prison staff (prison governors, prison officers and healthcare staff) and other prisoners. Organisational factors that reinforced the stigmatisation relating to MMT programmes ranged from a lack of confidentiality in delivering the programmes to the absence of family and institutional support.

Negative perceptions of people participating in MMT programmes as a driver of stigma

Methadone prisoners were perceived by both non-methadone prisoners and prison staff alike in similar ways to those taking illicit drugs. They were also seen as lazy and poor. A non-methadone prisoner from the general prison said:

> "I think cameras highlight those kind of people (methadone-prisoners). There are cameras (CCTV) here (in the clinic) and throughout the prison. It is easy to identify them as they are lethargic" (General methadone prison, Non-methadone prisoner, late 20s).

A non-methadone prisoner from the general non-methadone prison also suggested that:

> “Drug dealers and those (drug users) who have money would not take methadone; methadone is only for prisoners who have no financial support from their family” (General non-methadone prison, Non-methadone prisoner, early 30s).

Thus, poverty was also a source of stigma rather than compassion. Methadone prisoners were also assumed to be HIV-positive, as suggested by a non-methadone prisoner from the general non-methadone prison:

> "There is some stigma towards people who are injecting drugs in the prison - they are a dirty people and a source of disease. Fellow prisoners and prison staff think those prisoners in the methadone

> programmes are HIV-positive prisoners" (General non-methadone prison, Non-methadone prisoner, late 30s).

However, as one methadone-prisoner from the narcotics methadone prison pointed out:

> “People say that methadone-prisoners are HIV-positive people, even though not all methadone-prisoners have HIV infection” (Narcotics methadone prison, Methadone-prisoner, early 40s).

Another concern relating to the MMT programme participants was their low productivity. Prisoners receiving methadone were often perceived as being physically slow and lazy:

> “Many methadone-prisoners do not get involved in the prison activities such as sports and only a few of them joined the educational session. They just go back directly to their unit to sleep after taking their methadone, so the staff think we are unproductive ” (Narcotics methadone prison, methadone-prisoner, early 30s).

Many prisoners linked the high levels of stigma and discrimination in prisons with a lack of education and awareness about HIV prevention, as indicated by one non-methadone prisoner:

> “I think stigma is a normal thing in the prison and everywhere. I think because people do not know what HIV is and how it could be transmitted" (General non-methadone prison, Non-methadone prisoner, late 30s).

In sharp contrast to views held about the methadone programmes and their participants, many prison staff and both groups of prisoners appreciated the TC programmes because they are drug-free. They were perceived to be more acceptable in prison settings and provided nutritious meals and emotional support for their participants. A non-methadone prisoner said:

> “I like the TC programmes since their participants can talk and discuss all their problems in prison with the experts (psychologists) (Narcotics methadone prison, Non-methadone prisoner, early 30s).

Another emphasised:

> "TC is a good programme since it is making their members healthy. They fulfilled our needs by giving nice regular meals. It is because they have their funding. Frequently I saw them get snacks, curry chicken rice that sort of healthy nice food" (Narcotics methadone prison, Non-methadone prisoner, late 20s).

However, although TC programmes were perceived positively by prison staff and prisoners, many prisoners considered these programmes to be unsuitable for injecting drug use, as it was believed that injecting drug users found it more difficult to be drug free, a pre-requisite for joining a TC programme. As one non-methadone prisoner put it:

> “We are injecting drug users, while many of TC participants are non-injecting users. So, although TC programmes have many benefits we could not join the TC programme" (Narcotics methadone prison, Non-methadone prisoner, early 30s).

Understanding intersectional stigma and its impact on MMT programme participants in prisons

According to a member of the healthcare staff from the general methadone prison,12 of the 17 MMT programme participants were also HIV-positive. The connection made between MMT programme participation and having a positive HIV status was a concern for many prisoners in both methadone prisons. As one programme participant put it:

> “I felt quite different since being infected with HIV but joining the methadone programmes make things even worse (additional layer of stigma)” (Narcotics methadone prison, Methadone-prisoner, mid 30s).

However, healthcare staff in this study often failed to recognise the intersectionality of stigma, believing that stigma was simply attached to a known HIV positive status rather than also to participation in MMT:

> “I think the methadone-prisoners do not mind even when we have no private clinic, but I think it might be that some of HIV patients do not want to be known as HIV-patients. I know that some of them were not ready to disclose their (HIV) status afraid of being stigmatised by other prisoners" (Narcotics methadone prison, Doctor, female).

This intersectionality and the amplification of stigma can have a devastating impact on mental health and well-being leading to greater levels of depression and suicide. As one methadone-prisoner from the narcotics methadone prison explained:

> "Being ostracised, separated, and mocked are common practice, but not everyone can handle on their stress. You know that some people turned to depression and chose to commit suicide here" (Narcotics methadone prison, Methadone-prisoner, early 40s).

The stigmatising attitudes of prison staff may also reduce methadone prisoners’ oportunity to get parole and therefore their chance of an early release. In the narcotics prison with a MMT programme, many prisoners apply to participate in a work programme with the aim of obtaining a recommendation to join the parole programme. However, methadone prisoners have difficulty accessing work programmes since they were assumed not to able to work as hard as other prisoners. As one prison officer observed:

> “All prisoners are equal here since they can join any work programmes with no prohibition, but physically they should be able to perform well,

> and they should know their capacities at work (physically demanding job)" (Narcotics methadone prison, Prison officer, late 20s).

Similarly, some methadone prisoners linked this limitation of their work options directly to stigma associated with their participation on methadone programmes and their HIV status:

> "It was a shame that I could not join the work programmes. [A] prison officer said [this was] because of my participation in the methadone programmes and my health status (HIV-positive). I wanted to work so that I did not feel lonely. I know people see us as failures" (General methadone prison, Methadone prisoner, early 40s).

Many methadone prisoners also associated the uncaring behaviour of healthcare staff at the methadone clinic with their HIV-positive status. A methadone-prisoner from the general methadone prison said:

> "All the healthcare staff must have also known our HIV status, so when we stand in the clinic corridor waiting for the methadone, they walk cautiously because they feel disgusted by being close to us. I think it was not a good example from the healthcare staff to others, so the prison officers also acted like that" (General methadone prison, Methadone-prisoner, early 30s).

Indeed, some healthcare staff from the general methadone prison believed that such actions were justified and not discriminatory, indicating a lack of empathy for prisoner concerns:

> "I do not think there is a discrimination problem. It is just the matter of health concerns. Their hygiene was lacking so we liked to stay away from them" (General methadone prison, Doctor, male).

Rather than addressing stigma, senior prison staff suggested that HIV-positive prisoners should be segregated:

> "I think if we find HIV-positive prisoners we should separate them, but the doctors said HIV-positive prisoners could not be separated. Honestly, if I [had the] space, I [would] separate them, but according to the law, it is not allowed" (Prison Governor).

Regardless of their experiences of stigma, some methadone prisoners also used prison officers' fear of HIV infection to their advantage as a way of hindering security procedures. A methadone-prisoner from the narcotics methadone prison described the following scenario, while indicating by his aside to the researcher, that such discrimination was common knowledge:

> "I just pretended to use a mask and to cough, so they did not enter our cell. Mobile phones (prohibited in prison) and that sort kind of thing were possessed by most of the people here. Once they wanted to take our rice cooker, but we said, 'sorry sir, it belongs to the methadone-prisoners, and we are all sick here (HIV positive)'. Thus, they took other peoples' rice cookers, but they gave us ours back. You must already have known there is that kind of discrimination here" (Narcotics methadone prison, Methadone-prisoner, early 40s).

Such interpersonal stigmatisation was further reflected in and reinforced by organisational factors.

Organisational factors that promote stigmatisation of MMT programme participants

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

Lack of confidentiality

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

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

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

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

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

> methadone clinic at the end of corridor (away from the other health clinics)" (Narcotics methadone prison, Methadone-prisoner, early 40s).

One healthcare staff member from the general methadone prison, recognised that MMT programme participants experienced stigma but identified spatial constraints as a reason why nothing could be done to remedy the situation:

> "I know the methadone clinic should be in a separate place, and the recent clinic arrangement might make the prisoner uncomfortable, but we have no other space" (General methadone prison, Healthcare staff, female, mid 30s).

Even the size of prisoners' medical records could betray participation in MMT programmes. As a non-methadone prisoner from the narcotics methadone prison described:

> "People can spot the difference from their records. A methadone-prisoner has a big medical record while others have small ones" (Narcotics methadone prison, Non-methadone prisoner, early 40s).

Lack of family and institutional support for methadone prisoners

Many prisoners had already experienced stigma from their families. The importance of this stigmatisation is exacerbated in the Indonesian prison context by the fact that family members play an essential role in supporting prisoners. For example, at the time of the study, prisoners' families were expected to pay for X-rays and for medication for opportunistic infections because of limited financial resources in prisons. Prisoners also rely on family money to buy extra food to supplement the poor prison diet, as well as soap, toothpaste and other hygiene products. Consequently, the many HIV-positive prisoners, who have been rejected by their families face problems. As a prisoner from the general methadone prison explained, this has implications for HIV-positive prisoners:

> "I feel a lack of vitamin and fruit intake while in prison. Methadone is a hard drug, so it should be consumed with vitamins and fruits. I am afraid

> my health would deteriorate dramatically without those supplements" (General methadone prison, Non-methadone prisoner, mid 20s).

These prisoners also often lacked emotional support from their families:

> “I want the doctors to provide emotional support to boost our motivation to take ART (antiretroviral treatment) or to join the methadone programmes, since we have no families to support us" (General methadone prison, Methadone prisoner, mid 20s).

A member of healthcare staff from the general non-methadone prison seemed unaware of this problem of family stigma. She encouraged the disclosure of the prisoners' HIV-status to their family members to get support, seemingly unaware that it might not be forthcoming:

> "Being open about their HIV status to their family members is important because this is a long-life treatment and their health condition may deteriorate at any time here. We encourage them to disclose their HIV status at some point, so their family will be aware of their conditions and then give them support" (General non-methadone prison, Healthcare staff, female, mid 30s).

However, some health workers did recognise that there was a problem of trust. Some services for HIV-infected prisoners were provided, including a peer support group. However, some staff were aware of feelings of insecurity among prisoners when talking about sensitive issues, such as HIV, with them:

> "I used to ask psychology students who had an internship programme here to talk to the HIV-positive prisoners. I realised there would be some barrier when we talked to them because we wear this uniform. They were afraid that if they were honest with us that they would receive the consequences from the prison authority, but they would feel

safe talking with those students" (General non-methadone prison, Doctor, female).

Discussion

This study confirms that prisoners participating in MMT programmes experience considerable stigma from both prison staff and other prisoners. Furthermore, healthcare and other prison staff often failed to understand the intersectionality of stigma that linked MMT programme participation with HIV positive status and negative stereotypes of drug users; or how individual attitudes or institutional practices contributed to this. This not only had a profound effect on prisoners' lives while in prison, adversely affecting mental health and driving some to suicide, but also limited their access to the parole system and therefore the possibility of early release.

To our knowledge, this is the first focused qualitative exploration of stigma and MMT programme participation involving prison stakeholders, prison officers, healthcare staff, and prisoners. The results provide empirical insights about perceived and experienced stigma related to MMT programmes in Indonesian prison settings.

In both of the study prisons with MMT programmes, many prisoners indicated that they had experienced stigma associated with their participation in these programmes as indicated by previous study (Komalasari et al. 2020). This was confirmed by some healthcare staff in the general methadone prison and has also been recognised in studies in other locations (Woo et al. 2017; Carlin 2005; Mitchell et al. 2009). The findings also point to many organisational factors including policies, culture and practices that suggested negative beliefs and attitudes with regard to MMT programme participation. Such factors have been described as 'institutional stigma'. Harris and McEwan (2012) argue that such stigma leads to low levels of accessibility to participation in methadone programmes, as well as the development of general and mental health problems.

As in previous studies conducted in prison settings (Zaman et al. 2010; Moradi et al. 2015), negative perceptions of participants in MMT programmes were often associated with drug use, being lazy and poor and having a positive HIV status. Similarly, studies in the community (Nong et al. 2017) found that MMT programme participants were also perceived to be lazy. Both prison staff and prisoners linked these perceptions to the side effects of methadone. However, at the appropriate, therapeutic dose, methadone does not cause sleepiness or interfere with normal activity, but rather has a positive effect on overall physical health (Kheradmand et al. 2010). Stigmatisation was also linked mainly to negative perceptions of drug use as dangerous and integrally linked to violence and illegality (Ahern et al. 2007). Many prisoners, particularly in the general methadone prison, reported hurtful comments such as being told that they were 'dirty people' by healthcare staff.

This study supports previous studies on MMT programmes in community settings, which found that healthcare staff did not fully appreciate the associations made between MMT programme participation and a positive HIV status, or the breadth and scope of the intersectional stigmatisation of opioid-dependent clients (Medina-Perucha et al. 2019; Kuesza et al. 2016). Indeed, healthcare staff in the narcotics methadone prison thought that there was less stigma attached to methadone status compared to HIV status, even though other prisoners and prison staff automatically assumed methadone participants to be HIV-positive. The stigmatisation of people with HIV infection (Iskandar 2014) is matched by the stigmatisation of injecting drug use compared with other means of drug administration (Brener et al. 2017). Notably, some methadone prisoners in the narcotics prison linked the limitation of their work options, and therefore their reduced eligibility for parole, to such intersectional stigma.

Difficulties in maintaining privacy in prison settings, together with lack of a support system for additional health expenses, nutritious food, and hygiene products independent of family support, fuelled the stigmatisation of prisoners in the MMT programmes. The links between drug use and mental health problems have been identified in community settings (Park-Lee et al. 2017). However, prisoners are usually members of vulnerable groups that are particularly unlikely to receive

emotional support. This, together with overcrowding and insular prison environments in limited resource prison contexts, can provoke strong adverse emotional reactions to the stigma identified in this paper. For example, prisoners in the narcotics prison reported that some MMT programme participants had committed suicide because of stigma they experienced from their participation.

In the context of the limited resources of the Indonesian prison system, family plays a significant role in supporting prisoners by providing financial support. However in Indonesia, as in many countries (Fotopoulou et al. 2014; Yu, et al. 2018; Salter et al. 2010), drug use by a family member is considered a family disgrace that should be concealed to maintain 'family honour' (Ritanti 2017). Stigma associated with HIV also prevents family disclosure (Culbert et al. 2015a). As a result, although healthcare staff encouraged prisoners to disclose their HIV status to their families to get support, many prisoners declined to do this. Consequently, many methadone prisoners were unable to pay additional medical expenses, provide for their personal hygiene or purchase additional food to supplement inadequate prison food.

Education for prisoners and training for prison staff can both play an essential role in reducing stigma in prison settings (Tavakoli et al. 2019; Woo et al. 2017). Challenging specific misconceptions, such as all methadone participants are HIV positive, must be included to ensure that any strategy aiming to reduce stigma is effective. In particular, lack of understanding of how attitudes of healthcare staff can stigmatise methadone participants, which, in turn can negatively affect the attitudes of other prison staff and prisoners towards programme participants, needs to be addressed. Healthcare and other prison staff would benefit from training in: harm reduction and the provision of MMT programmes in prison; the intersectionality of stigma and guidance on working with drug users in a prison setting. In addition, where possible, encouraging prisoners' family members to participate in MMT programmes will help ensure that more methadone prisoners receive the emotional and financial support they need to succed in their treatment efforts while in prisons.

One limitation of the study was that it did not include female prisoners. This was because female only and mixed gender prisons were excluded during the prison

selection stage as HIV prevalence in these prisons is much lower. However, it is likely that the stigmatisation of male and female prisoners may manifest itself differently because of expectations associated with traditional gender roles. For example, women in MMT programmes may face greater stigma, as they are likely to be seen as failing in their family responsibilities. This remains an important area for further research. In addition, selection bias resulting from the reliance in part on prison managers to nominate study participants may have restricted disclosure or discussion of barriers to MMT programme implementation. The use of snowball sampling to recruit some study participants, however, overcame this to some degree and, in practice, there appeared to be open discussion of a wide range of issues during the interviews. In spite of these limitations, this study provides an in-depth exploration of stigma towards MMT programme participant and OAT programme participants more generally, and has revealed new and important consequences of stigma in prisons such as preventing access to parole programmes.

Conclusion

This qualitative study highlights the need for the development of prison policies and related guidance aimed at reducing the stigma associated with methadone programmes and discrimination by prison staff and prisoners in Indonesia. In particular, specific education programmes and information for prisoners and training for prison staff (including those working in security, healthcare and prison management) is required. This should focus on improving understandings of: i) the principles of harm reduction and how this relates to the provision of MMT programmes in prison; and ii) how institutional and individual practices of both prison staff and other prisoners promote the multi-layered and intersectional stigmatisation of MMT programme participants and deter others from participation.

The study also highlights the importance of education for prisoners' family members to alleviate stigma. Furthermore, incorporating prisoners' family members within programmes to ensure participants receive support might be an effective strategy to increase participation in and improve the quality of programmes in prison settings.

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