Perceived Partner Relationships and HIV Risk Behaviors

Among Recovering Female Injecting Drug Users in Jakarta

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THESIS

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AIDS	Acquired Immune-Deficiency Syndrome
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug user
MOH	Ministry of Health, Indonesia
STIs	Sexually Transmitted Infections
TGP	Theory of Gender and Power

SUMMARY

The number of women who inject drugs is rapidly increasing, and women now comprise 25% of new HIV infections in Indonesia. Many women are now in recovery programs, but little is known about them. This study explored HIV risk behaviors and partner relationships among women recovering from drug use in Indonesia.

Twenty-six women who were recovering from drug use were recruited from three non-governmental organizations (NGOs). Ages ranged from 22-41 years, and women were drug-free for 1-5 years. Interviews were audiotaped, transcribed, and translated into English. Guided by the Theory of Gender and Power (TGP), which identifies three interconnected constructs (the sexual divisions of labor, power, and cathexis, or emotional attachment), directed content analysis was used to identify themes.

Women described the importance of partner and family support when they quit using drugs, and their satisfaction in gaining a "normal" life after recovery. All women engaged in HIV risk behaviors when they still used drugs, and 21 women and 12 current partners were HIV positive. Currently, 11 were either not having sex or using condoms consistently. However, 15 still engaged in unprotected sex. Women identified all three constructs as important in relationships, especially cathexis, which they described as open communication, trust, and closeness. Seventeen of the 23 sexually active women said they had gender-balanced relationships that included high cathexis: equal decision-making power, and economic independence or shared control over finances. Half of the women in gender-balanced relationships had unprotected sex. Women in male dominant relationships had gendered

inequality in at least two areas, and all had unprotected sex. All but one of the women who used condoms consistently spontaneously reported that they received NGO counseling regularly.

Despite cultural norms of male dominance in Indonesia, most women described their relationship as gender-balanced. Gender and power in their relationships did not relate to their HIV risk behaviors. These results suggest that recovery programs should incorporate partner and family support and HIV education that addresses the needs of couples. NGO counseling services should be made more available to marginalized populations such as women recovering from drug use.

I. INTRODUCTION

A. Background

The total number of HIV cases in Indonesia is predicted to increase to 541,700 persons in 2014. Indonesia's HIV epidemic began primarily among injecting drug users (IDUs), and IDUs remain a group at high risk of HIV. Injection drug use is now the second major route of HIV transmission in Indonesia, after sexual transmission; it accounts for 36% of new HIV cases (Integrated Biological and Behavioral Surveillance, 2011). As in other countries, the number of women with HIV is increasing. Women make up 25% of all new HIV cases, and more than 50% of all new HIV infections among women were attributed to injection drug use (UNGASS, Country Report, 2012). Targeting female IDUs to stop using drugs and stay drug-free is a key component of reducing both drug use and HIV transmission.

Although the number of HIV prevention programs in Indonesia is increasing, these programs typically focus on active IDUs, especially men. There is no specific program that addresses the needs of recovering female IDUs who, in fact, still have high risk of being infected with HIV or transmitting HIV to their partners. The needs of the recovering female IDUs are different from those of both active female IDUs and their male counterparts. Although these women have stopped using drugs, they often still have contact with active IDUs, such as their partners and friends, and these contacts plus other factors put them at high risk of relapsing into drug use. Also, they may continue to be at high risk of becoming infected with HIV or infecting others due to unprotected sexual behaviors (Greenfield et al., 2007; Gyarmathy et al., 2002; Iskandar, et al., 2010), especially when their partners are current or recovering IDUs. Furthermore, as women, they also may lack the power for condom negotiation. These divergent

needs are critical to consider when implementing HIV prevention strategies for women recovering from drug use.

The Theory of Gender and Power is one theory that can explain the risk of HIV for recovering female IDUs. This theory describes three domains of heterosexual relationships, including the gender division of cathexis (emotional attachment), the division of power (decision making and control) and the division of labor (Wingood & DiClemente 2000). As described in more detail in Chapter 2, many researchers have identified gender-related power imbalances in relationships as a contributing factor for HIV risk behavior among women, particularly in developing countries (Harvey, Bird, De Rosa, Montgomery, & Rohrbach, 2003; Latkin, Hua, & Forman, 2003; Spittal et.al., 2002; Estebanez, Russel, Aquilar, Beland, & Zunzunegui, 2000). Cultural norms about gender, such as the expectation that the women should be passive, also contribute to these relationship dynamicss and sexual risk.

B. Statement of the Problem

Little is known about the pattern of relationships and risky behaviors among women recovering from drug use. There are no studies of the risk behaviors and partner relationships of women who have stopped using drugs. Indonesian women who stop using drugs need specific risk-reduction interventions that fit with the cultural values, beliefs, and gendered power dynamics in their relationships that may put them in HIV risk behavior.

C. Purpose of the Study

The purpose of this descriptive study was to explore HIV risk behaviors, partner relationships, and how gendered power dynamics in these relationships influence risk behaviors among women who are recovering from drug use in Jakarta. Previous studies define recovering from drugs as being drug free from 1 month to 5 years, after which a person can be considered to

be recovered (Betty, 2007). In this study, I define a recovering drug user as a womean who has stopped drugs for at least two months up to five years, to ensure that participants had achieved a stable condition as drug free. This study focused on the current self-identified primary partner.The primary partner was defined as the self-identified most important man with whom a woman has or had a sexual relationship. This study was guided by the Theory of Gender and Power to examine patterns of gender power in relationships that affect HIV risk behaviors among recovering female IDUs in Indonesia.

The specific aims were to:

- Describe the HIV risk behaviors (e.g. having more than one partner, not using condoms consistently, needle sharing) of women recovering from drug use during the two months before they stopped using drugs;
- Describe the current HIV risk behaviors of women recovering from drug use;
- Identify these women's primary current sexual partners and their perceptions of those relationships, including the sexual division of labor, sexual division of power, and the sexual division of cathexis;
- Determine whether the women's perceptions of their relationships relate to their current HIV risk behaviors with that partner.

D. <u>Significance of the Problem</u>

According to a Ministry of Health report (MOH, 2013), the number of women with HIV increased from 3,565 cases in 2008 to 12,279 cases in 2013, and women who inject drugs account for 50% of all new cases of HIV in Indonesia (UNGASS, 2012). Injection drug users have the potential to transmit HIV through unsafe injecting behaviors and unprotected sex and nultiple partners. (UNGASS, 2012). Among women who use injected drugs, several studies

indicate that they tend to engage in these same high risk behaviors, including having unprotected sex and sharing unclean needles, that increase their risk of becoming HIV infected or infecting their partner. Although women who stop using drugs are no longer at risk due to needle sharing, they remain a vulnerable population for HIV infection and have the potential to spread HIV to the non-injecting population through unprotected sex (Iskandar et al., 2010; Des Jarlais, et al., 2007).

E. Significance of the Study

This is the first study to describe Indonesian women who are recovering from drug use, their relationships, and their risky sexual behaviors. The findings add to knowledge about the role of relationships with men and how these relationships affect current HIV-related risky behaviors for women who stopped using drugs. This study systematically examined the perceptions of women about the different aspects of gendered power in their relationships and how power dynamics affected their risky behaviors. Results from this study will provide essential evidence needed to tailor HIV prevention interventions to the specific needs of women who are recovering from drug use.

II. CONCEPTUAL FRAMEWORK AND RELATED LITERATURE

This chapter will provide a review of theoretical and empirical literature on the relationship between HIV risk behavior and partnership. The literature review will focus on partner relationships, using TGP to understand the experiences of women recovering from intravenous drug use. TGP identifies three interconnected constructs, the sexual division of labor, the sexual division of power and the structure of cathexis (emotional connections of love and affection) that may be applied the Indonesian context.

First, this chapter provides information about the Indonesian social context that influences women who have stopped injecting drugs. Second, it reviews the existing research on relationships and HIV risk behaviors relevant to women who are recovering from using drugs. Finally, it presents the conceptual model of TGP and how the model may help to explain HIV risk behavior among recovering female IDU in the Indonesian context.

A. Demographic and Social Context of Indonesia

Indonesia is located in Southeast Asia, between Asia and Australia, and between the Indian Ocean and the Pacific Ocean. Indonesia is the largest archipelago in the world, with more than 17,000 islands. Administratively, there are 33 provinces, with 497 districts and cities, 6,578 sub-districts and 76,546 villages (WHO, 2013).

1. Social Demographics of Indonesia

Indonesia has the fifth largest population in the world, after China, India, the European Union, and the United States, with approximately 253.609,643 people in 2014 and a 0.95% annual growth rate. The sex ratio is 1.00 males/female and the infant mortality rate is 25.16 deaths per 1,000 live births (Central Intelligence Agency [CIA], 2014). The most populous city is Jakarta, the capital city. Java, where Jakarta is located, is the most populated island in

Indonesia, with approximately 9.1 million people (CIA, 2014). In 2013, Indonesia had a per capita gross domestic product (GDP) of $5,200 per capital and an annual GDP growth rate of 5.3%. The labor force (by occupation) is 47.9% services, 22.2% industries and 38.9% agricultural. Only 11.7% of the population lives below the poverty line (CIA, 2014).

2. Status of Women in Indonesia

Indonesia is a multicultural nation with approximately 30 native languages and ethnic groups. Javanese is the dominant group (40%), followed by Sundanese (15%), Madurese (3.3%), Minangkabau (2.7%), Betawi (2.4%), Bugis (2.4%), Banten (2%), and Banjar (1.7%). Other minorities comprise nearly 30% of the population (29.9%). Nearly 88% of Indonesians are Moslem. The most common other religions are Protestant (5.7%), Roman Catholic (3%), and Hindu (1.8 %) (CIA, 2014).

In Indonesia, the status of women is influenced by family law that is based on customs and local cultural practices (Asian Development Bank, 2002). As more than 88% of Indonesian population are Muslim, the definitions of "good" and "bad" women are influenced by Islamic religion. A woman is described as a good woman if she, as a daughter, obeys what her parents tell her, and if she maintains her virginity until her wedding night and only has sex with her husband. Once she loses her virginity before her wedding or has sex outside her marriage, she is culturally viewed as a "bad woman" (Bennett, 2005). Engaging in a premarital or extramarital sexual relationship is seen as immoral, sinful, and shameful (Bennet, 2005). Therefore, several cities in Indonesia have policies to punish women who do not follow "Syariah law" (Islamic law), such as wearing a scarf or covering their whole body, practices which are believed to prevent the arousal of men, which may lead to extramarital relationships (Noerdin, 2001). This

traditional norm of virginity may increase women's vulnerability to getting HIV. It restricts their ability to ask about safer sex because of the fear of being thought of as sexually active.

Another set of cultural norms in Indonesia that increase women's risk and vulnerability to HIV is that women are expected to be passive, obedient, patient, and loyal to men. Men, in turn, are viewed as the leaders of families. These norms give men more authority in their relationships. Men are usually the ones who have the power to make decisions in their relationships. These beliefs lead men to be more dominant and aggressive, which allows them to more actively negotiate sex and condom use (Baso & Idrus, 2002). It is socially accepted for men (but not women) to have more than one partner. In addition, it is culturally taboo to talk about sex, especially for women. A "good" woman is expected not to talk about sex and to be passive in sexual interaction. All these cultural norms make it more difficult for Indonesian women to be proactive in safer sexual negotiation with their male partners (Situmorang, 2003).

These norms about gender roles put Indonesian women at increased HIV risk by limiting their ability to negotiate condom use or other safer sex behavior. This power imbalance means that it can be difficult for women to protect themselves from getting infected with HIV if their partner is HIV positive. If women are HIV positive and their partners are HIV negative, these norms can also make it difficult for them to discuss their own HIV status and the need for condoms, thus increasing the risk of HIV transmission to their partners.

3. HIV Epidemic in Indonesia

When the HIV epidemic began in Indonesia, the primary mode of HIV transmission was sharing unclean needles during injection drug use. However, HIV infection has gradually spread to the general population. Now sexual contact is the leading cause of new HIV infections (58%), while injection drug use is the second most common mode of transmission (28%) (UNGASS,

2012). Among the 33 provinces in Indonesia, Jakarta, where the capital city is located, has the highest number of cases of HIV. As HIV increased in the general population, new infections for women increased significantly, from 3,565 cases in 2008 to 12,279 cases in 2013. Women make up 25% of all new HIV cases, and more than 50% of all new HIV infections occur among women (UNGASS, 2012). These trends show that women are an increasingly important group to target for preventing new HIV infections in Indonesia.

4. Drug Use in Indonesia

In Indonesia, the National Narcotics Agency (BNN, 2013) found that around 9.6 to 12.9 million, or 5.9% of people ages 10-59, had used drugs at some point in their lifetime, and approximately 4.7 million people had used drugs in the past year. Of those users, about 1.2 million used crystalline methamphetamine and 950,000 used ecstasy. Heroin is the third most common drug used, accounting for 40% of all drug use (BNN, 2013). For all types of drugs combined, the number of drug users has increased throughout Indonesia since 2008. In Jakarta, the capital Indonesia, the rate of drug use has increased sharply, from 4.1% of the population being drug users in 2008 to 7.0% in 2011.

The number of IDUs in the country has decreased, from 230,000 in 2008 to 70,000 in 2011 (BNN, 2011). The number of men who are IDUs is higher than that of women. In 2013, there were approximately 58,767 to 60,040 male IDUs, and between 10,533 and 10,722 female IDUs (BNN, 2011). The decrease in injection drug use is influenced by several factors, such as a decreased supply for heroin, particularly from Afganistan, the expansion of effective programs for controlling addiction (Subutex/Sobolon and Methadone), the fear of getting HIV infection, and the high death rates among IDUs due to overdoses and HIV/AIDS. Although the number of IDUs has decreased, heroin is still available in Indonesia, and still easy to get in many places,

including food stalls, campuses, the mall, and even small street vendors. In addition, there are several “hot spots” for buying drugs in Jakarta, such as Boncos (Awaludin, 2013).

Although heroin is only the third most common drug, heroin use causes serious public health problems, not only because of the high rate and severity of addiction but also because of its contribution to HIV infection. Sharing unclean needles among heroin injection users has been recognized as a major contributing factor for the transmission of HIV since the HIV epidemic began. In Indonesia, IDUs are the second highest risk group for HIV infection, accounting for up to 38% of new HIV cases (Integrated Biological and Behavioural Survey [IBBS], 2011).

Although infection through drug use has decreased, more effort is needed to prevent HIV infection in the general population (MOH, 2013). The government of Indonesia has provided several programs that target people who are IDUs. For example, the government has provided eight regulations that will strengthen their harm reduction program, increased the number of Needle and Syringe Program (NSP) from 120 in 2006 to 194 in 2011, and increased Methadone Maintenance Therapy (MMT) sites from 11 in 2006 to 74 in 2011 (MOH, 2013). In addition, the MMT program was also embedded in Community Health Services (CHS) and prisons.

However, the prevention and harm reduction programs in Indonesia only target IDUs to reduce drug consumption. None of these programs specifically target women or provide long-term services for recovering drug users, either male or female. In addition, most studies focus on men and on current IDUs, while little is known about women who are recovering from drug use in Indonesia. Even though women who stopped using drugs are no longer at risk from shared needles, they may continue to have a high risk of HIV infection due to their partner relationships and sexual risk behaviors. Furthermore, if they relapse into using injection drugs again, they are

even more vulnerable to HIV infection because of sharing unclean needles (Iskandar et al., 2010; Des Jarlais et al., 2007).

5. Summary

Indonesia is a vibrant, densely populated multiculutural nation with a predominately Muslim population. The prevailing cultural norms regarding gender are that men should be dominant and women subservient, limiting women's ability to negotiate for safer sex. As the HIV epidemic has expanded to the general population in Indonesia, women have become increasingly vulnerable to HIV infection. Although injecting drug use overall has declined, the number of women who are IDUs has greatly increased. Female IDUs are at high risk for HIV infection and many of them are already HIV positive. Government addiction treatment programs have expanded greatly, so the numbers of both men and women recovering from drug use are growing rapidly, but there are no specific HIV programs that focus on women who are recovering from drug use. Because of the prevalence of gender inequity in relationships, women recovering from drug use may be especially at risk for becoming HIV positive or infecting their partners through unprotected sex. They also remain vulnerable to drug use relapses.

B. Recovering Women's Relationships and HIV Risk Behavior

Women who are recovering from drug use are likely to either be HIV positive or continuing to engage in behaviors that put them at risk of HIV infection. It is important to understand how their livestyles and relationships put them and their partners at risk of HIV infection. Despite this, few studies have focused on women who are recovering from drug use. This section begins with a summary of that very limited research. To supplement the limited research on women who have quit using drugs, I also reviewed the evidence regarding relationships and risk behaviors for women who inject drugs and for women in the general

population, with a special focus on studies in Indonesia specifically and Southeast Asia generally. These studies also provide insights into intimate partner relationships and how those relationships may influence their HIV risk behaviors for women who have stopped using drugs.

One study in the U.K. examined the recovery processes of five women who formerly used heroin. This study found three major themes: childhood experiences, the physiology and psychology of drug abuse, and perceptions about recovery. They found several sub-themes that facilitate successful recovery, including the desire to gain normality and a fear of harm from continued drug use, including its violent subculture. They concluded that new family relationships, new responsibilities, and new opportunities become factors that influence women to reduce or stop drugs (Watson & Parke, 2011).

Regardless of whether they use drugs, all women may put themselves at risk for HIV due to unequal gender-based power relations. Previous studies among women in the general population demonstrated that gender inequality gives women less power in their relationships with partners and, therefore, they are less likely to participate in condom negotiations and condom use (Epele, 2002; Harvey et al, 2003; Latkin et al, 2003). The context of a monogamous, committed relationship can shape a woman's thinking regarding HIV risk behaviors. These woman may feel "safe" with their partners, and can believe that unprotected sex is a sign of trust that enhances a relationship (Bowleg & Belgrave, 2000; Harvey et al., 2003; Impett & Peplau, 2003; Latkin et al., 2003; Kapadia et al., 2001; Tucker et al., 2007). Thus, when women trust their partners in committed relationships, this may actually increase their vulnerability to engaging in unprotected sexual behavior.

For women who use drugs, several additional factors influence HIV risk behaviors. Female IDUs differ from male IDUs in terms of their social backgrounds, their reasons for

quitting drugs, and their psychological needs, and these gendered experiences shape their HIV risk behaviors (Magnus, et al 2013; Walitzer & Dearing, 2006). Female IDUs are more likely than men to have depressive symptoms, to have been physically or emotionally abused, to report childhood sexual abuse, and to have been pressured or forced to have sex (Magnus, et al 2013). In addition, female IDUs often experience social stigma, economic pressure, and lack of social support (Latkin, 2003; Cleland, 2007; The Jakarta post, 2014). These gender-related differences may make women who use drugs more vulnerable to pressures from male partners to engage in HIV risk behaviors.

Several studies indicated that trust in the faithfulness of their partners can encourage women who inject drugs to engage in unsafe sex behaviors. Female IDUs viewed long-term relationships as less risky than casual relationships (Harvey et al., 2003; Latkin et al, 2003; Spittal, 2002; Estebanez et al., 2000). Thus, many young women believed that sharing needles and having unprotected sex with a steady partner were symbols of trust, love, and commitment in their relationships, and that these practices were likely to please their partners (Absalon et al., 2006; Bruneau et al., 2001; Bowleg & Belgrave, 2000; Kapadia et al., 2007; Lazuardi et al., 2010; Rhodes & Cusick, 2000; Spooner et al., 2004; Tucker et al., 2008; Uusula, 2012; Wayment, Newcomb, & Hanneman, 1993). A study with women who injected drugs in three small cities in central Java also found that these women perceived not using condoms as a symbol of trust, love, and commitment (Spooner et al., 2010).

Partner relationships may play an important role for women who are recovering from using drugs. Women who stopped using drugs may continue to have unprotected sexual encounters, especially when their partners are current or recovered IDUs. Two studies in Indonesia found that most male IDUs were sexually active and engaged in multiple risk

behaviors, including sharing unclean needles with others, having multiple sex partners, and engaging in unprotected sex (Somlai et al., 2003; Pisani et al., 2003; Pinkham & Malinowska, 2008**)**. For example, more than two thirds of them had engaged in unprotected sexual intercourse in the last 12 months with their partner, and 48% had had multiple partners (Pisani et al., 2003). Furthermore, 35% of the participants had unprotected sex with female sex workers, and less than 10% used condoms consistently (Pisani et al., 2003). These findings indicate that female sexual partners of male drug users are highly vulnerable to HIV infection. These findings may also apply to women who have stopped using drugs.

For women who are recovering from using drugs, another risk factor of having an active IDU as a partner is the possibility of starting to use drugs again (Neale et al, 2014). Compared to men, women were highly influenced by men to use drugs, especially by sex partners who were daily drug users (Eaves, 2004; Wright, Tompkins, & Shead, 2007; Frajzngier, Neaigus, Gyarmathy, Miller & Friedman, 2007; Neaigus at al., 2001). Frequently, male drug users introduced drugs to their partners and forced or encouraged them to start using (Eaves, 2004; Higgs, Owada, Hellard, Power, & Maher, 2008; Go, Quan, Voytek, Cwooelentano, & Nam, 2006; Uuskula, Abel-Ollo, Markina, McNutt, & Heimer, 2012). If women who stopped using drugs relapse, they are vulnerable to HIV infection both from sharing unclean needles and by having unprotected sex (Des Jarlais et al., 2007).

Partner relationships may play an important role in female IDUs' decisions about whether to enter treatment or stop using drugs. Research demonstrated that female IDUs who have partners who are IDUs are less likely to enter treatment, to abstain or to use condoms, or to stop injecting drugs, unless their partner either agrees to go to treatment with them or their partner

enters treatment (Greenfield et al., 2007, Riehman, Hser, & Zeller, 2000; McCollum, Nelson, Lewis, & Trepper, 2005).

Currently, HIV testing is the key to early diagnosis of HIV, early treatment and reduction of viral load, and reduction in transmission to others (Ti, 2012). Despite the importance of HIV testing, less than 20% of IDUs reported receiving an HIV test in the previous twelve months (Pisani et al., 2003). A study of 40 drug users in Denpasar, Bali found that fear of positive test results, reactions from family and community members, and stigmatization were barriers toward HIV testing (Ford, K., Wirawan, N., Sumatera, G., Sawitri, A. & Stahre, M., 2004). As a result, women who are current or recovered drug users are not likely to know their own HIV status or the HIV status of their partners. If women who stopped using drugs are HIV infected, they can be a potential agent in spreading HIV to the general population (Iskandar et al., 2010; De Jarlais et al. 2007).

In conclusion, understanding how gender inequality in intimate partner relationships affect risk behaviors is an essential part of designing future HIV prevention interventions for women who have stopped or are stopping the use of injected drugs. Although there are many studies that show women's risk behaviors are affected by their partners, studies have not systematically examined the perceptions of women about the gendered power in their relationships and how that affects their risk behaviors. There are no studies of the risk behaviors and partner relationships of women who are recovering from drug use.

C. Conceptual Model: The Theory of Gender and Power

This study helps fill the gap in current research regarding the impact of relationships and HIV risk behaviors among women who are recovering from drug use. To ensure systematic exploration of gender and relationships, the study was guided by the conceptual model, the

Theory of Gender and Power (TGP). This theory provides a comprehensive approach to understanding the social construction of gender and power within sexual relationships, and how this affects risk-taking behaviors. Originally, Connel (1987) developed the TGP that focused on three constructs: "(a) sexual division of labor, (b) sexual division of power, and (c) the structure of cathexis (affective attachments and social norms)" (Panchanadeswaran, et al, 2007, p.158).

TGP focuses on three constructs: 1) the sexual division of labor, 2) the sexual division of power, and 3) the structure of cathexis (affective attachments and social norms). According to this theory, these aspects of TGP play an important role in all spheres of a woman's life. These constructs may also interact with and reinforce each other, increasing overall gender disparities in specific contexts.

Wingood and DiClemente (2000) extended Connell's (1987) theory by describing more specifically how each of these factors might affect a woman's risk of being infected with HIV. This study used their model to identify key areas to explore with women who stopped using drugs to help understand how their relationships with men affect their risk behaviors for HIV/AIDS. The TGP was used to describe the interrelated constructs of economic inequality, power imbalances, and cathexis within each current relationship, leading to a better understanding of how each of these inequalities relates to her HIV risk behaviors. Figure 1 shows how these three constructs interrelate to affect women's risk behaivors. Below, I review the evidence for each of thes constructs in the context of Indonesian women recovering from drug use.

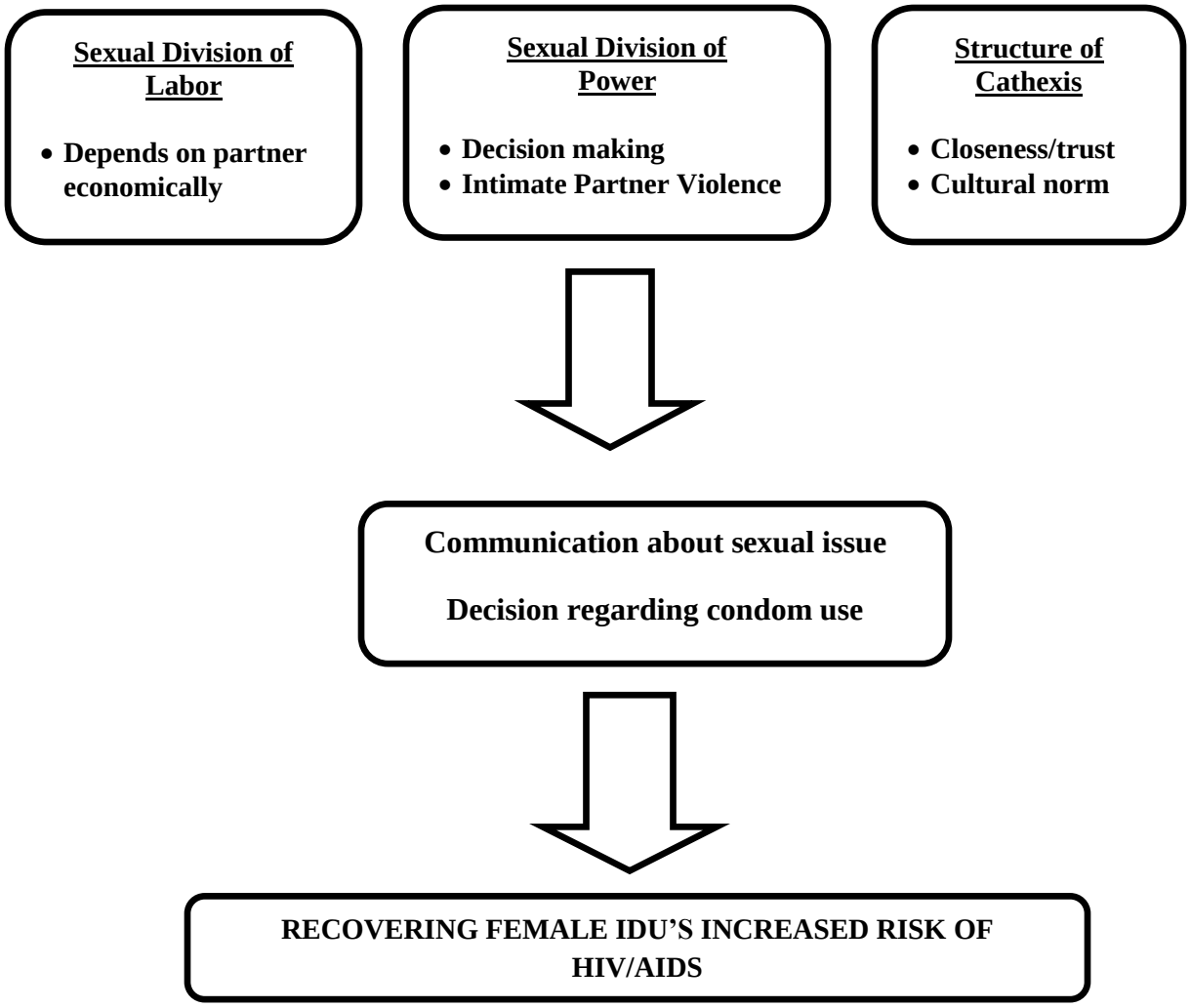

Figure 1: Conceptual model: The Theory of Gender and Power, modified from Wingood & DiClemente, 2000

1. The Sexual Division of Labor

Wingood and DiClemente (1998) define the sexual division of labor as "an allocation of particular types of work based on an individual's sex…manifested in the segregation of unpaid work, namely, housework and child care to women, and inequalities in wages and educational attainment between women and men" (p. 31). Previous studies among women in the general population demonstrated that, due to these macroeconomic reasons, many women rely on their intimate partners for economic resources, and this dependence limits their autonomy (Pinkham & Malinowska, 2008; Wingood and DiClemente, 2000; Woolf & Maisto, 2008). Few studies evaluate the risk to women recovering from drug use regarding the sexual division of labor. Gender inequality in the society means that most women, including those recovering from addiction, tend to have lower education, poorer jobs, and higher unemployment rates than men do. It is the the woman's economic position relative to her partner that affects her HIV risk behaviors.

The gendered division of labor also means that some female IDUs engage in commercial sex work, often under the domination of a man who may or may not be her sexual partner. Commercial sex work provides an opportunity to earn income more quickly than most jobs available to uneducated women. Commercial sex work increases women's vulnerability to HIV/AIDS due to unprotected sex with many different men. A study conducted among female sex workers in brothels in Jakarta showed that condom use was low (Basuki, 2002). These women had less power than their clients did in condom negotiation. With their clients, these sex workers did not used condoms, because the clients perceived sex with condoms as less pleasurable. The clients believed that they were acquainted with the sex workers so they did not

need protection against sexually transmitted infections (STIs) or HIV. These women also did not use condoms with their boyfriends, because they believed that their boyfriends, native Indonesians who look healthy in appearance, were unlikely to spread STIs. In addition, many took antibiotics as a precaution for STIs.

Based on studies among female IDUs and women in general, I would expect that women who are recovering from using drugs who are economically dependent on their partners are more likely than those women who are more economically independent from their partners to engage in high risk sexual behaviors, including not using condoms and/or engaging in commercial sex work. Women who are in a better economic position relative to their partners should have more economic power in the relationship and therefore engage in fewer risky sexual behaviors with those partners.

2. Sexual Division of Power

Wingood and DiClemente (1998) define the sexual division of power as dealing "with issues such as control, authority and coercion within heterosexual relationships" (p. 32). Several studies among women in general show that women are likely to have less decision-making power than their partners do in relationships, and therefore, they are less likely to participate in or initiate condom use (Panchanadeswaran et al., 2007; DePadilla, Wingle, Wingood, Cooper, & DiClemente, 2010; Pulerwitz, Amaro, DeJong, Gortmaker, & Rud, 2002; Woolf & Maisto, 2008). With less power to negotiate condom use, women who are recovering from using drugs may be at risk for HIV infection, particularly if their partners disapprove of condom use. On the other hand, if these women participate in making decisions in their relationships, especially about condom use and about when to have sex, they may be more likely to use condoms with their partners.

For women in general, fear of violence and abuse may exist, and this can deter women from initiating condom negotiation with their partners. Intimate partner violence then becomes an obstacle to negotiating condom use. Many studies demonstrate that a woman who is abused is unlikely to confront her partner about condom use (Mittal et al., 2003). Empirical studies have linked intimate partner violence with inconsistent condom use, which increases HIV risk for women (Mittal, et al., 2013; Seth et al., 2010; Silverman et al., 2011).

As discussed earlier, unequal power and intimate partner violence in sexual relationships still occur frequently in Indonesia. In a study by Hakimi et al. (2001), 41% of women in central Java suffered physical or sexual violence at some point in their lives, mostly from their husbands. Among married women, sexual violence (23%) was greater than physical abuse (11%) by their husband. Sexual violence puts women at risk for unsafe sexual practices. Encouraging women to use condoms in monogamous relationships may not be effective for women who do not have control or power in their relationships. Another study by Harvey et al. (2003), conducted in four cities in the USA, found that although relationship power was not directly correlated with condom use, condom use was higher among women who made decisions together with their partners.

In Indonesian society, Islamic law still influences the relationships between men and women (Basso, 2012). Based on the Koran, men are the leaders and decision makers in families and women, as wives, are responsible for the household. These roles give men more authority than women have, and sometimes men and women accept male partner violence in their relationships (Hayati, 2014). Based on research conducted among women in general and female IDUs, I would expect that women who are recovering from using drugs who participate less in

decision making in a relationship or experience partner abuse (physical, sexual, and/or emotional) are more likely to engage in high-risk behaviors than other women.

3. The Structure of Cathexis

The sexual division of cathexis "govern[s] appropriate sexual behavior for women and encompasses the emotional attachments involved in social relationships" (Wingood & DiClemente, 1998, p.32-33). The construct of cathexis includes the laws, taboos, and prohibitions that define normalcy, restrain sexuality, and localize the cultural norms of femininity within relationships (Wingood & DiClemente, 1998).

Trust is one component of cathexis in the original TGP. As already discussed in the above review of studies of women who are injecting drug users, trust in a partner in an intimate relationship influences HIV risk behavior. Several studies indicate that if women feel trust in their partners, it can lead them to perform unsafe sexual practices (Amaro; 1995; Wingood & DiClemente,1993). Furthermore, previous studies indicated that women who have a long term relationship with their partners have trouble negotiating condom use. (DePadilla et al., 2011; Wingood and DiClemente, 2000). Thus, women recovering from drug use may engage in unsafe sex when they are in committed long term relationships and when they perceive that trust and care are deeply embedded in their relationships. Subsequently, they are more likely to place their relationships at a higher priority than their self-protection (Logan, Cole, & Leukefeld, 2002; Harvey et al., 2003).

Saktiawati et al. (2013) conducted a recent study with 19 Javanese women who injected drugs in three small cities in central Java, Indonesia to evaluate the HIV risk among female IDUs. They found that condom use was very low with regular partners. The reason that women reported they did not use condoms was that they trusted their partners, although they realized this

trust was shaky. The women used traditional Javanese cultural concepts of consideration to explain why they did not use condoms. The situation of "trust" for these women is heightened by Javanese cultural imperatives. In Javanese society, women are expected to behave in a manner that is polite and "proper." Sex is a taboo issue that will never be discussed among couples, and pre-marital sex is not permitted and thus even less subject to discussion. Although the women in the study are outside Javanese mainstream culture in many ways because of their drug use, they still hold to many cultural precepts, including consideration and care for the other above the self in their relationships with intimate partners.

Cathexis also refers to women's emotional closeness with their partners. It refers to how women feels, and how meaningful she believes relationships are. More importantly, cathexis incorporates women's feelings about their needs for emotional development and commitment in their relationships. Women who are recovering from using drugs may develop trust as a foundation for their relationships, and they may feel close to and have feelings of love for their partners. Consequently, they may place their relationships as a priority over self-protection. In addition, women who stopped using drugs sometimes viewed sexual intercourse as a bonding mechanism with their partners, and this makes them less likely to negotiate for condom use. This situation may make them more vulnerable to HIV transmission because it may lead to less consistent condom usage. Based on this theory, I expect that women who have strong cathexis (emotional attachment) are more likely to engage in unsafe sexual practices, such as not using condoms.

III. METHODS

A. Design

A descriptive design was used to describe recovering female IDU's perceptions of their relationships and their risky sexual behaviors regarding HIV/AIDS. The results of this study provide the first descriptions of the patterns of relationships, gendered power in those relationships, and risky sexual behaviors among women who are recovering from drug use in Indonesia.

B. Setting

This study was conducted in three non-governmental organizations (NGOs) in Jakarta, Indonesia. Institutional approvals from both the University of Illinois and the University of Indonesia and approval letters from the NGOs are in Appendix A. Two NGOs focus on people living with HIV (PLWH), while one NGO focuses on HIV prevention among high risk groups such as IDUs. These NGOs provide many services, including counseling and HIV testing for current and/or former IDUs, community outreach programs for drug users, support peer programs for PLWH, life skills education, home care for PLWH, and peer education for adolescents and high risk populations. These NGOs do not provide a methadone program, but they can refer people who need methadone programs to the community health services. One NGO has a clinic that provides more complex care, voluntary counseling and testing, support, and anti-retroviral therapy. The NGOs know most of their clients and see them frequently, so they have a good informal sense of who is still not injecting drugs and who has relapsed. The NGOs employees were very supportive of the study and helped identify potential participants. Interviews were conducted in a private room at the NGO's office to maintain the confidentiality of the women.

C. Sample

In this study, I defined a "woman recovering from drug use" as a woman who had stopped using drug for between two months and five years, at which point a former drug user can be considered recovered (Betty, 2007). A convenience sample of women who said they had stopped using drugs was recruited. The selection criteria for the study were: (a) being female, between the ages of 18 to 46 years, (b) previous regular use of injected heroin and (c) current abstinence from injected drugs (self- report of recovering from IDUs) for at least three months or through completion of a methadone program. The exclusion criteria in this study were: (a) having stopped using drugs more than 5 year ago, (b) anyone who cannot follow the conversation in the initial discussion regarding interest in participating in this study (this may be due to cognitive impairment, mental illness or being "high").

Thirty women consented to be in the study and were interviewed. Recruitment and consent materials are in Appendix B. Three women were later excluded because they revealed during the interview that they did not meet the inclusion criteria because they were still using drugs or had relapsed within the last two months. Another participant was excluded because her transcript contained insufficient information and was internally inconsistent. Repeated attempts to conduct a second interview with her were not successful. This gave a final sample of 26 women.

D. Interview Guide

I developed a semi-structured interview guide to evoke women's perceptions of their relationships and their risky sexual behaviors, which may be related to HIV transmission. Semi-structured interviews allow for individual variations in responses (Patton, 2002; Munhall, 2012;

Sandelowski, 2000). This study focused mainly on each woman's current relationship with her primary partner. The interview guide was developed based on the TGP to address the perceptions of the young women of each of dimensions of the TGP, as applied to her most important current relationship(s) and her current risky sexual behaviors. The interview guide also covered areas such as when and how she quit using drugs, whether her partner at that time (who could be the same person as her current partner or someone else) influenced her decision to stop using drugs, her HIV-related risk behaviors before she stopped using drugs, and whether she had an HIV test and know her status and that of her partner. At the end of the interview standard demographic information was obtained, e.g., age, ethnicity, marital status, educational background, type of job if working, religion, number of children, and their current living arrangements. Appendix C provides the interview guide in English and Bahasa Indonesia.

E. Data Collection Procedure

Data collection was conducted during a ten week period, from May, July 2013. After receiving IRB approval from University of Illinois at Chicago (UIC) and University of Indonesia (UI), I discussed the project with the NGOs and obtained permission to recruit and interview participants at the sites where they serve women who stopped using drugs (See Appendix A). I then met with staff to explain the study and ask them for suggestions about how to recruit. The participants were recruited by distributing fliers with a brief description of the study and the researcher's contact number. I also posted flyers on the information board at the NGO's office. The participants called me and arranged a meeting to learn about the project and be interviewed. I also recruited participants by attending meetings and support groups for current and former IDUs, where I explained the study, gave out flyers, and asked those interested in the study to put

their name and contact number on the flyer or to meet briefly afterwards to arrange for an interview.

I gave information about the study, including the purpose of the study, to the potential participants who expressed interest in participating. Each participant was informed about the study, risks and safeguards, and her right to decline to participate or withdraw from the study at any time without penalty. All participants gave signed informed consent before the interview began. (See Appendix B for the recruitment script and informed consent for participants in English and Bahasa Indonesia).

I then conducted face-to-face interviews with the 30 women who consented to be in the study in a quiet and private place at the NGO office sites. The interviews were conducted in the official language, Bahasa Indonesia. The interviews took approximately 60-90 minutes and were digitally audio-recorded. At the end of the interview, each participant received money as a thank you token in appreciation of their participation and their time to complete the interview. The amount of money was Rp 50 (US $6).

All interviews were digitally recorded and transcribed verbatim. After listening to each interview, I made notes about anything that was unclear or needed further discussion and if so arranged for a second, shorter meeting. I did second interviews successfully with five participants to gain further information.

After transcription, the entire interview was translated from Indonesian to English. According to Chen and Boore (2009), there are four procedures that a researcher should do in translation, namely: “1) verbatim transcription of content in the original language and then analysis of the content; 2) Two bilingual translators then translate the emerged concepts and categories; 3) back translation is then employed; and finally, 4) an expert panel committee is

involved in reaching final agreement on the translation" (p.234). In this study, the initial translation began once transcription had been completed. Two bilingual Indonesians (fluent in both English and Indonesian) translated the data from Indonesian into English and then did a reverse translation. Finally, the translation committee (the researcher and the translators) met again to discuss the material and decided whether the translations were accurate and suitable to the content.

F. Data Management and Analysis

1. Data Management

The qualitative data analysis software, Atlas.ti, was used to organize and manage data. There were two types of data: interviews with the women who stopped using drugs and also field-notes by the researcher. After collecting data, the data were transcribed verbatim and translated as an ongoing process for each interview as described above. The field notes included any observations during the interview including the body language of participants.

The data were stored in a secure computer using password protection that only the I could access. The personal information sheet data was also be collected in order to evaluate the factors that might influence risky sexual behavior among women who stopped using drugs such as age, level of education, and marital status. All identifying personal information, including informed consent forms and the participant's identification number, were kept in a locked cabinet that only the PI could access. Once the interviews were entered into ATLAS.ti, they were saved using password protection.

2. Data Analysis

Content analysis was used in this study to analyze the data. Content analysis is "a research method for the subjective interpretation of the content of text data through the

systematic classification process of coding and identifying themes or patterns" (Hsieh & Shannon, 2005, p.1278). Content analysis is a way to make sense of any qualitative data and attempt to identify the core consistencies and meanings (Patton, 2002, p.453). Zhang and Wildemuth (2009) also point out that content analysis can be used to "identify important themes or categories within a body of content." It can also provide a rich description of the social reality created by those themes/categories within in particular setting (Zhang, 2009 p. 11).

Hsieng & Shannon (2005) identified three approaches to content analysis: conventional content analysis, directed content analysis and summative content analysis. In conventional content analysis, open codes are defined during data collection and the source of the data is coming from interview text. In directed content analysis, the researcher defines open codes before and during data analysis. The codes are derived from the existing theory, which is applied in that study. The summative content analysis is the last approach, which uses keywords that are defined before and after data analysis. The keywords come from the researcher's previous review of the literature and represent concepts that the researcher would like explore in more detail. In the summative approach, the researcher tries to understand the contextual use of words.

In this study, I used directed content analysis based on the Theory of Gender and Power (TGP) as a framework to guide understanding about the partner relationship and HIV risk behaviors among women who are recovering from drug use. Using the TGP framework, I identified three constructs based on TGP: labor, power and cathexis. The open codes were defined before and during data analysis, using TGP as a framework.

First, data were transcribed verbatim from the digital recorders, and then translated into English. To ensure accuracy of the data obtained, the principal investigator audited the transcripts through listening to the interview tapes and comparing them with transcribed and

translated scripts. During this time, I made notes or summary points from the interview that I was listening to. If some area needed additional clarification, I made notes about it. I then tried to arrange another interview with that same woman to clarify these points. I tried to do this approach for eight women, and only successfully did clarification with five women in this study. This process also identified several important areas for further exploration during future interviews.

Then, preliminary codes were developed based on the three constructs of the Theory of Power and Gender: Cathexis, Power and Labor. After close reading of all the interviews for this study, I developed codes and operational definitions for each of the three constructs. For cathexis, women recovering from drug use perceived three different aspects of their emotional attachment with their partner. The three sub concepts of cathexsis were: open communication, closeness, and trust in the faithfulness of the partner. In the sexual division of power, we included decision making in the relationship, intimate partner violence, and condom negotiations. In the sexual division of labor, we included economic dependency on their partner, including their economic support; whether the woman or the man is mostly in charge of the money, and whether the woman feels dependent on her partner for money. For all discussion about relationships, a second set of codes identified who the woman was talking about, e.g., her current primary partner, her current non primary partner. Other codes captured other aspects of the women's discussion: HIV risk behaviors, reasons to stop using drugs, support to quit, relapse, recovery process, benefits after quitting drug and challenges after quitting drugs. During the coding process, some codes were combined and others were divided into subcategories. The complete list of codes and their operational definitions are in Appendix D.

To establish inter-coder reliability, I worked closely with another PhD student who coded the transcription independently; then we compared the results. Any differences in coding were discussed in order to increase the credibility of this study. The final step was to establish inter-coder reliability. Formal inter-coder reliability was calculated by comparing my codes with those of my advisor, who coded the same transcription independently. When the two sets of codes were compared, there was 97% agreement.

Then the predominant themes in each category were described. I also created within and across case matrices that organized different information from each participant (Appendix E). These matrices helped me to understand the flow, location, and connection of the themes or findings (Miles & Huberman, 1994). The columns were developed based on the key codes and themes, and each case was a row. By doing this, key codes and themes could be visualized in one or several large tables that allowed the researcher to see patterns across cases in this study.

3. Rigor and Trustworthiness

Lincoln and Guba's (1985) criteria for trustworthiness were used in this study, which include credibility, dependability, transferability and confirmability. The reason for choosing the Lincoln and Guba model is that their criteria for rigor are well developed conceptually and has been used by many descriptive researchers, particularly nurses, for a number of years.

Credibility means that the researcher checks for the accuracy of all findings by employing certain procedures (Lincoln & Guba, 1985). To address the credibility in this study, the researcher re-checked the interview tape to ensure that the words in Indonesian and the translations were correct. High inter-coder reliability was established to enhance credibility. In addition, an audit trail was used to document the analysis process. Member checks were conducted with three women in this study and they agreed with researcher's interpretations.

Dependability implies that the researcher's approach is consistent across multiple researchers. Memo writing and regular meetings with committee members, particularly with the Indonesian committee member, were used to maintain the dependability of the findings.

Transferability refers to whether the findings are transferable to different settings. In a qualitative study, researchers seek to generate findings based on a particular small group of participants; therefore, the results may only apply to a specific settings. In this study, the researcher has provided a detailed description of the context from which the data emerged, such as the participants' characteristics, the setting, the location, the process of data collection, and in depth analysis. By doing this, other researchers will be able to decide if the findings are applicable to their settings.

Confirmability refers to findings that can be confirmed by others. In this study, all details of the procedure were documented, checked, and rechecked by the researcher and committee members in order to ensure the confirmability of the findings.

IV. RESULTS

The purpose of this descriptive study was to explore the HIV risk behaviors and partner relationships of women who stopped using drugs in Jakarta, and to examine how gendered power in these relationships influences risk behaviors. The study focused on the current self-identified primary partner among recovered female IDUs after they had stopped using drugs. This study was guided by the TGP, which identifies three interconnected constructs: the sexual division of labor, the sexual division of power, and the structure of cathexis (emotional connections of love and affection). These interrelated factors can result in gender and power imbalances in relationships, and these may influence HIV risk behavior among recovered female IDU.

In this chapter, I present the results of the study. The first section describes the context of the lives of recovered drug users, including their personal characteristics and relationships, their experiences of quitting drugs, and their perspectives on their current lives. Then each aim of the research is addressed, based on the women's perceptions about their current lives and relationships.

A. Contextual Factors: Living as Recovered Drug Users

1. Personal and Relationship Characteristics

Women recovering from intravenous drug use shared many characteristics with other working class women in Jakarta. The average age of participants in this study was 30 years, ranging from 22 to 41. The women had lived in the Jakarta for an average of ten years. In terms of self-identified ethnicity, 16 participants identified themselves as belonging to groups living on the island of Java: Betawi, Javanese, and Sundanese. The rest came from groups who originally lived outside of Java Island, including Ambonese, Aceh, Palembang, Makassar and Batak.

Almost all of the participants were educated up to the senior high school level, but only three women had any tertiary education (Bachelor's degree).

Although the majority of women were low income, they were living well above the poverty level and obtaining a living did not seem to be a major concern for any of these women. Six participants were employed, and three women ran their own small businesses as their sources of income. Two women earned a portion of their money through sex work. Although 17 women did not have jobs, they received financial support and other supplies for their living from their partners or by living with parents who provided them with what they needed.

Of the 26 women, 17 were married and living with their husbands. Only two women were unmarried and living with their boyfriends. Four women had boyfriends they did not live with. Two of these four women were also married but currently did not live with their husbands either. One woman's husband was in Europe and lived there with her son. She also had a boyfriend who had lived with her for seven months but recently moved away to go to school; they saw each other periodically. The second woman's husband had been in jail for the past three years; she had two boyfriends but did not live with either. The remaining three women who participated in the study were single and did not have current partners.

Regarding their partners' characteristics, the majority of the women's partners (16) were former injection drug users. Sixteen of the partners had a job and an additional two men ran businesses with their partner. The women were not asked about their partners' ages or educational status.

More than half of the participants had children and most of them lived with their children. Four women had children living with others; two children lived with their grandmothers, one lived with another relative, and one lived with the woman's ex-husband. One woman lived with

two of her children but the third son lived with her parents-in-law in Bandung, approximately two hours from Jakarta by car.

TABLE I

DEMOGRAPHIC CHARACTERISTICS OF PARTICIPANTS

Characteristics	Number (N= 26)
Age	
22-30	10
31-40	15
41	1
Religion	22
Islam	4
Christian	
Ethnicity	7
Betawi	6
Javanese	3
Ambonese	10
Others	
Education	
Junior High School	1
Senior High school	22
Diploma- Bachelor	3
Current Work Status	
Yes	
Employee	6
Self employed	3
No	17
Current partner status	
Married and lived together	17
Not married and lived together	2
Has a boyfriend, not living together (Include two women	4
who had multiple partners).	3
No current partner	
Children	
Yes	18
No	8

2. HIV Status

Among the 26 women, 21 were HIV positive and only five were HIV negative. Of the 23 women currently engaged in sexual relationships, 12 of their partners were HIV positive and seven were HIV negative. There were six discordant couples: four couples in which the woman was positive and two couples where the woman was negative. Ten couples were both HIV-positive, and only two couples were both HIV-negative. In five cases, women did not know their partners' status; all five of these women were HIV-positive.

TABLE II

HIV STATUS

Couples	Number
Discordant	
Woman HIV +; Man HIV –	4
Woman HIV -; Man HIV +	2
Concordant	
Woman HIV +; Man HIV +	10
Woman HIV -; Man HIV-	2
Partner HIV status not known	
Woman HIV +; Man's status not known	5

3. Quitting

When women reflected on the process of quitting drugs, the major theme that emerged was that quitting was very challenging and required both personal motivation and strong support. These women had used drugs for three to 20 years before they stopped. The majority of them initiated drug use with inhaled drugs and then shifted to injection due to limited access to heroin

(less heroin is required when the drug is injected). All of them had tried more than once to quit drugs. They reported from three to 10 prior attempts to quit. Almost all women in this study were in a methadone program, and only one woman had quit "cold turkey." Although the women did not discuss whether they used methadone in their prior attempts to quit, the women perceived that a methadone program was important to their recovery efforts and helped them to be "free from drugs." The recruitment criteria only required that women had not injected drugs for at least two months, but all participants reported being drug-free for at least one year up to five years – considerably longer than two months.

In discussing the success of their most recent attempts to quit drugs, each participant repeatedly emphasized the importance of her personal motivation to quit using drugs. "Being tired with drugs" was the most common factor they identified that made them successful in quitting drugs. As one woman said, "The main reason [for quitting] was I got tired of using drugs." Another woman said, "The reason came from myself. I wanted to stop using drugs, because I had a different kind of world before and after I started using drugs."

The women also emphasized the importance of having substantial support from partners, parents, siblings, or friends. They said that having someone who cared for her while trying to overcome heroin addiction was a very important factor to be successful in quitting drugs.

During the quitting process, almost all these woman received support to quit using drugs from their partners, beginning when they decided to stop using drugs and in the months that followed. Only two women did not have partners when they stopped injecting drugs; one woman was in jail, while the other had broken up with her partner at the time. Having support from their partners increased women's confidence that they would not relapse during the methadone program. For example, one woman said: "Yeah, he did everything. The point is he supported

me…just like, he has never asked me to stop drug[s] suddenly." Women said they received a variety of supports from their partners, including providing emotional support, accompanying her to get treatment, and reminding her to adhere to the medication regimen. As one woman said:

> "I do not really know how. But [he] supported me more than my parents. My mother had [a] job to sell stuff at market, and my father-in-law was at home. I felt like he was the one to whom I can go home. He did not ask me to stop drugs suddenly, no. But he enrolled me [for the methadone program] at Fatmawati hospital."

All women who had children said that having children made them strongly motivated to stop using drugs. For example, one woman said,

> Yes, I live with my husband, because we are a married couple. Then, we have three kids. Yes, they made me to stop using drug[s]. What will happen with them if I and my husband still use drugs? Who will take care of them?

Another woman also emphasized how her partner and children support her to not relapse, "Yes, I admit that sometimes I still have a craving for drugs, but I have my husband and my kids who strongly encourage me not to relapse now."

4. <u>Gaining a Normal Life</u>

The major theme women expressed about their lives after they quit using drugs was "gaining a normal life." After quitting drug use, all women highlighted the different life that they had now in comparison with their previous lives. They described themselves as living like ordinary people. They mentioned three aspects of their current lives that reflected a more "normal" life; freedom from the demand for drugs; having better relationships with their families and partners, and having a new capacity to meet normal expectations, such as taking care of their children themselves.

Once the women stopped using drugs, they did not have worry about money or how to get drugs when they woke up in the morning. As one women said, the constant need to obtain drugs was like a "devil cycle" in her past life:

> In the past, I had so negative a life. We may call it "devil cycle." Yeah, right, the devil cycle…I had a bad way to get money. Once I got money, I would buy heroin again. Got money, bought heroin again. Got money, bought heroin again. I used to do bad things [to get money].

Another aspect of gaining a normal life was having better relationships with their families and partners. Almost all women reported positive changes in their relationships with their families. One participant said that previously, her mother had kicked her out because of her drug addiction. Now she is accepted in her family again. She said, "My relationship with my family is getting better again. They trust me again." The women also described how their relationships with their current partners helped them to continue their normal lives as non-drug users. For example, one woman said;

> My current husband, he is so patient. Patient, so patient. He has never complained, never cursed me. If I am tired, I said 'Ah, so bad,' something like that. But he is patient: 'Mommy, if you are tired, stop it. Do not do anything.' …He helps me to get my life back, just like ordinary people, who do not use drugs.

Although the majority of these women still have to go to a methadone clinic to get their medication, they have integrated this into their lives. One woman described how she spent her life with her husband now:

> In the morning, we drink our medication together. My husband has a business, a laundry business. We usually go to our laundry place after we drink our medication in the morning. Now, we reduce the dosage of our methadone. We reduce half dosage of our methadone drug every two weeks.

Some women also experienced health benefits, such as gaining weight and better health knowledge, as part of the positive changes in their life after stop drug. One woman said,

> Yes, definitely. There were some changes. My life is much better...much better compared to the time when I still used drugs. I mean, my life is much better. Before I stopped using drugs, I felt like…I was a scumbag. After starting using methadone, there were many changes. For example, I gained my more weight, and I have a better knowledge about HIV. I get a lot of information from the methadone clinic.

Gaining a normal life is also described as having capability to take care their children. In the past, all of the women who had children were not able to care for their children when they were using intravenous drugs. For example, one woman said,

> … I can live normally, my husband has a job, and I look after children. In the past, I could not do it. My mom took care of my children.

The one concern each woman expressed regarding her current life was fear of relapse with heroin. All women were afraid that they might try to use drugs again because they still had cravings for drugs. Some of the participants preferred to stay away from their old community and even moved to a different neighborhood in order to prevent relapse. As stated by one woman,

> Yes, I met some of them [former friends who use]. They were wondering how I did it, 'how could you do that?' I said, 'come on, don't make it complicated. Stay away from this world and find a place where no one knows who you are, what you are, and who your family is. Just do it!' Just create your new world!

B. Past HIV Risk Behaviors of Women Who Stopped Using Drugs

We examined two possible past HIV risk behaviors among the women during the two months before they stopped using drugs: risky sexual behavior and sharing unclean needles. Since the majority of the women in this study were HIV positive, the concept of HIV risk behavior for this study had to be defined in a way that recognized their HIV positive status. Sexual HIV risk behaviors were defined for this study as behaviors that put the women and/or

their partners at risk for HIV virus exchange. This exposure may lead to a new HIV infection for those currently HIV negative or further exposure to the virus for those already HIV positive. For persons already living with HIV, such re-exposure may introduce new strains of the virus, potentially including drug resistant strains.

We found that that before they stopped using drugs, all the women in this study engaged in risky sexual behaviors. Four had multiple partners, including two of them who said they engaged in sex for money. None had used condoms consistently, and, in fact, 14 women reported that they had never used condoms with their partners in the past. Eight of these women reported that in the past they did not have adequate information about HIV and condom use.

In addition to their risky sexual behaviors, all but one woman in this study shared needles with their partners, who were also injecting drug users. As one of them explained, "I did not share unclean needle with others, but with my boyfriend, yeah, sometimes, I shared needles with him." These women said the reason that they shared needles with their partner was because they were a couple. Four women reported that they had bought drugs together with their partner and shared needles, and two women reported that their husbands prepared drugs and all the equipment and they shared the needle. The women reported that they did not care who used the needle first, as long as they were able to get high. "Firstly, he injected me…yeah, we shared the needle. At that time, I didn't really know what he did. I just got it set for me. Then, he did it. He did it to himself first…sometimes, I had it first."

Many women also shared needles with other people, such as siblings or friends. There were several reasons why they shared unclean needles. Three women said that they hadn't known about the impact of sharing unclean needles with others. One woman said, "Yes, I shared needles with him. We didn't know about the effects of sharing needles. So, we often shared

needles." Other reasons for needle-sharing included having cravings for drugs when the woman did not have a new needle, and barriers to carrying needles and syringes outside due to the fear of being caught by the police. One woman said, "Because if we were craving for drugs but we did not have a needle, what else could we do, instead of sharing needles? So, whether you wanted it or not, you would share needles."

One woman said that she only shared needles with her partner and did not share with other IDUs because she was afraid to disclose her identity as a drug-user. As she explained,

> We always shared needles, yeah we shared everything, but I did not share with other people. No, I didn't share with others. I only shared with him…Never, I was afraid to disclose my situation to others as a female who used drugs.

Three women said that they knew that sharing needles put them at risk for HIV, and therefore had adopted some risk reduction strategies, such as sharing only with one IDU or being the first to use the needle. One woman said that she always used an antiseptic called "Bayclean" [brand name] to clean a used needle before using it again,

> If I have the drug, but I do not have a needle, I used [other people's] needles…I cleaned it with—what—Bayclean, always. I always carry Bayclean with me, and I had an open bottle of Bayclean in my car, in case we need to use unclean needle, so I will clean it with Bayclean [laugh]. I did it. I was informed by one drug dealer, a foreigner. He informed me about it.

Only one participant reported never having shared needles with others. In the past, she had a partner who did not use drugs. She used to carry her own needle or use drugs at home.

> I did not share with others [IDUs]. I did not like to put a used needle into my body. I felt disgusting. That's why I used to carry my own needle. In addition, I used to have non-IDU partners, so they did not use drug at all. If I wanted to use needle, I would use it behind his back, or I went to ladies room.

C. Current HIV Risk Behaviors of Women Who Stopped Using Drugs

Participants' current patterns of HIV risk behavior were different from those they'd engaged in before stopping intravenous drug use. Since they had stopped injecting drugs, the participants were no longer at risk from sharing needles. Eleven women were also no longer at risk from their sexual behaviors. However, the majority of women were still engaging in risky sexual behaviors that put them and/or their partners at risk for HIV.

1. Lower Risk Behaviors

Eleven women did not engage in higher risk behaviors. Three women were not currently engaged in sexual relationships, and eight reported that they now used condoms consistently with their current partners. Among the three women who did not currently have sexual relationships, one woman had broken up with her boyfriend seven months earlier and the other was widowed two years prior when her husband died in a car accident. The third woman had been dating a new man for two weeks, and they were not yet sexually active. She explained,

> [We have] not engaged in a sexual relationship. We are dating since two weeks ago…we had our first date last Saturday night...well, we usually meet at methadone. We meet, and we went to his place and chatted. Then, I went back home around 7 pm, we did not go anywhere. I went back home.

Eight women reported that they used condoms consistently with their current partners. This number included a woman whose husband lived in Europe, and she did not have sex with him currently. However, she did use condoms consistently with her boyfriend. One woman said,

> Although we are HIV positive, we like to use condoms…one of the doctors in Cipto hospital suggested we wear condoms although we are people with HIV…So, we use condoms. He is the one who always reminds us to use condoms. Sometimes, I feel uncomfortable for [my boyfriend to wear condoms], I said: You do not have to wear condoms. Then he will say, 'Don't you remember what the doctor says about it? So, do not make any additional diseases, okay?'

Having a commitment with their current partner to use condoms consistently for mutual benefit was mentioned by seven women in this study. One woman reported, "Yes, we have a commitment to always wear a condom. We both know the benefit of condom use. So, we have an agreement to use condoms. So, well, if I get the latest information, I will pass it to him."

2. Higher Risk Behaviors

The majority of participants currently engaged in HIV risk behaviors that put them and their partners at risk for HIV. Ten participants reported that they used condoms inconsistently, and four participants reported that they had never used a condom with their current partner.

In addition to inconsistent condom use, four participants indicated that they were currently involved with multiple partners. Two of them were the women who were married but did not live together with their current husbands or boyfriends. Neither of these women currently had sex with their husbands, but one of them had two current boyfriends. Two women reported that they occasionally had sex for money. One woman described her activity:

> I am a naughty girl, particularly if my friend offers me a [sex] job. M, do you want this guest? He is a foreign man, for $100. wah[ooh]...so, from home, I only carry my nightgown...so, I use my nightgown and I carry a bag [for changing clothes].

D. Perceptions about Gender-Related Power Dynamics

I examined the gender-related power aspects of partner relationships among women who had stopped injecting drugs, using the Theory of Gender and Power (TGP), which consists of three constructs: cathexis, power, and labor. To address this aim of the study, we did not include the three women who were not currently having sex. For the two women with multiple partners, I focused on their primary current sexual relationships. Both women were still married but no longer had sex with their husbands, so the relationship examined was with a boyfriend. One of

these women had two boyfriends; I chose as her current primary partner the boyfriend she felt closer to. This resulted in 23 relationships included in the analysis.

Before beginning the analysis, I provide a brief summary of the women's relationships. Ten women were in long-term relationships with the same partners they'd had before they quit using drugs. Six of their partners had also used injection drugs in the past and they quit together. Four of these partners were not using intravenous drugs when their wives or girlfriends quit using drugs. The length of these relationships ranged from five to 13 years, and the couples were all together when the women went through detoxification and recovery. These shared experiences made them feel close to each other. The women expressed how much they and their partners supported one another in quitting drugs. All but two reported that their relationships improved after the women stopped using drugs. These other two felt that their relationships had not gotten better, and now they felt distant from their current partners.

The majority of women (16) reported that they were no longer with the same partners they had been with when they were injecting drugs. Most of them had started new relationships with new partners. Most of these male partners were also recovering drug users who had gone through the quitting process and did not use drugs anymore. Many of these women met their new partners during the quitting process, often in a methadone center. All of the women in this group said that their current relationships with new partners were better than their former relationships. They described how their new relationships with their current partners helped them to continue their "normal lives" as non-drug users. Their new current partners supported them in not relapsing. Relationships begun after women quit using drugs were shorter, ranging from three months to two years.

1. Gender and Power: Cathexis

Open communication was the major theme that dominated the women's discussions about their relationships. The majority of women (17) said that open communication was an essential part in the relationship. They believed that couples should be able to talk openly to each other, which they described as discussing everything with their partners and not hiding things from each other.

When the women described their own relationships, the majority (17 participants) reported that they openly communicated with their partners. In general, these women described open communication as "sharing all information with their husband[s]," "not hiding anything from [them]," or "being honest to each other."

The women described their own communication with their partners as "talk[ing] like friends," "having less stressful conversation[s]," and "talking, like regular talk." They said that they discussed everything and made decisions as a couple. One woman put it this way,

> We discuss everything together. We usually watch TV together, then have a discussion at home. Then, play with children. We divide our task together…He will do mopping, and I do washing dishes.

Although the majority of the women reported open communication, they also admitted that at some point, they may have disagreements with their partner. These women expressed several ways to deal with disagreements, such as asking for forgiveness, talking to find solutions together, or walking out for a short period to cool down. The majority of these women discussed their problems and found solutions with their current partners.

The women also said that open discussion included disclosure of their HIV status to their current partners and discussions of sexuality. As one woman said; "Yes, we did the HIV test at the same time. We opened the envelope with the result of our HIV test together, because we

wanted to know the result. So, we opened it together." Almost all women in this study said that they had open communication about sexuality and safer sex practices, including condom use, with their partners.

Only five women said that they did not have open communication with their current partners. These women described how difficult their communication was with their current partners. For example, communication about when to have sex or whether to use condoms was difficult or did not take place. They said "we just do it without communication," or "it just happens when he wants it." Three women explicitly mentioned that they just agreed whenever their husbands wanted to have sex. They described several ways of dealing with difficult communication with their partners such as, "keeping silent," "just follow[ing] what he wants," "arguing," or "writing [a] diary." At the end, some of their problems were never resolved.

The two participants who were involved with multiple partners said they communicated differently with their different partners. These women felt that they could openly communicate with the men they felt closest to, yet did not share everything with husbands who lived apart from them. One woman said:

> …Although he [boyfriend] is still young, he can give me advice. So it is the opposite [with her current husband], my boyfriend can guide me. But I am with these [drug users]…But he [boyfriend] does not keep distance with me. He even supports me, gives me this, a support to stop drugs. So he guides me. Well...that's it. It is impossible for me to talk like that with my husband. I am more open with him [boyfriend]. He gives me advice [to stop drugs]. Do this, that…as long it is good for me. I could not inform my husband about my drug habit in the past...I can't discuss it with him. He may divorce me, if he knows it.

Closeness is the second theme regarding emotional attachment in women's intimate partner relationships. Closeness was described as an important part of their relationships. Almost all participants perceived that they had close relationships with their partners. They

described this closeness as doing daily activities together, such as walking together with their children, discussing their problems together, or even relapsing together in the past. As one women said,

> We usually go to the hospital [methadone clinic] together, go to our laundry business together, go to our parents together. The point is, we always go together. He does not like to make a friend. So, we fit each other.

Closeness was also described as being present when their partners accepted the women for who they were, leading the women to feel their partners were the right men for them. For example, one woman said, "I am sure that we are made for each other." These women perceived themselves as knowing their male partners well, and it was part of their relationship that tied them to each other. One woman said "even though he does not tell me, I know that he is using again, because I know him very well." Another woman felt so close to her partner that even though she distrusted him and they had broken up several times she always reconciled with him again:

> Yeah. He didn't ask me to return. But, I knew that he also missed me. I know that he loves me. When he didn't live with me, he lost some weight. He and I are HIV positive. We actually love each other.

Trust in the partner's sexual faithfulness is another theme that occurred in this study. Among the twenty-four participants who had current partners, twenty-one reported that they fully trusted the faithfulness of their partners. They believed that their partners would not have sex with others, and any concern these women expressed related to their doubts were about relapse rather than their partners' having affairs. One woman said "He will not flirt with other women. Because, why, because, for that...not for women. I only afraid that he may relapse with drugs again, not women." Only three participants expressed doubts about their partner's faithfulness. One said, "I trust him, but he was unfaithful in the past."

Marital status and length of time together seemed to affect trust. All of the married women stated clearly that they trusted their husbands and made statements such as "He is my husband, so I definitely trust him." These women put trust as one of the essential parts in their relationships. One woman said, "He is my husband, so I trust him. I married him." The length of their relationship may also influence their trust. The majority of these women had been with their current partners for more than a year, and some of these women had been together with their current partners for more than 10 years, since they started using drugs. In contrast, one participant who had recently started dating said, "We just have started dating, so I do not really trust him."

2. Gender and Power: Decision-Making Power

Regarding their degree of involvement in decision making, the majority of women (18) said that they had equal or greater power. Only five felt they had less power than their partners did in their relationships.

Women who participated actively in decision making said that they discussed problems with their partners, particularly decisions for their families. They made comments such as "we discuss everything," and "we talked together" or "we find solutions together." Most women said they made most decisions about their personal expenses, such as clothing and jewelry and food for their families. Several said that they made decisions together, particularly to buy furniture or appliances like TVs. When they had disagreements, they discussed them with their partners.

Decision making regarding safer sex was also crucial to communication in these relationships. Some women said explicitly that they discussed and decided together when to have sex. If these women did not want to have sex, they explicitly communicated with their

current partners their unwillingness to have sex. The final decision depended on their agreement. In addition, these women said that they participated in decision making about condom use.

Six women said they had less decision-making power than their partners in their relationships. All of them were married and unemployed. One woman described her relationship as one in which the husband did not like her to raise any questions,

> I usually follow what he said. I used to talk a lot. Sometime, he is angry and says, "It is supposed to be me who controls our house. Why you are controlling me? I am the one who is the breadwinner in this house.'

Only two women had ever experienced physical violence from their current partners. One woman reported that she had experienced physical violence from her current partner in the past, but he had not hit her since she stopped using drugs. The other woman was still in a violent relationship and said,

> He used to give up on me. But I am talking too much when we had a fight. Then, I accidentally hit him first. Then, he hit me. He hit me so hard, as he would hit a thief, and this would happen if he gets drunk.

3. Gender and Power: Division of Labor

Every participant expressed the opinion that financial power issues or control over money was another aspect of their relationship. However, they did not seem to regard issues about money as really affecting the stability of their relationships, whether they were financially dependent on their partners or not. Financial issues did not seem to be as important a part of relationships to these women as emotional attachment.

As we discuss earlier in Chapter 2, it is an Indonesian social norm that men should provide financial support to their families and women are responsible for the household. In this study, I found that a prevalent theme was that a woman should use her partner's income; participants were often expected to control expenses at home, regardless of whether they also

earned money. For example, one participant who was financially independent because she had her own small beauty salon still expected her partner to pay their family expenses.

> He gives me money every week for shopping. Hm...yeah. Sometimes. I said, 'I do not want to give you more. We have to spend equal money. I will give you Rp 600.000 and you will give me Rp 600.000 ($60), equal for our family spending. I do not care [whether it is enough or not for our family expenses]. Why? Because you are my husband and your responsibility is to pay all our expenses, including our kids.'

Other financially independent women who also lived with their current husbands reported that they shared financial responsibilities with their partners. For example, a woman who ran a laundry business with her husband said,

> We have our laundry business. So, we usually go to the laundry together. I will manage our money. We discuss how we spend our money. If we want to buy something, we will discuss it together. We never do anything without informing each other.

For those women who did not live with their current partners, the social norm about financial responsibility did not apply. For example, one woman who worked as an NGO employee, was financially independent, and currently lived with her mother said,

> I work at an NGO so I receive regular income monthly. With my partner, he also has his salary. Because we aren't married yet, so, your money is for yourself and my money is for myself.

If their partners did not have adequate financial resources to support their families, the women expected them to share responsibilities at home, such as helping her to take care of their children. One woman who usually sold food for a living mentioned,

> Yes, I am the bread winner in this family. I cook and sell food at the hospital. He will accompany me to sell the food. He does not work, so I ask him to take care our kid if I work. I also ask him to go to market, using his motorcycle. I manage our money at home, because I am the one who has money. He does not have money, he depends on me.

There were 11 women who were financially dependent on their partners. These women said that they stayed at home and took care of their children and housework while their husbands worked primarily outside of their homes as breadwinners. These women received money regularly from their partners, on a monthly or daily basis, to spend on the families or for their individual personal expenses. They controlled expenses for their families, such as food, laundry, soap, and other necessities. They either managed their expenses by themselves or communicated with their partners. As one woman said,

> Yes, he gives me all his salary every month. All his salary…hem em, yes. 'This is my salary. Please help me to manage it, mommy.' From that time, I was thinking, this means serious. Even to buy cigarettes, he tries to find money for it. For gas, he asks money every three days. 'Mom, I run out of gas. Could you give me money Rp 15.000 ($1.5) for gas?' 'Yes.' So, from that moment, I was thinking, 'Okay, money, this money, he trusts me, you know. If I…I feel pity for him. So, I respect him very much.'

Thus, even the women who were economically dependent on their husbands shared in the economic decision making and managed household expenses. However, there were two financially dependent women who were exceptions. They both had little involvement in decision making in their relationships, and they did not control their family expenditures.

4. <u>Relationship Patterns</u>

Although the TGP describes three separate constructs of gender and power, we wanted to see whether the three aspects of gender and power in relationships were related to each other and whether there were distinct patterns of gender and power in the relationships of women who recovering from drug use in Indonesia. I found that there were two patterns in relationships: those where gender and power were relatively balanced and those where the male was dominant.

Most women (16) in this study described a gender-balanced relationship of fairly equal gender power with their primary partners. All of these women said that they had open communication, felt close to their partners, and trusted the sexual faithfulness of their partners

(cathexis). They also reported that they actively participated in decision making with their partners (power). There was some variation in economic dependency among women in relatively balanced relationships (labor). The majority were economically independent or shared economic resources. Five of the six women who said they were economically dependent said that they still had control over spending and autonomy in their relationships (see Table III).

TABLE III

TYPE OF RELATIONSHIP

	Gender-Balanced (n = 16)	**Male Dominated (n = 7)**	**Total (n = 23*)**
Cathexis High (all 3 components)	16	1	17
Decision making shared or by woman	16	2	18
Economically Independent	10	2	12

*Includes only women in a current sexual relationship

Seven women in this study described being in male-dominant relationships. Their partners dominated in at least two of the three areas. Only one woman had all three components of cathexis: open communication, closeness, and trust. Only two women said they had at least equal decision-making power and only two were not economically dependent on their partners.

In summary, it is clear that although these three aspects of gendered power are conceptually different, the three aspects were highly interrelated in the relationships described by the woman in this study.

E. Woman's Perceptions of Gender and Power in Current Relationships

In this section, I focus on whether there was a relationship between women's perceptions of their current relationships in terms of gender-related power and their risky sexual behaviors. I

also look at the reasons women gave for engaging in risky behaviors. To further explore factors related to risky sexual behaviors among women recovering from drug use, I examined factors related to couple HIV status and NGO counseling that might affect HIV risk behaviors,

The risk behavior I focused on was condom use. Women's adherence to condom use was categorized as lower risk (consistent condom use) or higher risk (using condoms inconsistently or never). Only three women currently had more than one sexual partner or had sex for money. All of these women were already in the higher risk group because they did not use condoms consistently. As a result, I did not separately examine the risk behavior of having a sexual relationship with multiple partners.

1. Gender and Power in Relationships

I found that 16 women perceived that they had gender-balanced relationships while seven felt that they had male-dominant relationships. All of the women in male-dominant relationships engaged in risky sexual behaviors by not using condoms or by using them inconsistently. However, only eight of the 16 women who had gender-balanced power with their partners consistently used condoms. Therefore, I cannot conclude that the woman's perceptions about gender and power in their relationships were related to HIV risk behavior (see Table V).

TABLE IV

RELATIONSHIP TYPE AND OTHER FACTORS AFFECTING CONDOM USE

Factors	Consistent Condom Use (n = 8)	Inconsistent or No Condom Use (n = 15)
Relationship Type		
Gender Balanced	8	8
Male-Dominant	0	7
Couple HIV Status		
Concordant:		
Women HIV +; Man HIV +	5	5
Women HIV -; Man HIV –	0	2
Discordant:		
Women HIV +; Man HIV –	2	2
Women HIV-; Man HIV +	0	2
Partner HIV status not known:		
Women HIV+; Man's status not known	1	4
Mentioned NGO Counseling		
Yes	7	0
No	1	15

I expected that the sexual risk behaviors of women recovering from drug use to also be affected by each of the three TGP constructs separately. For instance, with regard to the sexual division of labor, I expected that women recovering from drug use who were economically dependent on their partners would be more likely than those who were economically independent from their partners to engage in higher risk sexual behaviors. Among the 11 women who were economically dependent, all but two of them engaged in risky behaviors (defined as inconsistent or no condom use). Among the 12 who were economically independent, seven used condoms consistently and five did not. Because of the small numbers, it is difficult to reach a conclusion

about the relationship between economic dependence and risky sexual behavior, but there was a tendency for women who were economically dependent to have a higher rate of risky sexual behaviors.

In terms of decision-making power, I expected that women who felt that they participated less in decision making in their relationships or who experienced partner abuse would be more likely to engage in high-risk behaviors. Only one of the women was being abused currently, so this expectation could not be examined. Only five women perceived their relationships as one where they had little decision-making power with their partners, and all of those women engaged in risky sexual behavior. Of the 18 who felt that they shared decision-making in their relationships, only eight women used condoms consistently. Again, it is difficult to reach a conclusion about the relationship between decision-making power and risky sexual behaviors because of the small numbers, but there was tendency for women who saw themselves as having less power to have a higher rate of risky sexual behaviors.

In terms of cathexis or emotional attachment, I expected that the women who had high cathexis or emotional attachment with their partners would be more likely to engage in unsafe sexual practices, such as not using condoms. Only six women felt they did not have a strong emotional attachment in their relationship, and they all engaged in risky sexual behaviors. Among the 17 women who perceived that their relationships had high emotional attachment (defined as open communication, closeness, and trust), only eight of them used condoms consistently.

Overall, the HIV risk behaviors of these women, who were all recovering from drug use, did not appear to be related to their perceptions of gendered power in their relationships or to any of the three individual constructs of the TGP.

2. Reasons for Condom Use

As shown above in Table V, the majority of participants reported that they never used condoms or used them inconsistently. During data collection, I asked women who reported inconsistently or never using condoms an open-ended question about their main reasons for not using condoms. Although the women's perceptions about gender and power in their relationships with their partners did not correlate to their sexual risk behaviors, the reasons most women gave for not using condoms were related to their partners.

Partners' dislike of condoms was the most common reason women gave for not using condoms consistently. Nine participants said that their partners disliked condoms, and four of them said their partner's dislike of condoms was their main reason for not using condoms. One woman said, "He tried once...eh...then, when he tries, he said 'Ah, I do not feel comfortable with this.' We only tried once." One woman, who knew that her husband had an affair in the past, said that she asked him to use condom but he refused:

> [One time] I asked him to use condoms. I said, 'Can you use condoms?' He said, 'No, I don't want to use condoms. I feel uncomfortable with condoms. In addition, I am your husband and you only have sexual intercourse with me. It will be different if you have other partners.'

Trust in their partners was the second most frequent reason given for not using condoms consistently. Eight women said that trusting their partners to be faithful was an important reason for not using condoms consistently, and four said that it was the main reason they didn't use condoms. These women said, "I trust him, because he is my husband," and "I know him well, so I do not have to use condoms." Another woman also pointed out how trust influenced her decision to not use condoms. She said,

> For me, it is not a problem, [it does] not really matter for me. The important thing is that I know his behavior history in the past, whether he liked to do sex [with other women] or anything, did he inject, did he share needles or not with others. The point is that I believe that I know him, so whether we use or do not use condoms, it is not a big deal for me.

The desire to have children was the reason two women did not use condoms. As one woman who was a full time housewife said,

> This is my second partner. Until now, we have not used condoms because we want to have our own child. One time he suggested we adopt a child, but it did not work well with the mother of that baby. Therefore, we decide not to use condoms in order to have our own child.

Only six women mentioned reasons for not using condoms consistently that did not involve their partners or relationships. Three women mentioned that they only used condoms if they forgot to take their oral birth control pills. Two women said that they personally disliked condoms which was the main reason they did not use them. Two women did not use condoms now because they had already had sex with their partners without condoms and assumed they were already infected, or if they were not infected yet they would remain uninfected.

Thus, the main reasons women gave for not using condoms or for using them inconsistently related to aspects of emotional closeness in their relationships. Not using condoms because the women's partners don't like them or to show trust may reflect women's acceptance of gender norms in Indonesia: that women are expected to be passive, obedient, patient, loyal to men, and inclined to please their partners. These women appeared to accept the importance of pleasing their partners even if it meant risking their health.

3. Couples' HIV Status and Risk Behavior

In this study, I examined whether the couples' HIV status influenced HIV risk behavior. I expected that women who knew they were HIV negative would use condoms more consistently

than women who were HIV positive. This should be especially true for women in relationships with men who were HIV positive or whose status was not known. As shown in Table V, among 10 HIV positive seroconcordant couples, only five used condoms consistently. Neither HIV negative seroconcordant couple used condoms. Among the six HIV discordant couples, only two use condoms consistently. Among the five couples where the woman was HIV positive and did not know the status of her male partner, only one used condoms consistently. Thus, there did not appear to be a relationship between HIV status and consistent condom use.

4. <u>NGO Counseling</u>

An unexpected discovery was that practicing safer sex was related to counseling about HIV risk and condom use from the NGO where the women got referrals to methadone treatment. All but one of the women who used condoms consistently mentioned explicitly that the reason they used condoms was having received NGO counseling about the importance of using condoms consistently regardless of HIV status. One woman mentioned that she received regular information about HIV twice per month,

> I usually go to the NGO, to social support group for people with HIV. In this place, we usually receive some information about HIV, including condom use and also how we deal with ARV therapy. In addition, we also share our experience with our peers, about our HIV symptoms and how to solve our problems.

Similarly, another woman highlighted that she and her partner had a lack of information about HIV prevention in the past. She said,

> I had a lack of information about the benefit of condom use in the past. That is why I did not care about condoms use. Then, when my pregnancy was three months old, the doctor told me that I have to use condoms, because I am HIV positive and I also have sexually transmitted diseases.

One reason the counseling and support by NGOs may have been important in encouraging women to use condoms consistently was the lack of understanding about risk and HIV transmission that women revealed in their discussions of their behaviors. In discussing their HIV risk behaviors before they quit using drugs, almost half of these women reported that they did not have adequate information about HIV, including the importance of using condoms to protect themselves. Among HIV serodiscordant couples, lack of comprehensive understanding about HIV prevention for discordant couples contributed to their decision to not use condoms. The belief that condoms were unnecessary when both partners were HIV-positive reflected a lack of knowledge about the importance of preventing further exposure to different strains of HIV as well as exposure to other STIs. Among the HIV discordant couples, some of them said that they had already unprotected sex in the past. They believed that if HIV could infect the other partner that would have happened immediately. However, they had not gotten HIV yet, and therefore, they decided not to use condoms. As one woman stated,

> Why I should use condoms now? I did not use a condom the first time we had sex, and I am still non-reactive (HIV negative). If I used condom from the beginning of our relationship, I would still use condoms until now, but I did not use condoms. So, we do not use condoms.

In summary, the importance of in-depth information about HIV prevention, couple HIV status and condom use was evident from the way the women discussed condom use. They revealed a lack of understanding about the complexities of HIV prevention and how to apply it to their own specific situation as a couple.

Because the potential role of NGO counseling was a factor that emerged during the interviews, I did not systematically ask each women about it. The seven participants who discussed NGO counseling brought it up spontaneously when they discussed their main reasons

for using condoms consistently. Therefore, I cannot be sure that other women did not also receive this counseling from the NGO, which offers it to all the former drug users they serve. At least one woman indicated that she did receive counseling, saying:

> Yeah, we [woman and her partner] attend several seminar at NGO place. They also offer us condom for free. But, we do not use it. We still have a lot of condoms that we got from NGO.

This suggests that at least some of the women not using condoms consistently also had received counseling and condoms from the NGO, but they chose not to follow the NGO's recommendations.

V. DISCUSSION AND IMPLICATIONS

This is the first descriptive study of women who are recovering from drug use in Indonesia. This discussion begins with a summary of the major findings. I then discuss these findings in relation to the Theory of Gender and Power (TGP), which guided this study and to prior research. Then the strengths and limitations of this study are discussed. The final section discusses the implications of the findings and recommendations for HIV prevention and drug cessation programs and policies for women in Indonesia.

A. Summary of Findings

Each of the women described the experiences that led her to quit using drugs, as well as her current life after quitting drugs. There were two themes that emerged from the women's reflections on these experiences. First, they emphasized that quitting was an enormous challenge, which required strong personal motivation and strong support from others to succeed. Second, stopping drug use meant "gaining a normal life" for them. They emphasized improvements in their relationships with their partners and families. All of them expressed fear of relapse as a major concern.

All the women in the study had engaged in HIV risk behavior when they still used drugs. All of them engaged in unprotected sex and six of them also had multiple partners, including sex for money. In addition, all but one of the women also shared unclean needles with their partners and others.

Regarding current HIV risk, eleven participants were either not having sex or using condoms consistently, a major change from before they stopped using drugs, when all the women were engaged in risky sexual behaviors. However, the majority of women still engaged

in the risky behavior of unprotected sex. Two women also had two or more current partners, while two other women had sex for money.

The women in this study described in detail their relationships with their current partners. Using the TGP constructs, I categorized three aspects of their relationship: the sexual division of labor, decision making power and structural of cathexis. Women were most interested in talking about the structure of cathexis, which they expressed as the most important aspect of a good relationship. From their discussion of relationships, I identified three themes about cathexis: open communication, closeness and trust in sexual faithfulness.Women in this study described two types of gendered power relationships. The majority of women (17 of the 23 who were sexually active) reported that they had gender-balanced relationships. Women in gender-balanced power relationships described their relationships as having relative gender equality. All had high cathexis or emotional attachment and equal or greater decision-making power, and most also had economic independence or shared economic decision-making. Women in male dominant relationships had gendered inequality in at least two areas.

In term of gender and power and its impact on HIV risk behavior, I could not conclude that there was a clear relationship between type of partner relationship and HIV risk behavior. However, there was a tentative connection in that all the women who said they had a male dominant relationship engaged in higher HIV risk behaviors (inconsistent or no condom use), while about half of those who had gender balanced power used condoms consistently. I also found that the most common reasons for not using condoms were connected to the partner: partner dislike of condoms, the woman's trust in her partner, and the couple's desire to have children. The couple's HIV status did not seem to influence HIV risk behavior. There was no relationship between a couple's HIV status and condom use, even for HIV discordant couples.

One unexpected finding was that all but one of the women who used condoms consistently spontaneously reported that they received NGO counseling regularly. The NGO counseling provided knowledge and reinforced the benefits to them and their partners of consistent condom use. However, because this factor was not expected, not all the women who did not use condoms consistently were asked if they had also received NGO counseling.

B. Discussion of Findings

1. Contextual Factors*:* Living as Former Drug Users

The emphasis on the importance of partner and family support in helping women to quit using drugs is similar to a prior study of predominantly male IDUs in methadone treatment in China (Lin et al, 2011). For those men trying to stop using drugs, perceived family support was associated with increased physical, psychological, environmental, and social health, as well as lower current substance use.

"Gaining a normal life" was the main theme women expressed about their lives after they quit using drugs. This finding was congruent with the only previous study of women who had quit using drugs that I was able to identify in an extensive literature search. Watson & Park (2011) interviewed five women recovering from heroin use in the U.K., and those women also described quitting drugs as gaining a normal life. As part of their normal life, they too reported positive changes in their relationship with their partner and their family. Another study, conducted by Neale, Sarah & Pickering (2014) among 77 male and female former drug users in the UK, evaluated gender differences in recovery from heroin dependency. They found that although women reported more physical and sexual abuse than the men in their current relationships, they had better current family and social relationships and more access to informal support, including material assistance and housing.

2. HIV Risk Behaviors

When they still were using drugs, all the women in our study had engaged in HIV risk behaviors, including risky sexual behaviors and needle sharing. These findings are congruent with previous research with women who use drugs (Grella, Scott, & Foss, 2005; Higgs et al., 2008). Kapadia et al., 2007; Lazuardy, 2012; Uuskula et al., 2012; Walitzer & Dearing, 2006). Women in all these studies also shared needles, particularly with their partners. Uuskula (2011) also found that the practice of safer-sex was not the norm and was uncommon among couples who injected drugs. The women tended to avoid condom use because they placed a higher value on the relationship than on potential health risks, and women also perceived that condoms given by harm reduction programs were low quality. One study among 19 female drug users in Jogjakarta, Indonesia, found that most had male partners who also used drugs, and these partners these partners heavily influence women's drug life, including"the initiation of drug use, the provision of drugs, injecting behavior and in the constitution of women injectors' social networks" (Lazuardi, 2012, p.491). This study was among Indonesian women who shared similar societal norms and drug use context, and therefore, its results are especially comparable with our study.

I also found that all women in our study had support from their partners to stop using drugs. This finding is congruent with previous studies suggesting that women who are in relationships with drug-using partners are less likely to enter treatment or stop injecting unless their partner also begins treatment (Greenfield et al., 2007; McCollum et al., 2005; Riehman et al., 2000). It seems that male partners influence women's decision to stop using drugs.

3. Gender and Power in Women's Relationships

In this study, the majority of women perceived themselves as having a gender-balanced relationship, in spite of the prevailing male dominance in Indonesian society. Indonesia is patriarchal, and men are viewed as leaders of the family; men have more authority in their relationships, particularly related with sexuality and condom use. These cultural norms and beliefs lead men to be more dominant and aggressive, and to more actively negotiate sex. It is also accepted for men to have more than one partner but not for a woman to do so (Baso & Idrus, 2002). Men are usually the ones who have power to make decisions in their relationships. However, in this study, I found that the majority of women perceived that they had equal power.

There are several possible explanations for the discrepancy between the prevailing cultural norms and this study's findings. These findings were based on what women perceived about their relationships. Their perspective may not be objective. Different results might be found if I also asked their male partners about their relationships or observed the couples' behaviors. Second, all women in this study had successfully gone through quitting drugs. Succeeding at this very difficult process may relate to greater empowerment, either because only those who are relatively empowered attempt to quit drugs or because the process and the success of quitting are empowering. Therefore, this group of women may be quite different from typical Indonesian women. Another potential factor is that many of them had gone through their struggle to quit drugs with their current partners, who gave them strong support, or they met a new partner who supported them in staying drug-free. None of the women remained with a partner who continued to use drugs, although two of them continued to associate with friends who used drugs. Consequently, these women may have unusually strong and positive relationships with their current partners.

Another possible explanation is that changes are occurring in Indonesia that are leading to transitions in gender norms and relationships. A focus group discussions with six groups of local male community leaders in Purworejo was conducted by Hayati, Emmelin, &Eriksson (2014). They found that men faced challenges in the context of marriage relationships. Although the Koran said that men should be the leaders and the breadwinners in their families and the women should take responsibility for the household, some leaders recognized that women can do better than men at some traditionally male roles. These leaders encouraged gender equity in relationships. They also found that only the most traditional men accepted violence in their marriage in order to "correct the wife's behavior."

4. Women's Relationships and HIV Risk Behaviors

In this study I did not find evidence to support the idea that women who had less gender-based power in their relationships, including economic dependency, decision making power, and emotional closeness, were more likely to engage in HV risk behavior. Thus, these findings are not congruent with previous studies. Both studies that used the TGP as a whole (Wingood & DiClemente, 2000; Panchanadeswaran et al 2007) and those that examined one construct separately (DePadilla et al., 2011; Woolf & Maisto, 2008) found that gendered power imbalances in relationships put women at risk of behaviors that increased their chances of contracting HIV. In contrast, although women in this study who were in male dominated relationships all engaged in risky behaviors. Therefore, the Theory of Gender and Power does not appear to be applicable for this specific population of Indonesian women recovering from drug use.

Although gendered power in women's overall relationships did not relate strongly to their risk behaviors, the reasons women said they used condoms inconsistently or not at all related to their partners. Partner dislike of condoms was the main reason they did not use condom

consistently, closely followed by trust in their partners. Previous studies also identified partner resistance to using condoms as a major factor in not using condoms among both women in the general population and women who used injection drugs (Absalon et al., 2006; Bruneau et al., 2001; Kapadia et al., 2007; Lazuardi, 2010; Spooner et al., 2004;Rhodes & Cusick, 2000; Tucker et al, 2008). The finding that trust in their partners was a reason for not using condoms is congruent with a study in Java among women who were drug users (Saktiawati, et al 2013). In that study, the women also said that trust in their partners was the main reason they did not use condoms (Saktiawati et. al 2013).

It seems that women's and couple's HIV status did not influence condom use. Many women said that they did not care about condom use even when they knew that one partner was HIV positive.

An important and unexpected finding was that all but one of the women who used condoms consistently reported that they received NGO counseling regularly; they noted that this counseling reminded them to use condoms consistently to protect them and their partners. The importance of NGO counseling reflects the lack of knowledge that women displayed when discussing why they did not use condoms consistently. This lack of knowledge is congruent with previous studies (Minaya, 2008; Kassie, Mariam, D., &O Tsui, 2008; Lammer, Wijnbergen, & Willebrands 2013).

C. Strengths and Limitations of the Study

A strength of this study is that this is the first study in Indonesia of women recovering from drug use and their perceptions of their relationships and HIV risk behaviors. Another strength is the use of descriptive interviews, which provided detailed descriptions of the contexts of partner relationship patterns after study participants stopped using drugs.

There are also several limitations of the study. The characteristics of women's relationships were obtained from the women. It is possible that women perceived more gender-related power in their relationships than they actually had. They may also have been influenced by social desirability to describe their relationships more favorably than an outside observer might.

The sensitive nature of the study may have affected the openness of responses. Because these participants were asked about their risky sexual behaviors and HIV infection, they may have been reluctant to speak freely despite the researcher's efforts to establish confidentiality and trust.

Another limitation may be related to the sample. Because this is the first study of recovering female IDUs, little is known about how to access this group. This convenience sample was recruited from three NGOs, and they may have recommended women they regarded as "success stories." Thus, this sample may not be representative of the entire target group. This study focuses on only women; therefore, findings may not be applicable for men. Further study about partner relationships and HIV risk behaviors among older female IDUs or male IDUs may be necessary.

A final limitation is the retrospective nature of some of the information collected. When women discuss their past, they are presenting their current understanding of their former behaviors, filtered by their current experiences. It is important to keep in mind that the women were always reporting their current perceptions of both past and present events and relationships.

D. Implications

This study has strong policy implications. Findings from the women in this study suggest several unique needs of women who are recovering from drug use that should be incorporated

into programs for them. All of the women had made multiple attempts to stop using drugs prior to their most recent and thus far successful attempt to quit. Strong support programs might help women to be more successful in their attempts to stop using drugs. Women identified partner and family support as essential components that helped them successfully recover from drug addiction. Drug recovery programs should incorporate partner and family involvement.

Women also identified that they and their partners both need HIV education, specifically for those who are currently injection drug users or who have stopped using drugs. Although HIV education for IDUs tends to focus mainly on risks related to sharing needles, sexual risk reduction is also very important, especially among those who are recovering from drug use. Many former injection drug users are already HIV positive. A comprehensive program about HIV prevention should not only focus on HIV prevention among HIV discordant couples, but also should target HIV positive and negative concordant couples as well as individuals.

The role of NGOs in providing counseling and support to these women who were recovering from drug use was strongly related to consistent condom use. Therefore, NGOs should be encouraged to expand these efforts and strengthen ways to engage more women who have quit using drugs and their partners in these programs. Findings from this study imply that policies and programs should optimize the role of NGOs in supporting HIV prevention and drug cessation in the community. Having adequate support and counseling from NGOs would help address issues of inconsistent condom use among women who have stopped using drugs in Indonesia.

This study provides evidence of the need to increase the number of programs to help the growing number of female injection drug users trying to enter recovery. Methadone programs

appear to be especially helpful and should be expanded, especially for women. Women who succeed in quitting drugs regain a "normal life" and feel satisfied with their new lives.

This study also has implications for future research. To gain a more comprehensive picture about the drug recovery process, partner relationships, and HIV risk among women recovering from using drugs, quantitative studies should be conducted with larger and more diverse samples. A longitudinal study of women over time would be especially useful to increase understanding of the process of quitting drugs for women, including the problem of relapse and their different needs from men who are quitting.

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APPENDIX A

ETHICAL APPROVALS AND SITE PERMISSION LETTERS

1. University of Illinois at Chicago Initial Approval
2. University of Illinois at Chicago Continuing Review Approval
3. University of Indonesia Approval
4. Letters of Permission from the Sites
    a. Kios Atman Jaya
    b. Yayasan Hidup Positif
    c. Yayasan Pelita Ilmu

UNIVERSITY OF ILLINOIS
AT CHICAGO

Office for the Protection of Research Subjects (OPRS)
Office of the Vice Chancellor for Research (MC 672)
203 Administrative Office Building
1737 West Polk Street
Chicago, Illinois 60612-7227

Approval Notice
Initial Review (Response To Modifications)

May 14, 2013

Sri Yona, MN
Women, Child, & Family Health Science
845 S. Damen Ave., M/C 802
Chicago, IL 60612
Phone: (312) 413-1059 / Fax: (312) 996-8871

RE: Protocol # 2013-0324
"Perceived Partner Relationship and HIV Risk Behaviors Among Recovering Female Injecting Drug Users in Jakarta Indonesia"

Dear Ms. Yona:

Your Initial Review (Response To Modifications) was reviewed and approved by Members of IRB #2 by the Expedited review process on May 9, 2013. You may now begin your research

Please note the following information about your approved research protocol:

Protocol Approval Period: May 9, 2013 - May 9, 2014
Approved Subject Enrollment #: 35
Additional Determinations for Research Involving Minors: These determinations have not been made for this study since it has not been approved for enrollment of minors.
Performance Sites: UIC, Faculty of Nursing University of Indonesia, Kios Atmajaya, Yayasan Hidup Positif
Sponsor: NIH Fogarty AIDS International Training
PAF#: 2011-00687
Grant/Contract No: D43TW001419
Grant/Contract Title: UIC AIDS International Training and Research Program
Research Protocol(s):

a) Perceived Partner Relationship and HIV Risk Behaviors Among Recovering Female Injecting Drug Users in Jakarta Indonesia; March 2013

Recruitment Material(s):

a) Recovering from addiction, Initial Contact with NGOs, Version 1, 04/15/2013
b) Recovering from addiction, Initial Contact with NGOs. Indonesia, Version 1, 04/15/2013
c) Recovering from addiction, Meeting Recruitment Script, Version 1, 04/15/2013
d) Recovering from addiction, Meeting Recruitment Script. Indonesia, Version 2, 04/15/2013
e) Recovering from addiction, Recruitment Script for in person contacts, Version 2, 04/15/2013
f) Recovering from addiction, Recruitment Script for in person contacts. Indonesia, Version 2, 04/15/2013
g) Recovering from addiction, Research Flyer, Version 2, 04/15/2013
h) Recovering from addiction, Research Flyer-Indonesia, Version 2, 04/15/2013

Informed Consent(s):

a) Waiver of Signed Consent Document granted under 45 CFR 46.117(c)
b) Recovering from addiction, Informed consent, Version 2, 04/15/2013
c) Recovering from addiction, Informed consent-Indonesia, Version 2, 04/11/2013

Your research meets the criteria for expedited review as defined in 45 CFR 46.110(b)(1) under the following specific categories:

(6) Collection of data from voice, video, digital, or image recordings made for research purposes., **(7)** Research on individual or group characteristics or behavior (including but not limited to research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Please note the Review History of this submission:

Receipt Date	Submission Type	Review Process	Review Date	Review Action
03/26/2013	Initial Review	Expedited	03/28/2013	Modifications Required
04/16/2013	Response To Modifications	Expedited	04/18/2013	Modifications Required
05/07/2013	Response To Modifications	Expedited	05/09/2013	Approved

Please remember to:
→ Use your **research protocol number** (2013-0324) on any documents or correspondence with the IRB concerning your research protocol.

→ Review and comply with all requirements on the enclosure,
"**UIC Investigator Responsibilities, Protection of Human Research Subjects**"
(http://tigger.uic.edu/depts/ovcr/research/protocolreview/irb/policies/0924.pdf)

Please note that the UIC IRB has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

Please be aware that if the scope of work in the grant/project changes, the protocol must be amended and approved by the UIC IRB before the initiation of the change.

We wish you the best as you conduct your research. If you have any questions or need further help, please contact OPRS at (312) 996-1711 or me at (312) 355-2939. Please send any correspondence about this protocol to OPRS at 203 AOB, M/C 672.

Sincerely,

Jewell Hamilton, MSW
IRB Coordinator, IRB # 2
Office for the Protection of Research Subjects

Enclosure(s):

1. **UIC Investigator Responsibilities, Protection of Human Research Subjects**
2. **Informed Consent Document(s):**
   a) Recovering from addiction, Informed consent, Version 2, 04/15/2013
   b) Recovering from addiction, Informed consent-Indonesia, Version 2, 04/11/2013
3. **Recruiting Material(s):**
   a) Recovering from addiction, Initial Contact with NGOs, Version 1, 04/15/2013
   b) Recovering from addiction, Initial Contact with NGOs. Indonesia, Version 1, 04/15/2013
   c) Recovering from addiction, Meeting Recruitment Script, Version 1, 04/15/2013
   d) Recovering from addiction, Meeting Recruitment Script. Indonesia, Version 2, 04/15/2013
   e) Recovering from addiction, Recruitment Script for in person contacts, Version 2, 04/15/2013
   f) Recovering from addiction, Recruitment Script for in person contacts. Indonesia, Version 2, 04/15/2013
   g) Recovering from addiction, Research Flyer, Version 2, 04/15/2013
   h) Recovering from addiction, Research Flyer-Indonesia, Version 2, 04/15/2013

cc: Barbara McFarlin, Women, Child, & Family Health Science, M/C 802
Kathleen F. Norr, Faculty Sponsor, Women, Child, & Family Health Science, M/C 802

UNIVERSITY OF ILLINOIS
AT CHICAGO

Office for the Protection of Research Subjects (OPRS)
Office of the Vice Chancellor for Research (MC 672)
203 Administrative Office Building
1737 West Polk Street
Chicago, Illinois 60612-7227

Approval Notice
Continuing Review

March 13, 2014

Sri Yona, MN
Women, Child, & Family Health Science
845 S. Damen Ave.
M/C 802
Chicago, IL 60612
Phone: (312) 413-1059 / Fax: (312) 996-8871

RE: **Protocol # 2013-0324**
"Perceived Partner Relationship and HIV Risk Behaviors Among Recovering Female Injecting Drug Users in Jakarta Indonesia"

Dear Ms. Yona:

Your Continuing Review was reviewed and approved by the Expedited review process on March 13, 2014. You may now continue your research.

Please note the following information about your approved research protocol:

Protocol Approval Period: March 13, 2014 - March 13, 2015
Approved Subject Enrollment #: 35 (Limited to data analysis from 30 subjects)
Additional Determinations for Research Involving Minors: These determinations have not been made for this study since it has not been approved for enrollment of minors.
Performance Sites: UIC, Faculty of Nursing University of Indonesia, Kios Atmajaya, Yayasan Hidup Positif, Yayasan Pelita Ilmu
Sponsor: NIH Fogarty AIDS International Training
PAF#: 2011-00687
Grant/Contract No: D43TW001419
Grant/Contract Title: UIC AIDS International Training and Research Program
Research Protocol:

b) Perceived Partner Relationship and HIV Risk Behaviors Among Recovering Female Injecting Drug Users in Jakarta Indonesia; March 2013

Recruitment Material:

i) N/A- Limited to data analysis only

Informed Consent:

d) N/A- Limited to data analysis only

Your research meets the criteria for expedited review as defined in 45 CFR 46.110(b)(1) under the following specific categories:

(6) Collection of data from voice, video, digital, or image recordings made for research purposes., **(7)** Research on individual or group characteristics or behavior (including but not limited to research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Please note the Review History of this submission:

Receipt Date	Submission Type	Review Process	Review Date	Review Action
03/10/2014	Continuing Review	Expedited	03/13/2014	Approved

Please remember to:

→ Use your **research protocol number** (2013-0324) on any documents or correspondence with the IRB concerning your research protocol.

→ Review and comply with all requirements on the enclosure,
"**UIC Investigator Responsibilities, Protection of Human Research Subjects**"
(http://tigger.uic.edu/depts/ovcr/research/protocolreview/irb/policies/0924.pdf)

Please note that the UIC IRB has the right to seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

Please be aware that if the scope of work in the grant/project changes, the protocol must be amended and approved by the UIC IRB before the initiation of the change.

We wish you the best as you conduct your research. If you have any questions or need further help, please contact OPRS at (312) 996-1711 or me at (312) 355-2764. Please send any correspondence about this protocol to OPRS at 203 AOB, M/C 672.

Sincerely,

Betty Mayberry, B.S.
IRB Coordinator, IRB # 2
Office for the Protection of Research Subjects

Subjects

Enclosure: None

cc: Barbara McFarlin, Women, Child, & Family Health Science, M/C 802
Kathleen F. Norr, Faculty Sponsor, Women, Child & Family Health Science, M/C 802
OVCR Administration, M/C 672

UNIVERSITAS INDONESIA
FAKULTAS ILMU KEPERAWATAN
Kampus UI Depok Telp. (021)78849120, 78849121 Faks. 7864124
Email : humasfik@ui.ac.id Web Site : www.fik.ui.ac.id

ETHICAL CLEARENCE

The Ethical Committee of Nursing Research, Faculty of Nursing, Universitas Indonesia with regards of the protection of human rights and welfare in nursing research, has carefully reviewed the proposal entitled :

"Perceived Partner Relationship and HIV Risk Behaviors among Recovering Female Injecting Drug Users in Jakarta, Indonesia".

Name of researcher : Sri Yona

Name of institution : Faculty of Nursing Universitas Indonesia

And approved the above mentioned proposal.

Jakarta, 10 April 2013

Dean,

Dewi Irawaty, MA, PhD

Chairman,

Dra. Setyowati, M.App.Sc, PhD

UNIVERSITAS KATOLIK INDONESIA
ATMA JAYA

PUSAT PENELITIAN HIV - AIDS
HIV - AIDS RESEARCH CENTER
Gedung Santo Fransiskus Asisi (Gedung K3) Lantai 7, 8 dan 9
Jalan Jenderal Sudirman 51, Jakarta 12930 Indonesia
Telepon : (62 21) 570-8808, 570-7815 ext. 624
Langsung: +62 21 078 54227
Website : http://www.atmajaya.ac.id Email : hiv@atmajaya.ac.id

TO WHOM IT MAY CONCERN

Ms. Sri Yona is currently a doctoral student a doctoral student at the College of Nursing, University of Illinois at Chicago. She will collaborate with Kios Atma Jaya of the AIDS Research Center, Atma Jaya Catholic University, in conducting her study about Perceived Partner Relationship and HIV Risk Behaviors among recovering female injecting drug users in Jakarta, Indonesia. During her study, she will be able to use the facilities of Kios Atma Jaya, including private room for her study.

In order to recruit participant in Sri Yona's study, two recruitment strategies will be used. A flyer will be posted at NGO bulletin board with a brief description of the study and her contact number. She will also arrange to recruit participants by attending meetings and support groups for recovering IDUs where she will explain the study, give out flyers, and ask those interested in the study to meet briefly afterwards to arrange for an interview. Once participants have agreed to participate in Yona's study, they will contact her to make appointment for an interview. The Kios Atma Jaya will provide a private room for the interview, which will be accessible solely to staff members and the researcher. The room is 3m x 3m, with one door, a table and two chairs and is provided by the NGO to assure complete privacy for the participants.

Ms. Sri Yona will provide copies of IRB approval from the University of Illinois at Chicago and University of Indonesia as well as the recruitment script and inform consent for her study to Kios Atmajaya, to the start of her study. Ms Sri Yona will conduct her study in our office from April, 1st to August 30th, 2013.

If there are any questions, please contact our office

Jakarta, 22nd of March 2013

Sincerely,

Omar Syaiful
Research and Development Coordinator
KIOS Atma Jaya

Yayasan Pelita Ilmu

Tak Henti Berdedikasi dengan Spirit Mandiri

TO WHOM IT MAY CONCERN

Ms. Sri Yona is currently a doctoral student a doctoral student at the College of Nursing, University of Illinois at Chicago. She wil collaborate with Yayasan Pelita Ilmu in conducting her study about Perceived Partner Relationship and HIV Risk Behaviors among recovering female injecting drug users in Jakarta, Indonesia. During her study, she will be able to use the facilities of Yayasan Pelita Ilmu, including private room for her study.

In order to recruit participant in her study, two recruitment strategies will be used. A flyer will be posted at NGO bulletin board with a brief description of the study and her contact number. She wil1 also arrange to recruit participants by attending meetings and support groups for recovering IDUs where she will explain the study, give out flyers, and ask those interested in the study to meet briefly afterwards to arrange for an interview. Once participants have agreed to participate in her study, they will contact her to make appointment for an interview. The Yayasan Pelita Ilmu will provide a private room for the interview, which will be accessible solely to staff members and the researcher. The room is 3m x 3m, with one door, a table and two chairs and is provided by the NGOs to assure complete privacy for the participants.

Ms. Sri Yona will provide copies of IRB approval from the University of Illinois at Chicago and University of indonesia as well as the recruitment script and inform consent for her study to Yayasan Pelita Ilmu to the start of her study. She will conduct her study in our office from May, 5th to August 30th, 2013.

If there are any questions, please contact our office

Sincerely,

Yayasan Pelita Ilmu

(Toha Muhaimin, MD, MSc, DrPH.)

Chairman Pelita Ilmu Foundation

Yayasan Hidup Positif

Office : JL. Raya PKP Gg. Darusalam No.48, Rt.01 Rw.12, Kelurahan Kelapa Dua Wetan, Kecamatan Ciracas, Jakarta Timur, 13730, Indonesia
Telp : 021 – 91214792 / 0813-10068725, Email : yayasan.hidup@gmail.com

Jakarta, 28 March 2013

TO WHOM IT MAY CONCERN

Ms. Sri Yona is currently a doctoral student at the University of Illinois, Chicago, College of Nursing. She will collaborate with Yayasan Hidup Positif in conducting her study about Perceived Partner Relationship and HIV Risk Behaviors among recovering female Injecting Drug Users in Jakarta, Indonesia. During her study, she will be able to use the facilities of Yayasan Hidup Positif, including private room for her study.

In order to recruit participant in Sri Yona's study, two recruitment strategies will be used. A flyer will be posted at NGO bulletin board with a brief description of the study and her contact number. She will also arrange to recruit participants by attending meetings and support groups for recovering IDUs where she will explain the study, give out flyers, and ask those interested in the study to meet briefly afterwards to arrange for an interview. Once participants have agreed to participate in Yona's study, they will contact her to make appointment for an interview. The Yayasan Hidup Positif will provide a private room for the interview, which will be accessible solely to staff members and the researcher. The room is 3m x 3m, with one door, a table and two chairs and is provided by the NGO to assure complete privacy for the participants.

Ms. Sri Yona will provide copies of IRB approval from the University of Illinois at Chicago and University of Indonesia as well as the recruitment script and inform consent for her study to Yayasan Hidup Positif to the start of her study. Ms Sri Yona will conduct her study in our office from April, 1st to August 30th, 2013.

If there are any questions, please contact our office:

- Syahyan +6281310068725 syahyan_botax@yahoo.com (Director)
- Situmeang, Wilson +62817639709, wilsonsitindaung@yahoo.co.id (Program Manager)

Sincerely,

SYAHYAN

Director

APPENDIX B

RECRUITMENT AND CONSENT MATERIALS

1. Script - Initial Contacts with NGOs
2. Recruitment Flyer, English and Indonesian
3. Recruitment Script for Initial Contact, English and Indonesian
4. Consent Form, English and Indonesian

Recovering from Addiction, Relationships and HIV Risk Behavior

Script - Initial Contacts with NGOs
(English version)

Hello. My name is Sri Yona. I'm a nurse and PhD student in the University of Illinois at Chicago College of Nursing and I am conducting a study about recovering from addiction, their relationships, and their HIV risk behavior in Jakarta, Indonesia. I really appreciate your kindness allowing me to conduct my study in your organization.

The aim of this study is to explore partner relationships and HIV risk behaviors among recovering female Injection Drug Users (IDUs) in Jakarta. I will ask about their experience before and after they you stop using drugs. The knowledge gained from my study can provide a better understanding about the role of relationships with men and risky behaviors for recovering female IDUs. Thus, the findings can provide essential evidence needed to tailor HIV prevention interventions for the specific needs of recovering female IDUs.

I will interview recovering female IDUs and I would like to recruit some of them from your sites. The inclusion criteria will include being female, between the ages of 18 to 45 years, previous use of injected heroin regularly and current abstaining from injecting drugs (self report of recovering from IDUs) or has completed methadone program.

I may ask them some sensitive topics such as their sexual behavior, relationship and drug use, currently and in the past. Some women may get upset or distressed as they recall their previous experience with drugs in their life during the interview. If women request, I would like to refer them to the NGOs social workers for help.

The interview will take about 60- 90 minutes, and will be recorded. Their identity of participants will be kept confidential. When they have completed the interview, I will give them Rp 50.000 for their participation.

I will post flyers on the information board at NGO's office so it will be visible for potential participants to read and contact the researcher. I will also arrange to recruit participants by attending meetings and support groups for recovering IDUs where I will explain the study, give out flyers, and ask those interested in the study to meet briefly afterwards to arrange for an interview. Informed consent will be obtained before the interview begins. Face-to-face interview will be conducted in a quiet and private place at your office here and it will be digitally audio-recorded.

The decision to participate in this study is completely voluntary, and there will be no effect on their rights to NGO services. I will fully explain this to the potential participants.

I have obtained IRB approval from University of Illinois at Chicago (UIC) and from University of Indonesia (UI), and flyers. If you like, I can give you a copy of these for your records.

Do you have any questions?
We talk about this few months ago. Is it still all right to recruit participants in your place?
Thank you for your time. (If agrees), I look forward to working with you.

Leave box empty - For office use only

Recovering from Addiction, Relationship and HIV Risk Behavior

Female Volunteers are Needed for a Research:

Sri Yona, Indonesian nurse studies at the College of Nursing at the University of Illinois at Chicago is conducting a study about women who are recovering from addiction, their relationship and their HIV risk behavior.

Please tell us about yourself!

- You are eligible for the research if you are female, age 18 to 45 years, previously used injected drugs, and currently recovering or in a methadone program.
- If you decide to participate, you will:
  - Be interviewed about your life, before and after you stop using drugs
  - The interview will take 60 -90 minutes
  - Receive Rp50.000 at the end of the interview as a thank you token in appreciation of your participation and your time to complete the interview

If you are interested in this research please contact Sri Yona, MSN, RN

Telephone:_____ (mobile)

E-mail: syona2@uic.edu

Leave box empty - For office use only

Proses Pemulihan dari adiksi, Hubungan dengan Pasangan dan Perilaku HIV Beresiko

Dibutuhkan Partisipan Perempuan untuk Penelitian

Sri Yona, seorang perawat Indonesia yang sedang belajar di the College of Nursing at the University of Illinois at Chicago sedang melakukan penelitian tentang wanita yang dalan fase pemulihan dari adiksi, hubungan dengan pasangan dan perilaku HIV beresiko.

Silakan jelaskan tentang diri Anda !

- Anda memenuhi kriteria di penelitian ini jika anda adalah perempuan , usia 18-46 thn, memiliki riwayat menggunakan jarum suntik (penasun), dan saat ini dalam fase pemulihan atau mengikuti methadone program.
- Jika anda memutuskan untuk berpartisipasi, maka anda akan :
  - Diwawancari tentang pengalaman hidup anda , sebelum dan setelah tidak menggunakan jarum suntik.
  - Wawancara akan berlangsung selama 60-90 menit.
  - Menerima uang sebesar Rp50.000 diakhir wawancara sebagai ucapan terima kasih atas partisipasi dan waktu yang anda luangkan untuk wawancara.

Jika anda tertarik untuk berpartisipasi pada penelitian ini, silakan menghubungi Sri Yona, MSN, RN

Telephone:__021 924 27336_____ (mobile)
E-mail: syona2@uic.edu

Recovering from Addiction, Relationships and HIV Risk Behavior

Recruitment Scripts for Initial Contacts for Interviews (English version)

I. Scripts for in-person or telephone contacts

Hello. My name is Sri Yona. I'm a nurse and PhD student in the University of Illinois at Chicago College of Nursing and I am conducting a study about recovering from addiction, their relationships and their HIV risk behavior in Jakarta, Indonesia. I really appreciate your willingness to consider participating in my study.

You will talk to me about your experience before and after you stop using drugs**.** We may ask you some sensitive topics such as your sexual behavior, relationship and drug use, currently and in the past. The knowledge gained from my study can provide a better understanding about the role of relationships with men and risky behaviors for recovering female IDUs. Thus, the findings can provide essential evidence needed to tailor HIV prevention interventions for the specific needs of recovering female IDUs.

The interview will take about 60- 90 minutes, and will be recorded. Your identity will be kept confidential. When you have completed the interview, you will be given Rp 50.000 ($6) for your participation.
Did you have any questions that I can answer for you at this time?

Before we proceed, I'd like to determine whether you are eligible to participate in this study. May I ask you some questions to determine your eligibility?

1) How old are you? [Eligible if between 18 to 45 years]
2) Have you ever used heroin injection in the past? **[**Eligible if yes]
3) Are you currently drug free or in a recovery program, including methadone program? [Eligible if yes to one or more questions]
4) Have you been drug free for 5 years or less? [Eligible if yes]

IF YES TO ALL QUESTIONS, THE PERSON IS ELIGIBLE.

A) IF ELIGIBLE TO PARTICIPATE IN THE RESEARCH, THIS IS IN-PERSON RECRUITMENT, AND YOU WILL SAY:

Thank you. You are eligible to participate in the research.

If you have time now, we can go over the informed consent and the begin the interview. It will take about 60- 90 minutes.

B) IF ELIGIBLE AND THE WOMAN DOES NOT HAVE TIME NOW, OR THIS IS A TELEPHONE INTERVIEW,

Would you be willing to participate in this interview at another time?

The interview will be conducted at the NGOs office (Kios Atmajaya/Yayasan Hidup Positif/Yayasan Pelita Ilmu). Is that okay for you?

I could do this [insert next available time].Would that work for you? [if not,] what time would be good for you? [Arrange a time]

Would you please give me your telephone number so that I can confirm this arrangement or call if there's a problem? Thank you so much for talking with me today. Do you have any questions?

C) IF SHE IS NOT ELIGIBLE TO PARTICIPATE IN THE RESEARCH

I appreciate your interest in participating in the research. However, you are not eligible to participate in the research at this time. Thank you very much for your time.

Pemulihan dari Adiksi, Hubungan dengan Pasangan dan Perilaku HIV Beresiko

Script Recruitmen untuk kontak awal interview (Indonesian version)

1. Skrip kontak langsung dengan partisipan atau via telephon

Hello. Nama saya Sri Yona. Saya adalah perawat dan mahasiswa PhD di the University of Illinois at Chicago College of Nursing dan saat ini sedang melakukan penelitian tentang pemulihan adiksi, hubungan dengan pasangan dan perilaku HIV beresiko di Jakarta, Indonesia. Saya sangat menghargai kesediaan anda untuk berpartipasi pada penelitian ini.

Anda akan berbincang dengan saya tentang pengalaman anda sebelum dan setelah tidak menggunakan jarum suntik. Kami mungkin saja akan menanyakan beberapa topik yang sensitif seperti perilaku seksual, hubungan dengan pasangan dan pengunaan jarum suntik saat ini dan dimasa lalu. Hasil dari penelitian ini akan memberikan gambaran yang lebih baik tentang peran hubungan dengan pasangan dan perilaku beresiko pada perempuan dalam pemulihan adiksi. Hasil dari penelitian ini akan menjadi evident/ bahan dalam mengembangkan program yang dibutuhkan untuk mendesain program pencegahan HIV untuk perempuan seperti anda di masa depan.

Lama wawancara sekitar 60-90 menit, dan akan direkam. Identitas diri anda akan dirahasiakan oleh peneliti. Anda akan menerima uang sebesar Rp 50.000 (cash) diakhir wawancara sebagai pengganti uang transportasi dan waktu yang anda luangkan.

Apakah anda memiliki pertanyaan saat ini ?

Sebelum memulai, saya ingin mengetahui apakah anda memenuhi kriteria untuk penelitian ini. Bolehkan saya menanyakan beberapa hal terkait hal tersebut?

1) Berapakah usia anda? [Memenuhi kriteria jika usia 18-45 tahun]
2) Apakah anda menggunakan jarum suntik heroin di masa lalu? [Memenuhi kriteria jika ya]
3) Apakah anda tidak menggunakan obat-obatan saat ini atau sedang dalam proses pemulihan adiksi, termasuk program metadon ? [Memenuhi kriteria jika ya pada satu atau lebih pertanyaan]
4) Apakah anda bebas dari obat-obatan selama 5 tahun atau kurang dari 5 tahun? [Memenuhi kriteria jika ya]

JIKA YA UNTUK SEMUA PERTANYAAN, BERARTI DIA MEMENUHI KRITERIA UNTUK PENELITIAN

A) JIKA DIA MEMENUHI KRITERIA UNTUK BERPARTISIPASI PADA PENELTIAN INI, MAKA INI ADALAH SKRIP REKRUTMEN INDIVIDU, DAN ANDA AKAN MENGATAKA :

Terima kasih. Anda memenuhi kriteria untuk berpartisipasi pada penelitian ini.

Jika anda memiliki waktu sekarang, kita dapat memulai dengan memberikan surat persetujuan penelitian dan memulai wawancara. Wawancara akan berlangsung selama 60- 90 menit.

B) JIKA DIA MEMENUHI KRITERIA DAN DIA TIDAK MEMILIKI WAKTU SAAT INI, ATAU INI ADALAH INTERVIEW MELALUI TELEPHON,

Apakah anda bersedia untuk diwawancarai di lain waktu?

Wawancara akan dilakukan di NGOs office (Kios Atmajaya/Yayasan Hidup Positif/Yayasan Pelita Ilmu). Apakah ini OK untuk anda?

Saya bisa di [*tuliskan waktu anda*].Apakah anda bisa di waktu tersebut? [*jika tidak,*] Kapan anda ada waktu ? [mengatur jadwal]

Apakah anda bisa memberikan nomer telephon yang bisa saya hubungi jadi saya bisa mengkonfirmasi jawal pertemuan atau menelepon anda jika saya berhalangan ?
Terima kasih banyak atas waktu anda. Apakah anda memiliki pertanyaan?

C) JIKA DIA TIDAK MEMENUHI KRITERIA UNTUK BERPARTISIPASI PADA PENELITIAN INI.

Saya menghargai keinginan anda untuk berpartisipasi pada penelitian ini. Akan tetapi, anda tidak memenuhi kriteria untuk penelitian ini. Terima kasih banyak atas waktu anda.

University of Illinois at Chicago
Research Information and Consent for Participation in Social Behavioral Research

University of Illinois at Chicago Research Information and Consent for Participation in Social Behavioral Research

Recovering from Addiction, Relationships and HIV Risk Behavior

You are being asked to participate in a research study. Researchers are required to provide a consent form such as this one to tell you about the research, to explain that taking part is voluntary, to describe the risks and benefits of participation, and to help you to make an informed decision. You should feel free to ask the researchers any questions you may have.

Principal Investigator: Sri Yona, RN, MN
Department and Institution: College of Nursing University of Illinois at Chicago
Address and Contact Information: 845 S Damen Avenue Chicago Illinois, U.S.A

Why am I being asked?

You are being asked to be a subject in a research study about Recovering from addiction, relationships and HIV risk behavior in Jakarta.

You have been asked to participate in the research because you are female, age 18 to 45 years, previously used injected drugs, and currently recovering or in a methadone program.

Your participation in this research is voluntary. Your decision whether or not to participate will not affect your current or future dealings with the NGOs service at Jakarta, Indonesia. **If you decide to participate, you are free to withdraw at any time without affecting that relationship.**

We will talk to approximately 20-35 women in Jakarta, Indonesia.

What is the purpose of this research?

We would like to learn more about recovering female injecting drug users and their partner relationship and HIV risk behaviors, before and after they stopped using drugs

What procedures are involved?

If you agree to be in this study, you will talk to me about your experiences as a recovering drug users and how your partner influences your recovering process. I will ask you some sensitive topics such as your sexual behavior, relationship and drug use, currently and in the past. We will talk at the private room here and I will record the conversation. The interview will take about 60-90 minutes.

You will need to come to the study site one time only. At any time, you can refuse to answer any of questions and or withdrawn from this study.

What are the potential risks and discomforts?

There is the risk that others may find out of you are participating in the research, for example if they see you come into this room to talk with me**.** You may feel that you need to be in this study because the Kios Atmajaya/Yayasan Pelita Ilmu/ Yayasan Hidup Positif where you come is supported this study. However, it is up to you whether you participate or not and I will not tell NGOs who participates in this study

You may get upset or distressed as you recall your previous experience with drugs in your life during interview. If you request, I can refer you to the NGOs social workers for help.

Are there benefits to taking part in the research?

Taking part in this research study may not benefit you personally, but what you tell us will develop program to help other women like you in the future.

What about privacy and confidentiality?

The people who will know that you are a research subject are members of the research team. Others at these sites may know that you are being interviewed. However, the researcher will not disclose any information about you without your permission. Otherwise, information about you will only be disclosed to others with your written permission, or if necessary to protect your rights or welfare or if required by law. **The decision to participate in this study is completely voluntary, and there will be no effect on your right to service at this organization.**

In the beginning of interview, the investigator will use a unique number to identify each participant. The interview will be recorded. Then, I will give the recording to a person to transcribe (types) what was sound and translated into English. The persons who transcribe and translate will be trained to protect the privacy of the information. The recording will be destroyed when the transcript has been check for accuracy.

Will I be reimbursed for any of my expenses or paid for my participation in this research?

You will not have any expenses related to participating in this study.

You will receive Rp 50.000 (cash) at the end of the interview for your travel expense and time.

Can I withdraw or be removed from the study?

If you decide to participate, you are free to withdraw anytime without affecting your relationship with the NGOs where you receive services.

Who should I contact if I have questions?

Contact the researchers if:

- you have any questions about this study or your part in it,
- if you have questions, concerns or complaints about the research

Sri Yona, RN, Faculty of Nursing at University of Indonesia
Kampus Baru Universitas Indonesia (UI) Depok, Jawa Barat Indonesia 16464
Phone: +62 21 788 49120
CellPhone: (_____)
email : syona2@uic.edu

Kathleen Norr, PhD Professor, Department of Women, Children and Family Health Science, College of Nursing, University of Illinois at Chicago 845 S. Damen Ave, Chicago IL 60612
Phone: **+1** 312-996-7940 Email knorr@uic.edu

You can also call my office at the Faculty of Nursing University of Indonesia
Kampus Baru Universitas Indonesia (UI) Depok, Jawa Barat, Indonesia 16464
Phone: +6221 788 49120

What are my rights as a research subject?

If you feel you have not been treated according to the descriptions in this form, or if you have any questions about your rights as a research subject, including questions, concerns, complaints, or to offer input, you may call the call the IRB at Faculty of Nursing University of Indonesia: +6221 788 49120 or the Office for the Protection of Research Subjects (OPRS) at **+1** 312-996-1711 or e-mail OPRS at uicirb@uic.edu.

Remember:

Your participation in this research is voluntary. Your decision whether or not to participate will not affect your current or future relations with the NGOs. If you decide to participate, you are free to withdraw at any time without affecting that relationship.
If you agree to participate, you do not need to sign the consent. You should keep a copy of this document for your records.

I have read and understand about this study and what the investigator will be asked me to do, and that the study is voluntary

_____ _____

Signature of Person Obtaining Consent Date

_____

Printed Name of Person Obtaining Consent

University of Illinois at Chicago
Informasi Penelitian dan Surat Persetujuan Penelitian Untuk Partisipan pada Penelitian Sosial Behavior

Pemulihan dari Adiksi, Hubungan dengan Pasangan dan Perilaku HIV Beresiko

Anda diminta untuk berpartisipasi pada penelitian ini. Peneliti juga diminta untuk menyediakan format persetujuan seperti ini untuk menginformasikan tentang penelitian, menjelaskan bahwa penelitian ini bersifat sukarela dan untuk menjelaskan resiko dan manfaat dari keikusertaan pada penelitian ini serta untuk membantu Anda membuat keputusan. Bila masih ada yang belum jelas, Anda dapat menanyakannya kepada peneliti.

Peneliti Utama : Sri Yona, RN, MN
Departemen dan Institusi : College of Nursing University of Illinois at Chicago
Alamat dan Kontak Informasi: 845 S Damen Avenue Chicago Illinois, U.S.A

Kenapa saya diminta berpartisipasi?

Anda diminta berpartisipasi pada penelitian tentang pemulihan dari adiksi, hubungan dengan Pasangan dan perilaku HIV Beresiko.

Anda diminta untuk berpartisipasi karena Anda adalah perempuan, berusia 18 -46 tahun, pernah menggunakan jarum suntik, dan saat ini dalam proses pemulihan atau methadone program.

Partisipasi Anda bersifat sukarela. Segala keputusan yang akan Anda ambil apakah akan berpartisipasi atau tidak, tidak akan berdampak pada hubungan Anda dengan pelayanan NGO yang Anda terima di Jakarta, Indonesia. Jika Anda memutuskan untuk berpartisipasi, Anda dapat mengundurkan diri kapan saja tanpa memberikan efek pada hubungan Anda dengan NGO.

Kami akan berbicara dengan 20-35 perempuan di Jakarta, Indonesia.

Apakah tujuan dari penelitian ini ?

Penelitian ini bertujuan untuk mengetahui lebih jauh tentang perempuan yang dalam proses pemulihan adiksi, dan hubungan mereka dengan pasangannya serta perilaku HIV Beresiko, sebelum dan setelah mereka berhenti menggunakan jarum suntik.

Prosedur apa sajakan yang dilakukan?

Jika Anda setuju untuk berpartisipasi, maka Anda akan berbincang dengan saya tentang pengalaman Anda sebagai mantan pengguna jarum suntik yang dalam proses pemulihan dan bagaimana keterlibatan pasangan Anda dalam proses pemulihan Anda. Kami mungkin saja akan menanyakan beberapa topik yang sensitif seperti perilaku seksual dan pemakaian jarum suntik Anda saat ini dan di masa lalu. Kami akan berbicara dengan Anda di ruangan tertutup dan saya akan merekam semua perbincangan kita. Lama wawancara sekiar 60-90 menit.

Anda hanya diminta untuk datang ke lokasi penelitian satu kali saja. Setiap saat, Anda dapat menolak untuk menjawab pertanyaan dan atau mengundurkan diri dari penelitian ini.

Apa sajakah resiko atau rasa tidak nyaman yang mungkin terjadi?

Terdapat resiko bahwa orang lain mungkin saja mengetahui bahwa anda berpartisipasi pada penelitian ini, misalnya jika mereka melihat anda datang ke ruangan ini untuk berbicara dengan saya. Anda juga mungkin merasa bahwa anda sebaiknya berpartisipasi karena lokasi penelitian ini adalah di Kios Atmajaya/Yayasan Pelita Ilmu/ Yayasan Hidup Positif yang mendukung penelitian ini. Akan tetapi, keputusan untuk berpartisipasi atau tidak, berada di tangan anda dan peneliti tidak akan memberitahukan kepada NGO tentang siapa saja yang terlibat pada penelitian ini.

Anda mungkin juga akan menjadi tidak nyaman atau stress karena akan mengingat kembali pengalaman anda dimasa lalu tentang pengalaman menggunakan jarum suntik selama wawancara. Jika anda meminta, maka peneliti dapat merujuk anda ke NGO atau petugas sosial yang terkait untuk meminta bantuan.

Apa sajakah manfaat dari keikutsertaan pada penelitian ini ?

Keikutsertaan anda pada penelitian ini mungkin tidak memberikan manfaat langsung kepada anda, tetapi apa yang anda ungkapkan akan menjadi bahan dalam mengembangkan program untuk membantu perempuan seperti anda di masa depan.

Bagaimana dengan privacy dan kerahasiaan ?

Orang yang akan mengetahui bahwa anda terlibat pada penelitian ini adalah tim peneliti. Orang lain di lokasi penelitian mungkin saja juga mengetahui bahwa anda sedang diwawancarai. Akan tetapi, peneliti tidak akan memberikan informasi apapun kepada orang lain tanpa ijin anda. Jadi segala informasi tentang anda hanya akan diinformasikan kepada orang lain jika ada ijin tertulis dari anda atau jika dibutuhkan untuk melindungi hak dan keselamatan atau jika diminta oleh hukum. Keputusan untuk berpartisipasi pada penelitian ini adalah bersifat sukarela, dan tidak akan memberika efek pada hak anda pada pelayanan di NGO.

Diawal wawancara, peneliti akan menggunakan penomeran yang unik untuk mengidentifikasi partisipan. Sehingga, tidak akan ada data personal yang terekam seperti nama**.** Di transkrip wawancara, partisipan akan diidentifikasi hanya berdasarkan nomer. Tingkat pendidikan dan data demografik yang lain akan ditanyakan diakhir wawancara. Jika partisipan menyebutkan nama (diri sendiri atau orang lain) selama wawancara, maka nama tersebut akan dihilangkan dari transkrip.

Apakah saya akan mendapatkan uang pengganti untuk pengeluaran atau keikutsertaaan saya pada penelitian ini ?

Anda tidak akan mengeluarkan beaya apapun selama berpartisipasi pada penelitian ini.

Anda akan menerima uang sebesar Rp 50.000 (cash) diakhir wawancara sebagai pengganti uang transportasi dan waktu yang anda luangkan.

Bisakah saya mundur atau dihilangkan dari penelitian ini?

Jika anda memutuskan untuk berpartispasi, maka anda dapat mengundurkan diri kapan saja tanpa mempengaruhi hubungan anda dengan NGO dimana anda menerima pelayanan selama ini

Siapa yang bisa saya hubungi jika ada pertanyaan?

Silakan hubungi peneliti jika :

- Anda memiliki pertanyaan tentang penelitian ini atau tentang keterlibatan anda pada penelitian ini,
- Jika Anda memiliki pertanyaan, kekhawatiran atau komplain tentang penelitian ini.

Sri Yona, RN, Fakultas Keperawatan Universitas Indonesia
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Kathleen Norr, PhD Professor, Department of Women, Children and Family Health Science, College of Nursing, University of Illinois at Chicago 845 S. Damen Ave, Chicago IL 60612
Phone: +1 312-996-7940 Email knorr@uic.edu

Anda juga bisa menghubungi kantor peneliti di Fakultas Keperawatan Universitas Indonesia
Kampus Baru Universitas Indonesia (UI) Depok, Jawa Barat, Indonesia 16464
Phone: +6221 788 49120

Apa sajakah hak saya sebagai partisipan?

Jika anda merasa diperlakukan tidak sesuai dengan apa yang telah dijelaskan tentang prosedur penelitian, atau jika anda memiliki pertanyaan tentang hak anda sebagai partisipan, termasuk pertanyaan, kekhawatiran atau komplain, atau ingin memberikan masukan, maka anda dapat menghubungi IRB di Fakultas Keperawatan Universitas Indonesia : +6221 788 49120 di Depok atau the Office for the Protection of Research Subjects (OPRS) di Chicago, telp: +1 312-996-1711 or e-mail OPRS at uicirb@uic.edu.

Mengingatkan:

Partisipasi anda pada penelitian ini bersifat sukarela. Segala keputusan apakah berpartisipasi atau tidak berpartisipasi tidak akan mempengaruhi hubungan anda dengan NGO. Jika anda memutuskan untuk berpartisipasi, anda dapat mengundurkan diri kapan saja tanpa mempengaruhi hubungan anda dengan NGOs.
Jika anda menyetujui untuk berpartisipasi, anda tidak perlu menandatangani surat persetujuan ini. Anda sebaiknya menyimpan fotocopi dukumen ini sebagai berkas anda.

Saya telah membaca dan mengerti tentang penelitian ini dan hal-hal yang akan diminta oleh peneliti untuk saya lakukan, dan penelitian ini bersifat sukarela.

_____ _____

Tanda tangan yang meminta Surat Persetujuan Tanggal

_____

Nama yang meminta Surat Persetujuan

APPENDIX C:

INTERVIEW GUIDE

1. **Interview Guide (English**)
2. **Interview Guide (Bahasa Indonesian)**

Recovering from Addiction, Relationships and HIV Risk Behavior
Interview Guide

Introduction: Today, I want to talk with you about your experiences with stopping drug use, HIV risk and how your relationship with your male partner or partners has influenced your experiences. I'm really interested in learning from you about your own experiences.

A. Recovery

1. Tell me what it's been like for you to stop using drugs.
   PROBES: (If not discussed or incomplete)
   - How long ago did you stop?
   - What made you decide to stop using drugs at this time?
   - What has helped you to stop?
   - What has made it hard to stop?

2. Since you quit this time, have you ever relapsed? Tell me about it.
   PROBES: (If not discussed or incomplete)
   How many times has it happened since you stopped this time (USE time she already gave)
   ASK for each time: how long did you do drugs again?
   - How did it happen?
   - Did anyone encourage you to start using drugs again? (if yes, probe for partner)
   - Did you share needles or equipment when you used again?
   - What made you stop?

3. What's your life like now that you've stopped using drugs?
   PROBES: (If not discussed or incomplete)
   - What sorts of things do you do most days?
   - What do you like about your life now?
   - What things are hard for you or giving you trouble now?
   - Where do you live and who lives with you?
   - Do you have a partner you live with?
   - Do you have any children?
   - Do they live with you? Who take care of them?

B. Current Relationship

Now, I would like to talk about your current relationship

1. Do you have a partner(s) right now?
   [IF NO, GO TO NEXT SECTION]
   [IF YES} How many partners do you have right now?
   IF MORE THAN ONE, ASK: Which man is the most important in your life? I'd like you to talk about that person.

2. Tell me more about your partner, like how you met and how long you've been together.
   PROBE:
   - Does he use drugs now? Did he use drugs in the past? Did you and he ever do drugs together

3. <u>Perception About Relationship:</u> <u>CATHEXIS</u>
   Tell me about your relationship with your current partner.
   PROBE:

How much do you trust him?
How much do you share your thoughts and feelings with him?
How do you think he feels about you?
How much time do you spend together? What do the two of you do to relax or have fun?
Are there any things you'd like to talk about with him that you don't feel you can talk about together?
What do you do when you and your partner have a disagreement?
Tell me the last time about you have disagreement and what happened.

Intimate partner violence

4. Has your partner ever hit you, kicked you or hurt you in some way? IF YES, tell me about the last time this happened.
   Does your partner ever embarrass or humiliate you? IF YES, tell me about the last time this happened.
   Does your partner try to control where you go or what you do? IF YES, tell me about the kinds of things he does.

Sexual POWER

5. How do you feel about your sexual relationship?
   PROBE: Have you ever discussed your sexual relationship with your partner?
   How does the communication go? Who usually initiate the conversation?
   Who decides when you will have sex?
   Do you feel like you can refuse to have sex if you don't want to?
   Tell me how often your partner use condoms when the two of you have sexual relations.
   How does your partner feel about using condoms when he has sex with you?
   Have you ever asked your partner to use condom?
   If No, PROBE: What are the reasons that you do not ask him?
   If Yes: PROBE: How did you make him to decide to use condom?

Economic DIVISION OF LABOR: If she stays together with her partner

6. Tell me how you and your partner manage money in your house.
   PROBE: How much does your partner contribute to your household expenses? How much do you depend on him economically? Do you give him money?
   Who makes decisions about how money gets spent, do you and your partner has control for financial issue in your home?
   Does your partner sometimes tell you to have sex for money with other people?

If she does not stay with her partner;

Tell me how you manage your money in your house
Who has control for financial issue in your house ? family? friend?
Do you sometimes have sex for money with other people?

C. Current HIV risk behaviors

Next I'd like to talk about the kinds of things women do that might lead to getting HIV infection. You've already stopped injecting drugs, and that's great because one common way people can get HIV is from sharing their needles or other drug use equipment. Another way women can get HIV is from their sexual partners.

1. Since you stopped using drugs, how many male sexual partners have you had?
   PROBES: (If not discussed or incomplete)
   How often did you use condoms with your sexual partner(s)?
   How did you and your partner come to use condoms? [who suggest to use condoms?

2. Besides the partners you've mentioned, since you stopped using drugs, have you had sex with men for money, gifts or favors?
   PROBES: (If not discussed or incomplete)
   About how often do you do this?
   When you have sex for money, gifts or favors, do you use a condom? Why or why not?

3. One way to reduce the risk of getting HIV is to get your partner to use a condom.
   What has been your experience with using condoms, including female condoms?
   PROBE: Tell me more about when you use a condom and when you don't.
   Tell me more about the last time you used a condom.
   Tell me more about the last time you had sex and didn't use a condom

Is there anything else you would like me to know about your relationship?

D. Previous Drug Use and Past Risky Behaviors

1. <u>Initial drugs use</u>
   For the next part of the interview, I would like to ask about how you got started using drugs
   Tell me about the first time you injected drugs
   PROBES: How old were you?
   Who did introduce you to using drugs?
   How did you get your drugs and needle? Did you share needles or equipment?

2. <u>HIV Risk behavior: Primary Partner in the 2 months before quitting</u>
   In the 2 months before you quit using drugs, how many partners did you have at that time?
   If 1 or more continue] I'd like you to think about the one who was most important man in your life on that time and tell me about your relationship?
   PROBE: Could you tell me more detail about him?
   Did he use drugs? Did he influence you to initiate drugs?
   Did you borrow or share needles or equipment with your partner?
   Did you use condoms with him? How often?
   How did your relationship with him change when you stop using drugs?
   How much did you trust him?
   How much did you share your thoughts and feelings with him?
   Had your partner ever hit you, kicked you or hurt you in some way? IF YES, tell me about the last time this happened?
   Had you ever discussed your sexual relationship with your partner?
   How much did your partner contribute to your household expenses?

3. <u>HIV testing:</u> Now I'd like to ask you about HIV testing.
   PROBE: Have you ever been tested for HIV? When?
   Have you shared your results with your partner?
   Has your current partner had an HIV test?
   Has he shared his results with you?

Is there anything else you would like me to know about your relationship?

Socio-Demographics:

Now, I want to ask a few more details about you:

1. How old are you?
2. What is your religion?
3. What ethnicity are you?
4. What is the highest level of school that you completed?
5. Tell me all the people who live together in your household [if she lives with others such as family, friends and others]

Pemulihan dari Adiksi, Hubungan dengan Pasangan dan Perilaku HIV Beresiko
Interview Guide

Pendahuluan: Hari ini, saya akan berbincang dengan anda tentang pengalaman anda setelah anda berhenti menggunakan jarum suntik. Kita akan membahas tentang pengalaman selama proses pemulihan dari adiksi, hubungan dengan pasangan dan perilaku HIV beresiko. Saya ingin mengetahui lebih banyak dari pengalaman anda.

E. Pemulihan

4. Jelaskan tentang diri anda setelah berhenti menggunakan jarum suntik.
   PROBES: (jika tidak dibahas atau inkomplit)
   Berapa lama anda berhenti menggunakan jarum suntik?
   Hal-hal apa saja yang membuat anda memutuskan untuk berhenti menggunakan jarum suntik?
   Apa sajakah yang mendorong anda untuk berhenti?
   Apa sajakah yang menbuat anda susah untuk berhenti?

5. Setelah anda berhenti, apakah anda pernah relaps? Jelaskan!
   PROBES: (jika tidak dibahas atau inkomplit)
   Berlama kali anda relaps setelah anda berhenti menggunakan jarum suntik kali ini? (setelah berhenti)
   Berapa lama anda menggunakan jarum suntik lagi?
   Bagaimana hal tersebut bisa terjadi?
   Apakah ada seseorang yang mendorong anda untuk menggunakan kembali jarum suntik? Jika ya, probe untuk pasangan
   Apakah anda berbagi jarum atau peralatan dengan pasangan?
   Apa yang menyebabkan anda untuk berhenti?

6. Bagaimana dengan kehidupan anda setelah berhenti menggunakan jarum suntik?
   PROBES: (jika tidak dibahas atau inkomplit)
   Apa yang biasa anda sehari-hari?
   Hal-hal apa sajakah yang anda sukai dalam kehidupan anda saat ini?
   Hal-hal apa saja yang memberatkan atau menjadi tantangan dalam kehidupan anda saat ini?
   Dimana anda tinggal dan dengan siapa anda tinggal?
   Apakah anda memiliki partner atau pasangan?
   Apakah anda memiliki anak? Berapa?
   Apakah anda tinggal dgn anak anda? Siapa yang biasa mengurus anak-anak?

F. Hubungan dengan pasangan saat ini

Sekarang, saya akan bertanya tentang hubungan anda dengan pasangan anda saat ini

7. Apakah anda memiliki pasangan saat ini?
   [Jika tidak, lanjut ke pertanyaan berikutnya]
   [Jika ya] Berapa orang pasangan anda saat ini?
   Jika memiliki lebih dari 1 pasangan, Tanya: Pasangan yan mana yang merupakan pria paling dekat dalam kehidupan anda? Kita akan membahas tentang dia.

8. Bisakah anda jelaskan lebh detail tentang pasangan anda, seperti bagaimana anda bertemu dengan dia dan berapa lama anda berhubungan dengan dia?

PROBE:

Apakah dia masih menggunakan jarum suntik saat ini? Dimasa lalu? Apakah anda pernah memakai jarum suntik bersama bersama?

9. Persepsi tentang relationship: CATHEXIS

Jelaskan hubungan anda dengan pasangan anda saat ini.

PROBE:

Seberapa percaya anda dengan dia?

Seberapa banyak anda berbagi pikiran dan perasan dengan dia?

Menurut anda,bagaimana perasaan dia kepada anda?

Bagaimana anda membagi waktu dengan dia? Apa saja yang biasa anda lakukan berdua di saat senggang?

Apakah ada sesuatu yang anda ingin diskusikan tentang dia tapi anda merasa tidak bisa atau susah mengungkapkanya?

Apa yang anda lakukan ketika terdapat perbedaan pendapat antara anda dan pasangan?

Jelaskan kapan terakhir anda memiliki perbedaan pendapat dengan dia dan apa yang terjadi saat itu?

Intimate partner violence

10. Apakah dia pernah memukul, menendang atau menyakiti anda? Jika ya, jelaskan kapan hal tersebut terjadi?

Apakah dia pernah mempermalukan anda? Jika ya, jelaskan kapan terakhir kali hal tersebut terjadi?

Apakah dia pernah mengontrol kemana anda pergi atau apa yg anda lakukan?Jika ya, jelaskan hal-hal apa saja yang dia lakukan.

Sexual POWER

11. Apa pendapat anda tentang hubungan seksual anda?

PROBE: Apakah anda pernah membahas tentang seksualitas dengan dia?

Bagaimana jalannya diskusi? Siapa yang biasanya memulai pembicaraan?

Siapa yang memutuskan kapan anda akan berhubungan?

Apakah anda merasa anda dapat menolak berhubungan jika anda tidak menginginkannya? Jelaskan tentang seberapa sering pasangan anda memakai kondom selama berhubungan?

Apa yang pasangan anda rasakan tentang pemakaian kondom selama berhubungan?

Apakah anda pernah meminta dia untuk memakai kondom?

PROBE:

Jika tidak, apa alasan anda untuk tidak meminta dia memakai kondom?

Jika ya, bagaimana cara anda meminta sehingga dia bersedia memakai kondom ?

Economic DIVISION OF LABOR: Jika dia tinggal dengan pasangan

12. Jelaskan bagaimana anda dan pasangan mengatur keuangan rumah tangga?

PROBE: Seberapa besar konstribusi pasangan anda untuk belanja rumah tangga?

Seberapa derajat ketergantungan anda dengan dia secara ekonomi? Apakah anda memberikan dia uang?

Siapa yang mengambil keputusan tentang pembelanjaan dalam rumah tangga? Apakah anda dan pasangan yang mengatur pengeluaran rumah tangga?
Apakah pasangan kadang meminta anda untuk melakukan seks untuk mendapatkan uang?

Jika dia tidak tinggal serumah dengan pasangan
Jelaskan bagaimana anda mengatur keuangan anda ?
Siapa yang mengontrol keuangan dalam rumah anda? Keluarga? Teman?
Apakah anda terkadang melakukan sek suntuk mendapatkan uang?

G. Perilaku HIV beresiko

Selanjutnya, saya akan bertanya tentang hal-hal yang biasa perempuan lakukan yang membuat mereka beresiko terkena HIV.
Anda telah berhenti menggunakan jarum suntik dan hal tersebut adalah hal yang baik karena salah satu metode terkena HIV adalah melalui pemakaian jarum suntik dan peralatan secara bergantian/ bersama.Metode lainnya adalah melalui hubungan seks dengan pasangan

4. Semenjak anda berhenti memakai jarum suntik, berapa pasangan anda selama ini?
   PROBES: (jika tidak dibahas atau inkomplit)
   Seberapa sering anda memakai kondom dengan pasangan?
   Bagaimana anda dan pasangan memutuskan untuk memakai kondom? Siapa yang menyarankan?

5. Selain dengan pasangan anda saat ini, apakah anda pernah melakukan seks untuk uang, gift atau yang lain dengan pria lain di masa lalu?
   PROBES: (jika tidak dibahas atau inkomplit)
   Seberapa sering anda melakukan hal tersebut?
   Ketika anda berhubungan demi uang atau gift, apakah anda memakai kondom? Jelaskan

6. Salah satu cara untuk mengurangi resiko terkena HIV adalah dengan memakai kondom. Bisakah anda menjelaskan pengalaman anda terkait dengan pemakaian kondom, termasuk kondom perempuan?
   PROBE: Jelaskan kapan anda memakai atau tidak memakai kondom
   Jelaskan kapan terakhir kali anda memakai kondom
   Jelaskan kapan terakhir kali anda tidak memakai kondom

Apakah ada hal lain yang ingin anda sampaikan terkait dengan hubungan anda dengan pasangan?

H. Riwayat penggunakaian obat narkoba dan perilaku beresiko di masa lalu.

4. Initial drugs use
   Untuk selanjutnya, saya ingin bertnaya tentang bagaimana anda memulai menggunakan obat-obatan. Jelaskan kapan pertama kali anda memakai jarum suntik?
   PROBES: Berapa usia anda saat itu?
   Siapa yang mengenalkan anda dengan obat-obatan?
   Bagaimana anda memperoleh obat dan jarum? Apakah anda berbagi jarum dan peralatan?

5. <u>HIV Risk behavior: Pasangan utama 2 bulan sebelum berhenti memakai jarum</u>
   2 bulan sebelum anda berhenti, berapa pasangan yang anda miliki saat itu?
   [Jika memiliki lebih dari satu pasangan] saya ingin mengetahui yang man yang merupakan pasangan yang paling dekat dengan anda dan jelaskan tentang hubungan anda dengan dia.
   PROBE: Bisakah anda menjelaskan lebih detil tentang dia?
   Apakah dia memakai obat? Apakah dia yang mempengaruhi anda untuk memulai memakain jarum suntik?
   Apakah anda meminjam atau berbagi jarum atau peralatan dengan dia? Apakah anda memakai kondom dengan dia? Seberapa sering ?
   Bagaimana perubahan yang terrajdi dalam hubungan anda setelah anda berhenti memakai jarum suntik?
   Seberapa percaya anda dengan dia?
   Seberapa banyak anda berbagi pikiran dan perasan dengan dia?
   Apakah dia pernah memukul, menendang atau menyakiti anda? Jika Ya, jelaskan kapan hal tersebut terjadi?
   Apakah anda pernah berdiskusi tentang hubugan seksual anda dengan pasangan?
   Seberapa besar konstribusi pasangan anda untuk pembelanajdan dalam rumaha tangga anda?

6. <u>HIV testing:</u> sekarang, saya ingin bertanya tentang HIV test.
   PROBE: Apakah anda pernah melakukan test HIV? Kapan?
   Apakah anda memberitahukan hasil test ke pasangan anda?
   Apakah pasangan anda pernah melakukan test HIV?
   Apakah dia memberitahukan anda hasil testnya?

Apakah ada hal lain yang ingin anda sampaikan terkait dengan hubungan anda dengan pasangan?

Demografik:

Saat ini, saya ingin bertanya lebih lanjut tentang diri anda.

6. Berapa usia anda?
7. Apa agama anda?
8. Apa suku anda?
9. Apa pendidikan tertinggi anda?
10. Jelaskan tentang orang yang tinggal serumah dengan anda saat ini. [jika dia tinggal dengan orang lain seperti keluarga teman atau dengan yang lain]

APPENDIX D:

CODE DEFENITIONS

No	Code	Definition
A	**Partners – before coding, each transcript was read and the various partners were identified so that they would be consistently coded throughout! Note that if the woman is still in a relationship with the same man, it is coded as a current partner throughout although she may describe their relationship in the past as well as now.** **Some of the women also reported having sex for money currently (n=1) or in the past – these were not considered "partners" and are not coded as partners (in fact the women did not describe them individually). This is coded as HIV risk-multiple partners**	
	Current Primary Partner (CPP)	• A current relationship with a man that a woman perceives as important or close for her. • If the woman has more than one current partner (there are only 2 cases with 2 or more current partners). Both are married, and we have defined her husband or live-in partner as her current primary partner (in both cases the woman is close to the husband) and the partner so this is a somewhat arbitrary decision but provides a clear way to differentiate the 2 current partners). The other current partner is coded as the current non-primary partner
	Current non primary partner (CNPP-A; CNPP-B)	Any additional current relationship with a man who is not the primary partner (in only one case, the woman has 3 current partners and they are coded A and B, with B being the one the woman feels least close to)
	Past primary partner (PPP-A; PPP-B)	• A man that a woman perceives as important/ close in her past • Only 1 woman reported 2 past primary partners – in this case they are "a" and 'b"
	Past non primary partners (PNPP-A etc.)	Any additional relationships with men that a woman had that were not primary partner – numbered to differentiate if she talked about more than one..
B	**HIV RISK BEHAVIORS – current**	
	HIV status	Any result of HIV test that show whether she or her

		partner is positive or negative of HIV if tested.
	HIV risk behavior: share needle	Whether a woman share needle or not with others in the past or current (relapse)
	HIV risk: multi-partners	Whether a woman is at risk of HIV due to herself or her partner is having more than one sexual partners.
	HIV risk: multi-partners PAST	Whether a woman is at risk of HIV due to herself or her partner having more than one sexual partner IN THE PAST
	Condom use CURRENT	Any discussion about condom use and whether they use condoms or not in their relationship or sex IN THE PAST
	Condom use PAST	Any discussion about condom use and whether they use condoms or not in their intimate relationship or sex IN THE PAST
C	**RECOVERY PROCESS**	
	Reasons to stop using drugs	Any reasons that motivated a woman to stop using drug
	Support to quit drug	Any factors that encouraged or helped a woman to quit drug or not to relapse
	Relapse	Whether a woman used drugs again after quitting drugs
	Recovery process	Any process that a woman went through to stop addiction
	Benefits after quitting drug	The advantages the woman expressed about her current situation after quitting drugs
	Challenges after quitting drugs	Any problems that a woman faces after she has decided to quit drugs (an example would be wanting no one to know about her past which makes going to methadone clinic difficult)
	RELATIONSHIP NOTE, coded separately for each relationship the woman talks about	
1	**Cathexis**	
	Trust	The woman's views about whether her partner is/was faithful sexually.

		• Fully : She trusts her partner • Distrust: She does not trust him
	Communication	The degree to which a woman and her partner share information, do not hide any information from each; including how she discusses about sexuality with her partners and condom negotiation. • Open communication:The woman and her partner share all information and do not hide anything from each other • Not open:The women and her partner do not share all information to each other
	Closeness	Feel emotionally connected and tied with a significant person in her life. • Yes: The woman and her partner have emotional connected to each other • No: The woman and her partner do not have emotional connected
2	**Power**	
	Power	Degree of ability to influence her partner to be compatible with her wishes in their relationship and in decision making. • More or equal power The woman can control and active in decision making in her relationship or The woman and her partner have balance power in their relationship • Less power: The woman has less control/ authorize in decision making in her relationship
	Intimated Violence Partner	Whether there is physical and sexual abuse from her partner.
3	**Labour**	
	Financial	The level of a woman's economic dependency on her partner, include whether she earn one or not, or get money from other or receive other support for living.

		• Dependent: The woman is economically depend on her husband • Independent:The woman has earn money or receive other support for living • Shared:The woman share the financial responsibility with her partner in their relationship
	Cultural expectation for financial	Statements reflecting the Indonesian norms that husband should provide financial support to their family

APPENDIX E:

WITHIN AND ACROSS CASE MATRICES

1. Matrix 1. Theory of Gender and Power, Relationship Characteristics
2. Matrix 2: Factors Related to HIV Risk

Mstrix 1. Theory of Gender and Power, Relationship Characteristics

No	Case #	Open Communication:	Trust	Closeness	Power: Equal/More	Labor: Independent/ shared	Gender & Power with partner
		Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Balanced/ Male dominant
1	R3	Yes	Yes	Yes	Yes	No	Balanced
2	R6	Yes	Yes	Yes	Yes	Yes	Balanced
3	R17	Yes	Yes	Yes	Yes	No	Balanced
4	R21	Yes	Yes	Yes	Yes	Yes	Balanced
5	R23	Yes	Yes	Yes	Yes	Yes	Balanced
6	R29	Yes	Yes	Yes	Yes	Yes	Balanced
7	R30b	Yes	Yes	Yes	Yes	Yes	Balanced
8	R7 BF B*	Yes	Yes	Yes	Yes	Yes	Balanced
9	R11	Yes	Yes	Yes	Yes	Yes	Balanced
10	R20#	Yes	Yes	Yes	Yes	No	Balanced
11	R28#	Yes	Yes	Yes	Yes	Yes	Balanced
12	R12	Yes	Yes	Yes	Yes	Yes	Balanced
13	R15	Yes	Yes	Yes	Yes	No	Balanced
14	R18	Yes	Yes	Yes	Yes	No	Balanced
15	R27	Yes	Yes	Yes	Yes	Yes	Balanced
16	R14 1. BF B* 2. BF C	Yes No	Yes No	Yes No	Yes	No Yes	B- Balanced C-Male dominant
17	R24	Yes	Yes	Yes	No	No	Male dominant
18	R16	Yes	No	Yes	Yes	No	Male dominant
19	R13	No	No	No	No	No	Male dominant
20	R26	No	Yes	No	No	No	Male dominant
21	R8	No	No	Yes	No	Yes	Male dominant
22	R19	No	Yes	Yes	No	No	Male dominant
23	R22	No	Yes	No	Yes	Yes	Male dominant

Matrix 2: Factors Related to HIV Risk

No	Case #	Gender & Power with partner	Current condom use	NGO reinforcement	HIV status W/M	Marital status	Length years
1	R3	Balanced	Consistent	Yes	+/+	Married	8*
2	R6	Balanced	Consistent	Yes	+/+	Married	4
3	R17	Balanced	Consistent	Yes	+/+	Married	13*
4	R21	Balanced	Consistent	Yes	+/+	Dating	7 months
5	R23	Balanced	Consistent	Yes	+/+	Dating	3
6	R29	Balanced	Consistent	Yes	+/-	Married	7
7	R30b	Balanced	Consistent	Yes	+/-	Married	6*
8	R7 BF B	Balanced	Consistent	No	+/0	Cohabiting	5*
9	R11	Balanced	Never	No	-/-	Married	1
10	R20	Balanced	Never	No	+/0	Cohabiting	3
11	R28	Balanced	Never	No	+/-	Dating	7
12	R12	Balanced	Inconsistent	No	-/+	Married	13
13	R15	Balanced	Inconsistent	No	+/+	Married	3
14	R18	Balanced	Inconsistent	No	+/+	Married	5
15	R27	Balanced	Inconsistent	No	-/-	Married	9*
16	R14 1. BF B 2. BF C	B- Balanced C-Male dominant	Inconsistent	No	+ 0 0	B: Dating C:Dating	1 6 months
17	R24	Male dominant	Inconsistent	No	-/+	Married	10*
18	R16	Male dominant	Inconsistent	No	+/+	Siri' Married	3
19	R13	Male dominant	Never	No	+/-	Married	12*
20	R26	Male dominant	Never	No	-/-	Married	3*
21	R8	Male dominant	Never	No	+/+	Siri' Married	6*
22	R19	Male dominant	Inconsistent	No	+/0	Siri' Married	6
23	R22	Male dominant	Inconsistent	No	+/+	Married	8

*: the same partner before and after quit drug

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EDUCATION

Master of Nursing: Flinders University, South Australia, 2006

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PROFESSIONAL EXPERIENCE

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HIV/AIDS Clinical Nurse Instructor at Cipto Mangunkusumo, 1999-2009

Hospital and University of Indonesia College of Nursing, Jakarta, Indonsesia, 1999-2002

Lecturer- Medical Surgical Nursing Department, College of Nursing, University of Indonesia, Jakarta, Indonesia, 1999-present

Coordinator for HIV/AIDS Course- University of Indonesia, College of Nursing postgraduate and undergraduate program, Jakarta, Indonesia 1996- 2005

HONORS AND AWARDS

Beverly J McElmurry scholarship, 2013

Ohlson Scholarship, Global Health Leadership office, University of Illinois at Chicago , 2012.

Award from University of Indonesia: category “writing textbook national and international scale” with the title of the book: Patient's Perspective: Self-management of type 2 Diabetes Mellitus in Indonesia, 2010

Australian Development Scholarship, for Master Degree at Flinders University, Australia, 2005

Pre-doctoral Traineeship, Fogarty AIDS International Training and Research Program at the University of Illinios at Chicago, 2009

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OTHER EXPERIENCE AND PROFESSIONAL MEMBERSHIP

American Public Health Association (USA)- Member.

Midwestern Nursing Research Society, USA

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University of Indonesia, College of Nursing HIV/AIDS Development Program- Team Member.
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PRESENTATIONS

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