

# INDONESIA

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## **Current Status of HIV/AIDS in Indonesia and Prospects for its Spread**

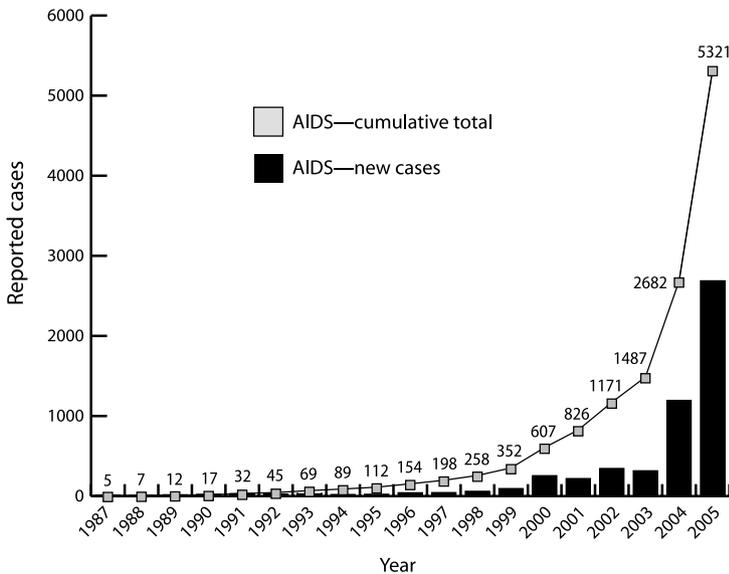
The first case of AIDS was identified in Indonesia in 1987 in a foreign male tourist. During the decade thereafter, the epidemic appeared to grow slowly, spreading primarily among men and almost exclusively through sexual transmission.<sup>1</sup> In the mid-1990s, however, injecting drug use, which historically had been very limited in Indonesia, began to increase dramatically. Community workers who were aware of the phenomenon expressed concern about the threat of HIV in the growing population of injecting drug users (IDUs).

Around the turn of the century, both the number and geographical distribution of drug-related AIDS cases began to rise sharply. While in 1993 there had been only one known IDU who was HIV-positive in Jakarta, by March 2002 there were 116 reported cases in 6 provinces, and two years later there were 922 cases in 23 provinces. During this same period, high infection rates began to be noted among prisoners as well. For example, 56% of drug-using prisoners on Bali were found to be HIV-positive. Likewise, infection rates among sex workers in some parts of the country also

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1. A total of five cases were reported in 1987. Over the next eight years, only 107 additional cases appeared. By contrast, in the first quarter of 2005 alone, 440 new cases were reported.

**Figure 1. Reported AIDS cases in Indonesia—cumulative total and new cases reported through end 2005**



Source: Indonesia Directorate General of Communicable Disease Control and Environmental Health (CDC; 2005).

began to rise. Prevalence among female sex workers, which had been 1% in 1995–1996, had climbed to more than 5% in several provinces by 1999, with a high of 26.4% in the Merauke district of Papua province (National AIDS Commission 2003).<sup>2</sup>

This shift in the mode of transmission from almost completely sexual transmission to progressively more IDU-based infection is only one of several changes in the epidemic in recent years. Early on, it was almost exclusively men who were directly affected by HIV. By the end of 2005, women represented roughly 21% of newly reported HIV and AIDS cases. However, variation across the country is significant. In Papua, for example, women accounted for 44% of new cases.

2. In Tanjung Balai Karimun, in the province of Kepulauan Riau, the infection rate among sex workers was 1% in 1995–1996 but had reached 8.38% by 2000. In Jakarta, rates had reached 3.36% in North Jakarta and 5.5% in West Jakarta (National AIDS Commission 2003).

Geographically the change is also striking. While initially HIV/AIDS was concentrated in a few major population centers, by March 2005 it was affecting both urban and rural areas; AIDS cases had been reported in 29 of 31 provinces and HIV cases had been reported in all provinces (CDC 2005).

In the early years (1987–1999), Indonesia was consistently listed among countries having “low level” epidemics. Eventually, pockets of rapidly rising HIV prevalence were identified among people with high-risk behavior—IDUs, male and female sex workers and their clients, men who have sex with men (MSM), and the prison population. Indonesia’s epidemic was classified as a “concentrated” epidemic.<sup>3</sup> Recently (2003–2005), in at least a few areas, HIV infection has been found more frequently among monogamous housewives, and a number of babies have been born HIV-positive as well.

Intensely urban Jakarta, the national capital, and Papua, the country’s largest and most sparsely settled province are the two provinces most seriously affected by the epidemic. Papua is the first to show signs that the epidemic may indeed have reached the general population. As of June 2005, the national AIDS case rate was 1.67 per 100,000 among individuals aged 15–49 (using the 2000 census as the base). Papua’s case rate was 26.65 per 100,000 and Jakarta’s was 19.35—both many times higher than the national rate. An additional issue of concern in Papua has been a persistent and growing imbalance between the spread of HIV/AIDS among the ethnic Papuans and other people in the province, with the Papuans being much more seriously affected.

By September 30, 2005, the government’s quarterly report on HIV/AIDS indicated a cumulative total of 8,251 HIV and AIDS cases—of which 4,065 were HIV cases and 4,186 were AIDS cases (see fig. 1). However, it is understood that this is only the tip of the proverbial iceberg. The gap between these reported cases and the government estimates of 90,000–130,000 people actually infected as of 2002 (CDC 2002) reflects the size of the task facing Indonesia in responding to the epidemic and bringing it under control.

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3. A “concentrated” epidemic is officially defined as an epidemic in which prevalence rates are 5% or higher among certain sub-populations.

## Challenges in Dealing with the Epidemic

### *Size and Diversity*

The fourth largest country in the world, Indonesia has a total population of over 206 million people who live scattered unevenly across the more than 17,000 islands that comprise the world's largest archipelago (Gov't. of Indonesia 2005). There is uneven access to communication and health services throughout the country. Any effective response to the epidemic will require careful, on-going monitoring and surveillance and high levels of local adaptation in programs to assure appropriate, effective action.

### *Thriving Sex Industry and Low Condom Use in All Contexts*

Indonesia has an estimated 250,000 sex workers (male, female, and transgender), and an estimated 8.5 million men buy sex annually (CDC 2002). In the early years of the AIDS epidemic, the spread of infection was largely tied to sexual activity—both through the commercial sex trade and the widespread practice of unprotected sex with both regular and casual partners.

### *Mounting an Effective Response to Injecting Drug Use*

In some parts of the country, injecting drug use accounts for 70%–80% of reported new infections. It is crucial that efforts be made to limit the damage caused by existing drug use and to bring its spread under control. Nonetheless, reaching drug users is extremely difficult. Likewise, harm reduction, prevention, and treatment are challenging for reasons of public policy, public opinion, and the complexities of treatment. While consensus has been reached among those concerned with HIV/AIDS, public health, and drug abuse in Indonesia about what needs to be done, progress remains slow, and some relevant laws have yet to be amended.

### *Inconsistency between Knowledge and Behavior*

Although much effort has been invested in promoting consistent condom use in high-risk sex, progress is slow. The challenge is to influence behavior, not just communicate information. Studies in several parts of Indonesia and among different segments of the population (sailors, high school students, IDUs, and truck drivers) have found with remarkable consistency that even when respondents know about the dangers of unprotected sex

and the protection from disease offered by condoms, their use was still low (Pisani et al. 2003; Pisani et al. 2004; MAP 2004). The same is true of needle sharing. Studies of knowledge and behavior find ever higher levels of understanding. And yet needle sharing and resistance to condom use continue to be the norm.

### ***Poverty***

The long-term impact of the economic crisis that hit Southeast Asia in the late 1990s contributes to the growing epidemic in Indonesia. Much of the progress in eliminating poverty that had been made in the 1970s, 1980s, and early 1990s was wiped out. Moderate and severe poverty are again facts of life for much of the population, and low levels of education are common. Globally, these are factors that often increase vulnerability to HIV infection, putting particular pressure on women to enter high-risk work situations to support, or to contribute to the support of, their families. Poverty also forces men and women into long-term migration, a pattern often associated with high-risk sexual behavior.

### ***Limited Health System Capacity***

In Indonesia, the impact of the economic crisis was accentuated and prolonged as it coincided with major political changes—reform, restructuring, and decentralization—triggered by the abrupt resignation of President Suharto in 1998. The promising but still evolving health system was badly hit by this combination of economic and political events. National budgets to keep the system going were sometimes frozen, sometimes reduced. Later, restructuring and decentralization of the government resulted in the transfer of responsibility for certain functions of many departments—including health—from the national to the local level. New systems are still evolving.

### ***Stigma and Discrimination***

Surveys, interviews, and research all indicate that although much progress has been made in recent years, serious problems of stigma and discrimination remain for people living with AIDS and their immediate family and friends. This causes a range of problems for those immediately affected and it discourages people from wanting to know their HIV status. Sadly,

problems of stigma and discrimination are often specifically mentioned in connection with public health facilities, with the result that many people particularly in need of care—female sex workers, transgender people, and others—choose to self-treat or seek out and pay the high price of private healthcare providers rather than use available public health facilities.

### ***Gender Inequities***

In most parts of Indonesia, there is common acceptance of patterns of gender inequity that work to the disadvantage of women and girls and often directly or indirectly increase their risk of HIV infection and limit their access to needed care and treatment. Particularly in sexual relations, male decision making is generally the rule both in and out of marriage, leaving most women little opportunity to influence if and under what circumstances they wish to have sex and whether or not a condom is used.

### ***Opposition Groups on Issues of Prevention, Condom Use, and Harm Reduction***

Small but vocal groups of people in many parts of the country contribute to delays in taking the decisive action needed to help bring the epidemic under control. In many areas, conservative groups (mostly faith-based) equate condom promotion with the encouragement of immoral behavior. They have always resisted condom promotion and any policy related to sex work other than its repression or elimination. In extreme cases, public pressure has forced disruption of commercial sex work, leading to its dispersal through the broader public, with the result that it becomes more difficult to reach sex workers and their clients with HIV/AIDS education, condoms, and more general health services.

In some areas, effective dialogue has led to increased understanding of the seriousness of the threat of HIV/AIDS and the urgency of offering a full spectrum of alternatives to reduce transmission of HIV. In a few areas this has made possible the adoption of comprehensive local regulations, including a requirement of 100% condom use in high-risk sex, an approach particularly effective in areas where sex work is concentrated in specific neighborhoods either informally or in the officially designated areas known as *lokalisasi* (sometimes referred to as “brothel complexes” in English).

There are other problems related to injecting drug use. Needle- and syringe-exchange programs have an important role to play in addressing injecting drug use as a cause of HIV infection, as has been well proven around the world. However, in Indonesia there are legal obstacles to the carrying of needles and syringes. Stemming from this, there is a school of thought that is firmly opposed to needle- and syringe-exchange activity until there has been a change in the law. In 2003, a formal letter of cooperation was signed by the National AIDS Commission and the National Narcotics Board that has made possible increased collaboration on a range of policy issues such as this and on practical field issues as well.<sup>4</sup> The issue was discussed in February 2005 at a National Meeting on Harm Reduction, where the urgency of finding a solution to this problem was emphasized.

While there were also issues that delayed the use of methadone maintenance outside of an extremely limited number of pilot project locations, these have been resolved and scaling-up of services is underway under appropriate medical supervision.

### ***Social and Economic Impact of the Epidemic***

Because of Indonesia's vast size and the relatively brief time since HIV/AIDS began to seriously affect some areas, the social and economic impact is not yet strongly felt on a national level. At the personal and family level, on the other hand, the impact is often severe, and those working with HIV-positive people are energetic in their advocacy for attention to such issues.

### ***What Is the Future of the Epidemic in Indonesia?***

At least three factors make it difficult to generate valid, quantitative projections about how the epidemic will develop in the near term as a national phenomenon: (1) the enormous diversity and wide distribution of the population; (2) the unevenness of the response to HIV both at the individual level and in terms of public policy; and (3) the still limited capacity for voluntary counseling and testing (VCT), which contributes to "blind spots" in our understanding of many aspects of personal behavior as they impact the epidemic. Nonetheless, it is clear that HIV/AIDS is

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4. The Indonesian designation for the agreement is Kesepakatan Bersama Antara Komisi Penanggulangan AIDS (KPA) dengan Badan Narkotika Nasional (BNN) Nomor 21 KEP/MENKO/KESRA/XII/2003 NOMOR b/04/XII/2003/BNN.

increasingly well established in many parts of the country and will not easily be brought under control. In some of the more seriously affected parts of the country, important work is increasingly being done to map various aspects of the epidemic and that work will begin to make possible more accurate local projections.

Notwithstanding the imperfections in the overall picture of the epidemic, knowledgeable observers of the Indonesian scene—both Indonesians and expatriates—are of the view that the situation in Indonesia is grave. On the other hand, it is also generally felt that there remains a brief window of opportunity when, with decisive action, Indonesia can avoid a broadly generalized epidemic.

## **The Government Response to the Evolving Epidemic**

There have been two clearly identifiable phases, a longer period of low prevalence and limited response, followed by a shorter period of much increased activity on many fronts that was stimulated by locally sharp increases in HIV prevalence starting around 2000.

### ***The Early Years***

From 1987 to 2000, the number of people affected, the pace of increase, and the socioeconomic impact did not seem to policymakers to call for any special response. Furthermore, these were years of economic crisis and political transition. Nonetheless, as in many countries, as the global epidemic began to take shape, a working group was formed within the Health Department in 1985, even before any HIV cases had been found in the country. In 1988, in recognition of the disease's presence in Indonesia, HIV/AIDS became a reportable condition and a limited number of laboratories were assigned as HIV test centers. A year later, a program of limited surveillance was started with the testing of female sex workers in select locations and regular screening of blood donations to the Red Cross Blood Transfusion Service.

A multistakeholder process started in late 1993, which culminated in the establishment by presidential decree (Keppres 36/1994) of a National AIDS Commission. That was followed by a succession of ministerial

decrees, including one on the structure and functions of the commission, a second launching the first National HIV/AIDS Strategy, and a third establishing the secretariat of the National AIDS Commission. These are still in effect. The commission, chaired by the coordinating minister of people's welfare and comprised of cabinet ministers, was charged with leading, managing, and coordinating the national response to HIV/AIDS. Local AIDS commissions were also stipulated at the provincial and district levels.

### *The Second Phase*

During the years 2000 and 2001, various changes took place that raised the profile of HIV in Indonesia and resulted in a gradual increase in government attention to the epidemic:

- Surveillance indicated startling increases in HIV prevalence in certain high-risk sub-populations, as well as increased prevalence among low-risk pregnant women seeking counseling and testing. In 1999, prevalence among pregnant women was already 0.35% in Riau and 0.25% in Papua. In Jakarta, it jumped from 1.5% to 2.7% between 2000 and 2001 (National AIDS Commission 2003).
- Data on the rapidly escalating epidemic of narcotics, including injecting drug use, and the high prevalence of HIV where tests were available dramatized the interaction between the two epidemics. In the year 2000, 90% of the IDUs who were tested in one area of Jakarta (Kampung Bali) were HIV-positive.
- The structure of government changed in 2001 from a strongly centralized system to a decentralized system, with major responsibility for HIV and related budgets moving to local government.
- Indonesia joined various international agreements related to HIV/AIDS—in particular the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) and the Association of Southeast Asian Nations (ASEAN) Summit Declaration on HIV/AIDS—which called for new levels of action, monitoring, and reporting.

Reflecting these changes, a new strategy was launched in May 2003 that included calls for 100% condom use in high-risk sex and harm reduction for IDUs, and that opened the door to strengthened partnership between government and civil society.

It should be emphasized that the issue of drugs is not just a “big city” Jakarta challenge. By 2003, when a nongovernmental organization (NGO) began offering VCT service in the provincial capital of Pontianak on the island of Borneo, health officials were taken aback to discover that 70% of the IDUs who agreed to be tested were already HIV-positive (MAP 2004).

The following year began with a new initiative on the part of the government. In January 2004, recognizing the importance of containing the epidemic and limiting the spread to less seriously affected areas, the coordinating minister of people’s welfare, in his capacity as chair of the National AIDS Commission, traveled to Sentani in the province of Papua for a working meeting on HIV/AIDS with governors of the six highest prevalence provinces (see fig. 2) as well as key members of the National AIDS Commission and the chair of Commission VII of the Parliament. The meeting concluded with the adoption of a declaration, the Sentani Commitment, which is a joint commitment of national and local governments to “fight HIV/AIDS through a national movement.”<sup>5</sup> The declaration set out a seven-point program that comprised a comprehensive, integrated response to HIV/AIDS:

- (1) promotion of condom use in all high-risk sex
- (2) harm reduction for IDUs
- (3) improvement of access to treatment including antiretroviral (ARV) treatment
- (4) reduction of stigma and discrimination
- (5) establishment and/or revitalization of local AIDS commissions
- (6) provision of supportive legal and financial environments for the fight against HIV/AIDS
- (7) promotion of multisectoral efforts that are known to be effective

Agreement was also reached on a set of process indicators for monitoring purposes.

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5. At the time of the Sentani Commitment, Commission VII was responsible for women’s affairs, health, social welfare, and family planning. Since that time, however, the work of all parliamentary commissions has been realigned, with the work of Commission VII now falling under the new Commissions VIII and IX. Commission VIII is responsible for religion, the role of women, and social affairs, while Commission IX is responsible for health, family planning, the Food and Drug Administration, National Health Insurance (Askes), labor, and Social Insurance (Jamsostek).

**Figure 2. Indonesian provinces participating in the 2004 Sentani Commitment (in dark gray)**



Note: Prepared with the assistance of United Nations Development Programme.

The Sentani Commitment had the effect of stimulating increased local discussion and action related to the epidemic. The executive and legislative branches of government became involved as well as NGOs. An evaluation conducted in the six provinces at the end of the first year found the following, among other results:

- Deputy governors, who served simultaneously as the chairs of provincial AIDS commissions and provincial narcotics boards, had become much better informed and were deeply committed to the fight against HIV and drugs.
- Local budgets for HIV/AIDS had increased fourfold between 2004 and 2005, going from Rp. 4.2 billion to Rp. 17.4 billion.
- Local regulations to fight HIV/AIDS, including 100% condom use in high-risk sex and harm reduction for IDUs, had been adopted in several areas and were under consideration elsewhere.
- Government-NGO cooperation was stronger in most areas, including regular participation by NGOs in local AIDS commissions.

During the same period, Indonesia joined the World Health Organization's global campaign to provide ARV treatment to all patients who need it. The target was to reach 3 million people by the end of 2005, which required a major expansion of services for both VCT and care, support, and treatment (CST). In 2004, using a combination of national funds and

resources from the Global Fund to Fight AIDS, Tuberculosis and Malaria, the government launched the first phase of a training program that reached 25 hospitals in 14 provinces.<sup>6</sup> By the end of that year, combining newly trained hospitals with existing VCT centers (both NGO and government supported), Indonesia had more than 60 functioning VCT centers.

In 2005, the government is building on the previous year's work in an effort to accelerate outreach and coverage. It is providing training for ARV teams in 50 additional provincial- and district-level hospitals, ensuring that by the end of the year at least one complete center (i.e., VCT and CST, including ARV) will be available in every province. The government is also providing testing centers with the reagents needed for HIV testing. Finally, free treatment of opportunistic infections and ARV treatment is being made available for 10,000 patients.

The Indonesian Forum of Parliamentarians for Population and Development, working in cooperation with the National AIDS Commission and Indonesia's two largest bilateral program partners, carried out a study of relevant existing Indonesian laws to determine the degree to which they supported or created obstacles for the fight against HIV/AIDS. The four laws examined included national legislation on health, epidemics, narcotics, and psychotropic drugs. The study concluded that amendments to existing laws would be most appropriate and action began on this in 2005.

While much activity and progress can be noted in recent years, it must be emphasized that the national response is still well below the level that will be needed to change the direction of the epidemic. The key challenges are providing coverage of effective programs in strategically important areas and building synergy among the multiple components and partners in the national effort.

### ***International Partnership***

In responding to the threat of HIV/AIDS and narcotics, Indonesia has benefited from a range of bilateral and multilateral partnerships. Working

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6. This initiative was launched under Ministerial Decree number 78/MENKES/SK/VII/2004. The decree named the provinces to be covered by the first training for provision of ARV treatment: Papua, Bali, Sulawesi Selatan, Sulawesi Utara, Kalimantan Barat, Jawa Timur, Jawa Tengah, Yogyakarta, Jawa Barat, Jakarta, Sumatera Selatan, Riau, Kepulauan Riau, Sumatera Utara.

with both government and NGOs, international partners have invested time, energy, and money in training, research, capacity building, and support for the delivery of services. They have worked at the provincial and district levels in seriously affected provinces throughout the country.

A particularly attractive pattern used for much of this work has been the subcontracting of work to local groups, providing technical assistance if needed to meet high standards of quality in service, evaluation, and management. The two largest and longest-term partners have been Family Health International (FHI), supported by the United States Agency for International Development (USAID), and the Indonesia HIV/AIDS Prevention and Care Project, supported by the Australian Agency for International Development (AusAID). Between them, they work in 13 provinces as well as at the national level.

On the financial side, more partners have been involved (see table 1). At present, about 70% of HIV/AIDS funding in Indonesia is from international partners and about 30% is from Indonesian sources. Although there is considerable progress in Indonesian funding for HIV/AIDS particularly at the local level, it can be expected that the majority of funding for HIV/AIDS work will continue to come from international sources for the foreseeable future.

**Table 1. International funding for HIV/AIDS programming in Indonesia, 2003–2004 (U.S. dollars)**

Donor	2003	2004
USAID (United States)	9,600,000	8,800,000
AusAID (Australia)	4,760,000	4,760,000
Global Fund to Fight AIDS, Tuberculosis and Malaria	2,100,000	2,000,000
DKT (United States)/KfW (Germany)	1,000,000	3,000,000
UN Joint Action Programme	1,941,073	3,915,675
Médecins Sans Frontières (Belgium)	—	150,000
Cordaid (Netherlands)	239,835	206,657
Save the Children USA	35,000	35,000
Total	19,675,908	22,867,332

Source: National AIDS Commission (2005).

As a recipient of large-scale international support for HIV efforts, Indonesia faces three notable challenges:

- (1) the difficulty of maintaining the identity and integrity of the national response
- (2) the degree to which the respective procedures and standards of planning and accounting for funds are distinctive among donors and other partners
- (3) the problem of displacement of attention and effort from “regular” tasks as donor-supported activities become larger and more complex, and as those budgets outstrip domestic programs

Notwithstanding an increase in positive global discourse on the importance of working toward harmonization of donor support, it would appear that the reality of international assistance is still that many donors take pride in their individuality and have limited latitude within which to adapt to the financial systems of recipients or other donors. Thus, for recipients, “managing” donors and donor accounts continues to be demanding and contributes to the issue we refer to as “displacement of attention and effort.” This is particularly serious where limitations are placed on the addition of new staff. As senior civil servants become responsible for more and more “extra” activity, the day-to-day work of government—planning, monitoring, training, advocacy with other sectors, to name just a few—may lose out.

## Civil Society Responses

Since the earliest days of HIV/AIDS in Indonesia, civil society has often taken the lead in calling for action and moving forward to address problems within its own scope. Responsible NGOs have identified and raised for public discussion a range of policy, program, and service issues important to the development of an equitable and comprehensive response to the epidemic. At their best they have been forceful advocates, compassionate service providers, and sources of reliable, up-to-date scientific and social information important to people living with HIV/AIDS (PLWHA) and their allies.

Some of the first organizations working with HIV/AIDS were NGOs that had long been involved in the reproductive health field or related fields who added HIV efforts to their work as it became apparent this was a new need

among their clients. While some groups were launched at the initiative of medical doctors and their friends, other people were active as well.

As the HIV problem became more pronounced, groups in a few major urban areas—particularly Jakarta, Surabaya (East Java), and Denpasar (Bali)—mounted innovative programs to reach populations at high risk of infection (commercial sex workers, truck drivers, transgender people, prisoners, and MSM) with basic education on HIV/AIDS, condom use, and safe sex, as well as improved sexually transmitted infection services. Other groups provided VCT services and quietly began providing on-going support programs for PLWHA. Coverage, however, was always limited.

While initially it was programs from outside the affected community that carried the message of HIV/AIDS, it soon became clear that the empowerment of community members themselves with information and skills would, in the long run, be more effective. Over time, more and more of the major work of AIDS education, condom distribution, advocacy for legal protection and better service, and the hard work of behavior change has been done by people already HIV-positive or at high risk themselves.

In 1995, a new and important organization, Spiritia, was born in Jakarta, specifically for PLWHA. Formed as “a support group for and by people living with HIV/AIDS,” and involving infected people together with their families, partners, and friends, Spiritia’s work is focused on “empowering HIV-positive people to take control of their own lives” and encouraging them to become involved in the response to AIDS (Spiritia 2004). This work has also led to the formation of the Indonesian Network of People Living with HIV/AIDS, pioneered and maintained by Spiritia as a network that provides moral, emotional, and intellectual support, as well as advice and information to individuals and groups of HIV-positive people. As of 2005, Spiritia works with nearly 50 groups in various parts of Indonesia. Spiritia’s work has contributed greatly to the acceleration of involvement of PLWHA in many aspects of Indonesia’s response to the disease, an approach that is in line with the principle of GIPA (greater involvement of people living with HIV/AIDS) that was enunciated at the 1994 Global AIDS Summit in Paris.

As it became obvious how closely intertwined drug use and HIV are, outreach workers who had regular contact with drug users and those working at the leading drug dependency centers became involved with HIV/AIDS.

They called for more effective action to provide the services necessary to stem the drug epidemic and to limit the spread of HIV among IDUs. In time, they added HIV information and services to their own programs as well.

It was initially assumed by many people that in Indonesia injecting drug use would be a problem of only limited scope found in a few major cities. In fact, it spread with great speed and has now been reported in almost all provinces. By 2002, active IDUs, former IDUs, and those providing services related to drugs felt the need for more effective organization among themselves. In November of that year, a network of organizations and individuals working on harm reduction for IDUs was founded, called Jangkar. Presently, they report 21 organizational and 18 individual members, activities in 11 provinces, and outreach to roughly 10,000 active IDUs. Jangkar is also a member of a regional initiative, the Asian Harm Reduction Network.<sup>7</sup>

A review of the civil society response to the epidemic in Indonesia would not be complete without mention of faith-based activity. Within faith-based organizations, as within the larger society, there has been tension between those opposed to condom use and those comfortable with that approach. Today, although opposition continues in some areas, the full spectrum of religious communities is represented among HIV/AIDS activists—Muslims, Protestants, Catholics, and Hindus. In general, the faith-based groups are most active in prevention, and most give special attention to reaching lay and ordained leaders of their own communities and their young people. In some areas, they also make an important contribution to the provision of more general services—hospital-based testing, community counseling, and clinic-based care and treatment.

As is clear from this review, civil society is involved in most aspects of the struggle with HIV/AIDS in Indonesia. However, coverage is enormously uneven, as is the quality of information and service provided. And this leads to the key question of how these organizations fit into the overall response to the epidemic. The chapter on “Partnerships, Roles and Responsibilities” in the National HIV/AIDS Strategy 2003–2007 provides a clear answer, stating that “NGOs and community-based organizations (CBOs) play a key role in HIV/AIDS prevention in Indonesia.” The importance of NGOs

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7. Based on an oral presentation by Jangkar (Indonesian Harm Reduction Network), using PowerPoint documents prepared 2 September 2004.

for action “on the ground” was clear from the beginning in Indonesia and local AIDS commissions have always had an obligation to provide encouragement, training, and leadership to the NGO community. The current national strategy, however, has taken a major step toward fuller partnership. It calls for the inclusion of NGOs in local AIDS commissions, which will allow their participation in key policymaking on and management of the local response (National AIDS Commission 2002).

What are now the main challenges related to civil society involvement in the fight against AIDS and drugs in Indonesia? There are a number of common issues frequently raised by NGOs themselves: concern about over-reliance on donors and sustainability of their own organizations; difficulty of access to timely technical information, support, and skill training; weak but improving collaboration among NGOs; and, perhaps most importantly, the continuing urgent challenge of scaling up—either on their own or in collaboration with government—to increase quickly and significantly the coverage and effectiveness of prevention education, service, and support.

## Corporate Responses

The consensus of those working on HIV/AIDS with business leaders in Indonesia (Indonesians and expatriates from the UN and in bilateral programs) is that the business community does not yet feel any significant threat from the epidemic. There is some evidence of a difference in attitudes between multinational corporations and domestic companies, with the multinationals tending to be more aware of the epidemic and more likely to have HIV/AIDS-related activities for their workers in line with the policy and programs of the parent company.

However, energetic efforts are underway to stimulate more workplace activity related to HIV/AIDS. During 2003, the International Labor Organization (ILO) Code of Practice on HIV/AIDS and the World of Work was translated into Indonesian, and in 2004, the minister of manpower issued a decree on HIV/AIDS that adopted the principles of the ILO code and set requirements for companies to implement prevention programs and protect the rights of HIV-positive workers. The ILO, in cooperation with government, business, and labor, has facilitated a variety of training

programs for high-level officials to familiarize them with the rationale and content of the code and decree. However, the outreach of the programs is still limited and the business world is vast. (ILO figures indicate a total of 60,000 companies located throughout Indonesia.) It is not surprising, then, that a recent survey of 195 business leaders in three provinces found that 165 had never heard of the code.<sup>8</sup>

A significant step toward broader policy implementation has been taken through integration of HIV prevention into existing national mandatory occupational health and safety programs. This program was launched by the minister of manpower in April 2004. Working with the ILO, FHI, and local NGOs, the Ministry of Manpower will train labor inspectors to facilitate and monitor prevention programs in 9,000 companies, covering an estimated 4–5 million workers in five priority provinces. The final component in this program (funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria in Round IV) will be the training and equipping of 1,000 labor inspectors to monitor HIV/AIDS prevention programs in the five priority provinces. Beyond these programs, FHI has worked with NGO partners to assist 110 companies with 550,000 workers to establish HIV/AIDS prevention programs, the majority of which are supported by the companies themselves.

Although no companies have officially reported workers with HIV, unofficial reports indicate that workers have been dismissed when it was discovered that they were HIV-positive.

## Media Responses

Although from the earliest days of the epidemic there were a few journalists who were seriously interested in HIV/AIDS, in general the media was slow to take up the issue. Occasionally there was a good article, but many others were sensational, inaccurate, and tended to focus on death, sex, or both.

In time, AIDS activists were concerned that the media was feeding the fire of misinformation and contributing to a climate that stimulated

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8. Personal communication between authors and UNAIDS specialist on AIDS in the workplace (13 April 2005).

fear, stigma, and discrimination. In 1994, with the support of the Ford Foundation, the Yogya Institute of Research, Education, and Publication (Lembaga Penelitian, Pendidikan dan Penerbitan, or LP3Y) initiated a regular program of training for journalists. Working with journalists from both print and electronic media from many parts of the country, the institute provided basic HIV/AIDS information and encouraged journalists to form their own groups to continue training and advocacy among their colleagues at home.

Monitoring the coverage of HIV/AIDS over the years, one can observe some positive changes—more frequent coverage, more diverse subject matter, and much wider geographical response to the field. Furthermore, with the increasing number of articulate, HIV-positive people, there are occasionally more positive pictures of people living with AIDS and the lives they can lead. The improvement can probably be attributed to three primary factors: (1) the efforts at media development by the institute, the United Nations Joint Programme on HIV/AIDS (UNAIDS), and others over a ten-year period; (2) the rise to positions of responsibility of some journalists who were among the first trained;<sup>9</sup> and (3) the growing awareness of HIV/AIDS among the public, which encourages the media to step up their coverage. It should also be said that the national and local press are influenced by increasing coverage of HIV/AIDS issues in the international press and by the participation of high-profile international figures in AIDS advocacy.

Notwithstanding the progress, serious problems remain. Observers point out that much of the coverage remains “reactive” and in some sense repetitive. That is, articles tend to appear when there is an “HIV/AIDS event”—a speech, a launching, a commemorative day—and, unless journalists are “fed” specific new information, the basic content is likely to be very similar to past articles. Unfortunately, there also continue to be sensational papers which are irresponsible both in their discussion of HIV/AIDS and their casual violation of the privacy and rights of individual HIV-positive people, publishing names without permission and increasing the likelihood of exposure to stigma and discrimination.

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9. For example, Ms. Nunuk Parwati, presently head of Televisi Republik Indonesia news, was in the first group of journalists trained in 1994.

## Prospects for Regional and International Cooperation

As is well known, both commercial sex and drug use, the twin motors of Indonesia's epidemic, are intimately tied into regional and ultimately global networks that cannot be controlled by any individual or country alone. Personal mobility, often a factor in exposure to infection, is also strongly influenced by local and regional issues of poverty, economic opportunity, and public policy related to them. Addressing any of these issues fully will require effective regional action with strong partnerships between the civilian world, the world of the uniformed services, government programs, and civil society.

There are already many nongovernmental groups and networks that have incidental or regular contact with counterparts throughout the region. For some, HIV/AIDS or narcotics are their *raison d'être*. Others have HIV/AIDS high on their agendas although they address other concerns as well, such as sex work, child abuse, or migrant workers. However, what exists is a patchwork of relationships; groups come together for periodic large regional or inter-regional meetings but have very few sustained working relations except with their issue-specific counterparts in other countries.

At the government level, Southeast Asia has a well established forum for regional cooperation, ASEAN, as well as a full range of UN agencies with regional offices. Since its establishment, ASEAN's fundamental focus has been on regional issues of economic development as well as on peace, prosperity, and stability. Responding to the growing presence of HIV/AIDS and its potential impact on the regional economy and on people's welfare, an ASEAN Task Force on AIDS was established in 1992 and held its first meeting in 1993. Since then, through two successive work plans they have been guided by the principle that "country specific programs remain the most effective response to the epidemic, [nonetheless] a regional approach can effectively and efficiently address commonalities between countries . . . thereby strengthening national responses or address transboundary issues for which inter-country responses have comparative advantage over national approaches" (ASEAN 2002). In this spirit, various important themes have been identified and pursued in collaboration with national and international partners, particularly

UNAIDS and other UN agencies. While the information exchange and encouragement of these activities is beneficial, like many national programs, the ASEAN programs suffer from limited scope and uneven application. This highlights a major challenge to such regional efforts: can devices be developed to increase practical national benefit from their association with such regional efforts?

## Conclusion

The twin epidemics of HIV/AIDS and narcotics are evolving quickly in Indonesia. Given the country's size and diversity, the mobility of its people, the multiple engines driving the epidemic, and the complexity of a number of key policy issues, it is difficult to predict at this time how quickly the epidemic can be brought under control. Ultimately, much will depend on leadership at all levels, the degree to which local communities engage in the battle with HIV, and the effectiveness with which critical services (preventive, promotive, treatment, and support) can be delivered and are accessed by those needing them. While the key to an effective, equitable, humane response to the twin epidemics of HIV/AIDS and narcotics clearly lies in the hands of Indonesia itself, regional and broader partnerships have had and will continue to provide valuable input and should be promoted and sustained.



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