



HIV/AIDS and Other Sexually Transmitted Infections in Indonesia

*Challenges and
opportunities
for action 2001*

Indonesian National AIDS Commission
Republic of Indonesia



Foreword

In assessing the epidemiological situation in Indonesia, one cannot deny that HIV/AIDS is already in Indonesia. The first case was reported in 1987. Cumulatively, just 630 AIDS cases have been reported in Indonesia since then. However HIV prevalence figures paint an alarmingly different picture. In 2001, Indonesian epidemiologists from the Ministry of Health with the assistance of WHO consultants estimated that there are around 80,000-120,000 people living with HIV.

The progression of the disease in Indonesia has followed the same pattern of other countries, appearing first in homosexuals and then in sex workers and their clients -- people who may ultimately spread the disease into the general population. In the last two years, HIV prevalence has increased exponentially among injecting drug users (IDUs).

It has been proven over time, all over the world that HIV/AIDS has major health, political, social, economic and legal consequences, which will touch almost all aspects of human life.

This in turn threatens national development and efforts to improve the quality of life of our people.

Since June 1994, Indonesia has been promoting its National AIDS Strategy through a national effort to control HIV/AIDS, carried out by the government, non-government organizations, private sectors and community, through a multi-sectoral collaboration.

This document reflects the lessons learned and identifies a window for effective prevention. It also looks at the challenges to prevention, and picks out opportunities through which Indonesia can limit the further spread of HIV and its development impact.

We hope that this country report will be able to support the global, regional as well as the Asia-Pacific collaboration in halting the spread of HIV/AIDS as has been stated in the joint declaration of the UNGASS as well as the 7th ASEAN Summit Special Session on HIV/AIDS with the signing of the ASEAN Joint Declaration on HIV/AIDS by the Head of State/Government of ASEAN in November 2001.

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Executive Summary

For many years, very few HIV infections were found in Indonesia, even among groups such as sex workers and drug injectors whose behaviour put them at high risk of being exposed to the virus. In the last two years, this has begun to change. HIV has risen to alarmingly high levels among drug injectors: 40 percent of injectors in treatment in Jakarta tested positive for HIV in 2001. In sex workers, too, HIV has risen sharply in several sites, reaching eight percent in one site in the far west of the country, 17 percent in the capital and 26 percent in one site in the far east. HIV infection rates have also risen among transvestite sex workers, standing at six percent the last time this population was surveyed.

Behavioural surveillance shows that Indonesians are well informed about HIV and how to avoid it. However only a minority of men who had sex with female or transvestite sex workers in 2000 used a condom the last time they bought sex, and fewer than one in 10 use one every time they buy sex. Condom promotion efforts appear to have made little difference to consistent condom use in the highest risk encounters over the past five years. This is probably in part because they have not focused sufficiently on the barriers to condom use. Rising HIV rates in sex workers and drug injectors coupled with low condom use rates in both groups mean that HIV infection will inevitably rise among the sexual partners of these men and women, and some of this infection will be passed on to their infants.

The extent to which HIV infection spreads into the wider Indonesian population will depend on three things. Firstly, it will depend on how much HIV infection is allowed to build up in populations with high-risk behaviour, since these populations provide "reservoirs" which can continue to leak HIV into a wider population. Secondly, it will depend on patterns of sexual networking between people with high-risk behaviour and those with lower risk: sexual relationships between these groups are the pipes through which HIV infection travels. Thirdly, it will depend on how much sexual mixing there is in the population at large: it is this sort of mixing which allows an epidemic to persist even if prevention programmes are successful at bringing down HIV infection in groups with high risk behaviour.

At present, there appear to be plenty of sexual links between high and low risk groups, but sexual networking in the general population remains relatively limited. Indonesia is, however, undergoing extremely rapid social and economic change, and

this change will almost inevitably have some impact on sexual behaviour, in all likelihood removing some of the "traditional" restrictions on sexual mixing.

If Indonesia can manage effectively to limit the spread of HIV in groups with high risk behaviours, and to reduce greatly the unprotected sexual encounters which carry HIV infection between those groups and a wider population, the country will be spared a major epidemic, even if patterns of sexual behaviour in the general population change. The country still has an opportunity to achieve this goal, but with HIV rates rising rapidly in key populations, urgent action is needed now. This action needs to be taken on a large scale, but should remain carefully focused on helping the populations most at risk for infection.

Challenges and opportunities for immediate action include:

- Universal adoption of measures aimed at achieving 100 percent condom use in high risk groups/commercial sex.
- Strengthening community participation in prevention, surveillance, and care.
- Provision of low-cost and effective STI screening and treatment services for women and men who sell sex.
- Active campaigns to discourage young people from starting to use drugs and the provision of services which will reduce the dangers of HIV infection among people who do inject drugs, within the confines of national laws.
- The provision of HIV prevention services for people in situations where the virus may spread rapidly, such as prisons and camps for displaced people.
- Provision of low-cost voluntary HIV testing services with appropriate counselling, and follow-up prevention and care services as needed.
- Empowering women.
- Developing pilot projects for mother-to-child transmission prevention in areas that have high prevalence of HIV, to serve as a model for related interventions.
- Improving human rights policies, laws and regulations to eliminate the stigma associated with HIV.

One thing is needed if all these other elements are to succeed: the commitment of the political, religious and community leaders of Indonesia to join hands with the Indonesian people to protect the country from HIV infection and the devastation it can wreak.

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Key Facts

Population of Indonesia, 2000	209,546,300
Reported AIDS cases, 1987- July 2001	630
Estimated total AIDS cases, 1987- 2000 ^a	5,056
Reported AIDS deaths, 1987- July 2001	217
Estimated total AIDS deaths, 1987- 2000 ^a	3,856
Estimated number of Indonesians living with HIV, 2001	80,000 - 120,000

HIV prevalence measured in different groups:

Highest percent measured in risk group, with number tested, year, location

Brothel-based female sex workers (FSW)	26.5 % (n = 83, Merauke 2000)
Indirect female sex workers (massage)	1.5 % (n = 251, Jakarta 2000)
Transvestite sex workers (waria)	6.1 % (n = 199, Jakarta 1997)
Injecting drug users in treatment	40 % (n = 156, Jakarta 2001)
Male STI patients	1.4 % (n = 273, Bali and Makassar 1999)
Blood donors	0.015 % (n = 708,861, national, 2000)
Pregnant women	0.35 % (n = 287, Riau, 1998/99)
Military recruits	0 % (n = 13,856, national, 1997/88)

Risk behaviour measured in 2000 (3 cities with comparable risk groups)

% sea workers/truckers buying sex last year	46.8 %
% clients always using condoms w. sex worker last year	6.9 %
% clients used condom at last sex w. sex worker	22.1 %
% Sex worker using condoms all clients last week	12.1 %
% Sex worker used condom with last client	41.3 %
% waria used condom with last client	59.9%
% drug injector shared needle in last month	47.0 %

^a Estimates prepared by WHO/UNAIDS Working Group on HIV and STIs, based on Indonesia's national estimate of HIV prevalence in 2001. WHO, Geneva.

1. Introduction

Background

Indonesia is the largest archipelago in the world consisting of more than 13,000 islands. Its population of nearly 210 million people is the fourth largest in the world after China, India, and the USA. Indonesia is a heterogeneous country consisting of over 250 ethnic groups, who speak hundreds of languages and espouse several religions, although the majority are Moslem. People's lives differ widely too. Over a third of the population lives in cities - crowded urban landscapes of modern skyscrapers and modern factories. The greater metropolitan area of the capital Jakarta alone is home to 12 million people - over half as many as the entire continent of Australia. The majority of Indonesians, however, live in rural areas, from the jungles of Sumatra at one end of the country through the rice fields of Java and Bali and the fishing villages and spice plantations of eastern Indonesia to the highlands of Irian Jaya at the other end - a distance that encompasses three time zones and is the equivalent of the distance between London and Moscow.

The country is currently facing an economic, social and political crisis that prevents full-scale implementation of National HIV/AIDS prevention and control programs.

HIV has already reached exceptionally high levels among drug injectors, and is rising rapidly in sex workers

Indonesia is also in the transition from centralised to decentralised administration. Until the mid-1990s, it appeared that Indonesia might escape the worst of the AIDS epidemic ravaging other parts of Asia and the world. But with recent social and economic changes have come a change in the HIV epidemic: the consistently low rates of HIV infection recorded over the last decade are a thing of the past. HIV has already reached exceptionally high levels among drug injectors, and is rising rapidly in both female and male sex workers in some parts of the country. But there is still an opportunity to contain the epidemic before it explodes through other segments of the world's fourth largest population.

This report is intended to give a picture of the

HIV epidemic in Indonesia, using data from many sources. It discusses HIV infection and risk behaviour in various groups whose behaviour makes them particularly vulnerable to HIV infection: sex workers and their clients, injecting drug users, men who have sex with men, and looks also at the problems associated with other sexually transmitted infections. It examines the likelihood that the virus could spread into a wider population: women and men who do not perceive themselves of being at risk for HIV

The report concludes by examining what current trends in the epidemic mean for HIV

prevention and care efforts in Indonesia. There is an opportunity to contain HIV at levels that would limit the development impact of the epidemic, but the opportunity requires immediate action.

The government has made a commitment to supporting that action. The national response began as early as 1986, as described below, but rising rates of infection suggest that more has to be done. The challenge now is to mobilise communities, skills and resources to turn the potential prevention success story into a reality.

National response and policy: part of a global commitment and responsibility

Recognising the threat that a widespread AIDS epidemic would pose to national development, the Indonesian government is acting to step up prevention efforts. A working group was established by the Ministry of Health even before the first case of AIDS was reported in the country in 1987. Since then, HIV/AIDS cases have been reported by 25 out of 32 provinces. In 1994, the National AIDS Commission was established by presidential decree. This brings together senior decision-makers from a number of social and economic sectors, and includes representatives of affected communities, religious leaders, local NGOs, private sectors and others. Similar committees have been formed at the provincial and district levels.

There is still an opportunity to contain the epidemic before it explodes

These committees are guiding the response in locally appropriate ways in Indonesia's newly decentralised governmental system. The Government is working to improve the surveillance system for HIV and behaviours that spread it, to improve data for decision-making so that the response can be intensified appropriately.

Changes in government structure have affected the national response. Currently, the National AIDS Commission is situated under the leadership

District AIDS committees aim to guide the response to HIV in locally appropriate ways in a newly decentralised Indonesia.

of the Coordinating Minister for People's Welfare. This allows leadership around many

of the societal and development aspects of the HIV epidemic, broadening what had previously been a health focus. Many sectors now share in the responsibility for combating the disease. The National AIDS Commission is the coordinating body which address inter-sectoral issues.

The national strategy aims to mobilise families and communities so that the people of Indonesia are able to protect themselves against infection with HIV. The national response also seeks to ensure the appropriate treatment, care and support services for people infected with HIV and their families.

The following specific principles guide the national response:

- HIV/AIDS control is mainly implemented by community participation, and the government should give direction and supervision and create a legal and policy environment in which others can easily work.
- HIV/AIDS control measures should reflect religious and cultural values in Indonesia.
- Activities should be aimed at defending the family welfare and resilience.
- HIV/AIDS prevention should be aimed at educating the public in order to prevent HIV transmission and to change high risk behaviour.
- Every individual has the right to get information on HIV/AIDS prevention.
- Policies, programs, services and activities should respect the dignity of HIV/AIDS patients and their family.

- Counselling should be provided prior to diagnosis and testing for HIV/AIDS and confidentiality should be guaranteed.
- Laws and regulations should be in line with the principles of AIDS control.
- Public services must not discriminate against HIV/AIDS patients.

The National AIDS Commission has identified National Program priorities for the prevention and control of HIV/AIDS. There are 10 priority programs identified: IEC (Information, Education, Communication), prevention, testing and counselling, treatment and care, education and training, research and development, monitoring and evaluation (surveillance), international cooperation, program institutionalisation, and laws and regulations.

With HIV rising rapidly among individuals with high risk behaviour, Indonesia is moving to target its prevention resources to reducing risk among those currently most likely to be vulnerable to infection. This means focusing resources on providing appropriate prevention services for specific sub-populations and in specific geographical areas.

11. The HIV epidemic in Indonesia

HIV/AIDS in Indonesia: a diverse country with a diverse epidemic.

Indonesia's social upheaval is reflected in a changing HIV epidemic: an epidemic that is as diverse as the nation itself. It is impossible to paint a single picture, to squeeze the country into a single, convenient epidemic category. As is to be expected of a country of 210 million people, virtually every behaviour that carries a risk of HIV transmission can be found in Indonesia, along with many behaviours, traditions and cultural institutions that protect against the spread of the virus.

Exact numbers of infected individuals cannot be known in a country this large. Indonesian experts have estimated that between 80,000 and 120,000 Indonesians are currently living with HIV. Numbers aside, As the map in Figure 1 makes clear, a high percentage of people in several sub-populations with risky behaviour are already

infected with HIV, and these high rates are spread from one end of the country to the other.

The very high rates of HIV infection recorded by the national HIV surveillance system among sub-populations with risky behaviour are not reflected in the general population. Data from screened blood donations, illustrated in Figure 2, show that fewer than two people in every 10,000 were infected with HIV by the start of 2001. However even those low rates represent a sharp rise in infection over the last two years.

Until 1998, only 10 or 15 blood bags infected with HIV were typically found among the hundreds of thousands of blood donations which are screened every year in Indonesia as part of the government's efforts to secure a safe blood supply. In the following three years, prevalence among blood donors increased more than tenfold. In fact, more infections were found in the year ending December 2000 than in the whole of the six year period from 1992 to 1998.

Figure 1: HIV prevalence in various groups, Indonesia 2000-2001
(Source: Ministry of Health, as of June 30, 2001)

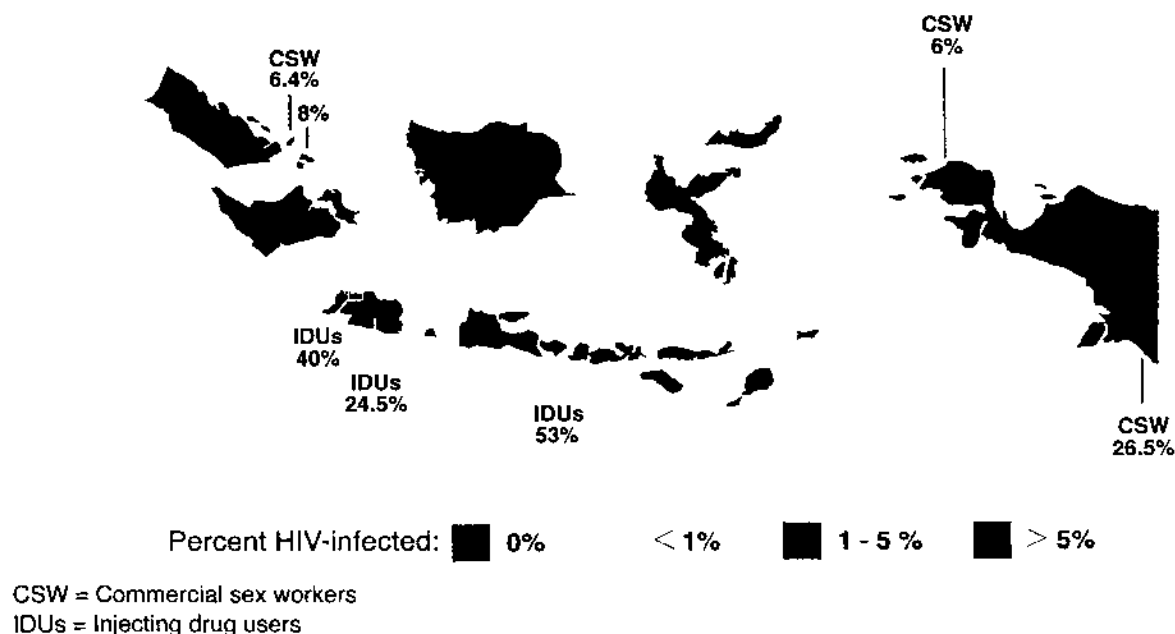
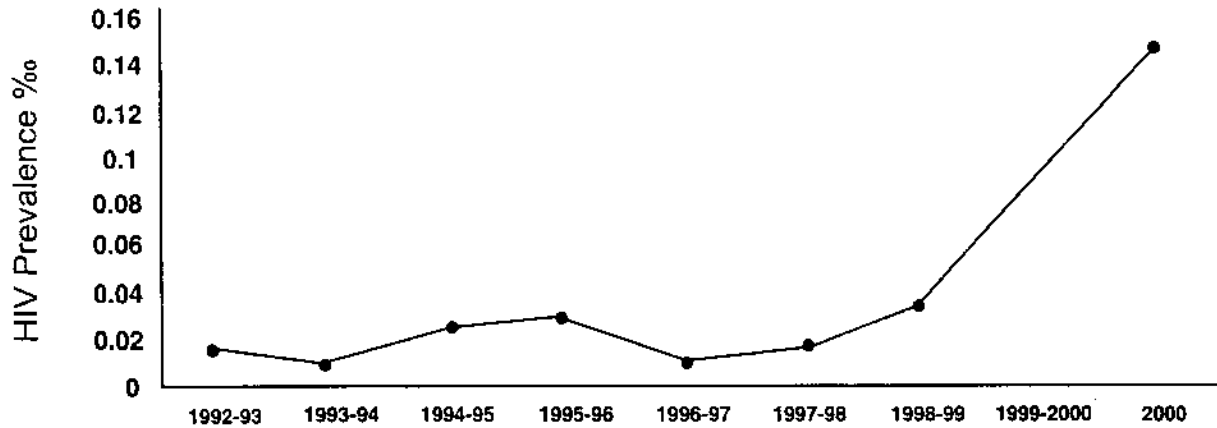


Figure 2 : HIV prevalence among blood donors in Indonesia, 1992-2000
 (Source: Indonesian Red Cross as of 31 December 2000)



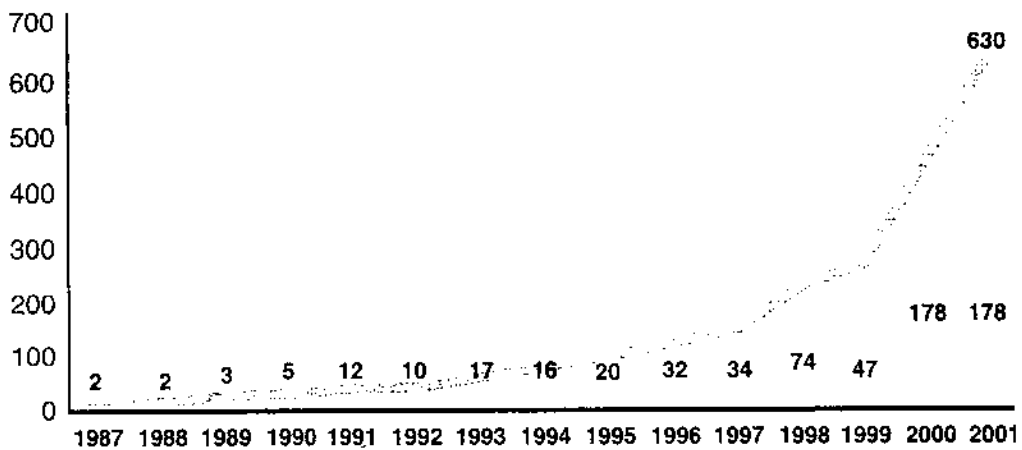
HIV can take many years to develop into AIDS, so current HIV infection will not be reflected in AIDS cases for some time. In addition, only a fraction of AIDS cases are reported to the health authorities. However, AIDS case reporting is a useful tool to look at such details as the age and sex distribution of infection, and the main routes of transmission. It is also vital for helping to plan appropriate care services for those living with AIDS. It should be remembered that AIDS

cases reflect the dynamics of infection up to 10 years ago.

As Figure 3 shows, reported AIDS cases have risen in recent years, although numbers remain small. In the light of the HIV prevalence numbers shown in Figure 1 and the trends shown in Figure 2, we can expect further dramatic rises in AIDS cases over the coming years.

Figure 3 : AIDS cases reported to the Ministry of Health, Indonesia 1987-2001
 (Source : Ministry of Health, as of 31 July 2001)

Number of cases



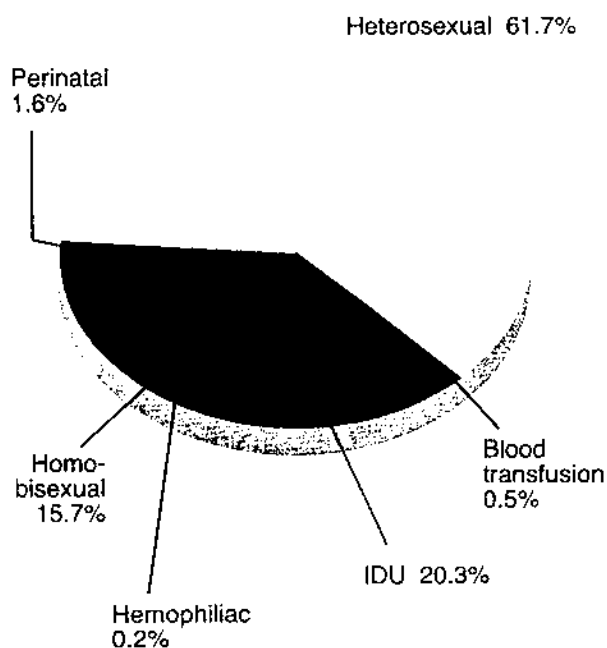
New cases

Cumulative cases

Until recently, the majority of infections reported have been sexual, as Figure 4 shows. However, in recent years injecting drug users have become an

ever more prominent part of the picture, as described on page 21.

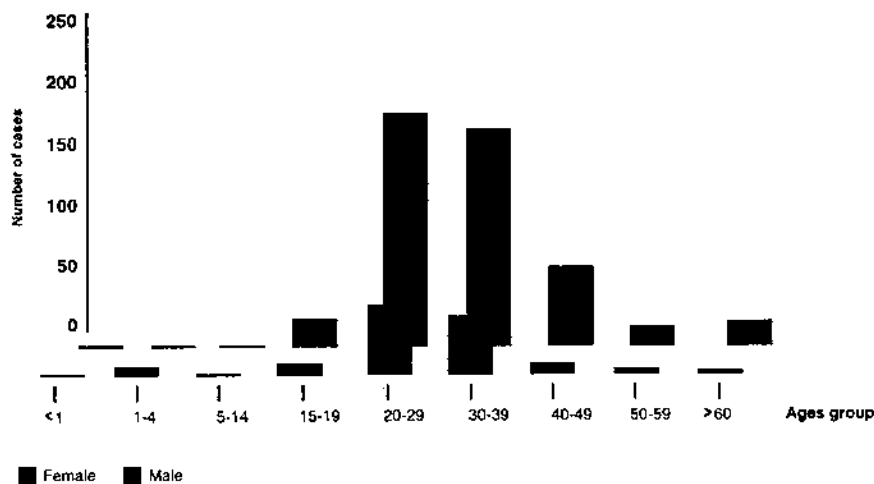
Figure 4: Reported modes of transmission of HIV infection in AIDS cases
(Source : Ministry of Health as of 31 July 2001)



The age and sex distribution of reported AIDS cases are illustrated in Figure 5. The majority of cases so far have been among men, with people in their 20s most affected to date. This is relatively unusual, indicating that people are becoming

infected with HIV in their late teens or early 20s. This pattern has emerged only recently in Indonesia, and is the result of a growing number of AIDS cases reported among very young injecting drug users.

Figure 5: Cumulative AIDS cases by age and sex from 1987 to July 2001
(Source : Ministry of Health, as of 31 July 2001)

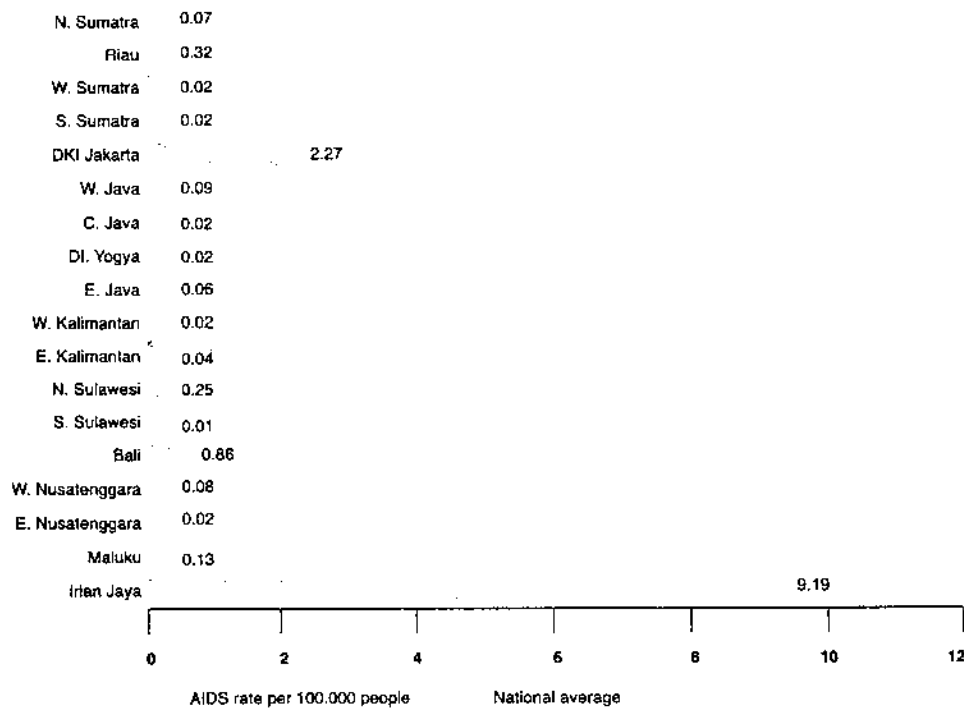


The geographical distribution of AIDS cases is by no means equal across this vast country. A disproportionate number of cases have been reported from the far western province of Irian Jaya, where patterns of sexual networking in the general population appear to differ from those most

commonly found in other areas of the country. This makes for high prevalence rates. However since the population of Irian Jaya is relatively small, the largest absolute number of AIDS cases are reported from the nation's capital, Jakarta.

Figure 6: Cumulative reported AIDS cases per 100,000 people, by province

(Source Ministry of Health, as of July 31, 2001.)



Other sexually transmitted infections (STIs)

The unprotected sex with multiple partners which spreads HIV infection also spreads other sexually transmitted infection, or STIs. In addition to being a public health concern in their own right, STIs greatly increase the chance of HIV passing from an infected to an uninfected partner during unprotected sex. Many STIs are curable, so they give a better picture of recent levels of risky behaviour than HIV, which because it is incurable can reflect risk taken many years ago. A few studies of STI prevalence in the general population are

available. A 1999 study of sexually transmitted infections among pregnant women not thought to be at any elevated risk for HIV shows that a not inconsiderable proportion of women do become infected with STIs. In Bali, 7.8 percent of pregnant women were infected with chlamydia and a total of 7.1 percent had at least one of three other STIs - gonorrhoea, trichomonas and syphilis. In Makassar, South Sulawesi, over eight percent of pregnant women had at least one infection. This indicates that many people in the general population are having unprotected sex with non-monogamous partners, either willingly or because their spouses or regular partners have sex with other partners without their knowledge.

111. Behaviour and its link with HIV infection

A wide gap between knowledge and sexual behaviour in some groups

A majority of Indonesians have heard of AIDS, but knowledge of how it is transmitted and how it can be prevented is far from universal. The Indonesia Demographic and Health Survey of 1997, based on interviews with 8,117 urban and 20,693 rural women found that 51.5 percent of married women aged 15-49 years had heard of AIDS. Among these same women 29 percent stated that AIDS could be prevented by having sex with only one partner, while 23.7 percent said it could be prevented by not having sex with prostitutes.

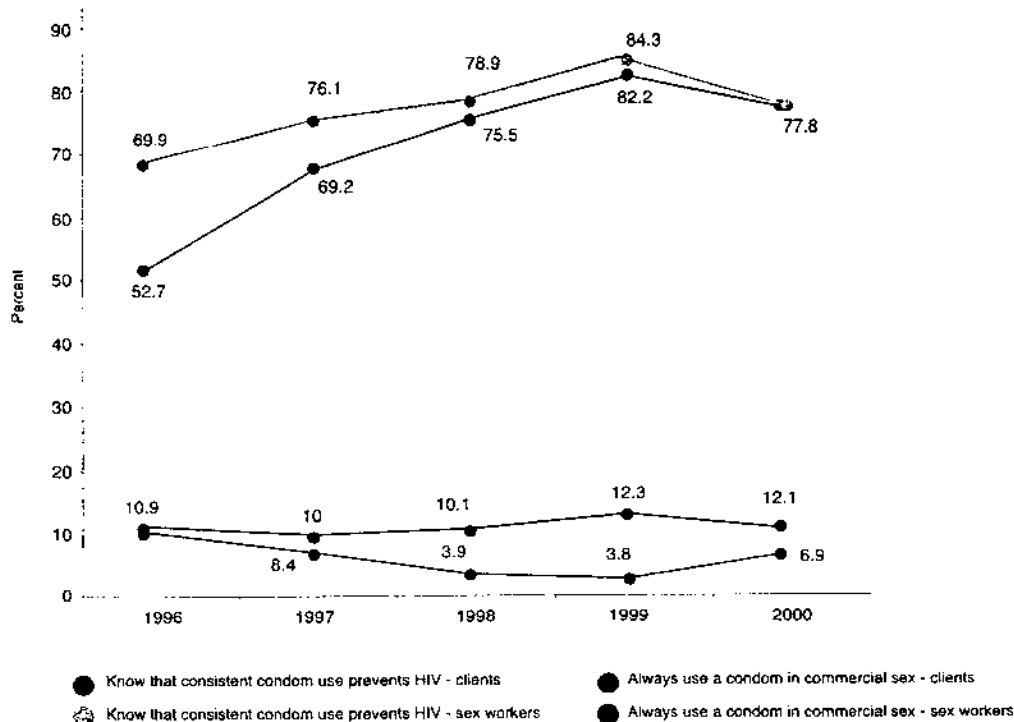
Encouragingly, knowledge about HIV and how to avoid it is far higher among those populations who are most at risk. Sex workers, for example,

all know about AIDS and over three quarters know it can be avoided by using condoms. However as Figure 7 shows there is a significant mismatch between what these women know what they do. The lines towards the top of the chart show the percentage of female sex workers and clients who know that they will not get AIDS if they always use condoms. The lower lines show the percentage of the same sex workers and clients who said they used condoms in all recent commercial sex. Clearly, there is a huge gap between the two.

Among women, this gap is often attributed to powerlessness: even though women know they can protect themselves through condom use, they are not in a position to force their clients to use condoms. In-depth studies confirm that this is at least in part true, although sex workers give other reasons for not using condoms, too. Firstly, many believe that taking antibiotics will also protect them from infection. Secondly, they say that clients who use condoms take longer at each act of sex.

Figure 7: Difference between knowledge and behaviour among sex workers and their clients in Jakarta, Surabaya and Manado, 1996-2000

(Source: Utomo et al., 2000)



Of course if it were only a matter of having the power to act on one's knowledge, one would expect to see a much smaller gap between knowledge

Sex workers all know about AIDS and over three quarters know it can be avoided by using condoms.

and behaviour among men than among sex workers, since they can easily decide to use condoms. But men who

bought sex were even less likely to say they always used condoms with sex workers than the women were, even though most knew that condoms can protect them from HIV and other STIs. The difference is consistent across the country. Similar behavioural studies started in another three cities in eastern Indonesia in 1998: Kupang in West Timor, Denpasar in Bali and Makassar in South Sulawesi. Among sex workers, their clients, and men in occupations providing cash and the opportunity for risky behaviour, between 80 and 95 percent knew that condoms prevented AIDS in two of the three sites. Yet only among taxi drivers in Bali was consistent condom use higher than 20 percent. Well below 10 percent of respondents in most groups in all other sites reported consistently using condoms with sex workers.

These high levels of risk behaviour persisted for

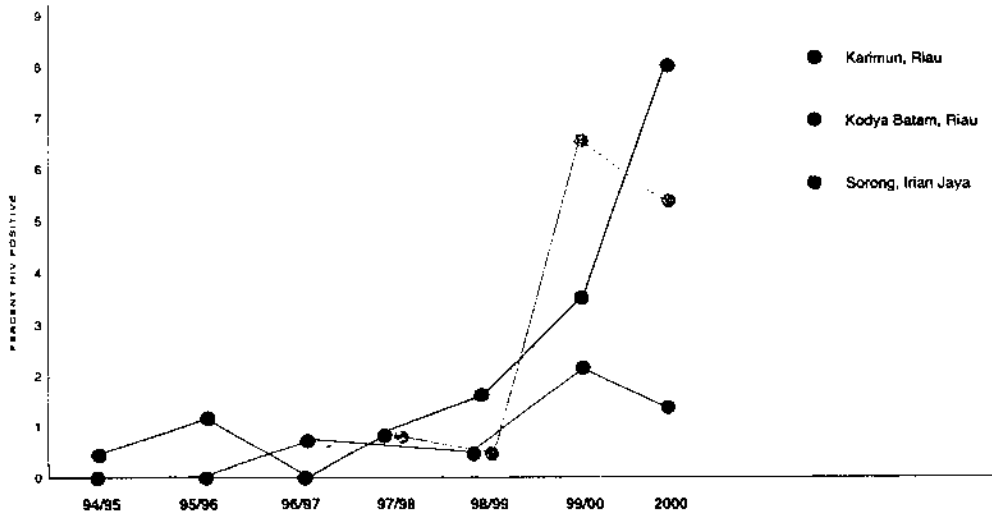
many years without a major impact on HIV infection. This may be in part because sex workers in Indonesia have a relatively low turnover of partners: - around seven in a week on average, compared with over 30 a week in Thailand at the height of the HIV explosion in that country. However recent data suggest that there has been a "take-off" of HIV infection among sex

There is a huge gap between what people know and what they do. Nine out of 10 sex workers and clients have had recent commercial sex without a condom

workers in some locations, and with the low level of condom use recorded, this will certainly be passed on eventually to their clients. In Tanjung Balai Karimun, in the province of Riau - a frequent holiday destination for people from other countries in the region - eight percent of sex workers tested positive for HIV in 2000. At the other end of the country, in Merauke district in Irian Jaya, over a quarter of sex workers included in regular sentinel surveillance tested positive for HIV at last screening. And in the capital, Jakarta, 17.5 percent of women working in massage parlours were found to be HIV positive in 2000. Figure 8 shows trends in HIV prevalence among sex workers in three cities in two provinces: the rise over time is clear to see.

Figure 8: HIV prevalence among sex workers in three Indonesian cities, 1994-2000

(Source: CDC-EH)



Elsewhere, HIV prevalence is lower, but other STIs and mobility spell danger

In other areas of Indonesia, the proportion of sex workers testing positive for HIV is currently lower than in the cities shown in Figure 8, however STI rates suggest these sex workers and their clients are also engaging in risk behaviour. STI reporting systems are far from complete in Indonesia, but a number of prevalence studies, such as those shown in Table 1, give cause for concern.

Another indication that HIV infection will rise among sex workers and their clients throughout the country is the extreme mobility of both groups. One study interviewed 300 clients of sex workers in Kupang, West Timor, and found among them

men from more than half the provinces of Indonesia. Eighty percent of these clients said they had bought sex in other cities around the province and country. Sex workers themselves work in one place for around a year before moving on to another location.

This kind of mobility obviously acts as an engine, driving the spread of the virus throughout the archipelago. But it also gives local communities an excuse to ignore the importance of the risk behaviours that are taking place in their midst, by claiming that commercial sex is an "outsiders" problem. This gives a false sense of security, because regardless of where the sex workers come from, a substantial proportion of their clients are always men from the local community. A study of the male and female sex industries in Bali estimates that four out of five clients were local, while in Kupang, a quarter of female sex workers and 37 percent of their clients were local.

Table 1. Prevalence of sexually transmitted infections in female sex workers, four cities, 2000

(Sources: Miller and Otto, 2000, Surjadi et al., 2000)

	Gonorrhoea % (95% CI)	Chlamydia % (95% CI)
Kupang, 1999 n=288	30.9% (25.4 - 36.4)	23.9% (18.9 - 29.1)
Jakarta, 2000 n=203	29.7% (23.0 - 36.1)	39.6% (32.4 - 46.4)
Surabaya, 2000 n=200	30.9% (19.2 - 31.8)	22.2% (18.8 - 30.7)
Manado, 2000 n=204	19.6% (13.9 - 25.3)	23.0% (17.0 - 29.1)

Who's next? Putting others at risk

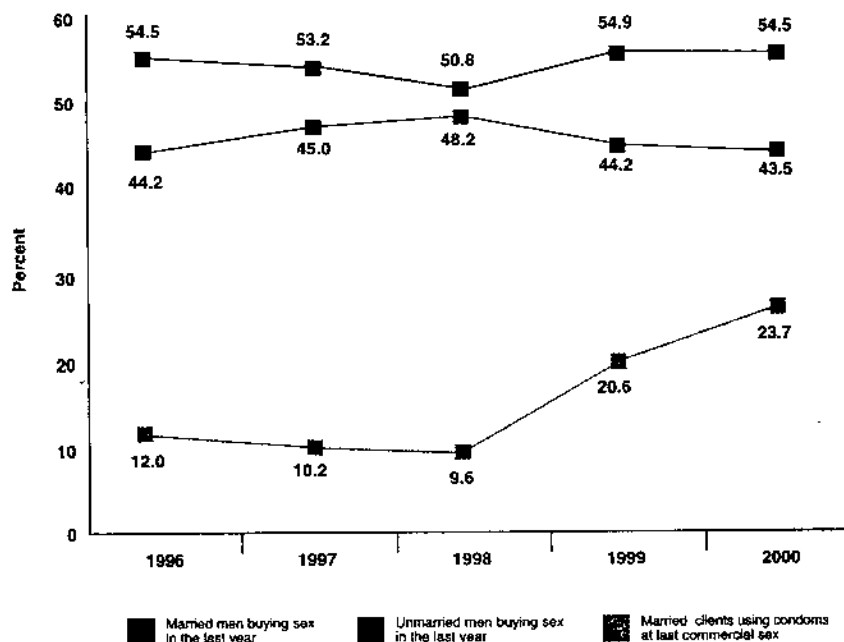
Men who have unprotected sex with sex workers are not just putting themselves at risk. They are also risking the lives of their wives, their girlfriends and other sexual partners, and their infants.

It is not easy to determine exactly what proportion of the overall male population regularly visits sex workers, since no nationally-representative data are available. One household study that questioned over 2,000 men in the general population in East Java found that eight percent of men in urban areas said they had ever had sex with a sex

worker: a proportion that is relatively low by Southeast Asian standards.^b In groups chosen because they represent men who travel frequently and have ready cash, the proportion buying sex seems to be on the rise. As Figure 9 shows, close to half of over 1600 male respondents in three

cities reported paying for sex in the previous year, and seven out of 10 had done so in their lifetimes. There is certainly no evidence that men are reducing their consumption of commercial sex because of any fear of AIDS.

Figure 9: Percent of married and unmarried sailors, port workers and truckers who say they had sex with a sex worker, Jakarta, Surabaya and Manado, 1996-2000.
(Source: Utomo et al., 2000)



It is clear from this graph that married men are even more likely to have sex with a sex worker than single men. And while more married men appear to be using condoms with sex workers than was the case five years ago, in 2000 three out of four men who are buying sex outside their marriage did not use a condom the last time they had sex with a sex worker. By definition, then, they are exposing their wives and - if their wives become pregnant - their infants to

Married men were even more likely to report sex with a sex worker than single men.

the risk of HIV infection as well as themselves. Sex workers, too, have partners other than their clients. The majority of sex workers questioned have been married, and although most are now divorced, 14 percent were currently married in the year 2000. A further 42 percent reported having a regular boyfriend in the last six months. Over half of these men appear to be regular clients rather than non-paying boyfriends, but condom use is considerably lower in these relationships than with one-off clients. Only 17 percent of women reported using a condom the last time they had sex with their "boyfriend", compared with 41 percent with men they regard as ordinary clients.

^b By comparison in Cambodia, the country with HIV prevalence in Asia, 21.4 percent of men in urban areas nationally said they had bought sex in the last year.

Because HIV can be transmitted from mother to child, both in pregnancy and during breastfeeding, the children of sex workers are also at high risk for HIV infection. Close to two thirds of sex workers questioned in 2000 already had children, and because the bulk of sex workers are in their early 20s, further pregnancies in this group are likely. Another study over 450 sex workers in a brothel

Male students were up to five times as likely to report sexual experience as female students

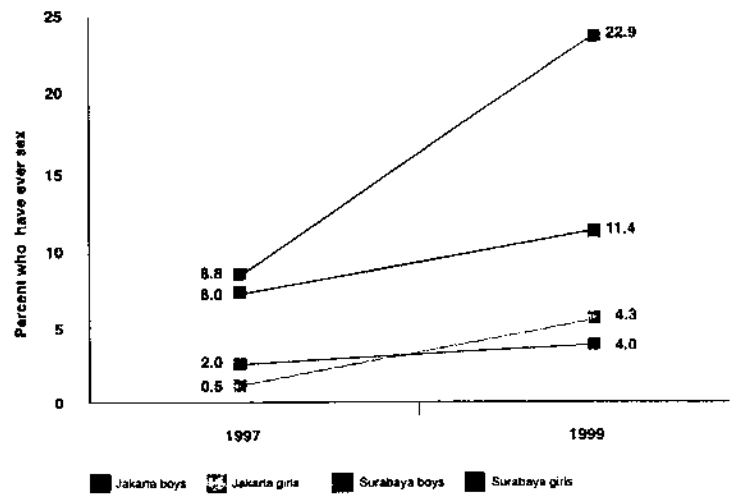
area of Jakarta found that over 40 percent were not using any contraceptive. Since only one in 10 reported in sex diaries that they always used condoms, the likelihood that these

women will become pregnant and expose their infants to HIV infection is significant. Children are at risk, too, because of their own sexual behaviour. Since the economic crisis burst on Indonesia in 1997, the number of children living on the streets of large cities is growing. Many of these children have sex, either as a source of companionship or as a source of income. A study among Jakarta street children conducted in 2000 found that almost a third of the children were sexually active and only six percent had ever used a condom. Not surprisingly, many were infected with STIs: chlamydia prevalence was 7.4 percent and gonorrhoea was 7.7 percent.

These data for urban street children can clearly not be taken as representative of all young people in Indonesia - a group for whom data are scarce. Information about sexual activity among young women is especially rare in Indonesia: most surveys to date have either restricted their questioning to married women or have concentrated largely on knowledge rather than sexual behaviour. Surveys among high school students have recorded low rates of sexual activity among young women, with fewer than five percent of respondents saying they had ever had sex. All around the world, girls in school are less likely to be sexually active than girls the same age out of school, so it is likely this under represents the true level of early sexual activity. And since male students were up to five times as likely to report sexual experience as female students, and high proportions of these youngmen reported that their first sexual experience was with a girlfriend, it seems likely that girls in school are not giving a true picture of overall levels of sexual activity. Having said that, it appears sexual activity among young unmarried women is probably truly rather low.

In the nation's two largest cities, the trend appears to be towards more premarital sex, as Figure 10 shows. These data are very limited, and while they are supported by anecdotal evidence, such as a massive upswing in attention paid to boyfriends and sexual relationships in young women's magazines, they obviously need far more systematic confirmation.

Figure 10: Percent of senior high school students Jakarta and Surabaya who reported ever having had sex
(Source: Utomo and Dharmaputra, 2000)



Other types of high risk sex: men who have sex with men

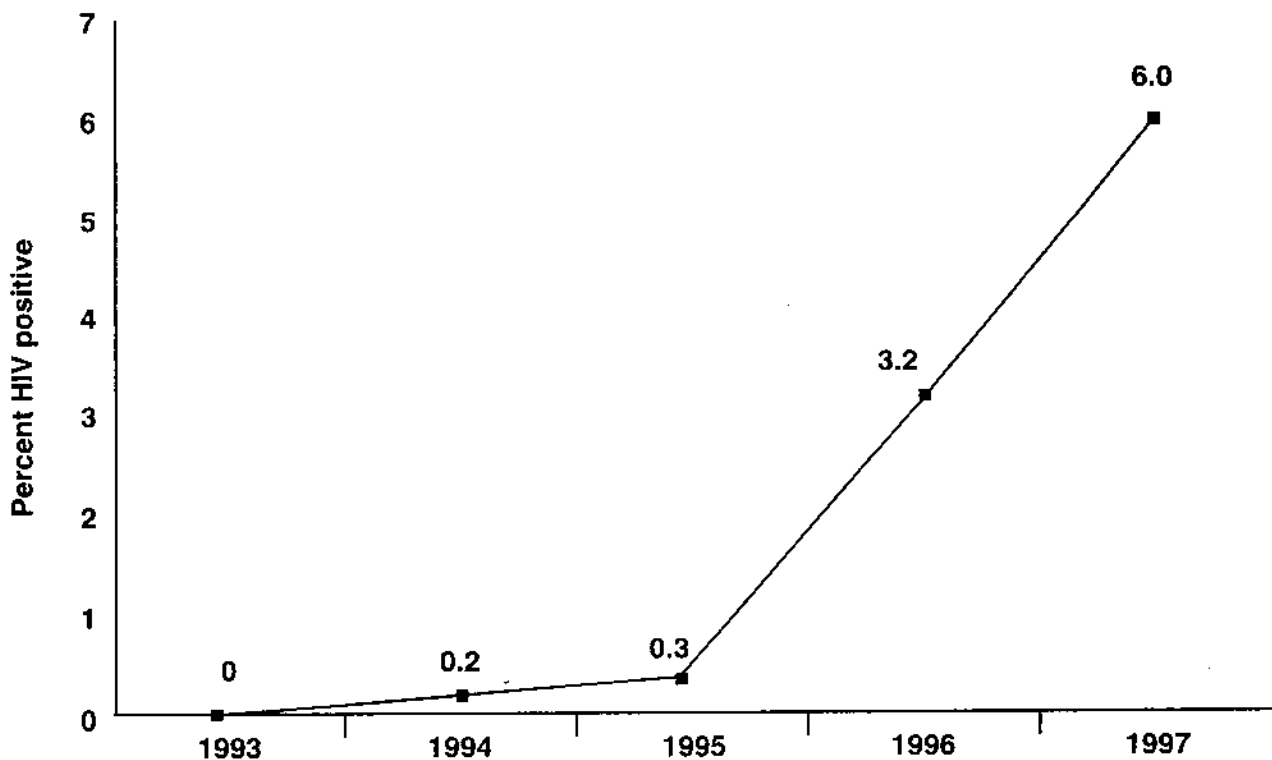
There is very little formal information about men who have sex with men in Indonesia. In a few large cities and tourist areas such as Jakarta, Surabaya and Bali, there is a fairly open "gay" scene. Men who self-identify as homosexuals live a lifestyle similar to that of gay men in many other countries of the world. Some live together with long-term partners, and others gather in predominantly gay bars and nightclubs and mix in relatively well-defined social circles. The "gay scene" is, however, just one part of the universe of men who have sex with men in Indonesia. Behavioural surveillance among gay men in Bali and Ujung Pandang found that nearly 10 percent of men who have sex with men included in the sample reported that they had sex with their wives or girlfriends in the last three months, and another 40 percent

reported sex with a "non-homosexual male partner". In many cities, transvestites (known as "waria") sell sex both as the active and as the passive partners to men who do not think of themselves as homosexual, and who only occasionally engage in anal or oral sex with other men. There is also a market for male sex workers who are not transvestites. These men, who may be married or have girlfriends, sell sex to other men and, less frequently, to women.

Rates of HIV infection among these different groups and their clients are unknown. As Figure 11 shows, HIV prevalence among waria, which was low at the start of the decade, doubled from 3.1 percent in 1996 to 6.0 percent just one year later, but there has been no systematic HIV testing in this group ever since. STI data, however, suggest that risk behaviour is rife. In a study in late 1999, close to half of nearly 300 waria tested positive for syphilis, and 27 percent had some other sexually transmitted infection.

Figure 11: HIV prevalence among transvestite sex workers, Jakarta, 1993-1997

(Source: Lubis et al. 1998)



Behavioural information confirm very high levels of risk among waria. The men in the 1999 study in Jakarta reported an average of four oral and three anal sex encounters per week, but fully a third said they had never in their lives used a condom, and just one in 10 said they used condoms every time they had anal sex. Since 12.5 percent of those who said they only had oral sex were found to have an anal infection, it appears men are deliberately

Nearly 10 percent of men who have sex with men reported that they also had sex with their wives or girlfriends

underreporting the true levels of risky behaviour.

In an initial round of behavioural surveillance among waria in Jakarta in 2000, the average number of anal sex clients in a week

was close to seven, while the average number of clients paying for oral sex was just over five. In this study, 60 percent of men said they used a condom with the most recent anal sex client, and 27.5 percent said they always used a condom with paying clients. Condom use with non-paying clients was far lower. Elsewhere in Indonesia, the pattern is similar. In Bali, waria reported having anal sex with an average of close to six partners a week in 2000 while in South Sulawesi the average was just under five a week. Condom use at last anal sex was lower among waria in Bali than elsewhere, and indeed fell sharply from 59 percent in 1998 to 41 percent in 2000. This included partners who were not clients, however, and the fall may be associated with a steep rise in the proportion of waria who report that their last sex partner was a "husband" or regular partner.

With high rates of partner exchange and low levels of condom use, waria are at high risk for HIV infection. That means their clients are also at high risk for infection, especially since unprotected anal sex is among the riskiest of sexual behaviours. In the most recent Jakarta study, several waria reported injecting drugs in the last year. Qualitative studies suggest that the majority of clients of waria do not think of themselves as gay, and some are married. More than half of the clients of gay and transvestite sex workers say they also have sex with female sex workers.

Why is condom use still low? Attitudes and beliefs about condoms

In some countries in Asia, notably in Thailand and Cambodia, a very rapid rise in condom use in commercial sex led over time to a slow-down in the HIV epidemic. Aiming to curb the spread of HIV, Indonesia issued a regulation making condom use compulsory in commercial sex transactions as early as 1996. As Figure 7 on page 14 showed, however, that regulation has been largely ignored and most commercial sex remains unprotected. Why do more than nine out of 10 sex workers and clients in Indonesia have unprotected sex even though most know the risks involved? Almost two thirds of the men who said they didn't use a condom in three cities in 2000 gave as an excuse the fact that it reduced the pleasure of the sex they were paying for. The issue of availability was raised by a few. Virtually all men knew about condoms and could name one or more places where they were available, though many men said they did not use condoms because

Many men don't use condoms because they think taking medicine before sex will protect them from disease

they did not have any available at the right time. Research conducted by condom manufacturers and distributors suggests that many men do not buy condoms even when they are cheaply available in convenient locations because they are embarrassed to buy them. Condoms are associated with "dirty sex", rather than with responsible behaviour.

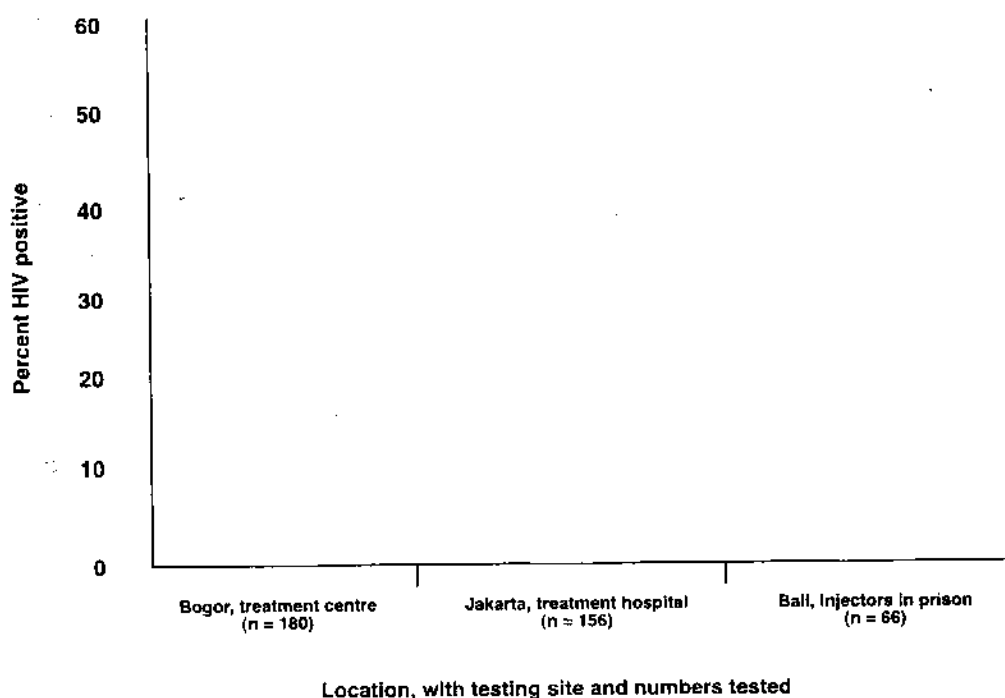
One other factor plays an important role in Indonesia. A high proportion of men questioned in qualitative studies say that they protect themselves from STDs by taking antibiotics or traditional medicines either before or after sex. Even though they know they are theoretically "at risk" because they are having unprotected sex, they are not actually afraid of HIV infection or other STIs, because they believe they are already taking effective action against infection.

An emerging epidemic among injecting drug users

Injecting drug use is an increasingly worrying problem in Indonesia. There is very little information available about the absolute number of injectors, but anecdotal evidence in the media together with statistics from the police and drug treatment centres suggest that there has been a dramatic rise in the overall number of people injecting drugs in the country in the last five years. The experience of other countries has shown that drug injection is an extremely efficient way of spreading HIV. In

countries as diverse as Thailand, Scotland, India and Ukraine, HIV prevalence among drug injectors has been known to shoot from zero to 50 percent or more in a matter of a year or less. There are indications that this explosive rise of HIV infection may already be underway among drug injectors in Indonesia. At present, the only information available comes from ad hoc HIV testing of drug injectors at treatment centres in Jakarta, Bogor and Bali, and among drug users at the main prison in Bali. Three years ago, HIV prevalence was around two percent. But as Figure 12 shows, among the relatively small numbers of drug users tested for HIV, infection is now extraordinarily common.

Figure 12: HIV prevalence among drug injectors 2000-2001
(Source: CDC-EH)



In one drug treatment hospital in Jakarta, for example, HIV prevalence had risen from 15.4 percent in 2000 to over 40 percent by mid-2001. The proportion of addicts admitted to the hospital because they were injecting drugs rather than inhaling or swallowing them also rose. The true magnitude of the problem, and thus the contribution of drug injection to the overall spread of HIV in Indonesia, cannot be calculated without a better idea of how many Indonesians are injecting drugs. But the regular HIV and AIDS reporting systems, which themselves capture a small fraction

of cases, have recently registered a sharp rise in the number of new HIV and AIDS cases attributable to drug use. The rise seems to be exponential: nearly as many new cases of HIV were detected in drug injectors in the first half of this year as in the whole of the previous year as figure 13 shows.

It is worth noting that HIV is not the only infection which is spread easily by sharing unclean injecting equipment. Hepatitis C, for example, which can cause chronic and fatal liver failure, also spreads through unclean needles.

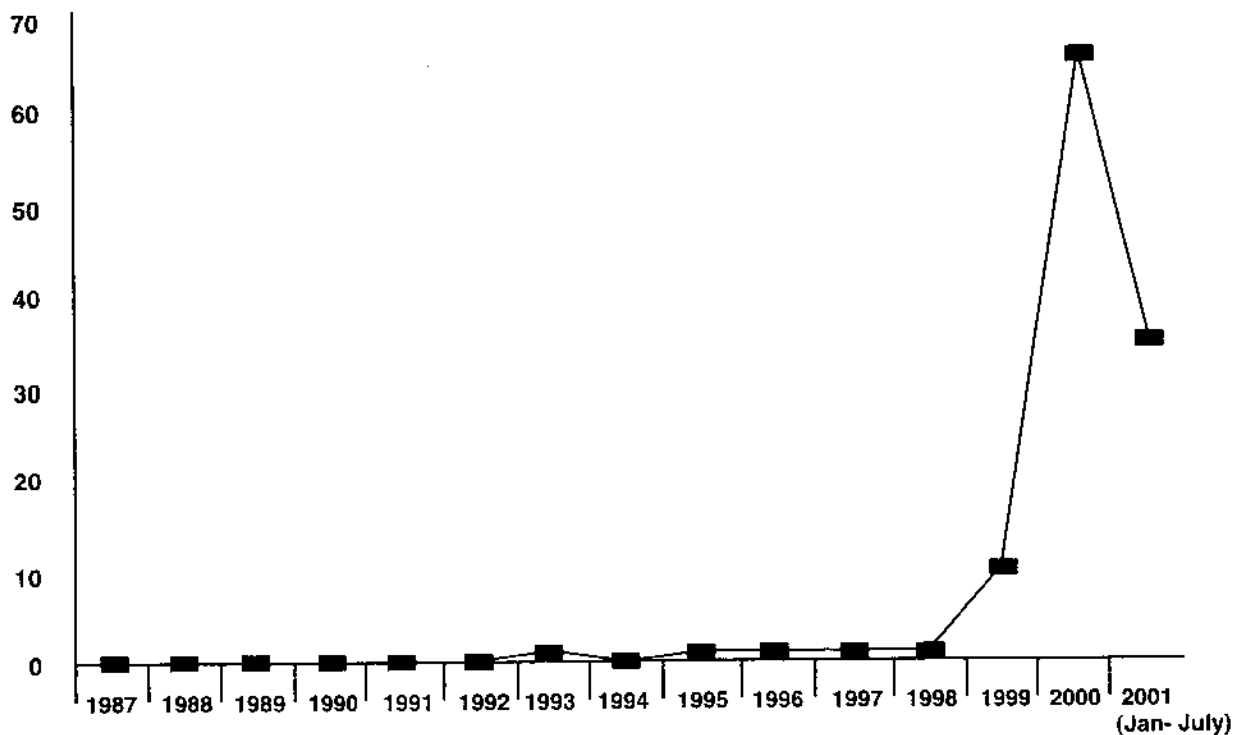
If any confirmation that needle sharing among drug users is a norm in Indonesia is needed, it is provided

*HIV prevalence has topped
20% in drug injectors
in several parts of Indonesia
and in some places
half of all injectors are HIV infected*

by the data showing that over 80 percent of drug injectors tested over two quarters in 2000 were infected with Hepatitis C. Data from Myanmar, India and elsewhere suggest that HIV can eventually rise to saturate virtually the entire population of needle-sharers in a drug using community. That means that over eight drug injectors out of 10 might become infected with HIV in Indonesia unless needle sharing practices change radically, and soon.

Figure 13: Number of new AIDS cases in injecting drug users, Indonesia, 1987-2000

(Source: compiled from various sources by CDC-EH)



as of 30 July 2001

IV. Lessons learned

Information alone is not enough to change sexual behaviour

Prostitution, or professional sex work, is one of the most universal professions in the world. Men regularly buy sex throughout Indonesia. The overall number of clients is not known, but it is undoubtedly in the millions: conservative estimates suggest around six million Indonesian men buy sex every year, and they do so often: on average a little less than once a month each. A national working group on HIV has estimated that there are at least 150,000 female sex workers throughout the country, fewer than half of whom are "officially" registered. According to the Department of Social Affairs there were 71,281 female sex workers based in brothel districts in Indonesia in 1995. Other publications estimate that there are about 500,000 female sex workers in Indonesia. Available data suggest these sex workers will probably average around 400 clients a year each.

Many will become infected with HIV by one of those clients, and they will in turn pass on the virus to some of their other clients. For these reasons, effective prevention programmes for sex workers and their clients are of critical importance in an epidemic such as Indonesia's. These programmes aim to stop these populations from becoming infected in the first place, and to limit the spread of the virus to other populations if it does become established through commercial sex.

Many partner organisations are already working to provide for the needs of sex workers and, more recently, their clients in Indonesia. However as the data presented above show, much remains to be done. It appears that the work of increasing awareness of the risks of HIV among those with high risk behaviour has largely been done. The weight of effort now needs to turn away from traditional "information, education, communication" techniques and towards providing services that will help or oblige people to act on the prevention information they already have.

Indonesia's changing socio-economic landscape may lead to increased risk

The extent to which an epidemic will become widespread in a country depends on many factors, some behavioural and some socio-medical. For example, it is now widely accepted that near-universal male circumcision in a population reduces the likelihood of a rapid increase in HIV prevalence at the population level. Most Indonesian men are circumcised in accordance with the traditions of

the Moslem majority, reducing the likelihood of a population-wide epidemic regardless of patterns of sexual behaviour.

Behavioural factors probably hold the most important key to the future of the HIV epidemic in Indonesia, however. And of behavioural factors, most important are the proportions of the population engaging in high risk sex and the patterns of sexual mixing between high and low risk populations. The extent of sexual mixing within the "low risk" population itself also plays an important role. The data presented so far clearly record substantial mixing between groups who perceive themselves to be at different levels of risk for HIV infection. Once HIV infection reaches a critical level in the populations with highest risk, this type of mixing provides a very efficient avenue along which the virus can spread into wider populations.

Data from the general population are limited, but they suggest that a large proportion of the population will remain protected from HIV if age at first sex remains relatively high and if premarital and non-commercial extramarital sex remains limited. However, the social and economic landscape of Indonesia is changing rapidly, and it is by no means certain that these patterns will hold, especially among young people. As shown earlier in this report, drug injection is on the rise, and there appears to be a rise, too, in the

The social and economic landscape of Indonesia is changing rapidly. Drug injection and premarital sex appear to be on the rise.

proportion of young people having sex before marriage. If risk behaviour rises in any part of the country, the prospects are that the rising risk will spread rapidly throughout the archipelago. Economic and political uncertainty have in recent years greatly increased population mobility, and there is no reason to believe that the trend towards greater mobility will not continue.

HIV and behavioural surveillance systems will continue to monitor trends in risk behaviour and infection. But if it is confirmed that young people are having more non-marital sex than their parents' generation, swift action will be needed to ensure that those who are sexually active have the means and the will to protect themselves against unwanted pregnancies and disease, including HIV.

Effective prevention is a complex task, in which many sectors must play a part

The social, economic and political landscape in which risk behaviour takes place focuses attention on another important lesson: there is no "magic bullet" for this epidemic. A rapid increase in condom use in the riskiest sex and a rapid decrease in sharing of injecting equipment are the key to effective prevention in Indonesia, but these changes must take place within a complex social, religious and political structure, and must be preceded and supported by a myriad of other activities. The long-term solution must include steps to reduce vulnerability to HIV, in other words, to give people social and economic alternatives so that no-one is forced to have unprotected sex or feels obliged to begin injecting drugs. These long term solutions

HIV prevention can work if it is undertaken early, if it is focused on those at most risk, and if it happens on a huge scale.

are likely to focus particularly on improving education, skills and employment opportunities for women, so that fewer are forced to sell sex. Work to maintain strong family ties and

intergenerational communication in this era of increasing urbanisation, mobility and fragmentation will also be necessary.

Even the most direct short-term "fixes" such as increased use of condoms and clean needles cannot be implemented without support from a wide range of people, including religious and community leaders. Support from other sectors such as the educational establishment and commercial companies are critical, too, to providing access to key populations for effective prevention.

Indonesia stands at the crossroads of an AIDS epidemic. HIV infection is rising rapidly in populations with high risk, but the absolute number of infections is still small relative to the size of the population. The steep rise in infection rates should act as a strong call to action.

The experience of other countries has shown that prevention can work if it is undertaken early enough, if it is targeted carefully to meet the needs of the populations with highest risk, and if it is carried out on a large enough scale to reach a significant

proportion of those populations. Prevention must also be comprehensive: condom promotion alone, for example, may not achieve much. However if it takes place in a wider context in which people can get screened and treated for STIs (and at the same time receive information about HIV prevention and referral to a service providing affordable voluntary HIV testing), the impact is likely to be greater.

As this report shows, in the Indonesian context effective prevention will mean working across the archipelago to encourage the use of condoms in high risk sex encounters, including commercial sex and sex between men. It will mean establishing a norm of condom use among young people at the start of their sexual lives. And it will mean working to limit the number of young people injecting drugs, and making drug injecting safer by eliminating the need to share needles.

HIV in Indonesia: an opportunity for action

**If the data in this report
add up to
a single message,
it is this:**

**If Indonesians
stand together
in support of
safer sex and drug-taking,
hundreds of thousands
of lives can be saved.**

**This requires courage
as well as swift,
focused action.**

**Let us seize
the opportunity
and act now.**

V. Challenges & Opportunities

Challenges

The impediments facing Indonesia permeate responses at all levels; from policy formulation to prevention, planning and implementation of strategies; and finally to individual change.

With the exception of certain sub-populations with high risk behaviour, most Indonesians still live in a landscape of low HIV prevalence. This leads to many challenges and misconceptions.

Low prevalence= low priority

At the policy level, low HIV prevalence typically translates into local governments assigning a low priority to HIV prevention. Since HIV is invisible in its early stages and early epidemics place few demands on the health sector, there are few readily apparent reasons to initiate a response or turn limited human resources and budgets to prevention. This is especially the case in the newly-decentralised system in Indonesia, where local policy-makers are preoccupied with tackling problems that their own voters consider to be of immediate and overwhelming importance.

Low prevalence = "Risk behaviour does not happen here"

At the moment, Indonesia is still hemmed in by cultural and religious barriers that restrict an open and frank dialogue about sexual and drug-related issues. Low prevalence is used to support the mistaken but often widely held claim that the behaviours that promote HIV transmission, such as multiple sex partners and injecting drug use, do not exist in a particular province or regency.

Low prevalence = "I am not at risk"

In low prevalence settings, even individuals who know that they have substantial risk behaviour may not see themselves as "at risk" since they do not believe that HIV is present at any significant level.

Even with appropriate interventions, changing behaviours in low prevalence settings is difficult, because of individuals' low risk perception. This may in part account for the failure of condom promotion efforts to bring about any measurable change in behaviour among people with high risk, as seen in Figure 7 on page 14.

Low prevalence = "No ability and no desire to prioritise the response"

At the prevention planning level, low HIV prevalence often translates into a lack of direction in the prevention response. Although a common issue at all epidemic levels, the debate over the appropriate balance between prevention efforts for the general population and for targeted interventions to more vulnerable sub-populations is particularly difficult to resolve in countries with low prevalence. Tangible political pressures often exist to protect the general population, while stigmatisation and disdain for groups at high risk often discourage efforts targeted at vulnerable populations. "General population" responses are less threatening and more politically rewarding, even though they may be much less effective at preventing epidemic growth. And yet, these are often the sub-populations where HIV gains its initial foothold before spreading more generally. Early prevention efforts to address the sub-epidemics in these groups could reduce the probability of more extensive epidemic spread dramatically.

Opportunities

The challenges are clear, but there is a clear opportunity for further appropriate interventions in the areas of HIV prevention, care and support.

Indonesia is a developing country with limited resources. We must therefore seize those opportunities which will have the greatest impact in preventing the further spread of HIV, at the lowest cost. This means focusing resources on behaviours that carry the highest risk of infection.

SEXUAL TRANSMISSION

- 100% Condom use programme
- Voluntary counselling and HIV testing programmes

TRANSMISSION THROUGH BLOOD

- Prevention of mother to child transmission
- Harm reduction programmes
- Blood safety

100 percent condom use programme

Heterosexual transmission of HIV plays a major role in the Indonesian epidemic. It is fuelled principally by unprotected sex between those with a high turnover of partners: sex workers and the clients who infect them. Once infected with HIV by their clients, sex workers may then transmit the virus to other male clients, who may infect their wives, girl friends or other sex workers. In an effort to reduce the spread of HIV, many countries have tried to increase condom use in commercial sex. Most interventions have focused on educating sex workers and providing condom supplies. These efforts have sometimes also included community education campaigns and the provision of STI treatment.

These programmes have sometimes succeeded in raising awareness of the seriousness of HIV and

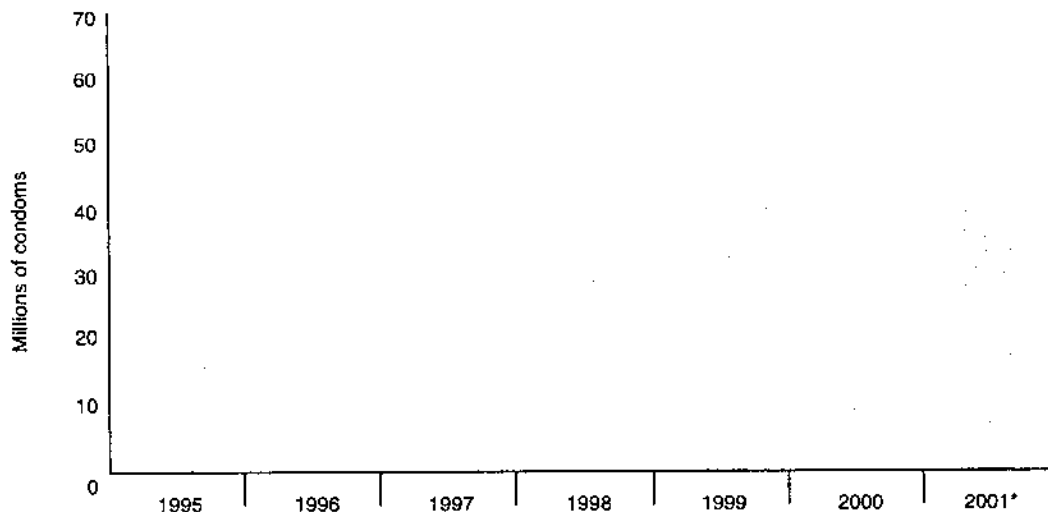
AIDS and teaching women techniques for negotiating condom use with their clients. However, many men continue to have sex with sex workers without using condoms. This results in an increasing number of sex workers and male clients becoming infected with HIV, and may ultimately lead to the expansion of the epidemic into the general sexually active population.

A 100 percent condom use programme tries to go beyond simply handing out condoms and telling sex workers and their clients to use them. The intention of this programme is to enforce and reinforce condom use in all acts of commercial sex in entertainment establishments. Success stories have been reported from Thailand and Cambodia -- both countries have succeeded in astronomically increasing condom use, and both have been rewarded with falling HIV and STI prevalence in groups with high risk behaviour. Key to the success of these programmes has been the active involvement of many different sectors, including health personnel, NGOs, brothel owners and pimps and law enforcement authorities.

If condom use in commercial sex can be increased to even 80 percent, the number of male clients exposed to HIV is dramatically reduced, and that in turn reduces the spread of HIV infection to their wives, girlfriends and infants, as well as to other sex workers. The most effective place to begin such an intervention in Indonesia is in brothel complexes, where clients and the women who serve them are relatively easy to reach with focused services, and where women have the highest turnover of partners. It seems obvious that condoms should be universally available to men and women in brothel complexes, but it is not yet the case. Of the sex workers who reported condom use in two locations in Riau and West Java, only one in 10 said condoms were supplied by the brothels they worked in. This suggests that there is a lot of scope for expanding distribution of condoms in the very places where men have sex with sex workers. The recent addition of a high-quality reasonably priced condoms which are widely distributed near night-clubs in some parts of the country has begun this process, and private sector sales have increased accordingly, as Figure 14 shows.^c

^c While private sector sales are increasing, government procurement of condoms have recently dropped to insignificant levels, from 21 million pieces in 1996.

Figure 14: Private sector condom sales in Indonesia, 1996-2001 (Millions)
 (Source: DKT, personal communication with CDC-EH)



* Projected

However as has been noted, simply expanding condom availability and promotion is not enough. There has to be an incentive to use condoms, from the point of view of everyone concerned: client, sex worker and -since they very often control the terms of a transaction -- brothel owner.

Requirements for a successful 100 percent condom use programme:--

- Co operation of police, political and health authorities
- Collaboration with owners of sex establishments and sex workers
- Availability of condoms
- Accessible STI services

Provision of effective STI screening and treatment

One of the basic elements of the 100 percent condom use programme is the STI clinic, which ensures regular check ups for sex workers in order to identify STIs cases and other diseases. Treating STIs is an important HIV prevention intervention in

its own right, since infection with other STIs increases the likelihood that HIV will be transmitted. And screening is important because in women, many STIs do not show any symptoms. However in the context of 100 percent condom programmes, STI screening has another important role: it provides the major indicator to ensure the implementation of the policy. If women from one brothel regularly test positive for STIs, it is almost certainly because that brothel is not requiring clients to use condoms. Under a well-implemented 100 percent condom programme, this can lead to sanctions for the brothel-owner -- for example the brothel may be closed down for a month. These sanctions provide a powerful incentive for the power brokers in the sex industry to support the use of condoms in their brothels. Without such mechanisms, condom campaigns are far less likely to succeed on the massive scale needed to brake HIV transmission in highly risky sexual encounters.

- Treatment of STIs will reduce HIV transmission.
- Screening for STIs will identify failure to comply with 100 percent condom use policy.

If compliance with the 100 percent condom use programme is good, the prevalence of STIs will decrease significantly, and with them the need for treatment and the costs associated with it.

Provision of voluntary counselling and testing

Voluntary counselling and HIV testing (VCT) has a vital role to play within a comprehensive range of measures for HIV/AIDS care and support, and has to be encouraged. The potential benefits of testing and counselling for HIV-infected individuals include the ability to protect sex and drug-taking partners from infection, improved health status through good nutritional practice and earlier access to care and treatment for HIV-related illness; emotional support and awareness of safer options for reproduction and infant feeding. Individuals who test HIV negative and get effective prevention counselling can act to reduce their future exposure to infection.

The demand for HIV testing and counselling is linked to the services available for those found to be infected. At present these are somewhat limited in Indonesia. However, small programmes demonstrate that a demand does exist. In Bali, for example, the NGO Yayasan Kerti Praja recently began offering voluntary counselling and HIV testing services together with free treatment for opportunistic infections in those testing positive. Most of the demand for these services so far has come from people with high risk behaviour: over half those seeking an HIV test through this programme in Bali were injecting drug users, and most of the rest described themselves as having high risk sexual behaviour.

HIV VCT is an essential component of:

- Care and Support Programmes
- Prevention of Mother to Child transmission

Prevention of mother to child transmission

Mother to child transmission (MTCT) of HIV is the most significant source of HIV infection in children below the age of 10 years. The strategy recommended by the United Nations Agencies to prevent MTCT of HIV includes:

- Primary prevention among parents
- The prevention of unwanted pregnancies in HIV-infected mothers
- The prevention of HIV-transmission from HIV-infected mothers to their infants.

While the best ways to prevent HIV-infection in infants remain primary prevention of HIV-infection and reduction of unwanted pregnancies among women who are infected with HIV, many HIV-infected women become pregnant. Often, they do not know themselves that they are infected, and they cannot therefore take measures to protect their infant from infection. If pregnant women in relatively high prevalence areas are able to choose to find out their HIV status, they can make important decisions about childbirth and infant feeding. In some parts of Indonesia, pregnant women who test HIV positive are being offered single dose anti-retroviral treatment and breastmilk substitutes to reduce the chance that they will pass the virus on to their infants.

Harm reduction programmes

Throughout the world, international and national approaches to control the use of illegal drug can be categorized into: 1) Supply reduction; 2) Demand reduction, and 3) Harm reduction.

Traditionally, drug control has focused on law enforcement to reduce the supply of illicit drugs, with mixed results. What is certain is that drug use in Indonesia has continued to expand in recent years despite efforts to reduce the supply of illegal drugs. This means that the demand for drugs is increasing. Demand reduction strategies are clearly needed. These strategies, which educate young people about the dangers of drugs, which work with families and communities to increase awareness of warning signals for drug abuse and how to respond to them, and which try to help current users give up their use of drugs, are in their infancy in Indonesia.

Efforts are now being made to expand them. Since the mid 1980's and the arrival of HIV/ AIDS among IDUs throughout the world, harm reduction strategies have become prominent. Harm reduction accepts that illicit drugs will not be eradicated in the near future, and tries to work to make drug taking safer. The strategy argues that the accessibility of illicit drugs and the social conditions creating demand for them will result in their continued use. While the strategies of supply and demand reduction are deemed to be useful, they are primarily focused on mid to long- term goals, which do not address the rapid transmission of HIV- infection. HIV spreads so quickly among drug users that long-term solutions are not good enough: action has to be taken to reduce the transmission of HIV among existing drug users and from them to their sexual partners while longer-term strategies are put in place. Harm reduction can be viewed as the prevention of some of the adverse consequences of illicit drug use without necessarily reducing their consumption.

The two major components of harm reduction are:

- Needle and Syringe Exchange Programmes
- Drug treatment and Substitution Programmes

Indonesia is just beginning to develop harm reduction strategies for injecting drug users. This is a controversial area, and strong political will is needed to ensure its success. The reward for success is substantial. Despite receiving no central government funding for harm reduction activities, New York City recently reported that it had cut new infections among injecting drug users to below one percent per year, from over five percent per year when needle exchange and other hard reduction programmes began.

Better laboratory services for improved surveillance and blood transfusion

Planning an appropriate national response to HIV depends on good information about HIV, STIs and the behaviours that spread them.

The data in this report come largely from the HIV and behavioural surveillance system run and co-ordinated by the Directorate of Communicable Diseases and Environmental Health. This system is being strengthened continuously. It is perhaps ironic that decentralisation has actually greatly increased the need for a strong central surveillance system. It is important that data are available for decision-making at the district level, but it is also important that a centrally-planned and centrally financed surveillance system continues to monitor the broad trends in infection and behaviour over the country as a whole.

This is especially so in the light of the challenged posed by the "low prevalence = low priority" mentality which often takes hold at the local level as policy-makers struggle to deal with immediate problems. Without a centrally-guided system, there is a danger that surveillance data could dry up entirely as people at the district level turn their attention to other priorities.

Good laboratory services are imperative for quality surveillance. Indeed the role of laboratories in facilitating various health care activities has grown considerably in the recent past, both in developed as well as developing countries. The emergence of HIV/ AIDS and infectious diseases such as hepatitis B, C and E, which cannot be accurately diagnosed without laboratory tests, has highlighted the importance of high quality health laboratory services.

Better laboratories mean better surveillance and diagnostic facilities, but they also contribute to a safer blood supply. Overall, Indonesia's blood supply system, which is maintained by the Indonesian Red Cross, works to a high standard. In urban areas all blood bags are individually screened for HIV and other infectious agents, although in some outlying rural areas unscreened blood is still occasionally used in times of emergency. Very few HIV infections have ever been attributed to blood transfusion in Indonesia. However rising HIV prevalence may put some strain on the current systems of both laboratory diagnosis and blood transfusion. Indonesia is therefore working with international partners to ensure that these important links in the chain of HIV prevention are strengthened in the immediate future.

VI. Bibliography

- **Dachlan D and S Silwana.** Treatment-seeking patterns of people with STDs in Ujung Pandang. Hasanuddin University, 1999
- **Djaelani Gordon J et al.** Rapid assessment on drug abuse and HIV/AIDS/HCV by drug addicts in recovery. Yayasan Kita, HIV/AIDS Prevention Project, 2000
- **Djalal,** quoted in Graeme Hugo: Internal and international migration in Indonesia and their implications for the spread of HIV/AIDS. Draft report.
- **Irwanto.** Rapid assessment and response pemakai obat suntik. Universitas Katolik Atma Jaya, 2001
- **Jones, Gavin, Endang Sulistianingsih and Terence Hull.** Prostitution in Indonesia. Working Paper in Demography No. 52, Research School of Social Sciences. The Australian National University, Canberra, 1995.
- **Lake, Primus, Eman Goring, Ady Lamury, Agus Agun, Yulius Detamauk.** Pelanggan pekerja seks di Kota Kupang. Yayasan Bina Insan Mandiri dan Indonesia HIV/AIDS and STD Prevention and Care Project, 2000
- **Lubis I, Manaf A, Yasan S, Abednego H, Lazzari S.** HIV prevalence and risk behaviour among male transvestites in Jakarta, Indonesia. International Conference on AIDS, 1998. 12: 367.
- **Sedyaningsih-Mamahit E, Firdous U, Yatim F, Maryorie D, Holly M.** Prevalensi infeksi menular seksual dan perilaku berisiko terkait di kalangan anak jalanan di Jakarta. Badan Litbangkes, Ditjen PPM-PL dan ASA, Jakarta 2001.
- **Murray, Allison.** No Money, No Honey: a study of Street Traders and Prostitutes in Jakarta. Oxford University Press, Singapore, 1993
- **Pangkahila W and Supriyadi.** HIV/AIDS/STD-related knowledge, attitudes, behaviours and practices of STD patients. Lembaga Kesejahteraan Keluarga Indonesia, 1999.
- **Ridwan, Joesoef, Mamoto Gultom, John Moran, Inong.** Skrining penyakit menular seksual dan pengobatan para waria di klinik IAKMI. MoH and HIV/AIDS Prevention Project, Jakarta, 2001
- **Sedyaningsih-Mamahit, Endang.** Perempuan-perempuan Kramat Tunggal. Seri Kesehatan Reproduksi, Kebudayaan dan Masyarakat, 1999.
- **Sutakertya B, Wayan Swastina, Ketut Yasa Jaya Christian Supriyadinata .** Hasil Studi Pelanggan Pekerja Seks (Gay, Waria dan PS Wanita) di Bali. Indonesia HIV/AIDS and STI Prevention and Care Project/Ausaid, 2001
- **UNAIDS.** Report on the global HIV/AIDS epidemic. Geneva, 2000
- **Utomo, Budi and Nick Dharmaputra.** Results of the Behavioural Surveillance among the Intravenous Drug Users in Jakarta. University of Indonesia and HIV/AIDS Prevention Programme, Ministry of Health and Family Health International
- **Utomo, Budi and Nick Dharmaputra.** The results of the behavioural surveillance among transvestites in Jakarta, 2000. University of Indonesia and HIV/AIDS Prevention Programme, Ministry of Health and Family Health International
- **Utomo, Budi and Nick Dharmaputra.** The results of the behavioural surveillance among students in Jakarta, Surabaya and Manado, 1996-1999. University of Indonesia and HIV/AIDS Prevention Programme, Ministry of Health and Family Health International, 2000
- **Utomo, Budi et al.** Findings of the behavioural surveillance survey (BSS 1996-2000) on female commercial sex workers and adult male respondents. University of Indonesia and HIV/AIDS Prevention Programme, Ministry of Health and Family Health International, 2000
- **Utomo, Budi et al.** Findings of the behavioural surveillance survey (BSS 1998-2000) on female commercial sex workers and adult male respondents. University of Indonesia and Indonesia HIV/AIDS and STD Prevention and Care Project, and National AIDS Commission, Coordinating Minister for the People's Welfare and Poverty Eradication, 2001
- **Yayasan Citra Usadha.** Studi Pelangahan Wanita Pekerja Seks. Indonesia HIV/AIDS and STI Prevention and Care Project/Ausaid, 2000
- **Yayasan Menuju Sehat - Cerdas.** Laporan surveilans perilaku pada wanita penjaja seksual di propinsi Riau dan Jawa Barat. 2000

