

Indonesia

Country Review October 2011

INDONESIA AT A GLANCE

Total population (in thousands)	232,517 (2010) ¹
Annual population growth rate	1.0% (2010-2015) ¹
Population aged 15-49 (thousands)	134,977 (2010) ²
Percentage of population in urban areas	44% (2010) ³
Crude birth rate (births per 1,000 population)	18.6 (2008) ⁴
Under-5 mortality rate (per 1,000 live births)	41 (2008) ⁵
Human development index (HDI) - Rank/Value	108/0.600 (2010) ⁶
Life expectancy at birth (years)	71.5 (2010) ⁶
Adult literacy rate	92% (2005-2008) ⁶
Ratio of girls to boys in primary and secondary education (%)	98 (2008) ⁴
GDP per capita (PPP, \$US)	4,198 (2009) ⁴
Per capita total health expenditure (Int.\$)	81 (2007) ⁵

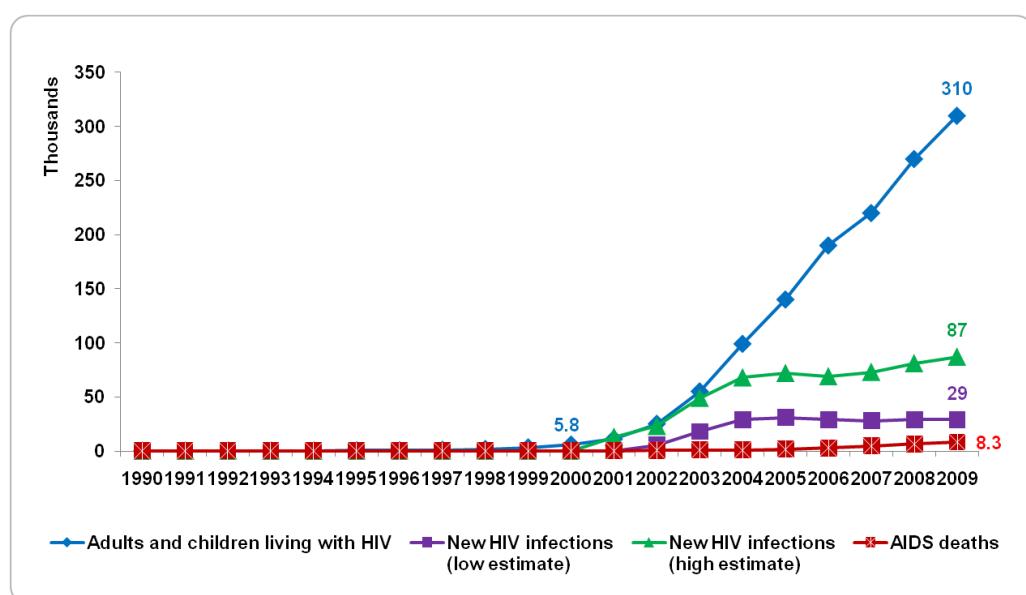


Source: www.worldatlas.com

HIV EPIDEMIOLOGY AND TRENDS

Since 1987, when the first case of HIV was reported, the rapidly increasing number of new HIV infections in Indonesia makes the epidemic one of the fastest growing in Asia. In 2009, an estimated 310,000 [200,000 – 460,000] adults and children were living with HIV of which an estimated 88,000 [58,000 – 130,000] were women 15 years and older (Fig. 1); a dramatic increase from the estimated 11,000 adults and children living with HIV in 2001.⁷ This can also be seen in the cumulative number of cases (aged 15-49) reported to the health authorities, which increased sharply from 1,487 cases in 2003 to 19,973 by 2009 and further to 24,131 in 2010, with 4,158 new cases reported in 2010 (MoH, Fig. 2a).⁸

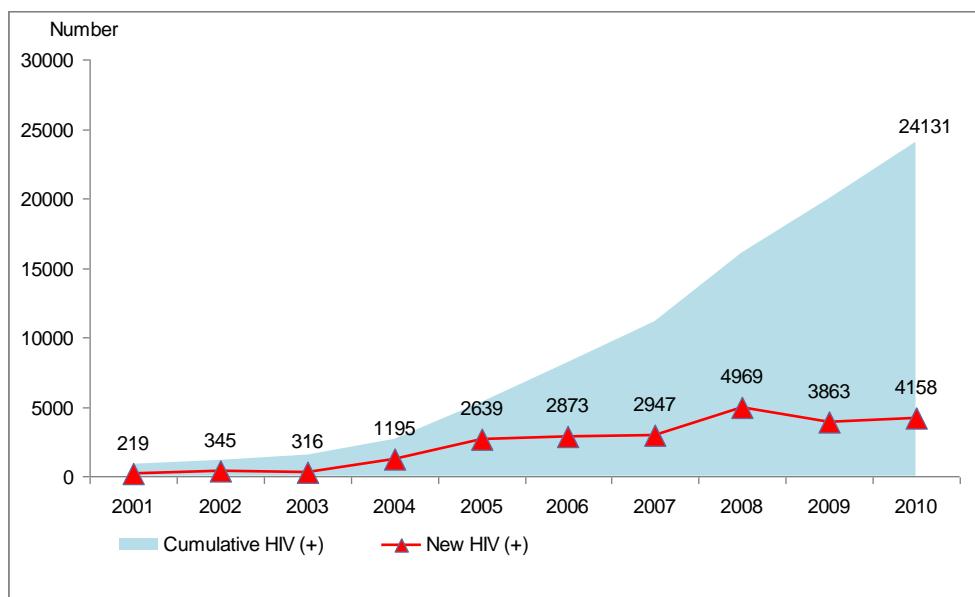
Figure 1: Estimated number of adults and children living with HIV, new infections and AIDS deaths, 1990-2009



Source: Prepared by www.aidsdatahub.org based on UNAIDS, Report on the Global AIDS Epidemic, 2010

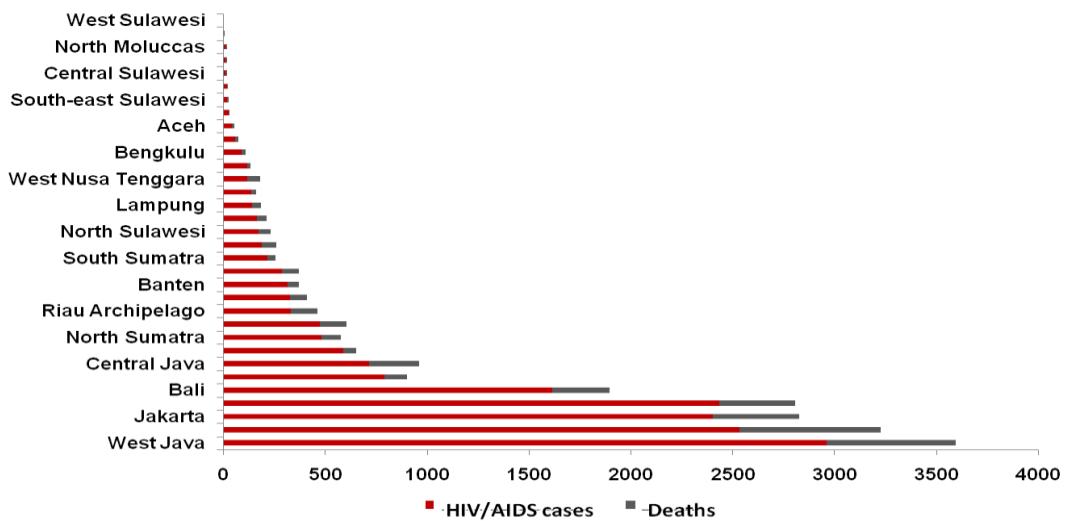
The epidemic now affects almost all parts of the country. In 2004 only 16 of the 33 provinces reported any HIV infections, however – by the end of 2009 – cases had been reported in all 33 provinces (Fig. 2b). HIV prevalence among the general population aged 15-49 in the two provinces of Papua and West Papua in the extreme east of Indonesia is particularly high at 2.4% and considered a ‘generalized’ epidemic.⁹

Figure 2a: Number of cumulative and new HIV cases, 2001-2010



Source: Directorate General Communicable Disease Control and Environmental Health, MoH

Figure 2b: Cumulative HIV/AIDS cases and deaths by province, 2009



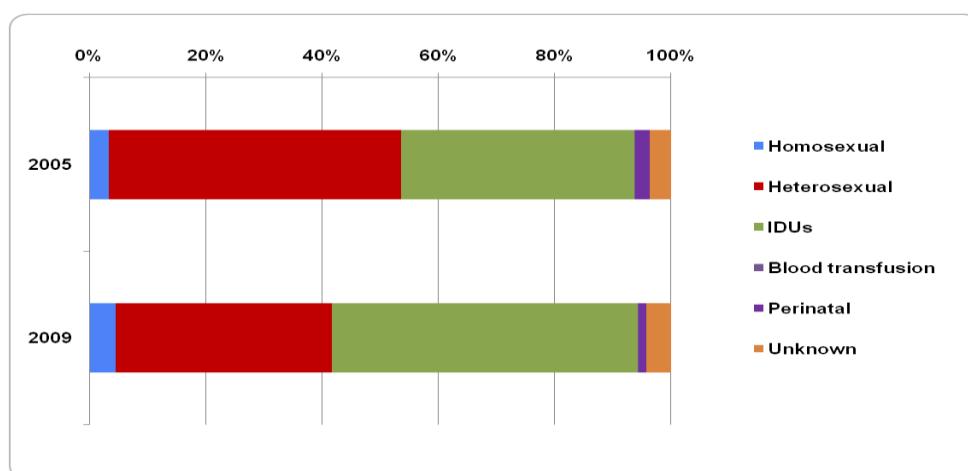
Source: Directorate General Communicable Disease Control and Environmental Health, Ministry of Health

WHO ARE AT RISK OF HIV IN INDONESIA?

The epidemic has changed from low to concentrated, with high HIV prevalence in certain populations, namely: injecting drug users (IDUs) - up to 56%; transgender ("waria") sex workers - up to 34%; female sex workers (FSWs) - up to 16.9%; and men who have sex with men (MSM) -up to 8.1%.¹⁰ Moreover, the intimate partners (primarily female) of key populations are increasingly at risk. More than a fourth (28.4%) of the estimated 310,000 PLHIV in 2009 were women.⁷

The main mode of HIV transmission driving the epidemic is the sharing of contaminated needles and syringes among IDUs (52.6%), followed by unsafe heterosexual intercourse (37.2%), homosexual intercourse (4.5%) and perinatal transmission (1.4%) (Fig. 3).¹¹

Figure 3: Cumulative percentage of HIV and AIDS cases by mode of transmission, 2005 – 2009

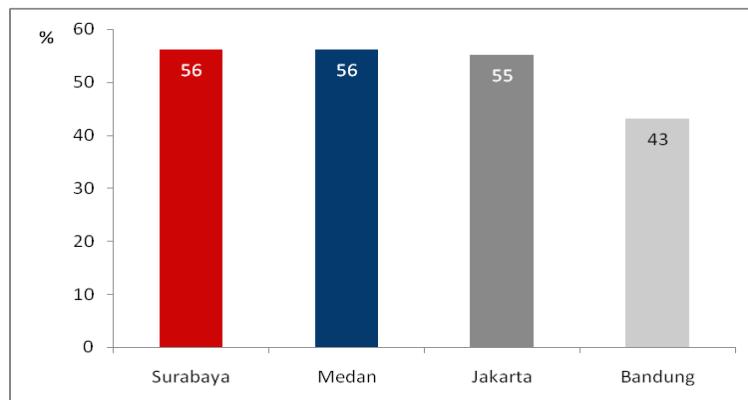


Source: Prepared by www.aidsdatahub.org based on Indonesia, Ministry of Health, Directorate General Communicable Disease Control and Environmental Health, Feb 2010

Injecting drug users

According to the 2007 IBBS, HIV prevalence among IDUs was more than half (52.4%). Specifically, in the four cities in which biological data were collected, HIV prevalence among IDUs was 55% - 56% in each of Surabaya, Medan and Jakarta and slightly lower in Bandung, at 43% (Fig. 4).¹² Prevalence was higher among female IDUs (57.1%) than among males (52.1%); and higher among older IDUs aged 25 and above (58%) than among their younger counterparts (41.5%).¹³ In 2006, it was estimated that there were over 219,000 IDUs and 93,420 partners of IDUs throughout the country.¹⁴

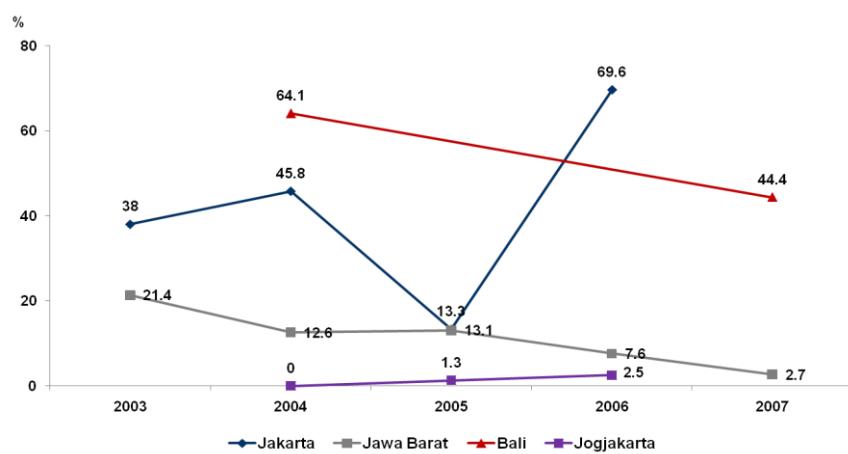
Figure 4: HIV prevalence among IDUs in selected cities, 2007



Source: Integrated Biological-Behavioral Survey (IBBS), 2007

Trends in HIV prevalence have been monitored through sentinel surveillance in selected sites from 2003 to 2007. Surveillance data displayed a decrease in HIV prevalence in Bali from 64.1% in 2004 to 44.4% in 2007 and Jawa Barat from 13.3% in 2005 to 2.7% in 2007 (Fig. 5). However, prevalence in Jogjakarta rose to 2.5% in 2006, which had been 0% only two years earlier. Jakarta's prevalence is somewhat irregular, likely due to inconsistencies in sampling methodology and/or sample size, but showed an overall increase over time to 69.6% in 2006.

Figure 5: Trends in HIV prevalence among IDU in selected sentinel sites, 2003-2007



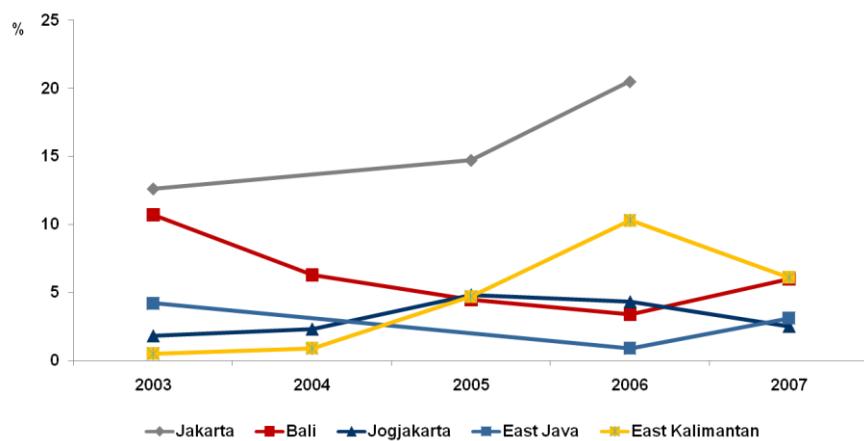
Source: HIV Sentinel Surveillance, 2003-2007, Ministry of Health

There exists an important epidemiological relationship between IDUs and prisoners. The 2004-2005 BSS found that 12% of IDUs reported they had been jailed, and that many prisoners continued injecting drugs while in prison.¹⁵ This finding challenges the assumption that the rise in HIV prevalence is only due to drug injecting practices occurring prior to imprisonment.

In October 2007, there were 127,238 prisoners in 363 prisons across Indonesia, nearly one quarter of whom had been arrested for drug-related offences. Seventy-three percent of those arrested on drug charges were drug users, 40% of whom were IDUs.¹⁶ In 2009, there were 1,341 prisoners in the 13 prisons specifically designated for drug offenders.¹⁶

Sentinel surveillance data showed that HIV prevalence among prisoners in Jakarta has grown since 2003, reaching 20.5% in 2006 (Fig. 6).¹⁷ In 2007, prevalence among prisoners was 6.1% in both East Kalimantan and Bali, 3.1% in East Java and 2.5% in Jogjakarta.¹⁷ Additional data from VCT in narcotics prisons showed very high rates of HIV among prisoners. Specifically, 200 of 250 prisoners (80%) in Jakarta's narcotics prison and 40 of 63 (63%) prisoners in West Java's Bandung narcotics prison tested positive for HIV.¹⁶

Figure 6: Trends of HIV prevalence among prisoners in selected sentinel provinces, 2003-2007



Source: HIV Sentinel Surveillance, 2003-2007, cited in Quarterly Progress Report HIV & AIDS Situation in Indonesia, 31st December 2009.

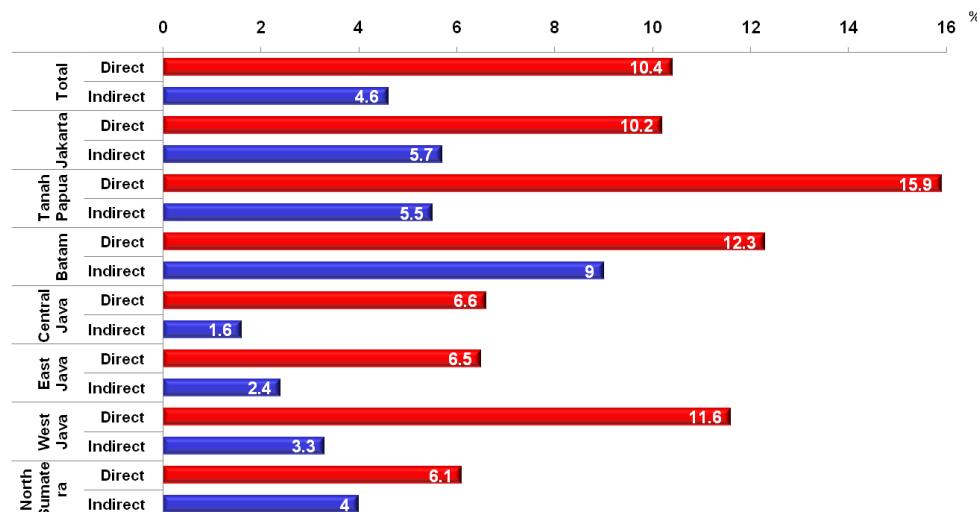
Female sex workers, Waria, and clients of sex workers

In 2006, there were an estimated 95,000 to 157,000 direct FSWs (those who work in brothels or are street-based) and between 85,000 and 107,000 indirect FSWs (those employed in karaoke bars, massage parlours, etc. who occasionally engage in sex work).¹⁴ Public health authorities have estimated that sex workers in Jakarta alone generate 850 billion Rupiah per year (approximately US\$ 100 million).¹⁸

Overall, HIV prevalence among FSWs was found to be 10.2% in 2007 (IBBS), slightly higher among younger sex workers, below the age of 25 (10.4%) as compared to those 25 years old and above (10.1%). In addition, prevalence was 10.4% among direct FSWs and 4.6% among indirect FSWs.¹⁶ The highest levels were found among direct FSWs in Tanah Papua and Bali, 15.9% and 14.1%, respectively, whereas they were highest among indirect FSWs in Batam and Jakarta, 9% and 5.7%, respectively (Fig. 7).¹⁹

Magnani *et al.* also independently analysed the 2007 IBBS data, and reported an even higher prevalence among direct FSWs in Sorong (16.9%) and Jayapura (14.8%) and among indirect FSWs in Sorong (8.3%).²⁰

Figure 7: HIV prevalence among direct and indirect FSWs in selected provinces, 2007



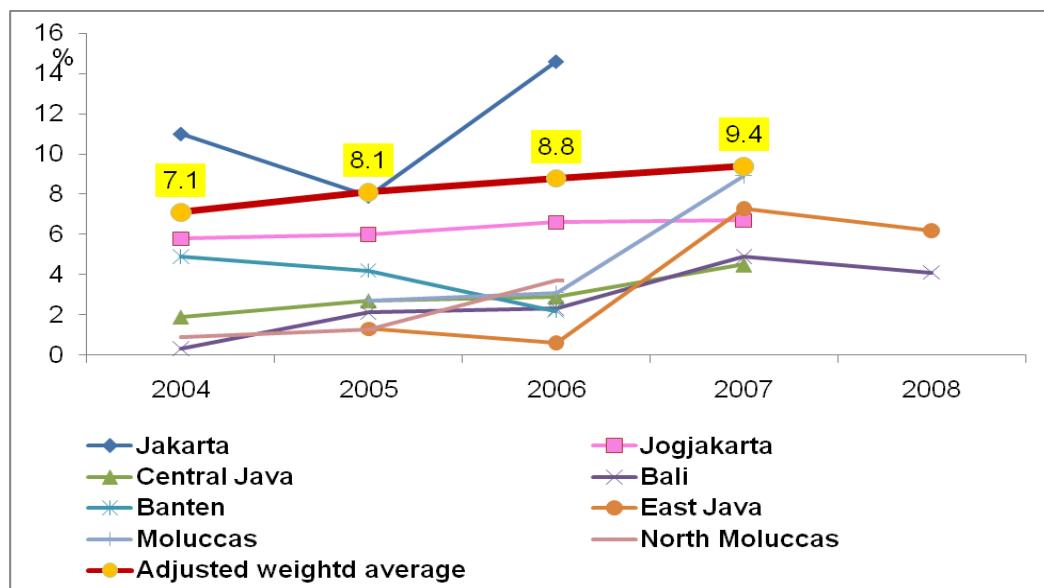
Sources: The Department of Health, The National AIDS Commission, Komisi Penanggulangan AIDS, USAID, et al. (2007). Integrated Biological - Behavioral Surveillance among Most-at-Risk Groups in Indonesia, 2007: Surveillance Highlights Female Sex Workers.

The 2007 IBBS also revealed that HIV prevalence among both direct and indirect FSWs was high even among those new to sex work, indicating that they are becoming infected very quickly after becoming involved in sex work. Indeed, prevalence was between 6% and 16% among direct FSWs and between 2% and 9% among indirect FSWs in the first six months after engaging in sex work.¹⁰

Sentinel surveillance showed fluctuating trends in HIV prevalence among FSWs in various sites from 2004 to 2008 (Fig. 8).²⁰ In general, HIV prevalence was on the rise in all sites except for Banten as of 2004. After 2007, HIV prevalence declined slightly in Bali and East Java – the only two sentinel sites surveyed during that period.

Although the trends of HIV prevalence among FSWs are not consistent across cities, the aggregated trend shows an increasing pattern of HIV prevalence (represented as adjusted weighted average, Fig. 8).²⁰

Figure 8: Trends in HIV prevalence among FSWs in selected sentinel sites, 2004-2008



Source: Magnani R, Riono P, Nurhayati, et al. Sexual Risk Behaviors, HIV and Other Sexually Transmitted Infections among Female Sex Workers in Indonesia, sti.bmjjournals.com, published online June 3, 2010

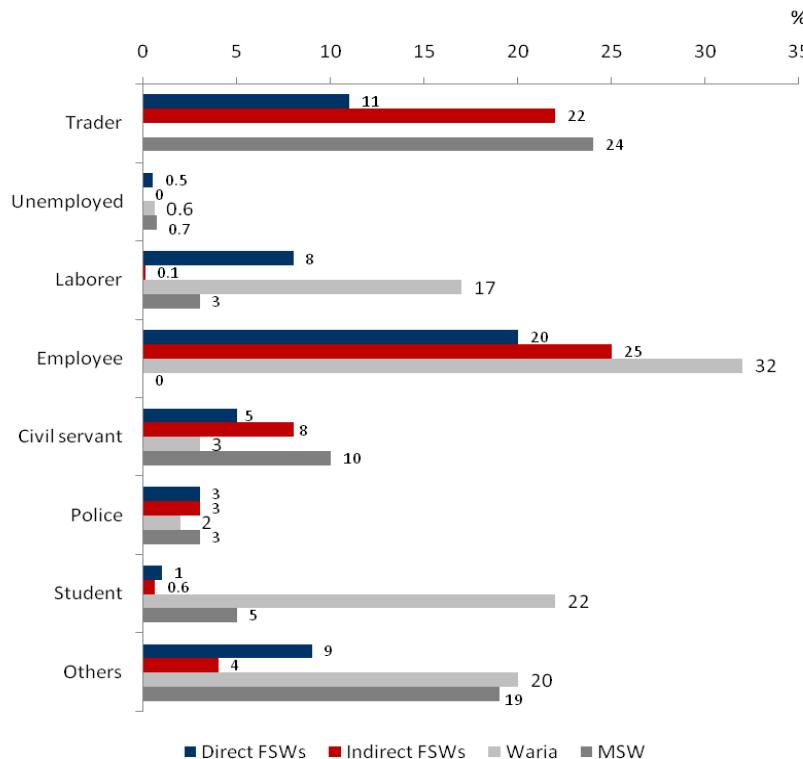
Waria (men who have assumed a female identity, also called transgenders) were included in the 2007 IBBS in Indonesia due to prior surveillance data indicating high risk behaviours – a large majority of *waria* sell sex to male customers – and a very high prevalence of HIV infection: 24.4% overall; ranging from 14% in Bandung to 25.2% in Surabaya and 34% in Jakarta.¹⁰

In 2006, it was estimated that there were between 20,960 and 35,300 *waria*¹⁴ and an estimated 83,150 clients of *waria*.¹⁴ Overall in the 2007 IBBS, 87% of those surveyed had sold sex in the previous year, with an average of two clients per week, ranging from 1 in Bandung to 4 in Surabaya.¹⁰

A cross-sectional survey conducted in 2002 among *waria* (n=241) and male sex workers (MSWs) (n=250) in Jakarta found HIV prevalence among these groups to be 22% and 3.6%, respectively, while syphilis prevalence was 19.3% and 2%.²¹

Results of the 2004-2005 BSS showed that clients of sex workers in Indonesia came from a wide range of occupations. Employees tended to be clients of transgender and FSWs whereas traders tended to buy sex from FSWs and MSWs. More students (22%) were clients of transgenders, probably due to the lower service fees charged compared with other types of sex workers (Fig. 9).¹⁵

Figure 9: Male clients of four different categories of sex workers, 2004-2005

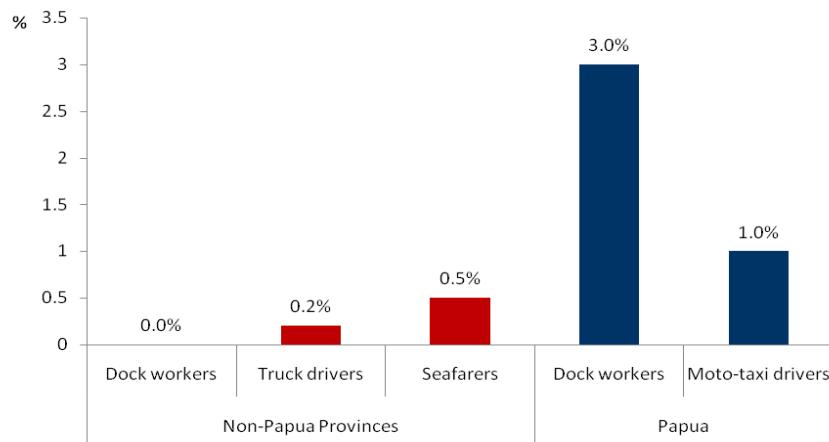


Source: Ahnaf, A., Anwar, J., Pramono, D., Mulia, I. A., et al. (2005). Behavioral Surveillance Survey (BSS) Result in Indonesia 2004-2005. Jakarta: Badan Pusat Statistik and Departemen Kesehatan.

In 2006, it was estimated that there were 3,124,370 male clients of FSWs and 1,813,880 regular partners of FSWs.¹⁴ In 2007, FSWs had a median of seven clients in the past week (ranging from 4 in Tanah Papua to 14 in Bali).¹⁹

Groups of men who are frequent clients of FSWs (truck drivers, seafarers, dock workers and moto-taxi drivers) were included in the 2007 IBBS given their important role as bridging populations between sex workers and the general population. High proportions of the groups had sex with a FSW in the past year – notably 60% of truck drivers, 46% of seafarers and 43% of dock workers in Tanah Papua.²² HIV prevalence was detected in all groups except dock workers in non-Papua provinces, and highest among groups surveyed in Tanah Papua (Fig. 10).

Figure 10: HIV prevalence among high risk men (frequent clients of sex workers), by occupational group and geographic area, 2007



Source: Integrated Biological-Behavioral Survey (IBBS), 2007

Men who have sex with men

In 2006, the number of MSM in Indonesia was estimated to be between 384,320 and 1,149,270.¹⁴ The 2007 IBBS found overall HIV prevalence among MSM to be 5.2%.²³ In particular, among the three cities which included biological data in the survey, prevalence was found to be 8.1% in Jakarta, 5.6% in Surabaya and 2% in Bandung.¹⁰ HIV prevalence was higher among older MSM – those aged 25 years and above – at 6%, as compared to their younger counterparts at 4.2%.¹⁰

MSM at a Glance

HIV prevalence, 2007 ^{14; 23}	<ul style="list-style-type: none"> The number of MSM was estimated to be between 384,320 and 1,149,270 (as of 2006). HIV prevalence increased from 3.5-4.5% in 2006 to 5.2%. HIV prevalence was 2% in Bandung, 5.6% in Surabaya and 8.1% in Jakarta. In Bandung, Surabaya and Jakarta, between 29% and 34% of MSM were infected with at least one sexually transmitted infection.
Selected behaviours, 2007 ²³	<ul style="list-style-type: none"> 57% reported the use of a condom the last time they had anal sex with a male partner. In 2004-2005, 63% of MSM reported unprotected sex with their commercial sex partners. 44% of MSM had comprehensive HIV knowledge. The percentage of MSM who had ever injected drugs ranged from 1.2% in Medan to 1.6% in Surabaya, 2% in Bandung, 2.4% in Malang, 2.8% in Jakarta and 3.5% in Batam.
National response, 2007 ^{23; 24}	<ul style="list-style-type: none"> 44% of MSM were reached by HIV prevention programmes. 34% received an HIV test in the last 12 months and knew the result. MSM are explicitly mentioned in the National response strategy (2010-2014); activities for MSM are explicitly funded through the Global Fund Round 8 as well as USAID.

VULNERABILITY & KNOWLEDGE

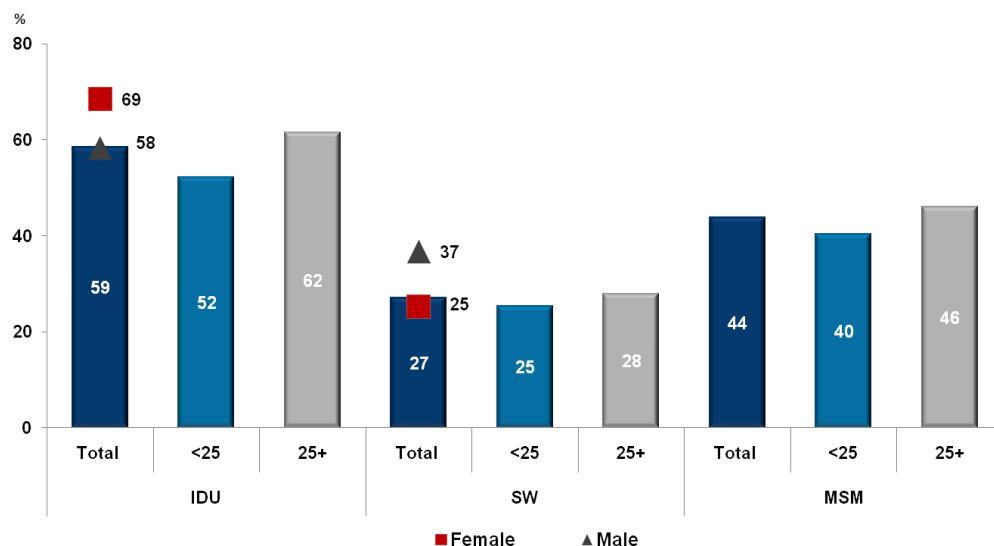
Vulnerability Factors

- Indonesia is the largest archipelagic country (with over 17,000 islands) and has a population of over 220 million people with very diverse cultural backgrounds, making communication and resource distribution very difficult.²⁵
- While many initiatives have been taken to encourage safer sex practices, barriers to condom promotion remain. The main challenge is in persuading religious authorities to adopt public health perspectives in dealing with the epidemic.
- Indonesia's punitive approach to drug use hampers prevention efforts as IDUs fear arrest, extortion and long prison sentences if they come forward to access HIV prevention programmes.²⁶
- Widespread stigma and discrimination persists, limiting the successful coverage of HIV interventions.²⁷
- Limited outreach to high-risk behaviour groups such as IDUs, MSM, sex workers and their clients, and partners of people in these groups.²⁵
- High levels of needle sharing among IDUs.²⁵
- Limited availability of testing and counselling related to HIV, and facilities for antiretroviral treatment.²⁵
- Limited facilities for STI management.²⁵
- Limited capacity of health personnel and distribution of appropriate health care facilities.²⁵
- Limited government funding and high dependence on foreign donors.²⁵
- Indonesia is the source of 3,500,000 documented and 175,000 undocumented migrant workers.²⁷ Despite the fact that internal and cross-border migrants are recognized as often being vulnerable to HIV infection and obstacles in accessing treatment and care, limited information is available on HIV infection rates and risk behaviours among this large migrant population.²⁷

Knowledge of HIV and AIDS

The 2007 IBBS surveyed key affected populations on comprehensive knowledge of HIV – that is, the ability to both correctly identify ways of preventing the sexual transmission of HIV and reject major misconception about HIV transmission (Fig. 11).¹⁰ The results revealed that IDUs had the highest comprehensive knowledge (59%), followed by MSM (44%) and sex workers (27.1%). Among each of these populations, fewer people younger than 25 years of age had comprehensive knowledge as compared to those 25 years and above. Among IDUs, females had better comprehensive knowledge than males (69% vs. 58%). The inverse was true among sex workers, where 37% of MSWs had comprehensive knowledge compared to 25% of FSWs.

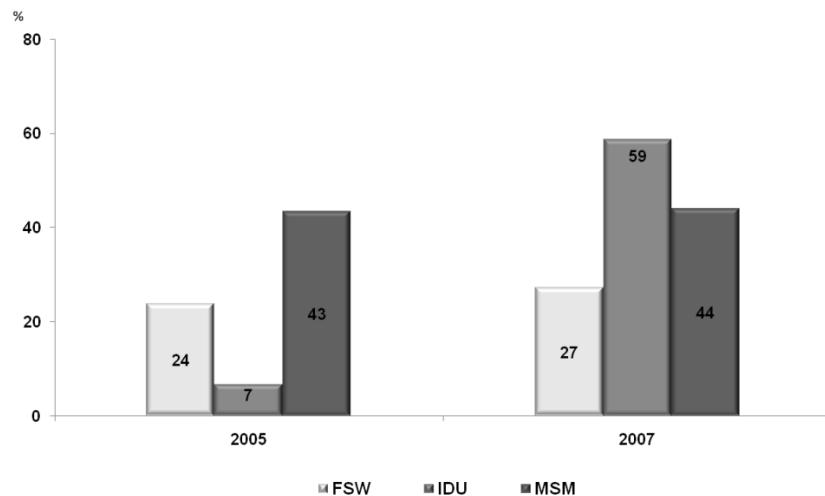
Figure 11: Percentage of key affected populations with comprehensive HIV knowledge by age group and gender, 2007



Source: Integrated Biological-Behavioral Survey (IBBS), 2007, cited in UNGASS Country Progress Report, 2010

Although overall comprehensive knowledge remains low, an increase among key populations from 2005 to 2007 was observed (Fig. 12)^{16; 28}.

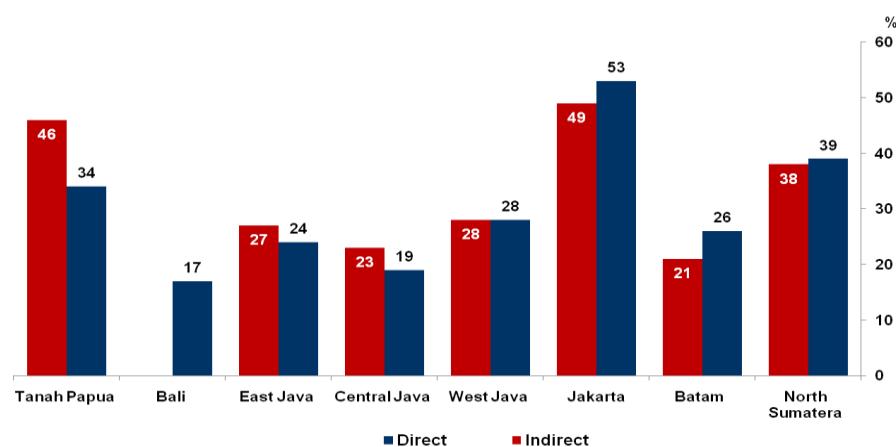
Figure 12: Percentage of key affected populations with comprehensive HIV knowledge, 2005 vs. 2007



Sources: UNGASS Country Progress Report, 2005 & UNGASS Country Progress Report, 2010

Within the series of responses to questions asked to discern comprehensive knowledge, it became evident that key elements of comprehensive knowledge were lacking among FSWs and IDUs. For instance, a high proportion of FSWs did not know that condom use could prevent sexual transmission of HIV (ranging from 21% in Batam to 49% in Jakarta among indirect FSWs; and from 17% in Bali to 53% in Jakarta among direct FSWs) (Fig. 13).¹⁹ In contrast, a survey conducted in late 2007 among 5,947 FSWs in 10 cities found that 89% of FSWs knew that condom use during vaginal sex could protect HIV transmission and 76% believed that condom use during anal sex could prevent HIV transmission.²⁰

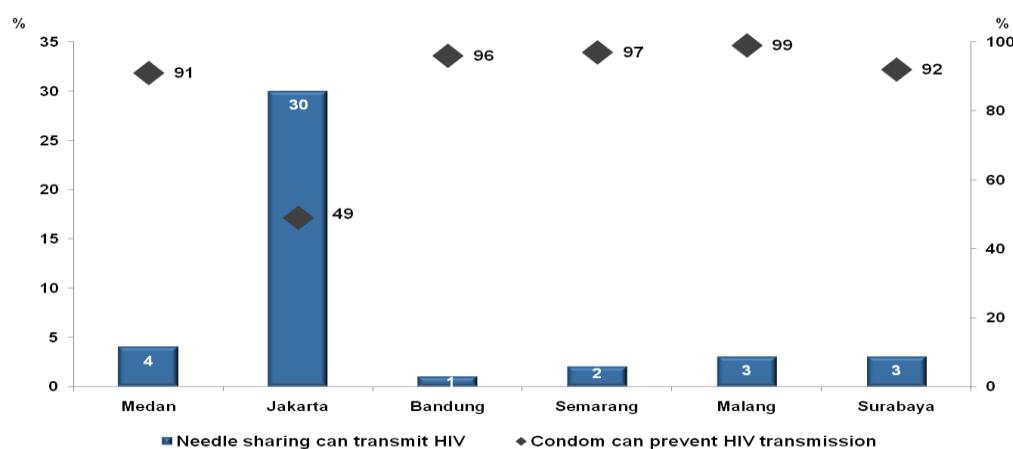
Figure 13: Percentage of female sex worker who does not know that condom use can prevent sexual transmission of HIV, 2007



Source: Integrated Biological Behavioral Survey (IBBS), 2007

Similarly, while most IDUs knew that using a condom could prevent HIV transmission (over 90% in all sites except for Jakarta at 49%), very few knew that needle sharing could transmit HIV (conversely, below 5% in all sites except for Jakarta at 30%) (Fig. 14).¹²

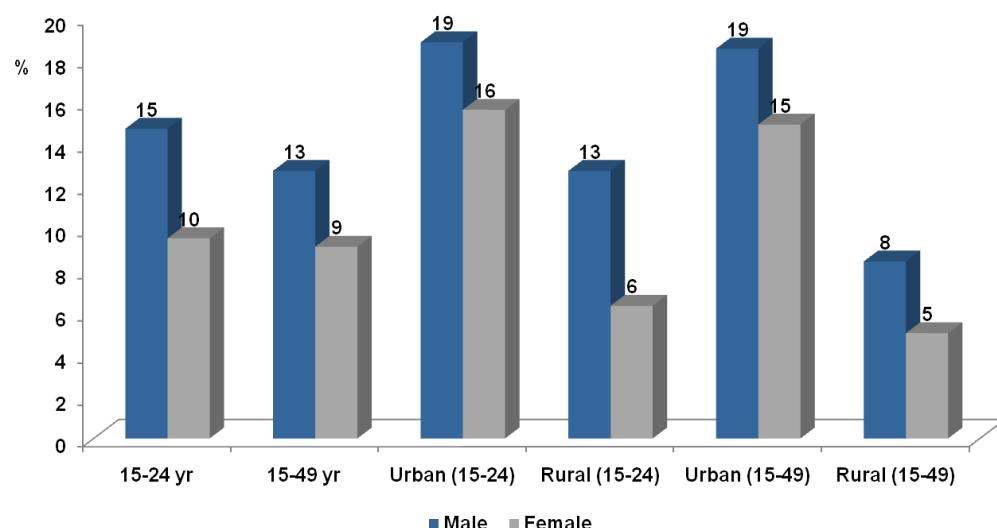
Figure 14: Percent of IDUs with correct knowledge of HIV transmission in selected cities, 2007



Source: Integrated Biological-Behavioral Survey (IBBS), 2007

Among the general population, findings from the 2007 Demographic and Health Survey (DHS) show very low levels of comprehensive knowledge of HIV among ever-married women and men – with women having lower levels of knowledge overall, based on age group and place of residence (Fig. 15).²⁹ Comprehensive knowledge among ever-married women and men aged 15-24 was 15% and 10%, respectively and was 13% and 9% among women and men aged 15-49, respectively. The same survey found that knowledge levels were higher among urban than rural dwellers, regardless of age group.

Figure 15: Percentage of ever-married male and female with comprehensive HIV knowledge by age group and place of residence, 2007



Source: Demographic and Health Survey (DHS), 2007

The 2007 Indonesia Young Adult Reproductive Health Survey – which covered young men and women aged 15 -24 from 33 provinces – found differing results: young women aged 15-24 had slightly higher levels of knowledge than their male counterparts (15.1% vs. 13.7%, respectively).³⁰ Despite the gender variations, both surveys revealed low levels of knowledge among the general young population.

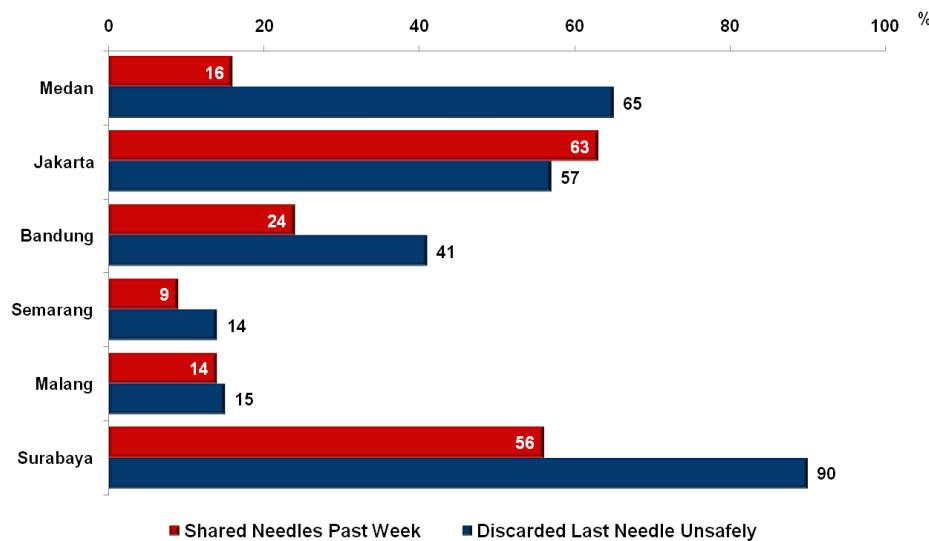
These low levels of knowledge are worrying, given the fact that the 2007 DHS found that many young people were sexually active. Indeed, 0.2% of ever-married males and 8% of females reported having had sexual intercourse before the age of 15; while 12% of males and 38% of females reported having had sexual intercourse before the age of 18. ²⁹

RISK BEHAVIOURS

Injecting equipment

Injection drug use is now the most common means of HIV transmission in Indonesia. According to the 2007 IBBS, 88% of IDUs used sterile injecting equipment the last time they injected; 87% among female IDUs and 88% among male IDUs.¹² This behaviour varied across regions, however, with anywhere from 9% of IDUs (in Semarang) to 63% (in Jakarta) having shared needles in the past week (Fig. 16).¹² Similarly, unsafe needle practice among IDUs ranged widely from 14% in Semarang to 90% in Surabaya (Fig. 16).¹²

Figure 16: Percentage of IDUs with selected injecting risk behaviours, selected cities, 2007



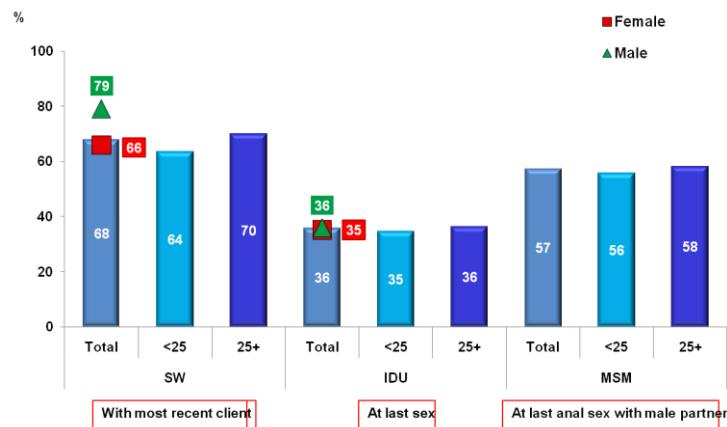
Source: Integrated Biological-Behavioral Survey (IBBS), 2007

Condom use

Condom promotion still faces constraints in Indonesia, given issues such as the lack of strong political support for the implementation of condom programs as well as the limited access to and availability of condoms. Only 17% of the Papua population reported that it is easy to get condoms. Pharmacies and clinics are the main sources of condoms.⁹

Of the key affected populations, condom use was highest among sex workers and lowest among IDUs. Thirty-six percent of IDUs reported the use of a condom the last time they had sexual intercourse, compared to 68% of sex workers and 57% of MSM (Fig. 17).¹⁰

Figure 17: Percentage of key affected populations who used a condom at last sex by age group and gender, 2007

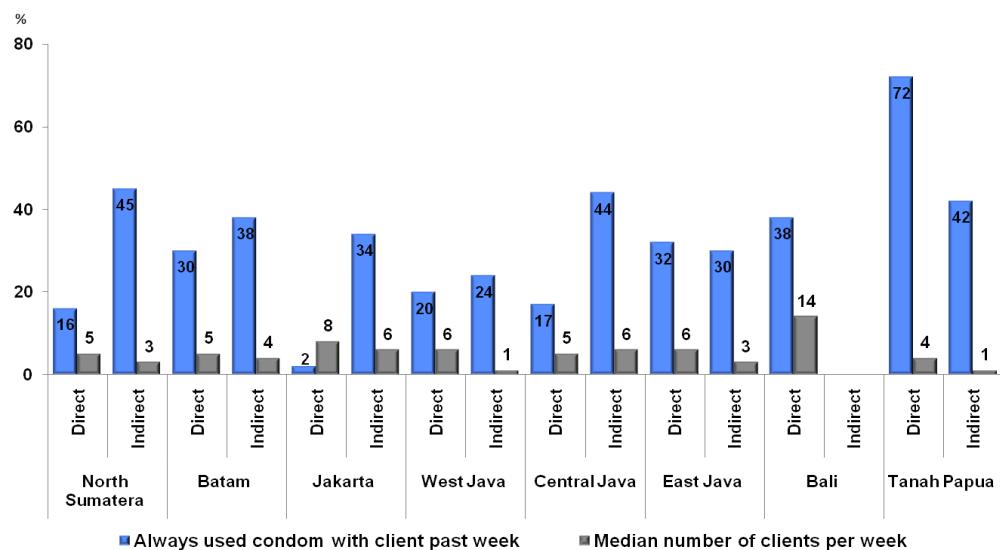


Source: Integrated Biological-Behavioral Survey (IBBS), 2007, cited in UNGASS Country Progress Report, 2010

An overall increase in condom use at last sex with a client among both female and male sex workers was noted, from 48% in 2004-2005 to 66% in 2007 and from 56% in 2004 to 79% in 2007, respectively.⁷⁻²⁸ Over the same period, only a negligible increase in condom use was observed among MSM at last anal sex with a male partner, from 56% to 57%.¹⁵⁻²³

Consistent condom use among FSWs and their clients in the last week was low in 2007, falling below 50% among both direct and indirect FSWs in all sites (except in Tanah Papua, where it was 72% among direct FSWs) (Fig. 18). It posed a potential threat to spread HIV given that FSWs had anywhere from 1 to 14 clients per week, on average, depending on the region (Fig. 18).¹⁹ High risk men (those occupational groups who are frequent clients of sex workers) reported low condom use with FSWs. In particular, the percentage of those who always used a condom with a FSW in the past 3 months was 7% among truck drivers, 16% among seafarers, 37% among dock workers in Papua, 10% among dock workers outside of Papua, 45% among moto-taxi drivers in Papua and 21% among moto-taxi drivers outside of Papua.²²

Figure 18: Percentage of female sex workers who always used a condom with client during past week and median number of clients per week, 2007



Source: Integrated Biological - Behavioral Surveillance among Most-at-Risk Groups in Indonesia, 2007: Surveillance Highlights Female Sex Workers.

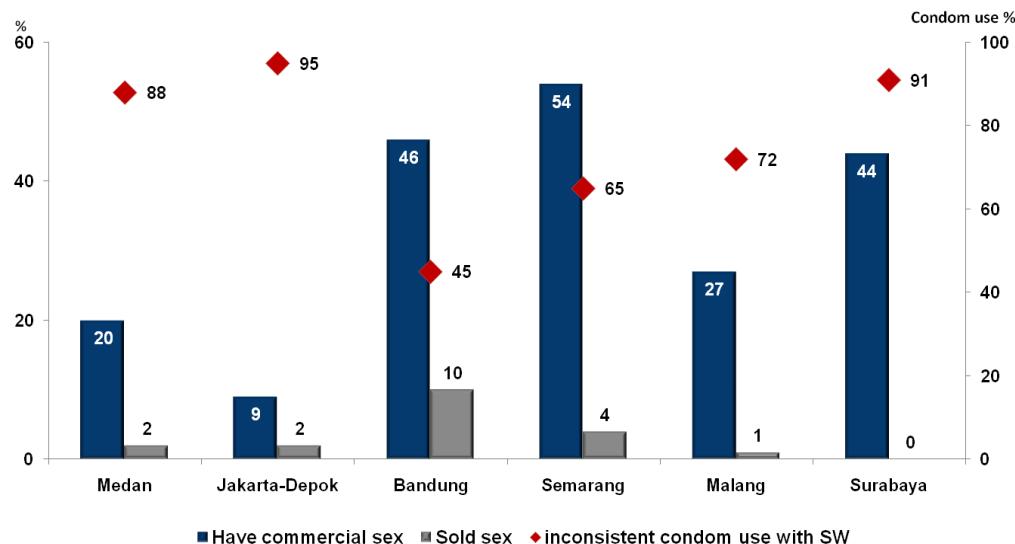
Consistent condom use was similarly low among *waria* and their clients. The percentage of *waria* who always used a condom at receptive anal sex with a client during the past month (in 2007) ranged from 15% in Jakarta to 32% in Malang, 34% in Semarang, 38% in Surabaya and 50% in Bandung.³¹

Overlapping risk behaviours

The overlapping of risk behaviours taken by key affected populations is of concern. For instance, the IBBS 2007 revealed that as many as 2.6% of direct sex workers (in North Sumatra) injected drugs in the last year¹⁹, together with 3.5% of MSM in Batam²³ and 3% of *waria* in Bandung who had ever injected.^{23; 31}

At the same time, IDUs also buy and sell sex, and have inconsistent condom use with sex workers. Figure 19 shows this interrelationship, where as many as 54% of IDUs (in Semarang) had commercial sex in the last year and as many as 10% sold sex (in Bandung). Furthermore, among those who had sex with a sex worker, inconsistent condom use ranged from 45% in Bandung to 95% in Jakarta-Depok.¹²

Figure 19: Percentage of IDUs with risky sexual behaviours during the past year in selected cities, 2007



Source: Integrated Biological-Behavioral Survey (IBBS), 2007

AGE DISAGGREGATION

A highlight of Indonesia's monitoring and evaluation system is its use of age-disaggregated data. Table 1 summarizes the most recent data that are disaggregated by age. As indicated, young people do not fare better than their older counterparts for almost all of the indicators – particularly those pertaining to vulnerability factors, risk behaviours and national response.

Table 1: Age-disaggregated data among key affected populations

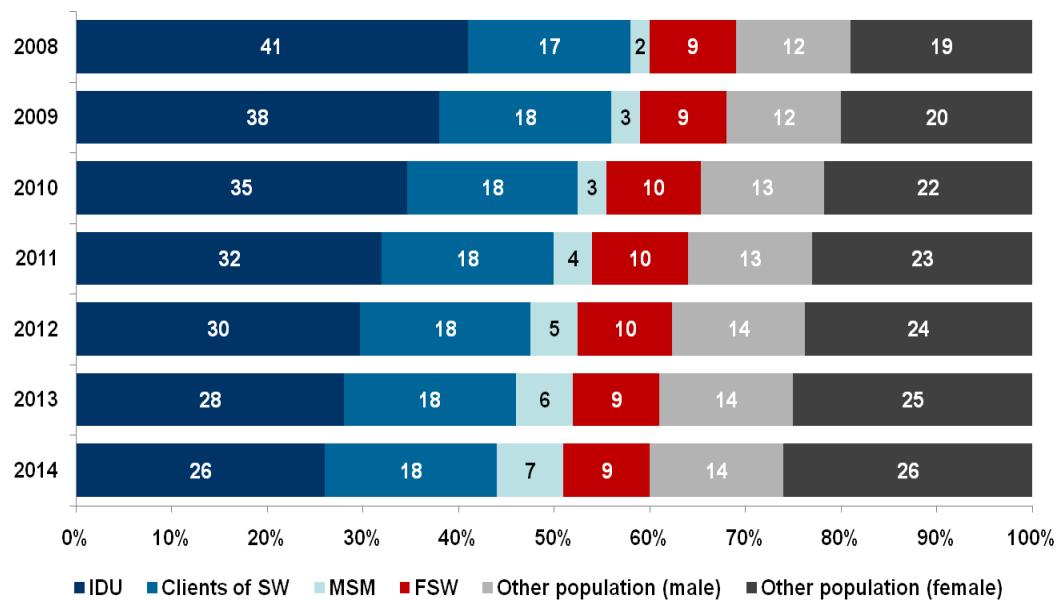
Indicator	Population	Year	<25	25+	Total	Young people fare better than average
HIV prevalence (%)	IDU	2007	41.5	58	52.4	X
	SW	2007	10.4	10.1	10.2	
	MSM	2007	4.2	6	5.2	X
Comprehensive HIV knowledge (%)	IDU	2007	52	62	59	
	SW	2007	25	28	27	
	MSM	2007	40	46	44	
Received an HIV test in the last 12 months and know the results (%)	IDU	2007	37	48	44	
	SW	2007	27	35	33	
	MSM	2007	31	35	34	
Reached with HIV prevention programmes (%)	IDU	2007	37	46	43	
	SW	2007	26	31	29	
	MSM	2007	38	48	44	
Used a condom with their most recent client (%)	SW	2007	64	70	68	
Used a condom the last time they had anal sex with a male partner (%)	MSM	2007	56	58	57	
Used a condom at last sex (%)	IDU	2007	35	36	36	
Used sterile injecting equipment the last time they injected (%)	IDU	2007	82	89	88	
Adopted behaviours that reduce transmission of HIV in the last 12 months	IDU	2004-2005	23	14	19	X
	IDU - Females		27	9	18	X
	IDU - Males		18.9	19.2	19.1	
Had sex with more than 1 partner in the past 12 months	Males	2007	0.2	0.3	0.3	X
Had more than 1 partner in the past 12 months reported condom use at last sex	Males	2007	100	58	60	X

Sources: Report on the Global HIV/AIDS Epidemic 2008 & Integrated Biological-Behavioral Survey (IBBS), 2007, cited in UNGASS Country Progress Report, 2010

HOW MIGHT HIV AFFECT INDONESIA IN THE FUTURE?

Asian Epidemic Model (AEM) projections show HIV prevalence among the population aged 15-49 increasing to 0.37% by 2014.³² It also projects that HIV transmission through injecting drug use will be progressively overcome by sexual transmission involving other risk groups, particularly MSM (Fig. 20). High risk groups currently influence and/or dominate the trend of the HIV epidemic, but the trend in the future may significantly involve lower-risk groups such as clients of sex workers and their female partners.

Figure 20: Estimated percent distribution of people living with HIV by population, 2008-2014



Source: Mathematical Model of HIV Epidemic in Indonesia, 2008-2014, Directorate General Communicable Disease Control and Environmental Health, Ministry of Health

This projected increase in the number of new HIV infections among women may lead to an increase in the number of new infections among children. The AEM projects that new infections among children will increase from 1,070 in 2008 to 1,590 in 2014, with the total number of children with HIV projected to rise from 2,470 in 2008 to 6,240 in 2014.³²

Despite the fact that ART drugs are subsidized in Indonesia, people living with HIV (PLHIV) face personal financial burdens of HIV care. A cross-sectional survey of 353 PLHIV in three cities in Indonesia (Jakarta, Jogjakarta and Merauke) revealed a significant financial burden for individuals in Jakarta and Jogjakarta (as opposed to those in Merauke where social health insurance and NGO schemes covered payments).³³ PLHIV in Jogjakarta spent 68% of their monthly expenditure for HIV-related care, while PLHIV on ART in Jakarta spent 96% of theirs. Findings from a seven province study presented in International AIDS Conference in Vienna indicated that – the loss of income by PLHIV households by way of caring for the sick is drastic and they lost 55% more income than the non-PLHIV households in this regard.³⁴

NATIONAL RESPONSE

Law and policy implementation

Sharia law is applied to regulate homosexual behaviour in Aceh province. In this province, homosexuality carries heavy penalties of 100 lashes (applicable only to Muslims).³⁵ The rest of Indonesia does not have laws that criminalize homosexual behaviour, although the Penal Code of Indonesia provides for a maximum imprisonment of 5 years for male-to-male sex by minors under the age of 16.³⁵

Sex work is legal in Indonesia, although crimes against decency/morality are sometimes enforced.³⁶

Furthermore, Indonesia retains the death penalty for drug offences.³⁷ And yet, Indonesia is one of few countries in Asia in which methadone is legally available, facilitating harm reduction. Moreover, the Supreme Court of Indonesia recently took steps to formally recognize the human rights of drug users. Following reports of widespread rights abuses, documented by the Indonesian Harm Reduction Network ("JANGKAR") in 2008, the Supreme Court issued a memo in early 2009 instructing judges to send drug users to rehabilitation, not to prison.³⁸

Governance

Over the years, the Government of Indonesia through the Ministry of Health has mounted a broad range of policy and programme responses to HIV & AIDS, among which include:

- Establishment of a Study Group on AIDS and a Working Group on AIDS (1985);
- Establishment of the National AIDS Committee (1987);
- Formulation of the first National AIDS Strategy in 1995 and the second National AIDS Strategy (2003-2007) in 2003;
- Reorganization and expansion of the National AIDS Commission to encompass 5 NGOs in addition to the 21 government ministries and agencies (2006); and
- Launching of the new National AIDS Strategy and formulation of the National HIV and AIDS Action Plan 2007-2010, and more recently the National AIDS Strategy and Action Plan for 2010-2014, which serves as a national guideline for HIV programs.

By virtue of Presidential Decree No. 36/1994, the National AIDS Commission (NAC) and Regional AIDS Commissions were established to coordinate the fight against AIDS. The NAC has 12 working groups that help formulate policies, with each working group responsible for a specific aspect of the HIV response. These working groups are focused respectively on: Papua, women, children and youth, harm reduction, communications and promotion, care, support and treatment, monitoring and evaluation, estimation and surveillance, world of work, migrant populations, law and human rights, and research and operational studies.²⁵

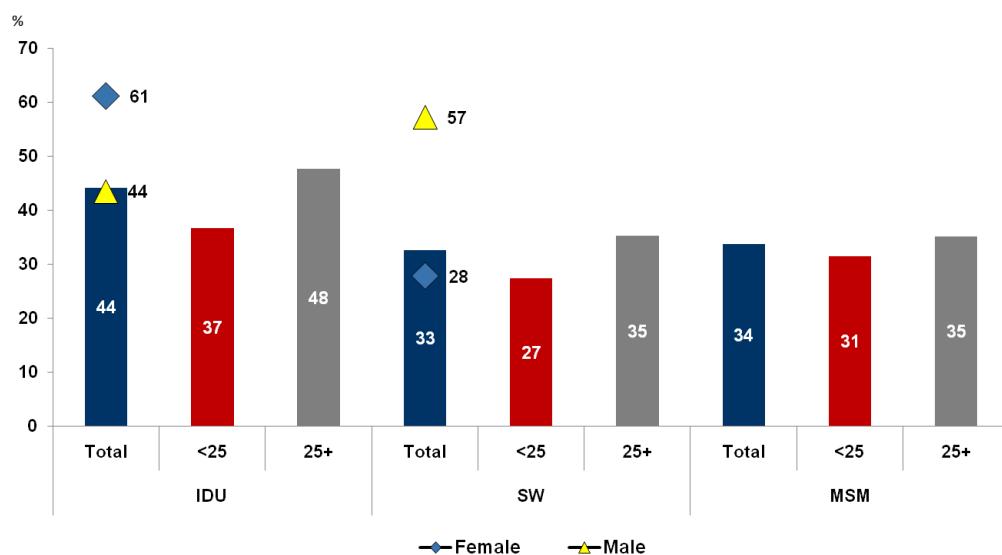
As abovementioned, a new National AIDS Strategy and Action Plan for 2010-2014 has been launched, which serves as the main reference for HIV prevention, care, support and treatment programmes by all levels of government, international development partners and other government and non-government institutions.²⁴ According to this Plan, the response to HIV and AIDS includes 4 major areas of concern: 1) prevention, including improving the quality and availability of reproductive health services and understanding reproductive rights; 2) provision of medication and comprehensive care, support, and treatment for people living with HIV and affected by AIDS; 3) Impact mitigation to reduce the negative socio-economic impact of HIV and AIDS on PLHIV and their families; and 4) conducive environment to strengthen management and institutional capacity.²⁴

HIV Prevention programmes

No national data is available on HIV testing uptake among the general population. However, 2006 data from the Ministry of Health reveals that 24% of the adult population (aged 15-49) in the two provinces of Papua had received HIV test and knew their results.⁹

Figure 21 shows the low percentages of key affected populations who received an HIV test in the last 12 months (in 2007) and knew their results. Overall, more IDUs (44%) received HIV testing than MSM (34%) and sex workers (33%). Among IDUs, women were more likely to have been tested (61% vs. 44%), while the reverse was true among sex workers, among whom 28% of females were tested compared to 57% of males. Moreover, in each group, younger populations (under 25 years of age) were less likely to have received testing than their older counterparts.¹⁰

Figure 21: Percentage of key affected populations who received HIV testing in the last 12 months and knew the results by age group and gender, 2007



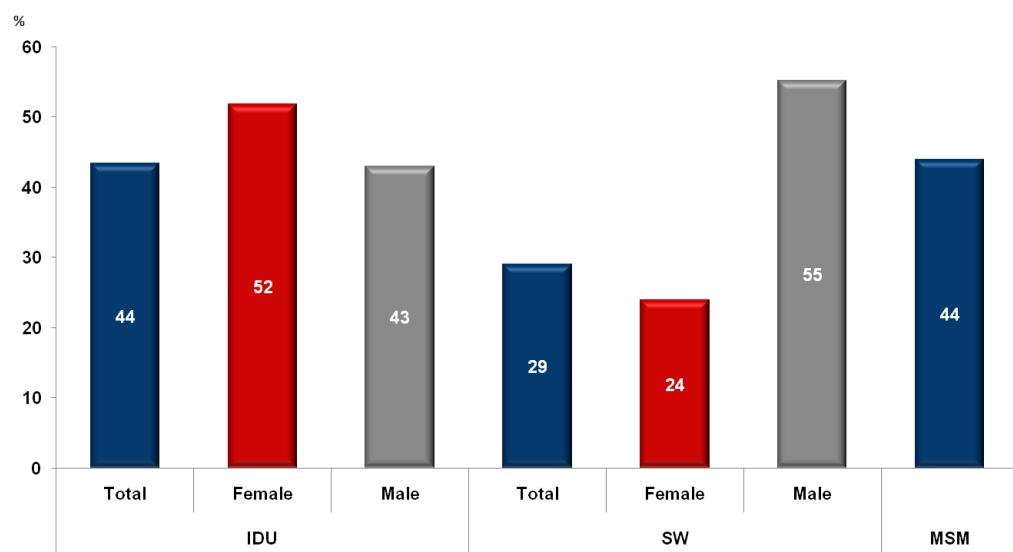
Source: Integrated Biological-Behavioral Survey (IBBS), 2007, cited in UNGASS Country Progress Report, 2010

HIV testing among high risk males was extremely low among those surveyed in 2007. Zero percent of dock workers and moto-taxi drivers outside of Papua had received testing in the last year.²² This figure ranged from 1% among truck drivers to 4% among seafarers to 5% among moto-taxi drivers in Papua and 7% among dock-workers in Papua.²²

HIV testing was more common among *waria*. Specifically, the percentages of those tested in the past year were 33% in Surabaya, 41% in Semarang, 60% in Jakarta, 77% in Malang and as high as 86% in Bandung.³¹

Key populations reached by prevention program coverage mirrors trends in HIV testing in terms of those groups most reached, by gender and by age. The percentage of those reached by HIV prevention programs was higher among IDUs and MSM (each at 44%) than among sex workers (at 24%) (Fig. 22).^{12; 19; 23} Also, more female than male IDUs and, inversely, more male than female sex workers were reached (Fig. 22). Across all populations, fewer younger individuals (younger than 25 years of age) were reached than their older counterparts.¹⁰

Figure 22: Percentage of key affected populations reached by HIV prevention programs, by gender, 2007



Source: Integrated Biological-Behavioral Survey (IBBS), 2007, cited in UNGASS Country Progress Report, 2010

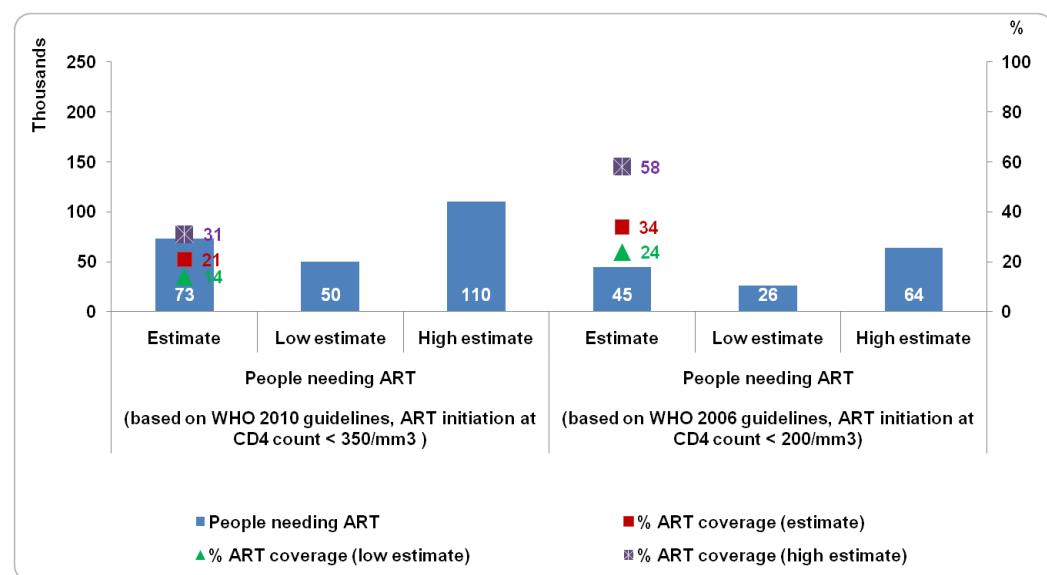
Harm reduction programs for IDUs were launched by the government in 2003, and are now available in 120 sites. According to the Towards Universal Access report, 2010 there were 1.1 needle and syringe programme sites per 1,000 IDUs and by the end of 2009, 6.8 syringes/needles were distributed per IDU per year by NSP.³⁹ According to the 2007 IBBS, the percentage of IDUs who received needles from a NSP in the last week ranged from 33% in Surabaya to 66% in Bandung, 73% in Jakarta and 96% in Medan.

In 2009, there were 0.2 opioid substitution therapy sites per 1,000 IDUs,³⁹ and by the end of 2009, 46 units health care centres, hospitals and prisons were providing methadone maintenance therapy (MMT).¹⁶

Antiretroviral treatment

While antiretroviral treatment (ART) could be accessed free of charge, there were persistent problems related to its distribution and availability. By end 2009, there were 565 VCT sites, up dramatically from only 25 in 2004.^{16; 39} In 2009, 180 facilities were providing ART, up from 150 in 2008 and 117 in 2006, and expected to increase to 234 by the end of 2010.^{16; 39} However, only 21% [14%-31%, based on 2010 guidelines] of adults and children with advanced HIV infection received ART in 2009 (Fig. 23).³⁹ By the end of 2009, 15,442 adults and children were receiving ART (up from 10,606 in 2008 and 5,100 in 2006). In 2006 and 2008, a higher percentage of females than males received treatment (44% vs. 22% in 2006; 49% vs. 32% in 2008).⁴⁰ However, in terms of absolute numbers, far more men received treatment (7,934 men vs. 2,682 women in 2008).³⁹

Figure 23: Number of adults and children who are in need of ART and % of ART coverage, 2009



Source: WHO, Towards Universal Access, 2010

Prevention of Mother-to-Child Transmission

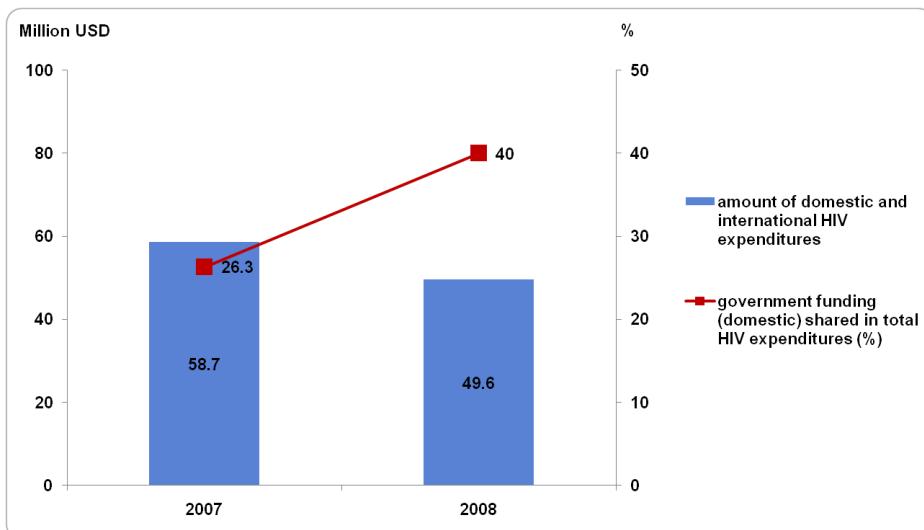
According to the Ministry of Health (MoH), in 2008, 3.8% of pregnant women living with HIV received ART to prevent the transmission of HIV to their babies – only a slight increase from 3.5% in 2006.⁴⁰ In absolute figures, it was estimated that in 2008, 196 out of 5,170 HIV-positive women were receiving antiretroviral prophylaxis.⁷ The MoH also reported on the percentage of HIV-positive women who received treatment for PMTCT – giving a range from 4% as a low estimate to 17% as a high estimate.³⁹ The same data presented estimates that only 1% of pregnant women were tested for HIV and that 7% of infants born to an HIV-positive mother received ART for PMTCT.³⁹

At the end of 2009, there were 37 PMTCT service centres available in 24 provinces, although a comprehensive package of services (including testing and counselling for pregnant women, delivery by caesarean section, provision of replacement feeding for infants, PCR testing for the infants) was available in only 9 provinces.¹⁶

ECONOMICS OF AIDS

In 2008, the total amount of expenditures on HIV and AIDS was US\$ 49.6 million.¹⁶ Of this total, 40% was financed by the domestic/public sector and 60% by international sources. The total amount spent was a slight decrease from 2007, US\$ 58.7 million of which nearly three fourths (74%) was from international sources (Fig. 24).⁷

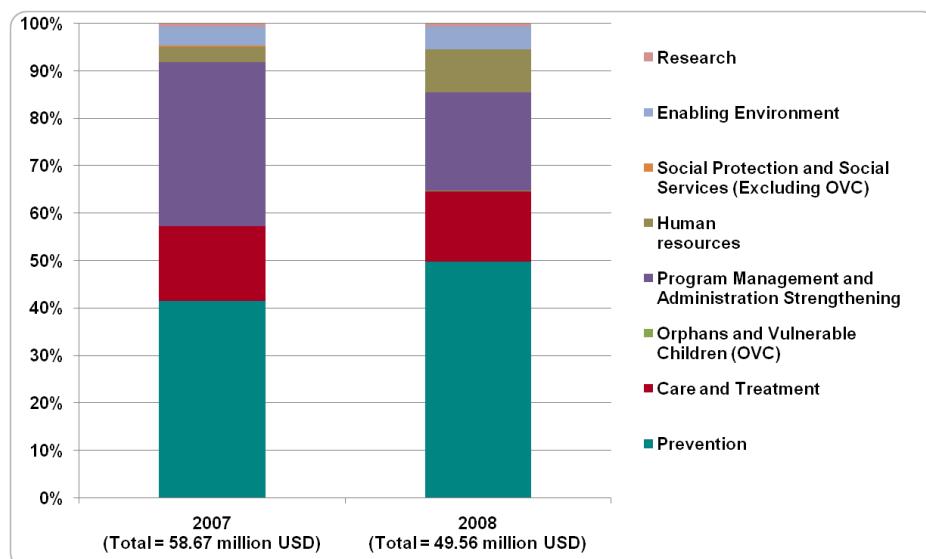
Figure 24: Amount of domestic and international HIV expenditures and % shared by government, 2007 - 2008



Source: UNAIDS, Report on the Global AIDS Epidemic, 2010

In 2008, the majority of funding was used in prevention programs (50%), followed by care and treatment (15%), and program management (21%) (Fig. 25).⁷

Figure 25: Percent distribution of total HIV expenditures by major spending category, 2007 - 2008



Source: UNAIDS, Report on the Global AIDS Epidemic, 2010

In 2008, bilateral funds (primarily from the United States, Australia and the United Kingdom) accounted for 66% of the total international expenditures on HIV and AIDS.⁷ Meanwhile, the Global Fund was the largest multilateral source of funding, providing 72% of the total multilateral contributions.⁷

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