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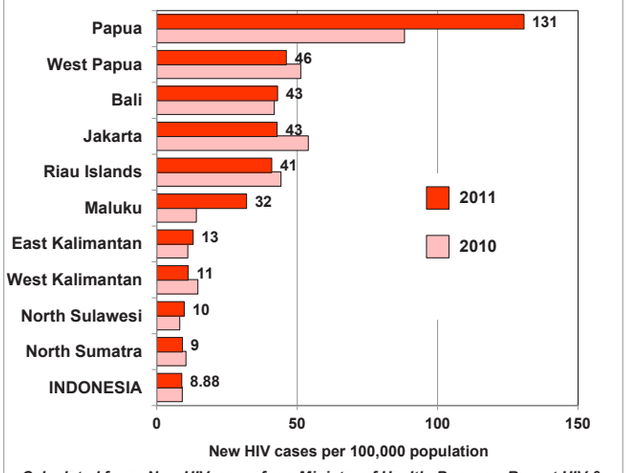
IssueBriefs

Responding to HIV and AIDS

Inequities

Every 25 minutes in Indonesia, one person is newly infected by HIV. One out of every five newly infected people is below the age of 25 years. Indonesia's Ministry of Health projections show that without acceleration of HIV prevention programmes, over half a million people in Indonesia will be HIV positive by 2014. The epidemic is fuelled primarily by sexual transmission and injecting drug use. Tanah Papua (the two provinces of Papua and West Papua), Jakarta and Bali lead in the rate of new HIV cases per 100,000 people (Figure 1). Jakarta has the highest number of new cases (4,012 in 2011).

Figure 1. The top ten provinces in new HIV cases per 100,000 population in 2011.



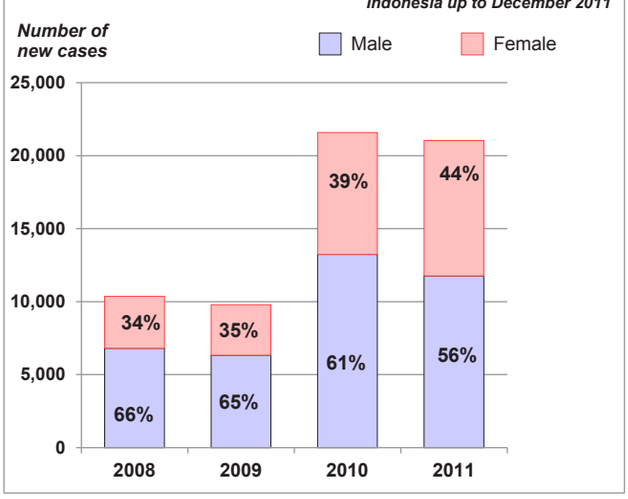
Calculated from: New HIV cases from Ministry of Health, Progress Report HIV & AIDS Situation in Indonesia up to December 2011. Population data from SUPAS 2005 (Intercensal Survey) projection for 2011 population. 2010 census for 2010 population (2011 projects unavailable at the time of this Report).

Tanah Papua illustrates a case of extreme inequity in infection patterns. With only 1.5 per cent of Indonesia's population, Tanah Papua accounted for over 15 per cent of all Indonesia's new HIV cases in 2011. Papua alone has a case rate nearly 15 times higher than the national average. Unlike the rest of Indonesia, Tanah Papua is experiencing a low level generalised HIV epidemic with a prevalence of 3 per cent in youth aged 15-24. HIV prevalence amongst the indigenous Papuan population is higher (2.8 per cent) than that amongst non-indigenous population (1.5 per cent) and higher in men (2.9 per cent) than in women (1.9 per cent).

The epidemic in Tanah Papua is driven almost completely by unsafe sexual intercourse. The underlying and structural causes include grinding poverty amidst unequal patterns of rapid development and natural resources exploitation, ethnic and linguistic inequities, low levels of education and knowledge about HIV, gender discrimination, a young age of sexual debut and other social and cultural norms.

The increasing feminization of the epidemic in the country highlights inequities in status and power. Women are more vulnerable due to their traditional roles in society, which extend to marital relationships. The proportion of women in new HIV infections in Indonesia has grown from 34 per cent in 2008 to 44 per cent in 2011 (Figure 2).

Figure 2. New HIV cases amongst women and men, 2008-2011.
HIV data from Ministry of Health, Progress Report HIV & AIDS Situation in Indonesia up to December 2011



The Ministry of Health has projected a rise in infections among children, as new HIV infections increase among women. Preliminary findings of a recent study commissioned by UNICEF and the

National AIDS Commission highlight the difficulties faced by children affected and infected by HIV/AIDS. Their access to education and health services is limited by discrimination, the family's financial difficulties because of the illness, the ill health of the child and the need to take care of the sick parent. The estimated number of children infected each year is projected to increase from 1,070 in 2008 to 1,590 in 2014.

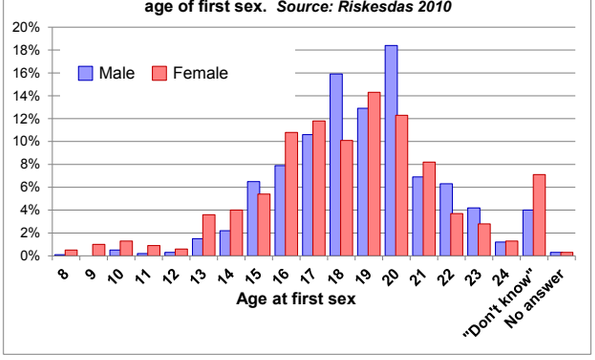
The age group 15-24 years accounted for 18 per cent of reported new HIV cases in 2011. Young people make up around 30 per cent of the most-at-risk population, where HIV prevalence is higher. Estimates in 2011 placed prevalence rates at 36 per cent amongst injecting drug users, 22 per cent amongst transgender waria, 10 per cent amongst female sex workers and 8.5 per cent amongst men who have sex with men.

Barrier

Young people have limited access to sexual and reproductive health information and services. Sex remains a taboo subject that is not openly discussed with parents, teachers, and even with health providers. Legal restrictions make it difficult for unmarried young people to access sexual and reproductive health services. Other legal provisions criminalize the dissemination of information on sex education.[1] The promotion of condom use is still problematic in Indonesia; certain regions oppose this on religious or moral grounds.

The age of sexual debut in Indonesia is quite young, especially for girls. Across Indonesia, some 1 per cent of boys and 4 per cent of girls have reportedly had sexual intercourse before the age of 13 years, some as young as before 10 years (Figure 3). By the time they are 17 years of age, about a third of young people will have had at least one sexual encounter. In Tanah Papua, 13 per cent of in-school and 19 per cent of out-of-school adolescents (aged 16-18 years) were reported to be sexually active. Of this sexually active group, about half of those who were out of school reported having two or more partners. The proportion drops to 15 per cent if they are still in school.

Figure 3. Percentage of unmarried young people aged 10-24 years by age of first sex. ***Source: Riskesdas 2010***



Amongst young people, knowledge about HIV has increased but is still limited. A study in five provinces by the Ministry of Health showed an increase in comprehensive knowledge about HIV and AIDS amongst youth (age 15-24 years) in the general population, from 11.4 per cent in 2010 to 20.6 per cent in 2011, with similar proportions for men and women. Over half the youth knew that AIDS could not be transmitted by sharing food, and two-thirds responded correctly that a healthy-looking person could be infected with HIV. In another 2011 study, only 22 per cent of grade 11 secondary school students had comprehensive knowledge of HIV transmission, and 64 per cent had misconceptions about HIV.

However, knowledge amongst young people is not sufficient to guarantee safe behaviour. Surveys of high school students in six cities over the period 2007-2009 showed low rates of consistent condom use (below 20 per cent), although over half the respondents were able to identify condoms as a means of preventing HIV. In 2011, of the senior secondary school students who admitted to having had sex, 49 per cent reported that they did not use condoms during their last sexual intercourse.

Knowledge levels are low amongst the general population aged 15 years and older. The Riskesdas 2010 survey found that some 42 per cent of the total population older than 15 years had never heard about HIV/AIDS. Only 10 and 13 per cent respectively of women and men had comprehensive knowledge of HIV prevention, although the proportions were higher for specific questions.

Fear, stigma and discrimination against people living with HIV still pose formidable barriers. Families and children living with HIV/AIDS are subject to stigma and discrimination, which translates to reduced access to services, loss of dignity and a greater degree of poverty and deprivation. In Tanah Papua, only 20.2 per cent of young people in school and 15 per cent of out-of-school young people had accepting attitudes towards people living with HIV. The fear amongst people creates resistance to HIV testing, embarrassment about seeking treatment, and in some cases, a reluctance to be educated. All these make it difficult to control the epidemic.

High-risk groups are more aware of HIV, but still engage in risky behaviour. In 2011, one-third of female sex workers reported not using a condom with their most recent client. Less than half of all injecting drug users (41

[1] Indonesia's Criminal Code contains legal provisions that criminalize supplying information to people relating to the prevention and interruption of pregnancy (Articles 283, 534, 535). The Pornography Law (No. 44/2008) could prevent people from disseminating information on sex education.

per cent) consistently use condoms with casual partners. Some 39 per cent of male clients of female sex workers did not use a condom at their last paid sexual encounter. Around 40 per cent of reproductive-aged men who had sex with more than one partner reported not having used a condom at their last sexual encounter.

The availability of and access to condoms is still an issue, although the use of condoms in Indonesia has more than doubled from 2006. Both the Population and Family Development Law (No. 52/2009) and the Health Law (No. 36/2009) stipulate that only legally married couples can access sexual and reproductive health services.[2] This makes it difficult for young people and unmarried adults to access contraception or family planning services from government clinics. However, condoms can easily be obtained from nearby markets, except in remote areas.

Although voluntary and confidential testing (VCT) services have increased throughout the country, knowledge about their existence is limited. In 2010, only 6 per cent of the population older than 15 years knew about VCT services. This proportion, the same for women and men, was only 4 per cent in rural areas. The higher wealth quintiles were better informed on both VCT services and HIV prevention. In December 2011, the Ministry of Health reported 500 active VCT sites in 33 provinces, up from 156 in 27 provinces in 2009. Confidentiality issues and fear of stigma and discrimination hamper efforts to increase the uptake of testing.

Capacity, attitudinal and cultural constraints affect measures to prevent parent to child transmission and promote follow up care for mother-baby pairs. Services to prevent parent to child transmission (PPTCT) are limited and the implementation at provincial and district levels is variable. The disparities in availability and usage are probably a reflection of the variation in local capacities, follow-up mechanisms (or lack thereof) and the local cultural norms and attitudes towards HIV. Thus, the numbers of pregnant women tested and the proportion of HIV-positive women receiving antiretroviral drugs vary widely from year to year. Less than one per cent of pregnant women were tested for HIV in 2008. In 2011, only 157 per cent of pregnant women living with AIDS received ARV to reduce mother to child transmission.

The knowledge and uptake of VCT remains low amongst young people in Tanah Papua. In 2006, less than 20 per cent of youth aged 15-24 in Tanah Papua knew an HIV testing site. The percentage of youth who reported having had a test was also low (23 per cent). The proportion having had a test and knowing the result was even lower (0.3-1.6 per cent).

2 Articles 72 and 78 of the Health Law, and Articles 21.1, 24.1 and 25.2 of the Law on Population and Family Development.

Opportunities for action

HIV/AIDS education amongst decision makers and opinion makers should focus on removing complacency and on the need to allocate sufficient resources to fighting HIV. In many low-prevalence countries, where the HIV/AIDS epidemic is concentrated amongst high-risk groups, the attitude is one of complacency and dismissal that HIV only "happens" because these groups have questionable morals. Indonesia is not an exception to this division between "them" and "us." Indeed, as in some other Asian cultures, one term used for a female sex worker is wanita tunasusila or woman without morals. People need to be made aware that the epidemic is also spreading amongst those who are not in high-risk groups, and that people are sexually active from a young age, yet lack the knowledge and services to protect themselves from HIV/AIDS.

Young people who are affected or at risk have special needs. Specific strategies and programmes for such young people need to be tailored to these needs.

Advocacy on HIV/AIDS will require credible data, especially on the nation's young people, and not just on high-risk groups. So far, HIV information systems have emphasized high-risk groups. Yet the trends show that increasingly, more information is needed on HIV prevalence and epidemiology, risk behaviour and knowledge amongst the general population. For instance, the National AIDS Commission (2012) in its UNGASS report mentioned the lack of data on some indicators considered by the government to be relevant for Indonesia, but on which data are not available. Similarly, there is a crucial need to obtain more disaggregated data amongst youth (age 15-24 years) in order to tailor programmes to their particular needs. Support is thus needed for district teams to build strong information systems disaggregated by age, gender, location and ethnicity. Having levels of different access to information can meet the need for confidentiality on HIV testing.

Legal and policy barriers that limit young people's access to information and services need to be lifted across districts and regions. The efforts should emphasize access to VCT services and condoms. Most young people do not normally use health services. Overcoming this inherent resistance will require the expansion and promotion of the Adolescent Friendly Health Services (AFHS) approach, launched by the Ministry of Health in 2003. In 2012, some 61 per cent of all districts had at least four health centres implementing the AFHS approach. Nonetheless, the approach remains limited. Better coordination will be needed with other relevant services, such as those relating to sexually transmitted infections, methadone maintenance therapy, and needle and syringe programmes.

The high HIV prevalence amongst Tanah Papua's youth needs special education and prevention efforts. Public education campaigns are urgently needed in Tanah Papua. The AFHS approach, with VCT and condoms as the key element, should also be accelerated. Peer education activities in communities and schools need to consider the extremely high proportion of out-of-school youth. Amongst 33 provinces, Papua has the highest proportion (38 per cent) of out-of-school children in the age group 7 to 15 years.

To eliminate HIV transmission to children, Indonesia will need to implement provider-initiated HIV testing and counselling for all pregnant women. HIV testing and treatment should be offered routinely by antenatal care services. This would require changing the existing minimum service standards on antenatal care. More rigorous follow-up and public education are also needed on PPTCT services. It is still unclear why the majority of pregnant women testing positive for HIV do not receive treatment. Most likely, the reasons include fear of stigma and leakage of confidentiality; lack of support from the husband, family and community; the poor quality of services received at initial contact and unsympathetic health staff. District assessments may be needed to determine why the majority of pregnant women diagnosed with HIV do not come back to undertake antiretroviral therapy.

Fighting HIV/AIDS will require better coordination between sectors on youth-related policy and programming. Most of the issues confronting young people are inter-related. National policy promotes cross-sectoral approaches to fighting HIV/AIDS, but the coordination and collaboration has to come at district and province level. Developing youth-related policies and programmes will also require greater levels of participation from youth and other stakeholders.

Social protection and social assistance programmes need to be HIV-sensitive. This means strengthening measures to protect and enhance the access to social services by HIV-affected families. Efforts are underway to include PPTCT services under Jamkesmas, the Government's health insurance programme for the poor. More needs to be done to support the education, protection, health and nutrition of children and young people affected by HIV/AIDS.

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