Indonesia Country Brief

HIV and Key Affected Women and Girls

Key affected women and girls include:

- Women and girls living with HIV
- Female spouses/intimate partners of men with high-risk behaviours
- Female sex workers
- Female drug users
- Transgender women
- Female migrant workers who may be vulnerable to HIV due to conditions by which they migrate

Percentage of total adults living with HIV who are women:

30%

Estimated number of women living with HIV (aged 15+):

110,000

Coverage of HIV prevention programmes for female sex workers is the lowest among all key populations.

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About the Country Briefs

- These country briefs synthesize some of the current available data and evidence on key affected women and girls into one, easy-to-read report. For the first time, available data and research on national AIDS responses as it specifically relates to key affected women and girls were collated and carefully reviewed together, to improve understanding of women and girls most at risk of, and most affected by, HIV in the region. In doing so, the aim of the briefs is to increase understanding of the specific needs of key affected women and girls in ASEAN Member States and to support national efforts to ensure prioritized and tailored national AIDS responses that protect and promote the rights of women and girls, in all their diversity. The briefs were developed in response to requests from partners at the regional and national level to assist them in prioritizing which women and girls to comprehensively target in national AIDS responses.

- A consistent approach has been applied in order to produce an off-the-shelf analysis of HIV and key affected women and girls which synthesizes information from disparate national sources. While multiple data sources have been used to compile each brief, country progress reporting on HIV and AIDS is widely cited. Each of the briefs includes an overview of the following as it specifically relates to key affected women and girls in the context of the national AIDS response:

  - Epidemiology
  - Modes of transmission
  - Social and economic vulnerabilities
  - Access to information
  - Access to services
  - Legal and policy environment
  - Current international and regional policy guidelines
  - Information gaps
  - Recommendations

From the cover page

Percentage of total adults living with HIV who are women: 30%[1]

1 UNAIDS. (2012). Global Report: UNAIDS Report on the Global AIDS Epidemic 2012. (http://www.aidsdatahub.org/dmdocuments/UNAIDS_Global_Report_2012_en.pdf)

Estimated number of women living with HIV (aged 15+): 110,000[2]

2 UNAIDS. (2012). Global Report: UNAIDS Report on the Global AIDS Epidemic 2012. (http://www.aidsdatahub.org/dmdocuments/UNAIDS_Global_Report_2012_en.pdf)

Coverage of HIV prevention programmes for female sex workers is the lowest among all key populations.[3]

3 National AIDS Commission/Republic of Indonesia. Republic of Indonesia Country Report on the Follow up to the Declaration of Commitment on HIV/AIDS (UNGASS) Reporting Period 2010-2011. 2012. (http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/)

EPIDEMIOLOGY

- In addition to female sex workers and female injecting drug users (IDUs), female spouses of high-risk men must be included in calculations of most-at-risk populations in Indonesia, which in 2009 reached a total of more than 6 million people.[4]
- Intimate partner transmission of HIV remains a cause for concern. Complex sexual networks put a significant number of women at risk of HIV infection although they would often be perceived and described as 'low-risk' because they have sex only with their husbands or long-term partners.[5]
- Multiple partners, more frequent sexual intercourse, low level of demand for condoms, low condom use and access have all increased the risk of transmission not only among key affected populations, but for women who are sexual partners of clients of sex workers or people who inject drugs.[6]

MODES OF TRANSMISSION

Sexual transmission

- HIV infection among female sex workers and their clients continues to play a significant role in the heterosexual transmission of HIV in Indonesia. However, the female sex worker population is not homogenous. The environments in the sites where they work and their mobility may have an important effect on sexual transmission of HIV.[7]
- Between 3.6% to 25% of direct female sex workers, 0.4% to 8.8% of indirect female sex workers, and 14.4% to 30.8% of waria (transgender) were infected with HIV, depending upon the province.[8]
- 27% of direct female sex workers and 30% of indirect female sex workers are below the age of 25.[9]
- 49.5% of sex workers under the age of 25 reported the use of a condom with their most recent client, in comparison to 61.7% of sex workers over the age of 25.[10]
- The proportion of female sex workers infected by HIV in their first six months of selling sex is high, indicating that they get infected very quickly after initiating sex work. The prevalence of sexually transmitted infections (STIs) which elevates the risk of acquiring and transmitting HIV infection was very high among brothel-based female sex workers.[11]
- Approximately 10% of surveyed men who have sex with men (MSM) are currently married.[12]
- In Papua and West Papua provinces the current HIV situation is reaching a critical level driven by unsafe sexual intercourse. The epidemic in Papua and West Papua is considered a low-level, generalized epidemic with HIV prevalence of 1.9% among females aged 15 – 49 years old.[13]

Injecting drug use

- Integrated Biological and Behavioral Surveillance (IBBS) data from 2007 reported that 57% of female IDUs were infected with HIV.[14]

Vertical transmission

- Less than 1% of pregnant women are tested for HIV.[15]
- The Ministry of Health estimated that there were 5,060,637 pregnant women in 2011, and 0.4% (21,103) of them have been tested for HIV and received the results. Of those who were tested for HIV, 2.5% (534 pregnant women) were HIV positive.[16]
- In 2011, it was estimated that only 15.7% of HIV-positive pregnant women receive antiretrovirals (ARV) to reduce the risk of mother-to-child transmission.[17]
- The proportion of pregnant women known to have received ARV prophylaxis is increasing.[18]

SOCIAL AND ECONOMIC VULNERABILITIES

- Studies and contemporary discussions emphasize the lack of efficacy of women and girls in many fields in Indonesia, in particular, in sexual decision-making. Improvements to reduce high-risk behaviour and increase the ability of young people, particularly girls, to protect themselves from HIV infection, will require intensive, gender appropriate programmes directed at both boys and girls, men and women.[19]
- Women are vulnerable to HIV infection not only due to biological factors but also due to various forms of gender-related violence.[20]
- A study conducted in 2011 by Ikatan Perempuan Positif Indonesia (IPPI), the Association of Indonesian Positive Women, among its members looked at violence as a consequence of HIV and reported that nearly a quarter of the women interviewed had experienced physical violence and almost a third had experienced sexual violence since disclosing their HIV status.[21]
- The dilemmas women face when deciding whether or not to share HIV test results with their sexual partners and family may be substantial, as antiretroviral treatment (ART) requires lifelong adherence and is much more likely to be sustained in a supportive situation.[22]
- In a 2010 study looking at 1,019 households of people living with HIV (PLHIV), it was found that twice as many girls drop out of school in the PLHIV households compared to boys whereas in the non-PLHIV households, more boys dropped out than girls.[23]
- The same 2010 study also reported that female-headed HIV-affected households (HIV-HH) were more likely to be in debt than male-headed HIV-HH. Female-headed (non-widowed) HIV-HHs were also less likely to own their home than male-headed (non- widowed) HIV-HHs and the majority of female widows in HIV-HH had been denied a share in their deceased husband's property and assets.[24]
- Adult women (wife or other elder female members) often become the breadwinner in PLHIV households (25%) compared to non- PLHIV households (15%).[25]
- Women from Indonesia, which has the largest number of women migrants in the region moving to neighbouring countries as domestic workers, now outnumber men in migration flows.[26]
- Indonesian women migrant workers, a majority of who work as domestic workers, are particularly vulnerable to gender based violence and to HIV throughout the entire course of the migratory cycle. [27]

ACCESS TO INFORMATION

- Sexuality education within schools is influenced by social norms. Rather than giving attention to the promotion of understanding and practice of safe sex, the primary concern of sexuality education in Indonesia is to delay sexual debut and promote fidelity within marriage. Sexuality is approached as a science and moral subject while the social context and issues of gender equity related to sexual practices is either left out altogether or given very minor attention in some schools.[28]
- Data from the 2007 Indonesia Young Adult Reproductive Health Survey reports that only 14.3% of young people aged 15 - 24 have comprehensive knowledge about HIV and AIDS.[29]
- The 2007 Indonesia Demographic and Health Survey (IDHS) reported that 9.5% of ever married women and 14.7% of currently married men aged 15 – 24 had comprehensive knowledge about HIV.[30]
- Data shows female sex workers have a lower understanding about HIV prevention than male sex workers and lack of gender-sensitive services might be one of the explanations. Among female sex workers, 37% reported knowing where to get an HIV test and 38% had received a condom in the preceding three months.[31]
- In general, female IDUs are more knowledgeable about HIV and AIDS than female sex workers. This is presumably due to the demographic characteristic of IDUs who generally live in big cities where the survey was conducted, and have higher levels of education, and better exposure to media. However, this population ranks the lowest in using condoms. Moreover, IDUs tend to have more networks and are better organized and there are more programmes for IDUs compared to other vulnerable populations, so they are more likely to be exposed to HIV education messages.[32]
- Women, who are likely to visit antenatal care (ANC) clinics on their own, have generally not thought about having an HIV test prior to being offered the opportunity as part of their ANC so most of these women have not talked with their partner prior to having an HIV test.[33]

ACCESS TO SERVICES

- A challenge continues to be the promotion of couples counselling and community based initiatives to assist women prior to, during and post HIV disclosure in addressing negative outcomes should they occur. Without such initiatives, the ARV treatment rate among (pregnant) women may remain low.[34]
- There is an absence of regulations that ensure equal access for women to various programmes of prevention, care, support and treatment.[35]
- Data from the 2011 IBBS showed that coverage of HIV prevention programmes for female sex workers was the lowest among all key populations.[36]
- Support to key affected women and girls is still limited through community health insurance (jamkesmas) and local health insurance (jamkesda) and is not accessible to all key populations, including female sex workers and female drug users.[37]
- The presence of female drug use is a hidden problem that needs a special approach. Sharing contaminated injecting equipment and the possibility of being involved in risky sexual practices makes them vulnerable to HIV. Family, outreach workers, and counselors need to understand their psychological situation to be able to encourage female drug users to seek the best treatment available.[38]
- Between 2008 and 2009, 51.85% of female IDU were reached with HIV prevention programmes.[39]
- Although the percentage of female IDU who received sterile injecting equipment is higher than their male counterpart (94% compared to 88%), in reality the number of male IDU exposed to harm reduction programmes was much greater than female IDU.[40]
- While the priority of the national response remains focused on efforts to work for and with people of key populations, the steadily increasing numbers of reported HIV-positive women has made scaling up of prevention of mother-to-child transmission of HIV (PMTCT) services a priority concern. By 2011, it was estimated that 8,170 pregnant women are HIV-positive in Indonesia.[41]
- At the end of 2009 there were 37 PMTCT service centres available in 24 provinces. However, comprehensive services (including HIV testing and counselling for pregnant women, delivery by caesarean section and provision of formula for infants) were available in only 9 of the country's 33 provinces.[42]

- The 2007 IDHS showed low involvement of a father during their partner's pregnancy, with only 32% of fathers talking to health care providers about the pregnancy care and health of their wife during their wife's last pregnancy.[43]
- A 2010 study conducted among PLHIV identified twice as many women as men who reported difficult access to healthcare facilities (20.83% vs. 10.31%) as the major reason for not accessing treatment. A higher number of women (23.6% women against 16.03% men) also cited fear of disclosure to their healthcare provider as a reason for not accessing treatment.[44]
- A 2011 study conducted with 109 HIV-positive women in Indonesia reported that opportunities for counselling on family planning were few and most HIV-positive women are uncomfortable to raise pregnancy prevention with their (mostly male) doctors. The study also found that among the respondents:
    - more than 1/3 had difficulty finding a gynaecologist to care for them due to their HIV status;
    - 40% were encouraged to consider sterilisation and most women were discouraged from becoming pregnant;
    - many spoke of discrimination from nursing staff and gynaecologists, especially maternal health care workers at the time of the delivery which included verbal and physical abuse, being left completely alone during labour, and nursing staff refusing to touch them or bathe their newborn infant.

  A separate survey conducted with 111 HIV-positive women across eight provinces in 2011 documented that 13.5% of the women had undergone a sterilization procedure without any counselling process or services.[45]

LEGAL AND POLICY ENVIRONMENT

- The priority of the national response remains focused on efforts to work for and with key populations, including female IDUs and female sex workers, in order to prevent HIV from spreading into the general population.[46]
- Policymakers recognize that prevention efforts also need to be broadened to reach other people such as HIV-positive pregnant women, women who are intimate partners of men with high-risk behaviour; migrant workers; and young people at risk.[47]
- A multi-pronged national strategy has been formulated to guide the response to a range of HIV and AIDS issues related to women. There are 5 main elements:

    1. Improving availability and quality of services for prevention, care, support, and treatment and impact mitigation for vulnerable women;
    2. Protecting the rights of women;
    3. Creating an enabling and conducive environment within family and community to protect women from infection with STIs including HIV, thus reducing women's risk of becoming AIDS patients;
    4. Conducting gender-informed operational research related to STI, HIV and AIDS to identify new approaches in responding to the epidemic which will increase acceptability and effectiveness in addressing the specific problems of women at risk or infected with STIs and HIV;
    5. Involving men in the response to HIV and AIDS and specifically in the search for more gender-appropriate approaches for women and men.[48]

- In some areas of Indonesia, addressing the risk of HIV transmission is being done through legal approaches rather than enhancing health services and repressive methods are more common than protecting the rights of key affected women and girls.[49]
- Sex work per se is not illegal but due to the complexity and ambiguity of the laws, female sex workers are marginalized and prone to discrimination from different agencies and through the divergent interpretation of the laws. For instance, crimes "against decency or morality" are enforced against female sex workers.[50]

- The punitive nature of the 2009 Law on Narcotics does not support harm reduction services, and special arrangements and negotiations with the local police are needed to enable needle and syringe programmes to be provided. More advocacy and better dissemination are needed in order to minimize violations of human rights, and to ensure the protection and promotion of women's human rights including those of female drug users.[51]
- There is a lack of gender-sensitive policies and programmes for female injecting drug users and the female partners of injecting drug users.[52]
- In addition to a specific law to protect women (Law no.7/1984 on the elimination of violence against women), Indonesia has a series of laws and government regulations to protect vulnerable groups. Unfortunately, not many key affected women and girls are familiar with these regulations.[53]
- Regulations to ensure the implementation of these anti-discriminatory laws include:
    - Regulation No 2/2007 on harm reduction among injecting drug users issued by the Coordinating Minister for People's Welfare;
    - Chief of National Police Regulation No 8/2009 on human rights approach in carrying out National Police tasks. Article no. 20 in this regulation particularly emphasizes the special approach to women;
    - Government Regulation no.9/1999 on gender mainstreaming.[54]
- The Population and Family Development Law (No.52/2009) and the Health Law (No. 36/2009) stipulate that only married women have access to family planning and contraception; excluding both adolescent and unmarried women from reproductive health services, thereby placing them at greater risk of unwanted pregnancies and STIs, including HIV.[55]
- Legislative frameworks that constrain women's rights to own economic assets increases the vulnerability of women to the economic impacts of HIV.[56]
- Services that provide access to justice for women and girls living with HIV and most-at-risk female populations whose behaviour are criminalized are limited. There are a few isolated examples of services that provide targeted legal aid and community legal education for these population groups such as the Community Legal Aid Institute.[57]

CURRENT INTERNATIONAL AND REGIONAL POLICY GUIDELINES

- HIV and the Law: Risks, Rights & Health (Global Commission on HIV and the Law, July 2012)[58];
- Sex Work and the Law in Asia and the Pacific (UNDP, UNFPA, UNAIDS, 2012)[59];
- UNAIDS Guidance Note on HIV and Sex Work (UNAIDS, 2009)[60];
- Agenda for accelerated country action for women, girls, gender equality and HIV (UNAIDS, 2009)[61];
- Community Innovation: Achieving sexual and reproductive health and rights for women and girls through the HIV response (UNAIDS/The ATHENA Network, 2011)[62];
- Joint UN Statement: Compulsory drug detention and rehabilitation centres (March 2012)[63].

INFORMATION GAPS

- Data concerning PMTCT services has suffered from inconsistent reporting which make sound evaluation difficult.[64]
- A major gap is the lack of sex disaggregated data and gender analysis of injecting drug users in the context of HIV.[65]
- Policies recognize the increasing impact of HIV on women in intimate partnerships, based on the epidemiological data and projections, but as yet there are no specific studies (quantitative or qualitative) on intimate partner transmission of HIV in Indonesia.[66]
- There is a lack of data and operational research on violence against women as both a cause and consequence of HIV in Indonesia.[67]
- Several factors hamper gender mainstreaming and the development of effective legal and policy frameworks on protection of migrant workers against gender-based violence and HIV/ AIDS, including weaknesses in coordination of government and civil society interventions. A major factor underlying these limitations is the poor availability and reliability of gender-disaggregated data, research, policy assessments etc. on areas related to labour migration, HIV/AIDS and gender and their interrelationship.[68]

RECOMMENDATIONS

- Expansion of life skills education for girls and adolescent females, both formal and non-formal, should be a priority.
- Intensify and scale up HIV prevention efforts with female key populations (including female sex workers, female drug users and transgender women) using rights-based and evidence-informed strategies that give greater attention to the gender inequalities that are a key driver of the epidemic in Indonesia.
- Engage men in a substantial way to address sexual communication, sexual behaviour and male responsibility in relationships and sexual health.
- Improve and evaluate couples HIV counselling and testing services and strategically promote these services among couples at risk of intimate partner transmission. This includes improving post-test counselling support for disclosure of positive status to long-term partners.
- Improved research and data related to intimate partner transmission by prioritizing operations and behavioural research on HIV transmission from key populations at higher risk to their intimate partners.
- Ensure meaningful involvement of key affected women and girls in the development of policies and programmes that affect them.
- Conduct operational research on violence against key affected women and girls as both a cause and consequence of HIV in Indonesia.
- Ensure increased, sustainable funding for HIV-positive women's networks and strengthen the meaningful involvement of women living with HIV in policy and programmatic interventions. Recognize and support the beneficial role that women living with HIV can play in delivering services and support within healthcare and community settings as highlighted in the 2012 WHO guidance on couples HIV counselling and testing.
- Institute legislative reform to ensure gender equality in the ownership of economic assets (e.g., property and inheritance rights) and autonomy over economic decisions.
- Design, implement and enforce anti-discrimination laws (both in relation to gender and HIV status) in institutional settings (workplaces, schools, healthcare settings, etc.) to combat stigma; minimize the threat of HIV-related income/ employment loss; and improve women's access to social protection, healthcare and psychosocial services.
- Review and amend the Population and Family Development Law (No.52/2009) and the Health Law (No. 36/2009) to bring them in line with international human rights law and standards. In particular legal provisions which discriminate on the grounds of marital status should be repealed and requirements for a husband's consent to access certain reproductive services, including contraception and family planning, should be removed.

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WHO ARE "KEY AFFECTED WOMEN AND GIRLS" IN ASEAN?

Depending on the circumstance and country, the following groups have been identified as key affected women and girls in ASEAN:

- Women and girls living with HIV
- Female sex workers
- Women and girls who use drugs
- Transgender women and girls
- Mobile and migrant women
- Female prisoners
- Women with disabilities
- Women in serodiscordant relationships
- Female intimate partners of men who engage in behaviours that put them at a higher risk of HIV infection
- Women and girls in HIV-affected households

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The country brief is available to download at www.aidsdatahub.org and www.genderandaids.org.

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