Life and death with HIV/AIDS: life stories from Karawang, West Java

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Chapter 3

The Structural Drivers of HIV in Karawang

This chapter focuses on the context of the HIV/AIDS epidemic in Indonesia, focusing on Karawang district where my study was conducted. I first discuss the blame, stigma, and denial that surround the disease. I then outline the ‘risk’ factors in Karawang society: its social, cultural, and political features that have accelerated the epidemic. Finally, I describe how PLWHA can gain access to health services in this resource-poor setting.

Since its inception, HIV/AIDS has been associated with moral blame. The common perception in many parts of the world is that HIV/AIDS is a curse on immoral behavior – homosexuality as well as premarital, extramarital, and commercial sex. HIV/AIDS in Indonesia was first ‘foreignized’ and then ‘feminized’ by blaming Western foreigners and then Indonesian female sex workers (Kroeger 2000:4). As the epidemic progressed, the discourse focused on prostitutes as the main cause of transmission. As I discussed in Chapter 2, the danger of focusing on ‘high risk’ groups and behaviors is that it both stigmatizes the people who belong to these groups and breeds complacency among those who consider themselves ‘safe’, such as monogamous couples, housewives, and adolescents.

Blame fuels stereotypes and stigma against people who are already marginalized because they fall outside of the moral standards of society. Many studies of HIV/AIDS stigma find its roots in processes of ‘othering’ (Posel 2004:1). For female sex workers, the stigma is twofold. First, they suffer stigma as wanita tuna susila or WTS (literally ‘woman without morals’) or perempuan nakal (naughty women). Second, they are stigmatized as the locus of disease or, to use Schoepf’s term, ‘a reservoir of infection’ that constructs HIV/AIDS as ‘a disease of women’ (2001:341). This

29 The term wanita tuna susila is gradually being replaced by pekerja seks or sex worker. Women’s and human rights activists prefer to use pekerja seks, though some activists use the term perempuan yang dilacurkan (prostituted women) since they perceive female prostitutes as victims. Local terms to address sex workers such as cabo, sundal, perek, lonte, jablay, and lontong have derogatory connotations.
notion that HIV/AIDS is ‘a disease of women’ is strong among the male clients of female sex workers. When I conducted an in-depth study of men who have sex with men in Jakarta in 2002, contracting HIV from waria (transgender) sex workers was thought to be a near impossibility. Some men said that after visiting female prostitutes they would go to waria sex workers for oral sex, explaining that this would ‘clean’ their genitals to prevent infection from female sex workers (they used the term ‘cuci mulut’, literally meaning ‘mouthwash’). More importantly, they did not regard oral sex as ‘sex’.

Blame and stigma are also attached to junkies and injecting drug users, who are often perceived as unemployed, criminal, and untrustworthy trash. Junkies are a closed group and are difficult to reach in intervention programs. Most harm reduction programs employ ex and active junkies as outreach workers as they have access to this group. Although harm reduction programs are now widespread, needle exchange and methadone substitution programs remain controversial.

HIV/AIDS stigma can take various forms in different cultural contexts. In many parts of the world, stigma leads to discrimination against marginal groups whose ‘perverted’ behavior should be punished. Fear of stigma and discrimination in turn fuels denial and concealment among PLWHA. Denial also often comes from families and communities ashamed that one of their members is HIV-positive. Numerous cases have shown that PLWHA experience exclusion and ostracism from their own families and communities.

Official denial generally invokes morality and religion. In the early years of the epidemic, government officials argued that Indonesia was protected by its religious and cultural values, family resilience (ketahanan keluarga) and strong faith (keteguhan iman). While the central government may now recognize the problem, denial persists among local governments and certain (mainly religious) groups in society.

This chapter outlines the factors driving the epidemic in Karawang society. I briefly describe the transformation of Karawang into an industrial zone. This is followed by a discussion of marriage, family, divorce, and local norms concerning gender and sexuality. I then turn to prostitution, migration, and drug use – the drivers of the epidemic in this changing society.
From rice granary to industrial zone

Karawang district is located on the northern coast of West Java, approximately 70 km from Jakarta. While agriculture and fisheries were traditionally the main sources of livelihood, Presidential Decree no. 53/1989 declared Karawang an industrial development zone, allocating about 20,000 hectares of land for this purpose. Rapid industrialization over the past two decades has transformed rice fields into roads, factories, warehouses, restaurants, and housing. The chemical, textile, electronic, pulp and paper, and automotive industries moved in, as did job seekers, not only from Karawang but from other areas of Java. Karawang natives thus have to compete with migrants who often have more education. Migration to the big cities, especially Jakarta and Bandung, is another option for the people of Karawang to improve their fortunes.

Figure 3.1. Map of Indonesia and Java Island

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30 The total population of Karawang district in 2005 was 1,907,483, with a density of 1,083 people per square kilometer (BPS-Statistics of Karawang Region 2006).
Rice production declined between 1990 and 2005 as rice fields shrunk from 103,000 to 92,000 ha. Nevertheless, Karawang remains one of the leading rice producing districts in the country. But as the population has increased, the average size of land holding has decreased (at present to less than 0.5 ha). The income\textsuperscript{31} of small farmers has dwindled accordingly, while a growing number of landless laborers now suffer from unemployment and under-employment.

Early August 2006 was harvest time in Karawang. Before noon, I visited a village in Cilamaya Wetan sub-district. The paddy harvest had started two days ago. I saw laborers – men and women – working in the fields, cropping paddy, pounding and weighing rice. Many laborers came from other sub-districts and districts. They slept in the rice fields in tiny plastic tents or under unused rice bags and coconut leaves. Land-owning farmers have several options when harvest season comes. First, they can sell their paddy to a broker (tengkulak) before it is harvested; the broker then hires laborers to harvest it. Second, farmers can use laborers in a share-cropping system where the laborers get a sixth (or less) of the yield. Third, farmers can hire laborers and pay in cash. The need for labor often puts farmers in a difficult situation. Ahmad (aged 50) complained, ‘It’s difficult not to involve many laborers when harvesting. The times have changed. Each hectare harvested means a blessing for tens of laborers’. He also admitted that he could not control the yield. Due to low pay or shares, laborers manipulate the system. For example, they pound paddy only two or three times instead of four or five times, which means not all of the grains fall off the straw. When they harvest at night to avoid the heat of day, farmers think it’s a way for them to gain more rice than their share. Ahmad said that it is a part of the picture of poverty in Karawang. There are few ways to make a living in this rice granary of West Java.

Unemployment among young people in rural Karawang has contributed to rampant \textit{premanisme} in the last few years. The word ‘premar’ is derived from the Dutch word ‘vrijman’ (free man), a term for seventeenth century merchants who were not employed by the

\textsuperscript{31} The average monthly income of farmers in Karawang is between Rp. 500,000 and 700,000 or US$ 55-78 (Radar Karawang 25 August 2006). This is below the minimum standard salary of Rp. 854,373 (US$95). The classic problem is that rice production costs outstrip harvest income (Radar Karawang 1 December 2006).
Dutch East India Company but were permitted to continue trading (Ryter 2001:130). The meaning of *preman* nowadays is similar to thugs and hoodlums: men who do what they want, regardless of the law.

Population growth, high unemployment, and poverty have taken their toll. Karawang is one of the five lowest ranking districts in West Java on the Human Development Index (HDI). During the monetary crisis, between 1996 and 1999, Karawang’s HDI dropped from 63.80 to 60.9. The 2003 *Susenas* (National Socioeconomic Survey) reported Karawang’s HDI to be 64.3; in 2004 it had improved to 65.04. In 2005 the index was 66.35, still below the 2005 HDI of West Java province at 69.35 (Badan Pusat Statistik Kabupaten Karawang 2006).

**Figure 3.2. Map of West Java and Karawang**

Karawang district is particularly vulnerable to the spread of HIV due to its proximity to the north coast highway, the main East-West artery linking the big cities on Java. Large mobile populations of truckers, bus drivers and other motorists – the usual customers of sex workers – ply this highway. Sex workers await clients at the many food stalls and restaurants along the road.
Marriage, family, divorce

Maryam is the eldest daughter of a peasant family. She was a migrant worker (tenaga kerja wanita or TKW) in Saudi Arabia in 1986-1989 and again in 2000-2002. Her younger sister, Mimin, is following in her footsteps as a TKW. Maryam married Akang in 1992 and had two children. When she was a domestic helper in Saudi Arabia for the second time, she regularly sent remittances to her family. But Akang spent the money for his own amusement and even married another woman. Maryam was upset and divorced her husband when she returned home. She remarried with Johan in 2004. She was tested for HIV when she applied again to be a TKW in a labor company in Jakarta; she tested positive. Nevertheless, sometime after her marriage she became pregnant. Maryam never understood how she was infected. Her work application was declined due to her seropositive status. Maryam was then referred to the YPI post in Karawang. Before the delivery of her baby, Maryam learnt that Johan already had a wife. For the second time, she filed for divorce. In August 2005, she went to Jakarta, accompanied by YPI staff, to give birth at Cipto Mangunkusumo public hospital. She entered the PMTCT program and underwent a caesarian section to prevent transmission to her baby. Maryam then returned to her village. When her baby was 7 months old, Johan reappeared, wanting to take care of his child. She agreed. But over the next few weeks, the baby started vomiting and had diarrhea, and died soon after. Her eldest daughter, 14 years old, is now working as a domestic worker in Saudi Arabia.

The above story reflects the state of marriage in Karawang, and to a wider extent, in the Pantura (north coastal area) region of West Java. To understand the effects of HIV/AIDS on marital and familial relations, I first discuss the meanings of marriage, family, and divorce in the local cultural context.

Although West Java consists of Muslim communities with various levels of religiosity, the people of Karawang are known for their lack of religious devotion. In this area, and West Java more generally, the age at first marriage for females tends to be lower than in many other areas. Jones (2001:68) states that in the early twentieth century, rural girls in West Java were married between the ages of 15 and 18. This pattern of early marriage has been stable over time; by the early 1970s, the average age at marriage had risen.
by less than a year. Girls who are married off at a very young age usually grow up in traditional patriarchal households and have limited autonomy and access to resources. They generally have no influence over when they get married.

Early marriage, arranged marriage, and family structure all contribute to the high divorce rate in these communities. Divorce can occur at any time, sometimes soon after marriage – a few months, a year, or after the birth of the first child. This can be followed by another marriage and another divorce. Jones’ study reveals that Kelantan (Malaysia) and West Java in the 1950s had the highest divorce rates in the world; in the mid-1960s, 59 out of 100 marriages in West Java ended in divorce (Jones 1997:96). The 1976 Indonesian Fertility Survey further found that a quarter of all marriages in West Java dissolved within 26 months (Jones, Asari, and Djuartika 1994:395-396). Although divorce rates declined sharply in the 1980s, the highest rates still centered on Indramayu and neighboring Kabupaten, and the northern coastal areas of Central and East Java (Jones 1997:100). Most divorces continued to occur in the early years of marriage, and were more common among the poor and less educated.

Based on survey data, the dramatic decline in divorce rates in the 1980s was related to the rising marriage age, the greater incidence of self-arranged or ‘love marriages’, higher educational attainment, enactment of the 1974 Marriage Law, and more fundamentally, changing family norms towards nuclear families and economic independence from parents (Heaton, Cammack, and Young 2001; Jones, Asari, and Djuartika 1994; Jones 1997).

More recently, observers have expressed concern over West Java’s once-again rising divorce rate. Sociologist Munandar Sulaeman in a 2004 study found the high incidence of divorce in six

32 Before the enactment of the 1974 Marriage Law, divorce could be registered in the Kantor Urusan Agama (Religious Affairs Office) at the village level. There are two categories of divorce: talak (husband’s request) and cerai (wife’s request). Since 1974, all requests for divorce have to be taken to the Pengadilan Agama (Religious Court) at the district level. The procedure is cumbersome as it involves counseling and a court hearing; fees must be paid. This has undoubtedly led to lower divorce rates.

33 A 2005 survey in seven big cities revealed that almost 70% of divorce cases were filed by women. The causes of divorce were disharmony, economic reasons, intervention of relatives, and incompatible character (http://www.solopos.com/2009/channel/nasional/angka-perceraian-meningkat-10-kali-lipat-515) accessed on 1 August 2011.
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study sites – namely Indramayu, Purwakarta, Garut, Cianjur, Majalengka, and Sukabumi – to run parallel to the number of early marriages (Pikiran Rakyat 4 February 2006). High divorce rates thus remain associated with the ‘classic variables’ of poverty and early marriage. In Karawang – a primary sending area of female migrant workers (TKW) to the Middle East – the high divorce rate is also informed by mobility.

I visited Panyingkiran, one of the villages producing countless TKWs, in early October 2006. There I met Dedeh, an ex-TKW, and Asnah, a volunteer teacher. I asked them about the history of women villagers becoming migrant workers. The first villager, Dedeh told me, went to Saudi Arabia to work as a domestic worker in 1982. Her success encouraged other women to try their luck. The peak was during the ‘krismon’ era in the late 1990s. Dedeh was in Saudi Arabia when the Rupiah collapsed and her salary soared from Rp. 350,000 to Rp. 2,500,000. One TKW brought home 50 million Rupiah and was able to buy one hectare of rice field. Like Dedeh, most TKWs went to the Middle East to improve their fortunes. Dedeh pointed out that she now has a better house.

Asnah said that female children are now considered assets as potential family breadwinners. When a woman delivers a baby girl, neighbors will say, ‘Well, it’s an Arab candidate’. It means she is a prospective TKW. Asnah and Dedeh said that men in their village tend to be lazy. When a wife works as a TKW and sends home remittances, the husband spends the money on other women, gambling, and buying unnecessary things. Many returned TKWs filed for divorce when they found out that their husbands were squanderers. But the husband can then demand money as he is not the one asking for divorce. Asnah said that in Panyingkiran, the husband can get 8-10 million Rupiah in compensation.

Samsul, an NGO staff member working on trafficking, added that Karawang men preferred putting their feet up. They don’t have regular jobs and are perceived as ‘lazy’ and ‘consumerist’ by outsiders. ‘It’s difficult to find a man who wants to work’, said Dedeh.

Rapid remarriage after divorce is encouraged in Sundanese culture. However, second (and subsequent) marriages tend to be more unstable than first marriages (Jones, Asari, and Djuartika 1994:399). The combination of women’s mobility, men’s behavior, divorce, and
remarriage increases women’s vulnerability to HIV infection. Marriage is no longer a safe haven for either women or men.

**Prostitution**

The 2002 Behavioral Surveillance Survey in West Java covered Bekasi city, Bekasi district, and Karawang district. Karawang district, which contains a number of *lokalisasi* (brothels or red light areas), was selected due to its concentration of prostitution (Biro Pusat Statistik 2003:3). Some *lokalisasi* have as many as 100 sex workers – for example, Betok Mati in Cilebar sub-district, Sungai Buntu in Pedes sub-district, and Kobak Biru in Teluk Jambe sub-district. Karawang city has one *lokalisasi*, called SR (read: se-er), beside the train station. A female sex worker is usually called *dongdot*, though the new popular term is *jablai* (from ‘*jarang dibelai*’ or ‘rarely caressed’). Alongside *lokalisasi*, one can easily find street sex workers at night, particularly around bus terminals and railway stations. In some poorer fishing villages in the north coastal area, prostitution is practiced openly. Gumilar, an ex-field coordinator at Klinik KITA, told me that sex workers in some villages in Tempuran sub-district work from their own homes. People call it an ‘open house’. The customers come to the house and the sexual transaction takes place in the bedroom, whether or not other family members are present. About this, Gumilar commented, ‘How can you get turned on?’

One evening Zaki and I rode his motorbike to *lokalisasi* Kobak Biru. It took 20 minutes from Karawang city. Kobak Biru lines one side of the road that connects Karawang to a neighboring district, Bekasi. On the other side of the road is a small river. The road is bumpy and there are many overloaded trucks. There are no public lights on the road. The lights come from a row of semi-permanent small houses where *dongdot* or *jablai* (sex workers) hang out, waiting for their customers. Each house has three to six sex workers. Some houses also function as small stalls selling beer, soft drinks, cigarettes, snacks, instant noodles, and other simple daily needs. *Dangdut* and house music

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34 *Lokalisasi* have typically been situated around train stations since the Dutch colonial era: Pasar Kembang in Yogyakarta, Saritem in Bandung, and Jatinegara in Jakarta to name but a few.
blare from the houses. The sex workers usually sit in front, chatting, joking, and texting on their cell phones. When motorbikes, cars or trucks pass by, the sex workers try to attract them by calling out, ‘Aa’, *mampir a*’ (Brother, please stop by) or ‘Aa’, *ka dieu heula*’ (Brother, come here). According to Zaki, most of the sex workers come from other parts of Karawang, Subang, Indramayu, and Bekasi.

We stopped at a house where three sex workers were sitting on a wooden bench. They knew Zaki as an outreach worker from Klinik KITA’s HIV/AIDS intervention program. Zaki introduced me and I tried to talk with Tari while Zaki chatted with the others. Tari came from Subang, the fifth child of seven. Her parents were poor agricultural laborers who could not afford to send their children to school. Tari only reached grade 4, then quit. She married at the age of 14, but her husband left when she was 8 months pregnant. Her daughter, now 11 years old, stays with her parents in the village. Tari had already been married three times. Each marriage had ended in divorce. ‘Where to go if not here?’ she asked. She not only worked in Kobak Biru, but moved between different *lokalisasi*. During our conversation, Tari kept holding her cell phone, talking to her two friends about new ring tones.

I asked Tari about what Zaki did in this place. She answered that he explained how to avoid diseases like syphilis, gonorrhea, and AIDS. He also distributed condoms. ‘Are you using condoms?’ I asked her. Laughing, she said, ‘The guest often does not like it’. Even though she was afraid of getting infected, she could not refuse her customers. When I asked whether she had already been examined at Klinik KITA, she replied, ‘Not yet. I don’t have a complaint’. One of Zaki’s tasks is to encourage Tari and her peers to check up on their health, particularly for STIs and HIV.

Tari’s story is not uncommon among sex workers from the Pantura region: poor family, dropping out from school, early marriage, divorce, remarriage, and so on; it is the ‘classic story’ in the prostitution world. Divorce is clearly one of the push factors leading young women into sex work.
Figure 3.3. *Lokalisasi* in Karawang district

Source: Mapping of *lokalisasi* in Karawang, Klinik Kita, FHI-ASA program, 2006
Migrant labor

In accordance with Indonesian government policy, many rural women have become migrant workers, particularly in the Middle East where they serve as domestic laborers. The number of documented migrant workers sent overseas between the onset of the *krismon*\(^{35}\) in 1998 and the end of 1999 was greater than all those sent under the country’s first five 5 Year Plans (Pelita I-V). West Java in particular produced the majority of these migrant workers (Hugo 2002:159). Surveys of female labor migrants from Indonesia, both documented and undocumented, reveal that these women tend to be in their 20s or early 30s and have relatively little education (Hugo 2002:164).

Since the 1980s, Karawang district has been the main supplier of TKI (*tenaga kerja Indonesia* or Indonesian migrant workers) and TKW (*tenaga kerja wanita* or female migrant workers) to the Middle East, especially to Saudi Arabia. Their remittances between January and September 2009 reached US$ 24,140,000.\(^{36}\) In the period between 2006 and 2010, 13,273 migrant workers\(^{37}\) from Karawang were officially working in the Middle East (Kompas.com 24 November 2010).

Migrant labor has been feminized. Enclaves of TKW in Karawang include Jatisari, Lemahabang, Tempuran, Telagasari, Rawamerta, Pangkalan, and Tegalwaru. Most Karawang women have little education; only 20% have finished junior high school. Though industrialization has created job opportunities, companies want high school graduates; Karawang women are thus marginalized in their own hometown. Agriculture no longer attracts the younger generation. To find work, many women have to migrate, either to the cities or abroad.

Maryam, whom I introduced above, is an ex-TKW who worked in Saudi Arabia on two separate occasions. The last time was in 2000-2002, though she did not remember her exact time of return. She only mentioned that Ramadan (the fasting month in the Islamic

\(^{35}\) *Krismon* means *krisis moneter* or monetary crisis, the popular term to describe the difficulties of making a living at that time.


\(^{37}\) The real number of TKW is hard to know since the local government only records those with legal documents. Many TKW go abroad illegally and are thus undocumented.
calendar) had come four times since her return. When I spoke to Maryam, her sister had already been in Saudi Arabia for two years, and would come home soon. Maryam’s eldest daughter, 14 years old at the time, was already working through a labor supplier firm in Jakarta. She also wanted to work abroad. Maryam recounted, ‘She said, if mother can’t go to Saudi, let me go to work’. As she was too young, her age was falsified on the documents. ‘Money talks’, Maryam added. Fortunately her daughter appeared physically mature, which eased administrative procedures.

Waisah binti Acik (35) – a TKW candidate from Turimulya II village, Lemahabang – had a long-suffering experience. She intended to work in Saudi Arabia, but in the end was sold to a pimp in Batam. For two weeks, this mother of two children was confined in the pimp’s barracks and would be sold as a sex worker along with 40 women from West Java (Pikiran Rakyat 2 July 2007).

This is but one example of how rural women are vulnerable to human trafficking. Reported cases of trafficking in the Pantura region have grown rapidly in recent years. I spent some time with Sidik, an outreach worker from Yayasan Kesejahteraan Anak Indonesia (YKAI) or Indonesia Child Welfare Foundation, in Panyingkirian village, Rawamerta sub-district. According to Sidik, 384 TKW were working in the Middle East in 2004, about 10% of the Panyingkirian population. But the demand for domestic workers in the Middle East was creating another problem in the village, namely child trafficking. Brokers and sponsors of TKW applicants could easily manipulate administrative requirements such as age, parent’s consent, ID cards, etc. In this village there were at least four sponsors. YKAI had run an intervention program to combat child trafficking, using community radio to raise awareness and providing scholarships to primary and junior high school students to reduce the drop-out rate. Sidik admitted that interventions at the family level were difficult. Some parents refused the scholarship and preferred their children to work.

38 The many ‘creative’ modes of human trafficking in Indonesia include bride order, child adoption, baby selling, and the recruitment of domestic workers, art performers, and undocumented migrant workers. More recently, street children have become the targets of pedophiles and human organ traffickers (CEDAW Working Group Initiative 2007).
Being a TKW increases one’s vulnerability to HIV/AIDS. Dedeh and Asnah, two female villagers, told me about the extramarital and unwanted pregnancies of some TKW in the village. They had probably had consensual or coercive sexual relationships with their employers or other men while in Saudi Arabia. According to Asnah, some TKW delivered babies who looked Arab, without clear legal status such as a birth certificate. Newspapers, radio, and TV often carried stories of TKW who were raped, tortured, cheated, trafficked, unpaid, etc., and even some who died. These stories, however, did not deter Karawang women from wanting to become migrant workers in the Middle East.

The threat of HIV/AIDS is not limited to when TKWs are abroad. Dedeh introduced me to the local term ‘duda bodong’, referring to husbands whose wives are working abroad as TKW. ‘Duda’ means widower and ‘bodong’ means ‘without letter’; thus duda bodong means ‘temporary widower’. The term implies that husbands will invariably look for new sexual partners: mistresses, prostitutes, even marrying other women (often secretly). More generally, these cases describe the ‘looseness’ of sexual norms in Karawang society compared to other communities in Indonesia.

Drug use

Let me begin with the story of Tatang, an injecting drug user and outreach worker for Pantura Plus.

Tatang, 25 years old, was born and grew up in Karawang. He is a high school graduate, and has used drugs since he was in primary school, in grade 6. At first, he took pil BK (benzodiazepine). Slowly he started to smoke gele (marijuana). At parties, his friends sometimes offered shabu-shabu (methamphetamine).

In 1998, he was in the second grade of high school when his friends introduced him to putauw (heroin). Initially, he snorted it and its effect came about 30 minutes later. Later, his friend taught him to inject (nyipet) it as this is more economical and has faster effect. A pack of putauw can be

39 Benzodiazepines are a type of tranquilizer.
40 Putauw is a slang word, from the word ‘putih’ (white).
used by two or three people. They always shared a needle. In September 2000, he was arrested by the police in Jakarta when buying *putauw*. For one year Tatang was locked up in Karawang penitentiary. Afterwards, he still used drugs. In 2005 he tested for HIV and was found to be positive.

Interviews with junkies revealed that injecting drug use entered Karawang in 1998, along with the economic crisis that smashed Indonesia. Most of the HIV-positive IDUs I interviewed admitted that they were highly addicted between 1998 and 2000 when they were in high school.\(^{41}\) Drug pushers were easy to find, either in Karawang or Jakarta. In recent years, pushers have entered the coastal area of Karawang, relatively far from Karawang town (Radar Karawang 7 September 2006).

A 2005 survey among IDUs in ten West Java cities (including Karawang) showed that they were most often in the 15-22 year old bracket upon first use. In general, they began with marijuana and pills. The survey revealed that most IDUs in Karawang spent between Rp. 100,000 (US$ 11) and Rp. 500,000 (US$ 55) per month on drugs. It was thus very likely that they used drugs in groups for economic reasons (Skepo 2006:38-42). A strip of 20 *koplo* pills (*koplo* means stupid and is associated with the pills for obvious reasons) could easily be had for just a few thousand Rupiah. Rohypnol was good for ‘forgetting’. Mogadon and Rohypnol can totally incapacitate their users for two to three days at a time.

I have used drugs since the first grade of senior high school. First, nyimeng [smoking marijuana]. Then, I took drugs. From *cimeng* [marijuana], it goes to anything (Rudi, age 25).

At first it was dragged, burned. But it’s too much. If you injected, you only need a little, and you are flying high fast. It was six months after I used it for the first time. I was in grade three of junior high school (Tono, age 26).

I began in the second grade of junior high school. I first drank liquor, then drugs, marijuana, finally *putauw*... injected.... The first time I was scared to see the blood. But

\(^{41}\) Although it only tested between 50 and 60 people a year, the major drug treatment centre in Jakarta found no cases of HIV between 1996 and 1998; there were then few needle users among those in treatment. In 2000, 39 out of 247 injecting drug users tested positive for HIV. Two years later, HIV prevalence among injectors at this site was 48% – by far the highest among Indonesia’s high risk groups (Pisani 2006:35).
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after I used it, I felt relaxed... it’s more practical (Iwan, age 24).

The effects of drug abuse are readily visible in Karawang society: dropping out of school, unemployment, TB and HIV infection, to name a few. While job opportunities are crucial for these young men, many have no marketable skills. Some HIV-positive IDUs have worked as outreach staff for Pantura Plus on a contract basis. Several IDUs were trained by the Social Affairs Office in T-shirt printing but did not have the capital to start their own businesses. Drug rehabilitation centers are not available in Karawang; most therefore continue to use drugs. In addition, their health is deteriorating.

The penitentiary

Unknown to politicians, bureaucrats, and the general public, penitentiaries can be key sites for HIV transmission. The social construction of HIV/AIDS in Indonesia has focused on transmission through (predominantly heterosexual) sex and injecting drug use. Prisoners as a result have not been considered a high risk group.

The growing number of IDUs in the general population has attracted the attention of law enforcement. Selling and using narcotics is illegal in Indonesia, and it much easier for the police to find and arrest drug users than pushers. In Karawang, many IDUs buy putauw in Jakarta to reduce the risk of arrest. The number of incarcerated drug users increased rapidly between 2000 and 2005; almost a third of prisoners in many penitentiaries were convicted of drugs-related offences.\(^\text{42}\) Many jails are also stretched beyond capacity, as is the case with Karawang’s Warung Bambu Penitentiary. In October 2007, this penitentiary, designed for 300 inmates, contained 800 individuals. Firman, an IDU, told me that he had to share a cell with three others when he was imprisoned there for one and a half years.

IDUs can continue to nurse their addictions in jail. Drugs and needles are available so long as they ‘coordinate’ their actions with

\(^{42}\) In 2005, there were 101,036 inmates throughout Indonesia. 22,372 (23%) were in jail due to drugs-related offences (Departemen Hukum dan HAM 2006:1).
the penitentiary’s officers. In Pisani’s survey of 1,500 IDUs in 5 cities, nearly 30% had been in jail, while one in three had injected while they were inmates. Drugs were actually cheaper within the penitentiary’s walls. Needles, however, were more difficult to obtain, leading to the sharing of needles among inmates (Pisani 2008: 451-452). Mirza, a 25 year old IDU and prison outreach worker, admitted that inmates in Warung Bambu penitentiary could secretly obtain drugs from pushers in the jail.

Another risk of HIV transmission is anal sex among inmates. Although there is scant hard evidence on this, living in crowded quarters does not prevent sexual activity.

This precarious situation for inmate health is exacerbated by the policies governing the penitentiary system. Amang, the Pantura Plus manager, told me that the annual health budget for Warung Bambu penitentiary is Rp. 1,000 (US$ 0.10) per head, which obviously would not cover costs even in the puskesmas, the country’s least expensive health service. A Department of Law and Human Rights report found the average annual health budget for penitentiaries to be 1-2 million Rupiah (US$ 100-200) (Departemen Hukum dan Hak Asasi Manusia 2006:3). In Warung Bambu, two paramedics with limited equipment must handle hundreds of inmates. Pantura Plus thus began work in Warung Bambu in 2007, with some inmates taking advantage of voluntary HIV counseling and testing.

The situation in the penitentiary is a good example of why we need to rethink HIV/AIDS prevention efforts which focus on changing individual behavior. Strategies that focus on ‘high risk’ behavior and groups encourage complacency among those who consider themselves ‘safe’ (Altman 2001; Patton 2002). But rather than looking at individual behavior, the penitentiary must be seen as a risky place.

Access to healthcare

The first AIDS case in Karawang was identified in 1996, a woman from a northern village in Tempuran sub-district who had been a sex worker in the Riau Islands. YPI established a branch in Karawang town in 1998. Beginning with educational campaigns among the
people, YPI has conducted advocacy through *Dinkes* Karawang and built up a network among local government institutions to address HIV/AIDS. With limited human resources, YPI offers VCT services and a support group for PLWHA in Karawang district. The support group Pantura Plus was founded on 1 December 2004 and legally became an NGO in 2006.

Karawang district has seven hospitals (six are private), 43 *puskesmas*, 72 *pustu* (support *puskesmas*), and 1,905 *posyandu* (*pos pelayanan terpadu* or integrated service posts at the village level). Private midwives play an important role within maternal and child health services in the villages, though many women still resort to *paraji* (traditional birth attendants) for delivery (Radar Karawang 26 August 2006). Numerous private health services – clinics, physicians, midwives, medical labs, places offering alternative treatments – can be found in the urban sub-districts.

Given the lack of urgency in the local government’s response to HIV/AIDS, *Odha* (PLWHA) and people who need information and services have been turning to YPI and Pantura Plus. These NGOs, however, have limited staff, facilities, and funds. People often have to wait for free HIV testing from YPI or Pantura Plus; testing in private labs is expensive – about US$ 10. Until 2006, YPI sent the blood to RSUP43 Cipto Mangunkusumo in Jakarta for analysis. In 2007, Pantura Plus arranged a discount for HIV testing with a private medical lab in Karawang.

The local government’s first real contribution came in mid-2006 when it established Klinik KITA at *Puskesmas* Karawang, a collaborative effort between *Dinkes* Karawang and the *Aksi Stop AIDS* program aimed at sex workers. Klinik KITA offers voluntary counseling and testing (VCT) for HIV, medical examination for STIs, and care, support and treatment services. Since it is part of *Puskesmas* Karawang, other wards can refer patients to this clinic. Yusuf, a young doctor working in Klinik KITA, told me that the mother and child health division and the TB division have referred patients for VCT.

RSUD44 Karawang, the main public hospital, has also begun serving HIV/AIDS patients. The hospital appointed an HIV/AIDS working group in November 2006. In a KPAD meeting in March

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43 RSUP is *Rumah Sakit Umum Pusat* or Central Public Hospital.
44 RSUD is *Rumah Sakit Umum Daerah* or Provincial/District Public Hospital.
2007, a doctor from RSUD Karawang revealed that the hospital was treating opportunistic infections but not yet prescribing ARV drugs. For ARV treatment, patients were referred to Dharmais hospital in Jakarta. For ELISA (Enzyme-Linked Immunosorbent Assay) tests, the hospital sent samples to a private medical lab, which was quite costly.

The growing number of Odha implies increasing need for appropriate health services. They include CD4 tests, particularly for Odha who are under ARV treatment and suffering opportunistic infections. The problem, again, is that the costs are too high for poor people. A doctor at Dinkes Karawang who often provides health services to Odha admitted:

Most Odha came late for treatment due to the cost factor and the unprepared existing health service. For instance, the CD4 test is still expensive.... In general, [their] diseases are cough, fever, diarrhea, and candidiasis... which can be treated by public health services.

I asked the same doctor whether the CD4 count could be replaced by other tests.

He replied:

Relatively it is possible. [CD4] is equivalent to a third of the lymphocyte total. I've never suggested the lymphocyte test.... But it is cheaper. The other day there was a patient who asked for ARVs because he always felt weak.... I suggested to him to take a CD4 test but he said he had no money....

The CD4 test is one measure to determine whether Odha should start ARV treatment. But since CD4 tests are costly, doctors sometimes prescribe ARVs based on disease symptoms without conducting them. In its 2007 budget plan, Dinkes Karawang had allocated funds for CD4 testing – a good step towards improving existing HIV/AIDS services.

The availability of ARV drugs is another problem. Presently, Odha can access ARVs through Pantura Plus. Every month, a

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45 Candidiasis or thrush is a common, opportunistic fungal infection.
Pantura Plus staff member goes to Dharmais hospital in Jakarta to collect them, thereby reducing travel costs for *Odha*. A doctor from RSUD Karawang explained in an interview:

> We are already trained, but limited to basic things. ARV prescription must be done by an authorized doctor. We are general physicians on the front line. ARV prescriptions are referred to the specialist.... The problem is we don’t have ARVs in this hospital.

Pantura Plus has been pressing RSUD Karawang to make ARVs available. In early 2007, Pantura Plus proposed a memorandum of understanding to the hospital to provide Care, Support, and Treatment (CST) services to *Odha*. Pantura Plus held CST training for health providers in the hospital in mid-2007; unfortunately, ARV medicines were not available at the hospital until the end of the year.

More generally, the readiness of health providers and the quality of services to tackle the epidemic remain inadequate. Some health providers admit to lack of knowledge, fear of infection, and prejudice against *Odha*. When I observed a PMTCT promotion event for midwives at *Puskesmas* Rawamerta in August 2006, it was apparent that their knowledge of HIV transmission was still very limited.

In a meeting with the Vice District Head held by Pantura Plus in September 2006, Endo, an outreach worker for IDUs, voiced his expectations:

> Access to [health] services in Karawang is less good. Many hospitals refuse *Odha* with IDU backgrounds. Perhaps you can appeal to RSUD officials to accept *Odha* patients and have a supply of ARVs. Access to ARVs is still difficult.... Many *Odha* are already in stage III or IV\(^{46}\) and need treatment...

The attitudes of health providers towards *Odha* need to be addressed as part of any HIV/AIDS prevention program. So long as they stigmatize and discriminate against *Odha*, HIV/AIDS prevention and treatment efforts will remain ineffective.

\(^{46}\) Stage III usually includes chronic diarrhea, severe bacterial infections and tuberculosis; stage IV shows more severe symptoms such as toxoplasmosis of the brain, Kaposi’s Sarcoma and other lungs diseases.
Conclusion

Industrialization, poverty, migration, changing marriage patterns, prostitution, proximity to the northern highway, stigma, denial, inadequate information and services – all have all contributed, either directly or indirectly, to the HIV/AIDS epidemic in Karawang district. These factors create risky situations for sub-populations like injecting drug users, the clients of sex workers, migrant workers, penitentiary inmates, and men in general. The case of Karawang district also shows how HIV transmission has accelerated in the general population. People generally are not aware of the risks of HIV and do not identify with risk group terminology, while health services are unprepared to deal with Odha. Primary prevention programs to control the spread of HIV are not adequately reaching the general population as the emphasis is still on high risk sub-populations.