“RISKY” BUSINESS: CULTURAL CONCEPTIONS OF HIV/AIDS IN INDONESIA

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RISKY BUSINESS: CULTURAL CONCEPTIONS OF HIV/AIDS IN INDONESIA

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This research examines Indonesian cultural conceptions of HIV/AIDS, including perceptions of "risk." Two years of fieldwork allowed for an in-depth assessment of three diverse and important populations in Jogjakarta, Indonesia: (1) female sex workers, (2) *waria*, Indonesia's third-gender, and (3) university students. Surveys (N=413) and interviews (N=60) were partnered with anthropological participant observation to form a more holistic understanding of the impact and efficacy of available HIV/AIDS education programs. Results suggest that Western notions of "risk" are utilized to define, construct, and fund HIV/AIDS education programs throughout the archipelago. These constructions often fail to adequately consider Indonesian cultural conceptions relating to HIV/AIDS.

This dissertation problematizes notions of "high-risk" groups, as well as "high-risk" behaviors. An anthropological understanding of the nuances of local cultural perceptions around HIV and "risk" helps to illustrate how Western notions of "risk" are incompatible with local Indonesian realities. For instance, fieldwork with Indonesian sex workers illuminates the importance of understanding identity as it applies to perceived "risk." Islamic ideas of polygyny often create an acceptable "non-risky" identity for sex workers as lesser wives. Information collected from and about Indonesia's third gender illustrates how cultural categories within the parameters of religious ideologies allows a niche market in which sex with a *waria*, not being between a man and a woman, is not considered "sex" nor "high-risk." Interviews with Indonesian university students exemplify how local realities and definitions

of “high-risk” sex and “low-risk” monogamy often differ greatly from the definitions assumed by HIV/AIDS prevention and education programs.

HIV/AIDS programs based on Western biomedical and cultural models can create pockets of misinformation and confusion when they fail to fully incorporate critical Indonesian cultural categories, identities, and definitions. Results of this study suggest that more effective HIV/AIDS educational programs in Indonesia would result from recognizing: (a) the multifaceted identities of the people for whom programs are provided; (b) the importance of cultural categories and how they operate within complex state and religious ideologies; and (c) that cultural and programmatic definitions of “risk” are often inconsistent. Understanding Indonesian cultural conceptions allows for a deeper understanding of effective ways to implement culturally sensitive and appropriate HIV/AIDS programs and policies throughout the archipelago.

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PREFACE

Acknowledgements: This research was conducted over a two-year period (January 2002-December 2003) in the amazing city of Jogjajkarta, Indonesia. I would like to begin by thanking everyone who shared their ideas and thoughts with me throughout my fieldwork; but most importantly, I'd like to thank all of the men, women and *waria* who shared their lives with me and allowed me to write about their marvelous stories here in this dissertation. Without them, none of this would have ever been possible.

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This dissertation is dedicated to Wanda and Jihan, two of my friends/informants who died while I was in the field. Also, I dedicate this dissertation to my three parents: Tom and Pam Crisovan, and Hindun Ichsan.

Nomenclature: Indonesian pronouns are non-gendered, thus the pronoun referring to a man, a woman, or a third-gender is non-differentiated (*dia*) (*see* Appendix J for a complete glossary of Indonesian terms used throughout this dissertation); In order to reflect this when referring to *waria*, Indonesia's third-gender, the pronouns *s/he* (he/she) and *hir* (his/her) will be utilized. These forms are also used in Blackwood 1998.

CHAPTER 1. INTRODUCTION: "RISK" AND DENIAL

Figure 1. Map of the Indonesian Archipelago.

This dissertation focuses on cultural conceptions of HIV/AIDS in Indonesia (*see* Appendix K for a complete list of all acronyms used in this dissertation). My research explores Indonesian culturally infused identities, definitions, and categories that pertain to HIV/AIDS issues, and how international funding that relies on Western-epidemiologically influenced ideas of "risk" and knowledge can influence the efficacy of health education programs in Indonesia. While my

research was primarily located in the Central Javanese city of Jogjakarta, Indonesia, I found similar cultural conceptions throughout the island of Java and even elsewhere in the archipelago. I believe that my research has broad implications for not only Central Java, but for Indonesia and the rest of the world.

By way of introduction, I'd like to begin with two events that influenced my understanding of HIV/AIDS knowledge and "risk." The first event is set in Pittsburgh, Pennsylvania, in the early spring of 1999. In my attempt to secure summer funding for preliminary dissertation research, I was interviewing for a scholarship that happened to have a group of medical physicians on its board. My proposed research introduced the idea that under Suharto's government, HIV/AIDS research in Indonesia was practically non-existent. Having been only a year since the Suharto regime fell, I explained how many physicians in Indonesia did not fully recognize the gravity of the epidemic. This was especially the case since Indonesia had (at the time) less than 1,000 officially diagnosed cases of HIV/AIDS despite the fact that it has with the fourth largest population in the world. I discussed the fact that HIV/AIDS was not as much a part of the cultural consciousness of the medical professionals in Indonesia as it was here in America, and that, according to a local source, many Indonesian physicians didn't even know how to diagnose or prevent HIV (*Jakarta Post* 1997). In response to these assertions, the committee sitting before me literally scoffed. They told me that my research was invalid and not fundable. When I asked for clarification, one physician told me: "First off… why should we give you money to study a country that, honestly, doesn't seem particularly at risk? Secondly, doctors all over the world know about HIV. Information about symptoms and prevention are accessible via the Internet. You can't really believe that Indonesian doctors don't know about AIDS!" These American physicians had a very rigid sense of "universal knowledge," and firmly believed

that the existence of a body of literature — in their words, accessible via the internet — was all that was needed for physicians the world over to grasp the gravity of the epidemic. Cultural factors did not seem to play into their logic. To these physicians "risk" was not considered a concept of weighing the odds, but instead something inherently either present or absent for an entire country.

My second story is set in Jakarta, Indonesia in the fall of 2002, where I found myself talking with an Indonesian medical physician, the head of a hospital in a large Javanese city. I was asking the physician about an article I had read in the *Jakarta Post* (April 3, 2001) that claimed that many Indonesian physicians re-used needles and syringes when vaccinating to cut costs. As I attempted to ask her about how she felt this might affect HIV/AIDS transmission, she became angry. She stated furiously:

> "I can NOT believe that you are trying to pin this disease on doctors and other medical professionals! We are here to help people! Sure, sure… sometimes we don't have access to clean needles or gloves… we make do with what we have. But those people… those people infected with HIV… they leave our hospitals and they go home to their families… and can you believe they drink out of the same glass as their children!!! You can't blame doctors for that!"

These two stories illustrate how both American and Indonesian physicians had ideas about HIV/AIDS knowledge and "risk" that were incompatible with real world happenings. The American physicians, like many other westerners who have certain ideas concerning how knowledge is accessed and utilized and about who is and is not at "risk," can have an impact on funding and HIV/AIDS programming throughout the world. The Indonesian physician, like many other Indonesian medical professionals and policy providers, believed she understood the situation when in fact she also lacked information. To address this lack of information, this dissertation provides a real world view of what people in Jogjakarta, Indonesia are thinking

about HIV/AIDS "risk," what they are saying about HIV/AIDS "risk," and most importantly, what they are doing about HIV/AIDS "risk."

1.1. THE CASE OF INDONESIA

Although the number of HIV-infected people in South and Southeast Asia is now more than twice the number of people infected in the entire industrialized world, the number of officially-reported AIDS cases in Indonesia remains suspiciously low (Geissler 1998; Warta AIDS 2000). In the past, Indonesia's government has pointed to Muslim ideologies that mandate "low-risk" behaviors to account for this discrepancy. However, Malaysia, which has a similar religious and cultural background, has not avoided this pandemic (Abrahms 1998; Beyrer 1998). Indonesia has the fourth largest population in the world, spreading across 17,000 islands. Yet, as of March 2005, there are less than 7,000 cases of HIV/AIDS officially diagnosed for all of Indonesia (Indonesian Ministry of Health 2005). Many groups, including UNAIDS, USAID, Ford Foundation, and Indonesian Planned Parenthood Organization, fear that these statistics are only the tip of the iceberg. Actual estimates of HIV infection are believed to range from 51,000 - 400,000 cases, and some argue that even this high range is still too conservative (Radnet 1999).

Under the Suharto regime, which ended in 1998, Indonesian research on HIV/AIDS was not allowed (Oetomo 1996). Recently, however, a large body of Indonesian literature about AIDS has begun to surface in Indonesia (Djoerban and Nenden 1998; Pona 1998; Surjadi et al. 2000; Suyanto et al. 1997; Widaningrum 1999). Though much of this literature calls for culturally sensitive programs, few offer insights into policy implications. Further, the literature produced by international health and development agencies about HIV/AIDS in Indonesia calls

for culturally appropriate programs but fails to implement them (Center for Health Research at the University of Indonesia and UNICEF 1996; World Bank 1996).

My research agrees with the importance of culturally appropriate programs, but problematizes policy makers' abilities to implement such programs when the basic building blocks of HIV/AIDS education are grounded in Western notions of "risk." Programs with the best of intentions often fail to understand how perceptions of "risk" are tied both to their own and their constituents assumptions about HIV/AIDS. This dissertation illustrates how problematizing ideas about "risk" can assist in the implementation of effective policy and prevention programs. Anthropologists are especially poised to create a critique of this kind, as anthropological methodologies allow for an understanding of the nuances of local and global cultures that can affect perceptions of HIV/AIDS "risk."

Indonesia is the largest Muslim country in the world (Kamil 1997). Although all major religions can be found in Indonesia, 90 percent of Indonesia's citizens are registered as Muslim. This means that "Islamic views on [gender ideologies] have a strong influence on state policy…." (Blackwood 1995a: 138). Not only do these views affect gender ideologies but they also have a tendency to thwart HIV/AIDS and STI prevention efforts: "In Indonesia… despite evidence of high rates of people with STIs and HIV infection, the Islamic nation does not recognize the country's significant sex industry or the existence of a homosexual community" (Abrams 1998:3). Islamic ideologies about sex and disease, therefore, play an important role in Indonesia's current HIV/AIDS reality.

The Javanese comprise the largest ethnic group within Indonesia, numbering more than 80 million people. This suggests that the Javanese culture is "dominant and that most government officials are also Javanese" (Gayatri 1996: 87). The Javanese far outnumber the

many other ethnic groups, with some ethnic groups comprised of as few as 100 people. "Most ethnic groups have been in the area for thousands of years, but there are also ethnic Chinese, Arabs, and Indians" (Oetomo 1991: 119). These statistics are important when dealing with HIV/AIDS and health, in general, since the people making the policies, those actually carrying out the practices, and the target population almost always belong to different social spheres and ethnic groups. In result, the official bureaucratic view is often far removed from the actual practices found in everyday Indonesia (Scirtino 1995).

While disparities in education and income levels are found throughout Indonesia, these inequalities are more significantly seen in rural regions where more than 80% of Indonesia's population resides (Oetomo 1991: 120). These discrepancies are further amplified by HIV/AIDS. HIV infection tends to worsen already existing forms of inequality and oppression based on class, education level, gender, ethnicity, and sexual orientation (Christensen 1990:5). Further, health and intervention programs focused on HIV/AIDS tend to be more accessible to urban populations through NGOs based in these urban areas, and tend to rely heavily on written material. These programs, therefore, tend to neglect much of the rural population by their location and also their education — more specifically literacy — levels.

Even with its immense diversity, the Indonesian state has managed to maintain strong regulatory power over its people. With the establishment of Suharto's New Order in 1965, the state dominated "the exercise of social control, the management of the means of production, the distribution of resources, and cultural reproduction" (Blackwood 1995b: 135). Further, Suharto's New Order "consciously built up a substantial ideological structure… to legitimate their considerable power and authority" (Blackwood 1995b: 135). Thus, a hierarchy of

knowledge was created, giving more legitimacy to the state's superimposed knowledge than to the people's local knowledge (Hooker 1999).

The religious, historical, economic, and political realities of Indonesia are inextricably tied to HIV/AIDS issues. One Indonesian website offered this advisory: "Caution due to the economic and political upheaval, Jakarta and other areas of Indonesia experience violent and dangerous situations. Recent elections have given a glimmer of hope for recovery, law and order. Please review current events when planning travels" (Utopia 1999:1). Unrest has also amplified the epidemic in Indonesia. Not only does warfare inextricably heighten the passing of more blood between individuals, but the economic upheaval is also said to have direct effects on the epidemic. Economic experts have said that the economic crises in Indonesia caused a shift in social behaviors which has helped spread the disease (BBC News: 1999). However, it will be years before any hypotheses about the link between the economic collapse and AIDS in Indonesia can be substantiated. This is because most cases of HIV/AIDS in Indonesia are not identified until they are in the late stages of the disease partly due to Indonesia's "medical personnel's poor knowledge of HIV/AIDS, including how to diagnose and prevent it" (AIDS News 1997:1).

Even if the reported number of AIDS cases is accurate, low rates of risk behaviors can ultimately lead to high AIDS incidence rates in a population of Indonesia's size if prevention and education are lacking. This has been the case for India and China (Beyrer 1998). In the '90s, Indonesia's understanding of the pandemic in other parts of Asia led to an ideology that stated that AIDS education and prevention are goals of their government. In 1994 the Indonesian National AIDS Strategy was implemented (Indonesian Ministry of Health 2004). One of the first of its kind, this initiative exists as a comprehensive statement of national commitment to combat

the impact of HIV/AIDS through the implementation of a cross-sectoral strategy partnering the government, non-governmental organizations (NGOs), and the community while simultaneously addressing human rights issues. Though this initiative seemed very liberal and innovative, especially in comparison to other policies mandated by the government, many Indonesianists speculate that this was simply an attempt by the Indonesian government to redeem itself in the eyes of the global community and of its citizens who were growing increasingly tired of the state's restrictive policies (Oetemo 1999). Others suggest that the Indonesian government presented a liberal front while simultaneously remaining steadfast to the idea that members of Islamic nations do not engage in any behaviors that would put them at risk for HIV/AIDS (Kroeger 2000).

While the Indonesian government took the initiative to put these goals into writing, a decade later the National AIDS Strategy is far from actually being implemented. This is because these goals are difficult to realize within a framework that in reality lacks cooperation between the government, NGOs, intergovernmental organizations, and the community. As will be discussed throughout this dissertation, other problems arise due to the fact that the programs being implemented tend to: 1) rely on Western forms of knowledge and biases surrounding HIV/AIDS and "risk"; 2) be centered on only "high-risk" populations; and 3) not take into consideration Indonesian cultural conceptions, including culturally infused definitions, identities and categories.

1.2. RESEARCH DESCRIPTION

Figure 2. Map of Java with the City of Jogjakarta Highlighted

In order to have a more complete picture of what people in Indonesia are thinking, saying, and doing about HIV/AIDS "risk," I decided that I needed to locate people who had utilized HIV/AIDS education programs, as well as their counterparts who had not. By doing this I hoped to understand what kinds of information people were getting out of these programs and whether or not this was affecting their behavior. To this end, I decided to focus my research in Jogjakarta (see map above) since I had previously volunteered with one of the HIV/AIDS education programs in the area. It was also the location of a language program I had attended at the University of Gadjah Mada which allowed me access to valuable libraries and support resources at the university.

Further, Jogjakarta is an ideal city from which to base research of this kind due to: the number of international and national tourists traveling to and from Jakarta, Bali, and other regions with high HIV incidence; the presence of a stable NGO base; access to numerous villages; as well as the influx of people from many islands looking for employment. Jogjakarta is also considered to have one of the best HIV education programs in the country, located at the local Indonesian Planned Parenthood Association (IPPA). Jogjakarta is considered to be Indonesia's "college town," boasting the oldest university in Indonesia (Gadjah Mada University), as well as many other universities and colleges.

Two-years of fieldwork allowed for an in-depth assessment of three diverse and important populations in Jogjakarta, Indonesia. Cultural perceptions from and about female commercial sex workers, third-gender *waria* and university students are presented here. Particpant observation was conducted with all three groups. This included: living with, engaging with, speaking with (in their language), and being a part of the daily lives of the members of the populations discussed here in this dissertation. Participant observation enhances other forms of data collection, such as interviews and surveys. As H. Russel Bernard (2002) states: "Qualitative and quantitative data inform each other. Whatever data collection methods you choose, participant observation maximizes your chance for making valid statements" (Bernard 2002: 335).

Two of the above mentioned groups (sex workers and *waria*) were chosen because they were considered to be "high-risk" populations and thus, had HIV/AIDS education programs available to them. The third group (students) was chosen because they were not considered "high-risk," and thus, did not have HIV/AIDS education programs available to them. A total of 413 surveys were conducted with sex workers and *waria* who had and had not attended

HIV/AIDS education programs (labeled “program” and “non-program” in the table below), as well as with university students who had not attended HIV/AIDS education programs since none were available to them (labeled “non-program” in the table below).

Table 1. Populations Surveyed
(N= total number of surveys)

Population	Program vs. Non-Program	N
Sex Workers	Program	60
Sex Workers	Non-Program	84
Waria	Program	30
Waria	Non-Program	30
University Students	Non-Program	209
Total	**Program and Non-Program**	**413**

These populations were assessed on issues pertaining to HIV/AIDS knowledge, perceptions, and behaviors, as well as demographic information and evaluations of the HIV/AIDS education programs they had attended. Program versus non-program labels were acquired through both self-identification as well as identification by HIV/AIDS non-governmental organization volunteers who had provided the programs. These labels were used for the sole purpose of statistical analysis.

This information served to subsequently inform the next step of my research in which 77 qualitative, open-ended, semi-structured interviews were conducted. Twenty members of each of the three groups (sex workers, *waria*, and university students) were interviewed to clarify and enhance some of the information revealed during the surveys. This included people living with HIV/AIDS (PLWHA) when available. Throughout my research I also interviewed what I refer to as other “stakeholders” involved in HIV/AIDS education in Indonesia, including: physicians and

health care providers, policy makers, HIV/AIDS non-governmental organizations volunteers and staff, and Westerners involved in HIV/AIDS education in Indonesia (*for a discussion of the importance of "stakeholders" in HIV education see* Gilliam et al. 2002). Though the bulk of this dissertation focuses on the particapnt observation, interviews and surveys from the three groups (sex workers, *waria*, and university students), my research findings were influenced by my discussions with these other stakeholders (see table below).

Table 2. Populations Interviewed
(N= total number of interviews)

Population	**N**
Sex Workers	20
Waria	20
University Students	20
Stakeholders	17
Total	**77**

The pairing of qualitative and quantitative research methods — including participant observation, in-depth interviews, and statistically significant surveys — allowed for a deeper understanding of the cultural conceptions around HIV/AIDS and "risk" in Jogjakarta. These methods allowed me to gain greater insight into culturally infused identities, categories, and definitions that affect assumptions about who is and is not "at risk" for HIV/AIDS. Throughout this dissertation I problematize western notions of HIV "risk," including what defines "high-risk groups" and "high-risk behaviors," as I illustrate the importance of understanding local cultural perceptions about HIV/AIDS.

1.3. "RISK" AND BLAME

As mentioned earlier, many HIV/AIDS programs still focus on "high-risk" groups (Patton 1985; Treichler 1992, Stoller 1998). Drawing from Foucauldian ideas of power, Michael Bloor links the public health discourse of "high-risk" groups to hegemonic "agendas for the policing of sexuality, the punishment of victims, and the surveillance of deviants (immigrants, gays, junkies, [sex workers])" (Bloor 1995; 84). A concentration on "risk groups" simply acts as a tool to stereotype and stigmatize people already seen as marginalized or outside the moral and economic "mainstream" of the general population. Even a broadening of terms to focus on "risk behaviors" instead of "risk groups" is problematic within a framework that understands contextualization. For example, "non-monogamous sex" is a risk behavior. This information, however, is not available in certain situations. A woman that does not know of her husband's infidelities is not at liberty to use that information to inform her understanding of whether or not she is engaging in such a behavior. Despite this lack of contextualization, many prevention programs ignore the negative effects of utilizing "risk groups" and "risk behaviors" and insist that by focusing on these constructions they are better able to tailor programs to meet the specific needs of those afflicted (Gagnon 1998).

Further, targeting only "risk groups" for prevention and education strategies gives the general public the perception that they are not at risk. This strategy also reduces the identity of the people incorporated into the "risk groups" into a single defining characteristic. Thus, multiple arenas of identification — prostitute, family breadwinner, mother, sister, single parent, teenager, etc. — are incorporated into a single stigmatized label of "high-risk group" (Kempadoo 1998). Such a focus on "risk behaviors" falsely assumes that individuals have all the information they need to assess whether or not they are engaging in a "risk behavior." This focus also fails to take

into consideration the daily realities of individuals by assuming that knowledge directly leads to action.

Recent trends in research on AIDS in Indonesia have focused on either knowledge levels about HIV/AIDS in certain populations (Kyles and Tumbleka 1994, Indrayanti 1997) OR social constructions around perceptions of HIV/AIDS (Djoerban and Nenden 1998, Kroeger 2000). My research bridges these trends by gathering and analyzing information on both knowledge levels and cultural perceptions of HIV/AIDS in Jogjakarta. By pairing these two tactics with assessments of information provided by prevention and education programs one can see changes in cultural perceptions as related to knowledge levels. An investigation such as this also allows for the assessment of whether international biases, such as ideas pertaining to "risk groups," become assimilated into Indonesian perceptions through these programs.

1.4. CHAPTER DESCRIPTIONS

Chapter Two further explores the concepts of "high-risk behaviors" and "high-risk groups" as it situates my research in the theoretical frameworks of applied and critical medical anthropology as well as public health's social ecology framework. These theories stress the importance of understanding an individual's experience as it is situated inside of larger national, international, and global paradigms. Understanding of cultural contexts, such as religion, medical belief systems, and economic constraints is essential in this process. Also critical to this analysis is the importance of understanding the cultural perceptions that influence categories, definitions, and identities surrounding such things as HI/AIDS and "risk." After explaining these contexts in general, I move to a description of the case of Indonesia, further situating my research for the

reader. This chapter also provides a more in-depth description of my field site of Jogjakarta, as well as my qualitative and quantitative methodology.

Chapter three, entitled "*Waria:* A Population Paradoxically Positioned," presents Indonesia's third-gender. Internationally marketed programs (such as the World Health Organization's ABC program) often fail to recognize the importance of cultural categories such as third-gendered populations. *Waria* are historically significant and culturally acceptable, yet marginalized and under-employed. Looking at societal perceptions of *waria* offers an understanding of how *waria* have found a niche market that operates within the parameters of deeply ingrained religious ideologies that assume sex is between a man and woman. The fact that "sex" with a third-gender does not fall into this definition of "sex" illustrates how focusing on "sex" as a "risk behavior" can be problematic. This chapter also explores *waria's* entrée into sex work as well as the socialization of *waria* into the world of *waria* which offers insight into the roles that "gatekeepers" (Darrow et al. 2004) can provide for future health programs. Other behaviors that make *waria* an important group to understand in the context of HIV/AIDS, including mobility, physical abuse, and beauty injections, are also discussed. Additional assessments include HIV/AIDS knowledge levels in this community as compared to condom usage pointing to the important dichotomy between knowledge and action/practice. Lastly, myths associated with HIV/AIDS that prevail throughout the *waria* community are discussed.

Chapter four, "Sex Workers as Women, Wives and Mothers," provides an in-depth examination of female sex workers in Jogjakarta. Gender constructions as they relate to Indonesia and HIV/AIDS are presented to situate the case of sex workers as women, wives and mothers. I describe the general situation of sex work in Indonesia, followed by a more specific description of the sex worker population of Sosrowijian (Sosro) and my entrée into it. I examine

the place of sex workers in the eyes of the public, their clients, and themselves. HIV/AIDS education programs that focus on sex workers as "high-risk groups" often fail to recognize the multifaceted identities of Indonesian sex workers. Understanding how Islamic ideas of polygyny create a culturally acceptable identity for sex workers as lesser wives is of the utmost importance, as this can impact their perceptions of "risk" and their safer sex choices. Lastly, this chapter presents how priorities of family and survival often override even the well-educated sex workers' ability and desire to negotiate condom usage, showing how knowledge does not necessarily lead to behavior modification.

Chapter five, "University Students: Simultaneously Exalted and Ignored," presents the last of three populations. I discuss the importance of university students, not only as a population with many unrecognized "high-risk" behaviors, but also as the future policy makers of Indonesia. This chapter not only examines university students' definitions and perceptions of what actually constitutes sexual intercourse and virginity, but also explores ideas pertaining to monogamy, "free" (American style) sex, and HIV transmission. Interviews with university students show that perceptions of "high-risk" behaviors are often inconsistent with Western assumptions of "risk." This includes such things as anal sex, oral sex, men having sex with men, and certain forms of non-monogamous sex. Understanding these definitions is crucial when implementing HIV education programs in Indonesia and elsewhere. This chapter concludes with a narrative of a university student and his experience finding out he was HIV+. His story illustrates the importance and need for HIV education programs aimed at the general public.

The dissertation's conclusion is presented in chapter six. Understanding the importance of cultural perceptions of HIV/AIDS and "risk" are important to create effective culturally relevant HIV/AIDS education programs and policies. Western notions of "risk" continue to be

utilized in HIV/AIDS education programs even after having been problematized by anthropologists, sociologists and public health providers. This chapter is a call for action to policy makers, academics, people living with HIV/AIDS, and other major stakeholders in the fight against HIV/AIDS. It is not enough to understand the biomedical nature of HIV/AIDS if we can't communicate about the virus in a culturally acceptable manner that incorporates local perceptions into global policies. "Cookie-cutter" health programs, like the World Health Organization's ABC program, need to take into consideration the diverging daily realities of the people to whom they are targeting in order to be more culturally appropriate. Understanding local realities within the broader contest of global processes of poverty and marginalization is the key for developing effective HIV/AIDS strategies in Indonesia and the world over.

As the stories at the beginning of this chapter illustrate, effective HIV education and prevention requires more than just a body of literature available via the Internet. As this dissertation will show, HIV/AIDS programs often incorporate Western perceptions that fail to understand Indonesian cultural conceptions. As is discussed throughout this dissertation, implementing HIV/AIDS education programs that solely fulfill knowledge gaps and fail to assist with behavior change by neglecting the larger issues of inequality is not a viable strategy to deal with this pandemic. Understanding the nuances of individual local realities is the first step in fighting global ones.

CHAPTER 2. MEDICAL ANTHROPOLOGY, PUBLIC HEALTH, AND HIV/AIDS IN INDONESIA

This chapter opens with a discussion of international health aid and its impact on the AIDS epidemic. I then discuss discourse on "risk" and how Western assumptions of HIV/AIDS "risk" greatly influence local and international HIV/AIDS education programs. Following this is an expansion of the major theories that informed my work, including: medical anthropology, applied anthropology, critical medical anthropology, and public health's social ecology framework. After discussing my theoretical framework, I situate Indonesia within this context and explain the importance of Jogjakarta as the focus site of my work. Lastly, I explain the methodologies utilized throughout my research, including: small focus groups, qualitative interviews, quantitative surveys.

2.1. INTERNATIONAL HEALTH AID AND HIV/AIDS

International cooperation in health-related fields has brought about new understandings of health and its impacts on all aspects of society and development. As the World Health Organization's second director-general, Dr. M.G. Candau, stated in 1968: "Health is part and parcel of economic and social development and man is the prime mover in that development. Without him development has no meaning. And without health, development has no hope of putting down

roots" (*as quoted in* Beigbeder 1998: 15). Understanding the multiplicity of factors interlinking and integrating health and society has not only allowed for more comprehensive and effective healthcare, but has allowed for more comprehensive and effective education, development, and policy measures (Chambers 1985; Gordon and Lock 1988; Lindenbaum and Lock 1993; Rosen 1974; Shore 1995). Though medical professionals have been aware of these intersections for quite some time, it is only through more recent developments that this knowledge has been extended to policy makers, politicians, and even the general public (Bolton and Singer 1992; Brown 1998; Feldman 1990). This is due in part to the AIDS pandemic.

No other disease has brought the social, cultural, and political dimensions of health to the forefront as much as AIDS (Feldman 1994, Schoepf 2001). This understanding has also provided new perspectives on other historical epidemics such as the Black Plague, syphilis and even influenza in the early 20th century (Garrett 2000). No population has been untouched by AIDS and its influences. Whether it has been the impact on media, health care, education, development or even closer to home in the loss of a loved one, AIDS has become the most influential pandemic of our time. It seems we have come a long way from a relatively unheard of virus in the early 1980's — thought originally to afflict only homosexual men — to an understanding of AIDS that has unequivocal influences on our daily lives. Our understandings of educational strategies, development implementations, policy implications, and healthcare orientations have all been profoundly affected by the world's collective experiences with AIDS, "[y]et when we look at what has actually changed, at what behaviors have fundamentally altered, and what social institutions have been restructured as a consequence of AIDS, it is striking how little has been accomplished in terms of getting the pandemic under control" (Feldman 1994: 1).

2.2. INTERNATIONAL AID GONE WRONG

"If I knew someone was coming over with the expressed intention of doing good, I would flee."

[Henry David Thoreau, as quoted in Fisher 1997:439]

Many international health and development strategies previously focused on top-down rather than bottom-up participation. Top-down strategies perpetuate ethnocentrism as they assume development is a one-way street typically flowing from the Western educated professionals to the supposedly disenfranchised local populations (Airhihenbuwa 1995; Foster 1999; Sillitoe 1998). Strategies that lack local input often fail due to a lack of understanding of individual, local, cultural and global contexts in which the development will be taking place (Baer et al. 1997). As Judith Justice states:

> The relationship between planning and performance can be perplexing, even in simple situations where few people are involved. It becomes much more complicated when plans are made on a vast scale for the benefit of people whom the planners themselves may never meet and whose view of their own most pressing needs may never be asked. [Justice 1986: 1]

New programs are switching "from a top-down intervention to a grassroots participatory perspective" (Sillitoe 1998:223). While necessary, programs of this kind are challenging on a number of levels. These challenges include difficulties in cross-cultural communication, cultural understandings, and inevitable political dimensions, as well as difficulties in understanding how development programs intervene in people's lives (Sillitoe 1998). As discussed in later sections of this chapter, anthropologists can provide invaluable insight to assist development programs through such murky waters.

Recent trends in the world of international aid which attempt to focus on "empowerment," albeit an ethnocentric form of empowerment, are at least on the right track in understanding the necessary components of more culturally and contextually appropriate programs. Ideas of "empowerment" often have their roots deeply engrained in the ideologies of the previously engaged top-down strategies. As such, "empowerment" is assumed to mean that "professionals should entrust themselves with the skill to endow the perceived powerless with the power to overcome the conditions that circumscribe their livelihood" (Airhihenbuwa 1999: 271).

Though international aid agencies, like the World Health Organization (WHO), have succeeded in some initiatives — such as the eradication of smallpox — their programs have often been ineffectual in ameliorating the consequences that the global economy has had on health. Health practitioners around the world are still faced with a ceaseless volume of patients in understaffed and deteriorating clinics with limited available resources (Garrett 2000; Schanker1993). Programs focusing on disease eradication often fail to address issues of empowerment and choice (Siddiqi 1995; *see also* World Health Organziation 1988 and 1989). According to Airhihenbuwa (1995), the key to empowerment is in raising critical awareness through confronting politics, history and power relations.

While the recognition that health impacts development and economics has spurred new programs addressing these issues (Sen 1999), this recognition has also allowed international health aid to become increasingly more political and allowed healthcare to become an economical interest (Baer et al. 1997). "Like the good intentions paving the road to hell, the evolutionary pathway of capitalist society is lined with the remnants of progressive initiatives" (Singer 1998a: 228). The World Bank has most recently become a key player in making financial

loans, doling out more than WHO or UNICEF to health care endeavors, and "has a strong influence on health policy as a result of its practice of co-financing resources from international and bilateral agencies and matching funds from recipient governments" (Baer et al. 1997: 29). When health policies are manipulated on a global level, the interests tend to be taken away from those who truly need the aid. Initiatives funded through international organizations, such as the World Bank and the U.N., often fail to "be designed not only to address medical concerns, but also to take into account what the people in the community actually believe about their own ill-health" (Helman 1990: 10).

2.3. BLAME AND PUBLIC HEALTH

When AIDS first appeared on the international health scene initial finger-pointing often blamed those considered "immoral." Representatives from some religions even described AIDS as "God's punishment for sexual sin" (Overberg 1994: 5). Official responses, based on moral interpretations, practically paralyzed prevention efforts (Beyer 1998). International policy circles based on "public health and medical texts infused with moral highness slowed prevention efforts since there was a 'reluctance to address the issues'" (Schoepf 2001: 340). Since "traditional religions have disproved of promiscuity and homosexuality, AIDS [has become] an issue of morality as well as of public health" (Greely 1994: 223). In result, HIV/AIDS policies and politics have become tied up in the "rhetoric and the fads" of blame (Stone 1989: 206).

When they did eventually come, international responses to AIDS tended to ignore cultural factors and even broader global concerns (Mann and Tarantola 1997). They typically failed to address such issues as the way globalization and structural violence "set the stage for

sex with multiple partners, gender violence, and widespread dissemination of STIs, including HIV" (Schoepf 2001: 342). Farmer (1992) illustrates how the world system impacts disease with an example of how the construction of a hydroelectric dam in Cuba, funded by USAID, drove peasants from their lands, resulting in greater poverty and migration to urban settings in search of livelihoods, and, increasing the risk and incidence of AIDS.

These initial notions of blame and immorality have created a discourse in which AIDS is often seen as a disease of the "Other" (Altman 2001). The "Other" has historically included foreigners, gay man, sex workers, and any other group that is seen as diseased or dangerous (Wilton 1997). The "Not Other," then, is seen "to be clean, healthy and safe" (Hsu et al 2004: 209). Both sociological and anthropological analyses of discourses about HIV/AIDS illuminate the social construction of disease as a social stigma (Hsu et al. 2004). Likewise, "risk groups" have been stigmatized and "have suffered the most to date from this epidemic …[and] are blamed for the spread of AIDS, e.g., intravenous drug users, gay men, people of color, and sex workers" (Bolton 1995: 307). Common in public health discourse, constructions of "high-risk groups" are "part of a 'hegemonic process' that helps dominant groups maintain, reinforce, re-construct, and obscure the workings of the established social order" (Schoepf 2001: 336). "Depiction of prostitutes as 'a reservoir of infection,' fueled local constructions of AIDS as 'a disease of women,' or of the 'lower orders,' from whom the 'pure' required protection (Schoepf 2001: 340; see also Lyttleton 1996). Concepts such as these contribute to an 'othering' process that allows people to scapegoat, dehumanize, and blame the victims and thus avoid responsibility for disease prevalence (Farmer & Kleinman 1989; Schoepf 1988).

Notions of "high-risk" have "resulted in data being collected chiefly on individuals with or at risk for AIDS, and rarely on the social context of their lives. Working under the rubric of

"objectivity" as defined by the biomedical model, scientists have failed to see how social biases affect the type of research questions they ask" (Fee and Kreiger 1993: 1481). To fully understand public health's "risk-group" initiatives, Junge (2002) details that:

> Public health research and program planning is grounded in the notion of a risk factor, that is, an individual trait that has been shown in empirical research to be associated with some negative (and presumably health-related) outcome. The association is by definition statistical. In and of itself, that conveys limited information regarding the nature of the linkage between the trait (the independent variable) and the outcome (the dependent variable)…. Populations in which a given risk factor and its associated outcomes are unusually prevalent are conceived of as a risk groups whose members are high-risk. [p. 194]

Epidemiology often uses "high-risk" groups to label people "rather than seeking to understand the contexts and constraints of their lives" (Schoepf 2001: 348). Attention is often focused on "*who* is risky, rather than *what* is risky" (Clatts 1995: 245, *emphasis in original*). Junge (2002) asserts that it is "difficult to locate precisely the sites of cultural production and reproduction for discourses in which the public health notion of risk group is thus distorted. Clearly, prevention programs—informed by epidemiologic research and terminology—seem likely" (Junge 2002: 196). Bloor (1995) also questions the use of "high-risk" groups as objective facts: "the assumption may be questioned that epidemiological findings are scientifically neutral, objective facts…To classify cases by reported exposure category is simultaneously to represent the epidemic in a particular form and few social representations have a more privileged status in our culture than official statistics" (p. 55).

Similarly, **"**assumptions of the biomedical model as embodied in the paradigms of gay plague and chronic disease have shaped scientific knowledge about AIDS as well as the medical and public health responses to this epidemic" (Fee and Kreiger 1993: 1481). The Western

biomedical model, from which public health endeavors are based, creates and stigmatizes "risk groups" with "no acknowledgement of the fact that when 'risk groups' succeed in identifying populations at risk of disease, it is because these risk groups typically overlap with real social groups possessing historically conditioned identities" (Fee and Kreiger 1993: 1481).

As a result, much of the public health discourse presents people such as "prostitutes and youth as irrational in their risk-taking" instead of contextualizing their lives and attempting to understand how the world system has affected their life strategies (Schoepf 2001: 348). Further, educational campaigns discussing risk factors have had little success in reforming risk activities. Brook Schoepf calls this phenomenon "more than a KAP-gap," referring to public health rapid assessments of knowledge, attitudes and practices (Schoepf 2001: 341). Schoepf discusses the fact that "around the world increased knowledge of AIDS did not translate into widespread protection, which, of course, anthropologists familiar with studies of past public health campaigns had predicted" (Schoepf 2001: 341).

Schoepf asserts that without attention to inequalities of class, ethnicity, and gender, education does little to no good since "poverty, powerlessness, and stigma [continues to] propel the spread of HIV" (Schoepf 2001: 335). Similarly, Goldstein (2004) believes that "the rationalistic models of risk-related behavior [espoused by public health theorists] all contain an inherent assumption that knowledge of risk factors will relate directly to the informed estimation of one's own risk" (Goldstein 2004: 163). She goes on to clarify that "where the models have not been successful is their lack of allowance for the cultural associations and meanings that feed individuals' abilities to internalize and apply notions of risk to themselves" (Goldstein 2004: 163). In adopting Western biomedical notions of research "we have privileged etic over emic,

data quantity over quality, reliability over validity and statistical significance over real significance" (Bolton 1995: 298). Paul Farmer (1999) furthers this line of thought, noting that:

> Modern inequalities are both local and global… a lack of systematic and critical analysis permits these global ties to be obscured. And yet new kinds of proximity mark inequality and the plagues that accompany it, very modern affairs… sickness and inequalities are themselves best thought of together constituting modern plagues. That they are not widely viewed as indissociably linked in is in part a result of the limitations of epidemiology and international health—disciplines that increasingly take shelter behind validated methodologies while ignoring the larger forces and processes that determine why some people are sick while others are shielded from risk. [p.281]

International aid tends to follow a public health model of epidemiology and individual risk. Dr. Jonathon Mann comments on how this affected international HIV/AIDS aid: "The focus on individual risk reduction was simply too narrow, for it was unable to deal concretely with the lived social realities.... applying classical epidemiological methods to HIV/AIDS ensures —pre-determines— that 'risk' will be defined in terms of individual determinants and individual behavior" (Mann 1996: 3). Mann also commented that much of the public health sector refrains from applying a cultural model to national and international issues out of fear of "the inevitable accusation that public health is 'meddling' in societal issues which 'go far beyond' its scope and competence and inevitably puts [researchers]... potentially 'at odds' with governmental and other sources of power in society" (Mann 1996:6). For international aid providers and public health personnel, therefore, culture is often seen as an "obstacle" to overcome rather than a framework in which to operate (Schoepf 2001).

2.4. APPLIED MEDICAL ANTHROPLOGY AND HIV/AIDS

Sociological studies have contributed greatly to the analysis of public discourse on HIV/AIDS by linking Foucault's ideas of power and discourse to disease and victimization (Foucault 1980). Public discourse on HIV/AIDS has been tied to political agendas for the policing of morals, and the punishment of victims (Bloor 1995; Patton 1985; Treichler 1992; and Watney 1987). Some suggest that more research on "power" relations is necessary: "[W]e need to return to theorizing social power and its impact on the disempowered, and construct strategies for change and for care that encompass the realization that HIV and AIDS are a private concern but also, and not paradoxically, a public issue — an issue of politics" (Small 1997: 23).

Anthropological studies, on the other hand, are more attuned to the details of the lived daily realities involving cultural perceptions of HIV and "risk." Long-term field work and ethnography are fundamentally at odds with public health and sociological "rapid assessments." Farmer argues that ethnography is an "indispensable tool for understanding the social constructions of AIDS" (Farmer 1992: 12). This idea is mirrored by Parker (1995):

> Ethnographic research, preoccupied with the nuances of local knowledge, the social and cultural particularities of sexual experience and the complex networks of power that condition not only the spread of HIV but the ways in which social systems respond to AIDS… has in fact developed one of the few bodies of knowledge that would appear to offer insights that might meaningfully guide epidemiological inquiry in different settings rather than simply being carried in its wake. [p. 265]

Like its mother discipline, anthropology, medical anthropology is a "holistic and interdisciplinary enterprise" (Brown et al. 1998:17). Medical anthropologists utilize an ethnographic approach involving, among other things, participant observation and interviews to study "relatively small groups of people, to understand how they view the world and organize

their daily lives. The aim is to discover — in so far as this would be possible — the 'actor's perspective'; that is to see how the world looks from a perspective of a member of that society" (Helman 1990: 6).

As interest in this field of medical anthropology has grown, an applied component has allowed medical anthropologists to become "involved in a variety of multidisciplinary projects in many parts of the world, aimed at improving health and healthcare" (Helman 1990: 8). Anthropology's hands-on approach to research attempts to understand the *emic* (insider's) perspective and facilitates such things as a greater understanding of the types of international aid — whether it is development, health, or other aid — that may be more effective than aid otherwise given. Applied anthropology "emphasizes the direct application of anthropological theory and method to particular social problems" (Brown et al. 1998:16). "Anthropologists' witness to suffering, their concern and engagement, are potent elements in the research process and in advocacy in national and international arenas" (Schoepf 2001: 335).

One form of applied anthropology has begun to specialize in applying indigenous knowledge to arenas associated with health and development (Sillitoe 1998). This new applied arena of anthropology looks to not only critique the hegemonic discourses latent in health and development project frameworks, but also looks to bring a whole new era of anthropology to the forefront. Through a focus on indigenous knowledge that concentrates on informants as collaborators and communities as participating user-groups, this new form of applied anthropology looks to touch "upon such contemporary issues as the crises of representation, ethnography's status with regard to intellectual property rights, and interdisciplinary cooperation between natural and social science" (Sillitoe 1998:223).

Anthropological AIDS literature from the last decade increasingly focuses on the "linkages between [1] local sociocultural processes that create risk of infection ... [2] the lifeworlds of sufferers... [and 3] the global political economy" (Schoepf 2001: 361; see also Baer et al. 1997; Farmer 1992; Herdt 1997; Mogensen 1995; Setel 1999; Treichler 1999). This literature shows the importance of not simply focusing on individual lives, specific cultural constructs, or even the international world system, but rather on the need to understand how all three interact together. Philip Setel (1999) discusses these interactions in his book A Plague of Paradoxes. Setel explains how strategies of living for people in poverty put them at higher risk for HIV, which is why he refers to AIDS as the "Acquired Income Deficiency Syndrome" (Setel 1999). This phenomenon of looking at the world system and its affects on disease and illness is one of the main goals of Critical Medical Anthropology (CMA). CMA is a relatively new theoretical paradigm in Medical Anthropology. As discussed below, CMA offers major revisions for the study of local diseases, global pandemics, health and health policies.

2.5. CRITICAL MEDICAL ANTHROPOLOGY (CMA)

An important outcome in anthropology has been the "development of critical medical anthropology (CMA), a perspective that coalesced in 1980s and 1990s" (Brown et al. 1998:15; *see also* Singer 1998b). CMA, which attempts to understand health and disease within a world system, offers the "critique … that many medical anthropologists have incorrectly attributed regional disparities in health to local sociocultural differences without examining the influence of global political-economic inequality on the distribution of disease" (Brown et al. 1998: 16; *See also* Farmer and Kleinman 1989). A second CMA critique "emerges from a heated

epistemological debate on the nature of medicine…. [which challenges] the medical anthropological presumption that Western biomedicine is an empirical, law governed science that is unbiased by its own cultural premises" (Brown et al. 1998:16).

CMA is "concerned in the ways power differences shape social processes, including research in medical anthropology.... [and how] dominant ideological and social patterns in medical care are intimately related to hegemonic ideologies and social patterns outside of biomedicine" (Baer et al. 1997: 26). According to a CMA perspective, in order to fully understand health and healthcare, one needs to understand that there are numerous levels in the healthcare system at the global, national, local and individual level that all can affect an individual's health outcomes. CMA "understands health issues within the context of encompassing political and economic forces — including forces of institutional, national, and global scale — that pattern human relationships, shape social behaviors, condition collective experiences, reorder local ecologies, and situate cultural meanings" (Baer et al. 1997: 27).

Critical medical anthropology is predicated on the awareness that "no anthropologist can escape involvement" (Singer 1998b: 235). Thus, applied critical anthropologists look to engage in "system-challenging critical action" (Singer 1998b: 230). According to Merrill Singer (1998b), the main proponent of applied critical medical anthropology, CMA has numerous special attributes to "offer system-challenging movements in health care" (p. 230). In his paper entitled "Beyond the Ivory Tower: Critical Praxis in Medical Anthropology" (*printed in 1995 and reproduced in 1998*), Singer identifies the following attributes:

> 1. The anthropological tradition of cultural relativism (whatever its limitations) and the discipline's enduring concern with insider understanding is critical medical anthropology with an appreciation of and commitment to self-determination….

2. Critical medical anthropology is empowered by its understanding of local contexts in relationship to their location in the encompassing world or national systems….
3. Recognition of the historic role of culture in the shaping of human behavior and social configuration, on the one hand, and of the contribution of social relationships to the generation of culture, on the other, establishes the ground for an awareness of the social origin and ideological function of such concepts as disease, medicine, and social development….
4. Acknowledgement of the contested nature of culture and the inherent contradictions of social relations directs the gaze of critical medical anthropologists towards opportunities for expanding the focus of health-related struggles from immediate to ultimate causes of illness and disease….
5. Concern with social relations as a determinant force in social life directs critical attention to the alignment of forces in practical work. [Singer 1998b: 235]

Along with the above attributes, the methodology employed by anthropologist — such as participant observation, in-depth interviews, and cultural relativism — offers humanist dimensions to the research process. “Like experiential community-based disease prevention methods, lived experiences of sufferers and their families shed light on the interfaces between structure and agency” (Schoepf 2001: 347). Yet, understanding the workings of the world system is not enough to advocate policy implementation. One must also understand the interactions of these policies on the individual level, since world structures do not act alone; instead they act within a framework that allows for forms of individual agency (Bourgouis 1995).

When using anthropological concepts in a public health setting it is important to examine things in a holistic and integrated way. A public health theory that allows for this is the social ecology framework (Baker & Goodman 2003). This theory discusses the importance of understanding how all aspects of health and society are interrelated, and how it is important to take a person and their surroundings (including culture) into consideration when addressing health needs.

Arihihenbuwa (1995) stressed this importance:

> There is no single strategy for understanding complex health problems, but an understanding of the complexity of the problems is a prerequisite of a proposal of effective solutions. It is more effective to adapt preventive health programs to fit community needs and cultural contexts than the reverse, hence the need to ensure that health promotion programs are culturally appropriate. [p. 25-26]

Arihihenbuwa's model creates a discourse in which to look at these dialectical processes within an open system, effectively transforming the "notion of cultural barriers to cultural dimensions, wherein barriers are understood as one unfortunate possibility" (Arihihenbuwa 1995: 43).

My research emphasizes the direct application of CMA perspectives partnered with a public health social ecology framework that focuses on the effects of the world system within a context that understands individual experience. This innovative understanding of disease and illness mandates an entirely new framework within which to understand such things as HIV/AIDS. This framework has slowly begun to emerge as anthropologists, health practitioners, and other individuals from around the world have begun to discuss such issues within new understandings of global health.

2.6. WESTERN "RISK" IN INDONESIA

According to Mary Douglas (1992) "risk" "is the probability of an event combined with the magnitude of the losses and gains that it will entail. However, our political discourse debases the word. From a complex attempt to reduce uncertainty it has become a decorative flourish on the word 'danger'" (p.40). As such, focusing on "risk" has created a discourse to marginalize groups

conceived of by the West as "dangerous." This has been the case for Indonesia. Focusing on "risk groups" and "risk behaviors" in Indonesia has brought Western biases about who is and is not at risk. Drawing funding from international sources, Lentera Sahaja, an Indonesian NGO, was granted money for programs targeting sex workers and homosexual men. This presented a precedent for stigmatization of such groups as homosexual men, a group which previously did not have such associations. According to my preliminary investigations during the summer of 2000, Indonesian homosexual men were not seen as "risk groups" by the general population because AIDS was perceived to be a heterosexual disease. Further, some of the university students I interviewed chose to engage in homosexual sex out of fear of contracting HIV from heterosexual acts. This illustrates that Indonesian perceptions of who is at risk and what Indonesians believe constitutes "risk behaviors" are not the feeding force for the policies being implemented. Instead, international biases are creeping into policy procedures. In result, homosexual transmission is one of the main focal points for prevention and education strategies in a country where homo/bisexual transmission accounts for only 8% of all known cases.

Mundiharno (1999) found that long-range truck drivers in northern Java maintain many culturally infused biases about HIV/AIDS, including: "(i) STI can only be transmitted from a man to a woman and not in reverse; (ii) AIDS can not reach truck drivers because it is a sickness for the upper social class in society; (iii) AIDS is a curse" (Mundiharno 1999: VIII). Thus, these drivers thought condoms were unnecessary because STIs and AIDS are considered diseases of the "other," and thus not something that "normal" people need to worry about. My own preliminary research in Indonesia revealed other common perceptions: AIDS is a white person's disease brought to Indonesia by Western travelers so there is only a perceived "risk" if you sleep with white tourists (*similarly found in* Hahn 1999); AIDS is a scourge from God, inflicted on the

insufficiently pious (*similarly found in* Djoerban and Nenden 1998); AIDS is ONLY a heterosexual disease, homosexual men and women are not perceived at 'risk;' and AIDS is a disease of the rich because, in reality, only the wealthy can afford to get tested (*similarly found in* Mundiharno 1999).

AIDS is further seen as a "modern disease," and as a result culturally infused rituals are perceived as having no risk because of their "distance" from modernity. For example, during my stay in Jogjakarta, I witnessed a public circumcision ceremony where 30 young adult males were circumcised using the same unsterilized ceremonial knife. Indonesian researcher, Primus Lake (1999), similarly found that beliefs around *Sifon*, the circumcision ritual among the Atoin Meto of West Timor, included the ritualistic practice of sleeping with a woman, often a sex worker, immediately after the circumcision ritual because of the belief that this will help the wound heal faster. Local constructions of AIDS as modern and Western, thus, allow Indonesians to assume immunity when engaging in traditional practices.

2.7. RESEARCH DESCRIPTION

My research examines how national and international cultural conceptions of HIV/AIDS affect the consumption of information and education of female sex workers, *waria*, and university students in Indonesia. HIV/AIDS programs being implemented in Indonesia are mostly accessible to only "high-risk" populations, such as sex workers. In result, information is not well disseminated to the general public. Though current programs aimed at "high-risk" groups are somewhat effective in negotiating Indonesian cultural beliefs around HIV/AIDS, they simultaneously increase stigmatization and the incorporation of Western epidemiological biases.

This project examines: 1) the types of nationally and internationally generated HIV/AIDS information, including the incorporation of international constructions of HIV/AIDS and "risk", aimed at populations that are targeted for HIV prevention and education programs (i.e. female sex workers and *waria*), as well as its influence on non-targeted populations (i.e. university students); 2) the extent of information dissemination via analysis of knowledge levels; 3) and targeted and non-targeted groups' cultural perceptions of HIV/AIDS (including culturally infused definitions, identities, and categories).

My research was conducted in Jogjakarta, Indonesia over a two year period beginning in January of 2002. Ethnographic data were gathered through formal and informal structured and open-ended interviews, small focus groups, and surveys, as well as through daily interactions with university students, sex workers, and staff and volunteers from HIV/AIDS prevention and education organizations.

The main purpose of this project was to assess the extent to which global and local forms of knowledge affect understandings and perceptions of HIV/AIDS in targeted and non-targeted groups in Indonesia. Because the general public's knowledge about HIV/AIDS issues is highly variable depending on such things as education level, socioeconomic class, and rural versus urban living, it is not possible to elicit everyone's beliefs. This research focuses on female sex workers and *waria* as targeted groups, and university students as a non-targeted group. University students are focused on because they are the likely policy makers of tomorrow, and because of this I believe they are an appropriate target for future education programs.

Aiming information more at the general public (such as university students) not only allows for broader reaching accessibility to education on preventative measures, but also breaks down stereotypes and stigmatization (Riyadi 2000). In assessing the amount to which global and

local forms of knowledge affect understandings and perceptions of HIV/AIDS in targeted and non-targeted groups, this study allows for a more complete understanding of how current programs could be used as a base to create more comprehensive programs in the future.

2.8. FIELD SITE DESCRIPTION AND METHODOLOGY

As discussed in the introduction, my research was conducted in the city of Jogjakarta, on the island of Java. Jogjakarta has the reputation of being both "the city of students" — with multiple universities and colleges throughout the area — and Indonesia's "cultural capitol" — with ancient Buddhist and Hindu temples nearby, rich artistic traditions, and numerous museums, etc. A desired location for traveling and living by both Indonesian nationals and international expatriates, the constant influx of students, tourists, and migrants, gives this city a unique flavor, as well as a number of scapegoats for HIV transmission. This unique flavor allows for the "othering" process to take place; with different populations (sex workers, tourists, migrants, etc.) being "blamed" based on associations with definitions of "high-risk."

Upon arriving in Indonesia, I was involved in the collection of background information not available in the United States which included epidemiological trends and current information on prevention and education programs being offered. This archival research took place in Jogjakarta at Gadjah Mada University's Population Studies Center, where Dr. Muhadjir Darwin, a prominent Indonesian AIDS researcher, gave his assistance to my endeavors. I also utilized the library of Lentera Sahaja, the STI/AIDS prevention project, which is a subsidiary of the Indonesian Planned Parenthood Association (IPPA). The program managers of Lentera Sahaja gave me their organization's full support and assistance. This time was also used to renew

academic and government connections made during my preliminary three month investigation during the summer of 2000.

During this time I also focused on identifying viable samples of HIV/AIDS "high-risk" targeted populations (sex workers and *waria*) and a population of university students. Griya Lentera, the component of Lentera that is specifically aimed at outreach and education to sex workers and *waria* in the Sosrowijayan area of Jogjakarta, agreed to assist me in the identification of suitable populations. Dr. Heddy Shri Ahimsa Putra, coordinator of the Center for Indonesian Language and Culture Studies at Gadjah Mada University, was my Indonesian research sponsor and assisted in the identification of a suitable university student study population. Due to the inaccessibility of sex workers and *waria*, a convenience snowball sampling of 144 sex workers and 60 *waria* was surveyed. For comparison measures, the same technique was used to access a sample of 209 university students.

Knowledge levels and cultural interpretations around HIV/AIDS were evaluated for all survey participants. To fully understand the impact of education programs on the populations that have access to them, sex worker and *waria* populations who had and had not attended education programs were surveyed. As discussed in the introduction, survey populations included: 84 sex workers and 30 *waria* who had <u>not</u> attended HIV/AIDS education programs, 60 sex workers and 30 *waria* who had attended HIV/AIDS education programs, and 209 university students who had <u>not</u> attended HIV education programs because of not having access to them.

At the time of creating my survey (see appendixes A and B for English and Indonesian versions of the survey), I found that three other similar survey instruments had recently been used by researchers in Indonesia (Indriyanti 1997; Kroeger 2000; Musa 1997). I translated these

survey instruments into Indonesian (see appendixes C, D and E) and then discussed them with my research assistants (*pictured below*).

Figure 3. Photo of my research assistants. They helped in conducting and creating culturally sensitive research tools.

Through discussions of the survey instruments with small focus groups (volunteers of Lentera Sahaja, to whom I was teaching English), as well as my research assistants (who were all university students who had either previously worked at Lentera Sahaja or been trained in Anthropological techniques), and the heads of the programs (Lentera Sahaja and Griya Lentera), I constructed an initial survey instrument. Preliminary testing was conducted on this instrument and was revised accordingly (*see Figure 4*).

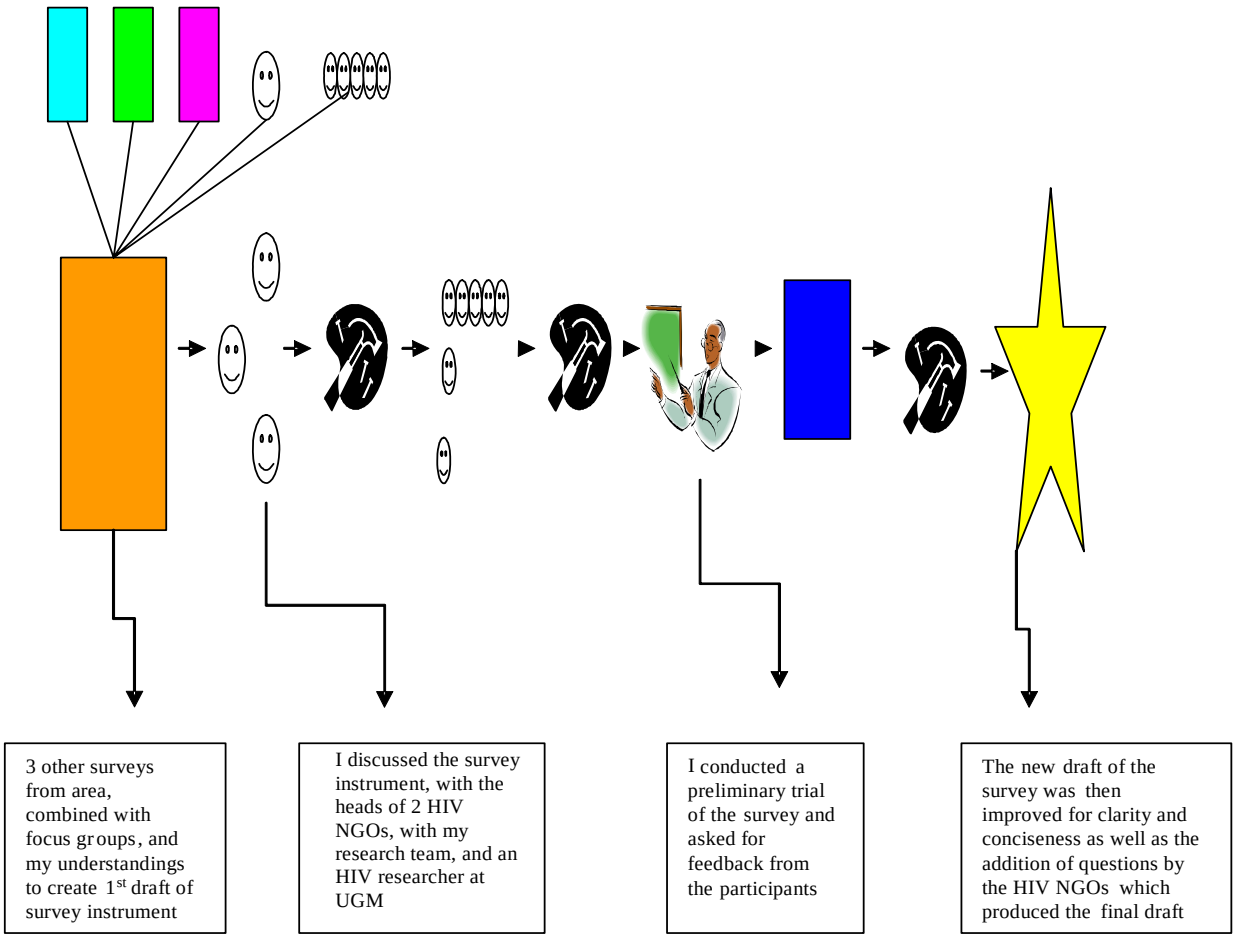

Figure 4. Flowchart of the steps utilized to construct a culturally sensitive survey instrument

Preliminary trials with this instrument indicated culturally important and necessary changes. For instance, the question "Would you drink from the glass of a person suspected of having HIV/AIDS?" is used routinely in HIV/AIDS education surveys. However, in Indonesia I found it necessary to include the following phrase at the end of the question: "even if it was a family member." The new question: "Would you drink from the glass of a person suspected of having HIV/AIDS (even if it was a family member)?" proved to be more culturally appropriate since social relationships are very important in Indonesian culture. The previously worded question was strictly answered "no" by all preliminary test respondents. When questioned about

it they replied that since they do not know anyone who has HIV/AIDS the question implies that they would be drinking from a stranger's glass. Within the Indonesian cultural context, these respondents would never be presumptuous enough to drink from the glass of a stranger.

After all parties involved had approved the survey instrument, my research assistants and I conducted the survey with 741 respondents [including the populations previously delineated and discussed in detail in this dissertation, as well as two populations that were required by the local NGOs: high school students (N=188), who were a newly targeted group, and the general public, who did not have education available to them (N=140)] (*see table below*) (*see* Appendix F, G, H for survey answers for all 8 populations).

Table 3. Total Populations Surveyed
(N= total number of surveys).

Population	Program vs. Non-Program	N
Sex Workers	Program	60
Sex Workers	Non-Program	84
Waria	Program	30
Waria	Non-Program	30
University Students	Non-Program*	209
High School Students	Program	69
High School Students	Non-Program	119
General Public	Non-Program*	140
Total	**Program and Non-Program**	**741**

(*) Denotes no programs available.

Each participant received a key chain (*see figure 5*) with HIV hotline information on the reverse. Informed consent was gathered previous to the survey being issued (Gray 2004).

Figure 5. Key chain given to survey respondents. Design for key chain utilized a saying from the local HIV NGO: "Open your eyes! Close your pants! AIDS is everywhere"

Figures 6 and 7 *(see below)* show exactly where the data were collected (through GIS coordinates and mapping). After data collection, information was entered into and analyzed with the Statistical Package for the Social Sciences (SPSS). Preliminary bivariate analysis of the quantitative data was accomplished using this program (Bernard 2002).

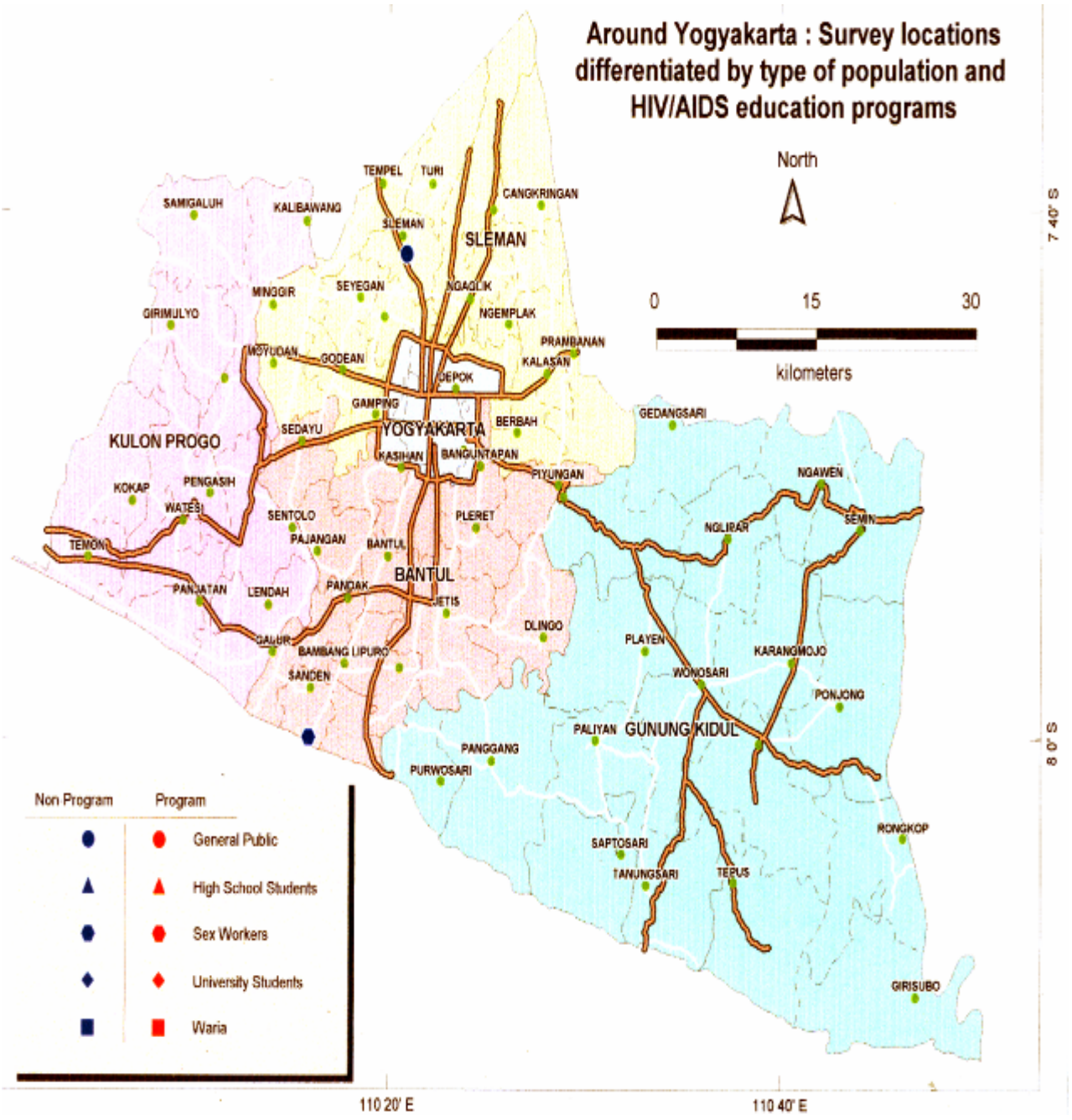

Figure 6. Survey respondent locations inside city limits of Jogjakarta

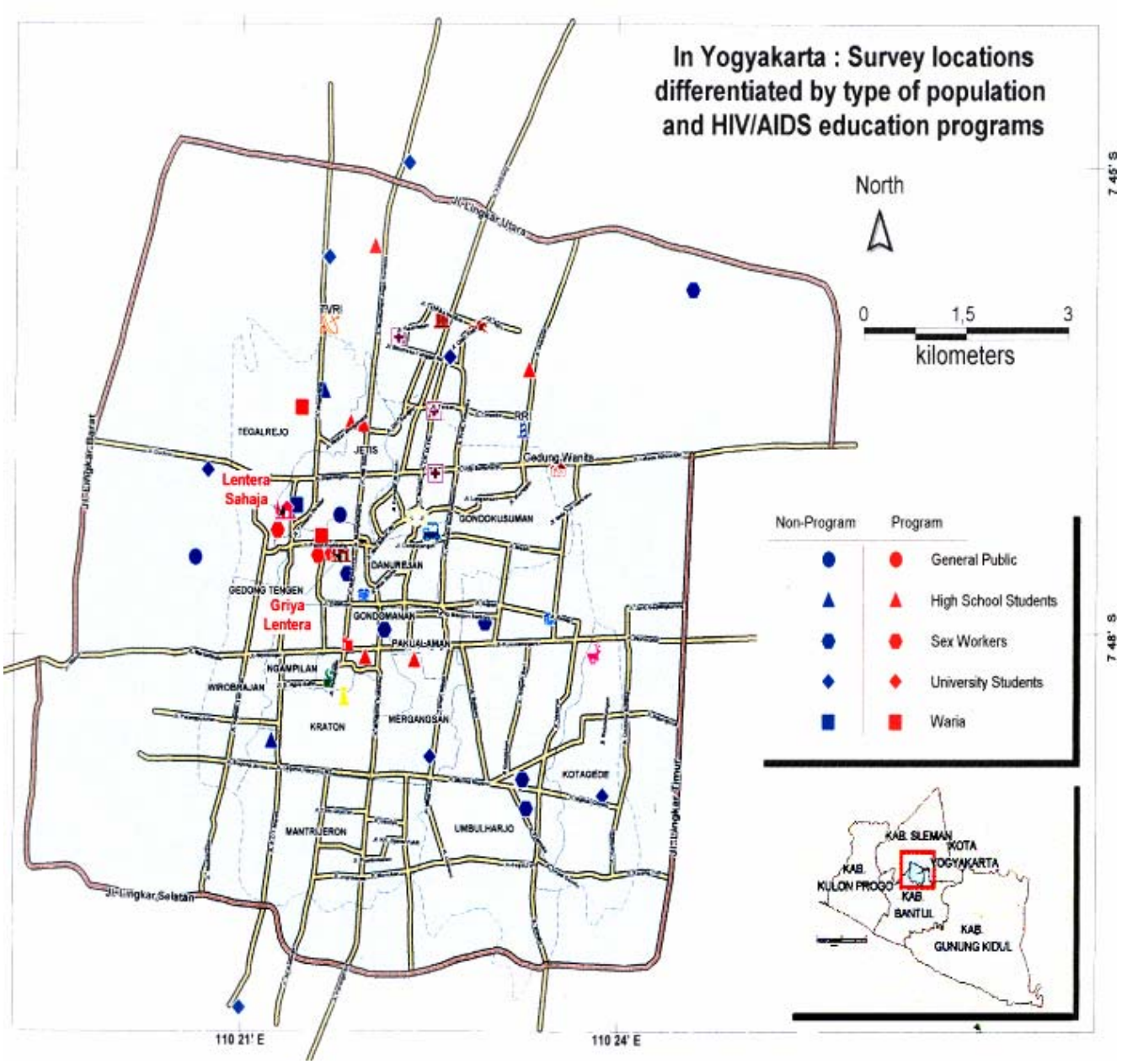

Figure 7. Survey respondent locations outside the city of Jogjakarta.

Once the surveys were analyzed, the information was used to create relevant and important interview questions that allowed for a more complete understanding of the information gathered in the surveys. Open-ended and free flowing 1-2 hour interviews were conducted with

20 sex workers, 20 *waria*, and 20 university students, as well as 17 other stakeholders (including policy makers, NGO volunteers, and physicians) (*see* Appendix I for examples of these questions). Each participant received a coffee mug (*see figure 8*) with an HIV brochure, condoms, and instant coffee packets inside.

Figure 8. Coffee mug given to interview respondents. Design on coffee mug says in Indonesian: "Our family cares about AIDS."

After informed consent was collected, I asked questions pertaining to information concerning the daily realities of those being interviewed; the identification of and ideas about

risk behaviors; knowledge of and about preventative measures; perceptions of where relevant knowledge was acquired; attitudes about people living with HIV/AIDS; and knowledge pertaining to available outreach and education programs.

Along with surveys and interviews I also conducted what is known as "participant observation." Participant observation is a strategic method often utilized by anthropologists. Since the days of Malinowski studying the Trobriand Islanders, anthropological fieldwork has included learning the language of the people you are studying, living with and engaging with the people you are studying, and conducting participant observation. Participant observation is about "establishing rapport and learning to act so that people go about their business as usual when you show up" (Bernard 1995: 324). It involves really getting to know the people you are working with, participating in their daily lives, while also observing them.

"Participant observation involves immersing yourself in a culture and learning to remove yourself every day from that immersion so you can intellectualize what you've seen and heard" (Bernard 2002: 324). By doing participant observation — including attending functions, having meals together, living together, setting up a volleyball court together, immersing myself in their lives and daily realties, etc. — I was able to understand their cultural views and identities much more completely than if I had solely done interviews or surveys. Participant observation allowed me to become a part of their lives, and they a part of mine. Participant observation is more than simply participating or simply observing: "participant observation helps you to understand the *meaning* of your observations" (Bernard 2002: 334).

According to H. Russell Bernard (2002), participant observation is an anthropological methodology tool that enables insight far beyond surveys and interviews: (*modified from* Bernard 2002: 333-335):

1. Participant observation opens things up and makes it possible to collect all kinds of data.
2. Participant observation reduces the problem of reactivity—of people changing their behavior when they know they are being studied.
3. Participant observation helps you to ask sensible questions in the native language.
4. Participant observation gives you an intuitive understanding of what's going on in a culture and allows you to speak with confidence about the meaning of data.
5. Many research problems simply cannot be addressed adequately by anything except participant observation…getting a general understanding of how any social institution or organization works — the local justice system, a hospital, a ship, or an entire community — is best achieved through participant observation.

As well as conducting participant observation, statistically significant surveys, and in-depth interviews with sex workers, *waria* and university students, I also interviewed what I refer to as other "stakeholders" involved in HIV/AIDS education in Indonesia, including: physicians and health care providers, policy makers, HIV/AIDS non-governmental organizations volunteers and staff, and Westerners involved in HIV/AIDS education in Indonesia (*for a discussion of the importance of "stakeholders" in HIV education see* Gilliam et al. 2002). To examine links between cultural cognition about HIV/AIDS issues and use of education and prevention programs targeting each group, as well as to identify effective strategies for implementing culturally sensitive prevention and education programs, I discussed my preliminary analysis with these "stakeholders." I held conferences, spoke at events, and had private discussions and interviews with stakeholders about my research and their perceptions about HIV/AIDS in Indonesia. These discussions and conversations informed my research, and my dissertation as well as becoming part of the discourse on the direction of future HIV/AIDS initiatives in Indonesia.

2.9. SIGNIFICANCE

This research is significant on descriptive, theoretical, and practical levels. It provides ethnographic information on third-gender *waria*, sex-workers, university students, and HIV/AIDS prevention and education programs in Jogjakarta. This research also contributes to the current dialogue within the global AIDS network on the importance of understanding the cultural framework within which a prevention or education program is implemented. International experts, led by the United Nations Educational, Scientific and Cultural Organization (UNESCO), just met in 2000 in Nairobi to discuss taking a "cultural approach" to HIV/AIDS. Discussions focused on cultural practices that have frustrated efforts against the spread of HIV/AIDS (Achieng 2000).

Though seemingly a new idea in the realms of global public health policy, anthropologists have discussed the importance of understanding cultural constructions of knowledge and disease for some time (*for example:* Berger and Luckman 1967; Brown 1998; Bruner 1986; Clifford 1986; Feldman 1995; Foucault 1972; Geertz 1973; Knorr-Cetina 1981). Even within medical anthropology's discussion of cultural constructions of disease, the cultural construction of AIDS itself has generated considerable attention (Crimp 1989; Farmer 1992; Farmer and Kleinman 1989; Grover 1989; Herdt 1997; Mogensen 1995; Setel 1999; Treichler 1999).

This study makes significant contributions to the anthropological literature on cultural constructions of disease, the public health literature on the targeting of "high-risk" groups and "high-risk" behaviors, and perhaps most importantly has critical implications for international and domestic HIV/AIDS policies. Understanding how cultural perceptions of HIV/AIDS are affected by local realities and global practices expressed via prevention programs allows for a

deeper understanding of effective ways to implement culturally sensitive education and prevention policies in Indonesia. This dissertation provides a holistic understanding that enables Indonesian policy makers to advocate for a new generation of HIV/AIDS education programs that effectively negotiates Indonesian perceptions of HIV "risk."

CHAPTER 3. *WARIA*: A POPULATION PARADOXICALLY POSITIONED

The purpose of this chapter is to provide an in-depth examination of one of the three populations studied. This chapter focuses solely on *waria*, the third gender population of Indonesia. The first section contextualizes *waria* in contemporary Indonesia, showing why the existence of *waria* as a third gender is important in fully realizing the ramifications of certain Indonesian understandings of HIV/AIDS. The second section describes the socialization of *waria* into both the worlds of *waria* and sex work. This is beneficial to future understandings of the role of gatekeepers in providing access to healthcare programs. The third section focuses on some of the behaviors that make the *waria* an important group to understand in the context of HIV/AIDS, including mobility, physical abuse, and beauty injections. The last section discusses HIV/AIDS knowledge levels in this population as well as myths associated with HIV prevalent throughout the *waria* community.

3.1. *WARIA* IN CONTEMPORARY INDONESIA

Waria are "the first sexual minority of any kind to be officially recognized by the [Indonesian] Government" (Indonesia's *Waria* 1999:1). This group has been referred to as Indonesia's third gender, an "in-between" gender that is neither man nor woman (Oetomo 1991). They have been labeled as *banci*, *becong*, *wadam*, or *waria*, but prefer to refer to themselves by the latter term

due to the negative connotations that have been associated with the others. *Banci*, for instance, is used to signify impotence and "to describe men who are wishy-washy and cowardly" (Oetomo 1996: 262). Typically, *waria* are "biological males who cross-dress, adopt the behavior and societal roles of females, identify themselves as *waria*, and socialize regularly with fellow *waria* in definable communities" (Oetomo 1991: 120). The word *waria*, which means "woman-man", is derived from the Indonesian words for woman (*wanita*) and man (*pria*). According to the Indonesia's *Waria* homepage (1999):

> Indonesia has always had a variety of roles filled by transgendered women. As in other cultures, they often fulfilled quasi-religious ceremonial and performing arts functions as priest/ priestess. The idea behind this was that the spirits are perfect and the perfect mortal equivalent must have the qualities of both sexes. In the old courts of the Southern Celebese, cross-dressing and transgendered persons were given the honor of guarding the royal court regalia. Ordinary citizens are not supposed to be even close to them so there is an almost sacred quality to being transsexual/transvestite. Even though modern Indonesia is an Islamic society, these attitudes are still present. [p.1]

Many *waria* are poor and illiterate but some have been able to increase their income and social status "especially those who run beauty parlors, or are entertainment artists or dance teachers" (Oetomo 1999:3). Other *waria* have found work in the sex industry:

> A strange paradox of Indonesian Islam is that its observance has opened a flourishing niche for transgendered sex workers. There seems to be less moral approbation placed upon a married man who has regular sexual relations with *waria* than with non-transgendered women... and 'homosexual' activity is far more acceptable socially if one of the partners can be identified as being at least in appearance, female. [Indonesia's *Waria* 1999:1]

Waria are tolerated quite well on a societal level in modern-day Indonesia (Oetomo 1991). As a third gender, *waria* feel comfortable associating with either men or women in a

world where segregation of the sexes is the typical cultural norm. "*Waria* identity is about the only 'acceptable' form of expression open to homosexuals" (Indonesia's *Waria* 1999:1). This is due to the above mentioned ideas that homosexual acts are more acceptable if one partner can at least pass as a woman.

According to Dede Oetomo (1991), "most of the general public lump together *waria* and male homosexuals" but, he maintains, "there is an almost watertight distinction between *waria* on the one hand and… gays on the other" (p.121). The main difference arises in the fact that *waria* see themselves as a third gender and they identify as neither male nor female but associate more with the female gender. Gays, on the other hand, identify as males who enjoy having sex with other males. No matter how many preconceived gender roles they conform to, they transverse gender distinctions when they choose their partners. As opposed to *waria*, who have different gendered relationships, homosexual gay men and their partners are both male identified (Boellstorff 2004). This watertight distinction is often not so easily discernible from appearances alone, since gays "on occasion have been known to dress in drag, and recently have even been winning *waria* beauty contests" (Oetomo 1999:3).

Although post-1990 writings on gender theory refer to transgender as something that transcends gender distinctions, laypeople and scholars not dealing with gender issues often assume transgender refers to transsexual (Wilchins 2002, LGBTA 2005). A good example of this can be seen when looking up the word 'transgender' in online dictionaries on the World Wide Web. One dictionary defined transgender as "best described as a person that crosses, or changes gender" (pinkmyst.com 2004). Another website states that "transgender" "is often used as a euphemistic synonym for transsexuals… [which] is a person who desires to have, or has, a different physical sex from what they had at birth" (Webster's online dictionary 2005). In

anthropological writings, you also find notions of a third sex or third gender distinct from Western notions of transsexual/ transgender (Herdt 1994; Nanda 1990). In the past, scholars have used both transgender/transsexual (*see* Boellstorff 2004; Joesoef et al. 2003, Totman 2003) and third gender (*see* Andaya 2000; Oetomo 1996) to describe the *waria* of Indonesia, often debating the pros and cons of each term. Since debating gender terminology is not the point of this chapter, I believe it is best to let the *waria* define themselves.

Throughout my interviews with *waria* the theme that they are neither men nor women kept emerging. When talking about how many children were in hir family *waria* #20 said: "The eldest is female, the second is male, and I am a *waria*. It is complete." #18 mirrored this, saying of her two older siblings: "One's a girl, one's a boy and then there is me… all complete, no?" *Waria* #17 said of her siblings: "3 male and 3 female and only I that deviate." *Waria* #7 commented that: "Fortunately we are all there… boys, girls and a *waria*" And *waria* #10 said that: "I have realized that I was a *waria* since I was a child. It continues until now. I don't understand it. Usually a woman is a woman, a man is a man. I don't understand why I am like this." This distinction is important when looking at the paradoxical positioning of *waria* in contemporary Indonesian society.

This positioning of *waria* as a third gender creates an interesting loophole for Indonesian male clients to rationalize their sexual transactions with *waria*. Since they are not seen as men, their clients are not seen as homosexuals. Similarly, since they are not seen as women, their clients are not cheating on their wives. Moreover, when asked why their clients preferred them, they often mentioned that "women get pregnant", "women menstruate", "women do not like variation", and most importantly, "women can spread disease". Dede Oetomo (1991) found similar results when interviewing men who have sex with *waria* in Surabaya, East Java: "Men

who have sex with *waria* are not considered homosexual by the general public, *waria*, or by themselves. Despite the fact that female prostitution is widely available in most Indonesian urban centers (and even in some rural areas) these men persist in having sex with *waria*" (Oetomo 1991: 123). Oetomo (1996) says that the men he interviewed have usually stated one of the following reasons for this behavior: "(1) one does not have to worry about responsibility because she cannot get pregnant, and (2) one cannot get sexually transmitted diseases from '*banci*'" (p. 263).

Understanding how the clients of *waria* view themselves is important when thinking about policy implications. A recent article published in the International Journal of STI & AIDS stated: "*[W]aria* have the highest rates of HIV and their clients consist of homosexual and bisexual men" (Joesoef et al. 2003). After having medically surveyed groups of *waria* in Jakarta and tracking sexually transmitted diseases, the article points to the importance of prevention efforts in these populations to curb the HIV epidemic. Policy makers reading this 'hard' science article might utilize it to rationalize prevention efforts with *waria* and their clients. But prevention efforts aimed at "homosexual and bisexual men" would fail to address the needs of either population, since both the *waria* and their clients identify as heterosexual. Prevention programs need to understand the contextual nature of these definitions when targeting these populations.

Similarly, prevention programs targeting these populations need to understand the contextual nature of sexual intercourse. As has been seen in the previous chapter, the definition of what constitutes sex is contextual. Sex is considered to be something that happens "between a man and a woman". It is considered to be when a "penis enters a vagina". Neither of these definitions applies to the *waria*. You should wear a condom when having sex to avoid STIs and

HIV. However, if you're not having "sex", why would you use a condom? As we will see by the end of this chapter, the answer is quite simply that you wouldn't.

3.2. SOCIALIZATION OF *WARIA*

If a *waria* is innately neither man nor woman, how do you know you are a *waria*? Is it something you grow into? Is it something that you "come out" as? Is it a self-definition or are others prescribing it to you? This section describes the socialization of *waria* as *waria* and as sex workers. *Waria* are both culturally accepted and culturally constructed. Thus, though many *waria* feel their families and neighbors accept them, they also feel marginalized due to the cultural assumptions of what it means to be a *waria*.

In contemporary Indonesia, everyone knows a *waria*; whether they're famous *waria* who host their own television shows, or local *waria* down the street. In Jogjakarta (Jogja), everyone I talked to knew someone who had some contact with a *waria*. Commonly heard comments include variations of the following: "My mother's hairstylist is a *waria;*" "My neighbor in my village had a child that was a *waria;*" and "At the corner of Malioboro Street the nighttime singers are *waria*. They are nice and I often give them money." Most Indonesians are familiar with *waria* on the television. Dorce is a famous *waria* who not only sings and dances but also hosts many charities and live aid auctions. Other *waria* have been on soap operas and commercials (Boellstorff 2004). As Tom Boellstorff points out, "If you were Indonesian, you would expect to find *waria* in salons and might assume a *waria* would apply makeup for your daughter on her wedding day. Some tailors and shopkeepers in your neighborhood would

probably be *waria*, and at night you might see *waria* looking for men near the town square" (Boellstorff 2004:165).

Boellstorff argues that "although rosy fantasies of tolerance are overstated, *waria* is now an important cultural category [in contemporary Indonesia]" (Boellstorff 2004:165). He goes on to explain that the position *waria* occupy is hardly one of respect or honor, even within their own families:

> Although *waria* are generally known to contemporary Indonesian society, this does not mean that families welcome a *waria* member…. Many *waria* are not accepted by their families at least initially. Young *waria* have been beaten until they bled, have been held under water by their fathers until they have almost drowned, or have an older brother stick their finger in a light socket. Estrangement from the family sometimes continues through adulthood…. Others are accepted to some extent. [Boellstorff 2004:166]

The *waria* that I interviewed expressed that their families generally accepted them to an extent, some for all their lives, and others later on in life. Almost every *waria* interviewed said their parents knew they were a *waria* at a young age. *Waria* #5 reflected: "My family and neighbors understood that I was going to be a *waria:* 'Oh, this child is so big, s/he's going to be a *waria*, you just wait and see.' As a child I liked playing with girls. I didn't want to play with boys my age; I was shy, if boys asked me to play in the village I would run away." And though s/he was accepted, *waria* #2 was sure to point out that it was not hir parents fault s/he was like this: "I came from a big family, I am the eighth of nine all total. They all knew I was different. I am like this not because of the environment, nor because of my parents' fault in educating. It happened all by itself… even when I was a child I already knew."

When asked if their parents knew if they were *waria*, 19 out of 20 said "yes." Some were even a little indignant about the question, commenting that: "Of course they knew, how could

they not?" Ultimately this indignation is fair, since I would have never presumed to ask a male if his parents knew he was a male. One *waria*, however, said that hir parents did not know and that s/he was afraid to tell them. However this is not the norm. *Waria* are generally told that they are different from a very early age. Boellstorff explains, "Unlike gay men, *waria* never speak of 'opening themselves' (*membuka diri*) in terms of revealing who they are; indeed they discover who they are because others point it out to them" (Boellstorff 2004:165).

Though *waria* generally feel accepted or at least tolerated, many still expressed dissatisfaction in disappointing their parents. As #8 put it: "My parents know I am a *waria*, they never give me any trouble. But when I am home I don't wear make-up and dresses. I don't want to hurt my parents' feelings." *Waria* #7 discussed being allowed to be a *waria* "within reason": "My mother gave me a green light and gave me my freedom. She said it was okay if I wanted to prove my *waria*-ness. She said I can be myself, but don't be too much. But I broke my mother's trust. For example, she told me that I must not inject my nose [with silicone]. But I disobeyed her."

Despite the fact that almost all of the families knew their child was a *waria* from an early age, family social pressure to marry still often applied to *waria*. Marriage is a very important concept in Indonesian culture. So important, in fact, that many gay men and lesbians marry heterosexually in public and then continue to live homosexual lives in private (Blackwood 1998; Oetomo 1996). *Waria* are not immune to this social pressure.

Interestingly, since they occupy a third gendered space, it is not always obvious who they might be marrying. When I asked the *waria* about marriage, many talked about their unofficial "husbands," some of whom they have been with for over a decade. When I talked about their parents, however, many talked about how they have disappointed their parents by not marrying a

woman. *Waria* #8 says hir mother is constantly bugging hir, saying "If you don't marry soon I will die." And the topic of marriage even stops some *waria* from being close to their families; more than once I heard "I don't go home because I am afraid they will ask me to marry." *Waria* #18 talks succinctly about both hir family's urgency to have hir married to a woman and hir "marriage" to a man:

> I never talk to my family. I am afraid they will ask me to get married again. They asked me before but my brother said I had to finish school first. They had a woman who wanted to marry me. I ran away from school. I didn't want to be married. I lived with a man for awhile. He was my husband. I supported him. This is his name tattooed on my arm. He is dead now. The police shot him. He was in a gang.

Waria #3 discussed the pressure s/he felt at home and hir thoughts about succumbing to it:

> "My mother often asks when I will get married. It is because most of my nephews are married, and my niece even has had children. My mother says, 'How come you're not yet married? Your father has grandsons. Don't you feel ashamed that your neighbors know you aren't married?' In my village there is an older *waria*. S/he does not use makeup so hir appearance is like a man. S/he's married. My mother asks, 'Why can't you be like hir?' It's not about why am I a *waria*… it's about why am I not married! Maybe soon I will return to my village. I want to be a good person, by marrying for example."

The *waria* of Indonesia are seen in a precarious light, and in turn, occupy a paradoxical space in society. Although they are accepted as a third gender, *waria* are often taunted and harassed (Boellstorff 2004). Attempting to make sense of the space they occupy in society, *waria* often turn to other *waria* for guidance and acceptance. Thus *waria* typically find solace working in areas that other *waria* dominate. In contemporary Indonesia, *waria* are often found in salons, in the entertainment sector, or in sex work. Tom Boellstorff delineates the following economic classes of *waria*: "those who own salons or some other business (and can be quite wealthy),

those who work in salons, and those who neither own nor work in salons and usually make a living as sex workers" (Boellstorff 2004:165).

This paradoxical positioning of *waria* is illuminated when taking a closer look at one specific case. This is the case of a *waria* who felt harassed at school, and left home to work and send money back to hir family. After being robbed, s/he eventually finds others like hir, who act as hir mentors. *Waria* #1 is a 30-year-old *waria* from Semarang, Central Java. Here s/he tells hir story of how s/he found hir way into the world of *waria*:

> My last education was elementary school. In elementary school, most of the students were from my village. When I went to junior high school there were many students from other villages. They did not know about me. In my village everyone knew I was a *waria*. Now in this new school I felt strange. When I walked, they laughed at me. When I talked, they made fun of me. In the end, I was not strong enough; so I quit. At home in the village, everyone knew about me and it was okay. There are three brothers and two sisters and me, a *waria*. So my family is complete. My parents and I have a good relationship. They've known about my condition since I was a child. I always played with my sisters. I did women's chores around the house. Even now they know I wear make-up and dresses. They think I am a *Dangdut* [folk] singer. When I left school, I told my parents I wanted to work. I wanted to be able to send money home and help my younger brothers and sisters. So I moved from the village to the city of Ambarawa. There was a furniture store there. I worked at the furniture store for 3 years but I could only support myself. I worked and still could not send money home to my family. Then one night, I went to the public entertainment at the Ambarawa market. People knew that I was a *waria*. People were snatching at me here and there. It's not like it is today. Then, men chased *waria*; now, *waria* chase men. I met a man I liked at the town square. I brought him home with me and he slept in my room. When I woke up, I left him sleeping and went to bathe at the small river nearby. When I returned, everything was gone. He had stolen everything. Even my clock was gone. In my confusion I wandered back to the town square. I thought maybe I could find him, but there was no sign of him. But there I saw four *waria*. They asked, "What are you doing here? You are a *waria*, aren't you?" They could tell I was one of them. Finally, I shared my problem with them. I felt so foolish and confused. They said, "Don't worry. Don't be frightened. Just follow us." I followed

> them to their beauty parlor, where I met many other *waria*. I hung out with them. They showed me how to put make-up on. They said, "Follow us to Jogja. There, you can work for just three months and you will be able to get all your things back. Work just for a year and you'll be able to buy electronics and send money home to your family." So I went. I went because I was confused. They promised it would make everything better. They made me feel better. I went to Jogja with only 24,000 *rupiah* [US $2.40] in my pocket. They showed me everything. They told me that I should get money for having sex with men. They taught me how to flirt and how to ask for a cigarette so the man will know I am interested. My first time I was paid 5,000 *rupiah*[US $0.50]. The average price for a *waria* at that time was 1,000 *rupiah* [US $0.10]. That was the first time I had sex with a man… well, I mean, for money. In Ambarawa it was different. It was for love. That's how I started. That's my story.

As has been seen in *waria* #1's case, *waria* often enter sex work because they feel isolated or abandoned and are looking both to "fit in" and to make a living in the niche Indonesian society has provided for them. Like *waria* #1, *waria* often turn to sex work because of their low levels of education, often as a result of dropping out of school because of fear of being different or after having experienced sexual harassment. Similarly, when they have tried other jobs, they are treated as sexual objects and made to feel uncomfortable. The following vignette from the life of *waria* #10 illustrates how society marginalizes *waria* through discreet and obvious forms of harassment until the *waria* are pushed to seek out acceptance from other *waria*:

> My friends and my teacher liked to make jokes about me, because I was like a girl. They called me *waria*, so I was not able to concentrate. I left school. I asked my parents for permission to leave. What else could I do? This is my destiny… to be a *waria*, to make a living on the street. Before this my mom had asked me to work in a telecommunications office as part of the cleaning service. I swept and mopped the floor. I was not comfortable there. The higher officials often asked me to do things. The higher officials would tease me. While I was sweeping they liked to touch my hip, brush against me. I was uncomfortable, so I quit.

Harassment and marginalization from society is often followed by a search for one's true identity. For *waria*, finding other *waria* and learning what it's like to socialize with them is usually part of this process. *Waria* often referred to the first step in finding your '*warianess*' as being a *banci kaleng* (tin can *waria*). During this "phase" *waria* often hang out on the street with or without other *waria* and attempt to find "boyfriends" or men to talk to and possibly have sex with for pleasure, acceptance, and reassurance — not for money. *Waria* #12 recounts:

> I had a close friend; we liked to walk together. We didn't directly look for men for money but for pleasure. We were what are called *banci kaleng* [tin can *waria*]. I got pleasure by having a chat and hanging out. I was on the street hoping someone would take me home with them. Finally someone told me where other *waria* hang out. I went to the salon. I chatted with them. They worked in the salon and on the street. Finally I hung out on the street. My house mother did my makeup for me. I acted like a girl. I had dressed like a girl. So I was not gay. The seniors said I had to do like this or like that. I was confused about what to do. I didn't even know what anal or oral sex was. I wasn't thinking of sex. I thought I should first talk to the man. Sometimes I regretted to Allah about what I was doing. I just wanted to leave this job because of the pain. But then a friend told me this is what a *waria* should do.

When hanging out with other *waria* and surveying the scene, many *waria* are 'adopted' by older, more experienced *waria*. The older *waria* often acts as a mentor, providing the young *waria* a place to live and lessons on how to put makeup on and how to get clients. *Waria* #7 explains:

> When I came to Jogja I didn't wear makeup. I was taking a hairstylist course and everything was so accidental. There was a *waria* there. S/he was the first to tell me where to go at night. S/he said to go to the station and you will have lots of friends. I went there at night and saw many *waria*. But I was scared. I just looked from a distance. Then one *waria* approached me. S/he took me in. S/he was my first mommy. S/he taught me how to hang out.

Waria #4 attempted meeting men on hir own, but was beaten up because s/he didn't know about *dandan* (the term *waria* use for the putting on of makeup and all the different actions this process entails) and in result was assumed to be a homosexual. S/he discusses hir experience of trying to find men and in the end finding a *waria* to mentor hir:

> I often hung out where other *waria* hung out. I was curious. I didn't know anything. I wanted to meet men, but I didn't know how. Once one of them said, "If you want to get men you have to put makeup on your face. What are you doing here with nothing?" In the end I met a nice *waria*. S/he asked me whether I was the same as hir. I thought about it carefully. Finally I confessed that I wanted to meet a man but was afraid to approach men because at the post office they tried to beat me up when I approached them. S/he said "If you wear those clothes, men are afraid of you. They will think you are a homosexual. If you use makeup it will be easy. You will get money. Or just a man if that is all you want. Come with me. I will do it for you. I will show you how." So s/he put makeup on me. S/he liked me. Maybe it was because I was so young. My skin was so fresh. S/he said, "My child I will take care of you." And s/he did.

Understanding how society simultaneously accepts, tolerates, and yet marginalizes *waria* is important for understanding their paradoxical positioning. As will be discussed later, prevention programs often replicate this paradoxical space by attempting to provide programming for *waria*, but at the same time marginalizing them for fear of their impact on revenue sources. When looking at prevention programs, understanding the role of mentors/procuresses/mommies is important as they provide access to younger *waria* as well as provide guidance and knowledge. In result, these *waria* effectively act as gatekeepers between younger *waria* and healthcare providers (Darrow et al. 2004). This population of older *waria* might otherwise be overlooked by healthcare officials and policy makers since *waria* that are younger (<=25 years of age) have 3.5 times the risk for sexually transmitted infections than those who are older (>25 years old) (Joesof et al. 2003).

3.3. BEHAVIORS THAT INCREASE THE LIKELIHOOD OF CONTRACTING HIV

Waria represent a logistical nightmare when talking about HIV infection rates due not only to their large numbers of clients (which will be discussed more fully in the next section), but because of the many other realities in their daily lives. Some of these realities include mobility, physical violence, and beauty injections, as well assumptions about *waria* and "their included-but-marginalized place in the nation" (Boelstorff 2004: 180).

Because of *waria*'s paradoxical position in society, many people have assumptions about what it means to be a *waria*. This often entails assumptions that *waria* are sexually promiscuous and even better at sexual acts than women. One of my confidantes suggested that "Men come to us [*waria*] because we know what to do, our mouths are better for firm suction, our anuses are tighter. Besides, they are bored with their wives… it's like if we eat the same vegetable everyday we get tired of it and want to eat a different vegetable."

Possibly because of these assumptions, *waria* are tolerated in society and yet sexualized at a very young age. Out of my 20 interviews I found that 6 (30%) had their first sexual debut during elementary school (*SD*), 2 (10%) as young as third grade (ages for *SD* typically range from 7-12); 8 (40%) during junior high (*SMP*) (ages for *SMP* typically range from 13-15); 3 (15%) during high school (*SMA*) (ages for *SMA* typically range from 16-18); and 3 (15%) after the age of high school. The fact that 70% of the *waria* I interviewed had their first sexual encounter before the age of 16 was closely replicated in my survey results. Out of the 60 *waria* surveyed 66.6% had a sexual debut by the age of 15 or younger. Similarly, a survey of 296 *waria* in Jakarta showed a median age of first sexual debut to be 15 years of age (Joesoef et al. 2003).

This differs significantly from the age of first sexual debut for non-*waria*. The USAID Country Statistical Report for Indonesia in 2004, though admittedly using data from 1997,

reported 19.6 years old as the median age of first sexual debut for women age 25-49 (USAID 2004). Another report from USAID, published in 2001, suggested that first sexual debut was between 20-24 years of age (again using 1997 statistics). My survey, conducted in 2002-2003, of 209 university students showed a similar age of first sexual debut, with the median being 19-21 years of age. Needless to say, it seems pretty obvious that *waria* are being "deflowered" at a much younger age than other Indonesians.

Why is this happening? Are assumptions that *waria* are sexually promiscuous true? And if so, who are they having sex with? Other sexually promiscuous *waria*? Since this question intrigued me, I asked the 20 *waria* I interviewed about their first sexual experiences. Seven out of 20 (35%) reported that their first time was with a classmate, often an older, more sexually experienced classmate. Five (25%) of the *waria* reported first having sex with an adult from their area. This adult might have been a neighbor, a police official, or the head of the village. It was always someone they knew, and most importantly someone that knew they were *waria*. Interestingly, the *waria* often used this to excuse the behavior of the adult, saying that: "They knew I was a *waria* so it was to be expected."

Another 5 (25%) of the *waria* interviewed also had their first sexual experiences with adults, but adults of a different categorization. These were adults from their schools, including teachers and headmasters. I categorize them separately not only because these are people who are entrusted with the livelihood of the children in their school/class, but because there seemed to be a reoccurring theme in these *waria's* accounts of being held after school or finding themselves alone in the bathroom with a teacher and not knowing what to do. Often times, these *waria* reported never before having thought of themselves as sexual beings until these defining moments. The aftermath of these encounters continued for a long time as their "little secret," or

led the *waria* to leave school because of feeling embarrassed or uncomfortable. *Waria* #7 describes hir first time:

> The first time I had sex was with my Junior high school teacher. It was during our scout campout. When I was guarding the camp… he knew I was a *waria*… he made the first move…He did oral sex on me… I was so surprised. I asked, "Are you a *waria*?" He said it didn't matter and that this was our little secret. Then I served him. It was strange. I couldn't go back to school after that.

The last 3 *waria* (15%) interviewed said that the first sexual experience they ever had was rape. *Waria* #17 recounts: "When I was in junior high I was at a party. I got drunk. I did not want that man. It was rape. I did not know about sex like that… anal sex." Another *waria* (#3) talked about getting jumped and forced to have sex just because s/he wore makeup (*dandan*):

> I used to sell *sate* [grilled meat skewers]. I had my own stall. I put makeup on. I did it myself so it was not serious makeup. I just wanted to wear makeup and show off… it's not like you think. If a man got close to me I would run away. If he asked to play or have sex I was ashamed and embarrassed. The first time I had anal sex, I was so afraid. There were three gang members. It was so painful… it was forced… I didn't really know about anal sex before that.

It is the *waria's* paradoxical space in Indonesian society, of not quite being accepted and yet not quite thrown out of society all together, that allows for such sexualization of young *waria*. It allows for the thinking that behaviors such as these are somehow legitimate behaviors for adults because the recipient is "just" a *waria*. And yet it is quite possibly because of these early experiences that *waria* are more likely to engage in activities that will make them more marginalized later in life.

Recent research on this topic was presented and discussed at a global consultative meeting held in New Delhi, India, in September 2003. In research about childhood and adolescence, sexual coercion — ranging from non-contact forms such as verbal sexual abuse and

forced viewing of pornography, as well as unwanted contact in the form of touch, fondling, or attempted rape — has been found to have links to HIV-related outcomes. "Perpetrators are usually people with whom the victim is familiar, including intimate partners, peers, family members, teachers, and other youth and adult acquaintances… Coercion often occurs in the course of routine activities in the home, neighborhood, community, and school" (Finger et al. 2004: 2). A Ugandan study presented in New Delhi surveyed 575 sexually active women ages 15 to 19 and found that those who had experienced sexual coercion were significantly more likely to be nonusers of contraception, to have unintended pregnancies, and to not have used condoms at last intercourse. The study also found that coercive first sex was associated with a 71% higher risk of acquiring HIV (Koenig et al. 2004).

Although the studies discussed in New Delhi were from a number of developing countries around the world, none were from Indonesia. More importantly, none were in reference to a third gender population. Still, I think it is important to understand the ramifications of these behaviors, especially since so many *waria* reported very similar activities. *Waria* #2 told me about her first time:

> In my village there were many boarding houses, and he lived next door in my neighbor's boarding house. He called to me, and said come here. I thought he was going to help me study. He showed me pornography, and then he had me perform oral sex on him. After that he lay on top of me and rubbed back and forth [*es gosrok* — literally shaved ice, because it is a similar movement as grating ice]. That's it. At the time I felt… afraid, disgusted, and displeased. I wondered how it could happen… I mean I just wanted to study.

Both forced viewing of pornography and unwanted contact and fondling figured centrally in the narrative of *waria* #2, as well as many of the other *waria* that were interviewed.

Understanding the links between cultural assumptions about *waria* and sexual coercion is necessary to fully understand the ramifications for HIV-related outcomes in these communities.

These same underlying assumptions about *waria,* along with society's tendencies to both tolerate and push *waria* to the fringes of society, may also explain the way *waria* are treated later in life. As *waria* #16 puts it:

> It's hard. I don't enjoy being a *waria*. If Allah allows me to live in another world I will ask not to be a *waria*. It's better to be a crazy man than a *waria*. If a crazy man passes by people don't scold him. They just ignore him. But if we pass by they'll yell at us. What's wrong with us??

Throughout their lives, *waria* experience all kinds of abuse and stigmatization while at the same time being generally tolerated as part of the cultural cornucopia that is Indonesia. Many of the *waria* I interviewed told me horror stories of being beaten, attacked, raped, or not paid for services. One young *waria* (#13) told me: "I don't care if my guests are young or old. I just care that they have money. I have been hit by people and kicked and I have had guests not pay me. It happens. What do you expect? We're *waria*." Many of the *waria* echoed each other about how reporting these crimes to the police would do no good since they are merely *waria*, and at times, because it is the police doing it.

At times, *waria* are beaten for stealing money from their clients. Only one *waria* that I interviewed admitted to this, but s/he assured me it was common practice (I had often heard that this happened from clients as well). S/he says s/he knows other *waria* do it because it is common for the *waria* of hir neighborhood to share the profits. S/he told me s/he preferred to do hir sexual transactions outside (as opposed to inside an abandoned train car) because the light was better and it was easier for hir to steal:

> I prefer to do it outside. In the room it is harder for me to snatch his money. All *waria* steal money from their guests. They just

> don't want to tell you that. If they say they don't, they are lying. The most I ever got was 3million *rupiah* [US $300] from a Papuan who was headed home. I shared it with my friends. It was gone in a day or two. That's how it is here.

Many *waria* don't have a choice as to whether they want to perform their transactions inside or outside. Because the cost to have sex with them is so cheap, *waria* typically provide services on the spot, whether at the train station, the abandoned parking lot, or the bus depot. Tom Boellstorff (2004) similarly found in Bali that *waria* "would find their clients among the men passing by on motorcycle or foot, and sex would take place right there in the grass" (p.173). The openness of the sex act between *waria* and their clients can also be part of the cause for violence, especially during Ramadan, the holy month for Muslims in Indonesia. *Waria* #11 explains:

> I almost got killed two times. The first time my head got jabbed and I had to get 25 stitches. The second time, oh, I was so afraid. It was during Ramadan and I was there with a guest in the ditch on the north side of the road. When I started to lower my pants, suddenly 6 motorcycles with 2 riders each appeared, shouting "*Allah Akbar*" [Allah is great]. They punched my head. I tried to raise my pants but I couldn't because we were in the ditch. They tried to punch me again but I quickly threw a brick at them. Then I ran to an elementary school. I jumped. Oh how fair God is! I could jump over that wall even though it was so high. I fell unconscious on the other side of the wall and woke up in the hospital. It was useless to report it to the police. They would do nothing. I am only a *waria*.

As you can see from these vignettes, abuse of all kinds is rampant in *waria*'s lifeworlds. They feel marginalized enough to believe reporting it to the police would do them no good. They even praise God/Allah when their injuries leave them in the hospital as opposed to dead.

Young age at first sexual intercourse, coerced sex, and abuse are only a few of the many activities that increase *waria*'s risk for HIV/AIDS. Other important activities include pervasive

travel in areas outside and inside the Republic of Indonesia, unsafe practices surrounding beauty injections, and myths about HIV and condoms pervasive throughout the *waria* community and clientele. I will discuss briefly the first two of these activities here, with the third being discussed in the next section about HIV/AIDS knowledge levels.

International travel to places with higher reported cases of HIV/AIDS than Indonesia (such as Malaysia and Thailand), coupled with domestic travel to different urban areas known for high cases of HIV/AIDS (such as Papua, Jakarta, and Bali) increases the likelihood that HIV/AIDS will be transmitted from these areas to lower incidence places such as Jogjakarta (UNAIDS 2004). *Waria* #4 told me: "I used to work in Papua. Then I went to Jakarta, Semarang, anywhere I like. As I am old now I stay here." *Waria* #17 talked about how s/he used to travel when she was younger but now just comes to check on hir children (meaning the *waria* s/he mentors): "I have done sex work in Papua, Sumatra, Java, Thailand, Malaysia and even Singapore, but I got thrown out of Singapore for not having any of the legal paperwork. In Java I started in Jakarta and moved to Solo and then to Jogja. I mostly stay in Jakarta now; I just come to check on my children." She went on to say:

> In foreign countries most guests don't want to wear condoms. Everyday we are challenged. It's dangerous to work abroad. Many friends have come back with AIDS. I had a friend who recently died of AIDS. S/he had just returned from Singapore. S/he seemed so healthy and in just 2 weeks s/he was so thin. People would tell me to stay away from hir. They would say I would get infected. But I took care of hir. S/he was my friend. I don't care. God knows everything. If he wants to take us now, that's up to Him.

Many *waria* reported "wearing out their welcome" in different cities and having to travel from site to site, and city to city, in order to find new clients. Often they traveled overseas illegally and were imprisoned upon being found out. Prisons in Indonesia are considered to have some of the highest percentages of HIV/AIDS of anywhere in the country (UNAIDS 2004). A

physician in Jogjakarta told me that the prison there had an estimated 75% rate of infection from sharing needles. *Waria* #19 confessed:

> I stopped going to school and started to sex work to give my sisters a chance. Honestly we didn't have the money and there were a lot of us kids. We were just farmers. I wanted to give them a chance. I went to Pekanbaru and then Batam and from Batam I entered Malaysia and worked in Johorbaru for about 6 months. Then I got caught and was put into prison for 3 months for entering the country illegally.

Waria are often able to travel because of offering sexual favors to officials or through having a procuress that will subsume a large amount of their intake. *Waria* #18 explains: "Well it was like this. In Jakarta we had a procuress, called an *emak-emakan* as in Malaysia. If we wanted to go to Malaysia we were given some capital. But there you have to be clever to get many guests or to have your own money by selling things." Upon returning from foreign countries or from different urban venues many of the *waria* interviewed said they would directly return to their villages to see their families, and to quite possibly spread HIV to rural areas as well.

Another activity that impacts *waria*'s risk for HIV, as mentioned earlier, is the use of beauty injections. In recent years silicone injections have become widespread throughout the *waria* community. There are no regulations on these injections and no training for those doing the injecting. "The cost of an injection of 10cc of silicone ranges from Rp50,000 (US$5) to Rp100,000 (US$10), depending on how well you know the person doing the injecting and how good you are at bargaining down" (Oetomo 2002: 15; abbreviation for *rupiah* as Rp in original). According to Dede Oetomo, for *waria* in Surabaya the rate can even be as low as 15,000 *rupiah* (US$1.50) to 20,000 *rupiah* (US$2). "This makes it possible for even poor *waria* who sing and beg for money in the streets to have their faces enhanced." (Oetomo 2002:15). Silicone injections are illegal in many Western countries, including the United States, because of the quick

degradation of the silicone in the body. "The medical literature warns that liquid silicone may be rejected by the body's immune system, causing bumps and tissue inflammation. It may also…cause illness or even death. Experts…estimate that injected silicone retains its shape for, at most, 10 years" (Oetomo 2002: 18).

Waria #16 told me innocently: "I've never gotten injected in my face… just these (lifts breasts). I don't know how many liters." *Waria* #7 was a little more ashamed of hir injections, mostly because hir parents asked hir not to get them:

> It was a trend. I followed a trend. At that time I had someone who was like a mother to me and s/he was able to inject my nose, but it ended like this. And then when I went home my father was so mad at me when he saw my nose. I ran away. I came back to Jogja. And then due to customer demands, I sacrificed my relationship with my parents to have breasts. I haven't been home in 4 years. I don't have the courage because of this (shows injected breast).

Waria # 11 talked in depth about hir injections, including how easy they were to get from a friend, how they make hir feel sick, and how they've started to sag:

> You know my silicone is not tight anymore, not as before. I got injected for the first time around 1996. I started with my chin and nose. A *waria* friend did it for me. She did her own, too. Then about a year and half later I did my cheeks. After that my breasts. One liter total, 500cc each. My face was cheap. But my breasts were expensive. Almost 3.5 million *rupiah* [US $350]. I am still in debt for them. I pay 100 [US $10], 200 [US $20], and 300 [US $30] up until now. My face is okay, but my breasts, I wish I didn't have them. When the temperature is hot, oh my, I feel cold and unwell. Maybe the size is too big. Indeed, I wish I could throw these away.

As can be seen in the photos below (figure 9), many *waria* inject their faces, breasts, hips and buttocks in order to look more feminine. They do this not only to compete with younger *waria* (figure 10), but also to compete with ideas of femininity (Boellstorff 2004).

Figure 9. Photo of *waria* and researcher in Jogjakarta

Figure 10. Photo of young *waria* without injections

The main problems with these injections are not only the degradation of the silicone in the body and the sagging it produces (as can be seen in figure 11), but also the fact that they are often administered by untrained professionals who repeatedly use the same unclean needle on many *waria*. "Syringes [are often] cleaned with alcohol and re-used… such practices are also carried out in many Indonesian health centers, in the name of saving poor patients from higher bills" (Oetomo 2002:17). In addition to this, the silicone used is not the highest quality to start with and yet is often cut with cheaper substances: "Some salon owners heat the substance and mix it with cod liver oil, lard or frying oil" (Oetomo 2002:16).

Figure 11. Photo of *waria* with injections. These *waria* have injected their chins, cheeks, noses, buttocks, and breasts

As you can see, many of the things that *waria* often come across in their daily lives put them at risk for HIV/AIDS. Mobility, physical violence, and beauty injections, as well as

assumptions about *waria* and their paradoxical place in society, all come together to create a marginalized space that is wrought with high-risk behaviors. On top of all of this, myths pervasive in the *waria* community and among *waria*'s clients make practicing safe sex nearly impossible. It is to a discussion of these myths that I now turn.

3.4. HIV/AIDS KNOWLEDGE AND USAGE OF THAT KNOWLEDGE

I've discussed *waria*'s position in contemporary Indonesia, as well as the socialization of *waria* into the worlds of *waria* and sex work. I have also discussed some of the behaviors that could possibly affect HIV outcomes for *waria*. In this last section, I discuss the characteristics of transactions, HIV/AIDS knowledge levels, condom usage levels, and myths and taboos that may contribute to the low levels of condom use among *waria* and their clientele.

Indonesian Ministry of Health estimates that the number of *waria* that engage in sex work in Indonesia is between 7,800 - 14,700. Regular partners of *waria* who engage in sex work are estimated at only around 3,000; but clients of *waria* who engage in sex work are estimated at a staggering 173,000 - 340,000 (Indonesian Ministry of Health 2003). According to a USAID program called AKSI Stop AIDS (ASA), rates of HIV infection for *waria* who engage in sex work in Jakarta is currently 22% , and rates of HIV for their clients are estimated to be around 5% (ASA 2004). If these numbers are extrapolated, even using the lowest side of the estimates (7,800 *waria* at 22%, and 173,000 clients of *waria* at 5%), a figure totaling more than 10,000 people living with HIV/AIDS (PLWHA) results. This is in a country where official rates for all PLWHA, including all forms of transmission, currently totals less than 4,000 people.

Interviews with outreach workers at the local Indonesian Planned Parenthood Association (IPPA) suggested that there are no official HIV/AIDS rates of *waria* in Jogjakarta; they did say, however, that over 300 *waria* in Jogjakarta have been involved in some sort of HIV/AIDS education program or outreach through their organization. Although HIV is mandated by the National Ministry of Health to be a reportable disease, surveillance questions only differentiate male and female, so no official numbers on the rate of HIV for *waria* in Jogjakarta is known. Outreach workers stated that there were 5 *waria* in Jogjakarta at the time who know they were HIV positive. This number says little about actual rates of HIV and more about how little testing is actually done on *waria*. The outreach workers also said that there were many other *waria* who have died of opportunistic infections without ever getting tested. Many *waria* are afraid of knowing due to the risk of stigmatization and discrimination. Other *waria* confess that they wouldn't know where to get tested.

There were no official numbers or even estimates of the number of *waria* in Jogjakarta engaging in sex work; and there is even less of an idea about numbers and characteristics of the clients of *waria* who engage in sex work. I asked the *waria* I interviewed about their customers, and although each *waria* had their own personal tastes, the majority of *waria* said they liked young, handsome, circumcised boys. *Waria* #18 told me bluntly: "I don't like Papuans. I like young people, teenagers, mostly. Most of my guests are college students." The comment about Papuans has less to do with racism and more to do with lack of circumcision. *Waria* #12 explained: "I don't want Papuans, they're not circumcised. Most Catholics aren't either. So I won't play with them." Ironically, this is one prejudice that is beneficial to have if you're trying to avoid HIV, since uncircumcised men have a much higher risk of transmitting HIV (Gregson et al. 2006). However, one *waria* (#1) told me that because uncircumcised penises look like mice,

s/he will refuse oral sex and opt for anal sex: “Last Saturday night I got an Ambonese man. He asked me to do oral sex with him, but I didn’t want to do it because he hadn’t been circumcised. It looked like a mouse. Instead I offered him anal sex. He didn’t want to use a condom. So I had no choice.”

When discussing the attributes of their customers, many of the *waria* interviewed discussed their fondness for youth. *Waria* #20 bragged: “The youngest I had was 12 years old. He didn’t even have hair down there. We just did it for fun. Karaoke style (oral sex).” It seems that younger clients would possess less money, but that doesn’t always matter, as *waria* #17 explains: “My youngest guests are around 14 or 15. Sometimes if they are young and just curious I will do it for free.” Not only do youth often obtain services for free, but so do attractive men. I heard many times that, “If he’s handsome, I will do him for free.” *Waria* #2 said this of hir last transaction: “I do it for cheap if he is cute. Besides, I hadn’t had a *penglaris* (1st customer of the night, which brings luck) so I didn’t care if it was only 1,000 *rupiah* (US $0.10).”

If inexpensive is US $0.10, what’s the normal rate? *Waria* #17 told me: “Sometimes I will do it for free but the most I was ever paid was ½ a million *rupiah* (US $50) by a foreigner. So *waria* can be cheap, but they can be very expensive too.” Although unsuspecting foreigners who overpay because they don’t know any better are not the norm, hir comments did show the wide range of possibilities for payment. Looking a little more at the norm, a study of *waria* who engage in sex work in Jakarta found that the median fee per sex act was US $1.25 (Joesoef et al. 2004). Jakarta has a much higher standard of living than Jogjakarta, so my research showed that the average price for *waria* in Jogja was about US $0.50 (5,000 *rupiah*) per transaction.

Some *waria* charged different amounts for different sexual acts. *Waria* #6 says: “If I have to suck I ask for more money. I would rather do anal sex.” Some charged more for anal

penetration, and others more for oral sex. It depended mostly on personal tastes. Other *waria* would charge more for what they considered "double duty," which was anal sex after oral sex. Still, the going rate was never much more than US $0.50- US $1. Unless, of course, your customers thought you were a girl. *Waria* #3 discusses how hir customers might not figure out that s/he is a *waria*:

> I use a different name if I am hanging out with girls or with *waria*. It is different because when I am with *waria* people realize I am a *waria*, but when I am with girls, people don't actually realize I am a *waria*. If they don't ask… I don't tell them. I get a higher price when I am with the girls. If my guest knows me as a real girl than it will be at least 20,000 *rupiah* (US$2). But if he knows me as a *waria* he will argue, "Real girls are expensive, I don't want to pay an expensive price for a *waria*." My guests that think I am a girl, they never know. I first do him orally and then I help him to slide his penis into my anus. He assumes it's a girl's hole. He is not allowed to see my genitals. I wear a skirt so he can put it directly in without seeing. I use hand lotion so it easy.

Just how many clients do *waria* have? As pointed out earlier, Indonesian Ministry of Health estimated that the number of clients of *waria* who engage in sex work are between 173,000 - 340,000 (Indonesian Ministry of Health 2003). But the study done in Jakarta reported that *waria* who engage in sex work have a median of 3 anal sex encounters and 5 oral sex encounters per week (Joesoef et al. 2003). This seems like a much lower number than the Ministry of Health's estimate. I would lean more towards the Ministry of Health's estimate, mostly because I know how difficult it is to have the *waria* come up with a number of clients on the spot. The *waria* I interviewed often had no idea how many clients they had in a night or in a week. They said it varied too much, and often if they were lucky one night then they might not go out for a few nights after that. Although many *waria* reported nights of few to no clients, others had great fortune. *Waria* #20 told me, "Once I had 20 guests in a night. Usually New

Years is good for many guests." Also, if certain days of the week correspond to Javanese days of the week it can impact your activities, with many Javanese believing it might bring luck or hardship.

Waria #16 said that Thursday *Kliwon* (when Thursday and the Javanese day of *Kliwon* fall together) is considered lucky: "I always go to the beach on Thursday *Kliwon*. On Thursday *Kliwon* there are a lot of guests at the beach. It is good luck. I don't have a target for a night. Sometimes I just do it for a plate of rice." *Waria* #19 said that "If we go out Monday *Kliwon* night we will see ghosts. It is an unfortunate night. We will get beaten." *Waria* #13 discusses that s/he doesn't go out when it is hir Javanese birthday (which happens many times a year) or when s/he is fasting:

> I grew up near the brothel area at the Prambanan Temple not far from here. When I go home I look for teenagers. I like teenagers. When I am here most of my clients are older. In an average night I get maybe 5 clients. But it's hard to say. Each night is different. Some nights I don't have any guests. I don't go out looking for guests on my Javanese birthday or when I am fasting. It's bad luck.

As discussed earlier, transactions typically happen out in the open in a field, train station, bus depot or wherever you happen to find *waria* hanging out. Overwhelmingly, the *waria* interviewed told me that they found out if a man wanted to "play" or not by asking him for a cigarette (even if they don't smoke). *Waria* #11 clarified: "Asking for a smoke is the first step. That's code for *waria*." Understanding all aspects of the *waria*'s transactions and ways of life is essential in building sound and effective HIV/AIDS prevention and education programs.

Another component of many *waria*'s lives are their regular partners. Indonesian Ministry of Health estimated that the number of regular partners of *waria* that engage in sex work is around 3,000 (Indonesian Ministry of Health 2003). This would mean that at any one time,

about a third of all *waria* engaged in sex work also have regular partners. These partners are important to HIV prevention efforts as well. Many of the *waria* I interviewed had stories of woe about past "husbands." Tom Boellstorff (2004) explains that "one way *waria* hold onto their male partners is by supporting them financially" (p.175). *Waria* #6 discusses the difference between satisfaction and money: "For satisfaction I have my own husband. So guests are just for money. And money is for my husband."

Often, when the money runs out, so does the man. But this isn't always the case. Some regular partners of *waria* are truly in it for love. *Waria* #17 speaks fondly of hir husband: "I have had a husband for 15 years. He is married and has 3 children now. His wife and children know about me. He brings his children to see me. I love him." *Waria* #4 also talks fondly of hir boyfriend, but lies to him to keep him around: "My boyfriend wants me to leave this job. He thinks I already have. He is a good boyfriend. He said although I am a *waria* I am not lower in society. He says I should have a real profession, even if only working at the salon. I should have an activity so that I am not dependent on the street."

Waria are not likely to use a condom with clients and are even less likely to do so with a regular partner. Out of the 30 non-program *waria* surveyed, only 1 (3.3%) said that it is okay for condoms to be used with regular partners. For the 30 program *waria*, 10 (33%) said that it is okay. Saying it is okay to use a condom and actually using one are two completely different things. Consistent with these findings, the Jakarta study found that the percentage of *waria* engaged in sex work and always using condoms during the last month with their regular partners was 12.1% (15 out of 296 participants) (Joesoef et al. 2003).

Are *waria* not using condoms because of their lack of knowledge about HIV/AIDS and STIs? According to the Indonesian Ministry of Health's estimates levels of HIV knowledge are

relatively high on the island of Java in result of mass media campaigns (AusAID 2004). For the *waria* I surveyed, I found a much higher understanding of HIV/AIDS than I had expected (see figure 12).

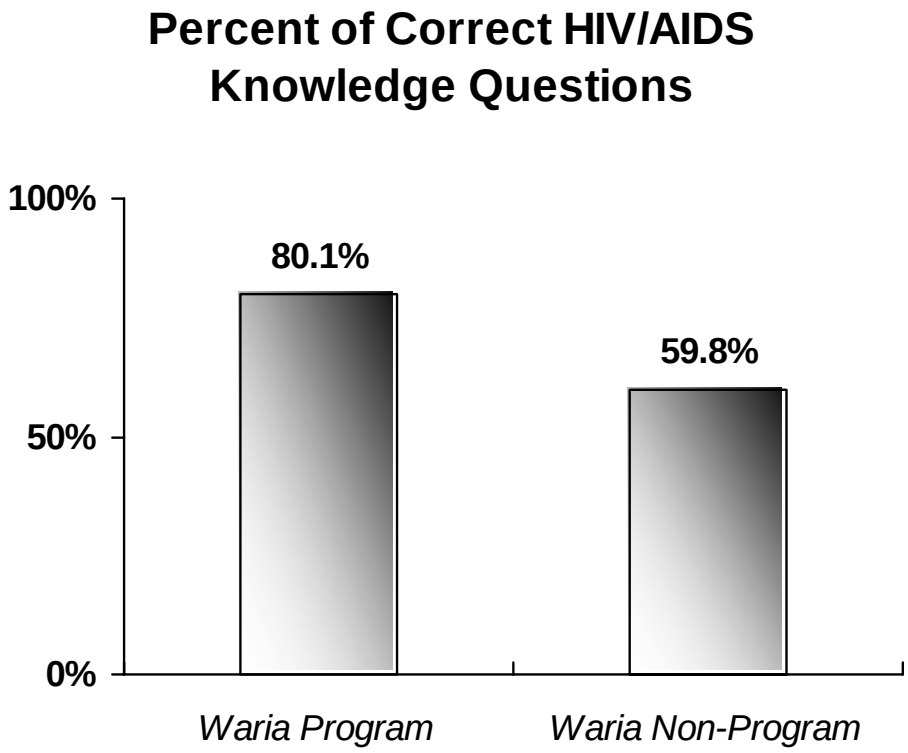

Figure 12. Graph of HIV/AIDS knowledge levels in program and non-program *waria*.

Both program and non-program *waria* seem to have a base understanding of HIV/AIDS facts as measured through certain survey questions (see table 4). Notably, HIV/AIDS knowledge levels were higher for program *waria* (80.1% correct responses) than non-program *waria* (59.8% correct responses).

Table 4. Percentage of correct answers to HIV/AIDS facts for program and non-program *waria*.

Question	**Waria Non-Program %**	*Waria Program %*
There is a possibility that HIV/AIDS can be spread through an immunization injection that is used on more than one person. *Terdapat kemungkinan virus HIV/AIDS tertular melalui jarum imunisasi yang digunakan secara bersama-sama*	**60**	*93.3*
AIDS is an abbreviation for "Acquired Immune Deficiency Syndrome." *AIDS singkatan dari "Acquired Immune Deficiency Syndrome".*	**56.7**	*76.7*
There is not yet a cure for someone who has been infected with HIV/AIDS. *Belum ada pengobatan yang efektif untuk orang yang terkena HIV/AIDS.*	**100**	*93.3*
There is a possibility that HIV/AIDS can be spread through circumcision knife/tool that is used on more than on person. *Terdapat kemungkinan virus HIV/AIDS tertular melalui pisau/alat sunat yang digunakan secara bersama.*	**56.7**	*75*
A person can be infected with HIV/AIDS just from being near someone who is already infected. *Seseorang bisa terkena HIV/AIDS hanya dengan berdekatan dengan mereka yang sudah terinfeksi.*	**44.8**	*86.7*
HIV/AIDS can be transmitted through bodily contact such as: hugging or shaking hands. *HIV/AIDS bisa menular melalui kontak badan seperti: berpelukan, bersalaman.*	**26.7**	*86.7*
Drug users who share the same needle increase their risk for being infected with HIV/AIDS. *Para pecandu obat bius yang menggunakan jarum suntiknya secara bersama-sama dapat meningkatkan resiko mereka tertular HIV/AIDS.*	**66.7**	*93.3*
Gradual weight loss is one early warning sign of AIDS. *Penurunan berat badan yang terus menerus merupakan salah satu gejala AIDS.*	**86.7**	*80*
A person can get HIV/AIDS from a blood transfusion. *Seorang bisa terkena HIV/AIDS melalui transfusi darah.*	**73.3**	*90*
Night sweats and chronic fatigue are some early warning signs of AIDS. *Berkeringat pada malam hari dan selalu merasa letih merupakan salah satu tanda gejala AIDS.*	**70**	*53.3*
There is a possibility that HIV/AIDS can be spread through a tattoo needle that is used on more than one person. *Terdapat kemungkinan virus HIV/AIDS tertular melalui jarum tatoo yang digunakan secara bersama.*	**70**	*90*
A pregnant woman infected with HIV/AIDS will definitely not transmit the virus to her baby. *Perempuan hamil yang terinfeksi HIV/AIDS pasti tidak akan menularkan virus ke bayinya.*	**46.7**	*70*
The HIV/AIDS virus can be transmitted through breast milk. *Virus HIV/AIDS bisa menular melalui air susu ibu.*	**70**	*80*
HIV/AIDS can be spread through sneezing and coughing. *HIV/AIDS dapat ditularkan melalui bersin dan batuk.*	**76.7**	*80*
HIV/AIDS can be spread through public toilets. *HIV/AIDS dapat ditularkan melalui WC umum.*	**66.7**	*80*
HIV/AIDS can be spread through mosquito bites. *HIV/AIDS dapat ditularkan melalui gigitan nyamuk.*	**30**	*60*
HIV/AIDS virus attacks and disturbs the functioning of the body's immune system. *Virus HIV/AIDS menyerang dan mengganggu fungsi sistem kekebalan tubuh.*	**76.7**	*96.7*
A person infected with HIV/AIDS can infect another person through sexual intercourse. *Seseorang yang terinfeksi virus HIV/AIDS bisa menularkan pada orang lain melalui hubungan seks.*	**96.6**	*96.7*
HIV/AIDS can be spread by using an AIDS- infected person's belongings such as a clothes or a towel. *HIV/AIDS bisa ditularkan melalui barang-barang miliki orang yang terinfeksi, seperti baju atau handuk.*	**20**	*80*
A baby that is born to a mother that has HIV/AIDS will definitely be infected with the virus. *Bayi yang lahir dari ibu yang terinfeksi HIV/AIDS pasti akan tertular virus tersebut.*	**3.3**	*26.7*
People with HIV will eventually develop AIDS. *Orang yang mempunyai virus HIV akhirnya menjadi AIDS.*	**56.7**	*93.3*
Total % Correct	**59.8**	80.1

Bivariate analysis of these data [% correct responses for each group x number of questions (22) x number of respondents in each group (30)] reveal that there is a significant difference in knowledge levels between program and non-program waria (see table 5).

Table 5. HIV/AIDS Knowedge Levels in Program and Non-Program *Waria*

2x2 CHI-SQUARE

Program *Waria*	Non-Program *Waria*	
529	395	correct responses
131	265	incorrect responses

df = 1
Chi^2 = 64.77633
p <= 0.00000

Bivariate analysis for the differences of HIV/AIDS knowledge levels between program and non-program *waria*.

Therefore it seems that these education programs are doing their job by increasing HIV/AIDS knowledge levels. The question then becomes: Is this enough?

Though correct responses on the fact section of the survey were high, both the opinion section of the survey and free-form answers during the interview produced low grades for both program and non-program *waria*. An example of opinion questions on the survey includes: “Would you drink from the glass of a person suspected of having HIV/AIDS (even if it was a family member)?” Only 26.7% of non-programs and 46.7% of program *waria* answered “yes” to

that question *(see table 6).* Thus, even after HIV education programs, over 53% of program *waria* were uncomfortable drinking from the glass of a person suspected of having HIV/AIDS.

Table 6. Opinion and Perception Survey: program versus non-program waria

Question	**Waria Non-Program %**	*Waria Program %*
Would you drink from the glass of a person suspected of having HIV/AIDS? (even if it was a family member) *Maukah anda minum dari gelas orang yang dicurigai terinfeksi virus HIV/AIDS? (bahkan jika famili anda sendiri)*	**26.7**	*46.7*
Intravenous drug users who get HIV/AIDS probably deserve it. *Pecandu narkoba yang terinfeksi HIV/AIDS pantas menerimanya.*	**36.7**	*48.3*
People with high levels of education are not at risk for being infected with HIV/AIDS. *Orang yang berpendidikan tinggi tidak memiliki resiko tertular HIV/AIDS.*	**90**	*80*

Examples of opinion and perception survey questions that show no significant difference between program and non-program ***waria***. Also, notice the last question, which shows a trend in which non-program ***waria*** more often answered correctly.

Thus, though information is being obtained, myths and taboos about HIV still exist and are not being broken down in these education programs. During interviews, when asked how HIV was spread, many *waria* simply said, "I don't know." Others thought it could be passed from sharing the same glass or living in the same place as a PLWHA. *Waria* #6 explained: "If a friend got infected with HIV I would be afraid. I would leave hir. I wouldn't want to get it… from hir drinking glass, or urine or blood." *Waria* #18 also explained that s/he would be scared of getting HIV from living near a PLWHA, but said that s/he would still take care of the PLWHA: "If a friend is infected I will take care of hir. Its not hir fault. It's just a matter of time. Today s/he got it, maybe tomorrow or someday soon it will be our turn. It's up to Allah's will."

One study done in Makassar, Sulawesi found an improvement in both condom usage and desire to be tested for HIV for *waria* who attended their *waria* support group. Activities for the support group included: "peer education about HIV infection and prevention including 100% condom use with all clients; counseling and encouragement to seek voluntary counseling and testing to determine their HIV status; [and] skills building training for alternative work in salons or tailor shops" (Gunawan & Halim 2004: 536). To quote the lessons learned by this program: "The great majority of *waria* sex workers understand transmission risks and basic facts about HIV. Many want to be tested for HIV. As of 30 November 2003, 22 *waria* in Makassar have been found to be HIV+. All are using condoms with all clients" (Gunawan & Halim 2004: 536). Other programs have been less effective. Even after programs in Jakarta have targeted *waria* who engage in sex work and attempted to increase knowledge levels about HIV, "only 12% of *waria* stated that they consistently use condoms during any sex act" (Joesoef et al. 2003: 609). Similarly, in my survey results I found that while none of the 30 (0%) non-program *waria* said they always use condoms, only 2 out of 30 (6.7%) of the program *waria* said they always use condoms (see figure 13).

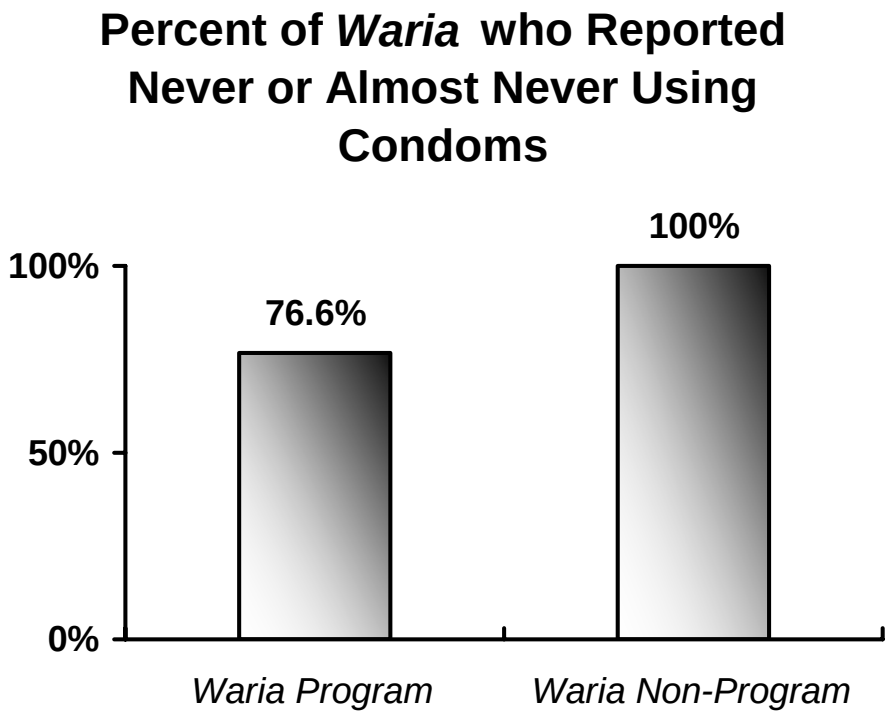

Figure 13. Graph of condom use for program and non-program *waria*

The above is true even though 100% of both program and non-program *waria* (60 out of 60) agreed to both of these statements: "In my opinion, condoms are easy to find;" and "In my opinion, condoms are easy to use." A high majority of both populations (86.7% for non-program *waria* and 80% for program *waria*) disagreed with this statement: "In my opinion, condoms are expensive" *(see table 7).* Thus, if HIV knowledge levels are high and condoms are considered to be easy to find, easy to use, and inexpensive, why aren't they being used to prevent HIV?

Table 7. Examples of condom knowledge survey questions for program and non-program *waria*

Question	Waria Non-Program %	*Waria Program %*
In my opinion, condoms are easy to find. *Menurut saya kondom mudah didapat. (yes)*	**100**	*100*
In my opinion, condoms are easy to use. *Menurut saya kondom mudah digunakan. (yes)*	**100**	*100*
In my opinion, condoms are expensive. *Menurut saya kondom mahal harganya. (no)*	**86.7**	*80*

Notice that both program and non-program ***waria*** agree that condoms are easy to find, easy to use, and inexpensive.

Understanding the myths and taboos associated with condom usage is important to create more efficient and effective programs. As we have seen, increasing knowledge levels about HIV/AIDS is simply not enough. An increased knowledge level does not change behaviors. Some of the reasons for this can be seen by looking at perceptions about condoms. As discussed in previous chapters, condoms are contextual. They are used for penetrative penis to vagina sex only. They are also only used between a man and woman. Neither of these applies to *waria*. Add to it the idea that condoms are only to prevent pregnancy, and top it off with the previously discussed idea that you can't get HIV or STIs from *waria*, and you end up with no condom usage. As *waria* #4 shows, these prevalent ideas not only prevent condom usage but even shames *waria* out of acquiring condoms: "I am ashamed to buy condoms. Why do *waria* need condoms? They would be suspicious that I was not a *waria*. That is why I am ashamed to buy them."

When I asked during interviews if they had used a condom during their last transaction, 100% (30 out of 30) said no they had not. This is true for those who had attended HIV education programs and those who had not. It was also true for *waria* that volunteered at the HIV education program to train and outreach other *waria*. It was even true for the 2 *waria* I interviewed that knew they were HIV+. Both were very knowledgeable about HIV, but had to make a living.

When discussing the last time s/he went looking for a customer, this is what one of the HIV positive *waria* had to say:

> I know the risk for not using a condom. But a man who comes for oral sex does not want to use a condom. If he doesn't reach orgasm I will offer something else. I will offer anal sex. He still doesn't want to use a condom. I mean, I know it needs a condom, but every time I offer they refuse it. I know it is my failure. But if I keep insisting he will go to my friend instead of me. He did not want a condom. What choice did I have?

The other HIV positive *waria* similarly said:

> I do not always use a condom. When I get a guest that I don't really have an interest in, that I am welcoming only because of his money, then I ask to use a condom. But if I like him, if he is cute, I do not push the use of a condom. I also don't use a condom with my boyfriend. He adores me. Sometimes I have to use my feelings with a guest. I use my instinct to tell if that guest should use a condom or not. I know if someone has HIV before s/he tells me. I can sense it.

God/Allah's will was often given as a reason for not being able to prevent HIV infection. *Waria* #14 explained: "I do not know if I will get AIDS. Only Allah knows. I just submit myself to Allah's will." *Waria* #16 similarly thought that all would be decided by Allah, but thought prayer and antibiotics might help: "I never use condoms. But I do protect myself from sexual diseases by drinking *Supertetra* (an over-the-counter antibiotic) and always praying. Besides, I always fast. I am from Kalimantan; we are good Moslems." *Waria* #2 discussed hir relationship with Allah, sex work and HIV:

> Honestly, I have no problem with being a *waria*. I am sure Allah the almighty knows everything. The point is Allah created me, and Allah has a secret that humans are not able to see. If Allah wants me to get HIV, there's nothing I can do about it. Humans are limited in their abilities. I think humans that judge us don't have any respect for other people's way of life. Only Allah has the right to judge who is a sinner. Humans cannot say that I am a sinner. I ask you, who is more of a sinner — the state officer who is corrupt

> or the *waria*? I think you cannot answer. Someone maybe says that my sin is mountains higher than the corrupt officer, or the man who cheats on his wife to have sex with me, or those who do not pray. But really only Allah has the answer. I always pray. And I always fast during Ramadan. I still look for clients during fasting, but I go home early and directly wash my hair, then I have *sahur* (breakfast before dawn).

Similarly, God/Allah's will was one of the reasons given for not wearing condoms. *Waria* #3 told me: "If Allah wants you to get HIV a condom won't stop Allah's will." There were many other justifications given for not wearing condoms, mostly due to discomfort and clients' unwillingness. *Waria* #19 explains: "Condoms hurt. For anal sex it rubs too much and for oral sex it tastes bad. If a client wants to use a condom he has to buy it himself. Most are scared to. Usually we just have sex without it. If he wants it we cancel the transaction. And that's okay. There are other guests who won't want it." *Waria* #11 who was very knowledgeable about HIV and very religious (s/he goes to Catholic mass daily), had this to say: "I know that a condom is for prevention but in fact I refuse to use them. Personally I like it bare. Using a condom makes me think of playing with rubber. If a guest offers it I refuse it. If he won't have sex without it, that's okay too. There are many other guests." Many *waria*, similarly to the two discussed above, discussed canceling a transaction if the client wanted to use a condom. Others talked about charging more for clients that use a condom. *Waria* # 10 confessed she's moved around a lot but never had such a hard time getting clients to wear condoms than in Indonesia. Ironically she now charges more for those who want to use a condom: "When I was a sex worker in Malaysia and Singapore I always carried condoms and gel with me. I like to protect myself from disease. But here guests don't want to use it. If my guest is drunk, I want to use a condom. Occasionally a guest brings his own condom. They usually pay a higher price." *Waria* #8 said that if a client

wants a condom she'll sell him one for five times the regular price, insisting that they are "from America, very special condoms."

Other *waria* expressed their concerns: #20 said, "Wearing a condom makes it hurt down there. If I am concerned with disease I will use it. If I am not I won't;" #18 adamantly stated, "I never, ever use condoms. I don't like them;" and #15 again reiterated how clients don't want to use them, "Usually a guest refuses to wear a condom because they are not comfortable. I myself don't want to use it. So why push?"

If *waria* aren't wearing condoms to protect themselves, what are they doing? The most common thing *waria* were doing to protect themselves from HIV was taking *Supertetra* (an over-the-counter antibiotic). *Supertetra* is widely sold at stalls throughout Jogja. It is considered a cure all. Through my interviews I found that this myth was pervasive throughout both the program and non-program *waria*. *Waria* #18 said: "I drink *Supertetra* when I am itchy to prevent disease." Similarly *waria* #20 explained: "I drink *Supertetra* twice a week. I must drink it that often because I do anal sex and you just never know." *Waria* #3 said: "To protect myself from HIV I often take drugs, such as *Supertetra* and amoxicillin. And occasionally *jamu* (traditional herbal medicine)."

Using *Supertetra* to prevent HIV was the most common myth, but others were also very salient in both the surveys (see figure 14) and interviews. These included the idea that you can see if someone has HIV/AIDS (the penis will be hot/heavy/green), as well as the idea that you don't have to worry about infection if you remember to wash your/their penis. *Waria* #6 explained: "Well, sometimes I take *Supertetra*. I take it to prevent disease. I use 1000mg. I think I got syphilis once. I felt like shit. Then I took *Supertetra*, up to six capsules, and it disappeared. So, I always take *Supertetra* to avoid disease. I can tell if my guests have a disease because they

will refuse to let me touch their penis. That's how I know." *Waria* #15 said: "I know if the penis is heavier than usual then it must be diseased. Or if we take it out and it has a bad smell." And *waria* #14 explained how careful s/he is with hir clients: "A man with AIDS is pale and thin. To prevent AIDS I am careful with picking my guests. I hold his penis first. After that I ask him to wash it. I also drink *Supertetra* three times a day and herbal medicine everyday."

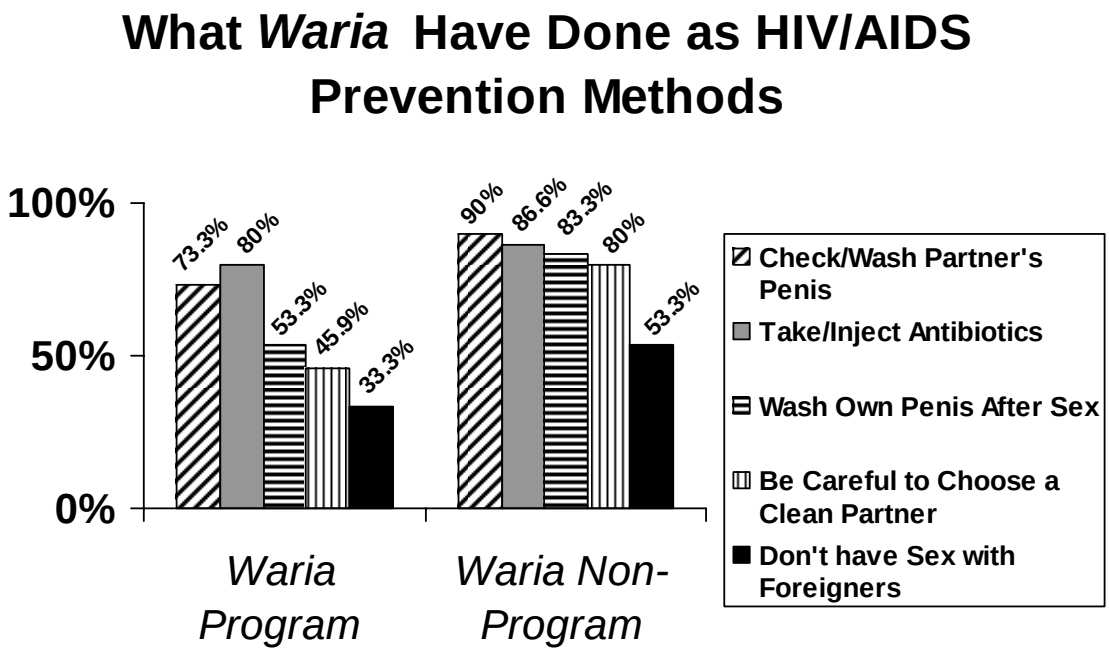

Figure 14. Graph of prevention methods utilized by program and non-program *waria*

Myths about HIV and taboos about who should and should not wear condoms are pervasive throughout Indonesian society. They cannot be ignored. Simple cookie cutter HIV/AIDS programs brought over from the West and applied to Indonesia are not going to deal with these myths and taboos. At best they are going to increase HIV/AIDS knowledge levels. This does not mean they will increase safe sex practices. Programs need to take into consideration taboos and myths, as well as *waria*'s place in society and in their families.

As Nancy Goldstein (1997) states: “The best-intentioned prevention campaigns are bound to fail if they assume that education combined with free condoms and clean “works” are all that is needed to prevent the spread of HIV. Since there is more to risk than microbes, there may be more to preventing people from contracting HIV than telling them to “just say no” to exchanging bodily fluids or sharing needles” (p.3). One must understand the daily realities of the *waria* before appropriate and effective prevention and education programs can be created. As *waria* #9 told me: “I understand about condoms. I understand about risk. But I have my nephews. I am able to support them and give them money. If I didn’t do this job anymore I wouldn’t be able to support them financially. I have thought about it a lot. This is my destiny.”

CHAPTER 4. SEX WORKERS AS WOMEN, WIVES AND MOTHERS

The purpose of this chapter is to provide an in-depth examination of female commercial sex workers (FCSWs) in the Sosrowijian area of Jogjakarta. While discussing the place of Indonesian FCSWs (simply referred to as sex workers throughout this chapter), I feel it necessary to discuss the place of females in general in regards to both vulnerability to HIV as well as their position in contemporary Indonesia. I also describe the general situation of sex work in Indonesia, followed by a more specific description of the sex worker population of Sosrowijian (Sosro) and my entrée into it. This allows for an in-depth discussion of my preliminary research which permitted me to break down my own assumptions about sex workers, and thus appropriately tailor my surveys and interviews to be more culturally relevant. Lastly, I examine the place of sex workers in the eyes of the public, their clients, and themselves. This includes a discussion of how sex workers are often seen as lesser wives to their clients and how this impacts their safer sex choices. Also, their roles as mothers and daughters are discussed in regards to their own definition of themselves and their need to provide for their families. This includes a description of the sex workers' perceptions about condoms and a discussion of how their need to provide for their families override their knowledge of HIV.

4.1. SEX WORKERS AS WOMEN

Women account for nearly half of all new HIV infections worldwide, and the number of women becoming affected each year is increasing. In several ways, women are more vulnerable than men to HIV infection:

> Male-to-female HIV transmission is about eight times more likely to occur than female-to-male transmission, often for a biological reason: During intercourse, the exposed mucosal surface of the female genital tract is much greater than the exposed surface of the male genital tract, and this facilitates infections by the virus. [DeCarlo 1999: 1]

In addition, women are generally more vulnerable to situations that increase their risk for contracting HIV, such as coercion and sexual abuse (Rosenberg 2003, Tumlin 2000). Often, women are less able to negotiate safer sex practices or to choose their sexual partners due to gender, social, and economic inequalities (Farmer 1996, Stein & Kuhn 1996).

Women are expected to fulfill the basic needs and desires of men in general, and their husbands, specifically. This often includes producing offspring. Not only do condoms present a problem when the object of sexual intercourse is to have children, but their presence also assumes that the husband is partaking in "risk" behaviors:

> Condoms represent your husband's risks, and … imply reduced fertility. Using them acknowledges that he *has* risks, has other partners, goes to brothels, has a mistress, sleeps with men, or injects drugs. And *he* has to put the condom on, has to accept the need to protect you from his behavior…. To speak of these issues is to suggest infidelity. This can be frightening. It can be deadly. [Beyrer 1998: 119-120]

There needs to be general recognition that it is impossible to offer women HIV education or give them condoms without also dealing with the gender-related issues that are involved in

HIV (DeCarlo 1999). When attempting to implement a preventative, educational strategy one must ask a number of questions, including (adapted from Schneider 1991):

> -In what ways is safe sex negotiated?
> -How do women speak about safer sex when there is an obvious cultural taboo against it?
> -How does cultural difference influence the response to prevention education?
> -What choices are available to women within their opportunity structures and their material conditions?
> -How are their perceptions of the possibilities for themselves and their children affecting their decisions?

Compared with men, women enter the AIDS crises with fewer resources and support systems, and yet are responsible for more people. “Women are normally caregivers of the ill, so when they themselves become ill, who will care for them?” (Ports 1988: 169). When women with AIDS die they are survived by their dependent children, some of whom may also be HIV positive since the mother-to-child transmission rate in Asia is 25-30% (Phanuphrak 1998), and often their dependent parents. This growing sector of orphans and uncared for elderly is another issue that must be addressed. Special training of health care workers and policy providers is essential when dealing with these sensitive topics (Ports 1988).

In Indonesia, low levels of formal education in women combine with religious and cultural beliefs, as well as state mandated ideologies to create additional barriers to health awareness and promotion programs. “To be effective, programs aimed at women must address education, equal rights, and access to full and comprehensive information… we need to deal with their own social problems before we can deal with HIV-related problems” (DeCarlo 1999: 4). Peer groups and community support networks are essential in combating the myriad of social forces and injustices thrust upon these women. “The empowerment of vulnerable groups to enable them to organize and take action is an essential base” (APN+Report 1999: 2). Though this

is true, my research shows that peer groups designed to educate sex workers in Jogjakarta accomplish very little if their clients are not also educated about HIV and condom use.

Although women account for over 50% of all HIV/AIDS cases worldwide, official numbers of cases of AIDS in Indonesia suggest that only 16% of people living with HIV/AIDS (PLWHA) are women (Indonesian Ministry of Health 2005). Similarly, statistics from "*Aksi* Stop AIDS" (Action to Stop AIDS - ASA), a USAID and Family Health International sponsored program based in Jakarta, estimate that females account for only 19.56% of the population of PLWHA in Jakarta (ASA 2004). These numbers suggest that women in Indonesia are either at a lower risk for HIV than women everywhere else in the world, or that women in Indonesia are not testing for HIV due to lack of knowledge or lack of empowerment. Due to cultural perceptions about who does and does not get HIV/AIDS, Indonesian women often believe they are not susceptible to HIV unless they have slept with a foreigner.

Even populations who are seen as having higher risks for HIV are estimated at relatively low rates in Indonesia. Sex workers in Jakarta are estimated to have an HIV prevalence of between 0.5% and 5.0%. Customers of sex workers in Jakarta are estimated to have an HIV prevalence of between 0.05% and 0.5% (ASA 2004). Similarly, the Indonesian Ministry of Health estimates that the 193,000 - 273,000 sex workers nationwide have an estimated HIV prevalence of between 1.98% and 5.20% (Indonesian Ministry of Health 2003). Taking the mean prevalence and extrapolating it to the population creates an estimation of 8,369 sex workers living with HIV/AIDS. Even with this estimated low prevalence, it's still twice as many as ALL officially reported HIV/AIDS cases in Indonesia. On top of these estimates of sex workers, their clients are estimated to have an HIV prevalence of 0.20% and 0.61%. The regular partners of sex workers' clients are estimated to have an HIV prevalence of 0.03% and 0.11% (Indonesian

Ministry of Health 2003). Even if these low estimates are correct, Indonesia is poised for an HIV explosion. Fear and denial about the amounts of unprotected extramarital sex, intravenous drug use and other higher risk behaviors have paralyzed the country's ability to control the epidemic (Djoerban and Nenden 1998).

Throughout the world, HIV has been linked to societal inequalities caused by globalization and industrialization (Farmer 1999, Garrett 1994). Such trends in industrialization have been shown to reproduce poverty and gender inequalities by the under-valuing of women's work the world over (Law 2000). These trends have also fostered conditions which increase the likelihood for risky sexual behaviors and/or an increase in sex work, such as: "the migration of men to find employment which may disrupt marital and family ties and the increase in women entering manufacturing sectors without the protective features of their families and home communities" (Whelan 1999: 1).

Similarly in Asia, sex work and sex trafficking has been found to be linked to numerous factors on the individual, family and societal levels (Law 2000; Sanghera 1999; Lim 1998). Specifically, the following individual and family factors contribute to the likelihood of entering sex work: level of poverty, dysfunctional home life, poor educational background, personal problems, history of sexual abuse, and age of first intercourse (Rosenberg 2003, Tumlin 2000). Societal factors include underemployment and a lack of income generating opportunities; cultural values (such as girls being required to help support the family, or acceptability of men taking sex workers as minor wives); village traditions, fragile environments (due to political instability or armed conflict); weak law enforcement and community support; globalization and related trends; and the profitability of the trade (Rosenberg 2003, Tumlin 2000).

Comprehension of how some of these factors play out in Indonesia can be seen through the life stories of the women I interviewed. The story of sex worker #2 shows how personal and societal factors influenced her entry into the world of sex work:

> I was married when I was 12 years old… I was just a little kid... I didn't even have my period yet… when my husband had sex with me I was so scared… I didn't know what to do… and he just did it. The next day I told my parents... and they said, it's ok… he is your husband. I told them it hurt so much. They took me to the doctor because of the pain. The doctor said, "Bu, she is still a kid, why did you make her get married? She is not old enough to be married." Then my mother said, "Her father is Maduranese, it's traditional, even this young, they have to be married." I knew nothing about sex, and nothing about children. I was still a child. At 13, I got my period, and I got pregnant and had a child. I didn't know how to take care of my baby, I was 13… no one ever taught me about that. But there I was… a wife and a mother. Soon I had other children… I was just an ordinary housewife, and then I had problems with my husband. My husband worked in the market, but after 1997 [when the Asian economic market crashed], he couldn't find work. Not working drove him crazy. He left me and our children. So I needed to get a job. I tried to find work, but no one had work. At that time I was so scared, how will I take care of my children? I have no skills. I wanted to drink *Baygon* [mosquito poison]. That's how bad it was. But my friend said not to worry. She asked me, "Do you want to work?" and explained that I could work in Sosro as a sex worker and support my family. I thought only about my three children and I said unabashedly: "Yes, I will do it." I will work to support my children. I will do anything as long as it's not stealing. I am not a thief, I have honor. So my friend brought me here. But I didn't know what to do. I asked her, "How do you give service?" She told me very matter of factly, "It's just like with your husband, like having sex with your husband. It's the same. Just treat the guests as you treated your husband." This confused me, because my husband and the guests are not the same, right? But I tried anyway. I was so confused with the first guest. He asked me to open my clothes. My husband had never asked me to do that. But I needed the money; my children needed the money, so I obeyed the guest. I opened my clothes. I cried. I had never done it like that… oh my God….I cried and I thought… it is all for my children… it is all because my husband abandoned us… My children need me to do this… they need a long education… schooling is important… it is so expensive… I do this so all my children can go to school. I have worked here since that day, June 29, 2000. I still keep the calendar to this day… to remind me that this is not who I was… but this is who my children need me to be.

4.2. SEX WORKERS AS MOTHERS

Though sex worker #2's entrée into sex work was used to illustrate how personal and societal factors interact to create the need to be employed as a sex worker, her story also illustrates another important principle; namely, that she is a mother first and foremost. Before exploring this issue in more detail with other sex workers, it is important to look at the background of how women in Indonesia generally are identified as caretakers of the family. This concept is important in understanding how sex workers identify themselves and their jobs.

"Perhaps the largest generalization we can make about the position of women in Indonesia today is that they are defined relationally to men" (Sears 1996: 19). For Indonesia, relations to men are part and parcel of an ideological structure of civil religion seen through nationalism that stresses the importance of a family that has a male head of household and a female caregiver (Blackwood 1995b; Suryakusuma 1996). "To hasten the transition from an agricultural to an industrial nation, the Indonesian state formulated new economic policies and programs and an ideology aimed at creating an Indonesian citizen in step with the 'modern' world" (Blackwood 1995b: 135). Through its national plan and *Pancasila*, Indonesia's five-point state ideology, it encouraged all Indonesians to be responsible for and participate in national development. Consequently, men were revered for their strength, courage and economic capabilities, while women were assessed by their dedication to their household (Verdery 1994; Yuval-Davis 1993).

These roles were further emphasized in government ideologies apparent in social reform movements such as *Panca Dharma Wanita* (the Five Responsibilities of Women). *Panca Dharma Wanita* was modeled after the Five Pillars of Islam and defined not only how to be a good Muslim and a good Indonesian, but also how to be a good woman. *Panca Dharma Wanita*

mandated these five precepts: "(1) support her husband's career and duties; (2) provide offspring; (3) care for and rear the children; (4) be a good housekeeper; and (5) be a guardian of the community" (Sunindyo 1996:125). The Islamic model of appropriate gender roles "corresponds to and validates the model set forth by the Indonesian State…. In the Qur'an, the man is said to be the ruler of the people of his house and the woman the ruler of the house of her husband...." (Blackwood 1995b: 138).

Indonesia developed models, mandates, and institutions that directed the formation of group and individual identities in the name of national identity. "In the process of state building, diverse ethnic groups are homogenized into national citizens through pronouncements concerning acceptable styles and images of life" (Ong 1995). This nationalistic discourse mandates a civil religion based on *Pancasila* and thus on *Panca Dharma Wanita*, which, in accordance with the view of Islam that the state is promoting, mandates the subservience of women to men (Lev 1996). Indonesian women are increasingly defined in national discourses "as mothers and bearers of future citizens, rather than in terms of kinship or other social roles that portrays them as full social beings endowed with autonomy, social control, and prestige in their own right" (Blackwood 1995b: 125).

Understanding how ideas of gender in Indonesia are mandated by both state and religious ideologies will assist in the comprehension of how the sex workers I worked with define themselves relationally to the men who visited them. I also extend this analysis to the examination of how their clients identify and view the sex workers. Understanding these definitions will lead to a realization of some of the difficulties involved with safer sex choices. As you will see in the quotes used in this chapter, the dominant identification for the sex workers

I worked with was that of being a mother who needs to provide for her children. This self-identification affects a sex workers' ability to negotiate safer sex practices such as condom use.

4.3. SEX WORK IN SOSROWIJIAN

Sosrowijian (usually referred to as simply Sosro) is where the publicly known brothel area of Jogjakarta is located. It consists of a neighborhood behind Jogjakarta's famous Malioboro Street which is always bustling with market trades and tourists *(see figure 15*). The area of Sosro that I worked in was approximately the area of six city blocks. Within these six blocks of winding back alleys (*see figure 16*), approximately 300 sex workers lived and worked. Some rented rooms by the hour in *losmens* (cheap hotels that doubled as brothels) whenever they had a transaction. Others lived there and rented rooms all the time (*see figure 17*).

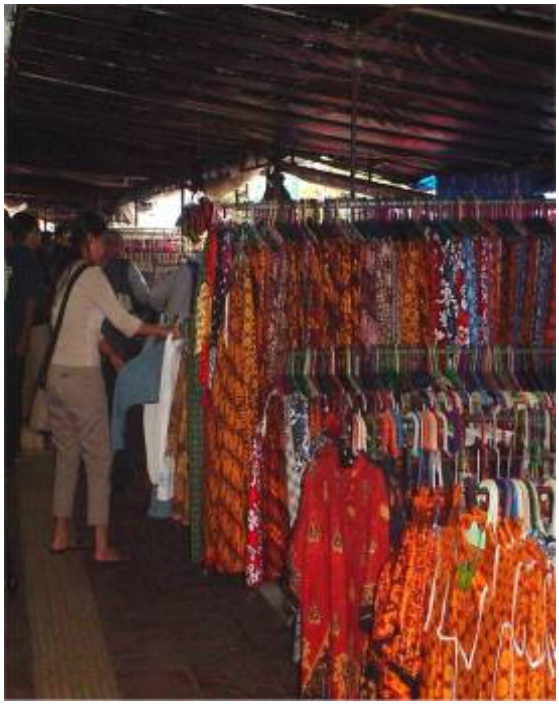

Figure 15. Photo of Jogjakarta's famous Malioboro Street.

Figure 16. Photo of the brothel area of Sosrowijian. Tihis depicts one of the back alleys of Sosro where a myriad of sex workers live and work.

Figure 17. Photo of a typical room in Sosrowijian. Rooms such as these can be rented daily or monthly by sex workers in Sosro.

Sex worker #15 explains how her guests find her:

> I do not go looking for guests. It is always through a broker. All of these guest houses, from this one until that front one over there, they all use brokers. The broker brings my guests to me. I have to pay him. But I don't mind, I mean he needs money too, right? If I get 50,000 *rupiah* for the transaction, then I give him 20,000 *rupiah*. That's how it works here… other places are different.

Sex worker #12 discusses her working environment: "Nobody pressures me to work. The owner doesn't pressure me. He doesn't care how much or how little I work, as long as I have 150,000 rupiah per month for the room". The average transaction for female sex workers in this area is between 20,000 and 25,000 *rupiah*, or approximately US $2.00-$2.50. To pay her rent, sex worker #12 must complete between 10-13 transactions per month or about one transaction every three days just to pay her rent. The typical Indonesian sex worker averages about 1-2 transactions every 1-2 days. This allows them to pay their rent, their children's school fees, their daily necessities, and sometimes even send remittances home. Most women working in Sosro originate from areas in the District of Jogjakarta or Central Java *(see figure 18),* and often return home to bring money and to visit.

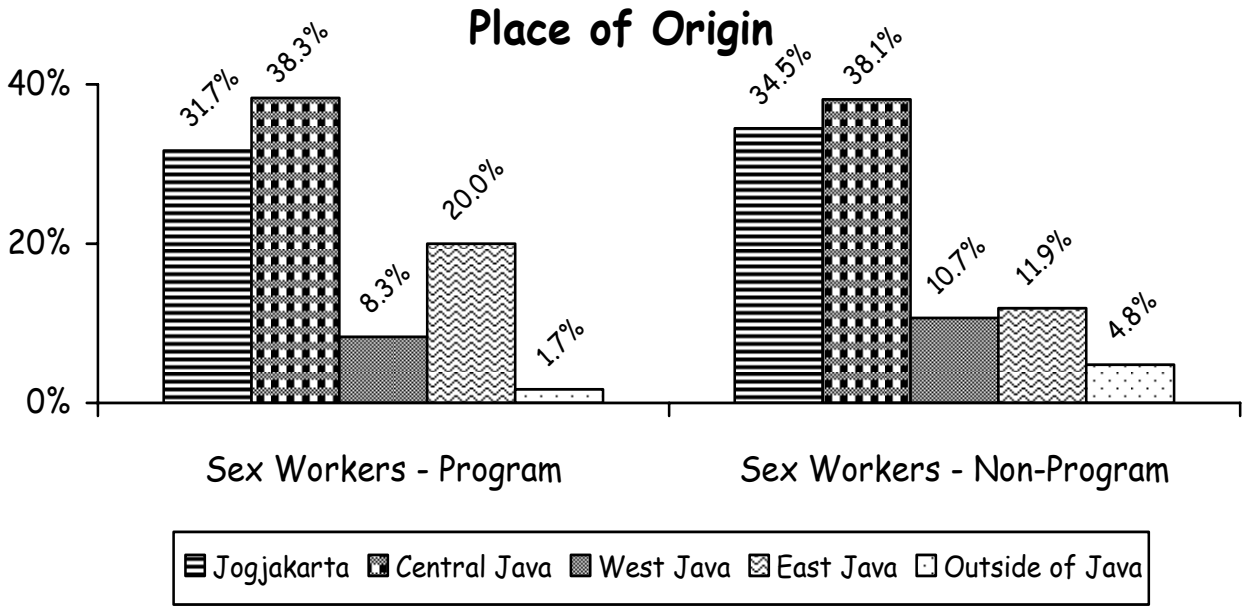

Figure 18. Graph of places of origin for program and non-program sex workers. The majority of sex workers surveyed came from Jogjakarta and Central Java, areas with a close proximity to where they now reside.

Sex worker #13 talks about how much she works in a given week and the ages of her clients: "I finish a typical transaction in 15 minutes… so I work around 3 hours a week total. But lots more time is spent waiting. If the guest who came is for me, I just take them home into the room. He agrees with my price, and then we do it. There are guests who are 20 years old, 25 – 30 years, even 40 years… mostly college students though."

Looking at the demographics of the sex workers in Sosro sheds light on the situations of sex workers in general. As has been discussed in the methodology section, sex workers who have attended HIV/AIDS education programs (N= 60) and their counterparts who have not attended HIV/AIDS education programs (N = 84) were surveyed. Figures 19, 20, 21 and 22 illustrate how sex workers who have attended HIV education programs tend to be, in general: older, married (at one time), have more children, and less educated than their non-program counterparts. This could

be related to the fact that sex workers who attend education programs tend to be more established in the neighborhood, possibly from living there longer.

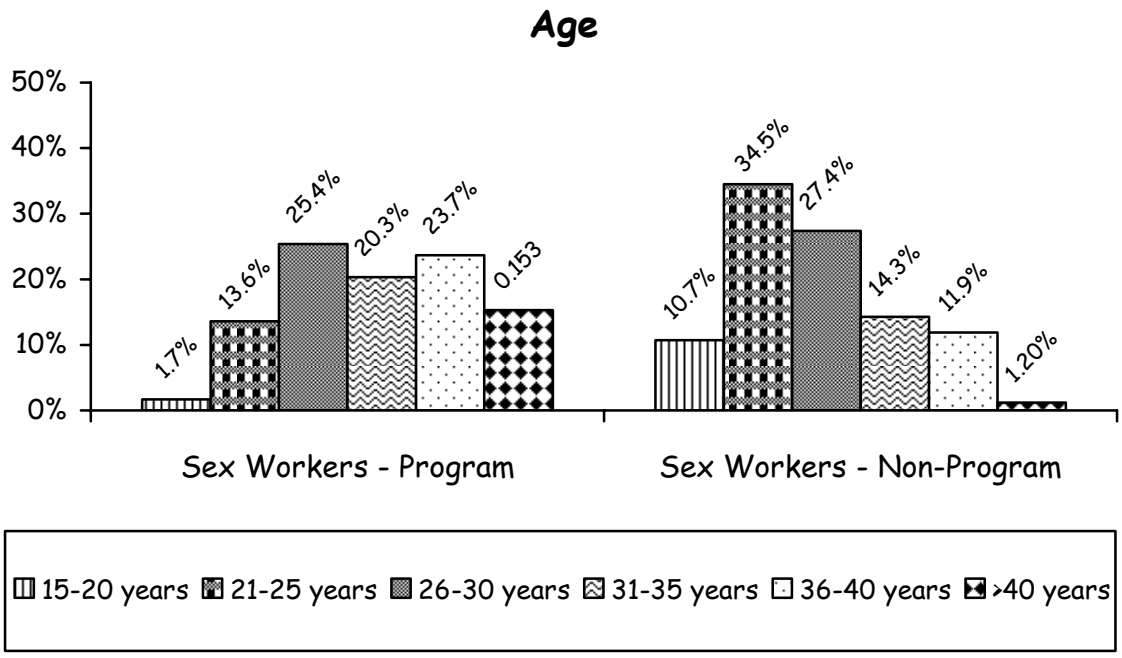

Figure 19. Graph of age ranges for program and non-program sex workers. Notice that sex workers who have attended HIV education programs in general tend to be older than their non-program counterparts.

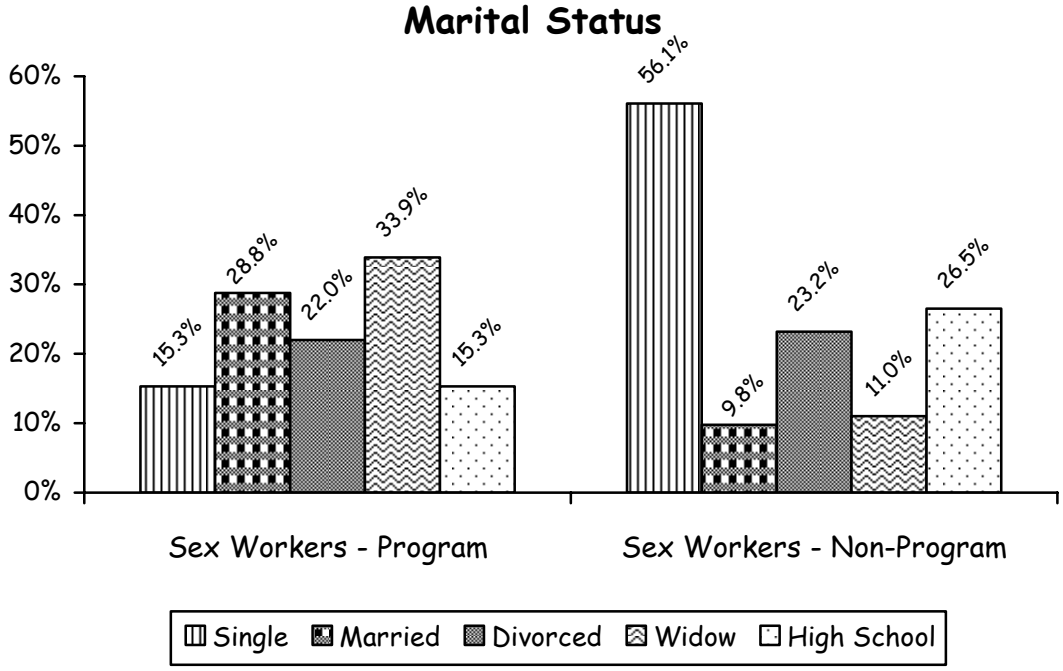

Figure 20. Graph of marital status for program and non-program sex workers. Notice that sex workers who have not attended HIV education programs more likely to be single than their program counterparts.

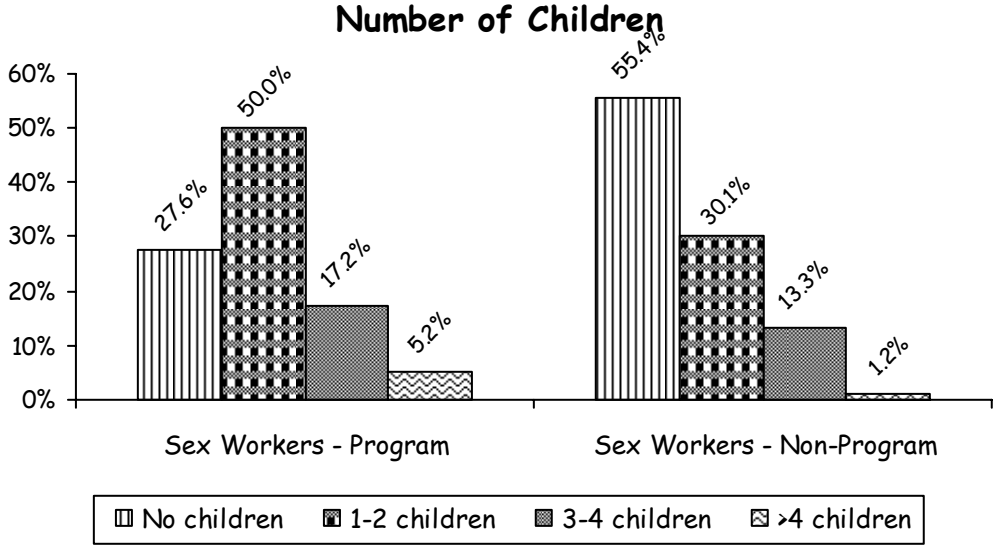

Figure 21. Graph of number of children for program and non-program sex workers. Notice that non-program sex workers are more likely to have fewer children than their program counterparts, including 55.4% of non-program sex workers who have no children.

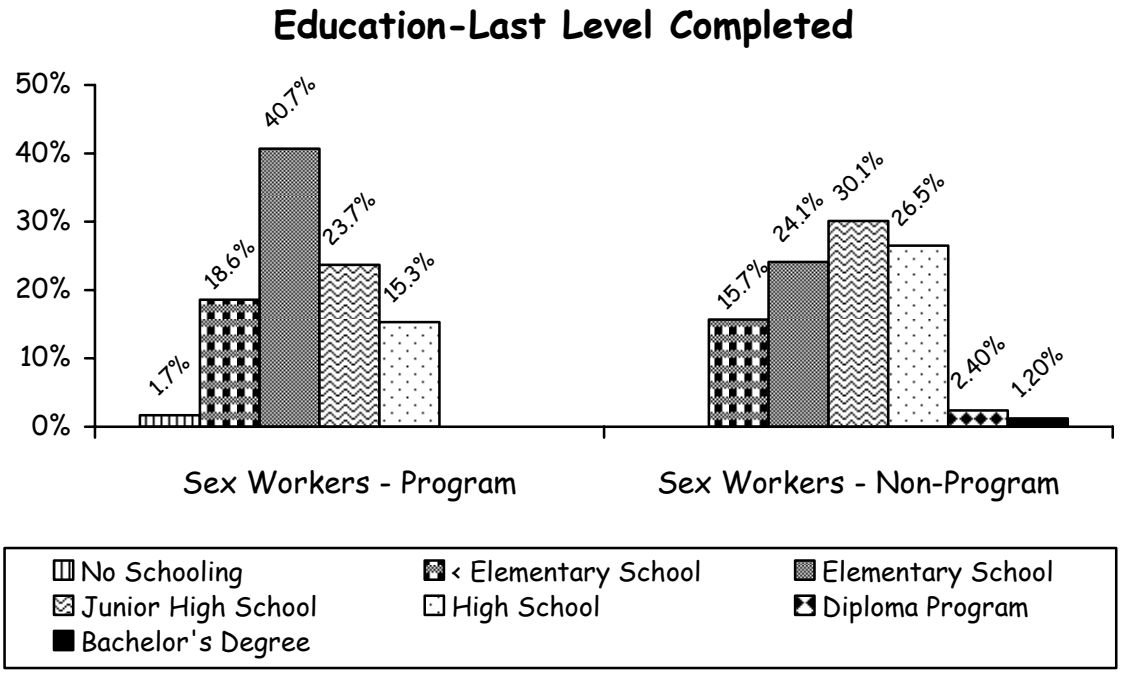

Figure 22. Graph of last education level completed for program and non-program sex workers. Notice that sex workers who have not attended HIV education programs in general tend to have had higher education than their program counterparts.

Though many sex workers have little formal education, many are trying to break this cycle by paying for their children to go to school. In Indonesia, every level of education from elementary onwards requires tuition. Sex worker #18's story reflects on the fact that though she has little education and no children, she is helping her "husband" put his children through college. This illustrates the concept of clients/guests as "husbands," an important concept that will be discussed in more detail later:

> I am from a very religious family in a very religious community. When I am home I wear a head covering and I pray five times a day. I adapt whenever I go home to visit my family. It is not difficult. Here I pray as well. I wear the head covering sometimes when I go out. But at home I always wear it. My family expects it. My brother and my father are very involved with religion. My brother is a religious leader in my community, and my father

recites the al-Koran at the Mosque. My village is very traditional. My parents arranged a marriage for me, but I did not like my first husband. We were married when I was 16. I did not want to have sex with him on our wedding night. I was scared. No one had taught me about sex. We were a religious community; we didn't talk about such things. My husband was mad because I wouldn't have sex with him… so he beat me. Then he tied my hands and feet and he raped me. My own husband raped me on my wedding night. I ran away from him. Then I chose my second husband on my own. He also was no good. The first husband beat me, the second one cheated on me. I don't know which was worse. Now I have a good husband. Well, we are not yet married, but still he is my husband. I have no children of my own. But I take care of my three stepchildren, my third husband's kids. They are all in college. I am so proud. I pay their tuition. My third husband is a good man, but he travels a lot to look for work. So, I stay here and do this. I send him money for the children's tuition. He comes here when he can. It's not too often.

My last guest was 3 days ago. There are fewer customers out here now… not like before. But it's ok. It's laid back here, no pressure. I get old men who are lonely or who say their wives can't satisfy them… But mostly they are college students who come out here with their friends. Three days ago, my guest was a student. He came here to the stall and had a drink. He drove here on his motorcycle. He asked how much and we discussed the price. He agreed on 25,000 *rupiah*. But then after he asked for a discount. He said he needed 5,000 *rupiah* back so he could put gas in his bike so he could make it home. It's funny, isn't it? He asked for a discount so he could get home!

I know about condoms and using them for health. I think I use them about 50% of the time… well maybe less. But I ask the customer to use it and he always says no… he says it doesn't feel good. I'm concerned about health so I ask again. But when he says no again, what can I do? I have to go along with what he wants… if I have no customers how will I survive?

4.4. PRELIMINARY RESEARCH, BREAKING DOWN ASSUMPTIONS, AND GAINING ENTRÉE

When I volunteered for the Pittsburgh AIDS Task Force (PATF), I received the opportunity to assist in conducting outreach to sex workers in downtown Pittsburgh. My outreach partner was Mack Friedman, a resident expert on the culture of sex work and "hustling" (*see* Friedman 2004 for an in-depth history of hustling). Between my conversations with Mack and my actual outreach activities talking with sex workers in Pittsburgh, I found that the sex workers of Pittsburgh agreed for the most part on the top three priorities PATF could assist with.

The first of these priorities was a clean place to shower. Many of the women were homeless, or had no running water in the places they were staying. Others were in shelters and couldn't go there to shower between clients. A clean place to shower was definitely something these women were prioritizing. This was something they thought the PATF could help them with and something that would be utilized more than the brochures they were currently receiving from the PATF. They also felt they would listen to HIV messages more readily if they were receiving some sort of benefit from them, like clean showers.

The second thing they prioritized was a needle exchange. Many of the women in Pittsburgh involved with sex work were also involved with drugs. Some were using intravenous drugs in order to try and forget that they were doing sex work, or to temporarily leave their bodies during the transactions. Others were doing sex work in order to afford their drug habits. Still, no matter why they were shooting up, they wanted to do it as safely as possible. A needle exchange would provide them with the safety they were looking for.

The third thing they wanted was protection of some sort. Many of them talked about the danger involved in doing sex work. They typically had multiple partners in any given night, all

of whom were anonymous sex acts. For the clients, the anonymity added to the excitement of the transaction, but it also added to the danger for the sex worker. If something goes wrong when you are doing something illegal with a complete stranger, there's not much you can do about it. Many of the women talked about being beaten and left to die. The women felt they had no recourse; there was nothing they could do in these situations since society didn't value their lives or their jobs. They couldn't go to the police and they had no protection unless they had a "pimp." Many of the women did not want a "pimp", however, since they were also often violent with the women.

Thus, these women wanted a clean place to shower, needle exchanges, and protection from the dangers of anonymous sexual partners. This was my knowledge base about sex workers when I applied to volunteer at an HIV/AIDS education program in Indonesia. My résumé discussed all the other things I had done at the PATF, and how most of my experience was with the speakers' bureau, providing AIDS 101 talks to schools and universities. In my cover letter I discussed how I was interested in working with their programs for high schools. The head of the organization felt that my limited experience with outreach was enough for me to do a complete evaluation of the programs they offered for sex workers. I wasn't naïve enough to believe that the situation would be the same in both countries, but I wasn't prepared for the stark differences I found.

Once asked to evaluate the programs offered to sex workers in Jogjakarta, I tried to do background research but found that there was nothing written and accessible at the time on sex work in Indonesia. The best information I could access was news paper articles from prominent Indonesian news papers that still to this day refer to sex workers as "WTS" (*wanita tuna susila* - women without morals) (*see Van Der Sterren et al. 1997 for a discussion of this usage*). This

was not the type of information I thought would be beneficial for understanding what programs were needed.

However, I did not want to be a typical Western researcher who often can fall into the "I know best" trap. My education and limited experience with sex workers in America did not mean that I knew what was best for the sex workers in Jogjakarta. I had already been warned of the tendency for Javanese, particularly, but Indonesians, in general, to honor the researcher by saying whatever they thought the researcher wanted to hear. I couldn't simply ask "Are the programs offered beneficial to you?" They would have all answered "yes." Thus, I decided to try another approach.

I tried a technique used for evaluating households of parents in Early Head Start programs that was briefly discussed in my methodology class (*see* McAlister 2005). "Photovoice" is a research method involving the participants' photography. The researcher gives disposable cameras to the respondents and asks them to take pictures of what is important to them and then you discuss what you see in the photographs. This method allows a look into their homes and lives that would not normally be afforded to researchers.

I used this technique with the sex workers I was working with. I held a workshop and showed them how to use disposable cameras. I then asked them to go out into their community and take pictures of things they liked in their community and things they didn't like. We then got together after the photos were developed. I took the group out for the day, outside of their typical environment, to a restaurant they had shown interest in. We spent the day there eating wonderful food and discussing the photos. The sex workers conducted the evaluation themselves using the photographs they had taken of their neighborhood. Their discussion was based on the photographs of what they liked in their neighborhood and what they wanted improved (*see figure*

23). I started by having the sex workers cluster the photos into "photos of things I like about our community" and "photos of things I don't like about our community."

Figure 23. Photo of sex workers conducting a program evaluation. Photovoice was utilized so that the evaluation could be conducted on the community, by the community, for the community.

One of the things that really stuck out in my mind was the fact that many sex workers took similar photos of a nice, quiet, and sunny alley. It could have been any typical alley in Sosro. I was sure this image would be "a good thing," but they all agreed that it was definitely a "bad thing." When I asked them to clarify why this nice quiet street was a "bad thing" they told me that it was "bad" because it was quiet, and quiet means no customers/guests. One sex worker explained: "Yeah, if there are no guests, then we don't have any money. If we don't have any money, how are we supposed to pay our rent and send our kids to school?" Another chimed in with: "Besides, if we don't have any guests, we will have too much time on our hands, we will

get bored and do things to fill the time. We will drink and play cards. And we know drinking and playing cards are sins. God doesn't want us to drink or play cards. So it's better to keep busy with guests." When I pushed the issue and asked if sex work was a sin, they all agreed that this was God's plan for them. They didn't know why God wanted them on this path, but they were sure they were here because of God.

During the photo evaluation and through interviews with both the sex workers and volunteers at the non-governmental organization (NGO), I found that all of my previous ideas about sex work were useless here. If you remember, many of the American sex workers wanted showers because they were homeless, needles because they were drug users, and protection against anonymous partners. The women I worked with in Jogjakarta needed none of these things.

The women I worked with were all *losmen* (brothel) based, so they had a place to *mandi* (Indonesian form of shower) and a bed to sleep in, as well as a place for transactions that was off the street. None of the women I worked with, and according to them, none of their friends, used any kind of drugs. They expressed disappointment in themselves for drinking alcohol, let alone doing something illegal. They also hated if their clients/guests were drunk or high as it would elongate the sexual transaction. These women also did not want protection. They felt that the *losmen* staff and the night security guards (all of whom got a share of the profits) were more than enough protection.

Unlike the sex workers in Pittsburgh, these women felt that they did not have to worry as much about violence because their clients/guests, like most everything in Indonesia, were based on social relationships. This is also evident in the use of the term "*tamu*" or "guest" to refer to their clients. Most of their clients/guests were repeat guests (not anonymous sex acts). Thus,

every Friday “Bob” would come to help his girlfriend/lesser wife/sex worker with paying rent. How clients/guests view the sex workers and how this affects safer sex choices will be discussed in the following section. Also, new clients were often referred from other clients, the security guards, or people they knew, meaning they were traceable and more accountable for their actions.

During this stage of preliminary fieldwork, information was also collected from extensive interviews with 16 sex workers in Jogjakarta, Indonesia. The results of this preliminary research suggest that HIV education programs in this area were effective in certain targeted “high-risk” populations. These targeted “high-risk” groups show a high working knowledge of HIV/AIDS. The targeting of “high-risk” populations, in general, though, has been shown to have little effect on the epidemic at large (Goldstein 1997). It has also been shown to highly increase stigmatization in the targeted populations (Bloor 1995).

Initial interviews suggest that sex workers in Jogjakarta have a high working knowledge of AIDS as a disease and a threat to their lives. Still, their ability to use this knowledge is mediated by several cultural factors (Rwabukwali et al. 1994; The World Bank 1997). Although most of the sex workers I interviewed understood the importance of condoms as a prevention strategy, many professed to not using them due to their clients’ lack of knowledge. Clients believed condom use would only be requested by someone who is already sick. Thus, a sex worker requesting the use of a condom greatly reduced the likelihood of the transaction being completed (for similar findings see Pona 1998 and Surjadi et al. 2000).

As one woman told me “I’d rather die in 15 years from AIDS than in 15 days from hunger.” As this quote suggests, sex workers often understand how HIV is transmitted as well as how long it takes before ultimately dying from the disease AIDS. Yet, they are incapable of

negotiating this space with their clients/guests. This suggests that knowledgeable sex workers could be more effective in their safe-sex strategies if the general public, and thus their clients, were more knowledgeable (Sedyaningsih-Mamahit and Endang 1999, Suyanto et al. 1997).

4.5. "GUESTS" OF SEX WORKERS

Upon initially arriving in Indonesia, I was required to obtain research permits in Jakarta. While waiting for my permits to be processed I was approached by many government officials who felt it necessary to keep me company. During this time, I had nearly the exact same conversation with each of them. It translated into something like this:

> **Government Official**: What are you doing here?
> **Me**: I'm waiting for my research permits to get processed.
> **Government Official**: What kind of research do you do?
> **Me:** I'm conducting my PhD research on AIDS in Indonesia.
> **Government Official**: Oh… so you're studying Bali?
> **Me**: No, actually my research is based in Jogjakarta.
> **Government Official**: Why there? There is no AIDS in Jogja. You should go to Bali.
> **Me**: Whether or not there is HIV in Jogja, I can still study cultural perceptions about HIV.
> **Government Official**: So you'll study university students, like yourself?
> **Me**: Well, yes. And I'm studying CSW…commercial sex workers.
> **Government Official**: What? 'WTS' [Wanita Tuna Susila]…Women without morals? There are none of those in Jogja. You should go to Bali.
> **Me**: I happen to work with approximately 300 sex workers downtown by Malioboro Street.
> **Government Official**: Oh them… ya, they are just for tourists.

Upon arriving in Jogjakarta, I proceeded to have this conversation about 10 more times with everyone who asked me about my research, including local government officials, university

professors and hospital doctors. It seemed the overwhelming perception by the general public was: A) there is no AIDS in Jogja, B) there are no sex workers in Jogja, and C) IF in fact I do find sex workers in Jogja, their clients are solely foreigners/tourists.

I had had similar conversations two years previously, when I had been conducting my preliminary research. Because of this, when conducting focus groups with sex workers I had eagerly asked them to list the kinds of clients they had. They shouted out occupations and titles ranging from government officials to farmers and village chiefs to students. I dutifully wrote each of their answers on a large piece of paper supported by an easel. When they had finished, we surveyed the list. I asked if anything had been left out. I even pressed a little, as I was sure they meant to list tourists. But they assured me it was a complete list. Over 50 different headings and not one had to do with foreigners. I asked them again, this time, a more leading question: "What about tourists? Aren't they your clients, too?" They looked at me quizzically, and then one slowly answered: "Sometimes there are foreigners, men who work here, not tourists… but not many… not many at all. Our clients are like us. They are Indonesians…mostly Javanese. They understand us. They understand building relationships."

Throughout my research, from the preliminary focus groups and later to the quantitative surveys and intensive qualitative interviews, I found that the sex workers I worked with were NOT there "only for the tourists" and, in fact, stayed away from foreign clients as a preventative measure against HIV. This was due to the fact that AIDS is seen as a foreign disease that you can get from having sexual intercourse with a foreigner. Similarly, Karen Kroeger observed throughout Java that "the dominant discourse about AIDS focused blame on two principal groups, white foreigners and Indonesian female sex workers" (Kroeger 2003: 245). She found that "female sex workers… in Surabaya's Dolly brothel area were wary of and sometimes

refused to have sex with white foreigners because they feared getting AIDS from them" (Kroeger 2003 245).

Consistent with this, I found that a large proportion of sex workers in Jogjakarta not only feared having sexual intercourse with foreigners but specifically feared having sexual intercourse with Americans. This was due to the fact that most sex workers believe that HIV originated in America. Interestingly, sex workers in Jogjakarta who have participated in HIV education programs were 6.5% more likely to say AIDS originated in America, as compared to their non-program peers (*see figure 24*).

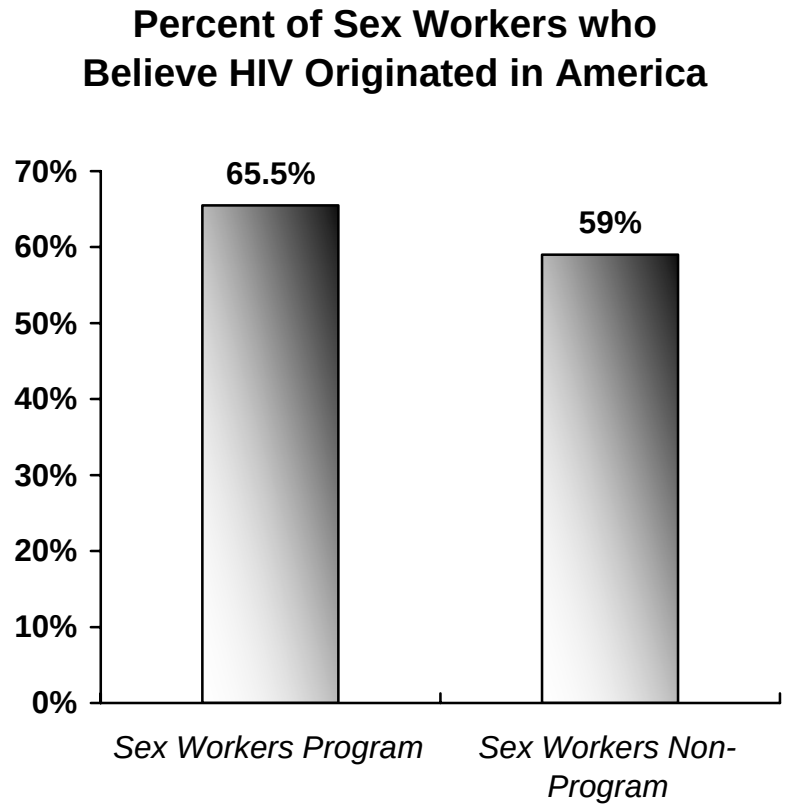

Figure 24. Graph of believed American origin of HIV for program and non-program sex workers.Survey question C7 illustrates that 65.5% of sex workers who have participated in education programs believe HIV originated in America. This is 6.5% more than their non-program counterparts.

This difference could have resulted from the fact that sex workers who have engaged in HIV education programs are more likely to be aware of the foreign funding, foreign workers, and foreign texts involved in the planning and implementation of these programs. It could also have to do with the interpretation of training materials used to inform the volunteers at HIV NGOs. In one training pamphlet I read that "AIDS was first reported in 1981 in America and from there it has spread into an international epidemic." Although this is a true statement, volunteers at the HIV NGO that I worked with pointed to this statement as factual proof that AIDS originated in America.

Research conducted in various parts of Indonesia has found that although common perceptions assume that sex workers are engaging in sex with foreigners, in fact this is rarely the case. As one study on the trafficking of women and children in Indonesia states: "Research conducted on all aspects of the sex sector highlight that the main consumers of sexual service in Indonesia are Indonesian males" (Rosenberg 2003: 89). Even a study conducted in Kuta, the tourist area of Bali, found that "the number of prostitutes that engage in sex work with foreign, tourist populations comprises a small fraction of the nation's entire sex industry" (Thorpe et al 1997: 183).

Thus, it is Indonesian men who are accompanying Indonesian sex workers and doing so on an ever increasing basis. Utomo and Dharmaputra (2001) conducted a 5 year behavioral surveillance survey on female commercial sex workers and adult male sailors, sea port workers and truckers in 3 major cities in Indonesia (Jakarta, Surabaya and Manado). Survey totals for male respondents ranged from approximately 1200 men for each of the first 4 years to 1603 respondents in 2000. Over time the percentage of men ever having sex with a sex worker increased 49.5% in 1996 to 70% in 2000. Nearly 50% of the respondents in 2000 reported to

having had sex with a sex worker in the last 12 months (Utomo and Dharmaputra 2001). According to the Indonesian Ministry of Health "on a national level, the client estimates suggest that between 12 and 17 percent of Indonesian men visit sex work annually" (Indonesian Ministry of Health 2003: 20). Based on a 2002 population (for when the report was written), that means the Ministry of Health estimates that between 6.9 million and 9.6 million Indonesian men are clients of sex workers each year.

Another interesting characteristic of the clients of sex workers in Indonesia is that they are generally married. According to the above study in Manado, Jakarta, and Surabaya, married men are more likely than unmarried men to have visited a sex worker in the last year, 54.5% compared to 43.5% (Utomo & Dharmaputra 2001: 49). Similarly, the Indonesian Ministry of Health estimates that over two-thirds of the clients of sex workers have wives or live-in girlfriends (Indonesian Ministry of Health 2003: 24). Thus, again based on a 2002 population, nearly 4.9 million to 7.3 million women are the regular partners of men who have sex with sex workers.

4.6. SEX WORKERS AS "WIVES"

When I asked the sex workers I interviewed about their clients marital status they indeed confirmed that most of their clients were married. Sex worker #17 told me: "Most of them are married. When I asked about their reason for coming here when they have wives, they said 'should I eat spinach all the time, sometimes I want to eat *sayur lodeh*' (*vegetables cooked in coconut milk*). Similarly, sex worker #4 said:

> I ask them, '*Mas*, why do you come here…' or if they are older guests I ask, 'Pak, you have a wife, right?' And he tells me: 'Sometimes I need something not from my wife. I have another kind of fun here. Should I eat *sayur asin (salty vegetables)* all the time? Sometimes I want *rawon (boiled meat).*' Men are different from us, aren't they?

Other than variety, having wives who are menstruating or pregnant were other reasons often cited as to why married men came to visit sex workers. Sex worker #1 stated matter of factly: "Men come here for different reasons. Married men often say their wives refuse them, or they come here because their wives are pregnant or menstruating." Similarly, sex worker #7 said: "Maybe they have problems with their families… or because the wife is on her period… sometimes I have customers whose hobby is to come to this kind of place… some come for *ngewek (fun, not serious)* only… they're not satisfied with only one woman… two or three women are needed to fulfill them."

The idea that 2 or 3 women are needed to fulfill a man relates to his *nafsu (desire)* and his inability to control it. As sex worker #8 stated: "Hmmm… maybe he hasn't got satisfaction with his wife. He wants to have another woman maybe, to make him feel younger. They also say that they just want to waste their time. Sometimes my guests are not able to control their *nafsu (desire).* They come to here to be fulfilled." A typical Javanese perception is that men cannot control their *nafsu* (desire). "Many Javanese men and women seem to take as a given that men have innately greater desire for sex than women, and that this desire is extremely difficult for them to suppress" (Brenner 1998: 150).

It is also often understood that not being able to control their *nafsu* (desire) is not their fault since God made them inherently different that women. According to sex worker #5:

> In my opinion, they come here for something to refresh themselves. You know, for comfort… and to decrease their burdens… I mean, that's what I think… but it's different… you

> know sexual intercourse is different for men and women… it means different things. So I guess I can understand why men like coming here… because God/Allah made men need sex more then women, didn't he?

Suzanne Brenner (1998) discusses the Javanese concept of *nafsu* (desire) in detail in her book entitled: The Domestication of Desire: Women, Wealth, and Modernity in Java. She starts with an important caveat: "[I]t is important to look at the ways that the concept of desire, *nafsu*, is figured in a specifically Javanese sense. Many Javanese believe that to experience desire is normal to the human condition, but to be governed by desire is dangerous, not only to the individual but also to the family and to society" (Brenner 1998: 150). She then proceeds to explain that "*[n]afsu* often connotes ardent longing or passionate desire that, if left totally uncontrolled, causes people to behave in an unbalanced, irrational, or socially unacceptable manner" (Brenner 1998: 150).

Brenner (1998) also found that among her female Javanese informants there was an acceptance and even tolerance of men's inabilities to control their *nafsu* (desire): "Since men are often thought unable to restrain their desire for sex, however, many women tolerate, and even expect, a certain amount of sexual infidelity from their husbands, although they certainly do not encourage it" (p. 151). Similar findings were reported by Hildred Geertz with her research in East Java in the late 1950's, "[Wives] are tolerant of their husbands' irregularities because men are considered to be by nature irresponsible. Their sexual promiscuity is called *nakal* (naughty), which is the same term applied to disobedient or unruly children, there being no connotation of adult misdemeanor; and they are expected to be *nakal* both during their bachelorhood and after marriage" (Geertz 1961: 131).

Sex worker #2 illuminates why this seems so normal from a historical point of view:

> According to the story, since along time ago, it's the nature of the law of men. Since long ago, usually men had many wives. They had 2, 3 and 4 wives, it's polygamy, right? Now we are their wives 2, 3, and 4.
>
> That's it… it's been like this since a long time ago. If he already has a wife but he still wants to buy sex, maybe he wants to refresh his mind from being tired and stressed. When he feels bored at home, his wife refuses to have sex with him, or he goes to another town, to refresh his mind, release the stresses of his work, or because his *nafsu* [desire] is too great… then he goes to prostitution. It will make him fresher, not too tense, not too heavy… that's what I think. This is how he can cheat on his official wife… I don't know, I mean it's the usual thing for me.
>
> You know the important thing is keeping the family together… and even with cheating for variety, the family is still complete, right? That is the important thing… that the family stays complete.

Sex worker #2 has succinctly shown the link between sex work, uncontrollable desire, polygyny, and keeping the family together. Though polygyny is legal in Indonesia and sanctioned by the Qur'an (in An-Nisa, chapter 4: verse 3), common practice dictates that men only take one wife as that is all they can afford. Many of the Javanese men and women I talked to discussed that the Qu'ran says that you have to treat your wives completely equally and if you cannot do that then you must take only one wife. While I was in Indonesia, media attention on polygyny focused on high-profile cases such as Sukarno (Indonesia's first president), Megawati's vice president Hamza Haz, and Puspo Wardoyo, the owner of a chain of fried chicken restaurants called *Wong Solo* (Person from Solo) that gives each wife her own restaurant in a different city. Often the ideal of equal treatment was put into financial terms, thus movie stars and corrupt politicians were assumed to be the only ones who could afford more than one wife. The Javanese women I spoke to seemed to be fearful of being made a co-wife; they

discussed the importance of keeping the family together and of having enough financial resources for the family.

Suzanne Brenner (1998) found similar findings in her research about batik traders in Solo. Brenner discovered that many of her female Javanese informants had similar views on men's inability to control their *nafsu* (desire) and yet were willing to forgive their husbands' indiscretions as long as the family was kept intact (Brenner 1998). Brenner states that most of the women she knew "found the idea of polygyny utterly repugnant… since it means that both the co-wife (or wives) and any children that she might produce are in competition with the first wife and her children for the husband's property" (Brenner 1998:152). Many women even preferred their husband's trips to the brothel area as opposed to taking a second wife; this was because the former was not as much of a constant drain on the family resources as the latter would be (Brenner 1998). Brenner (1998) concluded: "Women tacitly grant men considerable sexual license, as long as their promiscuity does not interfere too much with the interests of the household" (p. 152).

Karen Kroeger's (2000) work with housewives and sex workers in Surabaya had similar findings:

> What many women find more objectionable than sexual dalliance is that a man's propensity to "sniff everywhere" may lead to economic consequences for the family. However painful or humiliating it is for him to frequent prostitutes, it is infinitely preferable to him taking a mistress, or worse yet, a second wife. No woman I talked with wanted to be *dimadukan*, to be put in the position of having a second, newer wife to compete with for her husband's attention or economic resources. So while a woman might be unhappy with a husband's trips to the brothel, it was often viewed as understandable in the context of his more powerful desires, and perhaps even more tolerable compared to other alternatives." [p.167-168]

Kroeger (2000) finds that “a man, then who frequent prostitutes, or has casual liaisons with women, is fulfilling his nature. A man who brings home a second wife can destroy a household” (p.168). Thus, Javanese women seem to allow their men considerable sexual freedom as long as the family is kept intact.

While men are seen by their wives and themselves as incapable of controlling their *nafsu* (desire), too much *nafsu* is seen as a bad thing. It is understood that too much unreleased desire will interfere with your “spiritual potency,” which will affect your status in the community. Javanese “status is measured not only on the basis of factors like wealth, occupation, education, and descent line, but also according to somewhat less tangible qualities, such as cultural refinement, mastery of elaborate linguistic etiquette and social skills, and reputed possession of spiritual potency” (Brenner 1998: 140).

Nafsu (desire) needs to be kept in check, and according to the sex workers I interviewed, this was why men came to them when their wives were menstruating or pregnant. Sex under these conditions is believed to also affect one’s spiritual potency. It is important to keep your *nafsu* in balance even when your wife is unable to assist you in this endeavor. Other than menstruating and pregnancy, elderly wives were also cited as possible reasons for men coming to sex workers to stay “balanced.” Sex worker #13 mentioned that although most of her guests were young people (high school and college age), some of her guests were in their 60’s: “Many of the guests are young people, but the oldest are in their 60’s. The old married ones say that their wife is not able to do it with them anymore. Because at that age women must be too old. I feel bad for the husbands. How else will he keep in balance?”

Many Javanese, then, seem to hold a double-standard for sex work; on the one side they deny its existence or say it is wrong or something only tourists engage in. They even call sex

workers “women without morals,” and yet also approve and even expect men to control their *nafsu* (desire) by going to sex workers. After assuring many of the people I talked to that sex work does in fact exist in Jogja and that it is mainly Indonesians that utilize it, many Javanese men and women responded that sex workers were needed to keep other women safe. It seemed to be the common perception of “men not being able to control their *nafsu* (desire)” taken to the extreme: if sex work didn’t exist, these uncontrollable urges in men would materialize in the form of rape or sexual harassment that victimizes “respectable” women.

Karen Kroeger (2000) found similar perceptions both in the general population and in the sex workers she interviewed. She found that female sex workers subscribed to this view, arguing that they were contributing to the good of the society by channeling men’s energies into safe and acceptable outlets. One woman even told her that if it were not for sex workers, more women would be raped on the streets (Kroeger 2000).

Thus, as discussed previously, “a man’s ‘playing around’ is marginally acceptable, provided that he does not squander the family’s money in the process” (Brenner 1998:152). Understanding this Javanese construct has potential to facilitate communication when educating the regular partners of these men who visit sex workers. Discussing HIV and STIs in regards to acceptable visits to brothel areas in order to control *nafsu* (desire) could defuse a potentially volatile topic. Similarly, understanding the importance placed on making sure these “extracurricular” activities do not squander the family resources enables an open discussion of high-risk behaviors based on how contracting a disease such as AIDS could drain the family resources.

Also important to HIV/AIDS education programs is an understanding of the social acceptability of polygyny. Although most women don’t want to be made a co-wife, many men

feel that having multiple wives helps to prove their manhood. Legally, in Indonesia the first wife has to agree to any subsequent marriages. Despite this, men often have unofficial second wives. As one of Brenner's informants mentioned: "Women make better traders and entrepreneurs then men, because if you give them money, they'll spend it on getting women. Give them enough money and they'll have more than one wife, either out in the open or on the sly" (Brenner 1998: 33).

Sex workers told me they were often asked to become a second or third wife. Sex worker #4 explains: "Guests sometimes see me as a lover, or often they say 'I don't consider you as a sex worker but as a wife.' As a 2nd or 3rd wife, the point is they give me money for my daily needs. Because that's what we are doing here… looking for money. So we just say yes." Sex worker #6 says they may consider her a wife but she doesn't consider them husbands: "Some say 'I consider you as my girlfriend or my wife.' They say that but I don't pay attention to them, I tell them I have a husband and children, and I'm here just to work."

Due to the repeat nature of most of the clients in Sosro, it is common for a sex worker to be asked by her regular clients to become a second wife. Sex worker #2 explains: "Usually the regular customers say they want to take me as a wife and like that… and the others are also asked often… what I hear everyday usually is, 'you don't have to stay here… just be my wife'… you know, like that. I don't know if it's true or just to let them pay cheaper." It is important to note that even if a sex worker agrees to become a wife (officially or unofficially), this seldom means that she stops seeing her other clients. Many of the sex workers I interviewed told me of their "husbands" and how their "husbands" know where to find them when they need them. Often they told me that when their "husbands" come they would wait outside until their "wives" were finished with her client. One woman (#20), who I interviewed with her "husband" lying on

the bed next to her listening, said: “This is my third husband. It is not official but we have been together for years. He was a customer, but he always took care of me and my kids. Now I take care of him. When we got together I had stopped being a sex worker, but since the [economic] crash he can’t find work… so I go out and work for us.”

4.7. GUESTS AS “HUSBANDS” AND “BOYFRIENDS”

While conducting my research, I was able to spend a lot of time at the HIV outreach center for sex workers in Sosro. I attended meetings with the sex workers and observed and participated in some of their activities, including aerobics class, English class, candle making class and a retreat to the mountain village of Kaliurang. I was able to create relationships with both the volunteers and the sex workers I worked with. I was often invited by the volunteers to go on outreach rounds with them throughout Sosro, looking for new women to join in the group or reminding women of activities and the availability of condoms and medical expertise. The sex workers got to know me better with the passing time and eventually I became friends with many of them. Some invited me into their rooms in Sosro, usually a small closet size space with a bed and not much more. Winding through the tiny back alleys of Sosro I got to know the place and the people.

One woman, a sex worker friend of mine, asked me to take her to the medical clinic. The “clinic” consisted of an ancient dirty gynecological chair in one of the rooms of the outreach office that was staffed by a doctor once a week. The doctor was very curt and told my friend she needed to be more careful with her guests. She had contracted herpes. The doctor asked if she used condoms and she answered “Yes, all the time, well… not if they look clean, and never with

my husband." As long as I had known my friend she had never mentioned a husband. I asked her about this later and she told me that he wasn't officially her husband, but that he had asked her to become a second wife. She told me that he comes once a month or so and he pays her more than her other guests do. When I asked her why he paid her if he was her husband, she recanted slightly and said "well he doesn't really pay me for visiting… he just gives me money to help pay the bills."

The more I talked to other sex workers the more I realized that this was a common philosophy. Regular customers were often seen as husbands and their payments were simply helping to pay the bills. Some women in Sosro even told me that they weren't sex workers; they simply had a lot of boyfriends who helped them pay for their kids' school tuition or other bills. These women often didn't utilize the services of the outreach clinic, nor benefit form the HIV education provided there, because they didn't define themselves as sex workers. Understanding how people define themselves is essential when creating HIV education programs such as the ones offered at this NGO.

All too often, funding designations provided by absentee funders trained in Western ideas, the HIV education and prevention programs that do not reach the intended audience to reach due to such trivialities as labels. This has been true in Indonesia for many HIV programs. During the summer I did my preliminary research I was amazed to see that the two most funded programs were designated for sex workers who don't always define themselves as such, and homosexuals who never define themselves as such. Funding programs based on "risk-groups" often lead to this kind of inappropriate funding.

Building on this, I wanted to understand the ways in which women in Sosro and the men that visit them define themselves and how this interferes with both accessibility of HIV

education programs and the actual act of HIV prevention activities, such as using condoms. Women who do not define themselves as sex workers or do define their clients as husbands or boyfriends are less likely to use condoms at the time of intercourse. Studies "show that condom use tapers off as a sex worker establishes a regular relationship with a client….apparently, the better one knows a partner — paying or not — the less appropriate it seems to enforce condom use" (Patton 1994: 53).

This can be seen through a conversation I had during my interview with sex worker #5:

> **Me:** "Do you know what a condom is?"
> **Sex worker #5:** "Yes, I know about condoms. You use them so you don't get diseases."
> **Me:** "Do you use condoms when you have sex with your guests?"
> **Sex Worker #5:** "Yes, but not with my boyfriend."
> **Me:** "But the other guests… you always use condoms with them?"
> **Sex Worker #5:** "Yes, always… unless I consider him to be one of my boyfriends… otherwise always… except when I forget.
> **Me:** "Did you use a condom with your guest last night?"
> **Sex Worker #5:** "Um… No… I forgot."

Similarly sex worker #11 told me: "I had two guests last night. I didn't use a condom with either of them… because they were regulars. One had even asked me to be his wife. How can I ask him to use a condom after that?" Guests that are identified as husbands or boyfriends tend to not warrant the use of condoms due to familiarity and status. Thus it would be dishonorable to ask you "husband" or "boyfriend" to use a condom. Sex worker #6 admitted: "My last guest was last night. I didn't use a condom because he was a regular guest, you know like a boyfriend." Similarly, sex worker #3 stated: "I always use condoms… well, almost always… not with my boyfriend… and last night my guest didn't use one, but he's a regular."

Other reasons for not using condoms include, "knowing what a diseased penis/person looks like." Sex worker #15 discussed when she uses a condom: "I know when I have to use condoms… you know, when a guest's thing doesn't look healthy… or if it's dirty. Then I ask

him to use a condom. My guest last night was a regular, a boyfriend… he never uses them. I don't worry about it… because I know him." Sex worker #16 offered this as to how she negotiates condom use: "I say 'Mas, use a condom, ok?' He says 'No, we don't need that.' And I say 'it's better, Mas, it keeps it safe.' Sometimes they agree, but usually they don't want it. Sometimes I just look at their penis. If it is clean, I don't bother offering." My research showed an alarming prevalence of the assumption that one can pick a "clean" partner by looking at them and that washing after sex will prevent disease transmission (see figure 25). Most alarming, though, was the prevalent myth that taking over-the-counter antibiotics will prevent you from getting any sexually transmitted infections, including HIV.

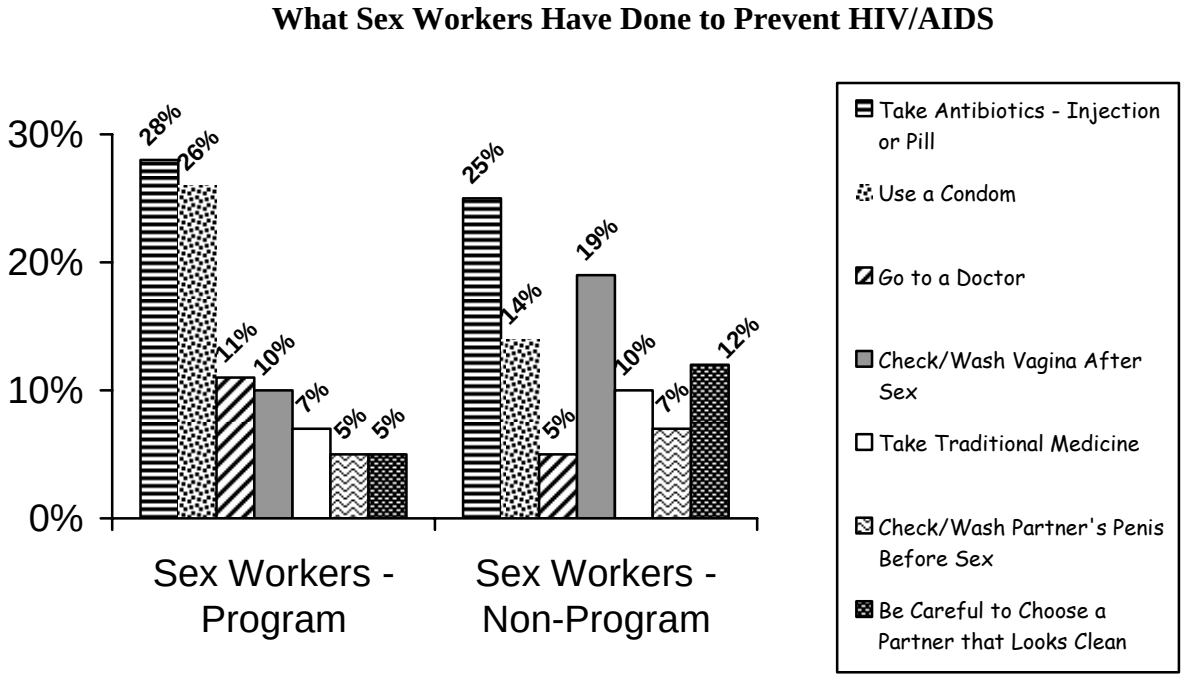

Figure 25. Graph of prevention methods utilized by program and non-program sex workers. This graph illustrates that the #1 most used preventive measure for sex workers (whether or not they have participated in education programs) is antibiotic use. Also note the prevalence of the assumption that one can pick a "clean" partner by looking at them and that washing after sex will prevent disease transmission.

4.8. PERCEPTIONS ABOUT CONDOMS

Condoms are associated with disease in two ways. Not only do sex workers assume they know when to use a condom because they can identify disease and thus decide to use a condom, but also guests often believe that if a sex worker offers a condom it is be because she is already diseased. Sex worker #19 told me this is how a typical condom negotiation goes for her: "I say 'Mas… why don't you use a condom?' And he asks 'Why, *Mbak*, do you have a disease?' And I say 'No.' If he still doesn't want to use it, that's fine. At least I offered." And sex worker #8 said she tries to offer condoms but the clients make assumptions about her: "Whenever I offer guests a condom they automatically assume I have a disease. I tell them I don't and that I just want to be safe…but they don't believe me. They think I'm diseased. That is what a condom means to them… if I am offering I must already have something."

The most common answer for not using condoms was that the guests just don't want them. Sex worker #9 divulged: "I **want** to use condoms 100% of the time because I am afraid of that disease… AIDS… the one with red dots… I don't want the red dots on me… then everyone will know I have it and they won't come close to me because they are afraid. But the guests they say 'No.' They don't want to use them." Sex worker #7 revealed: "No, I don't always use them. The problem is that sometimes the guests don't like them. What am I suppose to do? Should I push them to use it? I don't think so. I mean they say it's not comfortable… I can't push… or he'll leave. I'd rather have sex without the condom than have him leave without paying." Many sex workers asked similar questions. Sex worker #12 wondered aloud: "If I ask him to use the condom and he says no, then what can I do? I have to serve without the condom, right?" And sex worker #10 confided that, "Guests never want to use condoms. What am I to do? I have no choice. I need the money. I don't even bother offering anymore."

Many women suggested that more programs about condoms need to be made available to both them and their clients. Sex worker #2 told me: "I understand that because of our jobs we need to use condoms. But if we don't have sex with the guests that refuse the condom then we don't get any money, right? Then how do we afford our families? I think we need more programs about condoms and how to use them correctly… you know, not just for us but for our guests, too." Sex worker #8 suggested the need for programs for the general public. She told me that her clients don't know how to use condoms correctly: "If they do say yes they will use a condom, they have me put it on them… they say 'what do you do with this thing?'"

Sex worker #4 attempts to negotiate the slippery slope of condom use first by asking her clients to have pity and not pass diseases to their wives. If that does not work, she convinces her clients to engage in frottage instead of intercourse:

> Condoms help to keep my blood clean, isn't that right? I know I have to use them because I have "free sex." I tell my guests it is important to use them… I tell them to have pity on their wives. Use a condom for their sake. I tell my guests it is better to use condoms. Often they still say 'No! I don't want to use that thing.' Then I tell them 'that's fine… but you can't put it in me. Here simply put it in here' [she points to the tight space between her thighs]. We do it using body lotion. But he can't put it in me… not without a condom.

Even when condom use is negotiated, condoms are often not used correctly. Figure 26 illustrates how those sex workers who have participated in education programs were 17% more likely to answer "YES" to the statement that a condom can be used more than once. In fact, during my observations at the NGO for sex workers I overheard two sex workers telling each other how best to rinse out a condom.

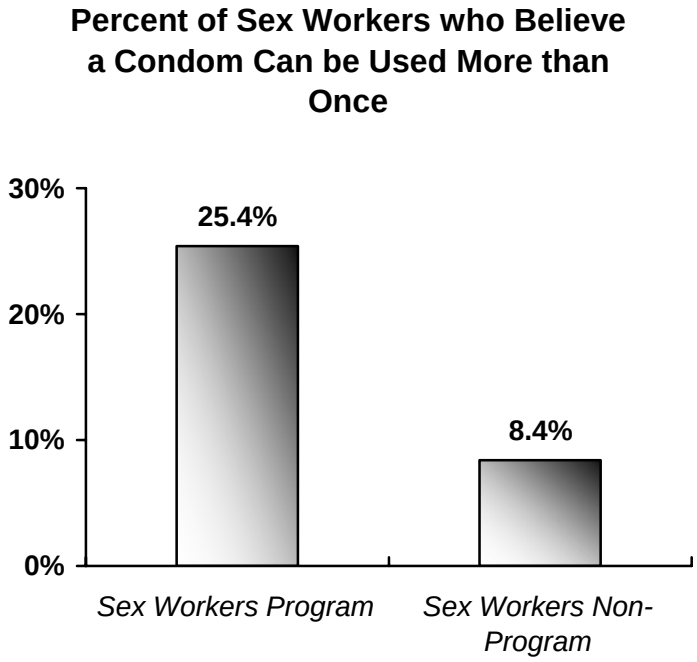

Figure 26. Graph of the belief that a condom can be used more than once for program and non-program sex workers. This graph illustrates sex workers who have participated in education programs were 17% more likely to answer "YES" a condom can be used more than once.

Condoms have been advertised in Indonesia for having different purposes for different groups. Condoms for married couples are wrapped in one color and touted as a birth control device. Condoms for sex workers are in another color wrapper and touted for prevention of sexually transmitted infections (STIs). The government did this so that they could not be accused of promoting the same values to both groups. Unfortunately, this has had negative consequences. Since most sex workers don't equate condoms with the dual purposes of both STI prevention AND birth control, utilization of condoms is very low. Figure 27 illustrates that only 13.8% of sex workers who have participated in education programs always use condoms. This is only a 6.6% increase over their non-program counterparts. Figure 28 illustrates that only 20% of sex workers who have participated in education programs and 11.9% of their non-program counterparts use condoms as birth control.

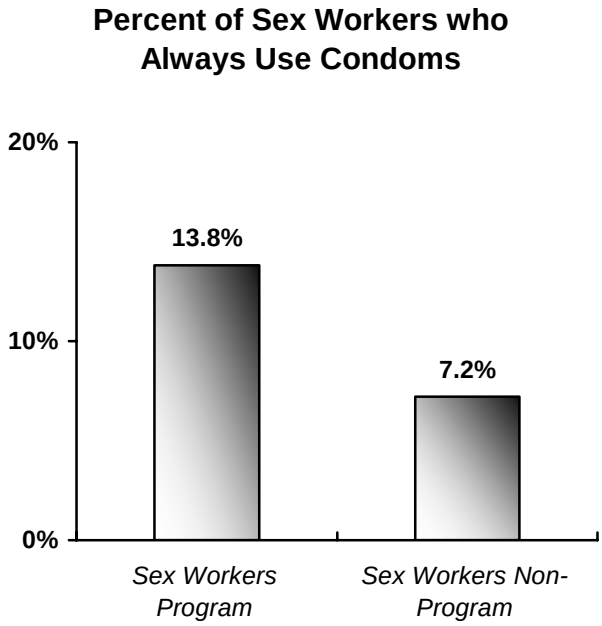

Figure 27. Graph of condom use for program and non-program sex workers. This graph illustrates how only 13.8% of sex workers who have participated in education programs always use condoms. This is only a 6.6% increase over their non-program counterparts.

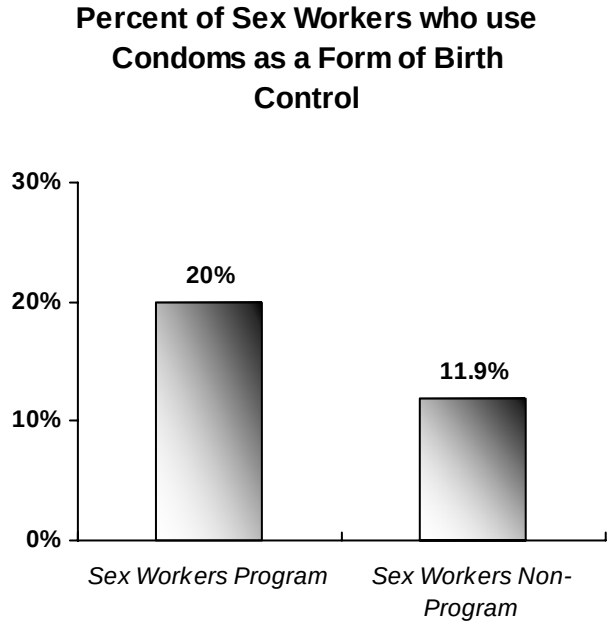

Figure 28. Graph of condom use as birth control for program and non-program sex workers. This graph illustrates that only 20% of sex workers who have participated in education programs and 11.9% of their non-program counterparts use condoms as birth control.

Table 8 below illustrates that the majority of sex workers surveyed understand that a condom can prevent HIV and pregnancy, and that they do not feel using a condom is contrary to their religion. Condoms are seen by both programs and non-program sex workers as inexpensive, easy to find and easy to use (*see table 9*). Table 10 below illustrates other perceptions that could explain the reasons why condoms are not being utilized more frequently even though they are perceived as cheap, easy, effective against HIV and pregnancy, and not forbidden by their religion

Table 8. Examples of condom knowledge survey questions for program and non-program sex workers.

Question	Program Sex Workers	Non-Program Sex Workers
Wearing a condom is one way to prevent HIV/AIDS. (yes) *Pemakaian kondom merupakan salah satu cara untuk mencegah HIV/AIDS.*	95.0%	79.5%
Condoms are against my religion. (no) *Menggunakan kondom bertentangan dengan agama saya.*	85%	59%
Condoms can be used to prevent pregnancy. (yes) *Kondom dapat digunakan untuk mencegah kehamilan.*	89.8%	89.0%

This chart illustrates that the majority of sex workers surveyed, both program and non-program, understand that a condom can prevent HIV and pregnancy, and they don't feel they are contrary to their religion.

Table 9. Examples of condom perception survey questions for program and non-program sex workers.

Question	Program Sex Workers	Non-Program Sex Workers
In my opinion, condoms are expensive.(no) *Menurut saya, kondom mahal harganya.*	91.7%	81.9%
In my opinion, condoms are easy to use. (yes) *Menurut saya, kondom mudah digunakan.*	93.3%	89.2%
In my opinion, condoms are easy to find. (yes) *Menurut saya, kondom mudah didapat.*	91.5%	92.8%

This chart illustrates that the majority of sex workers surveyed, both program and non-program, feel condoms are inexpensive, easy to find and easy to use.

Table 10. Examples of perception survey questions that could explain lack of condom use for program and non-program sex workers.

Question	Program Sex Workers	Non-Program Sex Workers
Condoms are not appropriate for married couples because they cause suspicion. *Kondom tidak baik digunakan untuk pasangan suami istri, sebab dapat menyebabkan kecurigaan.*	40%	60.7%
It's more appropriate if a man buys a condom than a woman. *Lebih baik jika laki-laki yang membeli kondom daripada perempuan.*	56.7%	70.7%
Condoms are only appropriate for people who change partners. *Hanya orang-orang yang berhubungan seks dengan berganti-ganti pasangan yang sebaiknya menggunakan kondom.*	78.3%	73.5%
In my opinion, condoms are dangerous and can get lost/stay in the body. *Menurut saya kondom berbahaya karena bisa hilang/tertinggal di dalam tubuh.*	28.3%	27.7%
Condoms decrease the pleasure for women. *Kondom mengurangi kenikmatan bagi perempuan.*	47.5%	61.7%
Condoms decrease the pleasure for men. *Kondom mengurangi kenikmatan bagi laki-laki.*	60.0%	65.9%

This table shows percentage of sex workers who agree with these statements. It illustrates other perceptions that could explain the reasons that condoms are not being utilized more frequently even though they are perceived as cheap, easy, effective against HIV and pregnancy, and not forbidden by their religion.

These include such perceptions as: "condoms are not appropriate for regular partners;" "it's more appropriate for men to buy condoms;" "condoms are only appropriate for people who change partners;" "condoms are dangerous, and can get lost in the body;" and "condoms can decrease the pleasure for men and women." If sex workers identify their clients as "boyfriends"

or “husbands,” they are less likely to use condoms. Understanding that it is more appropriate for a man to buy condoms than a woman underscores the need for HIV education in the general public, as opposed to handing out condoms to female sex workers.

Another reason that sex workers are not using condoms is that they do not believe they are at risk for STIs and HIV. They believe they can tell who is diseased. They also believe that if they don’t sleep with foreigners they can’t get HIV. More importantly, many sex workers practice the concept of “othering.” Thus they believe they won’t get HIV, because “other” people get it, not them. Interestingly, because sex workers engaged in education programs see that the only other HIV programs offered are targeting “homosexuals,” they are more likely than their non-program counterparts to project this “othering” onto homosexuals. Figure 29 illustrates that those sex workers who have participated in education programs were 15.7% more likely to answer “YES” **only** homosexuals can get HIV/AIDS.

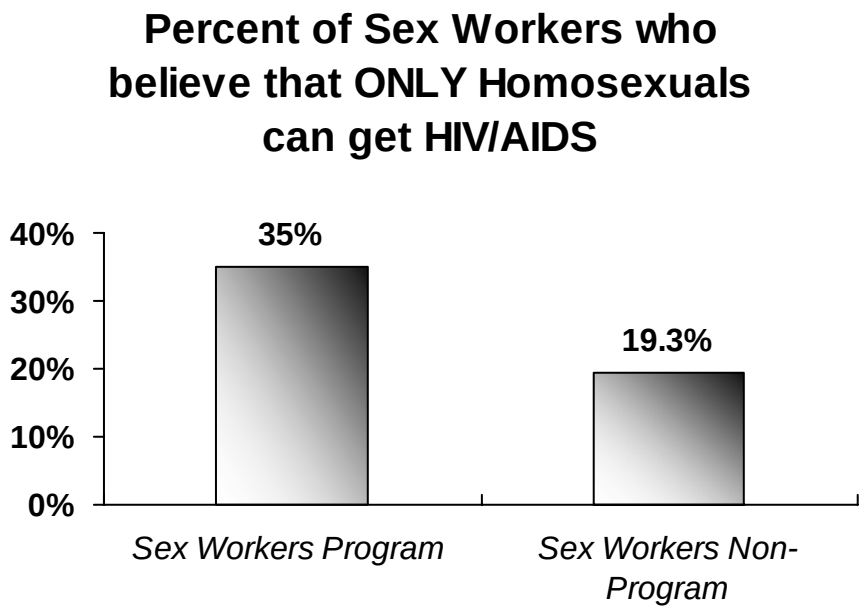

Figure 29. Graph of the belief that ONLY homosexuals can get HIV/AIDS for program and non-program sex workers. This graph illustrates the concept of "othering" associated with perceived HIV/AIDS risk. Here, sex workers who have been to HIV education programs and see they are also offered to homosexuals are more likely to say that ONLY homosexuals can get HIV.

Condoms represent a challenge in Indonesia for numerous reasons. Conservative politicians and religious leaders often believe that condom promotion promotes sex out of wedlock (Van Der Sterren et al. 1997). In a country that had an amazingly successful family planning program, condoms were seen as something used only by sex workers or suggesting infidelity. Under the government policies on family planning, condoms were seen as the least appropriate form of family planning (World Bank 1990).

The Indonesian government was able to reduce the number of births per woman from nearly 6 to 2 in less than one generation (Dwiyanto 1997). This was largely due to the state mandated policies that made everyone report their family planning choices to local and regional officials as well as post their contraceptive choices on their door. Civil servants were given bonuses and raises based on the type of contraceptive their wives chose. This included more

monetary/status gain from longer term contraceptives, such as IUDs and female sterilization, less for birth control injections and pills, and non-inspiring benefits for condoms due to their lack of long range effectiveness (World Bank 1990). In addition to this, until the 1990s condoms were illegal unless prescribed to a married couple by a physician.

As part of the government family planning initiatives, family planning methods were discussed in schools as young as elementary level. Birth control pills and injections, IUDs, sterilization, and even the rhythm method were discussed in these classes. They included all female-centered birth control devices. Condoms were not discussed. When I asked a number of my Indonesian friends, and even professors, about this, they all answered the same way, saying: women are responsible for family planning. As one middle-aged woman told me, “Every one knows you can train a woman, you can’t train a man!”

The Indonesian Ministry of Health even publicly condemned condom promotion, saying they would have no part in promoting condoms because they believe condoms promote promiscuity (Reuters 1996). Though Indonesian cultural perceptions about condoms are incredibly negative, many Western organizations, such as USAID, have decided to focus on programs that promote condom use without taking into consideration these cultural taboos. According to the USAID HIV/AIDS Indonesian Country Profile, “USAID behavior change interventions support a national “Abstinence, Be faithful, Condom” (ABC) strategy to prevent sexual transmission among high-risk populations” (USAID 2003: 3). The “ABC” approach is central to the United State’s Global AIDS Strategy, and as the “largest international funder of HIV/AIDS programs, the attitudes and recommendations of the U.S. government have far-reaching consequences for the health of people across the world” (Sinding 2005: 39).

This is problematic on a number of levels. As has been discussed, the use of "high-risk" groups proven to be effectively increase discrimination and stigmatization. Also, "ABC" interventions have been shown to not take into consideration the life circumstances of the women they target (Sinding 2005). "ABC" interventions do little to address a woman's ability to abstain from sex when her life circumstances does not allow this as an option, or to questions her husband's monogamy, or to even negotiate the use of condoms with her partners let alone addressing real issue behind HIV transmission such as poverty (Farmer 1999). "ABC" programs also do little to empower women or to address real life issues affecting their abilities to choose safer sex alternatives such as violence against women and the lack of resources for women the world-over. Throughout this, women are negotiating spaces of multiple identities daily. Resistance and agency are thus "figured in the minute, day-to-day practices and struggles of third world women," which "ABC" programs fail to address (Mohanty 1991: 38). Due to the multiple identities and realities of women in Indonesia, and the daily articulation of agency and resistance (Sciortino 1995), an "ABC" discourse that attempts to define what it means to be a normative woman is an "illusive and patronizing project" (Sears 1996: 24).

Organizations, such as those funded by the U.S. government, have little choice but to ignore these cultural sensitivities as well as concerns about the effectiveness of "ABC" programs when their funds are designated solely for abstinence promotion. Other programs that do promote condom use tend to forget to ask what kind of condoms would be most user-friendly. Throughout my interviews sex workers agreed on one thing: that the condoms used by NGOs in Jogjakarta were not as desirable as other brands. Sutra was, by far, the number one choice in condoms among sex workers. They told me that NGO issued condoms leaked lubricant outside of the package and often broke during use.

Having discussed all the reasons condoms aren't used by the majority of sex workers in Indonesia, I'd like to conclude this section with an example of an empowered sex worker who is able to negotiate condom use. Sex worker #1 is considered to be the most beautiful sex worker in Sosro, and this gives her considerable license with whom she chooses to have as guests as well as how much she is paid per transaction. Her story is interesting because although she has no biological children of her own, she adopts children from other sex workers. She, too, defines herself first and foremost as a mother:

> I'm not like my friends here. I don't bargain. I don't sleep with men older than me. I never have sex without a condom. I'm 25 years old; I have to think about my future… about my children's future. If a man doesn't want to use a condom, that's fine. He can go elsewhere. I don't need his money. There are others who will pay me the fee of 100,000 *rupiah* and wear a condom as I request. I do not waver for one moment. Those are the conditions. Take it or go be with one of my friends. It is of no concern to me. You come here because your wife is pregnant or on her period. You come here to have a good time. You come here because you are lonely. Why you come here doesn't matter; I don't care. I don't care what your story is. I only care about my children.
>
> I am not married. I will never get married. This is my choice. I am single, but I have 3 children. Well, two now that are with my parents, and one is on the way. She will be born any day now. All three are adopted. I adopt them from other sex workers here who can not raise them. I am a mother and father to my children. I provide for them financially and emotionally. I call them everyday. When people tell me my price is too high or that they don't want to wear a condom, I think only of my children… what price is their future? My children need me to be alive.
>
> I know people judge me. But it doesn't matter. Who is morally superior… a sex worker that takes care of our youth and adopts unwanted children or a family man that prays five times a day, goes to the mosque every Friday, and then lies to his wife so he can come here to me on Saturdays? I know people judge me… but only God has that right… God sees all… God knows I am a good mother… a good person.

4.9. SEX WORKERS' HIV/AIDS KNOWLEDGE LEVELS

As can be seen throughout this chapter, "safer-sex" choices are made or not made due to a variety of circumstances. Though sex workers who had attended programs answered more HIV/AIDS knowledge questions correctly than those who had not attended programs ($p < .01$), they are not significantly more likely to negotiate condom use (*see tables 11 and 12*).

Table 11. Percentage of correct answers to HIV/AIDS facts for program and non-program sex workers.

Question	**Sex Worker Non-Program %**	*Sex Worker Program %*
There is a possibility that HIV/AIDS can be spread through an immunization injection that is used on more than one person. *Terdapat kemungkinan virus HIV/AIDS tertular melalui jarum imunisasi yang digunakan secara bersama-sama.*	**66.3**	*85*
AIDS is an abbreviation for "Acquired Immune Deficiency Syndrome." *AIDS singkatan dari "Acquired Immune Deficiency Syndrome".*	**59.5**	*81*
There is not yet a cure for someone who has been infected with HIV/AIDS. *Belum ada pengobatan yang efektif untuk orang yang terkena HIV/AIDS.*	**75.9**	*76.7*
There is a possibility that HIV/AIDS can be spread through circumcision knife/tool that is used on more than one person. *Terdapat kemungkinan virus HIV/AIDS tertular melalui pisau/alat sunat yang digunakan secara bersama.*	**63.1**	*66.7*
A person can be infected with HIV/AIDS just from being near someone who is already infected. *Seseorang bisa terkena HIV/AIDS hanya dengan berdekatan dengan mereka yang sudah terinfeksi.*	**44**	*75.9*
HIV/AIDS can be transmitted through bodily contact such as: hugging or shaking hands. *HIV/AIDS bisa menular melalui kontak badan seperti: berpelukan, bersalaman.*	**42.9**	*75*
Drug users who share the same needle increase their risk for being infected with HIV/AIDS. *Para pecandu obat bius yang menggunakan jarum suntiknya secara bersama-sama dapat meningkatkan resiko merei tertular HIV/AIDS.*	**70.2**	*91.7*
Gradual weight loss is one early warning sign of AIDS. *Penurunan berat badan yang terus menerus merupakan salah satu gejala AIDS.*	**75**	*65*
A person can get HIV/AIDS from a blood transfusion. *Seorang bisa terkena HIV/AIDS melalui transfusi darah.*	**75**	*91.7*
Night sweats and chronic fatigue are some early warning signs of AIDS. *Berkeringat pada malam hari dan selalu merasa letih merupakan salah satu tanda gejala AIDS.*	**60.2**	*16.7*
There is a possibility that HIV/AIDS can be spread through a tattoo needle that is used on more than one person. *Terdapat kemungkinan virus HIV/AIDS tertular melalui jarum tatoo yang digunakan secara bersama.*	**68.7**	*86.7*
A pregnant woman infected with HIV/AIDS will definitely not transmit the virus to her baby. *Perempuan hamil yang terinfeksi HIV/AIDS pasti tidak akan menularkan virus ke bayinya.*	**43.4**	*50*
The HIV/AIDS virus can be transmitted through breast milk. *Virus HIV/AIDS bisa menular melalui air susu ibu.*	**55.4**	*73.3*
HIV/AIDS can be spread through sneezing and coughing. *HIV/AIDS dapat ditularkan melalui bersin dan batuk.*	**43.3**	*73.3*
HIV/AIDS can be spread through public toilets. *HIV/AIDS dapat ditularkan melalui WC umum.*	**44.6**	*75*
HIV/AIDS can be spread through mosquito bites. *HIV/AIDS dapat ditularkan melalui gigitan nyamuk.*	**22.9**	*67.2*
HIV/AIDS virus attacks and disturbs the functioning of the body's immune system. *Virus HIV/AIDS menyerang dan mengganggu fungsi sistem kekebalan tubuh.*	**67.1**	*93.1*
A person infected with HIV/AIDS can infect another person through sexual intercourse. *Seseorang yang terinfeksi virus HIV/AIDS bisa menularkan pada orang lain melalui hubungan seks.*	**84.3**	*93.3*
HIV/AIDS can be spread by using an AIDS- infected person's belongings such as a clothes or a towel. *HIV/AIDS bisa ditularkan melalui barang-barang miliki orang yang terinfeksi, seperti baju atau handuk.*	**37.3**	*73.3*
A baby that is born to a mother that has HIV/AIDS will definitely be infected with the virus. *Bayi yang lahir dari ibu yang terinfeksi HIV/AIDS pasti akan tertular virus tersebut.*	**2.4**	*20*
People with HIV will eventually develop AIDS. *Orang yang mempunyai virus HIV akhirnya menjadi AIDS.*	**69.9**	*90*
Total %	**55.8**	72.4

Table 12. HIV/AIDS Knowedge Levels in Program and Non-Program Sex Workers

```
2x2 CHI-SQUARE
     Program    Non-Program
   Sex Workers  Sex Workers
    _____________________
   |           |           |
   |  956      |  1031     |correct
   |           |           |responses
   |-----------|-----------|
   |           |           |incorrect
   |  364      |  817      |responses
   |___________|___________|

 df    = 1
 Chi^2 = 91.12071
    p <= 0.00000
```

Bivariate analysis for the differences of HIV/AIDS knowledge levels between program and non-program sex workers

Also, much like the *waria*, sex workers who have attended programs are not significantly different from their non-program counterparts with regards to their answers about opinions on myths and biases about HIV. Some questions even show a reverse trend. This can be seen with the earlier question that stated “only homosexuals can get HIV/AIDS.”

In conclusion, this discussion illustrates how increased HIV knowledge levels does not directly lead to behavior change. “[W]omen’s risk for HIV infection are not limited solely to physiological conditions, like the amount of HIV concentrated in seminal fluid or the vulnerability of vaginal mucosa, although those factors are very real, nor are they best addressed by forms of education and prevention that direct themselves to individuals without regard for the relations of power that underscore their lives” (Goldstein 1997: 5). One must take into consideration the daily realities of women before appropriate and effective HIV/AIDS education programs can be created. This includes looking more in-depth at world systems from a critical medical anthropology perspective. Understanding the myriad of influences on women in

Indonesia will allow for more culturally sensitive HIV/AIDS programming throughout the archipelago.

CHAPTER 5. UNIVERSITY STUDENTS: SIMULTANEOUSLY EXALTED AND IGNORED

The purpose of this chapter is to examine the place of university students and their relevance to HIV/AIDS education programs by exploring knowledge levels and cultural perceptions of HIV/AIDS from their perspective. I discuss the importance of this population, not only as a population with many "high-risk" behaviors and no HIV education programs available to them, but also as the future policy makers of tomorrow. This chapter explores university students' definitions and perceptions of what constitutes sexual intercourse, virginity, monogamy, "free" (American style) sex, and HIV transmission. Understanding these definitions is crucial when implementing HIV education programs. This chapter concludes with a narrative of a university student and his experience finding out he is HIV positive. His story illustrates the importance of HIV education programs aimed at university students, specifically, and the general public at large.

5.1. PRELIMINARY INVESTIGATIONS AND REASONS FOR CHOOSING UNIVERSITY STUDENTS

During my preliminary investigations in the summer of 2000, I attended the Second National Indonesian AIDS Conference in Jakarta. What impressed me at the time was the amount of

available information and the strong infrastructure that existed in NGOs and intergovernmental agencies (including UNAIDS) working on AIDS issues. However, upon returning to Jogjakarta and interviewing a sample of 20 university students, it became clear that none of the students I talked with had ever heard of the programs offered by these organizations, nor could they correctly identify simple "risk" behaviors for HIV.

Other studies support these initial findings. Kyles and Tumbleka's work (1994) shows that many university students believed that AIDS could be transmitted from touching alone. None of the university students I interviewed at the time (2000), including those who stated they were currently sexually active, had ever seen a condom before. This was true even though condoms are available in the local pharmacies, supermarkets, and clinics. This illustrated that either information and prevention strategies were simply not accessible to the general public, or culturally specific ideas and notions about who is and is not at risk for HIV/AIDS were preventing these young Indonesians from engaging with the available information.

When I returned to do my fieldwork, I decided to study university students' knowledge of HIV/AIDS for a multitude of reasons. First, I had easy access to university students since I was taking classes at the oldest university in Indonesia, the University of Gadjah Mada. I found myself spending time with university students all day at school and also at night when I volunteered at the local NGOs, which were staffed with volunteers from local universities. Overwhelmingly, it was university students who were handing out information and conducting HIV/AIDS education programs in these NGOs; I found it odd then, that this particular population had no HIV/AIDS education and prevention programs available to them. I also chose to study university students because this population is important as the future policy makers of Indonesia. Deciphering what they understand about HIV is crucial if the Indonesian government is going to

get more involved in HIV prevention and education. Lastly, as I engaged in "participant observation" with university students — both during my preliminary fieldwork and later during the two years I conducted my dissertation fieldwork — I witnessed and heard about numerous "high-risk" activities prevalent in this population which were not being addressed by the HIV programs in Jogjakarta.

5.2. WHAT IS SEX?

I initially conducted 209 quantitative surveys with the university students about HIV knowledge levels, background information, and sexual practices. I was astonished to find out that less than 10% of the university students surveyed had ever had sex. This confused me since after having spent time with many students and hearing them talk about their sex lives, I knew that more than 10% of them were sexually active. This discrepancy, between what the surveys were showing and what my student friends told me, made me adjust my interviews to address the possible reasons for this seeming contradiction.

During my interviews I realized one of the possible reasons for this apparent discrepancy between what was reported on the surveys and what I had seen in real life. As discussed before, Indonesian culture dictates that you tell someone what they want to hear. Out of respect, many of the university students told me on the survey that they were not sexually active. They thought that was what I wanted to hear. During the interviews, however, a different reality appeared. I interviewed 20 university students: 10 males and 10 females, representing 5 different universities and 4 different Indonesian islands.

Out of the 20 students I interviewed, 7 admitted to having had sex. Others (5 out of 20), professed to having conducted activities that I would have labeled sexual. This discrepancy, between what is and is not sex, could also explain why a low number of university students reported being sexually active; they don't define what they are doing as sex.

During these interviews, I discussed with the university students what constituted engaging in sexual intercourse versus being a virgin. Most of the students agreed with student #2: "Sex is when a penis enters a vagina." The more questions I asked the more I understood that sexual intercourse was considered to take place ONLY in the situation of a penis entering a vagina. As student #8 told me (and many others seem to agree): "Putting a penis anywhere other than in a woman's vagina is not sex." Or as university student #11 put it: "I think sex is when a man and a woman's genitals are united."

Each student seemed to mimic the notion that sex was strictly when a penis entered the vagina. Petting, oral sex and anal sex were not considered sexual intercourse. Students who had engaged in these activities did not identify as having lost their virginity. University student #18 told me: "I've never done drugs, never had sex, never even had a girlfriend. My studies are important to me. Frankly, I think it's best to wait until after marriage to have sex. But I don't think petting is considered sex. Sex is when the penis goes into the vagina…. That's it." University student #8 furthered this notion: "Petting, oral sex, anal sex… that doesn't take away your virginity… because there's no object inserted into the vagina."

If petting is not sex, then what does "petting" refer to? Definitions I encountered included: "Petting is just like sex without penetration, right?" (student #13); Petting is rubbing our genitals together. It can be with or without clothes (student #15); "petting is petting… it's not sex… its' just rubbing genitals together… you can do anything as long as the penis does not go

into the vagina, then it's still petting" (student #19); "Petting is when you touch all over naked or not but you don't put your penis inside her vagina" (student #9); and "petting is when a man and a woman's genitals have contact without underwear" (student #12). University student #2 discussed her college and high school friends' activities including sex and petting:

> A lot of my friends bring their boyfriends here (to the women only boarding house). They have sex all the time. We warn them if the house mother is coming. I know we're not supposed to, but its okay if no one knows. We even used to "play" in high school… petting… it started out as only above the navel but then it was all over… me and my friends were the same… there were 10 of them… they were all Muslim and wore veils… but they still played with boys… I was shocked… they had sex before me.

In discussing what constituted sex, the concept of virginity arose. Thus I proceeded to ask the students to define this as well. When asked about virginity, almost all of the students interviewed (18 out of 20) said that you either loose your virginity when a penis enters the vagina, or when your hymen breaks (for girls). Many students mirrored this opinion. For instance, university student #13 told me: "A virgin is when you still have your hymen… so if your hymen is torn, even from sports or falling, you're no longer a virgin." When asked for clarification, I was told again that you do not lose your virginity simply from petting, oral sex or anal sex. As university student #3 said: "I have a friend who likes to do all sorts of things, petting, oral, whatever… but since her hymen is intact… she's a virgin." University student #4 explained: "You're a virgin until you don't bleed when you have sex. If you've had sex four times but still bleed, then you're still a virgin. I know it's confusing, but it's true!" Student #18 had a different look at virginity/sex. She said sex only occurred between consenting adults. She claimed: "If you are raped or did not consent to the sex then you are still a virgin." But university student #9 stated bluntly: "If a girl puts anything in her she's not a virgin anymore… even if she masturbates… she's not a virgin anymore."

Virginity is considered an important concept in Indonesia today. This tendency is even clear from discussions in local newspapers. According to Champagne et al (2003), a *Kompas* article was quoted as saying that there's a tendency to consider non-virginity as a stigma, specifically that "non-virgins are *jelek*, bad, like trash;" and *The Jakarta Post* reported that an intact hymen is still a prerequisite for entering the military academy or the School of Public Administration. Many of the men interviewed said they wanted to marry a virgin even if they, themselves were not virgins. This patriarchal double-standard could very well be part of the reason that the definition of "virginity" does not include petting, oral sex or anal sex. It also conforms to notions set forth in the Koran and the Bible, keeping girls pure and "honorable."

Many of the students had opinions about virginity. University student #9 said, "A lot of men look for it…they want to have sex with virgins… and once she's not a virgin, she's cast aside!" He also said that, "You can tell if a girl is a virgin by her appearance." University student #1 mentioned that, "Virginity is clear for women but no such measure for men exists." This was echoed by university student #13: "It seems like 90% of guys are not virgins anymore… but who can tell… it's not fair."

Having a definition of sex that does not include petting, anal sex, or oral sex may allow a person to think of themselves as more marriageable or even morally superior; but, it also creates a culture of high risk activities. Students that don't identify these behaviors as sex are not likely to use condoms while engaging in them. This could be dire. For instance, engaging in anal sex to protect your virginity, and yet doing so without wearing a condom (since it's not considered sex), could have dire consequences.

During these interviews I was also told that the Bible and Koran both say that sex is between a man and a woman. Thus, sex with a *waria* doesn't count as sex (for a more complete

discussion of this see chapter 3). Many university students repeated this notion, like university student #13: “Sex is between a man and a woman.” Thus sex with a *waria* would not be considered sex. I was also told that Bible and Koran say that sex is between a man and his wife. University student #17 described an idea heard from his peers: “I think sex is between a husband and wife…. I’m a Muslim and I think that’s what the Qur’an says.” Thus, sex out of wedlock would not be considered sex. One university student (#6) even went so far as to say that sex without love is not considered sex: “I’ve had sex with four girlfriends… but I’ve played with sex workers, too… but that doesn’t really count since I didn’t love them.”

As can be seen by this discussion, the definition of sexual intercourse is highly variable. This is true in America as well as in Indonesia and elsewhere. In America, students that have taken an abstinence pledge are more likely to engage in anal sex and oral sex in order to preserve their virginity (Santelli et al. 2006). HIV education and prevention programs need to take this variability into account. Unfortunately, a majority of the HIV education and prevention programs that I have seen in Indonesia simply teach that sex leads to AIDS. They do not engage the definitions of sex, and they typically do not talk about the mechanics of how HIV/AIDS is transmitted (which will be discussed later).

5.3. “FREE SEX” VS. MONOGAMY

In Jogjakarta, advertisements, banners, and murals state boldly that: “Free sex = AIDS.” University student #13 agreed with this notion, stating, “I’m safe from AIDS because I don’t live that ‘free sex’ lifestyle.” And university student #20 said: “Some people say AIDS is from exchanging needles… but I don’t believe that… I’ve only read that it’s from ‘free sex.’ I’m not

sure what 'free sex' is… maybe like secret sex like that in Sosro." Figure 30 depicts an example of this pervasive message: "Beware: Free Sex = AIDS: Death." Equally important in this image is the heterosexual symbol depicted in the middle of the photograph. This is because, as discussed earlier, to Indonesians AIDS is a heterosexual disease. If "free sex" leads to AIDS and then presumably "death," what is "free sex?"

Figure 30. Photo of the message: "Fress Sex=AIDS."
This pervasive message is found all over Jogjakarta, translated here:"Beware: Free Sex=AIDS: Death." Notice, also, the heterosexual symbol depicted in the middle of the photo. This is because to Indonesians, AIDS is a heterosexual disease.

Most of my friends explained to me, rather sheepishly, that "free sex" is what Americans do. Most Indonesian ideas about American sexuality come freely from such sources as popular outdated television shows, like *Bay Watch* and *Dallas*, or from romantic comedies, like *Pretty Woman*. University student #14 told me that: "Foreigners wear vulgar clothes so I know they

engage in ‘free sex.’” University student #12 echoed that saying: “I’ve never been abroad… but from what I’ve seen in Western movies here, I can’t imagine how you can live like that, with all that ‘free sex!’ If we adopt Western culture 100% we will ruin ourselves.” Many Indonesians asked me, in one form or another, if it is true that Americans just walk into a room and have sex with whoever is there. University student #14 confides: “I don’t know where AIDS is from… but I do know that foreigners like to have ‘free sex’ so they probably have AIDS and they carried it to Indonesia. Especially in Bali… that’s where we have AIDS, and that’s where we have tourists.”

Thus, “free sex” is non-monogamous sex, usually in a casual context. It is often equated with “American sex,” but some people actually admit that Indonesians do it, too. University student #10 said: “Although free sex is not acceptable in Indonesia, nowadays a lot of people do it. The more sex is hid, the greater people want to know about it. That’s why Indonesia needs to add sex education into the curriculum.” University student #8 told me that: “90% of Indonesians have ‘free sex.’” University student #14 excused this behavior for men: “Men are like that… they have desire… free sex is okay for them… because a good man is hard to find.”

In reaction to these assumptions, I attempted to clarify what constituted “free sex” with the university students and how, exactly, “free sex” leads to HIV. To do this, during my interviews I drew a picture of four stick people and a circle around them (*see below*).

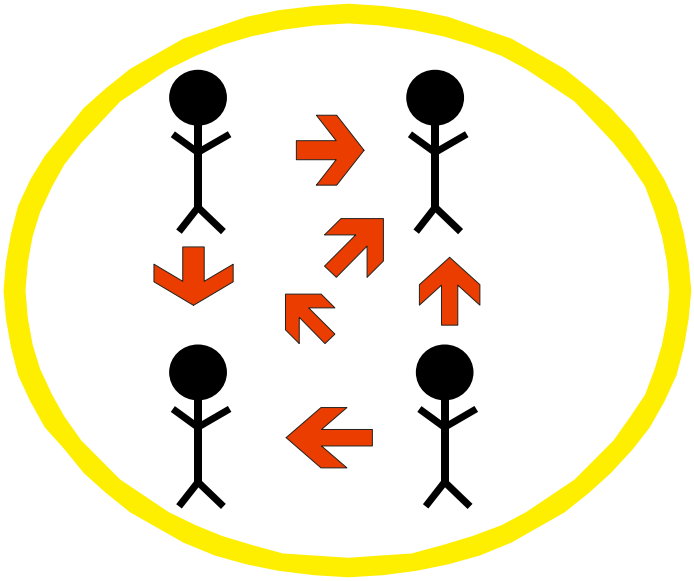

Figure 31. Picture to illustrate an interview question about "free sex" for university students. This picture was drawn for the all of the University Students interviewed. The question was asked "If these 4 people have tested their blood and all of them are 'clean' and do not have HIV/AIDS, but they chose to have 'free sex' with each other (but only each other, never outside the circle), will they get HIV/AIDS?"

I explained to the university students that all four of these people had their blood tested, and that they had tested negative for HIV; they have "clean" blood (as the students referred to it). I explained that while they are all currently HIV negative, they are engaging in "free sex." I stipulated, however, that these four people (non-gender specific pronouns made it easy to keep the people gender free), have "free sex" only within this circle (only with each other) and never outside of this circle (never with anybody else). I asked the 20 university students (as well as 5 of my professors) if any of these people will get HIV/AIDS. 100% of the students and professors I asked said: "YES, they will get HIV/AIDS." When I asked: "How?" Most of the replies dealt with free sex, God/Allah, and/or a complete lack of understanding of transmission routes.

University student #9 told me that even though no one in the circle had HIV/AIDS to begin with, and no one had sex outside of the circle, they still had a chance of contracting HIV:

"In that circle, it's 50/50 whether they'll get it or not… if they use a condom they're ok… but if not they will get it." University student #14 said: "AIDS is from free sex… so in that circle they're having 'free sex' so they will get AIDS." University student #13 similarly added: "For the people in the circle doing 'free sex' there's always a possibility they'll get AIDS, right?" University student #19 told me they would get HIV, but that it was time-dependent: "In that circle… HIV will appear if you wait long enough." According to university student #7, HIV would appear from "anal dirt": "These four people wouldn't get AIDS from normal sex if their blood is clean… but if they have anal sex, they'll get it… from the dirt in their butts." While university student #3 admitted to not knowing how HIV was transmitted, she still confidently stated: "I don't know how medically… but I firmly believe those people in that circle will get AIDS."

Many students discussed "free sex" in their answers, saying: "Because they are having 'free sex,' so they will get AIDS." This was also the case for university student #6's response: "All four people are clean, right… but then they have 'free sex' with each other, so the disease can appear from that. There's still a chance they will get AIDS even if they tested their blood." Others clarified how "free sex" led to AIDS by saying: "Allah/God will be mad at them for having 'free sex' and will give them AIDS." University student #1 said in his answer: "As for the 4 people in the circle…they are having 'free sex'… they will get AIDS… it is the will of Allah." University student #15 similarly evoked God in her answer: "There's no virus in that circle… but who knows if God will give it to them… only God knows."

AIDS was seen by these students as a scourge from Allah/God. They believed that you would be "punished" for having non-monogamous sex. This brings us to our next question: What

is non-monogamous sex? It is a message that, much like "Free Sex = AIDS," is pervasive all over Jogjakarta (*figure below*).

Figure 32. Photo of the message: "Love and be faithful to your partner." This is another HIV/AIDS message found all over Jogja.

In English this sentiment translates to: "Love and be faithful to your partner." *Saling setia* or "being faithful" was another concept that I wanted to clarify with the students. To do so, I drew another picture for the students (*see below*).

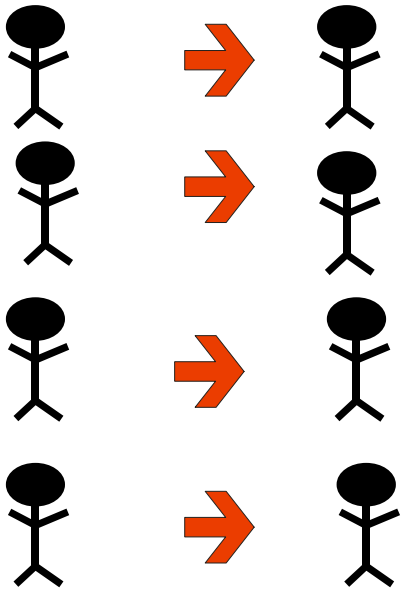

Figure 33. Picture to illustrate an interview question about "monogamy" for university students. This picture was drawn for the all of the university students interviewed. It was explained that this is the same student with different partners (one year after the other). And the question was asked "Could they get HIV/AIDS?"

I drew a stick figure and an arrow to another stick figure. I explained that this was a university student and the arrow to the other stick figure represented that this person was dating another university student (again non-gender specific). I explained that these students were dating for a couple of years and were planning on getting married. They ended up having sex premaritally. I went on to explain that for one reason or another they ended up breaking up. I then drew the picture again and I said that this is the same university student with a new girlfriend/boyfriend (*pacar*). I explain that, again, they are very serious and plan to get married, and again this university student and his/her partner have sex, and again, for whatever reason, they break-up. I draw this 4 times, each time explaining that it is the same university student with a new girlfriend/boyfriend. I asked the students: "Will this student get HIV/AIDS?" 100% of the students I interviewed said: "NO!" Some clarified by explaining that the student depicted in the picture is being monogamous within the context of the relationship. Because of this there is no

reason for Allah/God to get mad at him/her. As university student #1 told me: "Allah is not mean. He will not punish you if he has no reason."

In this way, many of the students felt that serial monogamy (even premarital) would not illicit a reaction from God/Allah, and thus was acceptable. Out of the students I interviewed, 7 admitted to having already had sexual intercourse. None of the students were married, and although most of them stated that pre-marital sex was "wrong," it seemed that this did not apply to them. When pressed, one student told me: "Ya, it's better to wait until you're married… but that's for girls. Guys can't wait. They can't control their *nafsu* (desire)." Many of the sexually active male students admitted to not being able to control their *nafsu* as early as high school: "I first had sex in high school… I was in senior high. Now I've had sex with… I don't know… five girls, I think" (student #10); "My 1st year of high school I had a girlfriend… she was already not a virgin… she showed me what to do. In high school I had sex with 4 or 5 girls" (student #9); "The first time I had sex was the 1st year of high school… there are many bad girls in my neighborhood" (student #6); "I first had sex when I was 14. Now I've probably had sex with 10 girls" (student #3).

Not being able to control one's *nafsu* was a concept we visited in Chapter 4, and it is revisited here. Again, it is applied to men but not women. Not being able to control *nafsu* was discussed by the students, as well, as one reason for visiting sex workers. For instance, university student #9 described: "I've cheated a few times… but nothing serious… it wasn't like it was for love… it was with a sex worker…just to get rid of *nafsu.*" University student #11 defended men's actions, saying in her opinion: "Men have a right to go prostitutes. They need it." Similarly, university student #12 told me: "Men can't help that they need prostitution. Just like people can't help that they need drugs. They wouldn't use prostitutes if they didn't have to."

Interestingly, university student #15 told me: “If when I’m married my husband goes to a sex worker, then I’d talk to him. I mean if God can forgive that why can’t I?” And university student #13 said: “If my husband went to a prostitute, I wouldn’t divorce him. But I’d want to know if it’s because of me. Did I do something wrong?”

Many of the students told me about “friends” of theirs who engage in “free sex,” and who regularly go to brothel areas. One student told me, “95% of my friends have ‘free sex’ all the time. They go to the brothel areas together, to hang out and get drunk and high, then they do it.” Other students confirmed this, saying that they’ve heard of friends of theirs who go to visit brothel areas together. University student #7 explained: “I first had sex in high school. It was with a sex worker. I was curious. I didn’t do it often. I never wore a condom. A bunch of us went to the brothel… none of us had condoms. They said sometimes it’s on a dare, and sometimes it’s just to get over losing their virginity. A couple of students told me that that’s where they learned how to ‘do it.’” One student asked earnestly: “Where else are we going to learn?” University student #6’s experiences with sex workers came out nonchalantly when we were discussing the first time he had ever worn a condom: “I first wore a condom in junior high… not with my girlfriend… but with a sex worker because I was curious.”

Another concept often discussed in regards to students and sex work was the concept of student sex workers, referred to as *ayam kampus* (campus chickens) (*For a discussion of this concept and term, see* Wijayanto 2003). University student #20 brought the subject up saying: “You know, there are students who do prostitution, too.” University student #1 told me: “*Ayam kampus*?? Some are sex maniac, some just want more money… They’re materialistic.” University student #2 similarly admitted: “I knew a girl who was a university student prostitute. She said she just did it with older guys because they bought her things.” And university student

#9 reiterated: "A lot of men like to pay college students for sex. College students like the extra cash. I have a friend who is an *ayam kampus*… men get addicted to her."

In other interviews, students discussed disease as it relates to sex workers. University student #6 explained: "With sex workers I'm afraid of disease… with my girls I'm afraid they'll get pregnant… so I pull out." University student #10 said: "I've visited the brothel area before…. I go when I want to have sex and not have to deal with my girlfriend. I don't really think about diseases… I'm healthy, that's all that matters, right?" He went on to explain: "I can be in love and still have sex with someone else… I mean sex is not love… So, I can have sex with someone else and still love my girlfriend." University student #9 mentioned that: "In high school, I had a friend with syphilis… he got it from sex workers…he never used condoms… he used to scream when he peed." Another university student told me about his "friend" who went to visit a *waria*: "He went there because he said being with a *waria* would heal his penis. Is that true? Does it work like that? Is that sex? I mean it was just a *waria*. No vagina, right?" His questions illustrate the lack of truthful sexual education available to these students, as well as cultural perceptions illustrating that sex with a third gender is not considered to be "sex."

5.4. IF ONLY "FREE SEX" EQUALS AIDS, THEN SHOOTING UP IS OKAY!

Drugs seem to be a regular past time for many of the students in Jogjakarta. In interviews drug use often came up in conversation as something friends engage in: "One of my best friends is an addict… but just cocaine and heroine" (student #19); "I have a lot of friends who have tried intravenous drugs" (student #11); "My brother shoots up… I don't know what kind of drugs though. And I know two people at school who are addicted to intravenous drugs… I try to give

them advice… but they're addicted, what can they do?" (student #16); "A friend of mine was a drug dealer in high school… he sold heroine and cocaine" (student #2); "I had a friend in high school who got addicted to drugs and his hands were all full of slash marks… I asked him why… he told me when he ran out of drugs he slashed his hands and drank his blood to get another high" (student #15); "I had some friends who did a lot of drugs… cocaine, heroine… needles and stuff… I tried it once but I didn't like it" (student #5).

Like student #5, other students talked about their own experiences with drugs: "I smoke marijuana, and I've tried pills;" (student #9); "I've tried all sorts of drugs… but mostly now just marijuana and crystal meth." (student #10); "In Islam, there's a hadith about if you have friends who like to play in fire, you have to be prepared to get into the fire, too. I experienced that. I had friends that were into drugs and then I got into it because of them. We did all kinds of drugs, mostly with needles" (student #17); "I've tried cocaine and marijuana… but that was a long time ago. A lot of my friends use drugs… they all share needles… you have to" (student #4); "I started using drugs in elementary school… I was addicted by high school… now I try not to do them very often… plus it's so expensive… I can't usually afford it" (student #6); "In senior high I used to do a lot of cocaine… I preferred to use a needle… no the powder. I still use it sometimes. I used to use with my friends… because it's not cheap and needles are hard to come by. When I used drugs I had a lot of sex… the drugs made my *nafsu* hot" (student #3).

One student even discussed going to prison for drugs. University student #7 explained:

> I went to prison a few years ago because of opium… I was caught. I used to inject with friends… we would pass the needle around and feel the rush. One of my friends was a cop's spy… he said he wanted to buy some… and I thought I could make a big profit if I sold it… but then he turned me in. I got out eventually because I promised never to use it again… but I have. We used to use in prison…. The guards would bring it to us. It's easier to get needles in prison than on the outside!

Interestingly, all of the students who discussed drug use never saw it as problematic from an HIV/AIDS perspective. Another student told me that he and his friends get their needles from the hospital rubbish sites. He explained how it is easy since all of the trash (syringes, scalpels, bed pans, waste, etc.) are thrown out in the same place. Supposedly, the hospital discards are often just dumped into the river, so you have to go through it before it drifts away. He says he's not worried about catching HIV from hospital needles since he's not having "free sex." Similarly, university student #11 told me that there is no link between AIDS and drugs: "I volunteer at an anti-drug NGO, but we never talk about AIDS… why would we?"

While living in Jogjakarta, I talked to many people about their drug habits. A lot of university students told me about their recreational use of heroine and cocaine. One student told me in detail how to find needles. He told me that since needles are in such short supply (even for hospitals) many of the cafés/clubs have a hiding place where you can find them. Polite drug culture dictates that you "borrow" it and then put it back where you found it. He told me about that in some cafés the needle hiding place is in the bathroom, where in other cafés it's located outside in an alley. He told me about a café near Malioboro Street, a busy street near the center of the city, where one leaves the back door and enters a small alley. There you find a brick wall with a loose brick. Behind the brick is a needle. According to my informant, everyone who "uses" knows where to find needles around the city when they need them.

Related to this, during a conversation about drugs with a friend of mine who had gone to rehabilitation for drug use, he confided in me that he gotten HIV from sharing needles. He said people think he's stopped using drugs, but he hasn't. He also said that he TRIES not to share needles, but admits it's hard to find your own. He also admitted that when you're high you really

don't think about HIV and risky behaviors. He told me that when he "needs to get high" nothing else matters and all his HIV knowledge seems unimportant. Interestingly, he's a national HIV spokesperson, with a lot of training and information. He decided that if I was going to write about people using drugs in Indonesia, then I should at least know what I was talking about. So he decided to "shoot up" in front of me.

Unlike America, where drug users often "cook" their drugs into liquid form (often with a spoon and lighter), in Indonesia people tended to simply mix their drugs (including raw opium and cocaine) with water. From what I'm told, this makes it much harsher on your system and harder for your blood to absorb; thus, you want to get more of it into your bloodstream. This is done by "pumping." "Pumping" is where you suck your blood back into the syringe and then push it out again into your veins. This is done in order to get all of the drug out of the syringe. It is done in America as well, but from what I understand, to a much lesser degree. The person I watched in Indonesia "pumped" over 20 times, pulling his blood into the syringe and pushing it back into his blood stream, over a 20 minute period. During this time, while walking around with a needle sticking out of his arm, he simultaneously smoked cigarettes and made instant noodles. "Pumping" is not only very dangerous for your heart, it also increases the risk involved in sharing needles. More blood product is likely to be transferred through a syringe that has been pumped, than a syringe that was just used for one straight injection.

I asked my friend about cleaning the needle and syringe after use. He told me that sometimes, if there's water around, he'll circulate water through it. He believes nothing kills a high faster than having to go to the well to get water to clean your needle. Again, he adds: "you don't really think about those things when you're getting high."

For almost the entire two years I was in Indonesia, I never saw an HIV education program that discussed the risk of intravenous drug use. Right before I left, a number of AIDS cases were detected in the local prison. It was found out that drugs were more available in prison then outside of it, but that needles were scarce. The inmates were said to be passing around one or two needles to support all their drug habits. Because of this new information, a task force was set up to go and do HIV/AIDS education in the prison. I sat in on a couple of task force, and for the first time I heard a discussion about drugs and HIV and prevention in Indonesia.

5.5. SEXUAL EDUCATION

Many of the university students I interviewed came from what they described as "conservative" or "traditional" families. They talked about having difficulties speaking to their parents about anything related to sexual education. University student #18 said: "My parents would never talk to me about such matters as sex. They're rice farmers… it's not their thing. I learned about sex from reading books as a kid. My parents have never discussed the matter." University student #2 similarly said: "My parents are strict Javanese… women are still prohibited from doing many things. Like in the old tradition. So we would never talk about such things." She went on to say: "I've had 7 boyfriends since I started dating in Junior high…. But my parents don't know about any of them."

Many of the students told me that all of the information they know about sexual intercourse they came across from gossiping with their friends or from TV and magazines. All of the students I talked to told me they had seen "blue films" (pornographic films). University student #8 told me that he's watched too much porn: "I've gotten terribly bored with porn… but

I still use it to masturbate." Many of the students told me that this is where they get their information about sex. University student #8: "My parents caught me watching a blue film in Junior High…I thought they would be mad… but they just ignored the incident… I think they thought I could use the education about sex."

Sexual education in the formal sense in Indonesia was often non-existent. University student #10 confirmed: "There's no sexual education in Indonesia… its horrible." And university student #18 admitted: "I think it would be good to have sex education in the school curriculum… I don't need it… but I know people who do." Some students told me that in high school there was one lecture about sexual education. However, they said that only some students were chosen to attend. University student #2 told me: "We had sexual education once in school… but just for an hour and just for a few people from each class. They were supposed to be representatives of the school." She went on to explain that when the taboo subject was discussed, both in the one lecture, and afterwards among gossiping children, it was met with giggles and whistles. No one, according to the students, learned anything. University student #8 said that he didn't understand how they could teach family planning (which is part of the school curriculum starting in elementary school) and not talk about sexual education: "I don't get it… I mean these 'moral' education programs seem to teach us to have 'free sex.' We can't discuss AIDS or condoms… but you can teach about family planning and the calendar method or whatever. That's what is teaching people to have 'free sex.'" He went on to say that even at the university level, sexual education was non-existent: "From the university there's no information, programs or references about sexual diseases. How are we supposed to know about these things?"

The students I interviewed admitted to getting most of their information about sex and HIV/AIDS from gossip, friends, porn, movies, and foreign magazines. University student #2 told

me that she relied on these methods to learn how to use a condom: “I learned how to use a condom from a foreign magazine. We never have any information like that around here.” These sources seemed insufficient, as many of the students often questioned me during the interview about facts they didn’t know about HIV: “Can you get HIV from mosquitoes?;” “Can you get AIDS from touching?;” “Do I have to worry about AIDS if I stay in school?;” etc. On the surveys, however, they were able to guess fairly well. Overall, HIV/AIDS knowledge was 71.8% correct (*see table 13*) — not bad for a population denied formal HIV education.

Table 13. Percentage of correct answers to HIV/AIDS facts for university students

Question	*University Students % Correct*
There is a possibility that HIV/AIDS can be spread through an immunization injection that is used on more than one person. *Terdapat kemungkinan virus HIV/AIDS tertular melalui jarum imunisasi yang digunakan secara bersama-sama.*	*98*
AIDS is an abbreviation for "Acquired Immune Deficiency Syndrome." *AIDS singkatan dari "Acquired Immune Deficiency Syndrome".*	*89.6*
There is not yet a cure for someone who has been infected with HIV/AIDS. *Belum ada pengobatan yang efektif untuk orang yang terkena HIV/AIDS.*	*84.2*
There is a possibility that HIV/AIDS can be spread through circumcision knife/tool that is used on more than one person. *Terdapat kemungkinan virus HIV/AIDS tertular melalui pisau/alat sunat yang digunakan secara bersama.*	*77.6*
A person can be infected with HIV/AIDS just from being near someone who is already infected. *Seseorang bisa terkena HIV/AIDS hanya dengan berdekatan dengan mereka yang sudah terinfeksi.*	*89.4*
HIV/AIDS can be transmitted through bodily contact such as: hugging or shaking hands. *HIV/AIDS bisa menular melalui kontak badan seperti: berpelukan, bersalaman.*	*90.4*
Drug users who share the same needle increase their risk for being infected with HIV/AIDS. *Para pecandu obat bius yang menggunakan jarum suntiknya secara bersama-sama dapat meningkatkan resiko mereka tertula* *HIV/AIDS.*	*98.1*
Gradual weight loss is one early warning sign of AIDS. *Penurunan berat badan yang terus menerus merupakan salah satu gejala AIDS.*	*56.3*
A person can get HIV/AIDS from a blood transfusion. *Seorang bisa terkena HIV/AIDS melalui transfusi darah.*	*97.6*
Night sweats and chronic fatigue are some early warning signs of AIDS. *Berkeringat pada malam hari dan selalu merasa letih merupakan salah satu tanda gejala AIDS.*	*15.6*
There is a possibility that HIV/AIDS can be spread through a tattoo needle that is used on more than one person. *Terdapat kemungkinan virus HIV/AIDS tertular melalui jarum tatoo yang digunakan secara bersama.*	*93.1*
A pregnant woman infected with HIV/AIDS will definitely not transmit the virus to her baby. *Perempuan hamil yang terinfeksi HIV/AIDS pasti tidak akan menularkan virus ke bayinya.*	*78.7*
The HIV/AIDS virus can be transmitted through breast milk. *Virus HIV/AIDS bisa menular melalui air susu ibu.*	*44.2*
HIV/AIDS can be spread through sneezing and coughing. *HIV/AIDS dapat ditularkan melalui bersin dan batuk.*	*53.9*
HIV/AIDS can be spread through public toilets. *HIV/AIDS dapat ditularkan melalui WC umum.*	*56.9*
HIV/AIDS can be spread through mosquito bites. *HIV/AIDS dapat ditularkan melalui gigitan nyamuk.*	*37.6*
HIV/AIDS virus attacks and disturbs the functioning of the body's immune system. *Virus HIV/AIDS menyerang dan mengganggu fungsi sistem kekebalan tubuh.*	*98.5*
A person infected with HIV/AIDS can infect another person through sexual intercourse. *Seseorang yang terinfeksi virus HIV/AIDS bisa menularkan pada orang lain melalui hubungan seks.*	*99*
HIV/AIDS can be spread by using an AIDS- infected person's belongings such as a clothes or a towel. *HIV/AIDS bisa ditularkan melalui barang-barang miliki orang yang terinfeksi, seperti baju atau handuk.*	*61.1*
A baby that is born to a mother that has HIV/AIDS will definitely be infected with the virus. *Bayi yang lahir dari ibu yang terinfeksi HIV/AIDS pasti akan tertular virus tersebut.*	*6.8*
People with HIV will eventually develop AIDS. *Orang yang mempunyai virus HIV akhirnya menjadi AIDS.*	*82*
Total %	71.8

As we have seen in other chapters, knowledge level does not equate to behavior. Figure 34 illustrates that 77.7% of all university students who have engaged in sexual intercourse "never or almost never" use condoms. Less than 23% of sexually active university students are sometimes using condoms, and this does not include the students who do not define their sexual activities as sex. No students (0%) reported always using condoms. One student even told me that though he is not gay, he engages in homosexual sex (without a condom) in order to avoid getting HIV. This is because a) homosexual sex is not sex, so no need for a condom; and b) AIDS is a heterosexual disease. The disjuncture between what is sex and what is not, and what transmits HIV and what does not, needs to be addressed in future education programs.

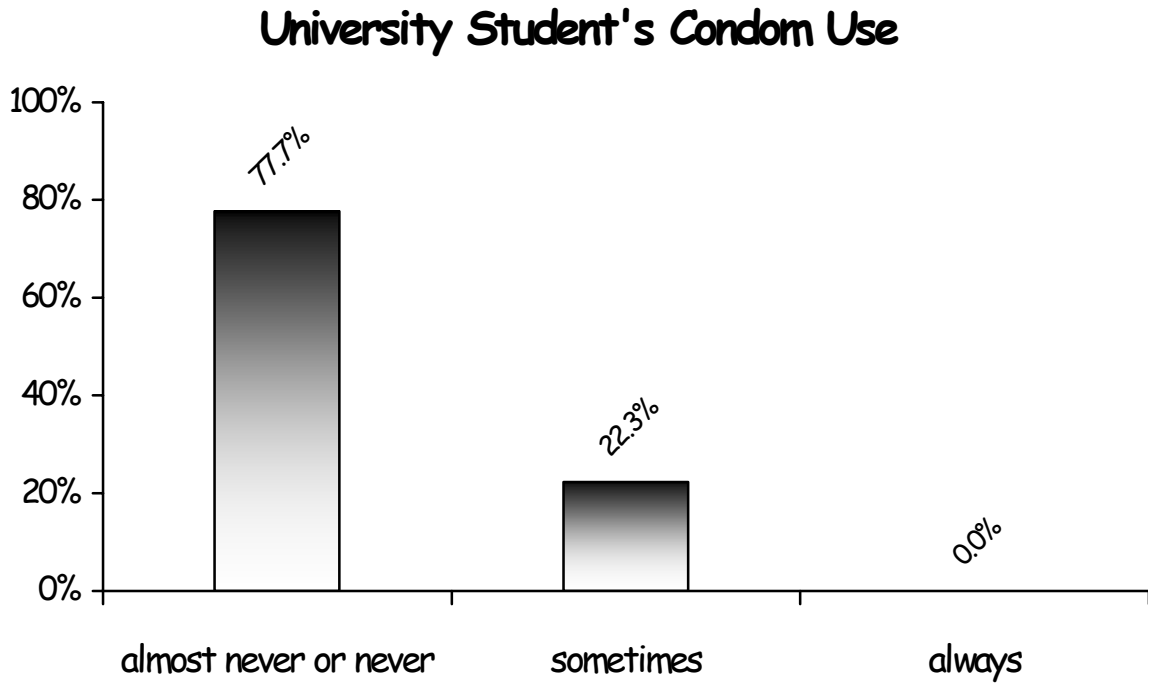

Figure 34. Graph of condom use for university students. Condom use percentage given for self-described sexually active university students surveyed.

When discussing condoms with the university students, the most pervasive ideas were that condoms were not needed and that if for some reason they did need them, men should buy

them. The perception of not needing condoms can be seen in the following quotes: “The first few times I had sex in high school I used condoms… but now after I came to Jogja, I don’t see any reason to use them. I can’t afford them, and besides if I’m going to cum, I pull out” (student #9); “I usually wear a condom with the sex workers… but with my own girls it’s different” (student #6); “Hmmm… the last time I wore one… it must be over two years now. Most people don’t bother with condoms” (student #8); “I have had sex with my current boyfriend. We used to use a condom but we don’t anymore. It’s not comfortable… besides we don’t need them – he pulls out so I won’t get pregnant” (student #5). Though condom promotion campaigns typically target women (sex workers), almost all the students, male and female, agreed that men should provide the condoms: “A condom? I think they’re like balloons. But it’s better for a guy to provide them, I’d be embarrassed” (student #15); “Definitely the male should buy condoms” (student #3); I’ve never bought a condom… that’s the boy’s job” (student #5); “Of course it’s more proper for a male to buy a condom… a female could never do it!” (student #18); “It’s better for a man to buy condoms… I mean what would people think? If I’m not married and I go into a store and ask for condoms… they’ll think badly of me. But if a guy does it, no one cares” (student #13). Stigma associated with condom use is culturally complex, and public discourse about male sexuality is more open in Indonesia. Therefore, there is a real need for HIV programs targeting men instead of sex workers.

University student #2 told me: “Condoms are forbidden in Indonesia. The majority of people here are Muslim and Islam prohibits condoms. Besides… a condom campaign would encourage people to have more ‘free sex.’” University student #10 explained how his mother introduced him to condoms: “My mom was pregnant before marriage… so she is very open with me about using condoms and such, I think she does not want me to make the same mistake as

her." Many university students, however, do not have such open relationships with their parents to learn about condoms and benefit from, as university student #12 admitted: "I've never even seen a condom."

5.6. MYTHS ABOUT HIV

The university students I interviewed reiterated many of the myths that have been discussed throughout this dissertation. The most prevalent myths were: "HIV is a heterosexual disease," "You can tell who has HIV," "You shouldn't hang out with someone who has HIV or you'll catch it," "You only get AIDS from 'free sex'," and "I'm not the type of person who gets AIDS." Many other misconceptions were expressed, such as: "AIDS is genetic, that's how children get it" (student #17); "You can get HIV through a mosquito, or free sex" (student #18); "AIDS is from a US soldier" (student #3); "I know AIDS comes from Africa… from having sex with a monkey" (student #8); "Kissing and sharing towels can transmit HIV" (student #2); "AIDS is a disease of the genitals. You can tell who has it by looking at his genitals" (student #6). Some of the misconceptions even contradicted each other, as was the case with these statements: "AIDS is from 'free sex'… but why can't sex workers be infected? Are they immune?" (student #2); and "The only way to get AIDS is from having sex with a sex worker" (student #7).

Another common misconception was that HIV/AIDS was curable. I often heard such comments as: "I'm sure there's a cure for AIDS but it's very expensive. Only rich people can afford it. I don't think it's a dangerous disease because there is a cure… other diseases are incurable, they're much more dangerous because they kill people" (student #10); "As far as I know a medicine has been found for AIDS…. But you can only get it in America, because that's

where AIDS is from" (student #11); "I heard HIV can be detected after just one year and it can be cured with traditional medicine" (student #2); "AIDS is a disease you get from 'free sex'… but there's a plant that cures it" (student #3); and "I think AIDS has a cure… anything can be cured if you have money" (student #4).

Although four of the students discussed homosexuality, only one equated it with HIV/AIDS. University student #14 stated, "Homosexuals and lesbians are the kinds of people who get AIDS… and they deserve it." The main concern among the other students in terms of homosexuality was not about AIDS, since in their minds this was a heterosexual disease, but instead about contagion: "I think homosexuality is contagious (student #16); "I have a friend who people say is gay… I don't know if it's true… but if it is, I'll stop hanging out with him because I don't want to get it" (student #20); and "Lesbianism is infectious, isn't it? I mean not from you… but others?" (student #2).

Many students thought they knew what someone with HIV/AIDS would look like, often based on the movie "Philadelphia." University student #9 explained: "AIDS is a skin disease… people get very thin and have red blotches. I saw it on TV like in that movie, 'Philadelphia.'" Similarly, university student #16 said: "When someone has AIDS, their face is absolutely normal but their body is eaten by the virus." University student #2 decided that: "A person with AIDS must be skinny and sickly looking." University student #8 similarly remarked, "People with AIDS are skinny and have skin cancer like Tom Hanks in that movie." University student #10 reiterated that, "AIDS is that disease that makes you super skinny, right? And you get it from 'free sex,' you know… changing partners all the time." More spectacularly, university student #4 was positive that, "People who have AIDS look like zombies."

Many students reported not wanting to drink from the same glass as a PLWHA I often heard comments such as these: “I wouldn’t drink from the same glass as someone who had AIDS, I have to look out for myself” (student #3); “If I know you are infected, there’s no way I’m drinking from the same glass as you!”(student #14); and “If I drink from a person’s glass I can get AIDS, too… I mean, if I’m not in good health to begin with” (student #13). But the most surprising comment along this vein was from the university student who said he would not drink from the same glass as a PLWHA but would have sex with them: “I don’t want to discriminate a person with HIV/AIDS… but I wouldn’t want to get drunk with him/her… because sometimes we a share glass… and he/she could pass it on like that, right? But I’m willing to make love to him/her… because I think the most important thing is that there is no blood” (student #10).

The most consistent idea among the university students was that, “HIV/AIDS is a scourge from God/Allah.” This concept took on many forms, but the point was always the same: “Everything is in God’s control… just look at how many bad people get AIDS. (student #20); “I’ve read in the Bible that it says there will be a new disease, incurable, and the person who is infected will be slender” (student #2); “I would give moral advice to people who have free sex and AIDS… I would tell them to get closer to their God… he gives us all our problems and he can take them away” (student #14); “I think AIDS is a warning from Allah. If I may say, the universe has its own law, some causes and effects. If things go this way, the effect will be this way. And if things go that way things will go that way… like the flood, so there’s a cause and effect for AIDS” (student #17); “Yeah… it’s God’s punishment. I mean everything must have control so if we’re just out of control maybe it is only God who can take control… God gives it to people that are real jerks” (student #1); “HIV/AIDS is a deadly disease, but if we look honestly at it, we see it’s true people are full of sin” (student #15); “It could be that one of them

will get AIDS… how can they know… it's up to Allah" (student #11); "AIDS is a disease from Allah… it's people's destiny if they get it" (student #12); "In the Bible there was a nation that ended because of sexual crimes. It's just happening again" (student #13). University student #16 even expressed this concept while empathizing with PLWHA: "I feel bad for them. I think it's hard for people living with AIDS... to live with their punishment from God."

In an attempt to combat some of these perceptions, my research team and I made postcards depicting mostly university students (and me) (see figure 35). The truthful caption read in Indonesian: "5 of us are HIV+… can you tell who isn't?" The reverse side had information about where to get more HIV/AIDS information. As I handed these postcards out on university campuses, I was bombarded with questions about the truthfulness of this postcard. I was accosted with students defiantly telling me that I was lying. They told me these are "normal" people they can't get HIV.

Figure 35. Photo used to make a postcard entitled "5 of Us are HIV+, Can You Tell Who Isn't?" This photo shows a number of university students, along with some of their friends. I made a postcard of this and handed it out to people in Jogjakarta attempting to fight the myth that "you can tell someone has HIV/AIDS by looking at them." The English translation of what was written on the postcards is: "5 of us are HIV+… can you tell who isn't?"

5.7. PRIMA'S STORY

Prima was one of the "normal" people in the postcard's picture. Prima was a university student who happened to be HIV positive. He decided to share his story with me so that I others could learn from it. A version of this was published in Latitudes Magazine (Crisovan 2003) and is available throughout Indonesia. His story illustrates some of the points about perceptions of HIV,

and HIV knowledge levels in the general public. It also depicts the state of being of a person living with HIV/AIDS in Indonesia. Here is his story:

> It's like this, in 1999 many of my friends wanted to get a general medical check-up… they wanted to work overseas. At that time it was to Saudi Arabia. What's important is that they needed to get a check-up. So I thought to myself, "Why not go along just for fun? Why don't I take a look at the shape my body is in?" So, I went in for the check-up and when I was finished I really had no idea what tests they did… they just took my blood and didn't tell me what for. When I wanted to get my test results, they took more blood, which they said was for confirmation… that was when I first learned they were testing me for HIV. And when I looked at the results — it turns out — I was for HIV positive!
>
> Right after I saw the results I told my older sister "Can you believe it!! I have HIV." When I was telling her about it, I really didn't understand what HIV was. Then we talked to my mom and still we had no solution because we still didn't know what HIV was. I tried to find out a little bit of information about HIV/AIDS, ya know by reading books. In my area no one knew what was meant by HIV… but I still tried to look for information.
>
> I began to learn about HIV and how people live with HIV. That was because I had some friends at IPPA (Indonesian Planned Parenthood Association). Then, one day my friend from IPPA invited me to participate in the National Meeting of PLWHA (People Living with HIV/AIDS), in Bali. Actually, I was afraid to go to Bali for the national meeting. I'm a PLWHA and I was afraid of meeting other PLWHA! But in the end I still went. And after I went to the meeting in Bali, it was the first time I really understood what HIV was and how people live with HIV. I went there with a friend, another PLWHA from Jogjakarta.
>
> Upon arriving in Bali she got really, really sick — she couldn't do anything… she couldn't walk — nothing! Everything fell apart! It was then that I found out she was actually sick before she went to Bali… but she couldn't go to the hospital in Jogja because there weren't any hospitals that were willing to admit a PLWHA. That was in 2001! Right then I knew the reality of the situation. I hadn't cried in nearly 20 years, but at that point I cried because if that was me… what would I do? But when I knew my friend's case was like that — I cried not because I was scared, but because I thought to myself, "These people are crazy!" Because, in my opinion, doctors are the ones that have to know more about HIV/AIDS —

compared to other people, especially compared to the general public. But they were the ones that refused us! And in the end… my friend died.

Her death made me furious — and out of that anger my friends and I created JOY (Jogjakarta's Network for People Living with HIV/AIDS). That's what we did because all of us were angry. We saw that we had a lot of "homework" to do. A lot of work to address the problems associated with HIV/AIDS.

A lot of my friends have a motto: "getting high, doing sex." It's best like that, see. And I used to say that too. I mean, if you can, ya- "say no to drugs!" It's better that way. If you can get far away from 'em, man! Even if you want to "get high," just do it once in a while, ya, and never share your needles! If you want to have sex, ya… do "safe sex," that's the way! Don't… don't do what's not right. Ya… I mean it's simple enough; sayings like this are so cliché... I know… But they're true.

The first time, before I knew I was positive, these sayings were already around, but who cared. They weren't cool, ya know! I heard them and I just threw them away, just like that. But now that I know I'm positive, actually, these sayings are coming out of my very own mouth! It turns out… ya those sayings were right on the money! "Say no to drugs" and "practice safe sex." I know it's so very cliché and maybe we're bored hearing clichés like these. But maybe we're bored because we don't understand the reality of it all, ya know? But if we understood the reality of the situation, if we knew "Oh, being infected with HIV is like that, huh?" or "Oh, being a drug addict is like that, huh?" Ya, then maybe those sayings would have more meaning to us! So I just want to say, "Enjoy your life, but don't make it more difficult than it needs to be!!" That's all!!

5.8. CONCLUSION

University students exist often as a population that lives far from their homes and villages and from the watchful eyes of their parents and community. Being their first time unrestricted, these students often engage in activities they might not engage in otherwise. The government of

Indonesia and local HIV/AIDS education programs are currently ignoring these activities and attempting to pretend they do not exist.

By focusing HIV/AIDS prevention and education programs at what are considered to be "high risk" populations, university students (and others who don't identify as having risk behaviors) are left unchecked. Many students felt they didn't need any information on HIV/AIDS. Just as university student #2 explained after expressing numerous misconceptions about HIV/AIDS: "I think there's sufficient information on HIV/AIDS in Indonesia. We don't need any more. Maybe you should be talking with sex workers." Focusing on "high-risk" sex workers has made other populations — such as university students — feel they are free from "risk." Similarly, by focusing on "free sex," other activities have gone unchecked. The HIV epidemic in Indonesia is currently spreading most rapidly through intravenous drug using populations (Lim 2006). Yet people who engage in intravenous drug use are not aware of their risk since there is no education programs aimed at them in Jogjakarta.

While ignoring both the prevalence of "risky" activities found in the university student population, as well as the lack of HIV education available to them, the government of Indonesia and local HIV/AIDS education programs are creating a culture in which university students think they are invincible. These students are then graduating and creating policies about HIV/AIDS as well as working for health NGOs. This chapter shows the importance of aiming HIV/AIDS prevention and education policies and programs more at the general public. If we expect university students to be the policy makers of tomorrow, then we need to give them the tools and knowledge to allow them to succeed and make appropriate decisions.

CHAPTER 6. CONCLUSION: LESSONS FROM INDONESIA

> The fundamental deficiency in HIV/AIDS prevention and control, which is characteristic of the traditional approach to public health in general, is the lack of meaningful, concrete, coherent action in addressing directly the societal determinants of health, which also influence vulnerability to HIV. While the tremendous importance of social context for health—and HIV/AID related behaviors—is readily acknowledged, little is done about it.
>
> [Mann and Tarantola 1996: xxxiii]

Unfortunately, not enough has changed in the decade since Mann and Tarantola made the above statement. Though academic communities and public health evaluators often agree that taking diverse cultural, social, economic, and political factors into consideration is a necessary and important step in creating effective HIV/AIDS programs, real-life realities of many of the programs being implemented are often not able to step out of the previous "old-school" Western epidemiological and bio-medical models focusing on "high-risk" groups and behaviors. This can be seen in examples throughout this dissertation, as "high-risk" categories continue to be utilized for HIV/AIDS program implementation throughout Jogjakarta and elsewhere in Indonesia.

Frakenberg (1998) stated that: "If not all epidemiologists have yet become properly cautious about such concepts as risk, risk behavior and risk group, [then] at least the clinical and social analytic view of their usefulness will never quite be the same again" (p. xvii) Unfortunately, both the first and second parts of this have yet to be fully realized. This was

evident when I spoke to an epidemiologist working for *Aksi Stop AIDS* (ASA), an HIV/AIDS program based in Jakarta and funded jointly by Family Health International and USAID. We were discussing the differences between American sex workers and Indonesian sex workers. She reiterated differences that I have talked about earlier in some length, including the number and anonymity of clients, drug-related behaviors, etc. Having agreed that American sex workers, in general, have higher "risk" due to more "high-risk" behaviors than Indonesian sex workers, I asked her why programs from ASA were still utilizing Western assumptions in targeting "high-risk" groups. Her reply was simply: "Well, what else would you have us use?"

Hoping to continue this conversation with another person who influences policies at *Aksi Stop AIDS*, I requested an interview with one of the heads of program design, an understandably very busy man. He kindly declined the interview, but did tell me he was "behind my research 100%... and feel free to take as many free condoms as you need." This statement, I felt, reflected what some researchers refer to as the "condomization" of AIDS (see for instance Arihihenbuwa 2001; Downing 2005). This refers to the tendencies of HIV/AIDS programs to focus much of the programs and policies around condom promotion and dispersal. "Management and marketing efforts focusing on purely persuasive techniques of risk reduction [such as the dispersal of condoms] must be replaced with new ways of listening and responding to lay perceptions of the situation, if they are to be at all effective" (Goldstein 2004: 68). Handing out free condoms to sex workers and *waria* will not be beneficial if their clients refuse to use them, or if their perceptions of their activities are incompatible with their perceptions of how HIV is acquired (such as not believing they are engaging in "sex" or not identifying with a "high-risk" category) .

During an interview with the head of *Spiritia*, a NGO for people living with HIV/AIDS in Jakarta, he discussed that he was "disgusted with 'high-risk' groups and behaviors constantly

being the focus of HIV/AIDS programs in Indonesia." He went on to discuss his years of experience with HIV programs in Irian Jaya, the Indonesian half of the island of Papua. He said that after years of studying the epidemic there and noting high differentials of HIV transmission between local Christian populations and Javanese Muslim implanted populations "with exactly the same 'high-risk' behaviors," all he can assume is that "'high-risk' behaviors don't mean shit… we should just focus all our programs on circumcising locals!" Other researchers have discussed the importance of circumcision to curb the transmission of the epidemic HIV (*as discussed in* Gregson et al. 2006), but this is a highly controversial topic. Researchers are quibbling over whether such measures are effective, let alone the human rights abuses that programs such as mandatory circumcision would cause. Still, the broader point is very valid: a focus on "high-risk" groups and behaviors is not particularly useful in Irian Jaya or elsewhere.

Still common in much public health discourse, constructions of "high-risk groups" are "part of a 'hegemonic process' that helps dominant groups maintain, reinforce, re-construct, and obscure the workings of the established social order" (Schoepf 2001: 336). "Depiction of prostitutes as 'a reservoir of infection,' fueled local constructions of AIDS as 'a disease of women,' or of the 'lower orders,' from whom the 'pure' required protection" (Schoepf 2001: 340; see also Lyttleton 1996). As discussed earlier, concepts such as these provide an 'othering' process that allows people in power to scapegoat, dehumanize, and blame the victims and thus avoid responsibility (Farmer & Kleinman 1989; Schoepf 1988). This also creates increased marginalization of those already marginalized.

I found evidence of increased marginalization when I spoke to *waria* about the programs they were offered. Many of the *waria* I interviewed expressed dislike with the programs offered to them. They especially did not like being grouped with either homosexuals or female sex

workers. I had already heard from many *waria* that they were upset about no longer being allowed in the main clinic and instead having to walk through the female sex workers area in order to get to the clinic that had been set up for female sex workers. They felt they were being pushed further and further out of the view of others. Interestingly, one of NGO volunteers mirrored their sentiments on why they believed they were being marginalized: "Yeah… it's because we're afraid the regular people will stop coming to the clinic… we don't want them to think it's dirty or infected by the *waria*."

Although NGOs tend to fill "the political space created by shifting interdependencies among political actors, by the globalization of capitalism and power, and by the decline of the state" (Fisher 1997: 440; See also Edelman 2001); their accolades are often "based more on faith than fact" (Fisher 1997: 441). "There are relatively few detailed studies on what is happening in particular places or within specific organizations, few analyses of the impact of NGO practices on relations of power among individuals, communities, and the state, and little attention to the discourse within which NGOs are presented as the solution" (Fisher 1997: 441). As Alex DeWaal asserts, this is "because those who work for them [NGOs] and those who comment on them belong alike to a cosmopolitan 'Humanitarian International' which is unable to question its own categories and moral assumptions, leaving little room for dissent" (African Rights discussion paper November 1994 as discussed in Benthall 1995).

NGOs often "must develop policy in the absence of much of the information that ideally should be available…. [A] common bureaucratic practice [is] the use of 'research' to legitimize previously decided-upon policies rather than to provide data for judging the desirability of the policies" (Foster 1999: 356). Another strategic problem is that people involved with NGOs rarely

publish about problems in NGOs because they "fear that a public which may be vulnerable to 'compassion fatigue' will refuse to keep on giving if it hears bad news" (Loizos 1991:1).

Other obstacles cited for the lack of effectiveness of NGO programs include high staff turnover and burnout (Mann et al. 1992), as well as poor and misallocation of resources (Hahn 1999). I saw first-hand how both of these obstacles existed at the NGO I worked with during my fieldwork. During my fieldwork I knew 3 different heads of the NGO Lentera Sahaja. The last head that I knew left due to irreconcilable differences between the board's opinions of what programs should look like and what he knew to actually work in the area. He had also presented information proving what he believed to be fund siphoning due to what Indonesians refer to as *KKN* (which is an acronym for the Indonesian version of corruption, collusion, and nepotism). The board promptly fired him. When he left, the entire paid staff (5 people) left with him in solidarity. Effective administration of programs is a concern in Indonesia and elsewhere: "[M]edical knowledge and medical research alone cannot bring health for all. Our problems lie in the fields of politics and commitment, of planning for health needs, and of administration of programs and projects" (Foster 1999: 346).

The same NGO had a huge influx of volunteers while I was there. Each year they would train new people who had to choose which program they were applying for: sex workers, homosexuals/*waria*, or the newest and not yet realized program for high school students. Not only were these groups "targeted" based on the constraints of available Western funding opportunities, but these volunteers often had no experience with these populations prior to their weeks worth of training. Interviews with volunteers spoke to the high-turnover of both staff and volunteers: "As soon as you get to know someone and their idea of what we should be doing,

they leave and we have to start all over." Another volunteer told me: "I just volunteer here to hang out with my friends… besides, it looks good on my résumé."

After perusing the training manual used by this NGO, I was disappointed that parts of it were in English and not the local language, much of it talked about "high-risk" groups and behaviors, and other sections were just misinformed (such as the article about the fact that mosquitoes do transmit HIV). As Hahn (1999) asserts, "the failure of some public health agencies to reflect on their own strengths and weaknesses may result in programs based on misleading concepts and erroneous theories and information" (p.5). He goes on to reiterate that "the failure of some public health programs to study and take into account the culture and society of the community toward which the program is directed has sometimes led to only partial program success or even program demise" (Hahn 1999: 5).

Though NGO programs are often under many constraints, blaming the situation for ineffectiveness is also not helpful. As one Indian writer speaking about medical care and public health planning in his country and other developing countries stated:

> We may blame the ignorance and apathy of our people, their fatalistic psyche, their time-worn attitudes, their fanatic adherence of myth and tradition, their inaccessibility – the remoteness of our interiors, etc., amongst other things responsible for the health status of our people. Or we may complain about our lack of imagination, resourcefulness and management abilities; our limited resources, poverty and population; or, simply blame the callousness, indifference and corruption that exist at all levels of our infrastructure…. While an understanding of the interaction of these forces and their detrimental impact is essential to create meaningful communication, we should be wary of sinking into a maze of excuses for the effective non-communication we provide. [Mathur 1998:23]

Parker notes that: "changing demands (and fashions) on the part of policy makers, and often funding agencies as well, has tended to shift more rapidly than behavioral research on

sexuality (or any other topic) can accompany" (Parker 1995: 262). These rapid changes include different priorities of different United States presidents — the most current of which includes the "abstinence only" policies of the present administration. The United States has exponential control in setting the global research agenda for biomedical science and HIV/AIDS prevention programming worldwide (Widdus 1996). These changing demands on the part of policy makers often create "wide gaps [that] separate public health capacities to advance global health and the fulfillment of these gaps" (Hahn 1999: 4). Some necessary and important HIV interventions "failed because of lack of national and/or international commitment to projects designed to address the perspectives and concerns of the populations in need" (Hahn 1999: 5). It is as though the world of international health aid, "although ostensibly geared toward maximizing its relevance to the poor of the Third World, has become like a mirror in which the values, interests and philosophies of the West are found reflected" (Stone 1989: 206). As Altman (2001) states: "Alongside Disney movies and American pop music, the particular apocalyptic vein of American religiosity is being exported" (p.156). This can often create contention and mistrust by Indonesians who fear Western aid comes with strings, and values attached. This contention can be seen by the photo below.

Figure 36. Photo illustrating a pervasive sentiment: "Go to Hell With Your AIDS America". This banner is quoting ex-president Sukarno and his rally against Western aid (displayed at major intersection on Kaliurang Road, in Jogjakarta).

HIV programs, based on rapid assessment and Western models of "risk," tend to focus on behavior change as the "quick fix" instead of looking at the "big picture." "In keeping with the dominant tendencies in much health behavior research, emphasis has been placed largely on the individual determinants of sexual behavior and behavior change, and diverse social, cultural, economic, and political factors potentially influencing or even shaping sexual experience have been more often than not ignored" (Parker 1995: 260).

As has been discussed throughout this dissertation, an obstacle to "the implementation of available techniques to reduce morbidity and mortality, as well as gaps in morbidity and mortality, worldwide…is the inadequate translation of public health knowledge into effective action across social and cultural boundaries that separate those who have specific preventative

and curative capacities and resources from those who may need them" (Hahn 1999: 4-5). The next section will reflect upon a new immerging world-health system that is starting to take some of these obstacles into consideration.

6.1. A NEW CULTURAL FRAMEWORK

When international aid ignores such things as local language, cultural frameworks, and political and economic realities at the local level, ineffective and inefficient aid is often realized (Helman 1990). To be more successful, international aid needs to take into consideration the interaction of local and global forms of knowledge and its impact on policy - both nationally and internationally. The current dialogue within the global AIDS network stresses the importance of understanding the cultural framework within which a prevention or education program is implemented. International experts, led by the United Nations Educational, Scientific and Cultural Organization (UNESCO), met in Nairobi to discuss taking a "cultural approach" to HIV/AIDS. Discussions focused on how efforts to stop the spread of HIV/AIDS have been globally frustrated due to the lack of cultural contextualization (Achieng 2000).

Over 90% of all new cases of HIV are located in four regions: Africa, Asia, Latin America and the Caribbean (Airhihenbuwa et al. 2000). To attempt to reduce the spread of the disease and strengthen programs in these areas, UNAIDS held five consultative workshops from 1997 to 1999 to discuss the limitations of current theories and methods used in AIDS campaigns in these areas. Each of these meetings was held in a different region of the world, including Africa, Asia, Latin America, the Caribbean, and Europe. One hundred and three leading

researchers and practitioners were selected to participate in this project, 80% of whom were representatives from the four specified regions.

Together these researchers and practitioners found five main limitations of the current theories and methods used to inform global public health programs and international public policies about the case of HIV/AIDS. These limitations are: 1) A focus on individuals that excludes contexts; 2) Assumptions that HIV preventative decisions are based on rational volition and not emotion; 3) Assumptions that knowledge leads to behavior; 4) Tendencies to ignore differences between single actions (i.e., immunization) and continuous life-long activities (i.e., life-long condom use); and 5) Tendencies to focus on condom promotion alone (i.e., the "condomization" of HIV/AIDS) (Airhihenbuwa 2001).

Based on these limitations, the participants developed a new communications framework for HIV/AIDS which moved from a focus on the individual to a focus on the contexts that influence behaviors. These contexts were broken down into five main domains: government policy, socioeconomic status, culture, gender relations, and spirituality (Airhihenbuwa et al. 2000). An understanding of these contexts provides an improved framework from which one can begin to assess global public health programs and international public policy.

Participants of these consultative UNAIDS meetings were not only able to define numerous obstacles and problems past education programs were unable to overcome, but they were also able to bring forth an understanding of what has worked in each region (Airhihenbuwa et al. 2000). Part of the process of building a new framework includes understanding past successes. In Africa, successes included community based approaches and regional collaborations. In Asia, successes revolved around the importance of the context of who is speaking about these issues (i.e. the king of Thailand versus European public health personnel),

and an understanding of the stages and contexts of the epidemic in various settings. In Latin America and the Caribbean, successes included a focus on advocacy and human rights as well as continuous involvement and input from people living with HIV/AIDS (Airhihenbuwa 2001).

The participants in these consultative workshops concluded that understanding contexts and building on past successes is of utmost importance in the fight against HIV/AIDS. Similar to the thoughts on the world-system by critical medical anthropologists, these UNAIDS participants believe that:

> The long-term solution to bridging symbolic and material inequity lies in structural reforms that change the manner in which resources are distributed in society. However, these transformations cannot be achieved in a short span of time. In the context of HIV/AIDS, short- and medium-term solutions are needed to alleviate the impact of AIDS along with long-term strategies. The contextual domains present some challenges to be addressed since they do not lend themselves to linear intervention strategies directed to solving a problem without focusing on the causes.... A focus on context not only addresses the physical and social environment, it also recognizes the importance of bringing a project to scale rather than perpetuating pilot projects only that focus on individual behavior. [Airhihenbuwa et al. 2000:109]

Breaking down western assumptions of “risk” allows programs to better aim information to the general public. This not only allows greater accessibility to education on preventative measures, but can also help break down stereotypes and stigmatization (Riyadi 2000). Processes such as these this must be done within this new framework for understanding HIV/AIDS and its situation within the world system. Current programs in Indonesia tend to under-utilize indigenous knowledge and perceptions. New programs designed under the rubric of contextualiztion need to address issues previously left unattended.

6.2. FUTURE SUGGESTIONS: "ACTION-RESEARCH"

As has been shown throughout the examples in this dissertation, programs in Indonesia often incorporate Western epidemiological biases into their education and prevention strategies. Indonesian cultural perceptions of HIV and "risk" as well as Indonesian cultural categories and definitions are often under-utilized in the creation of HIV/AIDS programming throughout the archipelago. This creates new biases (such as homosexuals as a high risk population in a country where 95% of sexual transmission of HIV is heterosexual) that either replace or enhance existing biases pervasive in Indonesian understandings of HIV/AIDS. Education programs that are dependent on Western funding are also affected by the uncertainties of our government's policies — such as "abstinence only HIV education policies" and the global "gag" rule (Behrman 2004). This can lead to ineffectual programs with high-turnover of employees and lack of sustainability. It also creates differing definitions of what kind of education is allowable and for whom, which creates pockets of misinformation and confusion.

Though AIDS education programs are being implemented at the local, national and international levels, these programs often fail to meet the educational needs of the general public in Indonesia due to a lack of contextualization of both individual lifeworlds and the larger global system. An article that was published in the *Jakarta Post*, the main English-language newspaper in Indonesia, declared: "Number of AIDS patients rises 700% in West Java" (*Jakarta Post* 2001). Obviously, there is a significant difference in the programs being implemented and the knowledge that is being derived from these programs. More research on the contextualization of HIV/AIDS in Indonesia will, hopefully, lead to more effective and culturally sensitive programs and policies.

Behavioral modification programs that are often employed by NGOs in Indonesia are often under the understanding that the existence of knowledge is merely sufficient. My research illustrates that increased knowledge often does not correlate to decreased "high-risk" behaviors. This is partially due to the fact that Indonesian perceptions of "risk" are not always compatible with HIV program assumptions. It also has to do with the fact that cultural, social, economic, and political realities of individuals are not taken into consideration with most behavioral modification programs. For instance, telling doctors to use new, sterile needles with every vaccination is only effective if there are available resources to do so.

Working within the new framework of contextualization, policy implementers and researchers need to engage in action-research (also called applied critical medical anthropology). Action-research "is a transdisciplinary method designed to foster social change" (Schoepf 2001: 348). Action research teams, "work with groups of people variously situated in society to discover how they constructed disease and risk, and how they would go about creating protective strategies over time" (Schoepf 2001: 349). Unfortunately, the literature "is only just beginning to take account of AIDS and its multifaceted impact on perceptions of risk" (Frakenberg 1998: xvii). Prevention frameworks informed by action-research "promote change through individual and community empowerment strategies informed by holistic understanding of the local context, [and] acknowledges the positive contributions of local values to the process of change, [as well as incorporating] an array of options that permit individuals to transform their lives in ways that enhance their physical, emotional, and material well-being" (Bolton and Singer 1992: 5).

Action-research, such as this, is the first step in creating effective HIV/AIDS policy and education campaigns in Indonesia. As this dissertation shows, understanding how Indonesians construct disease and "risk" is a necessary component for HIV/AIDS programs. Many of the

NGOs that I worked with unconsciously adopted Western notions of disease and "risk" through their utilization of Western funds, programs, and texts. These NGOs did so without fully realizing that "intervention, including public health action, is fundamentally a process of social and cultural exchange" (Hahn 1999:11) Simple word-for-word translations of programs found elsewhere or even mailed to them by UNAIDS, USAID, or WHO, was often the easiest and cheapest way to provide what they thought were viable health programs. This allowed for Western assumptions to stream through seemingly unnoticed.

This tendency can prove to be problematic since the dominance of Western discourses around HIV/AIDS is "founded on a phallocentric sexual universe that ignores the especially vulnerable position of women, children, transvestites, and other sexual 'passives' vis-à-vis the dominant, aggressive and active conquistador male sexuality" (Scheper-Hughes 1994: 96-97). Another problem with the Western paradigm is its "biomedical orientation [which] has led to an almost exclusive focus on HIV and the mechanisms – as opposed to the social determinants – of its transmission… Physicians and other health care workers have failed to see how similar assumptions, if not addressed, threaten to vitiate our still-inadequate response to the epidemic" (Fee and Kreiger 1993: 1481).

The NGOs I worked with not only adopted these Western assumptions through the adoption of Western programs and funds, but the programs they tended to adopt (as they were easiest for translation and most acceptable to the Indonesian government) were "Just Say No" style programs. These "campaigns that urge women to 'just say no' to sex without a condom presume not only heterosexuality, but a degree of physical, cultural, and economic parity that does not characterize the majority of women who are having heterosexual sex, whether as a form of pleasure, work, or cultural expectation — or under the threat of violence" (Goldstein 1997: 4).

Other problems with cookie-cutter programs from international health organizations include the fact that "acceptance or rejection of health programs decided upon by distant planners, programs in which the community has little input" (Foster 1999: 362).

Although a complete program evaluation of the HIV/AIDS NGOs in Jogjakarta was unavailable, those I interviewed had some suggestions. Sex workers, although more thankful in general than the *waria*, also offered critiques of the programs offered to them. The critique I heard most often was that they were bored with the same information presented over and over. As one sex worker told me: "Use a condom, HIV is from 'free sex,' don't do drugs… it's the same… again and again. I only go for the free food… I stopped listening a long time ago." The sex workers want programs that take their individual realities into consideration. They are tired of being treated as "immoral," and told to stop doing sex work without being provided an alternative money making skill. Many of the women asked for programs that truly taught them a skill, as opposed to one-hour workshops on candle-making and basket-weaving. In this vein, Altman (2001) suggests that "we badly need a political economy of sexuality, one which recognizes the interrelationship of political, economic, and cultural structures, and avoids the tendency to see sexuality as private and the political and economic as public" (p. 157).

Even university students, who have no programs available to them, offered suggestions for future programs: "I'm so tired of pamphlets… pamphlets for smoking, pamphlets for drugs, pamphlets for HIV… can't there be information in an exciting way?" Another university student offered "Let's have a concert… I see that on TV… concerts for Africa and stuff… we need concerts too… an AIDS concert… you could tell us about AIDS in a fun atmosphere!" Other students offered that HIV/AIDS programming should include Muslim leaders and mosques.

The concept of involving religious leaders and politicians in HIV/AIDS programming led Altman (2001) to reflect:

> Defenders of 'traditional morality' have been forced to make painful choices, involving a recognition that public health measures to prevent transmission of HIV and other sexually transmitted infections often conflict with dominant religious codes. Many countries have seen bitter battles over moves to advertise condoms, to develop sex-education programs in schools, or to openly discuss homosexuality. [p.145]

A bitter battle was the case in Indonesia when *Aksi Stop AIDS*, a program funded by Family Health International and USAID, together with other HIV/AIDS organizations and five Indonesian television channels jointly developed HIV prevention commercials. After the commercials aired for two days the Indonesian government yanked the ads stating that Muslim organizations were in an uproar about the content, which they said encouraged promiscuity (Deutsche Presse-Agentur 2002). Including Muslim and political leaders in the development of these commercials could have helped ameliorate the situation.

Based on the participant observation, surveys, and interviews with the populations discussed throughout this dissertation, I have four major suggestions for future HIV/AIDS initiatives in Indonesia and elsewhere: 1. Western education program designs need to take into account cultural ideas and perceptions. They need to be culturally sensitive and culturally appropriate, taking into consideration, among other things, definitions of "sex" and "risk;" 2. "Best processes" need to be utilized instead of "best practices," with flexibility being essential. Instead of taking a program as is and attempting to utilize it elsewhere, take what made it a good program (grass roots efforts, cultural accessibility, communication with stakeholders and participants, holism, etc.) and utilize that in your program; 3. Engage with the people you are supplying the programs for. Ask THEM what kind of program would be beneficial/utilized.

Empowered and informed constituents make the best consultants for education programs; and 4. Educate the general public. Educating "high-risk" groups only stigmatizes these groups, it doesn't curb the epidemic.

Action-research, the contextualization of HIV in people's lives, understanding the multiple realities of individuals and their understandings of disease and "risk," and asking people what kind of programs would most benefit them are all important steps that need to be realized in Indonesia. Other than these, however, the most important step is getting the Indonesian government, with its enormous influence over its people, involved with the process. With the government's involvement, HIV education and prevention programs in Indonesia will have more capacity for success.

International public policy that utilizes an action-research paradigm could be more effective in negotiating the worldviews of individuals in Indonesia and elsewhere. "Unless the familiar patterns of fear, denial, stigma, and disempowering education campaigns, coupled with conditions of widespread poverty, inequality, and violence are ended, Africa's tragedy [due to the AIDS pandemic] will be replicated [in Asia and elsewhere]" (Schoepf 2001: 336). Future research in Indonesia and elsewhere needs to take cultural perceptions and daily realities into consideration in order to create more effective and culturally appropriate programs and policies. The HIV pandemic has shown us the importance of coming together globally and creating understanding locally for the good of us all.

APPENDIX A

THE SURVEY INSTRUMENT IN ENGLISH

Research Questionnaire:

SOCIETY'S PERCEPTIONS OF HIV/AIDS IN YOGYAKARTA

By:
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University of Pittsburgh
U.S.A.

All information written in this questionnaire will only be used for the purposes of this research and not used for other purposes. This questionnaire is anonymous and all your confidential answers will be kept safe/not given out to anyone.

Jogjakarta
September – November, 2002

A. Background

Circle the letter in front of the answer you want to choose.

1. Sex ……..
   a. Male
   b. Female
   c. Waria

2. Age ……..
   a. 15 – 20 years
   b. 21 – 25 years
   c. 26 – 30 years
   d. 31 – 35 years
   e. 35 – 40 years
   f. more than 40 years

3. Where are you from originally?
   a. Jogjakarta
   b. Middle Java
   c. West Java
   d. East Java
   e. Jakarta
   f. From outside the island of Java, explain …….

4. How long have you stayed in Jogjakarta?
   a. Less than 1 year
   b. 1 – 5 years
   c. 6 – 10 years
   d. More than 10 years

5. What was the last level of schooling you completed?
   a. Did not finish elementary school
   b. Elementary school
   c. Junior High School
   d. High School
   e. Diploma program
   f. Bachelors Degree
   g. Above Bachelors Degree, explain …….

6. What is your occupation?
   a. Unemployed
   b. Government worker, explain …….
   c. Non-government worker, explain ……
   d. Student , at school …….
   e. University Student, at University …….
   f. Merchant, explain ……..
   g. Sex Worker, at ……..
   h. Other, explain…….

7. What is your monthly income?
   a. Do not yet have an income
   b. < Rp. 100.000,00
   c. ≥ Rp. 100.000,00 < Rp. 300.000,00
   d. ≥ Rp. 300.000,00 < Rp. 600.000,00
   e. ≥ Rp. 600.000,00 < Rp 1.000.000,00
   f. ≥ Rp. 1.000.000,00

8. Your marital status …….
   a. Not yet married
   b. Married
   c. Divorced
   d. Widow/widower

9. How many children do you have?
   a. Not yet have children
   b. 1 – 2 children
   c. 3 – 4 children
   d. More than 4 children, explain ……children

10. Your religion is ……
    a. Islam
    b. Hindu
    c. Catholic
    d. Christian/Protestant
    e. Buddhist
    f. Other, explain……

B. Sexual Health

Circle the letter in front of the answer you want to choose.

1. Have you ever had sex?
   a. Yes
   b. Not yet (go to number 10)

2. How old were you the first time you had sex?
   …… years

3. Who did you have sex with the first time you had sex?
   a. Boyfriend/girlfriend
   b. Friend
   c. Sex Worker
   d. Fiancé
   e. Husband/wife
   f. Other, explain …….

4. What type of contraceptive device did you use the first time you had sex?
   a. Did not use contraceptive device
   b. Condom
   c. Birth Control Pill
   d. IUD
   e. Hormone Injections
   f. Hormone Implant (Norplant)
   g. Vasectomy/ Tubal Ligation
   h. Calendar system
   i. Other, explain …….

5. What contraceptive device do you use now?
   a. Did not use contraceptive device
   b. Condom
   c. Birth Control Pill
   c. IUD
   d. Hormone Injections
   e. Hormone Implant (Norplant)
   f. Vasectomy/ Tubal Ligation
   g. Calendar system
   h. Other, explain …….

6. Have you or your partner ever worn a condom when having sex??
   a. Yes
   b. No
   c. Not Sure
   d. Don't remember

7. How often do you or your partner wear condoms during sex?
   a. Always
   b. Sometimes
   c. Rarely
   d. Never

8. What Sexually Transmitted Diseases (STD) have you ever had? (choose more than one answer if applicable)
   a. Never had any
   b. HIV/AIDS
   c. Syphilis
   d. Gonorrhea
   e. Chlamydia
   f. Herpes
   g. Crabs
   h. Hepatitis
   i. Other
      explain ……

9. What have **you ever done in the past** to prevent STD or AIDS transmission (choose more than one answer if applicable)
   a. Receive antibiotic injection
   b. Go to traditional healer
   c. Go to doctor
   d. Go to Public Health Clinic
   e. Go to Hospital
   f. Take medicine
   g. Take traditional medicine or herbs
   h. Wash your reproductive organs after having sex
   i. Check/wash your partners reproductive organs
   j. Be careful to choose a clean partner
   k. Wear a condom
   l. Nothing, never worried about it
   m. Don't have sex with foreigners/strangers
   n. Other, explain ……

10. Hypothetically if you found out you had an STD or HIV/AIDS, what is the first thing you would do?
    a. Do nothing
    b. Receive antibiotic injection
    c. Take medicine
    d. Take traditional medicine or herbs
    e. Go to traditional healer
    f. Go to Public Health Clinic
    g. Go to doctor
    h. Go to Hospital
       Consult with an NGO,
       name of NGO ……..
    i. Other,
       explain ……

C. Facts and Perceptions about HIV/AIDS

Choose the answer that you think is most right from the statements below. Mark an X in the appropriate column.

		Yes	No	Not Sure/ Don't Know
1.	Have you ever heard or read the word HIV/AIDS?			
2.	Would you avoid kissing someone who has HIV/AIDS (even if it was a family member)?			
3.	Would you avoid hugging or shaking hands with someone who has HIV/AIDS?			
4.	One condom can be used more than one time.			
5.	Would you drink from the glass of a person suspected of having HIV/AIDS?			
6.	A condom decreases the pleasure for women.			
7.	HIV/AIDS came from America.			
8.	There is a possibility that HIV/AIDS can be spread through an immunization injection.			
9.	AIDS is an abbreviation for "Acquired Immune Deficiency Syndrome."			
10.	Condoms are not appropriate for regular partners because they cause suspicion.			
11.	There is not yet a cure for someone who has been infected with HIV/AIDS.			
12.	There is a possibility that HIV/AIDS can be spread through circumcision knife/tools.			
13.	A person can be infected with HIV/AIDS just from being near someone who is already infected.			
14.	HIV/AIDS can be transmitted through bodily contact such as: hugging or shaking hands.			
15.	A person can get HIV/AIDS from being a blood donor.			
16.	It's more appropriate if a man buys a condom than a woman.			
17.	Drug users who share the same needle increase their risk for being infected with HIV/AIDS.			
18.	Gradual weight loss is one early warning sign of AIDS.			
19.	A person can get HIV/AIDS from a blood transfusion.			

		Yes	No	Not Sure/ Don't Know
20.	Condoms are expensive.			
21.	Night sweats and chronic fatigue are early warning signs of HIV/AIDS.			
22.	There is a possibility that HIV/AIDS can be spread through a tattoo needle.			
23.	Condoms are appropriate for people who change partners.			
24.	The HIV/AIDS virus is an epidemic in the Indonesian society.			
25.	Wearing a condom is one way to prevent HIV/AIDS.			
26.	A pregnant woman infected with HIV/AIDS can infect her baby.			
27.	Condoms are dangerous and can get lost in the body.			
28.	The HIV/AIDS virus can be transmitted through breast milk.			
29.	College students are a high risk group for being infected with HIV/AIDS.			
30.	People with HIV will eventually develop AIDS.			
31.	Condoms are easy to use.			
32.	HIV/AIDS can be spread through sneezing and coughing.			
33.	HIV/AIDS can be spread through public toilets.			
34.	HIV/AIDS can be spread through mosquito bites.			
35.	You can tell by looking at someone if they have HIV/AIDS.			
36.	HIV/AIDS virus attacks and disturbs the functioning of the body's immune system.			
37.	A person infected with HIV/AIDS can infect another person through sexual intercourse.			
38.	Condoms are against my religion.			
39.	HIV/AIDS can be spread by using an AIDS- infected person's belongings such as a comb or a pen.			
40.	Only homosexuals can get HIV/AIDS.			
41.	Condoms are easy to find.			
42.	I have talked with another person about HIV/AIDS.			
43.	I feel comfortable talking about HIV/AIDS with another person.			
44.	I believe that HIV/AIDS is God's way of punishing people for their evil acts.			
45.	I am personally concerned about the HIV/AIDS epidemic.			
46.	I believe that individuals infected with HIV/AIDS should not be allowed to work in public places.			
47.	I would personally like to learn more about AIDS and issues surrounding the disease.			
48.	Condoms decrease the pleasure for men.			
49.	Intravenous drug users who get HIV/AIDS probably deserve it.			
50.	There is a need for more HIV/AIDS information.			
51.	Condoms can be used to prevent pregnancy.			
52.	HIV/AIDS education should be part of school curriculums.			
53.	Information concerning HIV/AIDS should be distributed through mass media.			
54.	HIV/AIDS is already a major health problem in Indonesia.			
55.	I have adequate knowledge about HIV/AIDS to take action to prevent			

	contracting the virus.			
56.	I think it's better to delay sex until after marriage.			
57.	I'm not the kind of person that gets HIV/AIDS.			

D. HIV/AIDS Information Sources

From what sources *have* ***you ever heard/read/received*** *information about HIV/AIDS from****,*** *mark an X in the appropriate column using the scale below****:***

A lot *:Information source that has delivered* ***a lot*** *of information about HIV/AIDS to you.*
A little *:Information source that has delivered* ***a little*** *information about HIV/AIDS to you.*
None ***:****Information source that has delivered* ***no*** *information about HIV/AIDS to you.*

		A lot	**A little**	**None**
1.	HIV/AIDS seminars			
2.	News Papers			
3.	Magazines			
4.	School Book			
5.	Radio			
6.	Television			
7.	Internet			
8.	Banner			
9.	Announcement Boards			
10.	HIV/AIDS brochures and pamphlets			
11.	Friends			
12.	Teachers			
13.	Religious Leaders			
14.	Siblings			
15.	Parents			
16.	Public Health Clinic/Health Department			
17.	National Department of Information			
18.	Non-governmental Organization (NGO), explain ……..			
19.	Other Source, Explain …….			

E. Educational Media about HIV/AIDS

*In your opinion, **the general public** receives HIV/AIDS information from which of the media sources listed below, **give your opinion on each media source** by marking an X in the appropriate column using the scale below:*

Still needs a lot *: Media source that is a venue that **still needs to provide a lot more** HIV/AIDS education information.*

Still needs a little *: Media source that already provides HIV/AIDS education information, but **does not yet provide a sufficient amount** .*

Already sufficient *:Media source that **already provides a sufficient** amount of useful HIV/AIDS education information.*

		Still Needs A lot	Still Needs A little	Already Sufficient
1.	Film or video			
2.	Speech from Health Field			
3.	Speech from Religious Leaders			
4.	Pamphlet and brochure			
5.	Poster			
6.	Announcement Board			
7.	Magazine			
8.	Television			
9.	Radio			
10.	News Paper			
11.	Internet			
12.	School Books			
13.	Public Health Clinic/Health Department			
14.	National Department of Information			
15.	Non-governmental Organization (NGO), explain ……..			
16.	Other Media, explain …….…….			

F. HIV/AIDS programs from PKBI/Lentera Sahaja/Griya Lentera

Circle the letter in front of the answer you want to choose.

1. Have you ever heard of PKBI/ Griya Lentera/ Lentera Sahaja?
   a. Yes
   b. No (go to number **F.5**)

2. Have you ever used any of the HIV/AIDS programs offered by PKBI/ Griya Lentera/ Lentera Sahaja?
   a. Yes
   b. No (go to **F.5**)

3. What kind of programs offered by PKBI/ Griya Lentera/ Lentera Sahaja have you ever participated in? (choose more than one answer if appropriate)
   a. Speech
   b. Training
   c. Out-reach
   d. Seminar
   e. Other Program, explain ……..

4. How much useful information did you receive form the program above?
   a. A lot of useful information.
   b. A little useful information.
   c. No information was useful.

5. What kind of HIV/AIDS program could PKBI/Lentera Sahaja/ Griya Lentera offer that would be of interest to you? (choose more than one answer if appropriate)
   a. Speech
   b. Training
   c. Out-reach
   d. Seminar
   e. Other Program
      explain ……..
   f. There are no HIV/AIDS programs that would be of interest to me.

G. HIV/AIDS programs from Other HIV/AIDS NGOs

Circle the letter in front of the answer you want to choose.

1. Have you ever heard of and HIV/AIDS Non-governmental Organization (NGO) other than PKBI/ Griya Lentera/ Lentera Sahaja?
   c. Yes
   d. No (go to number **G.5**)

2. Have you ever used any of the HIV/AIDS programs offered by the above mentioned NGO?
   c. Yes
   d. No (go to **F.5**)

3. What kind of programs offered by the above mentioned NGO have you ever participated in? (choose more than one answer if appropriate)
   f. Speech
   g. Training
   h. Out-reach
   i. Seminar
   j. Other Program, explain ……..

4. How much useful information did you receive form the program above?
   d. A lot of useful information.
   e. A little useful information.
   f. No information was useful.

5. What kind of HIV/AIDS program could the Ngo mentioned above offer that would be of interest to you? (choose more than one answer if appropriate)
   g. Speech
   h. Training
   i. Out-reach
   j. Seminar
   k. Other Program
      explain ……..
   l. There are no HIV/AIDS programs that would be of interest to me.

Future Research and Closing

Thank you for all the time you gave in answering the above questions. The researcher very much appreciates your help with this research. As was stated in the beginning, all of the above answers will be confidential. Your name and other identifying information will be kept anonymous and will not be connected to the above answers.

This quantitative survey is part of a continuing research project. The Next phase of this research project includes interviews and small focus groups. Interviews and small focus groups are an important way to for you to express your thoughts. We care about what you think!

If you are interested in continuing with the next part of this important research project *please tear off this page* **and answer the questions below:**

1. Are you interested in clarifying the information above in the format of a private interview?

   a. Yes
   b. No

2. Are you interested in clarifying the information above in the format of a small focus group?
   a. Yes
   b. No

3. The easiest way to reach you so that you can continue to help us with this important research :
   a. Home phone
   b. Cell phone
   c. E-mail
   d. Visit my home
   e. Other, ...

4. Name : ……
5. Home phone : ……
6. Cell phone : ……
7. E-mail address : ……
8. Home address : ……

“Thank you for the time and energy you have given.”

APPENDIX B

THE SURVEY INSTRUMENT IN INDONESIAN

Kuesioner Penelitian:

PANDANGAN MASYARAKAT YOGYAKARTA TERHADAP HIV/AIDS

Oleh:
Piper L. Crisovan
Mahasiswa S.3 Jurusan Antropologi
Universitas Pittsburgh
Amerika Serikat

Semua informasi yang anda tulis dalam kuesioner ini hanya akan digunakan untuk kepentingan penelitian dan tidak akan digunakan untuk kepentingan yang lain. Kuesioner ini tidak bernama dan kerahasiaan jawaban anda akan sangat dijaga/tidak akan diberikan kepada pihak manapun.

Yogyakarta
September – November, 2002

A. Latar Belakang

Lingkarilah huruf di depan jawaban yang sudah di sediakan sebagai jawaban yang anda pilih.

1. Jenis kelamin anda ……..
   d. Laki-laki
   e. Perempuan

2. Umur anda ……..
   g. 15 – 20 tahun
   h. 21 – 25 tahun
   i. 26 – 30 tahun
   j. 31 – 35 tahun
   k. 35 – 40 tahun
   l. lebih dari 40 tahun

3. Dari manakah asal anda?
   g. Yogyakarta
   h. Jawa Tengah
   i. Jawa Barat
   j. Jawa Timur
   k. Jakarta
   l. Dari luar pulau Jawa,
      sebutkan …….

4. Sudah berapa lama tinggal di Yogyakarta?
   e. Kurang dari 1 tahun
   f. 1 – 5 tahun
   g. 6 – 10 tahun
   h. Lebih dari 10 tahun

5. Apakah pendidikan terakhir anda?
   h. Tidak tamat Sekolah Dasar (SD)
   i. Sekolah Dasar (SD)
   j. Sekolah Menengah Pertama (SMP)
   k. Sekolah Menengah Atas/Umum (SMA/SMU)
   l. Diploma (D1- D3)
   m. Strata Satu (S1)
   n. Diatas Strata Satu (S1),
      sebutkan …….

6. Apakah pekerjaan anda?
   i. Pengangguran
   j. Pegawai Negeri Sipil (PNS),
      sebutkan …….
   k. Pegawai Swasta, sebutkan ……
   l. Pelajar, di sekolah …….
   m. Mahasiswa, di universitas …….
   n. Pedagang, sebutkan ……..
   o. Pekerja Seks, di ……..
   p. Lain-lain, sebutkan …….

7. Berapakah penghasilan anda tiap bulan?
   g. Belum punya penghasilan
   h. < Rp. 100.000,00
   i. ≥ Rp. 100.000,00 < Rp. 300.000,00
   j. ≥ Rp. 300.000,00 < Rp. 600.000,00
   k. ≥ Rp. 600.000,00 < Rp 1.000.000,00
   l. ≥ Rp. 1.000.000,00

8. Status anda ……. Belum menikah
   e. Menikah
   f. Cerai
   g. Duda/Janda

9. Berapakah jumlah anak anda?
   i. Belum punya anak
   j. 1 – 2 anak
   k. 3 – 4 anak
   l. Lebih dari 4 anak,
      sebutkan …… anak

10. Agama anda ……
    g. Islam
    h. Hindu
    i. Katolik
    j. Kristen/Protestan
    k. Buddha
    l. Lain-lain, sebutkan ……

B. Kesehatan Seksual

Lingkarilah huruf di depan jawaban yang sudah di sediakan sebagai jawaban yang anda pilih.

1. Apakah anda pernah melakukan hubungan seks?
   d. Ya, pernah
   e. Belum (langsung ke nomer 10)

2. Pada umur berapakah anda pertama kali melakukan hubungan seks?
   …… tahun

3. Dengan siapakah anda pertama kali melakukan hubungan seks?
   g. Pacar
   h. Teman
   i. Pekerja seks
   j. Tunangan
   k. Suami / istri
   l. Lain-lain, sebutkan …….

4. Alat kontrasepsi apa yang anda pakai pertama kali berhubungan seks?
   j. Tidak pakai alat kontrasepsi
   k. Kondom
   l. Pil KB
   m. Spiral/IUD
   n. Suntikan KB
   o. Susuk KB
   p. Vasektomi/tubektomi
   q. Sistem kalender
   r. Lain-lain, sebutkan …….

5. Alat kontrasepsi apa yang sekarang anda pakai?
   a. Tidak pakai alat kontrasepsi
   b. Kondom
   c. Pil KB
   d. Spiral/IUD
   e. Suntikan KB
   f. Susuk KB
   g. Vasektomi/tubektomi
   h. Sistem kalender
   i. Lain-lain,
      sebutkan …….

6. Pernahkah anda/pasangan anda memakai kondom pada waktu melakukan hubungan seks?
   e. Ya
   f. Tidak
   g. Tidak yakin
   h. Tidak ingat

7. Bagaimana frekuensi pemakaian kondom anda/pasangan anda?
   e. Selalu
   f. Hampir selalu
   g. Jarang
   h. Tidak pernah

8. Penyakit Menular Seksual (PMS) apakah yang pernah anda derita? (bisa lebih dari 1 jawaban)
   j. Tidak pernah ada
   k. HIV/AIDS
   l. Sipilis
   m. GO/Kencing nanah
   n. Klamedia
   o. Herpes
   p. Kutu
   q. Hepatitis
   r. Lain-lain
      sebutkan ……

9. Apa yang pernah anda lakukan untuk mencegah Penyakit Menular Seksual (PMS) atau HIV/AIDS? (bisa lebih dari 1 jawaban)
   o. Menerima suntikan antibiotik
   p. Pergi ke dukun
   q. Pergi ke dokter
   r. Pergi ke PUSKESMAS
   s. Pergi ke Rumah Sakit
   t. Minum obat
   u. Minum jamu
   v. Mencuci alat kelamin sesudah berhubungan seks
   w. Memeriksa/membersihkan alat kelamin pasangan
   x. Hati-hati memilih pasangan yang bersih
   y. Memakai kondom
   z. Tidak ada, karena tidak pernah khawatir
   aa. Lain-lain, sebutkan ……

10. Seandainya anda terkena Penyakit Menular Seksual (PMS) atau HIV/AIDS, apakah yang pertama kali anda lakukan?
    j. Dibiarkan saja
    k. Minum jamu
    l. Pergi ke dukun
    m. Pergi ke PUSKESMAS
    n. Pergi ke dokter
    o. Pergi ke Rumah Sakit
    p. Konsultasi ke LSM,
       nama LSM ……..
    q. Tidak berhubungan seks dengan orang asing
    r. Lain-lain,
       sebutkan ……

C. Fakta dan Pandangan Mengenai HIV/AIDS

Pilih salah satu mana yang anda anggap paling benar dari pernyataan-pernyataan di bawah ini. Beri tanda silang (X) *dalam kolom yang tersedia.*

		Ya	Tidak	Ragu-Ragu/ Tidak Tahu
1.	Pernahkan anda mendengar atau membaca kata HIV/AIDS?			
2.	Apakah anda menghindari berciuman dengan orang yang kena HIV/AIDS? (bahkan jika famili anda sendiri)			
3.	Apakah anda menghindari berpelukan, bersalaman dengan orang yang terinfeksi HIV/AIDS?			
4.	Satu kondom bisa dipakai lebih dari satu kali.			
5.	Maukah anda minum dari gelas orang yang dicurigai terinfeksi virus HIV/AIDS? (bahkan jika famili anda sendiri)			
6.	Kondom mengurangi kenikmatan bagi perempuan.			
7.	HIV/AIDS berasal dari Amerika.			
8.	Terdapat kemungkinan virus HIV/AIDS tertular melalui jarum imunisasi yang digunakan secara bersama-sama.			
9.	AIDS singkatan dari “Acquired Immune Deficiency Syndrome”.			
10.	Kondom tidak baik digunakan untuk pasangan suami istri, sebab dapat menyebabkan kecurigaan.			
11.	Belum ada pengobatan yang efektif untuk orang yang terkena HIV/AIDS.			
12.	Terdapat kemungkinan virus HIV/AIDS tertular melalui pisau/alat sunat yang digunakan secara bersama.			
13.	Seseorang bisa terkena HIV/AIDS hanya dengan berdekatan dengan mereka yang sudah terinfeksi.			
14.	HIV/AIDS bisa menular melalui kontak badan seperti: berpelukan, bersalaman.			
15.	Lebih baik jika laki-laki yang membeli kondom daripada perempuan.			
16.	Para pecandu obat bius yang menggunakan jarum suntiknya secara bersama-sama dapat meningkatkan resiko mereka tertular HIV/AIDS.			
17.	Penurunan berat badan yang terus menerus merupakan salah satu gejala AIDS.			
18.	Seorang bisa terkena HIV/AIDS melalui transfusi darah.			
19.	Menurut saya kondom mahal harganya.			
20.	Berkeringat pada malam hari dan selalu merasa letih merupakan			

	salah satu tanda gejala AIDS.			
21.	Terdapat kemungkinan virus HIV/AIDS tertular melalui jarum tatoo yang digunakan secara bersama.			
22.	Hanya orang-orang yang berhubungan seks dengan berganti-ganti pasangan yang sebaiknya menggunakan kondom.			
23.	Virus HIV/AIDS merupakan wabah di masyarakat Indonesia.			
24.	Pemakaian kondom merupakan salah satu cara untuk mencegah HIV/AIDS.			
25.	Perempuan hamil yang terinfeksi HIV/AIDS pasti menularkan virus ke bayinya.			
26.	Menurut saya kondom berbahaya karena bisa hilang/tertinggal di dalam tubuh.			
		Ya	**Tidak**	**Ragu-Ragu/ Tidak Tahu**
27.	Virus HIV/AIDS bisa menular melalui air susu ibu.			
28.	Orang yang berpendidikan tinggi tidak memiliki resiko tertular HIV/AIDS.			
29.	Orang yang mempunyai virus HIV akhirnya menjadi AIDS.			
30.	Menurut saya kondom mudah digunakan.			
31.	HIV/AIDS dapat ditularkan melalui bersin dan batuk.			
32.	HIV/AIDS dapat ditularkan melalui WC umum.			
33.	HIV/AIDS dapat ditularkan melalui gigitan nyamuk.			
34.	Orang yang terinfeksi HIV/AIDS bisa dilihat dari penampilannya.			
35.	Virus HIV/AIDS menyerang dan mengganggu fungsi sistem kekebalan tubuh.			
36.	Seseorang yang terinfeksi virus HIV/AIDS bisa menularkan pada orang lain melalui hubungan seks.			
37.	Menggunakan kondom bertentangan dengan agama saya.			
38.	HIV/AIDS bisa ditularkan melalui barang-barang miliki orang yang terinfeksi, seperti baju atau handuk.			
39.	Hanya orang homo (gay) yang dapat terinfeksi HIV/AIDS.			
40.	Menurut saya kondom mudah didapat.			
41.	Saya pernah membicarakan tentang HIV/AIDS dengan orang lain.			
42.	Saya merasa nyaman ketika berbicara tentang HIV/AIDS dengan orang lain.			
43.	Saya percaya bahwa HIV/AIDS adalah jalan Tuhan untuk menghukum manusia atas kejahatan mereka.			
44.	Secara pribadi saya sangat prihatin tentang wabah HIV/AIDS.			

45.	Saya percaya bahwa orang yang terinfeksi HIV/AIDS tidak boleh bekerja di tempat umum.			
46.	Saya sendiri mau belajar lebih banyak tentang HIV/AIDS dan hal-hal mengenai penyakit tersebut.			
47.	Kondom mengurangi kenikmatan bagi laki-laki.			
48.	Pecandu narkoba yang terinfeksi HIV/AIDS pantas menerimanya.			
49.	Dibutuhkan informasi yang lebih banyak tentang HIV/AIDS.			
50.	Kondom dapat digunakan untuk mencegah kehamilan.			
51.	Pendidikan tentang HIV/AIDS seharusnya menjadi bagian dari kurikulum sekolah.			
52.	Informasi tentang HIV/AIDS seharusnya disalurkan melalui media massa.			
53.	HIV/AIDS sudah menjadi salah satu masalah kesehatan utama di Indonesia.			
54.	Saya memiliki cukup pengetahuan tentang HIV/AIDS untuk bertindak mencegah terinfeksi virus tersebut.			
55.	Saya pikir lebih baik menunda hubungan seks sampai menikah.			
56.	Saya bukan tipe orang yang sepertinya bisa terkena HIV/AIDS.			
57.	Perempuan hamil yang terinfeksi HIV/AIDS pasti tidak akan menularkan virus ke bayinya.			

D. Sumber Informasi Mengenai HIV/AIDS

Dari mana *informasi tentang HIV/AIDS yang* ***pernah anda dengar/baca/terima****, beri tanda silang* (X) *pada kolom yang sudah disediakan, dengan penjelasan:*

Banyak *: Sumber informasi tersebut* ***banyak*** *memberikan informasi mengenai HIV/AIDS kepada anda.*

Sedikit *: Sumber informasi tersebut* ***sedikit*** *memberikan informasi mengenai HIV/AIDS kepada anda.*

Tidak *: Sumber informasi tersebut* ***tidak*** *memberikan informasi mengenai HIV/AIDS kepada anda.*

		Banyak	**Sedikit**	**Tidak**
1.	Seminar tentang HIV/AIDS			
2.	Koran			
3.	Majalah			
4.	Buku bacaan sekolah			

5.	Radio			
6.	Televisi			
7.	Internet			
8.	Spanduk			
9.	Papan pengumuman			
10.	Brosur dan pamflet HIV/AIDS			
11.	Teman			
12.	Guru			
13.	Pemimpin agama			
14.	Saudara			
15.	Orang tua			
16.	Pemerintah/PUSKESMAS			
17.	Lembaga Swadaya Masyarakat (LSM), Sebutkankan ……..			
18.	Sumber yang lain, Sebutkan …….			

E. Media Pendidikan Mengenai HIV/AIDS

*Menurut pendapat anda, **masyarakat umum** memanfaatkan **lebih banyak** informasi HIV/AIDS dari media yang tersebut di bawah ini, beri penjelasan anda dengan memberi tanda silang* (X) *pada kolom yang sudah tersedia, dengan keterangan:*

***Masih Perlu Banyak** : media tersebut **masih perlu diperbanyak lagi** sebagai media pendidikan HIV/AIDS.*

***Masih Perlu Sedikit** : media tersebut **sudah** tersedia dimana-mana, tapi **belum cukup**.*

***Sudah Cukup** :media tersebut **sudah cukup** bermanfaat sebagai media pendidikan mengenai HIV/AIDS.*

		Masih Perlu Banyak	**Masih Perlu Sedikit**	**Sudah Cukup**
1.	Film atau Video			
2.	Penceramah dari bidang kesehatan			
3.	Penceramah agama			
4.	Pamflet dan brosur			
5.	Poster			
6.	Papan pengumuman			
7.	Majalah			
8.	Televisi			
9.	Radio			

10.	Koran			
11.	Internet			
12.	Buku bacaan sekolah			
13.	Pemerintah (PUSKESMAS/ Depertemen Penerangan)			
14.	Lembaga Swadaya Masyarakat (LSM), sebutkan …….			
15.	Media lainnya, sebutkan …….....			

F. Program tentang HIV/AIDS oleh PKBI/Lentera Sahaja/Griya Lentera

Lingkarilah huruf di depan jawaban yang sudah di sediakan sebagai jawaban yang anda pilih.

1. Pernahkah anda mendengar nama PKBI/ Griya Lentara/ Lentera Sahaja?
   e. Pernah
   f. Belum pernah (langsung ke **F.5**)

2. Pernahkah anda memanfaatkan program-program HIV/AIDS yang ditawarkan oleh PKBI/ Griya Lentara/ Lentera Sahaja?
   e. Pernah
   f. Belum pernah (langsung ke **F.5**)

3. Program HIV/AIDS seperti apa yang ditawarkan oleh PKBI/ Griya Lentara/ Lentera Sahaja yang pernah anda ikuti?(bisa lebih dari satu)
   k. Ceramah
   l. Pelatihan
   m. Pendampingan
   n. Seminar
   o. Program lainnya, sebutkan ……..

4. Seberapa banyak informasi bermanfaat yang sudah anda terima dari program-program HIV/AIDS tersebut?
   g. Banyak informasi yang bermanfaat.
   h. Sedikit informasi yang bermanfaat.
   i. Tidak ada informasi yang bermanfaat.

5. Program HIV/AIDS seperti apa yang dapat PKBI/Lentera Sahaja/ Griya Lentara tawarkan yang menarik bagi anda? (bisa lebih dari satu)
   m. Ceramah
   n. Pelatihan
   o. Pendampingan
   p. Seminar
   q. Program lainnya, sebutkan ……..
   r. Tidak ada program HIV/AIDS yang menarik bagi saya.

G. Lembaga Swadaya Masyarakat (LSM) lain yang bergerak di bidang HIV/AIDS

Lingkarilah huruf di depan jawaban yang sudah di sediakan sebagai jawaban yang anda pilih.

1. Pernahkah anda mendengar tentang Lembaga Swadaya Masyarakat (LSM) selain PKBI/Lentera Sahaja/ Griya Lentera, yang bergerak pada masalah HIV/AIDS?
   a. Pernah
   b. Belum pernah (langsung ke **G.5**)

2. Pernahkah anda memanfaatkan program-program HIV/AIDS yang ditawarkan oleh Lembaga Swadaya Masyarakat (LSM) tersebut?
   a. Pernah
   b. Belum pernah (langsung ke **G.5**)

3. Program HIV/AIDS seperti apa yang ditawarkan oleh Lembaga Swadaya Masyarakat (LSM) tersebut yang pernah anda ikuti?(bisa lebih dari satu)
   a. Ceramah
   b. Pelatihan
   c. Pendampingan
   d. Seminar
   e. Program lainnya, sebutkan ……..

4. Seberapa banyak informasi bermanfaat yang sudah anda terima dari program-program HIV/AIDS tersebut?
   a. Banyak informasi yang bermanfaat.
   b. Sedikit informasi yang bermanfaat.
   c. Tidak ada informasi yang bermanfaat.

5. Program HIV/AIDS seperti apa yang dapat PKBI/Lentera Sahaja/ Griya Lentara tawarkan yang menarik bagi anda? (bisa lebih dari satu)
   a. Ceramah
   b. Pelatihan
   c. Pendampingan
   d. Seminar
   e. Program lainnya, sebutkan ……..
   f. Tidak ada program HIV/AIDS yang menarik bagi saya.

Penelitian ke Depan dan Penutup

Terima kasih atas kesediaan waktu yang Anda berikan untuk menjawab semua pertanyaan-pertanyaan di atas. Peneliti sangat menghargai bantuan yang Anda berikan dalam penelitian ini. Sebagaimana tujuan awal penelitian, semua jawaban atas pertanyaan-pertanyaan di atas akan dirahasiakan. Nama Anda atau informasi penghubung lainnya tidak ada kaitannya dengan semua jawaban di atas.

Survey Kuantitatif ini adalah bagian dari proyek penelitian yang berkesinambungan. Langkah selanjutnya dari proyek penelitian ini meliputi wawancara dan diskusi kelompok kecil. Wawancara dan diskusi kelompok kecil adalah jalan penting untuk mendapatkan masukan dari anda. Kami peduli dengan apa yang anda pikirkan!

Jika anda tertarik untuk berperan serta lebih lanjut dalam proses penelitian yang penting ini, *tolong lepas halaman ini* dan jawab pertanyaan-pertanyaan di bawah:

1. Bersediakah anda nanti menjelaskan semua informasi tersebut di atas ke dalam bentuk wawancara pribadi?
   c. Ya
   d. Tidak

2. Bersediakah anda nanti menjelaskan semua informasi tersebut ke dalam bentuk diskusi kelompok kecil dengan orang lain?
   c. Ya
   d. Tidak

3. Cara termudah menghubungi saya untuk terlibat ke depan dalam penelitian penting ini adalah:
   f. Telepon di rumah
   g. Telepon di Hand Phone (HP)
   h. E-mail
   i. Menghubungi di rumah
   j. Lain-lain, ...

4. Nama : ……
5. No. Telepon Rumah : ……
6. No. Hand Phone : ……
7. Alamat E-mail : ……
8. Alamat Rumah : ……

“Terima kasih banyak untuk waktu dan tenaga yang sudah diberikan.”

APPENDIX C

SURVEY QUESTIONS FROM IDRAYANTI 1997

This is the first group of questions that influenced my survey. Indonesian translations of questionnaires used by Indrayanti (1997) for high school students in Bali (for English see Indrayanti 1997).

(1997) Kadek Wiwik Indrayanti

Master's Thesis, Sociology- Mississippi State University

"Knowledge of HIV and AIDS among Young Adults in Denpasar, Bali, Indonesia"

Latar Belakang

1. Jenis kelamin anda?
    1. Laki-laki
    2. Perempuan
2. Agama anda?
    1. Islam
    2. Hindu
    3. Katholik
    4. Protestant
    5. Buddha
    6. Kongfucu
    7. Lain-lain: _____
3. Status anda?
    1. Bujang
    2. Kawin
    3. Cerai
    4. Duda/janda
4. Jika anda belum menikah, apakah sekarang anda mempunyai?
    1. ya
    2. tidak
5. Pernakah anda melakukan hubungan kelamin?
    1. ya
    2. tidak
6. Dengan siapa saja anda melakukannya?
    1. Pacar
    2. Teman
    3. Wanita Tuna Susila
    4. Lain-lain _____

7. Pernahkah pasangan anda memakai kondom pada waktu melakukan hubungan kelamin?
    1. ya
    2. tidak
    3. tidak yakin
    4. tidak ingat
8. Bagaimana frekuensi pemakaian kondom pasangan anda?
    1. selalu
    2. hampir selalu
    3. jarang
    4. tidak pernah

Silahkan memilih mana yang anda anggap benar atau salah pernyataan dibawah ini

	Ya	Tidak	Tidak Yakin
1. Pernakah anda mendengar atau membaca kata AIDS.	( )	( )	( )
2. Apakah anda menghindari bericiuman dengan orang yang kena AIDS? (Bahkan jika famili anda sendiri?)	( )	( )	( )
3. Apakah anda menghidari berpelukan, bersalaman dengan orang yang kena AIDS	( )	( )	( )
4. Maukah anda minum dari gelas orang yang curigai mempunyai virus HIV?	( )	( )	( )
5. AIDS berasal dari Amerika.	( )	( )	( )
6. AIDS singkatan dari “Aqcquired Immune Deficiency Syndrome.”	( )	( )	( )
7. Belum ada pengobatan yang efektif untuk orang yang terkena AIDS.	( )	( )	( )
8. Sesorang bisa kena AIDS hanya dengan berdekatan dengan mereka yang mempunai virus.	( )	( )	( )
9. AIDS bisa menular melalui kontak badan seperti:	( )	( )	( )

berpelukan, bersalaman.

10. Seseorang bisa kena AIDS jika melakukan donor darah. ( ) ( ) ( )

11. Homoseksual adalah orang yang berisko tinggi untuk terkena AIDS. ( ) ( ) ( )

12. Lesbian adalah orang yang berisko tinggi untuk terkena AIDS. ( ) ( ) ( )

13. Para pecandu obat bius yang sama-sama mengnakan jarum suntiknya adalah group yang berisiko ( ) ( ) ( )

    tinggi untuk AIDS.

14. Perurunan berat badan yang terus menerus merupan salah satu gejala untuk terkena AIDS. ( ) ( ) ( )

15. Sesorang bisa memperoleh AIDS tranfusi darah. ( ) ( ) ( )
16. Berkeringat pada malam hari dan selalu merasa letih juga merupakan tanda-tanda terkena AIDS. ( ) ( ) ( )

17. HIV virus merupakan wabah di masyarakat kita. ( ) ( ) ( )
18. Pemakaian kondom merupakan salah satu cara untuk tidak tertular HIV. ( ) ( ) ( )

19. Perempuan hamil yang terinfeksi HIV bisa menularkan virus ke bayinya. ( ) ( ) ( )

20. HIV virus bisa menualr melalui susu ibu. ( ) ( ) ( )
21. Pendonor darah adalah orang yang bisa tertular HIV. ( ) ( ) ( )

22. Mahasiswa adalah grup yang berisiko tinggi terhadap HIV. ( ) ( ) ( )

23. Orang yang mempunyai HIV virus akhirnya menjadi AIDS. ( ) ( ) ( )

24. Tidak ada pengobatan untuk orang yang mempunyai HIV. ( ) ( ) ( )

APPENDIX D

SURVEY QUESTIONS FROM MUSA 1997

This is the second group of questions that influenced my survey. Indonesian translations of questionnaires used by Musa (1997) for high school students in West Java (for English see Musa 1997).

(1997) Risman Musa

PhD Dissertation, Education Theory and Practice, Florida State University

"A Comparative Study of High School Students' Knowledge of and Attitudes toward AIDS in Rural and Urban High Schools: the Case of West Java Province, Indonesia"

Angket Survei Penelitian untuk 10 SMA di Propinsi Jawa Barat, Indonesia

Bagian ke I

Baca setiap pertanyaan dengan seksama

Lingkari huruf sebagai jawaban yang anda pilih

1. Jenis kelamin anda?
   (a) Perempuan
   (b) Laki-laki
2. Apa nama sekolah anda? (tulis nama dan alamat sekolahmu)
   ……

3. Apakah bapak anda memiliki pendidikan formal
   (a) Ya
   (b) Tidak
   Jika tidak lewati no. 4

4. Apakah pendidikan terakhir bapak anda?
   (a) Sekolah Dasar (1-6 tahun)
   (b) Sekolah Menengah Pertama (7-9 Years)
   (c) Sekolah Menengah Atas (10-12 tahun)
   (d) Lulus Universitas (13-18 tahun)
5. Apakah ibu anda memiliki pendidikan formal
   (a) Ya
   (b) Tidak

Jika tidak lewati no. 6

6. Apakah pendidikan terakhir ibu anda?
   (a) Sekolah Dasar (1-6 tahun)
   (b) Sekolah Menengah Pertama (7-9 Years)
   (c) Sekolah Menengah Atas (10-12 tahun)
   (d) Lulusan Universitas (13-18 tahun)
7. Apakah bapak anda memiliki pekerjaan?
   (a) ya
   (b) tidak

Jika tidak lewati no. 8

8. Apakah pekerjaan bapak anda?
   (a) Petani
   (b) Pedagang
   (c) Pegawai pemerintah
   (d) Pegawai perusahaan swasta
   (e) Tentara
   (f) Lain-lain (tolong sebutkan) .....

9. Apakah ibu anda memiliki pekerjaan?
   (a) ya
   (b) tidak

Jika tidak lewati no. 8

10. Apakah pekerjaan ibu anda?
    (a) Petani
    (b) Pedagang
    (c) Pegawai pemerintah
    (d) Pegawai perusahaan swasta
    (e) Tentara
    (f) Lain-lain (tolong sebutkan) .....
11. Yang manakah pendapatan keluarga anda setiap bulan di bawah ini
    (a) Kurang dari $150
    (b) $150 - $400
    (c) Diatas $400

Bagian ke II

Baca setiap pertanyaan dengan seksama

Lingkari huruf sebagai jawaban yang anda pilih

12. AIDS kepanjangan dari “acquired immune deficiency syndrome”
    (a) Ya
    (b) Tidak
13. Virus AIDS (HIV) menyerang dan menganggu fungsi sistem kekebalan tubuh.
    (a) Ya
    (b) Tidak
14. Bisakah seseorang terkena AIDS dari suntikan narkotika bersama-sama orang lain?
    (a) Ya
    (b) Tidak
15. Bisakah seseorang terkena AIDS dari gigitan nyamuk atau serangga yang lain?
    (a) Ya
    (b) Tidak
16. Bisakah seseorang terkena AIDS dari tes darah?
    (a) Ya
    (b) Tidak
17. Bisakah seseorang terkena AIDS dari donor darah?
    (a) Ya
    (b) Tidak
18. Bisakah seseorang terkena AIDS dari hubungan seks tanpa kondom?
    (a) Ya
    (b) Tidak
19. Bisakah seseorang terkena AIDS dari siswa yang terkena AIDS/HIV di dalam kelas yang sama?
    (a) Ya
    (b) Tidak
20. Bisakah seseorang yang terkena virus AIDS menulari orang lain waktu hubungan seks?
    (a) Ya
    (b) Tidak
21. Bisakah wanita hamil yang terkena virus AIDS menulari virus tersebut pada bayinya yang belum lahir?
    (a) Ya
    (b) Tidak
22. Apakah benar bahwa AIDS bisa menyebar dengan memakai barang-barang milik orang yang terinveksi AIDS seperti sisir atau pulpen?
    (a) Ya
    (b) Tidak
23. Adakah penyembuhan untuk inveksi AIDS/HIV?
    (a) Ya
    (b) Tidak
24. Apakah benar bahwa hanya homoseksual (orang gay) dapat terinveksi AIDS/HIV?
    (a) Ya
    (b) Tidak
25. Dapatkah orang mengurangi kemungkinan mereka dari terkena HIV tanpa melalui hubungan seksual (pantang)?
    (a) Ya

(b) Tidak

26. Apakah anda tahu dimana mendapatkan informasi akurat tentang AIDS?
    (a) Ya
    (b) Tidak
27. Apakah anda tahu dimana mendapatkan tes untuk mengetahui jika anda terinveksi dengan virus AIDS?
    (a) Ya
    (b) Tidak
28. Pernahkah anda berbicara tentang AIDS/HIV dengan teman?
    (a) Ya
    (b) Tidak
29. Pernakah anda berbicara tentang AIDS/HIV dengan orang tua anda atau orang dewasa lain dalam keluargamu?
    (a) Ya
    (b) Tidak
30. Apakah anda merasa tidak nyaman dalam berbicara tentang AIDS dengan orang lain?
    (a) Ya
    (b) Tidak

31. salah pada nomor 29 dalam Kuesioner ini

Bagian ke III

Baca setiap pertanyaan dengan seksama

Lingkari huruf sebagai jawaban yang anda pilih untuk tiap pertanyaan pada skala berikut ini:

5 (SS) **jika anda Sangat Setuju dengan pernyataan tersebut**

4 (S) **jika anda Sangat dengan pernyataan tersebut**

3 (R) **jika anda ragu-ragu dengan pernyataan tersebut**

2 (TS) **jika anda Tidak Setuju dengan pernyataan tersebut**

1 (STS) **jika anda Sangat Tidak Setuju dengan pernyataan tersebut**

		SS	**S**	**TR**	**TS**	**STS**
32. Saya percaya bahwa AIDS adalah jalan Tuhan untuk menghakimi orang atas tindakan jahat mereka.	(5)	(4)	(3)	(2)	(1)	

33. Saya percaya bahwa wabah AIDS adalah kesalahan orang-orang homoseksual.	(5)	(4)	(3)	(2)	(1)
34. Saya secara pribadi prihatin tentang wabah AIDS.	(5)	(4)	(3)	(2)	(1)
35. Saya percaya bahwa orang yang terinveksi AIDS tidak boleh bekerja di tempat umum.	(5)	(4)	(3)	(2)	(1)
36. Saya sendiri mau belajar lebih banyak tentang AIDS dan hal-hal mengenai penyakit tersebut.	(5)	(4)	(3)	(2)	(1)
37. Pecandu narkoba yang terkena inveksi AIDS pantas menerimanya.	(5)	(4)	(3)	(2)	(1)
38. Ada kebutuhan untuk lebih banyak informasi tentang AIDS.	(5)	(4)	(3)	(2)	(1)
39. Pendidikan AIDS sebiknya menjadi bagian dari kurikulum sekolah.	(5)	(4)	(3)	(2)	(1)
40. Informasi tentang AIDS seharusnya disalurkan melalui media masa.	(5)	(4)	(3)	(2)	(1)
41. Siswa yang terinveksi AIDS tidak boleh masuk sekolah.	(5)	(4)	(3)	(2)	(1)
42. AIDS akan menjadi masalah kesehatan utama di Indonesia.	(5)	(4)	(3)	(2)	(1)
43. Pasangan yang menikah seharusnya memerlukan tes antibodi darah AIDS.	(5)	(4)	(3)	(2)	(1)
44. Saya percaya bahwa sebagian siswa di sekolah saya sudah cukup pengetahuan tentang AIDS dan penularannya.	(5)	(4)	(3)	(2)	(1)
45. Saya cukup pengetahuan tentang AIDS	(5)	(4)	(3)	(2)	(1)

untuk bertindak mencegah mengidap

virus tersebut.

46. Saya pikir lebih baik menunda hubungan seks sampai menikah.	(5)	(4)	(3)	(2)	(1)
47. Saya bukan jenis orang yang sepertinya bisa mendapatkan AIDS.	(5)	(4)	(3)	(2)	(1)

Bagian ke IV

Pertimbangkan setiap Sumber Informasi tentang HIV/AIDS yang kamu terima sendiri dengan menggunakan skala berikut:

(3) Sumber yang Penting dan memberi banyak informasi (SP)

(2) Sumber yang masih memberi infomasi, tapi lebih sedikit dari pada di atas (S)

(1) Bukan Sumber (BS)

	(SP)	(S)	(BS)
48. Seminar AIDS	(3)	(2)	(1)
49. Koran	(3)	(2)	(1)
50. Majalah	(3)	(2)	(1)
51. Buku bacaan sekolah	(3)	(2)	(1)
52. Radio	(3)	(2)	(1)
53. Televisi	(3)	(2)	(1)
54. Papan pengumuman	(3)	(2)	(1)
55. Brosur dan pamflet AIDS	(3)	(2)	(1)
56. Teman	(3)	(2)	(1)
57. Guru	(3)	(2)	(1)
58. Pemimpin Agama	(3)	(2)	(1)
59. Saudara	(3)	(2)	(1)
60. Orang Tua	(3)	(2)	(1)
61. Sumber lain (tolong sebutkan) …….	(3)	(2)	(1)

Bagian V

Pertanyaan di bawah menanyakan seberapa penting anda pikir setiap sumber akan memberikan informasi kepada siswa tentang AIDS. Gunakan skala berikut untuk merekam respon anda :

3 (SB) Sangat Berguna

2 (AB) Agak Berguna

1 (TB) Tidak Berguna

		SB	**AB**	**TB**
62. Film atau video di kampus	(3)	(2)	(1)	
63. Guru tamu di sekolah dari bidang kesehatan	(3)	(2)	(1)	
64. Guru tamu dari pemimpin agama	(3)	(2)	(1)	
65. Pamflet dan brosur	(3)	(2)	(1)	
66. Poster	(3)	(2)	(1)	
67. Papan pengumuman	(3)	(2)	(1)	
68. Kelas tambahan	(3)	(2)	(1)	
69. Buku bacaan	(3)	(2)	(1)	
70. Media tradisional	(3)	(2)	(1)	
71. Yang lain (tolong sebutkan) …….	(3)	(2)	(1)	

Terima kasih

APPENDIX E

INTERVIEW QUESTIONS FROM KROEGER 2000

This is the third group of questions that influenced my survey. Indonesian translations of questions used for open-ended interviews by Kroeger (2000) with housewives and sex workers in Surabaya (for English see Kroeger 2000).

(2000) Karen Ann Kroeger

PhD Dissertation, Anthropology, Washington University

"Risk, Boundary Making and the Social Order: Understanding the Social Construction of AIDS and sexuality in Indonesia"

Pertanyaan yang diajukan dalam interview dengan ibu-ibu di rumah.

1. Bagaimana anda memilih metode kontrasepsi yang digunakan? Sudahkah anda mendiskusikan hal tersebut dengan pasangan anda ketika keputusan tersebut dibuat? Bagaimana jika anda dan pasangan anda tidak setuju?
2. Ketika anda mendengar tentang kondom apa yang anda pikirkan? Jelaskan!
3. Ketika anda mendengar tentang AIDS apa yang anda pikirkan? Jelaskan!
4. Dapatkah anda jelaskan dengan kalimat anda sendiri apa yang anda ketahui tentang AIDS? Bagaimakah tentang AIDS di Indonesia? Bisa anda jelaskan apa saja yang anda ketahui tentang AIDS di sini?
5. Apakah anda takut apabila anda mungkin dapat terinveksi oleh AIDS? Mengapa atau mengapa tidak? Menurut anda, apakah anda bisa terkena AIDS? Jelaskan! Apakah anda pikir anda bisa terkena AIDS? Mengapa ya mengapa tidak?

6. Apa, menurut pendapat anda, apakah cara yang terbaik untuk mencegah terkena AIDS?
7. Pernahkah secara pribadi anda melakukan sesuatu yang khusus untuk mencegah terkena AIDS? Jelaskan!
8. Adakah orang yang anda kenal atau yang pernah anda dengar terkena AIDS? Apakah orang tersebut tetangga anda, orang di kota anda, teman, atau keluarga?
9. Apa yang akan anda lakukan untuk kesehatan anda? Apakah anda memakai jamu atau pengobatan yang lain? Seperti apa? Menurut pendapat anda adakah koneksi antara hubungan sex dan kesehatan? Jika demikian, bagaimana anda menjelaskannya?
10. Menurut penjelasan anda adakah perbedaan diantara laki-laki dan perempuan dalam hal seksualitas? Jika demikian, apa yang anda lihat dari perbedaan tersebut?
11. Bagaimana anda mempelajari tentang sexsualitas dalam kehidupan anda? Apakah orang tua mengajari atau membicarakannya dengan anda? Jika ada masalah dengan hal-hal seksualitas dalam pernikahan anda apakah anda merasa nyaman jika anda

mendiskusikannya dengan pasangan anda? Adakah teman anda yang lain yang dapat diajak bicara tentang masalah tersebut?

12. Jika anda punya anak apakah yang ingin anda sampaikan tentang sexualitas? Menurut anda, apa yang penting untuk mereka ketahui?
13. Menurut pendapat anda mengapa ada pasangan yang tidak setia?
14. Mengapa orang pergi ke tempat prostitusi?
15. Jika pasangan anda berselingkuh, apa yang akan anda lakukan? Apakah hal tersebut berbeda jika anda pikir bisa terinveksi oleh AIDS?
16. Jika anda curiga bahwa pasangan anda berselingkuh, apa anda pikir bahwa anda bisa menolak hubungan sex atau meminta hubungan sex dengan kondom?
17. Apakah anda punya komentar atau saran lain yang berhubungan dengan bagaimana orang Indonesia seharusnya berpikir tentang pencegahan AIDS?

Pertanyaan yang diajukan dalam interview dengan pekerja sex.

1. Bagaimana anda mulai sebagai pekerja sex? Bisakah anda memberitahu bagaimana hidupmu dan bagaimana anda mulai bekerja di tempat ini?
3. Bisakah anda gambarkan bagaimana anda berinteraksi dengan pelanggan/tamu baru? Bagaimana cara anda berbicara mengenai kondom dengan tamu baru?
4. Bagaimana anda memutuskan untuk memakai atau tidak memakai kondom dengan tamu?
5. Jenis praktek kesehatan apa yang anda gunakan? Adakah yang secara khusus anda lakukan untuk peduli dengan kesehatan?

APPENDIX F

PERCENTAGES FOR HIV/AIDS KNOWLEDGE LEVELS FROM THE EIGHT POPULATIONS SURVEYED

Question	SW-*NonP* %	***SW-Prog %***	Waria-NonP %	***Waria-Prog %***	HS-NonP %	***HS-Prog %***	G.Pub-NonP %	***Univ-NonP %***	Total %
There is a possibility that HIV/AIDS can be spread through an immunization injection that is used on more than one person. *Terdapat kemungkinan virus HIV/AIDS tertular melalui jarum imunisasi yang digunakan secara bersama-sama.*	**66.3**	*85*	**60**	*93.3*	**88.2**	*85.5*	**87.5**	*98*	**83**
AIDS is an abbreviation for "Acquired Immune Deficiency Syndrome." *AIDS singkatan dari "Acquired Immune Deficiency Syndrome".*	**59.5**	*81*	**56.7**	*76.7*	**76.1**	*73.7*	**71.2**	*89.6*	**73.1**
There is not yet a cure for someone who has been infected with HIV/AIDS. *Belum ada pengobatan yang efektif untuk orang yang terkena HIV/AIDS.*	**75.9**	*76.7*	**100**	*93.3*	**80.6**	*74.8*	**82**	*84.2*	**83.4**
There is a possibility that HIV/AIDS can be spread through circumcision knife/tool that is used on more than one person. *Terdapat kemungkinan virus HIV/AIDS tertular melalui pisau/alat sunat yang digunakan secara bersama.*	**63.1**	*66.7*	**56.7**	*75*	**52.9**	*61.5*	**60.1**	*77.6*	**64.2**
A person can be infected with HIV/AIDS just from being near someone who is already infected. *Seseorang bisa terkena HIV/AIDS hanya dengan berdekatan dengan mereka yang sudah terinfeksi. (no)*	**44**	*75.9*	**44.8**	*86.7*	**79.4**	*76.3*	**85**	*89.4*	**72.7**
HIV/AIDS can be transmitted through bodily contact such as: hugging or shaking hands. *HIV/AIDS bisa menular melalui kontak badan seperti: berpelukan, bersalaman. (no)*	**42.9**	*75*	**26.7**	*86.7*	**69.1**	*79.7*	**80.7**	*90.4*	**68.9**
Drug users who share the same needle increase their risk for being infected with HIV/AIDS. *Para pecandu obat bius yang menggunakan jarum suntiknya secara bersama-sama dapat meningkatkan resiko mereka tertular HIV/AIDS.*	**70.2**	*91.7*	**66.7**	*93.3*	**86.6**	*86.6*	**90**	*98.1*	**85.4**
Gradual weight loss is one early warning sign of AIDS. *Penurunan berat badan yang terus menerus merupakan salah satu gejala AIDS.*	**75**	*65*	**86.7**	*80*	**40.3**	*42*	**53.6**	*56.3*	**62.4**
A person can get HIV/AIDS from a blood transfusion. *Seorang bisa terkena HIV/AIDS melalui transfusi darah.*	**75**	*91.7*	**73.3**	*90*	**83.8**	*94.1*	**92.8**	*97.6*	**87.3**
Night sweats and chronic fatigue are some early warning signs of AIDS. *Berkeringat pada malam hari dan selalu merasa letih merupakan salah satu tanda gejala AIDS.*	**60.2**	*16.7*	**70**	*53.3*	**19.1**	*4.3*	**10.8**	*15.6*	**31.3**
There is a possibility that HIV/AIDS can be spread through a tattoo needle that is used on more than one person. *Terdapat kemungkinan virus HIV/AIDS tertular melalui jarum tatoo yang digunakan secara bersama.*	**68.7**	*86.7*	**70**	*90*	**77.9**	*87.3*	**83.3**	*93.1*	**82.1**
A pregnant woman infected with HIV/AIDS will definitely not transmit the virus to her baby. *Perempuan hamil yang terinfeksi HIV/AIDS pasti tidak akan menularkan virus ke bayinya. (no)*	**43.4**	*50*	**46.7**	*70*	**60.3**	*59.3*	**71**	*78.7*	**59.9**
The HIV/AIDS virus can be transmitted through breast milk. *Virus HIV/AIDS bisa menular melalui air susu ibu.*	**55.4**	*73.3*	**70**	*80*	**38.2**	*23.7*	**43**	*44.2*	**53.5**
HIV/AIDS can be spread through sneezing and coughing. *HIV/AIDS dapat ditularkan melalui bersin dan batuk. (no)*	**43.3**	*73.3*	**76.7**	*80*	**47.1**	*55.9*	**93.8**	*53.9*	**65.5**
HIV/AIDS can be spread through public toilets. *HIV/AIDS dapat ditularkan melalui WC umum. (no)*	**44.6**	*75*	**66.7**	*80*	**47.1**	*50.8*	**61.2**	*56.9*	**60.3**
HIV/AIDS can be spread through mosquito bites. *HIV/AIDS dapat ditularkan melalui gigitan nyamuk. (no)*	**22.9**	*67.2*	**30**	*60*	**41.2**	*43.2*	**48.2**	*37.6*	**43.8**
HIV/AIDS virus attacks and disturbs the functioning of the body's immune system. *Virus HIV/AIDS menyerang dan mengganggu fungsi system kekebalan tubuh.*	**67.1**	*93.1*	**76.7**	*96.7*	**97**	*87.3*	**93.5**	*98.5*	**88.7**
A person infected with HIV/AIDS can infect another person through sexual intercourse. *Seseorang yang terinfeksi virus HIV/AIDS bisa menularkan pada orang lain melalui hubungan seks.*	**84.3**	*93.3*	**96.6**	*96.7*	**93.9**	*96.6*	**97.1**	*99*	**94.7**
HIV/AIDS can be spread by using an AIDS- infected person's belongings such as a clothes or a towel. *HIV/AIDS bisa ditularkan melalui barang-barang miliki orang yang terinfeksi, seperti baju atau handuk. (no)*	**37.3**	*73.3*	**20**	*80*	**48.5**	*58.5*	**61**	*61.1*	**55**
A baby that is born to a mother that has HIV/AIDS will definitely be infected with the virus. *Bayi yang lahir dari ibu yang terinfeksi HIV/AIDS pasti akan tertular virus tersebut. (no)*	**2.4**	*20*	**3.3**	*26.7*	**10.3**	*5.9*	**5.8**	*6.8*	**10.1**
People with HIV will eventually develop AIDS. *Orang yang mempunyai virus HIV akhirnya menjadi AIDS.*	**69.9**	*90*	**56.7**	*93.3*	**70.6**	*65.3*	**75.7**	*82*	**75.4**
Total %	**55.8**	72.4	**59.8**	80.1	**62.3**	62.5	**68.9**	71.8	**66.7**

APPENDIX G

PERCENTAGES FOR CONDOM KNOWLEDGE LEVELS AND PERCEPTIONS FROM THE EIGHT POPULATIONS SURVEYED

Question	SW-NonP %	*SW-Prog %*	Waria-NonP %	*Waria-Prog %*	HS-NonP %	*HS-Prog %*	G.Pub-NonP %	*Univ-NonP %*	Total %
Condoms can be used to prevent pregnancy. *Kondom dapat digunakan untuk mencegah kehamilan.*	**89**	*89.8*	**82.8**	*100*	**70.6**	*60.7*	**84.2**	*81.9*	**82.8**
Wearing a condom is one way to prevent HIV/AIDS. *Pemakaian kondom merupakan salah satu cara untuk mencegah HIV/AIDS.*	**79.5**	*95*	**100**	*100*	**80.9**	*78.8*	**78.3**	*84.1*	**87.1**
One condom can be used more than one time. *Satu kondom bisa dipakai lebih dari satu kali. (no)*	**84.3**	*72.9*	**80**	*93.3*	**49.3**	*65.8*	**76.3**	*56.1*	**72.3**
A-Total:	**84.3**	*85.9*	**87.6**	*97.8*	**66.9**	*68.4*	**79.6**	*74*	**80.6**
In my opinion, condoms are easy to find. *Menurut saya kondom mudah didapat.*	**92.8**	*91.5*	**100**	*100*	**93.2**	*91.9*	**89.8**	*74.9*	**91.8**
In my opinion, condoms are easy to use. *Menurut saya kondom mudah digunakan.*	**89.2**	*93.3*	**100**	*100*	**30.9**	*42.7*	**64.4**	*38.5*	**69.9**
In my opinion, condoms are expensive. *Menurut saya kondom mahal harganya.(no)*	**81.9**	*91.7*	**86.7**	*80*	**35.8**	*35.6*	**64.5**	*37.9*	**64.2**
B-Total:	**88**	*92.2*	**95.6**	*93.3*	**53.3**	*56.7*	**72.9**	*50.4*	**75.3**
Condoms are not appropriate for married couples because they cause suspicion. *Kondom tidak baik digunakan untuk pasangan suami istri, sebab dapat menyebabkan kecurigaan. (no)*	**23.8**	*55*	**3.3**	*33.3*	**29.4**	*49.6*	**55.1**	*45.9*	**36.9**
It's more appropriate if a man buys a condom than a woman. *Lebih baik jika laki-laki yang membeli kondom daripada perempuan. (no)*	**17.1**	*36.7*	**6.7**	*26.7*	**7.4**	*15.3*	**23.2**	*15*	**18.5**
Condoms decrease the pleasure for men. *Kondom mengurangi kenikmatan bagi laki-laki. (no)*	**18.3**	*33.3*	**6.7**	*36.7*	**10.3**	*10.3*	**19.9**	*7.4*	**25.4**
A condom decreases the pleasure for women. *Kondom mengurangi kenikmatan bagi perempuan. (no)*	**9.9**	*3.4*	**0**	*35.7*	**7.4**	*13.6*	**14.2**	*8.3*	**11.6**
Condoms are only appropriate for people who change partners. *Hanya orang-orang yang berhubungan seks dengan berganti-ganti pasangan yang sebaiknya menggunakan kondom. (no)*	**13.3**	*16.7*	**3.3**	*16.7*	**27.9**	*42.4*	**42.3**	*55.1*	**27.2**
In my opinion, condoms are dangerous and can get lost/stay in the body. *Menurut saya kondom berbahaya karena bisa hilang/tertinggal di dalam tubuh. (no)*	**50.6**	*58.3*	**56.7**	*80*	**43.3**	*29.7*	**50**	*36.9*	**50.7**

Condoms are against my religion. *Menggunakan kondom bertentangan dengan agama saya. (no)*	**59**	*85*	**23.3**	*80*	**51**	*43.2*	**64.2**	*53.9*	**57.5**
C-Total:	**27.4**	*41.2*	**14.3**	*44.2*	**25.2**	*29.2*	**38.4**	*31.8*	31.5

APPENDIX H

PERCENTAGES FOR PERSONAL OPINIONS AND PERCEPTIONS FROM THE EIGHT POPULATIONS SURVEYED

A) High scores signify concerned people who are interested in HIV/AIDS issues and would like to be more informed.
B) Low score show perceptions consistent with”othering”
C) High score indicates goup thinks it’s best not to engage in pre-marital sex.

Question	SW-NonP %	*SW-Prog %*	Waria-NonP %	*Waria-Prog %*	HS-NonP %	*HS-Prog %*	G.Pub-NonP %	*Univ-NonP %*	Total %
Have you ever heard or read the word HIV/AIDS? *Pernahkan anda mendengar atau membaca kata HIV/AIDS?*	**86.7**	*96.7*	**100**	*100*	**97.1**	*99.2*	**96.4**	*100*	**97**
I have talked with another person about HIV/AIDS. *Saya pernah membicarakan tentang HIV/AIDS dengan orang lain.*	**59.8**	*86.7*	**90**	*86.7*	**61.8**	*79.5*	**75**	*84.7*	**78**
I feel comfortable talking about HIV/AIDS with another person. *Saya merasa nyaman ketika berbicara tentang HIV/AIDS dengan orang lain.*	**41**	*60*	**80**	*86.7*	**32.4**	*29.8*	**35.1**	*52.7*	**52.2**
I am personally concerned about the HIV/AIDS epidemic. *Secara pribadi saya sangat prihatin tentang wabah HIV/AIDS.*	**81.9**	*88.1*	**96.7**	*96.6*	**98.5**	*97.5*	**94.9**	*99*	**94.2**
The HIV/AIDS virus is an epidemic in the Indonesian society. *Virus HIV/AIDS merupakan wabah di masyarakat Indonesia.*	**73.5**	*71.2*	**93.3**	*83.3*	**54.4**	*67.8*	**50.7**	*62.7*	**69.6**
I would personally like to learn more about AIDS and issues surrounding the disease. *Saya sendiri mau belajar lebih banyak tentang HIV/AIDS dan hal-hal mengenai penyakit tersebut.*	**86.7**	*88.1*	**96.7**	*96.7*	**92.6**	*87.2*	**78.1**	*86.3*	**89.1**
HIV/AIDS is already a major health problem in Indonesia. *HIV/AIDS sudah menjadi salah satu masalah kesehatan utama di Indonesia.*	**69.9**	*82.8*	**100**	*93.3*	**89.7**	*80.2*	**84.8**	*83.7*	**85.6**
There is a need for more HIV/AIDS information. *Dibutuhkan informasi yang lebih banyak tentang HIV/AIDS.*	**88**	*91.1*	**96.7**	*89.7*	**100**	*97.5*	**97.1**	*97.1*	**94.7**
HIV/AIDS education should be part of school curriculums. *Pendidikan tentang HIV/AIDS seharusnya menjadi bagian dari kurikulum sekolah.*	**56.6**	*41.7*	**90**	*83.3*	**76.5**	*78*	**63.3**	*79.5*	**71.1**
Information concerning HIV/AIDS should be distributed through mass media. *Informasi tentang HIV/AIDS seharusnya disalurkan melalui media massa.*	**78**	*78.3*	**96.7**	*100*	**92.6**	*89.8*	**95.7**	*97.1*	**91**
I have adequate knowledge about HIV/AIDS to take action to prevent contracting the virus. *Saya memiliki cukup pengetahuan tentang HIV/AIDS untuk bertindak mencegah terinfeksi virus tersebut.*	**31.3**	*62.7*	**43.3**	*83.3*	**48.5**	*45.8*	**31.6**	*55.6*	**50.3**
A-Total:	**68.5**	*77*	**89.4**	*90.9*	**76.7**	*77.5*	**72.3**	*81.7*	**79.3**
I'm not the kind of person that gets HIV/AIDS. *Saya bukan tipe orang yang sepertinya bisa terkena HIV/AIDS. (no)*	**48.2**	*40.4*	**40**	*63.3*	**29.4**	*12.1*	**10.4**	*8.4*	**31.5**
Would you avoid hugging or shaking hands with someone who has HIV/AIDS? *Apakah anda menghindari berpelukan, bersalaman dengan orang yang terinfeksi HIV/AIDS? (no)*	**33.3**	*65*	**20**	*56.7*	**76.2**	*65*	**59.6**	*68.8*	**55.6**
People with high levels of education are not at risk for being infected with HIV/AIDS. *Orang yang berpendidikan tinggi tidak memiliki resiko tertular HIV/AIDS. (no)*	**59.8**	*70*	**90**	*80*	**82.4**	*86.4*	**89.2**	*93.2*	**81.4**
Only homosexuals can get HIV/AIDS. *Hanya orang homo (gay) yang dapat terinfeksi HIV/AIDS.*	**56.6**	*55*	**90**	*93.3*	**70.6**	*75.4*	**85.6**	*84.1*	**76.3**
You can tell by looking at someone if they have HIV/AIDS. *Orang yang terinfeksi HIV/AIDS bisa dilihat dari penampilannya.(no)*	**22**	*56.7*	**10**	*66.7*	**40**	*45.8*	**38.7**	*49.3*	**41.2**
HIV/AIDS came from America. *HIV/AIDS berasal dari Amerika.(no)*	**18.1**	*10.3*	**10**	*41.4*	**16.9**	*16.5*	**18.9**	*28.1*	**20**
Would you avoid kissing someone who has HIV/AIDS? (even if it was a family member) *Apakah anda menghindari berciuman dengan orang yang kena HIV/AIDS? (bahkan jika famili anda sendiri) (no)*	**29.8**	*61.7*	**33.3**	*56.7*	**34.3**	*25.9*	**30.7**	*22.4*	**36.9**
Would you drink from the glass of a person suspected of having HIV/AIDS? (even if it was a family member) *Maukah anda minum dari gelas orang yang dicurigai terinfeksi virus HIV/AIDS? (bahkan jika famili anda sendiri) (no)*	**38.1**	*35.6*	**26.7**	*46.7*	**16.4**	*23.9*	**25.4**	*15.3*	**28.5**
I believe that HIV/AIDS is God's way of punishing people for their evil acts. *Saya percaya bahwa HIV/AIDS adalah jalan Tuhan untuk menghukum manusia atas kejahatan mereka (no).*	**38.6**	*55*	**30**	*63.3*	**19.1**	*34.7*	**34.1**	*31.1*	**38.2**
I believe that individuals infected with HIV/AIDS should not be allowed to work in public places. *Saya percaya bahwa orang yang terinfeksi HIV/AIDS tidak boleh bekerja di tempat umum (no).*	**39.8**	*46.7*	**40**	*70*	**50**	*59.3*	**61.6**	*67.8*	**54.4**
Intravenous drug users who get HIV/AIDS probably deserve it. *Pecandu narkoba yang terinfeksi HIV/AIDS pantas menerimanya. (no)*	**28.9**	*46.6*	**36.7**	*48.3*	**35.4**	*25.9*	**25.5**	*34.2*	**35.2**
B-Total:	**37.6**	*49.4*	**38.8**	*62.4*	**42.8**	*42.8*	**43.6**	*45.7*	**45.4**
I think it's better to delay sex until after marriage. *Saya pikir lebih baik menunda hubungan seks sampai menikah.*	**59**	*63.3*	**80**	*73.3*	**88.2**	*94.9*	**93.5**	*93.2*	**80.7**
C- Total:	**59**	*63.3*	**80**	*73.3*	**88.2**	*94.9*	**93.5**	*93.2*	**80.7**

APPENDIX I

ENGLISH TRANSLATION OF SAMPLE QUESTIONS USED IN INTERVIEWS

A sample of the English translation of the open-ended interview questions used with sex workers. Similar questions (but a variant) were used with university students and waria. Other questions often stemmed off of these. The interviews were fluid and unforced.

Interview Questions

A. Background Information

1. What's your name?
2. Where are you from?
3. Are you married? (ask about husband, boyfriend, children)
4. When was the first time you had sex? With whom?
5. Where did you first learn about sex ed, and from who?
6. What's your opinion about sex ed?
7. Before you became a sex worker, did you have a different job? When did you start sex work? How did you start?
8. How's your communication with you family? Does your family know about your occupation?
9. What are your daily activities here like? Tell me about an average day.
10. What do your guests usually call you? And why?
11. What do you usually call you guests? And why?
12. DO you have/or have had in the past regular customers? Why do you think some men want to be your regular customer?
13. What's your opinion of your regulars? Do they differ from your other guests?
14. How do regulars view you? (girlfriend, wife, friend)
15. In your opinion, why do married men come here?
16. Do all the guests who come here want to have sex?
17. About sexual violence: What do you know about it? Have you heard of violence happening here? What happens to the man when it happens here?
18. If you have children, how will you talk to them about sex ed?

B. Condoms

1. What do you think of when you hear the word condom?
2. Explain what you know about condoms.
3. Do you always use condoms when you have sex?
4. What happens if a guest doesn't want to use a condom?
5. Where do you get condoms from? (explain)
6. Tell me how a transaction with a guest usually goes?
7. How do you negotiate the price with a guest?
8. Do you know how to use a condom? Please explain.
9. How do you negotiate condom usage with your guests?
10. When was the last time you had a guest? Tell me about it. Did you use a condom?

11. What brand of condom do you like? Why?

C. Program Evaluation

1. What do you know about HIV/AIDS? Where did you receive this information?
2. Have you ever attended a HIV/AIDS education program?
3. (if yes) Tell me about it. What was your experience like?
4. What's you opinion of the program you attended? Did you have fun?
5. In your opinion, what kind of programs would you like to see?
6. Are you scared of HIV/AIDS? Why?
7. What have you ever done to prevent HIV/AIDS? Explain.
8. What's the best way to prevent HIV transmission in your opinion? Explain.
9. In your opinion, what's the best possible kind of program for Indonesia about HIV/AIDS?
10. Have you ever heard of a PLWHA in your area? Tell me about it.
11. What kind of program would you like Griya Lentera to offer?

APPENDIX J

GLOSARY OF INDONESIAN TERMS

Allah Akbar- Allah is great
Ayam kampus- campus chickens, also a slang for student sex workers
Banci kaleng- tin can *waria* (often considered first phase in becoming a real *waria)*
Banci- slang for waria
Baygon- mosquito poison
Becong- slang for waria
Dandan- the term *waria* use for the putting on of makeup and fixing their hair
Dangdut- Indonesian folk music
Dia- he/she
Emak-emakan- procuress
Es gosrok- literally shaved ice, sexual action involving rubbing back and forth
Jamu- traditional herbal medicine
Jelek- bad/ugly
Jogja- slang for Jogjakarta (also spelled Yogyakarta), a city in Central Java
Kliwon- Javanese day of the week
Kompas- compass, also an Indonesian news paper
Losmens- cheap hotels that often double as brothels
Mas-sir
Mbak- mam
Mandi- Indonesian form of shower
Membuka diri- opening yourself or coming out
Nafsu- desire
Nakal- naughty
Ngewek- *fun, not serious*
Pacar- girlfriend/boyfriend
Panca Dharma Wanita- the Five Responsibilities of Women
Pancasila- Indonesia's five-point state ideology
Penglaris- 1st customer of the night, which is said to bring luck
Pria- man
Rawon- boiled meat
Rupiah- Indonesian currency
Saling setia- be faithful
Sate-grilled meat skewers
Sayur asin- salty vegetables
Sayur lodeh- vegetables cooked in coconut milk
Sifon- the circumcision ritual among the Atoin Meto of West Timor
Sosro- slang for Sosrowijian, the brothel area of Jogjakarta
Spiritia- an NGO for people living with HIV/AIDS in Jakarta
Supertetra- an over-the-counter antibiotic
Tamu- guest/client
Wadam- slang for waria
Wanita- woman
Waria- third gender population in Indonesia
Wong Solo- a person from the city of Solo, also a chain of fried chicken restaurants

APPENDIX K

LIST OF ACRONYMS USED

Acronym	Stands for:
ABC	Abstinence, Be Faithful ,and use Condoms
AIDS	Acquired Immune Deficiency Syndrome
ASA	*Aksi* Stop AIDS (Action for Stopping AIDS)
AusAIDS	*Australian* Agency for International Development
CMA	Critical Medical Anthropology
FCSW	Female Commercial Sex Worker
FHI	Family Health International
HIV	Human Immunodeficiency Virus
IPPA	Indonesian Planned Parenthood Association
KKN	*Korupsi, Kolusi, dan Nepotisme* (Corruption, Collusion, and Nepotism)
NGO	Non-Governmental Organization
PLWHA	Person/People Living with HIV/AIDS
PATF	Pittsburgh Aids Task Force
SD	*Sekolah Dasar* (Elementary School)
SMA	*Sekolah Menengah Pertama* (Junior High School)
SMP	*Sekolah Menengah Atas* (Senior High School)
SPSS	Statistical Package for the Social Sciences
STI	Sexually Transmitted Infection
UN	United Nations
UNAIDS	United Nations AIDS Program
UNESCO	United Nations Educational, Scientific, and Cultural Organization
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WTS	*Wanita Tuna Susila* (Woman Without Morals)

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