



**USAID**  
FROM THE AMERICAN PEOPLE

**HEALTH POLICY  
INITIATIVE**

# **IMPLEMENTING 100% CONDOM USE POLICIES IN INDONESIA: A CASE STUDY OF TWO DISTRICTS IN JAKARTA**

**OCTOBER 2007**

This publication was produced for review by the U.S. Agency for International Development (USAID). It was prepared by Kai Spratt, Senior Technical Advisor for HIV/AIDS, Health Policy Initiative, Task Order I, with data collection assistance from Dr. Izhar Fihir and Dr. Claudia Surjadjaja, Health Policy Initiative-Indonesia.

The USAID / Health Policy Initiative, Task Order I, is funded by the U.S. Agency for International Development under Contract No. GPO-I-01-05-00040-00, beginning September 30, 2005. Task Order I is implemented by Constella Futures, in collaboration with the Centre for Development and Population Activities (CEDPA), White Ribbon Alliance for Safe Motherhood (WRA), Futures Institute, and Religions for Peace.

# **IMPLEMENTING 100% CONDOM USE POLICIES IN INDONESIA: A CASE STUDY OF TWO DISTRICTS IN JAKARTA**

**OCTOBER 2007**

The views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the U.S. Government.

The USAID | Health Policy Initiative does not support the legalization of prostitution or sex trafficking. It is, however, committed to supporting effective strategies to prevent the spread of the HIV and other STIs and mitigate their impacts. The sex industry is often one of the primary mechanisms through which HIV spreads in a country. Respecting the dignity and rights of sex workers is essential for developing effective HIV prevention and care programs. The use of the terms “sex work” and “sex worker” in this report does not imply support for prostitution as a legal form of employment; rather they are used as a way to reduce the stigma and discrimination faced by sex workers, who may be vulnerable to exploitation and lack access to health-related and other types of information and services.



# TABLE OF CONTENTS

<b>Abbreviations</b> .....	<b>iv</b>
<b>Introduction</b> .....	<b>1</b>
<b>Background</b> .....	<b>2</b>
Epidemiology .....	2
Indonesia Policy Response.....	2
Decentralization in Indonesia: Current Policy Implementation Environment .....	3
Lessons Learned: 100% Condom Promotion Programs in Southeast Asia .....	4
<b>Approach of the Case Study in East and West Jakarta</b> .....	<b>5</b>
Contextual Interaction Theory Approach .....	5
Case Study Methodology .....	6
Analysis .....	7
<b>Findings</b> .....	<b>7</b>
Motivation.....	7
Information .....	10
Power/Collaboration .....	11
Other Factors Affecting Implementation of the 100% CUP .....	12
<b>Discussion</b> .....	<b>14</b>
Potential Advocacy Strategies .....	15
<b>Endnotes/References</b> .....	<b>17</b>

## ABBREVIATIONS

ART	antiretroviral therapy
ASA	Aksi Stop AIDS Project
CDC-EH	Center for Disease Control–Environmental Health Department (Ministry of Health, Indonesia)
CIT	Contextual Interaction Theory
CUP	Condom Use Program
D.A.R.E.	Drug Abuse Resistance Education
DOH	Department of Health
DOR	Department of Religion
DOT	Department of Tourism
FHI	Family Health International
GF	Global Fund
HAPP	HIV/AIDS Prevention Program
HIV	human immunodeficiency virus
HPI	Health Policy Initiative
IA	implementing agencies
IDU	injecting drug user
KPA	National AIDS Commission
KPAD	Provincial AIDS Commission
MARP	most-at-risk population
MOH	Ministry of Health
MOT	Ministry of Tourism
MSM	men who have sex with men
NAC	National AIDS Commission
NGO	nongovernmental organization
NSEP	needle and syringe exchange programs
Perda	Peraturan Daerah (local regulation)
PIBA	policy implementation barriers analysis
PLHIV	people living with HIV
RT	Rukun Tetangga (head of a neighborhood association)
RW	Rukun Warga (head of a group of neighborhood associations)
S&D	stigma and discrimination
SK	Surat Keputusan (municipal decree)
STI	sexually transmitted infection
SWs	sex workers
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Program
UNGASS	United Nations General Assembly Special Session
USAID	United States Agency for International Development
VCT	voluntary counseling and testing
WHO SEARO	World Health Organization Southeast Asia Regional Office

## INTRODUCTION

USAID and its partner organizations have extensive history in collaborating with the government of Indonesia to address the HIV epidemic; and they are now working in seven provinces and 78 of the 100 priority regencies/municipalities to support prevention, care, and treatment services for the most-at-risk populations (MARPs). As is the case in many countries, policy implementation remains a challenging area for HIV efforts in Indonesia, where many economic, environmental, and social issues vie for policymakers' and implementers' attention and action.

Policy implementation lags universally behind policy formulation.<sup>1</sup> Pragmatic experience demonstrates that the implementation of a given policy is rarely assured, and the process may be rife with delays, reinterpretations, and turf battles. There are multiple social science disciplines seeking to develop concise, testable theories and models through which policy implementation can be improved. The research literature on policy implementation has presented an enormous number of explanatory variables—a succinct, unifying theory or model has yet to emerge. However, themes emerging from several research fields suggest that barriers to implementation are not related solely to the policy's quality or operational guidelines but also from implementer belief systems, value priorities, understanding of causal relationships, and the perceptions about the importance and magnitude of the specific problems the policy is meant to address.<sup>2, 3, 4</sup> Efforts to improve policy implementation must therefore include an advocacy strategy that addresses policy implementers' values and perceptions, as well as the necessary technical solutions.

USAID | Health Policy Initiative (HPI), Task Order 1, with funding from USAID/Indonesia, is collaborating with the Family Health International (FHI) Aksi Stop AIDS (ASA) Project to address some of the policy challenges to a more comprehensive approach to the HIV epidemic. Activities include the following: (1) strengthening the capacity of the National AIDS Commission (KPA) and provincial AIDS commissions (KPADs) to do evidence-based resource allocation; and (2) working in select districts to conduct a policy implementation barriers analyses (PIBA) to address factors hindering HIV-related policy implementation. With reference to the PIBA, HPI staff met with seven of nine ASA regional directors in August 2006 to discuss the most important policy issues they faced in implementing their field-based programs. Five of the seven regional directors stated that prevention, especially the ability to implement the 100% Condom Use Program (100% CUP) endorsed in the Indonesia National HIV/AIDS Strategy, was a key priority because few municipalities were moving forward with local legislation to endorse and operationalize the program. In further discussion with ASA's headquarters staff, Surabaya, East Java, due to its high HIV prevalence, was identified as a target district in which to conduct the PIBA of the 100% CUP. Data for the PIBA were collected in three districts in East Java in January and February 2007. The data are currently being analyzed, and dissemination will begin in November.

Several questions are of interest. Given that the Indonesian National HIV/AIDS Strategy has been updated recently and that prevention remains a priority endorsed at the highest levels of national government, why have so few local municipalities, especially in highly affected provinces, taken steps to pass appropriate legislation and develop operational guidelines? Of equal interest, how and why have some districts or municipalities succeeded in getting legislation approved? Which factors influenced the development and implementation of 100% condom-use programs at a local level?

HPI conducted a case study of two municipalities located within the Special Province of Jakarta: West Jakarta, where a municipal decree (*Surat Keputusan*, SK) has been endorsed, and East Jakarta, where an SK has not been endorsed. Studying two contiguous districts provides for more valid comparisons than looking at districts in different provinces or regions, controlling for historical or temporal differences. The limitation of conducting the case study with these two districts is that differences exist in the governance

structures of the five districts that make up metro Jakarta. Unlike other provinces of Indonesia, where the districts are the ultimate arbiter of local policies, the policymakers in the districts of Jakarta can write their own SK and other decrees, but these SK/decrees cannot be implemented or funded without approval by the provincial parliament. District policy instruments, such as mayoral decrees and SK, are superseded by provincial parliamentary legislation and governor's decrees. In addition, Jakarta district legislation does not include technical or operational guidelines and sanctions. In terms of supporting the 100% CUP, the SK is more of a symbolic than substantive policy instrument. An additional limitation is that some people may not have been interviewed because they were not available or we were not aware they were key actors in the districts. These limitations notwithstanding, understanding the motivations of local officials and the barriers they overcame to support even symbolic policy might be informative for developing advocacy approaches that motivate other local officials and communities to implement the 100% CUP.

This paper presents the results of interviews conducted for the case studies, thus providing a more nuanced understanding of the environment within which local actors interpret the program; and also presents some theoretical perspectives that might frame efforts to reduce disagreement about the program.

## **BACKGROUND**

### **Epidemiology**

The HIV epidemic in Indonesia remains concentrated among MARPs, including injecting drug users (IDUs), transgender sex workers, female sex workers (SWs) and their clients, prisoners, and men who have sex with men (MSM).<sup>5</sup> The epidemic initially was driven by heterosexual sex, but, in the last 10 years, prevalence among the approximately 219,000 IDUs<sup>6</sup> has exploded—with reports which give a range from zero percent in 1997 to 47 percent by 2003.<sup>7</sup> There is now growing concern about increasing HIV prevalence among the sexual partners of IDUs. There is little evidence that HIV is spreading widely among people who do not engage in risk behaviors or their primary sexual partners. An exception to this is in the country's easternmost province of Tanah Papua. District-level estimates in 2006 suggest that HIV already exceeds 2 percent in the general population.<sup>8</sup> From the low rates recorded in the mid-1990s, HIV has begun a steady climb among SWs across the country. As early as 1996, the Center for Disease Control/Environmental Health Department (CDC-EH) issued a circular to provincial health departments to promote 100 percent condom use in all *localisasi* (areas of a town where brothels are concentrated, referred to as “localizations” in English). While condom use has risen marginally in a number of sites, unprotected sex with clients remains the norm among SWs. This is confirmed by consistently high rates of sexually transmitted infections (STIs) measured in a recent survey in eight cities.<sup>9</sup> Behavioral surveillance studies conducted in Indonesia from 1996 to 1998 showed that although a high percentage of the respondents had heard of HIV, knowledge of STIs remained relatively low, the percentage of male respondents who reported sex with a SW had increased, and the use of condoms with a SW had decreased.<sup>10</sup> Putting effective prevention efforts in place in direct and indirect sex work is still urgently needed. While several local regulations or decrees have been drafted in a few districts that support condom use programs in brothel areas, none has been fully operationalized or implemented yet.

### **Indonesia Policy Response**

The “Sentani Commitment” serves as Indonesia's pledge to address HIV and AIDS. The statement was adopted at a January 19, 2004, meeting between the Coordinating Minister for People's Welfare, six ministers constituting key members of the KPA, and provincial leaders from the six provinces most affected by HIV. The Sentani Commitment established seven objectives, including promoting condom



use in every high-risk sexual activity; preventing HIV among IDUs; providing antiretroviral therapy (ART) to at least 5,000 people living with HIV (PLHIV) by the end of 2004; reducing stigma and discrimination toward PLHIV; establishing and empowering provincial and district AIDS commissions; developing laws and regulations conducive to HIV prevention, care, and support programs; and scaling up efforts for information, education, and communication, including collaboration with religious groups. Like the United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/AIDS, the Sentani Commitment is not a legal document and thus does not legally bind the government at the national or local levels to implement programs in support of reaching these objectives.

At the national level, prevention has been a prominent concern in Indonesia's national policy and strategy documents. The KPA's recently revised 2007–2010 National HIV/AIDS Strategy specifically endorses 100% CUP as a critical component of prevention efforts:

2.2.7. One effective method of HIV prevention is the 100 percent use of condoms during high-risk sex, solely for the purpose of breaking the chain through which HIV is transmitted.

### 2.3 Strategies

2.3.1. Promoting and expanding tried and tested prevention methods, and assessing new methods. The scaling-up and expansion of prevention efforts focused on effective methods of prevention, such as condom use during high-risk sex, harm reduction among injecting drug users, and upgrading the effort to prevent the spread of sexually transmitted diseases. This strategy also involves the scaling-up and expansion of voluntary counseling and testing services and the prevention of mother-to-child transmission. This is in line with the prevention principles recommended by UNAIDS.

Other priorities outlined in the strategy include: (1) preventing the transmission of STIs and HIV; (2) providing care, treatment, and support to PLHIV; (3) conducting HIV, AIDS, and STI surveillance; (4) conducting operational and other forms of research; (5) encouraging environments conducive to HIV prevention; and (6) engaging in multiparty coordination and collaboration. These priorities are appropriate for the concentrated epidemic in Indonesia (outside of Tanah Papua) and also were emphasized in the National HIV/AIDS Strategy for 2003–2007. One question addressed in this paper is “What is the process by which the priorities of national policymakers are disseminated to provincial and local level policymakers and implementers?”

### **Decentralization in Indonesia: Current Policy Implementation Environment**

Since 2001, Indonesia's rapid decentralization initiative has fundamentally altered the country's system of governance by shifting power and resources from the central government to the regions. Two laws enacted in mid-1999 (Law 22/1999 and Law 25/1999) rapidly transferred substantial responsibilities to municipal- (*kota*) and district- (*kabupaten*) level governments. Districts and municipalities have become the primary administrative units responsible for providing 11 key government services. Further amendments to the Constitution in August 2002 (Chapter VI, Article 18) stipulated that each province, regency, and town would have regional governments regulated by law. These regional governments can regulate and administer matters of government on “the basis of autonomy and the duty of assistance.” The Ministry of Health (MOH) reserved for itself the tasks of “exercising functional control and supervising the planning and use of resources,” while at the same time indicating that districts would be accountable for the planning, implementation, and supervision of health services; and that provinces would be responsible for supervising policy implementation and handling activities “beyond the scope of districts.” The actual health responsibilities of the districts still are not clear, nor are the role distinctions of the central MOH and province-level entities. By making local governments accountable for health, Law 22 designated the district as a key arena for policy implementation and formulation; meanwhile, Law 25

greatly increased the availability of resources. These steps were supported by strong rationale, as districts own and operate health centers and public hospitals and are responsible for supervising most health staff.<sup>11</sup>

Although national, provincial, and municipal authorities still lack clarity about the extent of their authority to make policy and guidelines and how these should be funded and implemented, several provinces and municipal governments have demonstrated leadership by issuing their own local regulations (*Peraturan Daerah*, Perda) and decrees (*Surat Keputusan*, SK) related to 100% CUP. East Java (August 2004) and Riau (June 2006) have passed provincial regulations on Prevention and Control of HIV/AIDS; three districts in the province of Tanah Papua (Jayapura, Merauke, and Nabire) have a Perda for HIV prevention approved by the local government; the city of Jayapura has a Perda that has been awaiting approval since December 2003; and the provincial government of East Java approved a Perda based on a draft written for the city of Surabaya.

For the policy statements outlined in the Sentani Commitment and national strategy to be implemented, local governments must develop Perdas. By having a provincial regulation on HIV prevention, the relevant technical department (e.g., health, manpower) at the provincial and district levels can request funding from the local government. The provincial regulation also serves as the basis for providing resources and personnel to support HIV prevention programs—for example, condom use programs for SWs and their clients.<sup>12</sup> At the municipal and district levels, for a 100% CUP to be implemented a Perda must be signed by the local authority (mayor). With the endorsement of the Perda, operational guidelines are developed, the responsibilities of agencies involved in the implementation of the Perda are elaborated, and sanctions are determined. In some districts in Indonesia, a Perda has been endorsed, but no further progress has occurred. This paper will address some questions regarding the progress of 100% CUP implementation. Why have the next steps not been taken? What lessons can be learned from other countries in the region that could facilitate the implementation process of the 100% CUP in Indonesia?

### **Lessons Learned: 100% Condom Promotion Programs in Southeast Asia**

One hundred percent condom use programs seek to address structural barriers that reduce the efficacy with which sex workers ensure condom use by their clients. The decision to use a condom is often outside the direct control of a sex worker<sup>13</sup>. Introducing 100% condom use programs support prevention by changing the context within which condoms use is negotiated and makes condom use a shared responsibility of brothel managers, clients and sex workers. Successful 100% condom use programs have been implemented in the US, Australia, Europe and at the provincial level in several countries in Asia, including Cambodia (in 12 provinces), China, Lao PDR, Burma, and Vietnam,<sup>14</sup> although many of these have yet to be evaluated thoroughly. In 1998, Thailand initiated the first nationwide 100% CUP, resulting in a highly significant reduction in HIV prevalence rates among SWs and their clients. Sex work was (and remains) illegal in Thailand. Rather than trying to suppress sex work, which would not curtail demand but rather drive the industry underground and make prevention efforts more difficult, officials opted to take a harm-reduction approach by encouraging safer sex through condom use. The 100% CUP in Thailand was implemented as a result of extensive collaboration among different governmental sectors and those who influence the sex industry: police, brothel owners, SWs, and clients.<sup>15, 16</sup> An important component of the program involved placing responsibility for compliance with the CUP on brothel owners and clients, rather than on SWs only, who are not always successful in convincing clients to use condoms. Compliance was monitored regularly through STI incidence among SWs and clients, HIV rates among SWs, and condom distribution. SWs were provided with free or reduced price STI checkups and treatment. Men attending STI clinics were routinely asked which brothels they had visited; these brothels then were visited by public health staff to reinforce the program and provide any needed information. Brothels found to be the source of repeated STIs could be fined or closed by the police—although it appears that these sanctions were rarely applied.<sup>17</sup>

One important component of the program was its coverage of a wide geographic area, which limited the ability of clients to visit a competing brothel where condom use was not required. Implementing the CUP in a wide geographical area also was important in terms of compensating for the limited exposure of SWs to HIV prevention programs and peer outreach messages. SWs are a highly mobile group:<sup>18</sup> when an HIV program is initiated, not all SWs will benefit. One research team in Bali, in a study testing interventions to increase condom use, found a 50 percent turnover every six months among SWs. While providing behavioral and medical interventions to SWs did increase their knowledge about HIV and STIs, as well as their ability to ask clients to use condoms,<sup>19</sup> higher condom use requires cooperation of the clients and constant outreach efforts to ensure that all SWs new to a particular area are covered by the program. The Thai 100% CUP, by focusing on clients and brothel managers, compensated for the lack of exposure of *all* SWs to high-quality condom use programs.

Other critical components to national scale-up in Thailand were reliable surveillance data, political commitment, a good network of STI public health clinics, and nongovernmental organization (NGO) capacity to work with and on behalf of the MARP.<sup>20</sup> Condom use program activities were integrated into the responsibilities of a number of different departments or units at the public health and infection disease divisions of provincial and local governments rather than by the creation of a new vertical program. This helped to contain costs, produced a sustainable program, and provided sufficient staffing to support the required activities.

Condom use programs in other countries have adapted various components of the successful Thai model. Although there is not a “one size fits all” approach to the 100% CUP concept, a common strategy underlies all programs: the mobilization of local authorities to create an environment in which SWs can refuse unprotected sex.

A multi-country report in 2004 by the World Health Organization Southeast Asia Regional Office (WHO SEARO, 2004) found that a 100% CUP did not require the involvement of every ministry or level of government, but rather the engagement of a group of actors directly involved in or affected by a CUP, including the following:

- Local community, political, business, and professional leaders;
- Technical and professional staff from government agencies, especially local administrators of health and police/public security;
- Representatives of the sex work industry, especially establishment owners/managers and SW associations or peer educators; and
- NGOs, especially those involved in condom promotion or condom social marketing programs.<sup>21</sup>

Operations research that monitors the perception, attitudes, and concerns of communities and stakeholders implementing a CUP is also essential for successful adaptation and eventual scale-up of condom use programs.

## **APPROACH OF THE CASE STUDY IN EAST AND WEST JAKARTA**

### **Contextual Interaction Theory Approach**

Recent policy implementation research suggests that rather than viewing the policy process as a production system with specific outputs, it should be viewed as a network of interconnected actors participating in the process—in which the interactions among these actors are the central concern. The basic assumption of this approach, derived from the Contextual Interaction Theory (CIT), is that “the course and outcomes of the policy process depend not only on inputs (in this case, the characteristics of

the policy instruments) but more crucially on the characteristics of the actors involved, particularly their motivation, information, and power.”<sup>22</sup> “Motivation” refers to the degree to which the implementation of the policy or program is perceived as contributing to the goals and interests of the actors involved. “Information” refers to whether policy and program implementers and target groups have sufficient technical, administrative, or management information to benefit from the program; if actors feel they will benefit from a policy they are much more likely to request or seek out the information they need to adequately implement it. Information also refers to the effectiveness with which different actors in the network communicate and understand each other’s organizational culture. “Power” refers to understanding who is empowered to implement a policy and to what extent. Policies are implemented within a network of actors. Levels of dependency among actors in the network vary and successful implementation depends on successful collaboration within the network. For example, if actor A is not motivated to implement a policy and actors B and C are dependent on actor A to do their work, lack of collaboration may result in poor implementation. In this case, B and C may appeal to government authorities with formal authority to enforce collaboration by A. In other cases, collaboration may be improved through informal means, such as negotiating or bargaining with actor A by actors B and C or by advocacy by target group for the implementation of the policy. Other forms of power may derive from formal sources (for example, using the legal system to challenge a policy). In most interaction processes, informal sources of power may be highly important and, in many cases, can balance the often more formal powers of the implementing authorities.<sup>23</sup>

## **Case Study Methodology**

In preparing the case studies, we focused our interview questions on exploring motivation, information, and power among actors with a role in CUP implementation in the districts. Learning from the experiences of leaders and staff in East and West Jakarta may help us understand the contribution each of these factors is making to implementation condom use policies in other municipalities.

*Informants:* HPI’s local senior consultant, who is familiar with the governmental departments and NGOs in these two districts, created a short list of potential informants and conferred with the local ASA office staff on who to interview. Criteria for inclusion in the case study included (1) staff and leaders within the municipal government who were or would be involved in writing the SK and getting it approved by the mayor; and (2) staff from district government departments, NGOs, and brothels that would be involved in efforts to implement a 100% CUP. Twelve potential respondents were selected, and interviews were scheduled with the assistance of the East and West Jakarta ASA offices.

Over three and a half days in April 2007, HPI conducted 11 key informant interviews—five in West Jakarta (2 men, 3 women) and six in East Jakarta (3 men, 3 women). Standard techniques were followed for conducting qualitative research and in-depth interviews. The interviews were not tape recorded. Of the respondents in West Jakarta, three worked in the public sector and two worked with local NGOs. Of the respondents in East Jakarta, three worked for the public sector and three worked with NGOs. The interviews ranged from 45 to 120 minutes; government respondents were interviewed in their office or department conference rooms. NGO respondents were interviewed in their offices or in the health clinics where they provided services. All interviews were conducted in Bahasa with simultaneous translation (the interviewer did not speak Bahasa). Two respondents in West Jakarta were interviewed a second time to gather more details and validate information given by other respondents.

During the interviews, the following themes were explored:

What was the process through which the 100% CUP SK was written and endorsed in West Jakarta but not endorsed in East Jakarta?

Which agencies were most important in supporting or opposing the endorsed SK, and why?

What kind of advocacy was done to gain support for the SK? Who advocated, and to which other agencies or organizations was the advocacy directed?

What are the next steps in implementing the 100% CUP?

## **Analysis**

Extensive notes were taken at each interview and then transcribed. The transcripts were shared with an HPI/Indonesia consultant and staff to get their clarifications or corrections of the content. HPI staff also incorporated into the transcripts additional clarifications provided by the two respondents interviewed a second time. After a final review of the transcripts, the text was coded for consistency with the constructs of the CIT (motivation, information/communication, and power/collaboration), as well as additional themes that arose. The findings below are organized by theme: Clarifications of informants' quotes are written in brackets []. Interview transcripts are available by special request.

## **FINDINGS**

### **Motivation**

They say “In Indonesia, a program is successful if it is successful in Jakarta.” If Jakarta had a Perda, it would work in other places as well. We have other examples of success with other kinds of Perdas. (Government staff; Interview #7, East Jakarta)

In many ways, Jakarta is a modern and contemporary city, but the five districts of the city vary by wealth, type of resident (religious and age composition and proportion who are migrants), and social/political outlook. Several respondents mentioned that East Jakarta is more “conservative” than West Jakarta—evident by the number of entertainment sites licensed by the Department of Tourism (DOT) in each district. (The term “entertainment site” refers to massage parlors, discos, billiard halls, and karaoke venues but does not include brothels.) West Jakarta has approved licenses for 60 entertainment sites and promotes itself as an entertainment destination (for locals as well as tourists), while East Jakarta has only 20 licenses for such establishments. West Jakarta has recognized the incidence of HIV in ways that East Jakarta has not. For example, West Jakarta has approved a special clinic for PLHIV. One NGO respondent mentioned that the government of West Jakarta is easier to work with, resulting in a positive relationship between them; this is not the situation in East Jakarta. Perhaps West Jakarta is more responsive to the epidemic because there are more entertainment sites, and the awareness of the risk posed to workers there is higher.

One crucial component for policy “take-off” is a high level of motivation by key stakeholders to implement the policy. In Indonesia, as in other countries, building consensus to implement a 100% CUP starts with achieving a local enabling policy instrument and the financial and human resources to move the program forward. One indicator of stakeholder motivation is the origin of the SK. In West Jakarta, the SK was drafted by local government staff in collaboration with NGOs; in East Jakarta, it was drafted by five NGOs working on HIV issues and then shared with the district government staff for review and revision. Interviews revealed that, 20 years into the epidemic, motivation to protect most at-risk populations for HIV infection is still low within most levels of the Jakarta provincial and district governments. As one respondent noted:

The province has done some work on this issue, but there is not a serious commitment to it. They are not serious about HIV or the Perda. The Provincial KPA [AIDS Commission] has a working group, not a committee at the district level—it should be the other way around. The province is not the implementer of the SK. We asked the province to change this arrangement

because we are not seeing local results. The province thinks the districts are not capable yet. But it is not about capability, it is about willingness. (Government staff, Interview #1, West Jakarta)

Several issues undermine the motivation of leaders and staff in both districts: (1) stigma and discrimination associated with high-risk sexual behavior, (2) organizational arrangements that undermine momentum on the SK (i.e., transfers of knowledgeable staff), and (3) conflict over the meaning of “condom promotion.” The first two of these are addressed at length below. The third issue will be explored in the section “Information/Communication.”

### ***Stigma and Discrimination (S&D)***

In a concentrated epidemic, educating the public about the 100% CUP may not be as important as providing education about HIV prevention in general and instituting policies and programs to reduce S&D against those affected by HIV.

We have good policies; the problem is implementation. Lack of implementation is due to stigma and discrimination (S&D). There is S&D even among high-level government officials. We attended a meeting with the Vice Mayor who is chief of KPA and even he expressed S&D against PLHIV. He said, “Why look after these people?” We helped write the SK for West Jakarta but there was no follow-up. (NGO staff: Interview #5, West Jakarta)

It is in entertainment places where HIV is transmitted, but HIV is kept like a secret; in our culture, people with HIV are considered bad people. Prostitution is not legal, and promoting condoms [is seen to] promote prostitution. We have talked to hotel management and told them to put condoms in the rooms, and if necessary, the customers can contact reception if none are available in the room. We have to keep HIV quiet so our efforts do not blow up... The regulation is not written yet. No decree. There is just talk about it. If we have regulation, it means we support prostitution. We used to promote condoms, not just for family planning but for health. Not just for prostitution, but for other illness like hepatitis—we hid condom use under health.... (Government staff; Interview #3, West Jakarta)

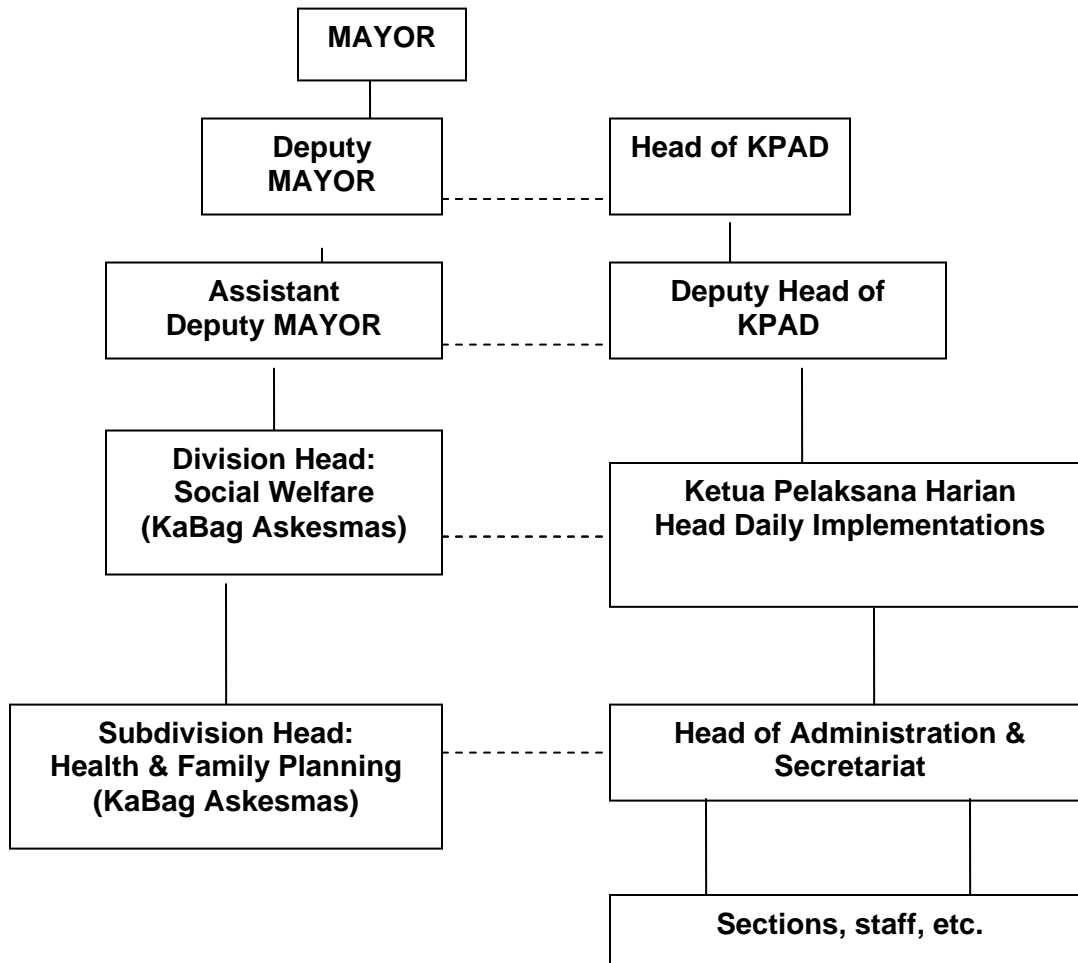
The mayor is supportive but cannot act due to religious groups... From discussions with other departments, there are some people with correct understanding, but superiors do not have this perspective. Even if the Perda was written, we would still have major problems with perception and denial. In our work, we have tried to keep our activities with at-risk groups under the wire. (Government staff; Interview #7, East Jakarta)

### ***Rotation and selection of representatives***

One issue that undermines political commitment (and that can affect motivation) is the frequent transfer of staff and the way in which positions within the District AIDS Commission (KPAD) are assigned. Several respondents mentioned difficulties in getting the time and attention of government employees who sit on the KPAD but who have many competing responsibilities. Respondents also mentioned that appointment to the KPAD is not based on interest or commitment to HIV but rather on a person’s position within the government (see Figure 1). Note that the KPAD structure is related to the municipality’s organizational structure; officers in the KPAD are appointed based on their designations in the municipality. Even when members of the KPAD are concerned about HIV they may lack the technical expertise to effectively address some of the issues they are asked to work and the National AIDS Commission has pledge to provided TA to the KPAD across the country. The initial development and endorsement of the SK in West Jakarta was a multisectoral success because several individuals effectively reached out, found allies, and facilitated collaboration. With those leaders gone, efforts to move forward on the SK have faltered. In East Jakarta, leaders persuasive enough to motivate collaboration have yet to

emerge. Differing agendas, ambivalence or hostility toward addressing HIV, and lack of accountability all undermine an effective multisectoral approach in West and East Jakarta.

**Figure 1. Municipality and KPAD Organization Structure**



There is a civil service rule that staff have to be transferred after 2 or 3 years. People are routinely rotated around different ministries....Actually that may not be a policy, but it is a practice. NGO X\* spent a lot of money for study tours with government officials, but then these officials are rotated and the investment is lost. All levels of civil servants are rotated in this fashion. Another barrier is that the government has certain structures. For example, the chair of the KPAD has to be the Vice Mayor; the Secretary of the KPAD has to be from the Social Welfare Department Unit. But these may not be the best people for these jobs. The role is based on position in government not because the person knows much about or supports AIDS. (NGO staff; Interview #5, West Jakarta)

Previously, NGO Y was involved in the KPAD, but with [the] new structure, some are not involved, not invited to meetings. The new people don't know much about the SK. They say

\* The names of the NGOs are not being used in order to protect their privacy.

they have not been able to learn much about the SK, though they all came seven months ago. They haven't been able to learn about the SK because of poor transfer of knowledge from old group to new group. Head of KPAD has not encouraged staff to learn about previous work. Also the staff assigned to the KPAD have other duties; they are not focused on the KPAD. They prioritize their work in the government over KPAD duties. (NGO staff; Interview #9, East Jakarta)

## Information

In the current situation there are still arguments between parties about 100% CUP. We need better coordination to implement. Even if we had a Perda, we would need stronger coordination. We all do not have the same perspective on condoms; some say condom use is promotion of free sex. (Government staff; Interview #7; East Jakarta)

### **Conflict over the Meaning of Condom Promotion**

Conflicts over policies can arise from differences in beliefs and values that are informed by “boundary judgments”—the information (“cognitions”) held, consciously or unconsciously, to be true and how those cognitions align with the goals and objectives of the policy or program.<sup>24</sup> How a person defines a problem, the range of acceptable solutions, and the identification of preferred solutions to that problem will influence whether or not a person supports a policy or works to oppose it. Having endorsed a particular explanation for and the appropriate solutions to a problem, people become invested in defending that position against alternative explanations.<sup>25</sup>

Promotion of condom use in high-risk sex is defined by many in Indonesia as a moral issue and not as a public health issue. In East and West Jakarta, opponents to the 100% CUP judge that the policy will encourage pre- or extra-marital sex, which are considered “immoral.” Policymakers and implementers who endorse the policy fear that their support will be seen as admitting sex work exists and thereby endorsing infidelity. They risk a strong backlash from religious groups if they appear too supportive of the CUP.

Legally, there is no prostitution. (Government staff; Interview #11, East Jakarta)

We had difficulties in brothels with the managers and local authorities. If we insist on condom use, we are then recognizing that prostitution exists in these sites and we cannot admit that; prostitution is illegal. (Government staff; Interview #1, West Jakarta)

Conflict over meaning and fear of negative consequences limit the development of the kinds of guidelines and technical information that would facilitate communication and collaboration among organizations with a role in implementation the CUP.

If public sector actors deny the existence of sex work, there is little incentive for key actors in the sex industry—brothels, massage parlors, karaoke bar managers and pimps, *Rukun Warga* (RW—head of a group of neighborhood associations), and SWs to collaborate on CUP implementation. In the absence of government commitment to the 100% CUP, NGOs have been funded by donors to provide programs that reach out to SWs and their clients to increase their knowledge about HIV and their skills in condom negotiation and use, and to provide STI treatment and psychosocial respite from sex work through peer support and drop-in centers. Some NGOs have successfully organized pimps into groups, *pokjas*, to disseminate HIV prevention information and condoms to SWs and clients, but without much apparent impact.<sup>26</sup> The work of NGOs helps government achieve some public health goals without appearing to endorse illegal activities or associate with stigmatized, marginalized, and vulnerable groups. In an environment of policy and program implementation gridlock, NGO programs, while crucial, are not



sufficient to address the spread of HIV within MARP. Large-scale coverage of surveillance, prevention, and treatment programs can only be achieved through pragmatic partnerships among the government, NGOs, MARPs, and the community.<sup>27</sup> To move forward, a shared understanding of the goals of condom promotion has to be found.

## **Power/Collaboration**

### ***Interdepartmental Coordination***

The likelihood of successful implementation varies inversely with the number of organizations involved in implementation, the number of levels of government involved in implementation, and the number of checkpoints required before action is taken.<sup>28</sup>

While the multisectoral approach has been promoted for more than a decade, empirical data suggest that the more actors and layers of government involved, the more the challenge of “multilayer complexity” arises, which delays the implementation of policies<sup>29</sup> that can be held hostage to political differences and conflicts over resources and lines of authority. With reference to HIV, some have even questioned the effectiveness of multisectoral engagement, especially in a low-prevalence, concentrated epidemic such as that in Indonesia.<sup>30</sup>

The multisectoral approach has been embraced in Indonesia since 1994, when it was endorsed by the first National HIV/AIDS Strategy and the establishment of the KPA, which comprises representatives from ministries, donors, and NGOs. Currently, the Coordinating Ministry of People’s Welfare coordinates the strategy. The KPA includes 11 ministries, and its chair reports directly to the president. With decentralization of authority to the district and provincial levels, the KPA has no enforcement capacity but rather crafts national policy and acts as a strong advocate for HIV within the government, the public sector, and civil society. Provincial and district AIDS Committees (KPAD) reflect the structure of the KPA and receive funding from provincial governments (and, in some localities, from international donors). The KPADs have a role in drafting but not approving SKs and Perdas, developing workplans with and among various ministries, supervising the work of NGOs (although they do not fund these NGOs), and most important, coordinating various actors and activities related to HIV at the local level. Like the KPA, KPADs do not have an implementation role.

In my opinion, the multisectoral approach is problematic because the management system of government is to involve everyone in decisionmaking, but there are many who do not have a good understanding of HIV, but all have to make decisions. As a result, many decisions are delayed. (NGO staff; Interview #5, West Jakarta)

So we designed the SK, did advocacy, and decided to take action. We decided to work at the village level, in a village with many HIV infections. The local people were willing. We got opposition from the departments of tourism, religion, public order, and social welfare. They refused to support it initially. We had different policies than the department of tourism; they considered that no SK was in effect in this village... We have not determined which agency will provide which sanctions. The DOT has not instructed lower levels to implement the 100% CUP. Instructions have been sent to the entertainment site owners, but they do not carry any sanctions for failing to following the SK. There is local autonomy at the provincial level, but they think they do not have authority to impose sanctions. Entertainment site licenses are issued at the provincial level, so it is even more difficult [for us to influence them]. (Government staff; Interview #2, West Jakarta)

### **Collaboration with Sex Establishments**

The fact that the sex industry is a multimillion-dollar business in Indonesia is not news. Thousands of people living in the neighborhoods surrounding the brothels and entertainment sites depend on the commerce generated by these enterprises. Spend any time in a brothel and one will note the steady stream of entrepreneurs flowing through with various goods and services: clothing, food, and medicine vendors; carpenters and other tradesmen making repairs or renovations; and beer and liquor distributors. Staff includes security guards, cleaning staff, “reception” desk attendants, bartenders, pimps, parking attendants, and brothel managers. Business partners are rarely seen: RWs, local police and military personnel, and people referred to as the local “mafia.”

The key issue here is not that sex work is hidden but that the necessity of sex work as an economic option is increased where official unemployment is high and social and gender inequality is widespread.<sup>31</sup>

We still have difficulties with the RWs. We have invited them to meetings. We conveyed the idea that our objective is to save the nation from HIV epidemic, and they understood. Some difficulties diminished after we spoke to them. We had difficulties in brothels with the managers and local authorities....We need to get around owners and pimps by going to sex workers and educating them so they can insist on condom use. But if managers do not support 100% CUP, then condoms do not get used. (Government Staff; Interview #1, West Jakarta)

Some informants suggested alternative determinants of low motivation to implement the 100% CUP:

[The DOT provides licenses to massage parlors.] They know there is prostitution in these places, but law does not allow it. So recognizing sex work happens legalizes prostitution, in their way of thinking. They get funds from licenses they give to entertainment sites [such as karaoke bars, massage parlors]. They fear losing money if 100% CUP is enforced. (Government staff; Interview #2, West Jakarta)

So we developed another SK for this municipality, number 2004/1 (in 2004). Implemented it but not satisfactorily; we had clashes with the business sector, disagreements with our colleagues who regulated entertainment site... There are still some people who think that if the SK is issued it will hamper their activities. (Government staff; Interview #1, West Jakarta)

A lot of people violate the regulations because of economic problems. (Government staff; Interview #4, West Jakarta)

### **Other Factors Affecting Implementation of the 100% CUP**

#### ***Little Investment in Advocacy***

Lessons learned from evaluations of policy implementation in other countries make it clear that (1) both the technical and political feasibility of any policy must be considered and addressed during its design and implementation; (2) opposition to the policy must be clearly understood and appropriate advocacy strategies and policy champions developed; (3) the engagement of civil society must be nurtured and continuously supported or effective programs can become vulnerable to political pressures; and (4) lack of incentives for public sector employees to implement a policy, or sanctions against inaction, reduce the likelihood that contested policies will be implemented.

The interviews revealed that advocacy to influential stakeholders has not been a consistent component of the overall strategy to affect 100% CUP implementation. For the most part, advocacy efforts could be described either as periodic dissemination of information and data to government departments, the KPAD, and individuals, or confronting the government about its lack of action. As experience has

demonstrated all too frequently, without the continuous and strong mobilization of advocates, efforts to implement a specific policy or program will be eroded by bureaucratic inertia, resistance, and turf battles over resources and territory.<sup>32</sup>

In West Jakarta, if we look at the roles of NGOs, there is strong support for HIV, but in East Jakarta, there is no support from the NGOs [for advocacy work.] They do not want to do advocacy and invest in communication with government. Advocacy is slow, boring, difficult work that needs constant pushing. (NGO staff; Interview #5; West Jakarta)

We do advocacy with provincial government, but [we're] not making much progress. We are part of the NGO Forum of Jakarta. We have been sharply critical of the government, so now they don't have much time for us. (NGO staff; Interview #10, East Jakarta)

Our NGO did not do advocacy in the past. We have a very bureaucratic system in Jakarta, so we only work at provincial level. We work mostly with MARPs [most at-risk populations]. We have not done much advocacy with local parliament or with provincial officials. We assist West and East Jakarta KPADs to develop workplans and budgets. (NGO staff; Interview #4, West Jakarta)

Almost certainly, the 100% CUP was fiercely debated among policymakers, donors, NGOs, and organizations representing SWs and other MARP when it was proposed for the National HIV/AIDS Strategy. Unfortunately, strategies used to gain support for the program at the national level have not penetrated to provincial and municipal level advocates, where implementation occurs.

### **Religious Leaders' Response to HIV Prevention**

In 1995, Indonesia's Council of Ulemas urged that condoms be sold only to married couples—and then only by prescription from a general practitioner; the belief was that strong religious convictions would stop people from having extramarital sex.<sup>33</sup> In Indonesia, as in many other countries, one reason for lack of action on HIV has been the assumption that premarital sex, adultery, prostitution, homosexuality, and intravenous drug use happen so infrequently that the risk of a generalized epidemic is low. Yet, there are an estimated 250,000 SWs in Indonesia, and seven to 10 million men who visit them at least annually.<sup>34</sup> Many of the underlying factors that contribute to high-risk behavior and the spread of HIV—poverty, gender inequality, and weak legal structures—also are ignored by these assumptions.

Nearly all respondents in West and East Jakarta mentioned that the major barrier to 100% CUP implementation was the opposition—or fear of opposition—from the religious community and the Department of Religion (DOR). These respondents used similar language to explain this resistance: support for the CUP condones promiscuity; HIV is a retribution for “bad” behavior; condoms recognize and therefore promote prostitution. Despite this common language, the SK was approved in West Jakarta with the passive cooperation<sup>†</sup> of the DOR. The two respondents most influential in getting the SK passed used their personal relationships and credibility to persuade members of the DOR to allow it to go forward.

---

<sup>†</sup> Bressers (2004, p. 8) makes a distinction between three types of interaction among actors involved in implementing a given policy: *cooperation* (active, passive, or forced), *opposition*, and *joint learning*. “‘Active’ cooperation occurs when both parties share a common goal (remembering that the goal also can involve an attempt to hinder the application of the instrument). We speak of ‘passive’ cooperation when one of the parties adopts a relatively passive stance which neither hinders nor stimulates the application of the policy instrument. ‘Forced’ cooperation is a form of passive cooperation that is imposed by a dominant actor. ‘Opposition’ occurs when one of the actors tries to prevent application by another actor; and ‘joint learning’ occurs when only a lack of information stands in the way of application. There are also situations in which there will be no interaction at all between the responsible authorities and the target group. In this case the possibility that the instrument will be applied is remote indeed.”

We face Islamic organizations that will push back and fight us. Their influence is strong even at the provincial level. Their mindset is fixed. We have had many meetings with religious leaders, but we need more sophisticated advocacy approaches. Even the Mayor's office cannot write the SK due to the religious groups. We are working at a small, local level so that religious leaders do not know our actions.... We do not want to apply strict sanctions because we would face resistance by religious leaders, but we do want sanctions imposed. (Government staff; Interview #2, West Jakarta)

One stakeholder that is impossible to work with is PKS, a religious party. They are strongly opposed to HIV [prevention]. They are very religious. Also a community-based organization named FPI (Front for Islamic Liberation) is opposed [to prevention activities for HIV]. These two can really shoot down officials at the top level if they talk about HIV. (NGO staff; Interview #4, West Jakarta)

The interviews showed, however, that the perspectives of religious leaders are not homogeneous and, in fact, religious leaders can be convinced of the contribution 100% CUP could make to public health.

*Can you give me an example? How did you approach those people in the religious department? Did you receive a lot of resistance?*

I went to Askesmas (Social Welfare Division) which basically consists of civil societies, e.g., representatives from Forum Kerjasama Umat Beragama (Forum for Inter-faith Communication). They have representatives from Islam, such as Nahdlatul Ulama (one of the major Islamic faith-based organizations), Catholic, Christian, Hindu, etc. I talked to them during coffee break, just chit-chat. Or maybe before Jumatan – Friday prayer.

*Did they perceive the problem from the same perspective? If not, how did they come up with the same solution – 100% CUP? Did you use the argument of harm reduction?*

Not at first. But I used the analogy of landslide. The cause of landslide, natural disaster, is mismanaging the environment. Do we want to wait until HIV and AIDS wipe out our societies? This is the landslide. We don't want that to happen. When I presented this to them, they could not rebut. Then I asked what solution they would offer. They were silent. Then, I emphasized that condom use is one of the feasible alternatives at this moment. This is how we reach consensus to move forward. (Government staff; Interview #1; follow-up interview, West Jakarta)

They each have a wide network with NGOs, MOH, and MOT [Ministry of Tourism]. One of these people used to serve in the DOR. He was able to convince the religious people to support the SK. He was once a head of a subdistrict, so he has a lot of respect. He linked with NGO Z to get the SK written. At first, the DOR did not endorse it, but they agreed not to get in the way of the SK. (NGO staff; Interview #8; East Jakarta)

## **DISCUSSION**

Research in the policy implementation field points to several key issues that must be addressed in West and East Jakarta, as well as in other areas of Indonesia:<sup>35</sup> the motivation of stakeholders to implement the policy, the level of information/communication among actors, and the balance of power among those actors in a position to oppose or collaborate with the policy's implementation. Policies such as the 100% CUP, which invoke highly salient symbols (e.g., morality, gender relations), often produce high levels of conflict. The intensity of the conflict determines the strength of the barriers to policy implementation. At

low levels of conflict, advocacy often works to reduce the barriers; when conflict is high, bargaining, coercion, and incentives often are needed to overcome barriers. The means through which a policy will be implemented successfully thus depends on the strength of local coalitions. In the case of the 100% CUP, coalitions supporting the program have not been strong enough to ensure its implementation or find ways to position their goals and objectives as compatible with those who oppose the program.<sup>36</sup>

## Potential Advocacy Strategies

Barriers to implementation of the 100% CUP in West and East Jakarta reflect the axiom that “all politics are local.” Coalitions in East and West Jakarta opposed to 100% CUP implementation are much more influential than the weak coalitions supporting it. As we can see from the efforts made in West Jakarta, a few people highly committed to addressing HIV used persuasion and personal credibility to get the SK signed, but without greater coalition strength, resistance by other actors still is preventing policy implementation and wider action. In East Jakarta, where there are few policy champions, little action related to the SK has been taken at the government level.

In East and West Jakarta, action on the 100% CUP is blocked by mutually exclusive frames of reference; for some officials and community leaders, promoting condom use contradicts their concept of a moral society. For HIV activists, promoting the 100% CUP is one way to protect the lives of marginalized and stigmatized populations. Viewing the lack of movement on the SK in West Jakarta and the absence of an SK in East Jakarta through the lens of loss and risk may provide an advocacy approach that attempts to reframe the 100% CUP in a manner compatible with the values and acceptable solutions of those who oppose it. For example, condom promotion actually may address some of the concerns of these opponents: some studies have found that, where condoms have been widely promoted for high-risk sexual encounters, many men give up paying for sex and/or reduce the number of unpaid casual partners. Moreover, condom promotion has not been found to promote prostitution.<sup>37</sup> Unless an alternative frame or common vision can be formulated, it is unlikely that much progress in implementing the program will be made.

Successful advocacy on HIV prevention *has* been done with religious leaders around the world. In December 2004, following intensive work by the United Nations Development Program in 15 countries throughout the Middle East and North Africa, Muslim and Christian leaders met in Egypt and endorsed the Cairo Declaration that states, in part:

### On Prevention

- We reiterate that abstinence and faithfulness are the two cornerstones of our preventive strategies but we understand the medical call for the use of different preventive means to reduce the harm to oneself and others.
- We view as impious anything that may cause infection through intention or negligence – as a result of not using all possible preventive means available, in accordance with heavenly laws.
- We emphasize the importance of reaching out to vulnerable groups which are more at risk for being infected by HIV/AIDS and/or spreading it, including commercial sex workers and their clients, injecting drug users, men having sex with men, and those who are involved in harmful practices. We emphasize the importance of diverse approaches and means to reach out to those groups, and although we do not approve of such behaviors, we call on them to repent and ask that treatment and rehabilitation programs be developed. These programs should be based on our culture and spiritual values.<sup>38</sup>

By refocusing the discourse on HIV prevention from the issue of morality to that of public health or economic and social development, the stigma of pre- or extramarital sex and fear of exposure and

condemnation heightens people's motivation for sexual secrecy and personal denial of risk. A refusal to acknowledge that sex work exists also undermines government commitment to developing economic and social programs that target at-risk girls, young women, and SWs so they will have options outside of the sex industry.<sup>39</sup>

In Indonesia, religious leaders are strong advocates for the protection of human life. During the New Order regime of Suharto, Muslim leaders were a crucial voice of resistance<sup>40</sup> and remain influential and vocal watchdogs in a country where faith and statecraft merge<sup>41</sup> and democratic practices and protection of human rights remain weak.<sup>42, 43</sup> Clearly the religious discourse around HIV and the roots of risk behaviors cannot be ignored but should not be viewed as the sole reason that the 100% CUP is not being implemented. There are political and economic issues at stake as well. Sex work is a multi-million dollar business in Indonesia. People with vested interests in the sex industry may fear that implementation of the 100% CUP will not only expose their involvement but will also curtail their enterprises.

In West Jakarta, political leadership by just a few individuals was sufficient to get the SK written and approved by the mayor. Effective advocacy by credible actors, using persuasive arguments, was critical to achieving cooperation from groups in West Jakarta who traditionally had been opposed to implementation of a comprehensive 100% CUP. The transfer of these advocates to other sectors of the government and lack of a long-term advocacy strategy that would have built on the momentum generated in West Jakarta resulted in a leadership void, avoidance of risk taking among remaining government leaders, and the re-emergence of overt opposition to the policy.

We know that advocacy works, but to have long-term action on the 100% CUP, advocacy must be a sustained and organized effort. Advocates must be developed at *all* levels of government and civil society, including NGOs, FBOs and affected communities, so that the loss of a few advocates due to transfer or relocation does not result in collapse of the activities that support the program. It is critical to find incentives for government departments and sex industry stakeholders to reach an agreement on a geographically focused comprehensive plan for implementing the 100% CUP, thereby allowing higher level actors (e.g., the department heads) to exercise more oversight and influence. With a common language that enables government, religious, and NGO activities to frame the 100% CUP in mutually acceptable terms, implementation strategies then can focus on securing the compliance of the network of actors whose resources are vital to its success.

## ENDNOTES/REFERENCES

---

- <sup>1</sup> Alesch, D. J., and W.J. Petak. 2001. "Overcoming Obstacles to Implementing Earthquake Hazard Mitigation Policies: Stage 1 Report." *Technical Report* MCEER-01-0004.
- <sup>2</sup> Sabatier, P. A. 1991. "Toward Better Theories of the Policy Process." *Political Science and Politics* June: 147–156.
- <sup>3</sup> Kayaba, K., C. Wakabayashi, N. Kunisawa, H. Shinmura, and H. Yanagawa. 2005. "Implementation of a Smoke-Free Policy on School Premises and Tobacco Control as a Priority among Municipal Health Promotion Activities: Nationwide Survey in Japan." *American Journal of Public Health* 95: 420–422.
- <sup>4</sup> Deibert, R.J., G. Goldbaum, T.R. Parker, H. Hagan, R. Marks, M. Hannrahan, and H. Thiede. 2006. "Increased Access to Unrestricted Pharmacy Sales of Syringes in Seattle-King County." *Washington: Structural and Individual-level Changes, 1996 versus 2003* 96(8): 1347–1353.
- <sup>5</sup> Grassley, N. C., and G.P. Garnett. 2005. "The Future of the HIV Epidemic." *Bulletin of the World Health Organization* 83: 378–383.
- <sup>6</sup> UNAIDS/WHO. 2004. *Case Study on Estimating HIV Infection in Concentrated Epidemics: Lessons from Indonesia*. Working Group on Global HIV/AIDS/STI Surveillance.
- <sup>7</sup> Pervilhac, C., J. Stover, E. Pisani, T. Brown, R. Mayorga, O. Mugurungi, M. Shaukat, L. Fan, and P.D. Ghys. 2005. *Using HIV Surveillance Data: Recent Experiences and Avenues for the Future* 19 (Supplement 2):S53–S58.
- <sup>8</sup> Ministry of Health and the Central Statistics Bureau. 2007. *Risk Behavior and HIV Prevalence in Tanah Papua: Results of the IHBS 2006 in Tanah Papua*. Jakarta: Government of Indonesia.
- <sup>9</sup> Elmendorf, A.E., E. Jensen, and E. Pisani. 2005. *Evaluation of the World Bank's Assistance in Responding to the AIDS Epidemic: Indonesia Case Study* Washington, DC: World Bank Operations Evaluation Department.
- <sup>10</sup> Family Health International (FHI). 2000. *Behavior Surveillance Survey: Indonesia*. Arlington, VA: FHI.
- <sup>11</sup> Lieberman, S.S., and P. Marzoeki. 2002. "Health Strategy in a Post-Crisis, Decentralizing Indonesia." *Health, Nutrition, and Population Family (HNP) Discussion Paper*. Washington, DC: World Bank Human Development Network.
- <sup>12</sup> Health Policy Initiative (HPI), Task Order 1. 2006. *Indonesia HIV/AIDS Strategy Audit*. Washington, DC: Constella Futures/HPI.
- <sup>13</sup> Sumartojo, Esther. 2000. Structural Factors in HIV Prevention: Concepts, Examples and Implications for Research. *AIDS*: 14: Supplement 1: S3-S10.
- <sup>14</sup> WHO SEARO. 2004. *Experiences of 100% Condom Use Program in Selected Countries of Asia*. Geneva: WHO.
- <sup>15</sup> Ibid.

- 
- <sup>16</sup> UNAIDS and AIDS Division, Ministry of Public Health, Thailand. 2000. *Evaluation of 100% Condom Programme in Thailand: UNAIDS Case Study*. Bangkok: UNAIDS and AIDS Division, Ministry of Public Health, Thailand
- <sup>17</sup> Ibid.
- <sup>18</sup> Basuki, E., I. Wolffers, W. Deville, N. Erlaini, D. Luhpuri, R. Hargono, N. Maskuri, N. Suesen, and N. van Beelen. 2002. "Reasons for Not Using Condoms among Female Sex Workers in Indonesia." *AIDS Education and Prevention* 14(2): 102–116.
- <sup>19</sup> Ford, K., D.N. Wirawan, B.D. Reed, P. Muliawan, and R. Wolfe. 2002. "The Bali STD/AIDS Study Evaluation of an Intervention for Sex Workers." *Sexually Transmitted Diseases January* 29(1): 50–58.
- <sup>20</sup> Ainsworth, M., C. Beyrer, and A. Soucat. 2003. "AIDS and Public Policy: The Lessons and Challenges of 'Success' in Thailand." *Health Policy* 64(1):13–37.
- <sup>21</sup> WHO SEARO. 2004. *Experiences of 100% Condom Use Program in Selected Countries of Asia*. Geneva: WHO.
- <sup>22</sup> Bressers, H. 2004. "Implementing Sustainable Development: How to Know What Works, Where, When and How." In *Governance for Sustainable Development: The Challenge of Adapting Form to Function*. William M. Lafferty (Ed.), Edward Elgar: Cheltenham.
- <sup>23</sup> Ibid.
- <sup>24</sup> Ibid.
- <sup>25</sup> Des Jarlais, D.C., X. Sloboda, S.R. Friedman, B. Tempalski, C. McKnight, and N. Braine. 2006. "Diffusion of the D.A.R.E. and Syringe Exchange Programs." *American Journal of Public Health* 96(8): 1354–1358.
- <sup>26</sup> Basuki, E., I. Wolffers, W. Deville, N. Erlaini, D. Luhpuri, R. Hargono, N. Maskuri, N. Suesen, and N. van Beelen. 2002. "Reasons for Not Using Condoms among Female Sex Workers in Indonesia." *AIDS Education and Prevention* 14(2): 102–116.
- <sup>27</sup> Godwin, P., N. O'Farrell, K. Fylkesnes, and S. Misra. 2006. "Five Myths about the HIV Epidemic in Asia." *PLoS Medicine* (3)10, e426: 1703–1707.
- <sup>28</sup> Alesch, D. J., and W.J Petak. 2001. "Overcoming Obstacles to Implementing Earthquake Hazard Mitigation Policies: Stage 1 Report." *Technical Report MCEER-01-0004*.
- <sup>29</sup> Hill, M., and P. Hupe. 2003. "The Multilayer Problem in Implementation Research." *Public Management Review* 5(4): 471–490.
- <sup>30</sup> Godwin, P., N. O'Farrell, K. Fylkesnes, and S. Misra. 2006. "Five Myths about the HIV Epidemic in Asia." *PLoS Medicine* (3)10, e426: 1703–1707.
- <sup>31</sup> Blackwood, E. 2007. "Regulation of Sexuality in Indonesian Discourse: Normative Gender, Criminal Law and Shifting Strategies of Control." *Culture, Health, and Sexuality* 9(3): 293–307.



- 
- <sup>32</sup> Jahan, R. 2007. "Securing Maternal Health through Comprehensive Reproductive Health Services: Lessons from Bangladesh." *American Journal of Public Health* 97(7): 1186–1190.
- <sup>33</sup> Kelly, L.M., and N. Eberstadt. 2005. "Behind the Veil of a Public Health Crisis: HIV/AIDS in the Muslim World." *National Bureau of Asian Research Special Report*. Seattle, Washington: National Bureau of Asian Research.
- <sup>34</sup> USAID. 2005. *Health Profile: Indonesia*. Washington, DC: USAID.
- <sup>35</sup> Jahan, R. 2007. "Securing Maternal Health through Comprehensive Reproductive Health Services: Lessons from Bangladesh." *American Journal of Public Health* 97(7): 1186–1190.
- <sup>36</sup> Matland, R.E. 1995. "Synthesizing the Implementation Literature: The Ambiguity–Conflict Model of Policy Implementation." *Journal of Public Administration Research and Theory* 5(2): 145–174.
- <sup>37</sup> Hearst, N., and S. Chen. 2004. "Condom Promotion for AIDS Prevention in the Developing World: Is it Working?" *Studies in Family Planning* 35(1): 39–47.
- <sup>38</sup> UNDP. HIV/AIDS Regional Programme in the Arab States (HARPAS). 2004. *The Cairo Declaration of Religious Leaders in the Arab States in Response to the HIV/AIDS Epidemic*. <http://www.harapas.org/products.asp>
- <sup>39</sup> Asia Development Bank. 2006. *Indonesia: Gender Integration Assessment*. Manila: Southeast Asia Regional Department, Regional and Sustainable Development Department.
- <sup>40</sup> Conway, G., and N. Kishi. 2002. "Conflict Risk Assessment Report: Cambodia, Indonesia, and Philippines." *Country Indicators for Foreign Policy Project*. Toronto: The Norman Paterson School of International Affairs, Carleton University.
- <sup>41</sup> Blackwood, E. 2007. "Regulation of Sexuality in Indonesian Discourse: Normative Gender, Criminal Law and Shifting Strategies of Control." *Culture, Health, and Sexuality* 9(3): 293–307.
- <sup>42</sup> Kelly, L.M., and N. Eberstadt. 2005. "Behind the Veil of a Public Health Crisis: HIV/AIDS in the Muslim World." *National Bureau of Asian Research Special Report*. Seattle, Washington: National Bureau of Asian Research.
- <sup>43</sup> Human Rights Watch. 2002. *Breakdown: Four Years of Communal Violence in Central Sulawesi*. December, 14 (9) (C). Accessed: <http://www.hrw.org/reports/2002/indonesia/indonesia1102.htm#>.

Health Policy Initiative, Task Order I  
Constella Futures  
One Thomas Circle, NW, Suite 200  
Washington, DC 20005 USA  
Tel: (202) 775-9680  
Fax: (202) 775-9694  
Email: [policyinfo@healthpolicyinitiative.com](mailto:policyinfo@healthpolicyinitiative.com)  
<http://ghiqc.usaid.gov>  
<http://www.healthpolicyinitiative.com>