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According to the World Health Organization, Indonesia has the fastest growing HIV epidemic in Southeast Asia. In the provinces of Papua and West Papua, the epidemic has reached the general population at a prevalence rate of 2.4 percent which is twelve times the national average. It is clear that an increased effort to combat the HIV/AIDS epidemic must be put in place. HOPE *worldwide* is a United States-based organization with satellites all over the world serving others based on country specific needs. An HIV prevention program called Positive Choice was created by HOPE *worldwide* to educate young people about sex and how to make positive and healthy choices to avoid sexually transmitted diseases (STDs) or further, HIV/AIDS. Positive Choice has been implemented in places like the United States, Ivory Coast, and Jamaica. The programs are similar in objective; however, they vary to adapt to the particular environment, culture, and specific obstacles that each country faces in their fight against HIV/AIDS.

This document provides recommendations and guidance for HOPE *worldwide* Indonesia's implementation of Positive Choice. It discusses the current HIV situation; obstacles the country faces in implementing a school-based HIV-drug prevention program; criteria for the start-up, approach, and implementation of Positive Choice; and finally recommendations for further action. On the basis of extensive field research, it is recommended that HOPE *worldwide* institute a curriculum-based HIV-drug prevention pilot program in Jakarta, the province with the third highest rate of HIV

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infections in the country. This program should be rooted in evidence-based effective practices which incorporate the Abstinence, Be faithful, and Condom use (ABC) approach as well as life-skills education. The purpose of this program is to increase the knowledge of adolescents about HIV/AIDS and ways to prevent transmission and to provide them with the skills needed to translate this knowledge into positive life choices. With the proper development and implementation of this pilot program in Jakarta, Positive Choice will be a powerful tool in the overall national strategy to combat the spread of HIV/AIDS.

METHODOLOGY

The research described in this document is a necessary component to the development of Positive Choice. The recommendations provided are specific to the needs of Indonesia; they are based on research of best program practices, interviews in the field, and a sex and drug behavioral survey conducted at high schools in Jakarta. The survey was administered at three private and one government-operated senior high-schools in Jakarta, and 217 responses were recorded.*

The purpose of survey conducted in Jakarta was to gather data on students' attitudes, knowledge, and behavior regarding sexual intercourse and drug use. Due to the limited length of time given for the completion of this assignment and the time of year that this assignment was undertaken, the survey was constrained by some limitations. It was conducted in the month of June, which affected the stock of schools available for the survey because many schools were finishing or had finished their terms. Due to the sensitive nature of the survey, it was not possible to randomly select the schools that participated. The schools that were most likely to participate were those that already had an established and good relationship with HOPE. In sum, school participation was limited to 1) those that were in session; 2) those that agreed to have the survey conducted in their school; and 3) those that had a positive relationship with HOPE.

The survey responses may also be limited due the sensitive subject

* The survey was conducted independently from Pepperdine University and its results were solely for the use of HOPE.

matter and resources available at the school. In two out of the four schools, there were a large number of students in one area without adequate space to spread out. This lack of privacy may have affected students' inclination to answer questions completely honestly. Students benefited from completing the survey by participating in a question and answer session about the United States.

Indonesia's HIV Situation Continues to Worsen

Indonesia is a unique country because it comprises over 17,000 islands, and its roughly 350 ethnic groups make for an environment of great cultural diversity.[1] It is the most populous Muslim country on the planet, but also contains hundreds of tribes that hold onto traditional beliefs and practices, and its urban capital features mega-malls and skyscrapers. This multiplicity means that there can be no uniform way to deal with the HIV/AIDS epidemic in Indonesia. Among the provinces with the highest HIV prevalence are Papua and DKI Jakarta. These two provinces contrast sharply with each other, since the former is sparsely populated and still maintains tribal behaviors while the latter is densely populated and has had a wider exposure to the broader world. Because of Indonesia's diversity, methods for combating HIV/AIDS differ in each region, creating the need for a complicated national strategy.

According to the United States Agency for International Development (USAID), Indonesia has the fastest growing HIV infection rate in Southeast Asia.[2] For the first few years following the onset of the disease in 1987, HIV infection rates were steady and low. At the turn of the millennium, Indonesia saw a dramatic increase in HIV infection rates, as the number of injecting drug users increased dramatically. Since the spike in infections, Indonesia has not been able to reverse those numbers. According to the World Health Organization, AIDS cases were reported from sixteen provinces in 2000; by the end of 2009, thirty-two of the thirty-three provinces reported infections.[3] The number of people who reported AIDS cases increased from 5,321 in 2005 to 8,194 in 2006. The estimated number of adults and children living with HIV was 93,000 in 2001 and 270,000 in 2007, making the prevalence in the adult population (aged

fifteen through forty-nine) increase from 0.1 percent to 0.2 percent in the respective years.[4] This rapid growth in the number of infections, as well as the geographic spread of the disease in only the past decade, illustrates its aggressive nature.

The current situation across Indonesia is a concentrated epidemic in which HIV prevalence is above five percent in four key subpopulations: injecting drug users (IDUs), female sex workers, men who have sex with men, and "warias" (or transvestites/transgender persons). The situation in the provinces of Papua and West Papua is much different and more serious. The virus has already spread into the general population, as unsafe sexual intercourse is the almost exclusive mode of transmission.[5] With the sparse population and difficulty of communicating behavior-changing messages, HIV prevention efforts do not produce optimal results. While the epidemic is considered low-level among the general population with the HIV prevalence rate at 2.4 percent among the adult population, it is significantly above the national average of 0.2 percent.

According to Asian Epidemic Modeling (AEM), HIV prevalence among Indonesian adults is projected to increase from 0.22 percent in 2008 to 0.37 percent in 2014. It is predicted that new infections among IDUs decrease from forty percent in 2008 to twenty-eight percent in 2014 and sexual transmission will rise from forty-three percent to fifty-eight percent.[6] The AEM projection is agreed upon by experts in the field, and was supported by the 2008 Report on the Global AIDS Epidemic.[7] Sexual transmission of the disease can increase the risk that the epidemic will enter the general population as it has in Papua. AEM indicates a need to encourage the use of condoms—a task made more difficult by the many religious leaders who denounce what they see as the "condomization" of society.[8]

Without an increased effort in the overall HIV/AIDS strategy, these projections will almost certainly become reality. According to the 2010 United Nations General Assembly Special Session on HIV/AIDS (UNGASS) report, prevention efforts remain focused on key populations with high HIV prevalence. However, in order to prevent HIV from spreading into the general population, as it has in Papua, prevention efforts

should be expanded to reach other people, especially the youth. Young people can be at risk in a number of situations if they are not equipped with the knowledge and skills to deal with the pressures involving sex, drugs, and general hardships of life. The World Health Organization (WHO) published a report in 2006 asserting that young people are at the center of epidemics around the world. This is true in Indonesia, where twenty to twenty-nine year olds have a greater number cumulative AIDS cases than any other age group.[9]

Numerous studies done on school-based sex education programs have given significant evidence of the benefits of widespread implementation. Spending on these programs in Indonesia is insufficient. Of the total AIDS spending (USD 49,563,286) in 2008-2009, spending on HIV prevention accounts for USD 24,703,080 or about fifty percent of the total budget; however HIV prevention for youth in school is only USD 592,689 or about two percent of the total prevention budget.[10] In 1997, the Indonesian Ministry of National Education increased its effort in the fight against HIV/AIDS by initiating school-based Life Skills-based HIV Education (LSE) which was used on a "limited basis."[11] To date, it is not included in the national education agenda; however, it is in the initial stages of integration into the national curricula.

A study done in 2005 by Douglas Kirby of ETR Associates explored the effects of curriculum-based programs on sexual and reproductive health (RH) knowledge, attitudes, and behavior and identified common characteristics that successful programs shared in their curriculum. It evaluated eighty-three sex and HIV/AIDS education programs for youth implemented in both developing and developed countries. Two-thirds of the programs had the desired impact on one or more of the sexual behaviors measured.[12] Thirteen of the eighteen programs in developing countries had a positive impact (i.e. delaying sexual debut or decreases sexual activity among those sexually active); none of them had a negative impact. The study maintains that "curriculum-based RH/HIV education can be effective in widely differing geographic areas, various cultural settings, and among youth of different income levels and both sexes."[13] Curriculum is defined as an "organized set of activities or exercises ordered in a developmental fashion and designed to enable its target audience to

obtain specific knowledge, skills, and/or experiences."[14] The results of the study concluded that there are seventeen characteristics that almost all of the successful programs incorporated at some level.

HOPE FACES CHALLENGES IN DEVELOPMENT STAGE

Gathering support from stakeholders for the implementation of a school-based HIV-prevention program is likely to be the largest obstacle that HOPE faces. Opposition may arise from numerous sources: the Ministry of Education, National AIDS Commission (NAC), and local schools. Without the consent of the most influential entities, implementation will be impossible. It is critical that the Positive Choice program be a collaborative effort so as to maintain support throughout its operation. The Ministry of Education, NAC, and local schools must agree on the need for the program, the objective, the goals, and the messages transmitted through the program. By collaborating throughout the development and implementation of the program, support is more likely to remain constant.

As in many Asian cultures, the subject of sex is taboo in Indonesia. Overcoming the stigma associated with sexual issues is a challenge. According to the International Center for Islam and Pluralism, many Muslim religious leaders are vehemently opposed to condom promotion. At the extreme, some believe that HIV/AIDS is a curse from God and those infected must be punished.[15] The UNGASS 2010 report states that the number of adults with accepting attitudes towards people living with HIV is approximately nine percent.[16] These strong sentiments, which are often accompanied by stigma and discrimination towards those infected, are not unique to the Muslim community but are present in many others. Consequently, gathering support for an HIV-prevention program offering education in disease avoidance is expected to be a challenge.

To gain the Muslim community's support, it will be important to speak with ulamas (key religious leaders) who are very influential. Explaining the program's purpose and goals while asking for their input and perspective is an appropriate start to gaining their support. Once achieved, the ulamas' support will play an integral part in implementing the program, particularly in the private schools which are predominately

Muslim.

Parents can also be skeptical of information of this kind being disseminated at school, believing that the information will cause their children to become more likely to engage in risky behaviors. Research shows that curriculum and school-based HIV prevention programs do not increase promiscuity.[17] It is important to try to include parents in the discussion of the development of Positive Choice, and to give them evidence that if correctly developed and implemented, the program will most likely be a powerful tool in providing youth with the knowledge and skills needed to make positive decisions relating to sex and drugs.

Another significant issue that HOPE faces is the diversity of schools existing in Indonesia. There are three main categories of schools: international, private, and public (or government run) schools. International schools have the opportunity to implement a more liberal curriculum. Private schools are less flexible than international schools regarding curriculum; however, they have more liberty than public schools because parents finance the students' tuition. Government run schools will likely be the hardest places to implement an HIV-prevention program, as they are the most constrained by the policies of the Ministry of Education. With such diversity, it will be difficult to implement a "one model fits all" program. A flexible program that can adapt to different types of schools is necessary.

A successful Positive Choice program must also overcome the setbacks of school-based programs. Those people who do not go to school cannot be left out, since they are most likely the youth facing the highest risk. Therefore, it is recommended that HOPE utilizes its already well-established Saturday Academy program to implement a Positive Choice program that is age-appropriate to the children in attendance. Saturday Academy is a program that provides education to children who do not have the opportunity to go to school because they live on the street or in slums. It is an invaluable program because it reaches out to future generations that otherwise would fall through the cracks of society. In the development of an HIV prevention program for schools, the ultimate goal is to increase the knowledge of adolescents about HIV/AIDS and ways to

prevent transmission, as well as provide them with the skills needed to translate the knowledge into positive life choices.

ESTABLISHING CRITERIA FOR APPROACH AND CONTENT

In developing appropriate content for a Positive Choice program in Indonesia, it is important to understand the needs and the culture of the youth. As HIV incident rates are continuing to increase and transmission by sexual intercourse is becoming more dominant, there is an urgent need to focus on the population that serves as a link from the sub-populations with high HIV prevalence rates to the general population. According to the 2008 UNAIDS Report on the Global AIDS Epidemic, the future of countries experiencing concentrated epidemics will be "determined by the frequency and nature of links between highly infected subpopulations and the general population."[18] In many respects, a school-based HIV education and prevention program can serve as an effective front to combat the spread of the disease.

It is difficult to identify the linkages from the subpopulations to the general population. According to a USAID official in Indonesia, conversations with sex workers have identified the most common customers of the industry. These are taxi drivers, migrant workers such as truckers, and sea and airport authorities.[19] USAID and other government agencies already implement direct intervention to these subpopulations, by setting up clinics at workplaces, dispensing free condoms, and offering free blood testing. School-based programs can offer a more thorough strategy since many of the clients of sex workers have received at least a high-school education.

Not only do the links to the general population normally attend school, so do some sex workers and injecting drug users. According to a woman who is directly exposed to the sex working industry, though some sex workers come to Jakarta from other islands, many of the young girls who are sex workers are between the ages of thirteen and twenty-five and do attend school.[20] She mentioned one in particular who goes to high school during the day and is a sex worker at night. Numerous interviews with university students also revealed that some girls pay for

school by selling their bodies at a nightclub or a karaoke establishment.[21] As for injecting drug users, drugs know no boundaries and young people get involved for a number of reasons, most of them consistent with users in other developed and developing countries. According to interviews with people who were once injecting drug users, many children grow up in environments inundated by drugs.[22] Individuals' surrounding environment and hardships can play a role in drug addiction, independent of socio-economic status.

A school-based prevention program can offer other benefits for the general young population. It would facilitate conversation among adults and students about sexuality, the risks of being sexually active, and using drugs. According to the survey conducted for this report, when students were asked if they had someone in their life with whom they felt comfortable talking freely about sex and the risk of STDs, forty-seven percent responded with "no," and eighteen percent responded with "don't know" —a total of sixty-five percent unable to respond with a "yes" to the question. According to the 2010 UNGASS report, the percentage of young people (aged fifteen through twenty-four) who both correctly identified ways of preventing sexual transmission of HIV and rejected major misconceptions about HIV transmission was approximately fourteen percent for males and females.[23] According to the survey findings, thirteen percent responded negatively that a condom can help prevent the transmission of HIV and another twenty percent said that they did not know if it could. This lack of knowledge and existent stigma makes young people more vulnerable to sexually transmitted diseases.

Elements of the Program

Numerous reasons support a school-based HIV-drug prevention program. Some young people in the most vulnerable sub-populations (i.e. sex workers and injected drug users), as well as those likely to serve as a link to the general population, attend or have attended school in their life, making this type of program implemented on a wide scale a powerful tool for prevention. Because the number of HIV cases originating from sexual transmission is increasing, it is important to further advocate condom use. There is a need to dismantle the strong stigma towards sex and

increase students' knowledge of sex. In light of these established needs, it is appropriate to incorporate the ABC values for a comprehensive HIV prevention program.

The program must be focused, follow a logical sequence, and teach the lessons that will be the most effective in producing positive results according to the given needs. According to Kirby et al., the most common sequence among school-based programs included basic information about pregnancy and HIV/STDs (including susceptibility and severity); behaviors to reduce vulnerability; knowledge, values, attitudes, and beliefs involving these behaviors; and the skills needed to perform these behaviors.[24] The main targets of Indonesia's national strategy for sexual and reproductive health education include:

> 1) to increase knowledge among young people about reproductive health and safe sex, 2) to promote and facilitate a change of attitude among young people, including to increase respect for the rights of others, and 3) to provide young people with the knowledge, skill, and motivation to behave in a safe manner relative to their reproductive health.[25]

In accordance with the national strategy and the country's needs, the program must possess these three main components.

The program must increase the knowledge of reproductive health and safe sex among young people.[26] As reported earlier, there is a significant lack of knowledge among students regarding the prevention of STDs and HIV. Education should include information about HIV prevention through condom use and testing, how the disease is transmitted and progresses, and its treatment. The curriculum may also improve knowledge about the risks and damage drug use can cause. The results of the survey conducted suggest that many students reported not having anyone to talk to about sex and the dangers of HIV/AIDS. Creating an environment that encourages questions, participation, and interaction will relieve some stress within the environment, thereby enhancing the quality of education. The facilitator must be available for all questions and must also directly include those who are not actively participating so as to incorporate as many people as

possible into the learning experience.

Any HIV prevention program with the goal of increasing knowledge must also strive to change behavior to actually have an effect on the epidemic. Based on the needs assessment of the country, it is important that the program promotes the following behaviors: delayed initiation of sex; reduced number and frequency of partners; reduced or prevent drug use; and reduced stigma, measured by attitudes towards those who are infected and assessing the comfort level of talking about sex.

The most celebrated mode of inducing behavior change is life skills education. Life skills education is strongly promoted by the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO) as an essential component to a school-based HIV/AIDS prevention program. Providing life skills is an important tool in translating increased knowledge of HIV/AIDS into desired changed behavior. The definition of life skills provided by the WHO is "abilities for adaptive and positive behavior that enable individuals to deal effectively with the demands and challenges of everyday life."[27] UNICEF makes the assertion, based on research-based evidence, that "shifts in risk behavior are unlikely if knowledge, attitudinal- and skills-based competency are not addressed."[28]

According to a 2003 USAID study which reviewed lessons learned from Life Skills programs in Sub-Saharan and West Africa, data suggested that life skills learned within these interventions have led to a delay in initiating sex among young people and also improved other HIV-related behaviors like violence or drug and alcohol use.[29] Life skills should be a major component of this program because students will be taught to explore alternatives to difficult situations, weigh pros and cons, and will be helped to make sound decisions as everyday problems arise—the precise goal of Positive Choice. WHO divides a core set of life skills into three components: thinking skills, social skills, and negotiation skills.

Thinking skills involve the dissemination of reproductive health, STD, and HIV/AIDS information as well as developing the ability to think critically and to make positive choices when life presents a dilemma involving risky behavior. Other elements of thinking skills are self-awareness, social awareness, goal-setting, problem solving, and decision-making.[30] Both creative and critical thinking skills will be beneficial for

those students who may be tempted to find—or may already have found—work in the sex industry, by helping them to practice thinking about the future and setting goals. Critical thinking about values and goals in one's life may help youth to see that there are alternatives to engaging in such behavior.

Social skills are necessary for building positive relationships. They include working together with peers, listening and communicating effectively, and taking responsibility and coping with stress.[31] Social skills can help open the communication lines between adults and young people about hardships in their life, perhaps helping them to seek guidance. Having effective communication among adolescents and with adults is important in the prevention effort.

Negotiation skills help adolescents to assertively reject risky behavior that lead to STDs or HIV. It is important that young people know their own values, and that they establish self-awareness and self-esteem.[32] With an increased sense of self, one can be firm in one's beliefs and be more equipped to reject pressures like sexual activity or drug use. According to the findings from the Indonesian survey described above, seventeen percent of students feel pressure from the people around them to engage in sex. Negotiation skills will be useful in handling this pressure.

The incorporation of these elements in the Positive Choice program will lead towards the fulfillment of the national goal for reproductive health, "to provide young people the knowledge, skill, and motivation to behave in a safe manner relative to their reproductive health."[33]

ELEMENTS FOR IMPLEMENTATION

Many logistical questions must be answered for the program's successful implementation, including: where within Indonesia HOPE should conduct the program; at what grade level the material should be taught; who should conduct the program; how long the program should be; what curriculum should be used; and how sustainability will be accomplished.

Jakarta, like Indonesia as a whole, is experiencing HIV infection rates that increase each year. It is the province with the third highest HIV infection rate. According to Indonesia's Ministry of Health, the number

of AIDS cases per 100,000 people has continued to grow. In 2006, the prevalence was 28.15 per 100,000 people (when the national average was 3.61); in 2008 it was 30.52 (when the national average was 7.12); and in 2009 was 31.67 (when the national average was 8.66).[34]

In addition to the need for increased prevention effort in Jakarta, piloting Positive Choice in this city makes the most sense for HOPE because its resources are already well established in the area. HOPE has well developed relationships with various government and international schools in the Jakarta area, which will become quite valuable when trying to find a suitable school in which to implement the pilot program. These advantages will prove invaluable in the early stages of developing a Positive Choice program. The main goal will be to have a Positive Choice program that optimizes HOPE's capacity to implement the program and the number of schools willing to participate. A successful Positive Choice program will likely open the door for other government or non-government agencies to implement programs of their own using the effective characteristics of Positive Choice.

According to Kirby et al., 2005, nine of the ten programs that measured and found behavioral effects for two or more years were either multi-year programs or sessions provided over two or three years. Another type of program provided most sessions during the first year and then offered refresher sessions in subsequent months and even years later.[35] Determining the exact timetable of the program will take further collaboration between the Ministry of Education and HOPE, as well as an assessment of the capacity of HOPE Indonesia to implement it.

According to UNICEF, sex education programs are optimally introduced "as soon as possible."[36] In local field interviews, the most common recommendation was to begin the program with thirteen-year-olds. Positive Choice Jamaica implements their program in the seventh through ninth grades. However, the final age of participants in Positive Choice in Indonesia will be determined along with the curriculum, since it must be age appropriate, as a result of a consensus among stakeholders, particularly the Ministry of Education and local schools. According to the 2010 UNGASS report, only secondary schools in Indonesia offer sex education.[37] Consequently, HOPE can expect to implement the program in

secondary schools.

An already well-established HOPE program implements a teacher-training program, which imparts information on disaster preparedness and relief. Having this system already in place will make it easier to implement a teacher-training portion of the Positive Choice program, to ensure that teachers are both able and willing to facilitate it. Teachers chosen to participate should demonstrate enthusiasm and believe in the program, and should be committed to its goals and objectives. A supervisor should monitor and evaluate the quality of teaching in the program. If teachers do not meet the set standards, the school should insert a trained volunteer who can take over facilitation of the program.[38] As suggested by the "Standards for Curriculum-Based Reproductive Health and HIV Education Programs" published by Family Health International, teachers should feel comfortable to teach all portions of the curriculum; if they are not, guest speakers should teach that particular lesson.

Kirby et al., found that, among the seventeen characteristics of effective curricula with desirable effects on HIV reduction was the employment of "instructionally sound teaching methods that actively involved the participants, that helped participants personalize the information."[39] Some teaching methods included skits, role-playing to practice assertively saying "no," problem solving activities, homework assignments to talk to parents or adults, visits to drug stores, condom demonstrations, and quizzes. It is recommended that HOPE Indonesia follow the Positive Choice model that is implemented in Jamaica, as it is full of interactive activities and lessons. The program incorporates a variety of different interactive lessons including classroom group work; simulations of difficult decision-making situations; exercises to uncover peer perceptions; and interaction with parents to get them involved in their child's sex education.

Among the most important elements of Positive Choice is the monitoring and evaluation of the effects of the program. Reports must provide a detailed account of the curriculum, any changes made to the program, and details of the evaluation methods. They will not only document the progress of the program, but will also contribute to the archive of effective school-based HIV prevention programs that may help

other countries in similar situations. Pre-tests and post-tests of participants need to be conducted in addition to follow-up tests months later to measure long term effects. If possible, randomized controlled trials are extremely beneficial in evaluation of effectiveness. Consulting a university to assist in the formation of an appropriate evaluation system is highly recommended. Among the indicators to be measured are: initiation of sex; frequency of sex; number of sexual partners prior to survey; frequency of condom use; contraceptives in general; frequency of drug use; comfort level in speaking or negotiating sex; perceptive of peer norms involving sexual behavior; values on sex and abstinence; and knowledge on HIV/AIDS and risks of contraction.[40]

The implementation of Positive Choice will be dependent on funding. Donors must be reassured of the credibility of the program and its promising effectiveness, since it is rooted in extensive research of the HIV situation in Indonesia, the needs of the country, and the best preventative practices. Continued funding will be heavily reliant upon evidence of a beneficial impact of the program. Therefore, it is critical that the pilot program implement a rigorous monitoring and evaluation system to ensure that the practices and activities are in fact effective—so that if they are not, changes may be made accordingly. If there is a positive impact, the results should be documented and published to advertise the program's worth. As Positive Choice gains momentum, there may be a chance for public funding.

Conclusion

There is no time like the present for implementing an HIV-drug prevention program in Indonesia, as the national government verbally and financially supported an increased effort by increasing the budget in 2006 of $11 million to $73 million USD in 2009.[41] Due to the decentralization of the government, the real challenge will lie in obtaining support from local entities. By keeping evidenced-based research at the center of the program, and making necessary changes if results suggest ineffectiveness, it is quite possible that HOPE can pioneer a successful Positive Choice program in Jakarta with the hope of opening doors to other organizations to help

in sex education and HIV prevention. With a stronger emphasis on HIV prevention education, in combination with the current national strategies in place, perhaps Indonesia will become closer to reversing its increasing HIV infection rates.

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