

# **Young Muslim Leaders Confront the AIDS Pandemic in Indonesia**

**The role of Young Muslim Leaders in fighting the spread of HIV/AIDS in Indonesia**

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## **I. Introduction**

HIV/AIDS has become a major international public-health problem. Based on reports from the World Health Organisation (WHO) and Joint United Nations Programme on HIV/AIDS (UNAIDS), the estimated number of people living with HIV was approximately 33 million worldwide at the end of 2007 (1, 2). New cases of HIV infection and mortality due to AIDS were predicted to reach about 2.7 million and 2 million respectively, including 270,000 children, in the same year(1, 2). Furthermore, 25 million people have died from AIDS globally since the beginning of the HIV epidemic in 1981(1). In Asia, it is estimated about 5 million (4,1-6,2 million) people were living with HIV in 2008 Of the Southeast Asian nations, Indonesia has the highest number of cases. In Indonesia, which has the largest Muslim population in the world, the prevalence of HIV in high risk groups is alarming. The prevalence of HIV is estimated to be 43-56 % among injecting drug users, 6-16 % among female sex workers, 16-39 % among transgender groups, and 2- 8 % among homosexuals (men who have sex with men) in Indonesia (3).

One of the most effective means of transmitting HIV and other blood borne viruses (BBVs) is the shared use of drug injecting equipment and drug preparation (4-6). According to the United Nations Office on Drugs and Crime (UNODC), once the virus is introduced into an injecting drug using (IDU) community, the prevalence of HIV can increase by up to 90 % in less than two years (7). Intravenous injection is the most efficient route of drug administration because it produces the strongest drug effect at the lowest cost (5). Aceijas et al (8) suggest that IDUs account for 10 % of HIV cases worldwide and are driving the epidemic in some countries, including Indonesia. Moreover, other high risk groups, including sex workers, homosexual and sexually active transgender groups, are also responsible for the spread of HIV/AIDS and other sexually transmitted diseases(3).

Although there is the potential for extremely rapid transmission of HIV, there is also the possibility of extremely effective prevention of HIV transmission in this same population (5). UNAIDS (2005), cited in Des Jarlais et al. (5), states that there is no single intervention or approach that will effectively prevent or control HIV epidemics associated with the high risk groups; however, a comprehensive

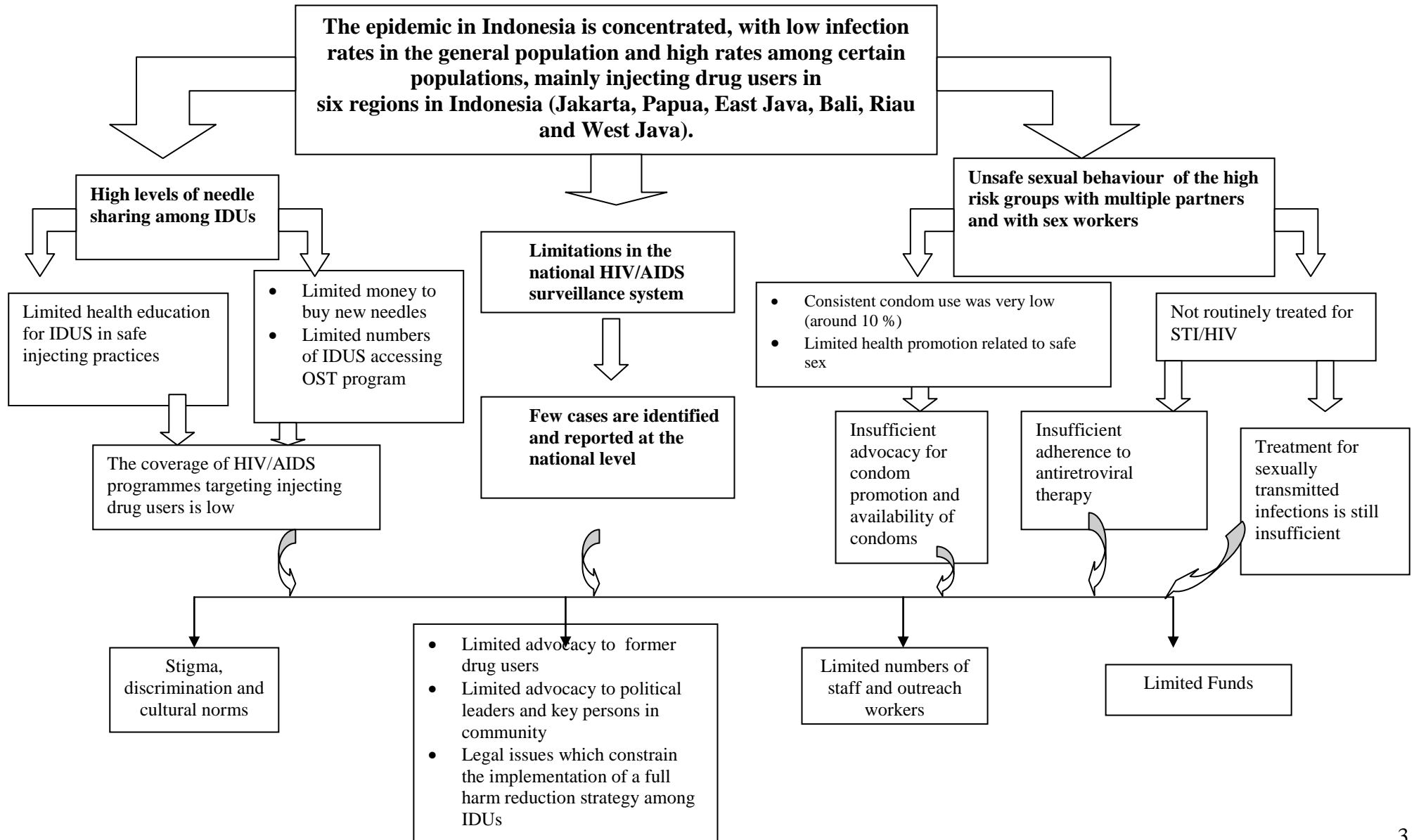
intervention package centering on harm reduction is required. This includes strategies that aim to prevent the spread of HIV quickly (5, 9): needle and syringe programmes (NSP); opioid substitutions therapy (OST); voluntary HIV counseling and testing (VCT); anti-retroviral therapy (ART); sexually transmitted infections (STI) prevention; condom programs for IDUs and partners; targeted information education and communication (IEC) for IDUs and their sexual partners; Hepatitis diagnosis, treatment (Hepatitis A, B, and C) and vaccination (Hepatitis A and B); and Tuberculosis (TB) prevention, diagnosis and treatment(20).

On the other hand, harm reduction programs have not been implemented effectively in Indonesia. One recent study in Palembang, South Sumatra, found no association between the existence of needle and syringe programs and the sharing of needles by IDUs (10).

**In Muslim countries like Indonesia, preventing the spread of HIV/AIDS is complex and multifactorial. Like most religions, Islam condemns drug use and promiscuous sex. Islam, therefore, can be seen as providing a model of primary prevention for its believers, involving the avoidance of illicit drugs, sex outside of marriage and marital infidelity. However, religious teachings and individual behavior are often at odds, and risky behaviors that are prohibited by religion still go on, including injecting illicit drug use and promiscuous sexual behavior (11). For this reason, a comprehensive harm reduction program with particular attention to local religious and cultural views is urgently required.**

This paper discusses the situation in Indonesia as background for addressing the need for a public health response related to human rights, ethical challenges, equity issues and the role of young Muslim leaders in working to stem the HIV/AIDS epidemic. It also describes Indonesian policy and strategies on HIV/AIDS. A proposed framework for an effective, evidence based public health response will be presented to minimize the spread of HIV/AIDS with particular attention to local religious and cultural conditions.

## II. Situation Analysis of HIV Epidemic in Indonesia



**Figure 1. Problem Tree of HIV/AIDS among drug users in Indonesia (modified from WHO, 2005, Pisani, 2003, Ministry of People's Welfare, 2003, National AIDS Commission Republic Indonesia, 2007)**

Figure 1 shows the nature of opportunities and constraints relating to HIV/AIDS prevention among IDUs in Indonesia. To address this complex problem, Indonesia has implemented a national HIV/AIDS strategy with seven main aims (15). These are: 1) promoting and expanding tried and tested prevention methods and assessing new methods; 2) empowering individuals, families and communities to prevent the spread of HIV in their environment; 3) strengthening the basic healthcare and referral systems so as to anticipate an increase in the number of people living with HIV requiring access to treatment and medication; 4) strengthening the capacity of those involved in the HIV and AIDS response at both the center and in the provinces through continuing education and training; 5) increasing research and survey efforts so as to obtain accurate data on the progress of HIV and AIDS responses and prevention efforts; 6) improving national HIV and AIDS monitoring capacity; and 7) mobilizing resources and integrating their use at all levels. To achieve these aims, the priority areas for HIV and AIDS response during the period from 2007 to 2010 focused on seven priority areas, including: 1) preventing the transmission of sexually transmitted infections, HIV and AIDS; 2) providing care, treatment and support to people living with HIV; 3) HIV, AIDS, and sexually transmitted infection surveillance; 4) conducting operational and other forms of research; 5) encouraging conducive environments; 6) engaging in multiparty coordination and integration; and 7) ensuring a sustained response (15).

Based on these national aims and priority areas, policy-makers in Indonesia and international donors have increased their attention to HIV/AIDS. A range of approaches and programs for harm reduction are viewed as beneficial for all parts of Indonesia, not just those areas that have been identified as having large numbers of IDUs or the majority of the nation's HIV/AIDS cases.

### ***3.1 Harm Reduction***

The short term goal of these harm reduction programs is to prevent HIV transmission as quickly as possible (12). Harm reduction must involve a comprehensive strategy that decreases drug-related harms or the negative consequences of drug use among IDUs

(13). The hierarchy of harm reduction goals is: first don't use drugs; second, if you use drugs, don't inject; third, if you inject drugs, use sterile injecting equipment and never share injecting equipment; and fourth, if you use non-sterile equipment or share equipment, use bleach to clean equipment between injections (12).

The hierarchy indicates that abstinence remains the most effective way of reducing the negative consequences of drug use. However, few clients are able to abstain from drug use after leaving treatment for drug dependence (9). Therefore, it is essential to provide harm reduction services to IDUs who may relapse soon after leaving treatment (9). This measure may be given higher priority than even reducing drug consumption (13). It has been argued that IDUs have the right to make their own life choices, including to use illicit drugs. Estella (14) noted that IDUs have rights and are entitled to equity in accessing an adequate level of education, to enjoy the highest attainable standard of health and facilities for the treatment of illness and rehabilitation of health, to rest and leisure, to maintain their personal privacy without arbitrary or unlawful interference, to obtain information from diverse national and international sources, and to access health services.

If IDUs are unable or unwilling to stop using drugs, **harm reduction** offers other options to reduce drug-related harm at the individual, family and community level. As a result, this approach may positively impact the health, social life, and economic status of IDUs and their families (9, 15). As government should respect, protect and guarantee the right and equity of IDUs (14), the Indonesian government is obliged to support harm reduction programs and prevent rights violations and ethical issues affecting IDUs. In this context, the government is also obliged to make policy and programs that will prevent the spread of HIV/AIDS while protecting the rights of IDUs (14). At present, there are nine harm reduction programs in Indonesia that target IDUs in the context of HIV/AIDS. They are the Needle and Syringe Programme (NSP); Opioid Substitutions Therapy (OST); Voluntary HIV Counseling and Testing (VCT); Anti-Retroviral Therapy (ART); Sexually Transmitted Infections (STI) Prevention; Condom Programs for IDUs and partners; Targeted Information Education and Communication (IEC) for IDUs and their sexual partners; Hepatitis diagnosis, treatment (Hepatitis A, B, and C) and vaccination (Hepatitis A and B); and Tuberculosis (TB) prevention, diagnosis and treatment (16).

Numerous studies in diverse epidemiological settings have demonstrated the effectiveness of harm reduction in preventing the spread of HIV. Moreover, there is no convincing evidence of major negative consequences of harm reduction. Needle and syringe programmes and opioid substitution programmes are now provided in more than 60 countries around the world (17). In Europe, all 25 members of the European Union now offer these programs. In Eastern and Central Europe and Central Asia, needle and syringe programs are numerous, but coverage is still poor (17). However, certain aspects of harm reduction remain controversial in some parts of the world. Counterproductive laws and policies in some countries also ban substitution therapy using methadone or buprenorphine and NSPs (18). For instance, the United States has maintained a ban on federal government funding for needle and syringe programs (17). In Indonesia, some local governments, particularly in Java and Bali, have started to implement harm reduction programs. ( dates? Size of programs?

### ***3.2 Recent Research Related to One Harm Reduction, Needle and Syringe Program in Palembang, Indonesia***

Research was conducted by Najmah et al (2010) on the accessibility of needle and syringe programs (NSP) and IDU behaviour in using non-sterile injections and syringes. which involved forty six mostly male respondents from the NSP group and 75 mostly male respondents IDUs from the non-NSPgroup. Most of these individuals had a high school education and were unmarried. It was determined that IDUs accessing NPS had a 1.07 odds ratio of sharing a needle or syringe compared to IDUS who did not participate in an NSP When this odds ration was adjusted for knowledge about HIV/AIDSand harm reduction, IDUs' attitude towards harm reduction, education level, income level, it was found that IDUs accessing NSP tended to minimize their needle and syringe sharing behavior as compared to IDUs in the non NSP group by 29 %..

The availability of NSP seems to reduce the use of shared or non-sterile injections or needles. Although no significant association could be detected, free access to needles and syringes in pharmacies could be one confounding factor that contributed to the significant association between NSP and change in IDU behaviour in using sterile injections and syringes. Further research is urgently needed using larger sample sizes to

better elucidate the significance of association as is qualitative research that will allow a more nuanced understanding of IDU behaviour in using non-sterile injections and syringes and to underpin religious and cultural approaches that may be more effective in this social context.

Another research by Najmah(2011) found that IDUs who have positive attitude towards harm reduction concept on NSP and longer use of injected drugs more likely access NSPs(19). The bivariate analysis indicates that IDUs who have positive attitude towards Harm reduction and needle and syringe program tend to 2.76 times to access NSP compared to those who have negative attitude ( OR 2.76(95 % CI 1,30-5.89), p.0.008). Then, IDUs who inject drugs tend to access 1.09 times for each increase of year using drugs with moderate significance to reject the null hypothesis (OR 1.09(1.003-1.19), p. 0.04). However, variables of education, age, income and knowledge about HIV/AIDS and Harm reduction did not differ between IDUs accessing and not accessing Needle and Syringe Programs. After possible confounders adjustment, association between length of use injected drugs and IDU's attitude towards accessing NSPs(19). Therefore, enhancement peer educators from ex-IDUs is important to increase positive attitude towards harm reduction among IDUs. Moreover, further research with big sample size and qualitative approach are urgently needed.



### III. Potential Role of Young Muslims in a Strategic Framework of Preventing HIV/AIDS among Injecting Drug Users' Harm Reduction in Indonesia

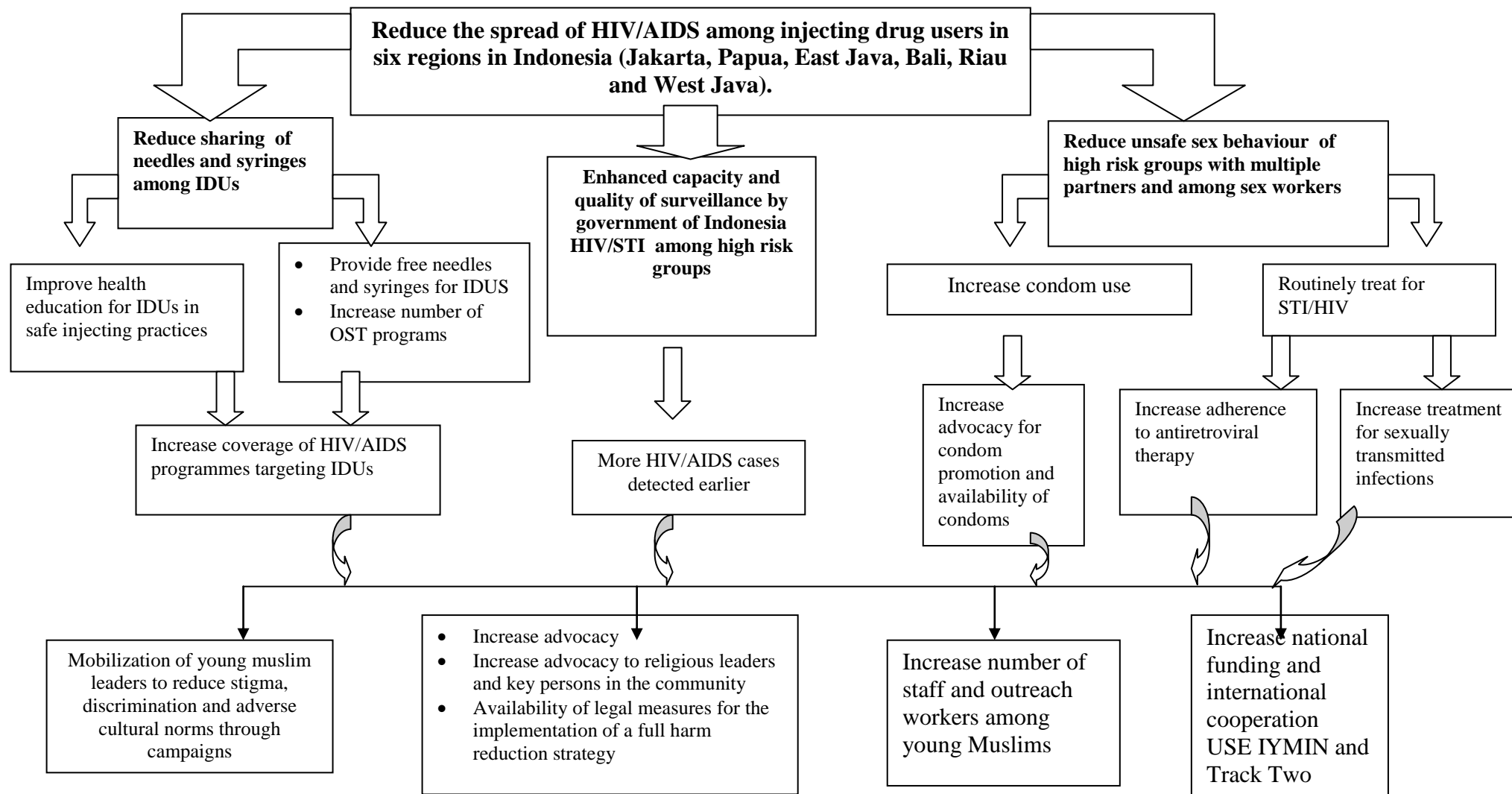


Figure 2. Objective trees for HIV/AIDS Prevention among Drug Users in Indonesia (Modified from WHO, 2005, Pisani, 2003, Ministry of People's Welfare, 2003, National AIDS Commission Republic Indonesia, 2007)

### **3.1 Research related to HIV/AIDS in Muslim Countries**

Few studies have explored Islam's contributions to HIV/AIDS prevention and treatment. One study in Senegal describes how Muslim leaders have been actively involved in HIV/AIDS campaigns for some decades (20). Although the study found that participants with a high religiosity score were not more likely to report that they did not use condoms when sexually active, the study found that participants with a higher religiosity score were more likely to abstain from sex (20). In another study that focused on HIV patients, spiritual support was also related to better health status and perception among patients with HIV (21). In other words, this research suggested that addressing the spiritual needs of HIV patients could be one means to reduce depressive symptoms in people living with HIV/AIDS (21). Another study, Cotton et al (2006), concluded that HIV/AIDS patients with greater optimism, greater self-esteem, greater life satisfaction tended to be both more spiritual and religious with these spirituality levels remaining stable over 12 to 18 months (22). Therefore, spirituality could be considered one important means in preventing the spread of HIV/AIDS and prolonging the life of HIV/AIDS patients.

### **3.2 Roles of Muslim Leaders in the Strategic Framework of Preventing HIV/AIDS among IDUs in Indonesia**

The success of the proposed framework detailed in figure 2 will depend on the harm reduction programs themselves but also on intersectoral cooperation with religious institutions that structure much of the social context in Indonesia. Stigma and discrimination, gender inequality, misinformation about IDUs and HIV are still rampant in the Muslim community (11). In practice, this is a frequent impediment in reaching IDUs through harm reduction programs. **For this reason, there is a pressing need to strengthen the capacity of the Muslim community to respond with awareness and understanding, to foster regional cooperation and networking, and to respond to legal, ethical and human rights issues.** Surveillance, monitoring and evaluation of the programs are also important components of successful harm reduction programs (23). One potential means of achieving this is through the use of religious institutions and

young Muslim leaders. There are a number of possible activities that could be run by these means. These include:

1. Call for a commitment to meet by young Muslim leaders. The participants would be from the top levels of faith based organizations, government (Ministry of Health, Ministry of Religion, Ministry of Social Affairs, National AIDS Commission (NAC), Coordinating Ministry for Public Welfare, Ministry of Women's Affairs) NGOs and donors. A facilitator will be drawn from among the nation's young Muslim leaders.
2. Conduct a national workshop which would involve participants from the national levels of religious organizations. The aim of the event would be to develop strategies and increase capacity of religious leaders in managing a response to HIV/AIDS in the Muslim community.
3. Run comprehensive training programs about HIV/AIDS for Muslim leaders with the aim of giving religious leaders increased knowledge, understanding and capacity about HIV/AIDS. Following the training, participants will design and facilitate workshops at the regional level And the Regional Level.
4. Workshops will be held at the regional level by previously trained Muslim leaders to build capacity at this level. These workshops will be conducted together with other stakeholders in each province or region.
5. A Peer Education Program for young Muslims will be set up for the young Muslim leaders who have already taken part in the training.

Youth are recognized as one of vulnerable groups for HIV/AIDS. Therefore, enhancement of capacity building among the younger generation is very urgent. This enhancement program has been implemented by the national chapters of The Asian Muslim Action Network (AMAN) in Thailand, India, Cambodia and Vietnam targeting youth, through workshops, training of trainers, and participatory planning consultations (24). The objectives of these activities have been:

- a) To provide information about HIV/AIDS, its transmission, preventative measures, and the impact of HIV/AIDS.
- b) To foster volunteerism among young people and students and encourage understanding of the core values underpinning social development.
- c) To convey to young people the important role they can play in the prevention of HIV/AIDS.

- d) To increase the capacity of young people to teach others about HIV/AIDS through session planning, communication, networking, facilitating peer group discussions, and counseling.

These young muslim leaders should be able to be actively involved in each harm reduction program. Continuing activities should include the following(23);

- Developing effective health promotion among communities to explore, understand and respond to the development implications of injecting drug use and the HIV epidemic such as getting key persons in community involved with IDUs and HIV epidemic socialization and campaign.
- Empowering community based religious organizations and networks as key resources to make successful harm reduction programs such as youth organizations in schools and having ex-drug users deliver safe injecting equipment to their peers who are IDUs.
- Developing and disseminating IEC materials, technical assistance manuals and other information on HIV prevention among IDUs in local languages with a religious approach.
- Disseminating the findings of scholarly papers via specific consultations and workshops, featuring action-plans for further discussion, dissemination and action on emerging findings nationally and internationally.
- Supporting regional networks through the sharing of information, training programs, consultations, lessons learned across borders and technical support mechanisms for HIV prevention among IDUs, for instance by arranging regular meetings among regional networks.
- Conducting research related to legal, ethical and human rights issues concerning injecting drug use and HIV in Indonesia

The existing Islamic institutions/ organizations can be of help in promoting awareness of prevention and services for HIV/ AIDS affected persons (24). This might be done through the following institutions:

### **1. Mosque**

In the Islamic communities of Indonesia, almost every village has a mosque. Most residents attend Friday prayers. Mosques have traditionally been a venue for

education, discussing social problems and finding solutions. The imams can play a vital role in promoting awareness. Trained volunteers and educational materials can help build awareness in this context.

## **2. Islamic schools**

Thousands of students attend Islamic schools in Indonesia. If teachers are retrained and given promotional materials, they can play a vital role in disseminating information.

## **3. Hospitals and clinics run by Islamic institutions**

Hospitals and clinics run by Islamic Institutions already offer services to the community. With their expertise, community leaders, imams and teachers in Islamic schools can be trained to set up centers for HIV/ AIDS affected adults and children. A mobile team of doctors and nurses can provide support to such outreach centers.

## **4 Conclusion**

Spread of HIV/AIDS is rampant, including in Indonesia. Youth are recognized as one of vulnerable groups for HIV/AIDS. However, in Muslim countries like Indonesia, preventing the spread of HIV/AIDS is complex and multifactorial. Therefore, prevention of HIV/AIDS and treatment of people living with HIV/AIDS with harm reduction program with particular attention to local religious and cultural views is urgently required in Indonesia

Few studies have explored Islam's contributions to HIV/AIDS prevention and treatment and effectiveness of harm reduction to reduce the spread of HIV/AIDS. A pressing need to strengthen the capacity of the Muslim community to respond with awareness and understanding, to foster regional cooperation and networking, and to respond to legal, ethical and human rights issues. The existing Islamic institutions/ organizations can be of help in promoting awareness of prevention and services for HIV/ AIDS affected persons

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