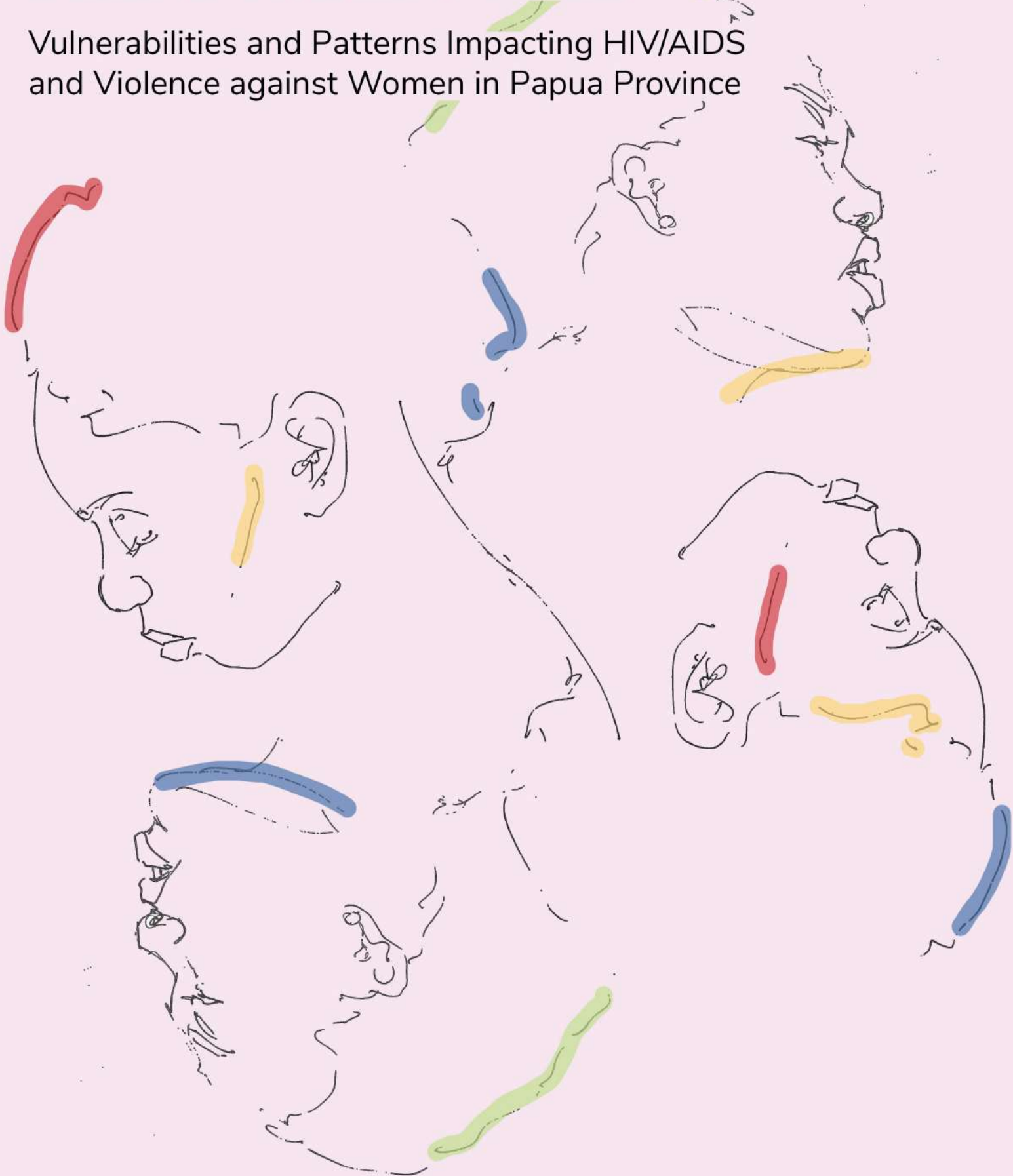


Between a Rock and a Hard Place:

Vulnerabilities and Patterns Impacting HIV/AIDS
and Violence against Women in Papua Province



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Jayapura Support Group

**Between a Rock and a Hard Place:
Vulnerabilities and Patterns Impacting HIV/AIDS and Violence against Women in Papua
Province**

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About Asia Justice and Rights

Asia Justice and Rights (AJAR) is a non-profit organisation based in Jakarta, Indonesia. AJAR has a mission to increase local and national actors' capacities, particularly victim organisations, in fighting against impunity and also encouraging life that is based on accountability, justice, and willingness to learn from the root of Human Rights violations. AJAR focuses its work on conflict transformation issues, Human Rights, and educating and strengthening communities in the Asia-Pacific region.

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Chapter 1: Executive Summary

I was born in 1986, the oldest of eight siblings. My father died in 2003, then my mother took a partner. My parents often hit me in the head because I was naughty. Then I had a partner; we fought a lot, until I even broke a tooth. . . . I began [antiretroviral] therapy in 2007. I am grateful I have friends my age and an organisation that supports me, reminds me about my medical consultations and to take my medicine. I sell handicrafts and work at the organisation to help people who are infected. I support my family: my mama, younger siblings, and my children. All the healing activities [in this workshop] have made me strong. (AB, peer supporter, 33 years old)

Overview

From June to August 2019, Asia Justice and Rights (AJAR) collaborated with four local organizations in Papua Province to study the links between violence against women (VAW) and women living with HIV/AIDS. We worked with Yasanto, eL_AdPPer, Katane Support Group, and Jayapura Support Group to answer several questions:

- What factors contribute to women's vulnerability to HIV and violence
- What impact of violence on women living with HIV/AIDS as they seek access to prevention, treatment, care, and support, including legal services?
- What national and local initiatives address the links between HIV/AIDS and VAW in Papua Province?

Using participatory research tools, we analysed the experiences and hopes that 42 women living with HIV/AIDS shared in five group sessions. Four of the two-day workshops took place in Merauke and one in Jayapura. All 42 women were active in support groups facilitated by our local partners. Twenty-six were Indigenous Papuans, and 16 were women from other islands of Indonesia who have lived in Papua Province a very long time. We also interviewed 18 stakeholders, including policymakers, service providers, and local leaders.

The study found that women in Papua are vulnerable to HIV/AIDS and violence in three ways: (1) they are vulnerable because they are **women**; (2) they experience stigma and discrimination as persons **living with HIV/AIDS**; and (3) **Indigenous and indigent women** in particular face increased vulnerability when displaced from their land and culture by rapid development and protracted conflict. When women become HIV positive their burdens intensify.

Our findings also revealed underlying patterns that impact women's experience of HIV and violence, namely: (1) **impunity** that leads to acceptance and recurrence of violence; (2) vulnerability that extends to the **next generation**; (3) and a vicious cycle of **gender-blind policies**.

Between a Rock and a Hard Place

The lack of attention to the intersection of HIV/AIDS and violence impedes efforts to address both problems. Without resources and long-term programmes to address gender-based violence among women and men living with HIV/AIDS, as well as the impact of both factors on children's lives, many of the gains made in the last two decades could become undone.

Of the 42 women who participated in the study, 41 experienced violence at some time in their lives. Thirty-two had experienced violence from an intimate partner. Many of the women's stories depict a time when their lives veered out of control, with almost no safety nets available. Three significant categories emerged from the information collected in this study: (1) Those who had to survive on their own as young children or teenagers as a result of the death of one or both parents; (2) former transmigrants who faced destitution due to drought and failed crops, leading them to become sex workers; and (3) the majority (30 out of 42) who had partners who were also positive. In most of these relationships, the women had few ways to protect themselves.

In this context, the study found that many women living with HIV/AIDS were exposed to various forms of **gender-based violence** by partners, parents, siblings, and other family members. They experience physical and psychological abuse, neglect, trafficking, and sexual violence after and even before their HIV status became known.

When known to be HIV positive, both men and women are judged, ostracised, and neglected. However, our study showed how, due to gender roles and health status, the vulnerability to violence for women living with HIV/AIDS differs from that of men in several ways:

- A woman may be beaten when she confides her health status to her partner or family.
- A woman may be reluctant to breastfeed for fear of transmitting HIV to her child, rising violence and discrimination if her family learns the reason for her reluctance.
- Some women do not want to ask their partners to be tested for HIV/AIDS or to use a condom because they are afraid the request will incite a violent reaction
- One woman was violently prevented from taking medicine because her husband did not want the extended family to know her health status
- One woman whose husband died from AIDS was threatened with violence by her late husband's family because she refused to marry his brother
- Women living with HIV/AIDS have experienced discrimination by medical officials and personnel who assume they are promiscuous.

Impunity Leading to Acceptance and Recurrence

We found that women living with HIV/AIDS often do not report their partners to the authorities when they experienced violence. Instead, they were either passive or sought to resolve the problem on their own, seeking support from within the family or from a counselor. Of the 32 women who experienced violence from an intimate partner, only 12 reported the violence to the police or authorities, resulting in a signed statement from the perpetrator promising not to repeat the abuse. Only seven resulted in detention for the perpetrator. Those who did not make report gave a variety of reasons:

- Two women said their families prevented them from reporting the abuse.
- One woman said she did not know where to report the abuse.
- Another declined to report because she did not have a marriage certificate, a prerequisite demanded by the police.
- One woman said she could not report her abuser because of her financial dependence on him. Another woman said that her family still owed a bride price to her husband's family.
- Other reasons women gave for reluctance to report incidents of domestic violence included fear of revenge or because they still loved their husbands.

Our study found that services for women victims of violence are less developed than health services to treat those with HIV/AIDS. Without any working referral mechanism, these two service infrastructures are like neighbouring islands unconnected by any bridge.



The Next Generation at Risk

Although efforts to combat the spread of HIV/AIDS in Papua Province are in their second decade, the volatile combination of HIV/AIDS and violence is having an enduring impact on the next generation. When mothers must battle stigma and cope with declining health, injury, and trauma, while struggling for economic survival, there are long-term consequences of their diminished capacity to nurture and educate their children.

- Of the 42 participants, 11 spoke of being “married off” before age 18.
- Eight lost one or both of their parents as young children or teenagers. Some were then married off as children and others attempted to make a living as young teenagers, independent of their family.
- Thirteen women spoke about becoming sexually active at an early age without enough information on reproductive and sexual health choices. Programmes on teen health and sexuality for high school students that were very successful in the 1990s, such as “Daku Papua”, have not continued due to lack of funding.

Counselors who have worked in Merauke for decades believe that the rise of street children addicted to sniffing glue correlates with families affected by HIV/AIDS and the lack of programming to help affected children. Street children are at risk for violence, HIV/AIDS, and addiction.

Policies Targeting Women, and Policies that are Blind to Their Impact on Women

Social drivers of HIV/AIDS and violence in Papua include rapid change in development, prolonged conflict, migration/transmigration and the infusion of cash under special autonomy.

We found that the policies enacted to prevent the spread of HIV/AIDS were discriminatory towards women, reflecting gender biases that lead to the criminalisation of women. Such practices and policies include: (1) a narrowing interpretation of reproductive health, focusing mostly on HIV and STDs testing, (2) the closure of large brothels across Indonesia without anticipating impact, and criminalisation of sex workers and women as mothers, (3) lack of sustainable access to health care, and (4) short-term and poorly conceived approaches.

Resilience and Hope

Locally-driven, multisectoral responses to HIV/AIDS in Merauke and Jayapura have adopted empowerment approaches. Over the more than 20 years since the first case of HIV in Papua, these responses have included Indigenous women and women living with HIV/AIDS in the mechanisms that allow them to engage in decision-making and everyday activism. We heard that the existence of a shelter in Merauke, and later in Jayapura, became a critical turning point in many of the women’s lives. Half of all study participants affirmed that by providing much-needed protection, the shelters gave women the time to regain some control over their lives.



Civil society, led by groups like Yasanto, have given birth to Papuan-led HIV/AIDS interventions, including peer support groups. This movement is well placed to develop an integrated response to issues around violence against women. However, a steady decline in funding is putting at risk the achievements of this two-decade long process. We must ensure on-going support for the basic services provided by government and civil society groups, including support groups and the regeneration of new advocates and counselors. Such support will allow local groups to develop a comprehensive response, involving and led by Papuan women themselves.

The title of this report, *Between a Rock and a Hard Place*, describes the difficult position of Papuan women who suffer violence, are cornered by gender discrimination, and pinned down by the impact of HIV/AIDS. Many stay silent due to the fear of violence, even as they must access proper medication to live. The phrase also captures the challenges that policymakers and donors face. Do they carry on with "business as usual" like an immovable rock maintaining the disconnect between efforts? Or do they choose the difficult road of empowering locally-driven approaches that are committed to long-term, integrated strategies? The study concludes with recommendations.

AKU PAPUA -
MEMBANGUN
TANAH -
PAPUA



Chapter 2:
Introduction

Papua and West Papua are Indonesia's eastern-most provinces, governed under a Special Autonomy Law. The 2001 law includes a promise to address past conflict, strengthen the rights of Indigenous women, repair inequality, and improve the participation and reach of development to fully engage Indigenous Papuans. Previous and current administrations have focused on accelerating development, improving infrastructure, and investing in health care.

In 2019, The Papuan Women's Working Group (PWG)¹ released its report, *I am Here: Voices of Papuan Women in the Face of Unrelenting Violence*, which found that violence against women in Papua is a critical public health and human rights issue, as previous inquiries have affirmed. The forms of violence perpetrated against women are wide-ranging. The report documented cases of wide spectrum of violence, such as conflict over natural resources and loss of Indigenous lands, and sexual violence related to political conflict. They found domestic violence and violence and discrimination experienced by women when they were children. Women spoke of violence in the past and its long-term impact on their health and social economic welfare, as well as the impact of ongoing political and domestic violence.

The PWG research raised AJAR's awareness of the double threat of HIV/AIDS and violence against women. AJAR and eL_AdPPer, joined by Yasanto, Katane Support Group, and Jayapura Support Group followed up with a close examination of the subject in Merauke and Jayapura.

The HIV/AIDS epidemic in Papua surfaced in Merauke in 1992 when around 50 Thai fishermen, contracted by large fishing vessels in the Arafura Sea, tested positive. At about the same time, the new fish canning industry led to a surge in prostitution around the port.² Shortly after, a locally-owned, multi-sectoral response, pioneered by Merauke District, offered a holistic and empowered approach to the epidemic in Papua Province. The prevalence of HIV/AIDS in Papua fell to 2.3% over the last seven years.³ Considering that a study in 2006 estimated the prevalence to be 3.4% to 6.8%, this reduction is significant.⁴ Nevertheless, there are still more than 40,000 people in Papua known to be living with HIV/AIDS as of the first quarter of 2019⁵, or about 2,000 known new cases since September 2018, as reported by the Health Agency of Papua Province.⁶

1 AJAR, as a member of the PWG, co-facilitated a process of action research from 2013 to 16 that involved 249 Indigenous Papuan women. A report in Indonesian was launched at the Papuan Governor's Office in 2016 and an updated English version followed in 2019. The report's key findings and recommendations on violence against women are reproduced here. The full report can be accessed online: <asia-ajar.org/wp-content/uploads/2019/04/I-am-Here-Voices-of-Papuan-Women-2019.pdf>.

2 Komonbut R. *Thai fishermen and their local contacts in Irian Jaya: an assessment of issues related to the spread of HIV/AIDS in Merauke*. Jakarta: Program for Applied Technology in Health (PATH), 1995.; cited in Leo Mahuze's presentation at the methodology workshop for this study on 11 June 2019 in Merauke.

3 Government of Papua Province, "KPA Sebut Prevalensi HIV Akhir 2017 Turun," accessed 15 August 2019, <www.papua.go.id/view-detail-berita-5532/index.html>.

4 John Kaldor, et al., "Impacts of HIV/AIDS 2005-2025 in Papua New Guinea, Indonesia, and East Timor: Final Report of HIV Epidemiological Modelling and Impact Study," February 2006, <www.hivpolicy.org/Library/HPP000960.pdf>.

5 "Jumlah Kasus HIV/AIDS Triwulan I 2019 Capai 40.805 Kasus," *Papua Today*, 9 May 2019, <www.papuatoday.com/2019/05/09/jumlah-kasus-hiv-aids-triwulan-i-2019-capai-40-805-kasus/>.

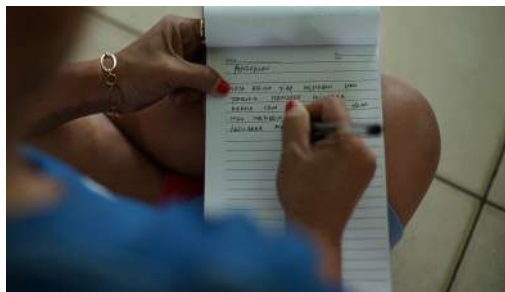
6 "Angka Penderita HIV/AIDS di Papua Tembus 38.874, Nabire Peringkat Pertama," *Papua Satu*, 1 December 2018, <www.papuasatu.com/kesehatan/angka-penderita-hiv-aids-di-papua-tembus-38-874-nabire-peringkat-pertama/>.

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Studies from 2016 have shown that in Papua the ratio of female to male HIV positive patients is 3:1.⁷ This means about 60% of reported cases in Papua are women, whereas the national figure is only about 37%. A majority of HIV positive women in Papua were infected through high-risk sexual activity among heterosexuals. The response for prevention and mitigation initially focused on select populations, such as sex workers, slowing transmission in the groups. However, HIV/AIDS in the general population in Papua has now become a greater public health issue.

A study by the Women's Study Centre of Cendrawasih University (*Pusat Studi Wanita Universitas Cendrawasih*) in Jayapura points to patriarchy and social attitudes about sex and reproduction as major contributing factors to women's vulnerability to HIV/AIDS.⁸ As sexual and reproductive health rights are still considered taboo in society, there is little information about safe sex. Many couples do not realize the importance of using condoms to help prevent the spread of HIV/AIDS. Patriarchal culture further makes it difficult for women to encourage their partners to use condoms. The study found that almost half of male perpetrators of violence refused when their partners requested safe sex with contraception.⁹

Papua Province is thought to have the highest incidence of violence against women in Indonesia.¹⁰ Although some work supports a connection between violence against women and the HIV/AIDS epidemic in Papua, further investigation is needed. A study by UNAIDS indicates that women who have experienced intimate partner violence are 1.5 times more vulnerable to contracting HIV from their partners.¹¹ A study in Nigeria found that women who tested positive for HIV were six times more likely to experience physical violence during pregnancy and four times more likely to experience sexual violence compared to women whose tests were negative.¹² A global study by UN Women has identified violence as a main obstacle to women's access to health services and that women are vulnerable to violence when they reveal their health status.¹³



7 The Indonesian Ministry of Health, "HIV Epidemiology Review Indonesia 2016," accessed 15 August 2019, <www.siha.depkes.go.id/portal/files_upload/HIV_EPIDEMIOLOGY_REVIEW_INDONESIA_2016.pdf>.

8 "Pendidikan Publik HKSR dan Kebijakan Pembangunan di Jayapura," *Jurnal Perempuan*, 23 May 2017, <www.jurnalperempuan.org/warta-feminis/pendidikan-publik-hksr-dan-kebijakan-pembangunan-di-jayapura>.

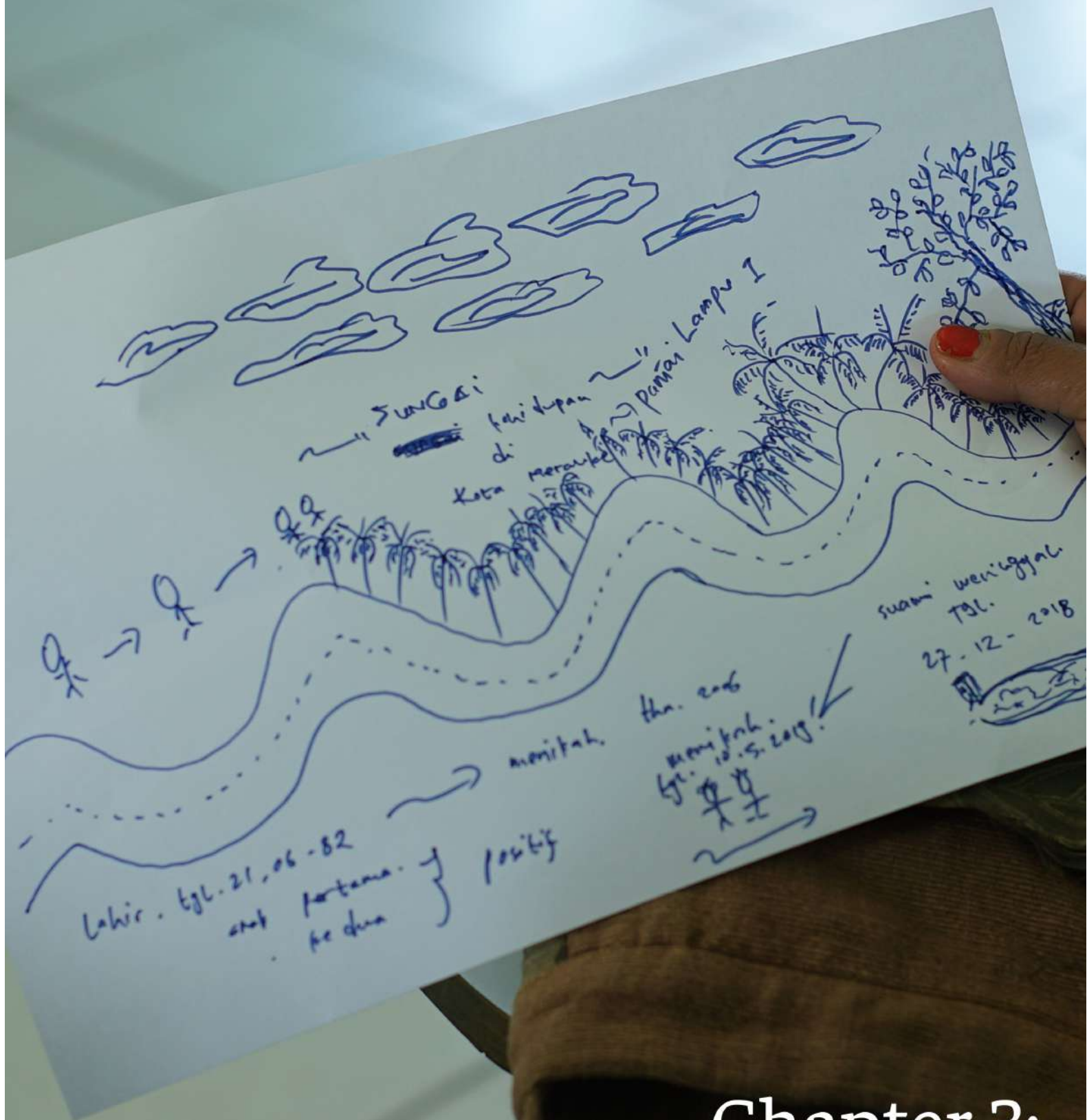
9 Ibid.

10 "Bumi Cendrawasih Urutan 1 Kasus Kekerasan Terhadap Perempuan," *Noken Live* 3, 27 February 2019, <www.nokenlive.com/2019/02/27/bumi-cendrawasih-urutan-1-kasus-kekerasan-terhadap-perempuan/>.

11 UNAIDS, "Women Lead to Reduce the Impact of HIV and Gender-Based Violence in the Middle East and North Africa," 23 April 2019, <www.unaids.org/en/resources/presscentre/featurestories/2019/april/20190423_mena>.

12 NACA, "National Plan of Action: Addressing Gender-based Violence and HIV/AIDS (GBV/HIV/AIDS) Intersections 2015-2017," December 2014, <www.ilo.org/wcmsp5/groups/public/-/-ed_protect/-/-protrav/-/-ilo_aids/documents/legaldocument/wcms_361989.pdf>.

13 UN Women, "Key Barriers to Women's Access to HIV Treatment: A global review," December 2017, <www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2017/key-barriers-to-womens-access-to-hiv-treatment-a-global-review-en.pdf?la=en&vs=3431>.



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Chapter 3: Methodology

Between a Rock and a Hard Place

Information for this study was shared by 42 women living with HIV/AIDS in workshops using participatory action research (PAR) methods. These participatory tools have been developed by AJAR and partners, including the Papuan Women's Working Group (PWG).¹⁴ Using carefully planned and crafted activities, women shared their experiences through their life stories, body and community mapping, and reflections on truth and justice. For this research AJAR adapted our PAR tools, in consultation with Katane Support Group and eL_AdPPer, after our first workshop.

These grassroots tools reflect our commitment to involve women as active agents for change. As part of our methodology, we built in activities beneficial to victims of violence: facilitating a way to tell their stories in a collective healing process, while building solidarity, awareness and a common ground for action.¹⁵

Of the 42 participants, 27 were Indigenous Papuans and 15 were from outside Papua. In this study, a person is considered Indigenous if at least one parent is Papuan. The participants' information was compiled during the workshops conducted in Merauke and Jayapura in the following stages:

Group	Date	Participants	Location
I	12–13 June 2019	9 women	Merauke
II	22–23 June 2019	7 women	Merauke
III	25–26 June 2019	7 women	Merauke
IV	28–29 June 2019	7 women	Merauke
V	16–17 July 2019	12 women	Jayapura

Each group participated in a two-day workshop. Ages ranged from 18 to 55 years old. Six of the women have known their health status since they were children, including one who discovered she her positive status when she was just 13 years old. On average, the women have known their health status for over eight years. Some have been living with HIV/AIDS for 22 years, while others only discovered their status in 2019. Thirty of the

¹⁴ Galuh Wandita, et al., "Mama Belajar: Membangun Metode Penelitian Partisipatif Bersama Perempuan Papua," 2017, <www.asia-ajar.org/wp-content/uploads/2017/11/Photo-book-Mama-Belajar.pdf>.

¹⁵ *Stone & Flower* and *Mosaic* comprise a series of manuals published by AJAR. *Stone & Flower* outlines a variety of methods to document women's stories, facilitate community-based healing, and develop advocacy initiatives on behalf of gender justice at a local level. Similarly, *Mosaic* provides a series of exercises to strengthen state accountability for the elimination and prevention of torture and impunity in Asian countries. Galuh Wandita, et al., *Stone & Flower: A Guide to Understanding and Action for Women Survivors*, <www.asia-ajar.org/files/stone%20%26%20flower.pdf>; Galuh Wandita, et al., *Mosaic: A manual for rebuilding lives and communities after torture*, <www.asia-ajar.org/wp-content/uploads/2018/01/Mosaic-Unlearning-Impunity-Series-Manual-2018.pdf>.

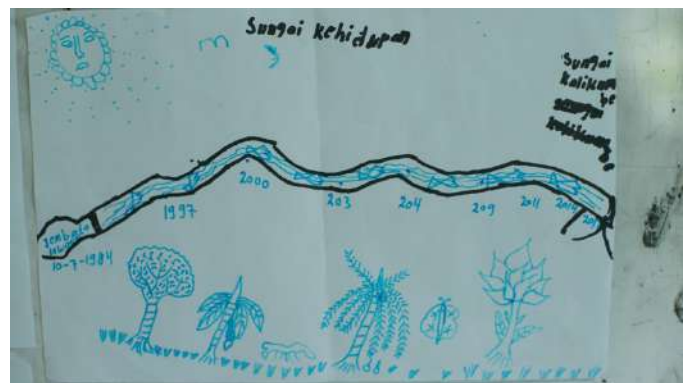
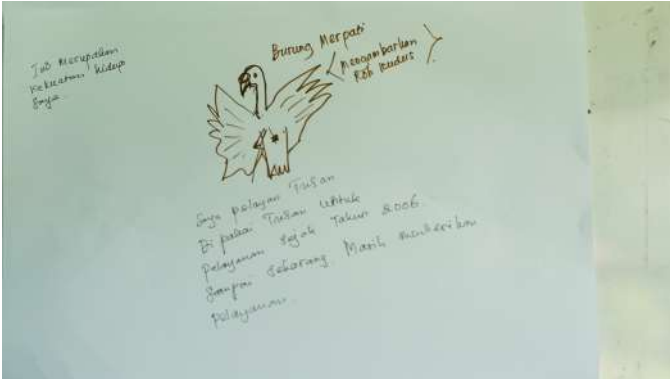
participants know that their partners are also positive, and 12 had children who were also positive. The majority of participants are married and have children whose status is negative.

All participants are involved in support group activities provided by civil society groups such as the Santo Antonius Merauke Foundation (Yasanto) or the United Cendrawasih Foundation in Merauke. Some are also members of peer support groups such as Katane in Merauke, the Jayapura Support Group, and the Indonesian Association of Positive Women in Papua. Their experience may be different from women living with HIV/AIDS who are not in support groups or have not received assistance from non-governmental organisations (NGOs).

We interviewed eighteen stakeholders, 12 of them women. Eleven were Merauke District or Papua Province employees, while the other seven were community mobilisers. The 18 included four health workers, four people providing support for people living with HIV/AIDS, and two police officers in units that handle violence against women. Each had more than ten years of experience providing services and support for women victims of violence or living with HIV/AIDS. A literature study provided further data.

Merauke District was chosen as a case study because other regions often refer to its successful multi-sectoral response to the epidemic. Gathering information in Jayapura, the capital of Papua Province, provided comparative data as well as a provincial perspective. Comparative study with other Indonesian regions is also needed so that this study's findings do not contribute to stigmas about Papua.

Between a Rock and a Hard Place





Chapter 4:
Six Key Findings
on Links between
HIV/AIDS and Violence
Against Women in Papua

Of the six key findings, three concerned vulnerability to violence and discrimination, and three related to underlying patterns that impact women's experience of HIV/AIDS and violence. Although we address these findings separately, they are interconnected and jointly contribute to repeated patterns of vulnerability and violence.

Triple Vulnerability: As Women, Women Living with HIV/AIDS, and Indigenous and Poor Women

The participants in this study were vulnerable to violence and discrimination in at least three ways: as women, as women living with HIV, and as poor and/or Indigenous Papuan women. Where these identities overlap, violence and discrimination are often exacerbated. Conversely, women who face repeated violence from their husbands, male partners, or other family members are also vulnerable to HIV/AIDS. Our study confirmed a mutually reinforcing vulnerability for HIV/AIDS and violence.

1. Vulnerability: Widespread Violence and Discrimination Against Women

For three years we had no children. All that time he liked to hit my head because, he said, "This woman can't give children." He'd hit me all over my body. . . . I finally got pregnant with my first child. . . . the second child is a boy, in secondary school. . . . Then [my husband] took a civil servant test in Wamena and left Merauke. . . . He worked in Lani Jaya. He liked women. When he was here it didn't seem that he liked women. Then he got sick in Wamena . . . [and] died there. I went to Wamena for the funeral. After returning home, I began to get sick down to my bones, coughing and vomiting. I was taken to the hospital. Slowly my weight began to fall. The nurse said I had to have my blood checked. When I was told I had AIDS, I fainted. (BC, housewife, 42 years old)

Data from the Ministry of Women's Empowerment and Child Protection indicates that Papua may have the highest incidence of violence against women¹⁶. Unfortunately, as stated by the National Commission on Violence Against Women, data on violence against women in Papua is not available¹⁷.

Interviews with police, women's organisations, and the Women's and Children's Integrated Service Centre (P2TP2A) reveal that the most common domestic violence cases involve physical abuse, infidelity, or neglect. Because communities and even victims consider violence by partners so commonplace, the actual number of cases likely far exceeds the number reported.

¹⁶ "Bumi Cendrawasih Urutan 1 Kasus Kekerasan Terhadap Perempuan," *Noken Live* 3.

¹⁷ ANTARA, "Data Kekerasan Terhadap Perempuan Papua Tak Bisa Diakses," 7 March 2019, <www.jubi.co.id/data-kekerasan-terhadap-perempuan-di-papua-tak-bisa-diakses/>. Data for the annual report of the Indonesian National Commission on Violence against Women is voluntarily collected and submitted by institutions across Indonesia. However, other organisations have collected data about VAW in Papua from recent years. The Institute of Science and Technology in Papua recorded a jump from 97 reported cases of VAW in 2017 to 550 cases in 2018. The Papua-province branch of Center of Integrated Services for Women's and Children's Empowerment (P2TPA), a national program mandated to support women victims of violence, reported that they dealt with 71 cases in 2017 and 63 in 2018. From January to July 2019, P2TPA Papua received 35 cases.



This study supports a finding that violence against women in Papua is prevalent. Forty-one of the 42 participants experienced violence, 32 of them from their partners. Thirteen participants said they had married or had a partner when they were children. Some experienced violence from their parents or brothers when they were children or adolescents. Some experienced violence from a brother-in-law, a partner's wife, a friend, or a stranger. Only about one third (12 of 32) of those who experienced violence from a partner reported the case.

Almost all those facing domestic violence mentioned extramarital affairs as a reason. This fact is important considering that HIV/AIDS in Papua is mostly transmitted sexually. A study in India found that men who commit violence against their partners are more likely to engage in extramarital sex, exposing them both to sexually transmitted diseases¹⁸. The Papuan experience is consistent with this finding:

The past was so hurtful that I did not want to remember. I used to live with my . . . husband on Komolom Island, Kimaam Village. At first our life was very happy. Then . . . the family was destroyed because there was another woman. . . . When I was one month pregnant, he refused to believe it was his child, so I asked for a separation. . . . I moved and took the children back to my parents' house in Merauke. . . . I became very sick and was taken to the hospital. I was feeling down in the hospital. While there I never asked for a cure . . . The doctor said I had no hope of living. But, I said to God that I just wanted to return to my children. I have

¹⁸ WHO, "Violence Against Women and HIV/AIDS: Critical Intersections—Intimate Partner Violence and HIV/ AIDS," Information Bulletin Series No. 1, accessed 1 July 2019, <www.who.int/hac/techguidance/pht/Info BulletinIntimatePartnerViolenceFinal.pdf>.

five children—two boys and three girls. The oldest is 17 years old, then 16, 14, and 6 years old, and the youngest is only 8 months old. (CD, ice seller, 34 years old)

The two youngest children are also HIV positive.

2. Vulnerability: Violence and Discrimination Against Women Living with HIV/AIDS

We also found that women are vulnerable to violence and discrimination because they are HIV positive. The stories of some women point to a pattern of intimacy and infection, followed by a broken relationship.

My [marriage] was arranged by my parents. When my first child was four months old, my husband re-married and we separated [after we had] two children. I had diarrhea, was ill. The health clinic ordered a blood exam. I tested positive. I don't know where it came from. I began ARV drugs in 2008. In 2010 I remarried. My second [husband] liked to beat me because I wouldn't say whether or not I was positive. I didn't tell my family. I wasn't open about my status. (DE, betel nut seller, 37 years old)

Many participants were scared to tell their partners about their health status or ask partners to be tested for fear that would trigger violence. Several women said they escaped violence when they left their partners or their partners died. However, the death of BC's husband left her vulnerable to violence by her husband's brother. A Papuan widow is customarily expected to marry the brother of her late husband. If she resists, the remarriage is often forced.

Trafficking children through child marriage also illustrates the link between violence against women and HIV/AIDS. One woman was exposed to HIV when, at 15, she was given in marriage to a man willing to pay for surgery her father needed. The marriage was suggested by her brother-in-law who had been accepting money from her future husband. During the participatory research activities, she said, "It's like my brother-in-law sold me for money and now I'm sick." (EF, child carer, 22 years old)

Violence against women living with HIV/AIDS may prevent them from being able to access treatment, as FG's case illustrates:

[My husband] is also positive but he doesn't trust the medicine. If I took medicine, he'd throw it out and beat me. So, when my daughter died, I decided to leave. If I stayed with him it would mean suicide. (FG, laundry woman, 30 years old)

In addition to violence, women living with HIV/AIDS also experience discrimination and rejection by their families and communities, stigmatised as promiscuous and immoral. In a patriarchal society, women are considered symbols of their society's purity. Some PAR participants said that because they feared rejection, they remained silent about their status and focused on maintaining their health and that of their children. Only a few received family support once their test results were known.

It turned out I was positive When [my father] heard, he said, "It doesn't matter. We don't need to listen to others; we need our own principle. They can say whatever they want, but they don't bring us even one plate of rice to eat. We look for our own food. (GH, housewife, 35 years old)

Most participants said they depended on their peer supporters, whom they often referred to as "angels".

A discussion with peer supporters revealed how the situation can become worse for mothers who remain silent about their condition. In one case, a child of a woman living with HIV/AIDS was taken by the family of her late husband. This child, also positive, is at risk of not getting treatment if the mother remains silent. If she notifies the family, then her own health status will be revealed, risking violence or exclusion. In another case, a woman living with HIV/AIDS faces a dilemma regarding her infant who is not HIV positive. She could transmit HIV/AIDS to her child if she succumbs to her family's demand that she breastfeeds her child without proper treatment. If she does not breastfeed, she risks psychological and physical violence if her family finds out the reason.

Even medical staff discriminated against people living with HIV/AIDS, through unfriendly attitudes and efforts to humiliate those who seek medical services. At least two participants said that staff at a medical facility had violated confidentiality principles, deliberately revealing their health status in front of visiting family members.

Sometimes if [a health worker] knows a person's status . . . the worker intentionally doesn't want to provide service What's more, friends who have just recently [learned their status] feel uncomfortable and become reluctant to access services. (IJ, peer supporter, 30 years old)

Many times, I see there is no justice. For example, services at the health clinic, sometimes the workers didn't know about the referral. I'd usually say my face hadn't changed and my data was already there. So, they already knew and there

was no need to ask again, but they liked to ask [about my status] in front of people gathered there. That's why many are reluctant to go I also once went to the ER; [the doctor] was very nasty. We arrived, but he told me to wait because he'd heard the patient was B20 [the code for HIV positive]. How is that justice? (JS, peer supporter, 29 years old)

Several women in Merauke mentioned that staff at a health clinic pretended not to know that the B20 code meant patients needed reference documents to access ARV medication available at another clinic¹⁹.

Women's also directed complaints at counselors who asked questions about their sexual activity in an accusatory manner and who did not believe them when they gave information. Under the Declaration on the Elimination of All Forms of Violence against Women, harassment and intimidation by medical staff, as described by HF and others, can be categorised as discrimination and psychological violence.

People living with HIV/AIDS also face discrimination in prison and correctional facilities. Although there is access to health services, detainees living with HIV/AIDS are placed in separate cells to prevent the transmission of disease. This is unjustified, especially considering that HIV/AIDS is transmitted in very particular ways compared to far more contagious respiratory or skin diseases.

Merauke District Regulation 3 of 2013 and Papua Province Regulation 8 of 2010, which cover the handling of infectious disease, including HIV/AIDS, do not include a mechanism to prevent discrimination. There is no mechanism to file and address complaints, nor is there a penalty for perpetrators of discrimination.

Our study found a direct relationship between VAW and women living with HIV/AIDS in Papua. Violence can be an entry point for women's exposure to HIV/AIDS, and conversely, their health status can make women more vulnerable to violence. Violence may cause women's health to decline and create barriers to access the treatment they need.

3. Vulnerability: Violence and Discrimination Against Indigenous and Poor Women

HIV/AIDS and violence against women are an excess [resulting from] the policy that forcibly opened Papua [to development]. The sea, land, and forests have all been demolished for the benefit of non-Papuans. Prostitution develops. Papuan men ... use the money they get [from cutting down agarwood] to buy alcohol and sex.²⁰ That's how they bring illness into the home. The family . . .

¹⁹ B20 is the code for HIV disease resulting in infection and parasitic diseases according to the International Statistical Classification of Diseases and Related Health Problem developed by WHO <apps.who.int/classifications/apps/icd/icd10online2007/index.htm?gb20.htm>.

²⁰ Agarwood is a fragrant, highly valuable tropical hardwood.

is disturbed, even destroyed. These practices reach the village. Then the Papuan culture is stigmatized as one where partners are freely exchanged. (JAG, community organiser of Indigenous peoples, Merauke)

HIV/AIDS in Papua cannot be addressed merely as a matter of individual choice or behaviour. Alcoholism and prostitution are only symptoms on the surface. From discussions and interviews, we identified three social drivers that increase women's vulnerability to HIV/AIDS and violence, namely: (a) extractive industries, transmigration, and impoverishment; (b) prolonged conflict; and (c) Special Autonomy status without proper governance.²¹

(A) Extractive Industries, Transmigration, Impoverishment

Civil society leaders involved for more than two decades in the response to HIV/AIDS, spoke about the impact of extractive industries, including fisheries, logging, and palm oil plantations. The influx of migrant workers and transmigrants from outside of Papua created conditions conducive to the spread of the epidemic without an adequate plan and resources to mitigate it.

One local leader, who observed the progression of the epidemic in the early 1990s, pointed to the proliferation of new industries across the district. Regarding palm oil plantations in Merauke Regency, she commented:

Palm oil companies have [been] on Indigenous people's lands without seeing their local wisdom, without regard for the sacred boundaries of customary land, without thinking about the impact on the reproductive health of women palm oil workers. . . . [Workers'] boarding houses were used for [sexual] transactions, in conjunction with "extra-service" food stalls. Meaning, the cost of a meal is IDR. 25,000, whereas the price of sex is IDR. 100,000 and above. (Herlina Fonataba, HIV/AIDS worker, Merauke)

From 1964–99, Indonesia's transmigration programme moved around 78,000 households from Java and other densely-populated places to Papua.²² Although the programme was suspended in Papua in 2001, migration continued, causing Indigenous Papuans to become a minority group in many urban centres.²³

Our study paints a bleak picture of the gendered impact of transmigration. From the 16 non-Indigenous Papuans in our study, eight found their way to Papua through this national program. Of these eight, six became sex workers due to their dire economic

²¹ More supporting and secondary data is needed to determine whether these drivers have a heavier or disproportionate impact on Indigenous populations.

²² Government of Papua Province, "Program Transmigrasi di Papua," accessed 1 September 2019, <www.papua.go.id/view-detail-berita-1308/program-transmigrasi-di-papua.html>.

²³ According to the Central Bureau of Statistics (BPS), from 1980 to 2015, 585,231 migrants moved to Papua and West Papua Provinces. <www.bps.go.id/statistictable/2011/01/07/1273/migrasi-risen-recent-migration-tahun-1980-1985-1990-1995-2000-2005-2010-dan-2015.html>.

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situation. Of these six, four had experienced violence from their partner or husband. MN and her husband moved from Java to Merauke in 1999, but shortly after she became a sex worker. Another woman shared:

[I] transmigrated from East Java with my husband; we flew on a Hercules plane ... [I] worked planting rice and cassava. My husband didn't want to work, just to eat, sleep, and abuse me. I sold all my belongings and moved to town in 2000. My husband returned to Java.... I worked for three years at Sumur Bor [a brothel area]. I found out I have HIV in October 2006, after a test at the AIDS Working Group. My friends cried, but I had no regrets. Just acceptance. Since I found out my status, Yasanto has helped me. They continue to provide me with support. (YW, former sex worker, 47 years old)

AD was also a transmigrant who turned to sex work. Her family moved from East Java to the Kurik region of Merauke in 1983 when she was 11. As her family's economic situation worsened, she began working as a domestic servant. By the age of 14 she was married, but this did not relieve her economic hardship.

Initially I did field work but didn't make any money. The transmigration location had little water during the dry season. Most of the well water was also red and tasted sour. So, I had to become a brick worker and a sex worker to buy fertilizer. (AD, former sex worker, 48 years)

Meanwhile, the lives of Indigenous people often get worse along with the development of extractive industries in Papua. The absence of social safety nets for Indigenous women living in poverty was a driving factor for several participants who became sex workers and then became ill with HIV.

JK, an Indigenous Papuan woman, came from a poor fishing family. The youngest of six children, both her parents died when she was a teenager. She decided to look for work in Merauke and became friends with a group that drank a lot. She often got drunk and eventually had to serve customers. In 2009, she learned she was HIV positive. She went through a very difficult time, even wanting to commit suicide. Since then she has joined a peer support group and is now taking steps to improve her life.

(B) Protracted Conflict in Papua

Suharto's resignation in 1998 resulted in a profound political shift across Indonesia, bringing an end to Papua's status as a military operation zone. The first years of the reform period allowed Papuans and others new-found freedom to express their

discontent. The Special Autonomy Law (2001) for the Province of Papua was designed to share economic and political power with Papuans, in response to growing dissent and unrest. Unfortunately, provisions for conflict resolution were never implemented. As we complete the write-up of this study, civil unrest is taking place across many cities in Papua in response to racist harassment and attacks against Papuan students in East Java.

In its explanation section, the Special Autonomy Law acknowledged that the Indonesian Government “has yet to fulfil the feeling of justice, has yet to achieve prosperity for all people, has yet to uphold the rule of law and has yet to respect human rights in the Papua Province, in particular the Papuan community.” Further, to protect human rights, the Law provides for the establishment of a human rights court, a truth and reconciliation commission, and a local chapter of the National Human Rights Commission. However, plans for a court and for a truth commission have been abandoned. AJAR’s previous research in Papua has documented the impact of layers of unaddressed trauma, as Papuans, particularly women, experience one violation after another. Two women involved in this study spoke about a violent relationship with a soldier or police officer, a barrier for them in reporting the abuse.

Advocates in Jayapura and Merauke noted the army is proactive about HIV testing and counselling for soldiers, but has no guidance to minimize interaction with civilians, especially women.²⁴ Cases of sexual exploitation, in which young women are lured to have sexual intercourse by the promise of marriage only to be abandoned, are common in conflict zones and border areas where there is a heavy presence of security forces.²⁵ In addition to being exposed to HIV, another risk of sexual exploitation is unwanted pregnancy. One participant described a case of violence concerning a marine who impregnated her when she was still in high school:

At first our relationship went well, but after two years . . . I got pregnant. . . . As far as I knew I was healthy, but he had a lot of women. . . . We finally fought . . . I said, “Did you help my parents to buy a motorcycle for me? . . . but you ruined me.” . . . In October 2018. . . I started to feel sick, weak, short of breath. I thought it was because it was cold, not because I had a virus. . . . I returned to Merauke. . . . The third time I went to the hospital, the nurse asked to examine me. . . . I got counseling . . . and had a full blood exam. The results were positive. . . . I went to be treated for TB. The doctor said I had to be examined. The result was the same: positive. . . . I told [a family member]: “My guy sleeps around with this woman, that woman. I’m afraid he has infected me and my child. . . if I hadn’t met him, I wouldn’t have this disease.” . . . He is strong now . . . but one day he’ll get weak . . .

²⁴ Another study by AJAR found that a local women’s group has supported two women who gave birth out of wedlock having been impregnated by soldiers posted near the border with Papua New Guinea. In one case, a woman was passed from one soldier to another when there was a turnover of battalions at the border. From 2009 to 13, she bore three children from relationships with three different soldiers, none of whom provided child support.

²⁵ AJAR also had a similar finding from a separate study in Papua in which 65 of 249 women participants experienced violence. Besides loss of male family members, some also spoke of sexual violence related to military operations. Papua Women’s Working Group, *I Am Here*, 2019, p. 21.

May God see that what has happened to me, happens to him. He left me and I had to take care of myself. (AL, housewife, 29 years old)

(C) Special Autonomy Funds, Corruption, and Gender-based Social impact

From 2001 to 2017, the national government disbursed around Rp 67.1 trillion in Special Autonomy (known²⁶ by its Indonesian acronym, Otsus) funds for Papua Province and West Papua Province.²⁷ In 2018, Otsus funds amounted to nearly Rp 8 trillion.²⁸ More than Rp 19 trillion more went to infrastructure development in Papua from 2005–12.²⁹ Otsus brought an unprecedented flow of cash to the interior. However, without good governance, large funds are like water poured into the sand. Health, education, and poverty issues continue to surface while corruption cases involving provincial and district level officials have increased over the years.³⁰ More study is needed on the impact of Special Autonomy on gender relations in Papua.

Some Otsus funds have been used to develop services for addressing HIV/AIDS, such as transportation to access antiretroviral drugs and nutritional assistance. However, this support is limited and only available in large cities. The health facility infrastructure, centralized in cities, makes it difficult for poor women far from cities to get the treatment they need.

In rural areas, the impact of Otsus on gendered power relations has not been sufficiently studied. However, respondents repeatedly connected the social impact of Otsus funds in connection to the spread of HIV/AIDS and violence against women. One peer supporter said that in some villages she found that men disappeared from villages immediately after receiving an allotment from the Otsus funds.³¹ Presumably buying consumer goods as well as alcohol and sex, the men didn't return to their villages until the money ran out.

Several participants with backgrounds as sex workers confirmed this situation. Papuan men are known to be big spenders when they have lots of money in their pockets. It is also important to note that half of the PAR participants mentioned that alcohol contributed to violence. Others did not talk much about Special Autonomy, but one woman saw that the related regional expansion led to violence and HIV/AIDS, with a related impact on marriage.

26 Following the intention of improving democracy after the fall of the authoritarian regime in 1998 and the implementation of decentralization of government, Papua have obtained special autonomy status according to Law 21/2001 on Special Autonomy Status. The provincial government is authorised to issue local regulations, including regulating the authority of districts and municipalities within the province. Papua province is also provided with significant amount of special autonomy funds, which can be used to benefit its indigenous peoples. More complete provisions regarding this special autonomy status can be seen at <https://www.refworld.org/docid/46af542e.html>

27 BBC, "Puluhan Triliun Dana Otonomi Khusus Dialirkan, Mengapa Masih Ada Tuntutan 'Papua Merdeka?'" 22 November 2018, < <https://www.bbc.com/indonesia/indonesia-46289211> >.

28 Media Indonesia, "Paradoks Dana Otsus Papua," 23 January 2018, <www.mediaindonesia.com/editorials/detail_editorials/1276-paradoks-dana-otsus-papua>.

29 Linda Tangdiella, "Pembangunan Infrastruktur: Anggaran ke Papua Rp 11,68 Triliun," *Bisnis.com*, 27 Juni 2012 <www.ekonomi.bisnis.com/read/20120627/45/83370/pembangunan-infrastruktur-anggaran-ke-papua-rp11-68-triliun>.

30 The Indonesian Corruption Eradication Commission (KPK) has stated that 70% of corruption cases in Papua are connected to the procurement of goods and services. The bidding process is only a formality because the winner has been decided beforehand. See Government of Papua Province, "KPK Duga 70 Persen Modus Korupsi di Papua dari BPJ," accessed 1 September 2019, <www.papua.go.id/view-detail-berita-6071/kpk-duga-70-persen-modus-korupsi-di-papua-dari-pbj.html>.

31 Galuh Wandita et al., *I am here: Voices of Papuan Women in the Face of Unrelenting Violence* (AJAR, March 2019), 7.

When the district was subdivided, I got a job in the new recency. . . [We] moved to a new place. My husband . . . often got drunk. . . I managed to set up a company for my husband so he would have work . . . but his behaviour got worse and I was often disappointed. He often went away, leaving me with the children. . . He made so much money from his work that he rarely returned home. At the time, I never thought he was having affairs with other women because he had so much money. (CS, civil servant, 53 years old)

Three Patterns that Impact Women's Experience of HIV/AIDS and violence: Impunity, the Next Generation, and Vicious Cycles of Gender-Blind Policies

Our study shows that women living with HIV/AIDS and violence bear long-term consequences of stigma and abuse. Although the list of social-economic and political drivers can be endless, we have focused on three patterns: 1) Impunity that leads to acceptance and recurrence; 2) The next generation at risk; 3) A vicious cycle of gender-blind policies.

4. Pattern of Impact: Impunity Leading to Acceptance and Recurrence

My husband often hits me, sometimes he pulls my hair . . . [I] don't report to the family; they always side with my husband. Mama isn't brave enough to defend [me]. . . What's the use of reporting to the police? Mama says that just results in shame. Father says that if my husband is imprisoned, especially if he's been imprisoned before, then my children and I will be the ones with problems. But I said if Mama and Father don't defend me, then I'm going to make a report. (NN, housewife, 33 years old)

When women living with HIV/AIDS experience violence, a strong psychosocial impact arises from their consequent experience of impunity.³² Impunity normalizes violence, and puts pressure on survivors of violence to accept their circumstances, erecting barriers that stop women from reporting their cases. Many counselors we spoke to mentioned how victims of violence are further silenced by stereotypes of the nagging wife who deserves to be beaten when she speaks out against a husband who comes home late or drunk, spends money, or has an affair.

Of the 32 women living with HIV/AIDS who experienced violence from a partner, 20 did not report their case, several citing their families as a reason:

My husband always denies he did anything violent. I've never reported to the police. My older siblings always say it's my own problem. I once said I wanted a separation, I wanted to go home to Mama. Mama said that because I was married

³² Impunity is the inability to bring perpetrators to account. Update to UN Principles to Combat Impunity, Addendum, 2005.

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in church, I can't separate. [I] have to withstand it. My burden is that I suffer because I'm always being hit. (BC, housewife, 42 years old)

BC's experience shows that a family's religious view of divorce may stop women from reporting domestic violence. Another obstacle is the concern that reporting the case will result in acts of revenge from the perpetrators or trigger further violence, including fighting between families or tribal groups.

My former boyfriend was a police officer... He asked to have sex, but I didn't want to. Then he hit me till I was hospitalized and had an operation. I experienced trauma; he was just my boyfriend and still that had happened. [My family] wanted me to report him, but I was afraid he'd retaliate. (LM, betel nut seller, 32 years old)

When he beat me, he guarded me so [I] could not run away. . . . When he got drunk it was really messed up, he'd go out on the road and just curse. My parents in the village didn't know, but my husband's family did. But I was afraid for my parents to find out because it would become a family war. (KL, fish seller, 28 years old)

One woman said she did not know where to report the abuse, and another did not have a marriage certificate, which police demand to see when a woman reports domestic violence.³³

If there's a problem, I can't report it to my family. My mama will say, "Who ordered you to get married?" because my parents ordered me to go to school. I can't go to the police because I don't have a marriage certificate. They say, "You have to have a marriage certificate because this is the law." (FG, laundry woman, 30 years old)

One woman said she could not report her abuser because she depended on him financially. Another used her partner's debt to her family for her bride price as the means to separate from him.

One time, in a fight, I ran away with a motorcycle taxi, [my husband] pulled me down and strangled me. I reported to the family and my husband was beaten. [I] didn't report to the police because I didn't have the heart and was worried about not getting money. (DE, betel nut seller, 37 years old)

³³ Although Law 23 of 2004 on Domestic Violence does not require legal proof of marriage, the law is poorly worded so that it can be interpreted to mean a marriage certificate is required to file a complaint. This issue was also identified in the AJAR-PWG report, *op.cit.*, 30, 59.

I never resolved [the domestic violence] through the police, only with my uncle [a police officer] who has a weapon. Because my husband had not paid my bride price, he had debt, couldn't do anything, couldn't wound me. Because he was cheating on me, I just asked for a separation. (CD, ice seller, 34 years old)

Women also showed reluctance to report their husbands due to their love for them.

In 2019, I remarried to become his third wife. For every problem, my husband used his hands and words. [I] didn't want to report him because I loved him so much; he was willing to accept my status. I know I shouldn't think so. I don't care because I want to. (FG, laundry woman, 30 years old)

Barriers to reporting for women living with HIV/AIDS may be more severe due to the weak bargaining position resulting from their health situation.

Women Who Reported Their Cases

Of the 12 women who reported their cases to the police or to their partner's workplace, seven resulted in sanctions. The man was held a few days or months in detention or signed a form promising not to repeat the offence.

My husband [a police officer] targets my hands and feet when he beats me. When he finishes work at his office, he doesn't come straight home but goes to play billiards. If I get angry, we argue, he can't take it and beats me. That was 2016 to 2017. I reported to his office and, he was processed and detained for 21 days. I felt sorry to see the children cry, so had him released. (MN, peer supporter, 31 years old)

My husband beat me so severely because our relationship wasn't good. There was another woman in 2014. Because I was beaten so often, I reported it to the police, and it was processed. He was in prison for two years and three months. (NP, peer supporter, 31 years old)

My feet and hands often still hurt. The doctor said the illness had reached the nerve so I shouldn't be hit again. He hit me again. I could not stand it anymore, so I reported him at 10 pm, wearing only a sarung without a blouse or panties. . . . He was detained for one night. I withdrew the complaint but on the condition that he sign a statement saying that if he hit me again, he would be imprisoned for five years. (PR, sweet potato seller, 55 years old)

I divorced my first husband [in Java] in 1992 because he was having an affair. In 1993 I transmigrated alone to Irian Jaya.³⁴ I married a second time to a man from Lombok. He gambled, played with other women, and if I didn't give him money, he'd beat me [and because of that] I often had a headache and cramps in my hands ... I reported him to the police, but lost because he was a clever talker and the police defended him ... One time sister Herlin [HIV/AIDS counselor] defended me. He was once detained overnight and made a statement [promising he would not beat me]. Another time he was detained for gambling and for beating me, and was held in a cell for 16 days. He was sick for three years and died in February 2013. (RS, laundry woman, 47 years old)

Long delays and bureaucratic hurdles are common obstacles to a resolution:

I feel I don't yet have [justice] because of that case. I feel disappointed because the case still hasn't been processed yet. The divorce case has been [ongoing] since 2018. The files are already with the lawyer, but I have to pay the lawyer Rp 3 million. (NP, peer supporter, 31 years old)

Reporting one's case and even the perpetrator's detention is often not enough to change violent behaviour.

From 2016 to 2017, my husband was cheating on me; we fought. I reported to the police [and he was detained], but then later I withdrew the charge. In 2018 we had a big fight. I burned my husband's driver's license and diploma, and he burned my blouse. Then we reconciled. (TS, peer supporter, 29 years old)

Some women also said the police placed the onus of locating their abuser on the women if they wanted their case to proceed:

I'm from Biak, my parents are there. In 2000, I moved to Jayapura to attend high school. I didn't finish because I got married in 2001. My husband is a police officer; we just got married in church, but it was never registered. I had one child. Everything seemed to be fine, but it turned out my husband was cheating on me. . . . In 2015, I had my fourth child who became sick when six months old. I had the baby checked due to shortness of breath. I took the baby to the children's ICU. The baby's weight dropped from 8 to 2 kg. I was very sad. . . . I didn't know why my child was like that. I was told to have a blood test, it turned out I was positive. My husband apparently had been keeping two mistresses. I decided to return to Biak. . . . I feel I am my husband's legal wife, but his police unit doesn't

³⁴ Papua has had a number of names over the years. From 1963–73 it was called West Irian until President Suharto changed its name to Irian Jaya. The name changed again to Papua with passage of the Special Autonomy legislation in 2001.

recognize me as such. I did not get any justice even though [our marriage was finally] legitimised by the court. Now he is dead. (TY, housewife, 36 years old)

Parallel to the cultural and structural barriers women face in reporting violence is the dearth of attention and resources dedicated to building a response to this widespread pattern. Many counselors, medical personnel, and peer supporters acknowledged that violence was pervasive, but had nowhere to refer the women for support.

In the counselling process, [clients] usually mention cases of violence they've experienced. There's a woman who takes medicine without the knowledge of her husband. There's a woman who says, "Don't tell my husband yet." There's a story about a woman's partner who gets drunk and is always violent . . . but we aren't ready yet. . . . We can't do anything because there is no [collective effort] with women's organisations on how to make referrals with each other. (Sitti Soltief, counselor/nurse, Jayapura)

We found that those providing services for HIV/AIDS are not trained to deal with cases where women experience violence, and there are no standard operating procedures. Many service providers said they felt overwhelmed just trying to assist women living with HIV/AIDS and had no capacity or resources to deal with another difficult issue. At one time, Yasanto's shelter for people living with HIV/AIDS had the Integrated Service Center for Women's and Children's Empowerment (P2TP2A) sign on its door because the government's national programme for domestic violence did not actually have its own shelter in Merauke.³⁵

When I was staying at the shelter, my husband [came and] hit me. I had a bad toothache at the time, so I wanted to sleep and didn't pick up my phone when my brother called. . . . I was beaten [by my husband] because of that. (PR, sweet potato seller, 55 years old)

Although there are regulations on violence against women at provincial and district levels, implementation and awareness remains weak. None of the 42 women living with HIV/AIDS who participated in our study knew that this "one stop service" for violence against women existed. Victims must bear the cost of a medical report. Shelters for victims of domestic violence are few and far between. In Jayapura, the shelter is housed at the police station, and Merauke has no shelter. Consequently, there is little opportunity for cross-referrals between services for people living with HIV/AIDS and those who experience domestic violence in the home.

³⁵ In Indonesia, attaching a sign to another program's building may be an indication of misappropriated funds, where a photograph is taken as proof of the existence of a program that does not really exist.

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The national P2TP2A programme is supposed to provide protection for women and children, but its implementation depends on resources and personnel.³⁶ In Merauke, this integrated service falls under the umbrella of a bureaucratic hybrid named the Women's Empowerment Child Protection Population Control Family Planning Agency.³⁷ This chimera reflects a pragmatic approach of pooling scant resources, but in practice creates confusion about priorities and approaches.³⁸ Poor coordination can be fatal in cases of sexual violence. In our interviews with service providers, we noted that many victims of rape are not properly counselled about the risk of HIV infection and options for testing.

It is important to note that in some cases of rape, law enforcement still prioritises mediation, seeking peaceful or family solutions that, at best, impose customary fines in place of the more difficult enforcement of the rule of law.

Culturally and geographically we must have a different system, not the same as Java. The type of violence may be the same but the attitude of dealing with it is different. Our interventions and culture cannot be ignored. . . . We can use mediation, which actually exists but is carried out by the government, for example bargaining fines for rape cases. At first it was not allowed, but [to] help the victims we have made [it]. (P2TP2A employee, Jayapura)

Asked whether they felt they were treated fairly or had some justice in their lives, more than half of workshop participants answered positively. They expressed an acceptance of themselves, and a feeling of gratitude for the support they have found from their peers:

God is just. Although my husband left me, there was another way. I got work so I could see my child. [I] have become a father to my child. (MN, peer supporter, 31 years old)

When I first entered the clinic, I was sort of anxious, but no more. I'm used to having my cheeks and head wiped. I like the small nurse; she is most friendly and fast. In a safe space, we don't hide anything, we're open about everything. At Mama Herlin's [Herlina Fonataba's place], it's also good. (CD, ice seller, 34 years old)

[I feel] safe with friends at the hospital, with the services. (AD, former sex worker, 48 years old)

[I feel] safe with friends at the hospital, with the services. (AD, former sex worker, 48 years old)

³⁶ In Indonesian, the *Pusat Pelayanan Terpadu Perlindungan Perempuan dan Anak* is commonly referred to by its acronym, P2TP2A.

³⁷ In Indonesian, the *Badan Pemberdayaan Perempuan Perlindungan Anak Pengendalian Kependudukan Keluarga Berencana* is commonly referred to by its acronym, BP3APK2B.

³⁸ In Greek mythology, a chimera is a fire-breathing monster comprising parts of different animals.

It's safe now. No one bothers me when I go to health services. (HH, motorcycle washer, 37 years old)

I have never been ostracised in my neighbourhood; they are good to me, they check on what I'm eating, etc. (YW, former sex worker, 47 years old)

[This flower symbolises a sense of justice] because my family and I always love each other. If I have a problem, they help me. (SS, laundry woman, 35 years old)

A majority of the participants felt they could begin to heal their lives because they have access to free ARV drugs and are part of a support group. A majority live very simply, working odd jobs that include making noken (traditional woven bags), caring for livestock, hunting crabs, washing clothes, and washing motorbikes. Some depend on help from family or others. A small portion have salaries as civil servants and counselors, or income from renting out rooms or sex work. Some participants stated that the support they needed most was food or a few pieces of zinc and wood to strengthen their simple houses.



5. Pattern of Impact: The Next Generation at Risk

Although efforts to combat the spread of HIV/AIDS in Papua Province are now into their second decade, the volatile combination of HIV/AIDS and violence is having an enduring impact on the next generation. When mothers must battle stigma, bear the burden of declining health, injury, and trauma, and struggle for economic survival,

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there are long-term consequences of their diminished capacity to nurture and educate their children. Significant impacts on the next generation include death, life in broken homes, and rejection. For some mothers, the death of a child is how they learn about their own health status. At the same time, some of the women spoke movingly about how their children served as the source of support and inspiration to stay alive and struggle for a better life.

Infection and Death of the Next Generation

Data from the Papua Province Health Department show that 14% of those infected by HIV/AIDS are children. They account for more than 5,000 cases from 40,805 cases as of 31 March 2019, of which 718 were infected through maternal transmission. Sources interviewed described a scarcity of medication needed for infants who tested positive.

Several women spoke of the death of their children. In some cases, it was when they gave birth that they learned about their own status as women living with HIV/AIDS.

When I gave birth, I was told my status. I was confused; why must it be me? A nurse gave me counselling, explained about the medication therapy. . . . For three weeks I just cried in my hospital bed: Why me? Why must my baby also have [a HIV positive] status? . . . From 2011 to 2012 I was shaken because I had to have therapy without any family support because they were disgusted with me. . . . However, in 2012 my father nursed me. . . . he's the one who gave me strength. . . . In 2013 my child died and at the same time my husband left me and remarried. (LM, betel nut seller, 32 years old)

From 2009 to 2011 I had my second and third child. In 2015, I had my fourth child who got sick when he was six months old. The baby was having trouble breathing, so I went to the children's ICU unit. The baby dropped from 8 kg to 2 kg. I was very sad and disappointed. I didn't know why my child was so sick like that. I was told to get my blood tested. My husband apparently had two mistresses. I decided to return home. . . . I was taking cotri [medicine] but stopped for two years. Then my baby died. I was alone in Jayapura until he died. I said, if I don't take my medicine I will die. I remembered my other three children still in school and started to take the medicine again. (TY, housewife, 36 years old)

I was tested in 2004, but didn't believe the results. . . . My second child died in 2005, my husband died in 2006. Then I joined Yasanto and worked there in 2006 to provide services to infected people. (AB, peer supporter, 33 years old)

Children Growing Up with Single Parents

Without special programs to assist families, children growing up with single parents become vulnerable to poverty and poor education. NP, who comes from a broken home, lost her child when she and her husband separated.

When I was small, I lived with my grandmother and grandfather; my parents had separated. I went to school, but then dropped out. . . . In 2004 [my health] began to drop. I had a very bad cough. I didn't know I had TB. . . . In 2005 I took VCT and tested positive. . . . In 2008 I met another guy. . . . I became pregnant and had a child in 2009. In 2011 we married in church, but because I couldn't stand [the violence] we separated in 2019. My child, who is negative, is now in third grade. I'm living at Yasanto and my child is with his father. (NP, peer supporter, 31 years old)

I was born in East Java. When I was just ten [my father died] and I left for Jakarta. . . . I love my mother and older sibling very much, but I left when I was ten. I don't know their address. I don't have any news about them. . . . I married in January 1988 and had a child that year. My second child was born in 1990. I divorced my husband in 1992 because he was having an affair. In 1993, when I was 20, I transmigrated to Irian Jaya and left my two children with my mother-in-law. I transmigrated by myself. (RS, laundry woman, 47 years old)

Several women had a similar story, single mothers struggling to raise children because they have separated from their husbands. Stricken economic conditions reduce opportunities, even causing poor nutrition, for the children.

I gave permission to my former husband to remarry, but he must share his salary because he has three children here. . . . I have never known how much he gets. If the children contact him and explain our condition, he doesn't want to talk to me. . . . Usually he sends Rp 1,000,000, (about US\$70) [a month]. We use it, but it's not enough. I usually spend Rp 300,000 on rice. If we have only rice, we fry it and eat it. If I run out, I ask my sister to help. If she doesn't have anything, she'll still give Rp 10,000 or 2,000. If she has some money, she'll give Rp 100,000. (BC, housewife, 42 years old)

Children Suffer Rejection

Several women participants spoke about the rejection they and their children have faced.

I have a big family, so why must I go it alone like this? One night I was chased away. [I had] to search for a boarding room. I dragged along my child who can walk and had my baby in my arms. I walked to my uncle's house. He took me in and I've been living there since. (IK, laundry woman, 27 years old)

I got tested and found out I was HIV positive. . . . My husband's family and my own family didn't want to see my child. If I die now, it would be such a pity for my child because there is no one who cares about him. I stay here because it is comfortable; I can't go back to my village because I don't feel welcome there. . . . My heart breaks when I look at my son who now has a scholarship from the government to study. He always reminds me to take my

medicine. He wanted to stop his studies to take care of me, but I said no because that would just kill me. He is now studying in Manado. (MT, peer supporter, 46 years old)

Counselors who have worked in Merauke for decades observed that children of a HIV positive parent face discrimination and sometimes rejection at school.³⁹ They also believe that the rise of street children addicted to sniffing glue correlates with families affected by HIV/AIDS.

Street children, a phenomenon in some towns, are at risk for violence, HIV/AIDS, and addiction. In Merauke there is insufficient programming for children whose parents are sick or have died of HIV/AIDS, although Katane Support Group provides support to some of the street children in Merauke. Herlina Fonataba remarked:

The children who sniff glue, drink alcohol, are sex workers, and who live with HIV/AIDS range in age from 2–18. Some are still in school, some have dropped out, some cannot read or write. On average, their parents are poor. Some parents who don't work intentionally leave their children to support themselves. . . . These children grow up with behaviours that are not controlled . . . [T]hey are often involved in cases of theft that bring them into contact with the police, and some are held in detention in Merauke. My question is: Who is responsible for this generation? Do they belong to a handful of people who have hearts and love so that they work together to save them? We need to do this so that an entire generation doesn't disappear and become extinct in the land of Papua.

6. Pattern of Impact: Vicious Cycle of Gender-blind Policies

We observed that gender-blind policies⁴⁰ that reflect the lack of attention to the impact of HIV/AIDS and gender-based violence exacerbate both problems. Such practices and policies include: (a) a narrow interpretation of reproductive health; (b) closure of large brothels and criminalisation of women, particularly sex workers and mothers; (c) discontinuity of support to accessing health care; and (d) ad hoc approaches that are short-term and poorly conceived.

(A) Narrow Interpretation of Reproductive Health

Dr. Soewahyudi, director of the general hospital in Merauke at the time, established the Reproductive Health Centre (PKR) in 2004 to play a critical role in the response to HIV/AIDS.⁴¹ The PKR was initially designed to provide both holistic reproductive health services to women and men, and also comprehensive information and counselling on reproductive health and rights. The centre also helped women to

³⁹ Discussion with Herlina Fonataba, Merauke, July 2019.

⁴⁰ Here we are referring to policies created without considering how women and men may experience a situation differently due to their gendered role and status, thus also requiring different approaches.

⁴¹ In Indonesian the *Pusat Kesehatan Reproduksi* is known by its acronym, PKR.

have healthy pregnancies and births. To ensure its longevity, Dr. Soewahyudi placed the PKR inside the public hospital.

However, in recent years the PKR, working in conjunction with neighbourhood health clinics, has reduced its scope to focus mainly on testing for HIV and STDs, targeting sex workers and young mothers. This narrowing of PKR's role has also closed the door to developing a holistic approach to preventing and mitigating domestic violence as these issues arise during counselling.

During its journey, the Reproductive Health Centre has become more focused on handling STDs, including HIV/AIDS. We conduct routine checks on key populations and work closely with neighbourhood clinics to provide services for pregnant and birthing mothers. Through counselling, we know that many clients are victims of violence, especially from their partners. The violence definitely has a negative impact on the women's health as a whole. However, there isn't much we can do. We do not know what to do, and there is also a lack of human resources. (I, Doctor, Merauke)

(B) Closure of Large Brothels & Criminalisation of Women

HIV/AIDS activists noted an increase in the number of sex workers coming to Merauke when large brothels in Surabaya and Jayapura were forced to close. Studies have shown that such closures are counterproductive to HIV/AIDS prevention, in addition to being ineffective in curbing prostitution.⁴² Problems are also found in new locations where displaced sex workers move to, such as in Merauke. Many have come as part of a pattern of spontaneous migration in search of work, as opposed to those brought to Papua through an agent or the "entertainment" industry. They are beyond the radar of infection control as they are not obliged to follow test procedures before conducting sexual transactions and are difficult to reach because their homes and work are spread out, aggravated by weak control of health service outreach. The Head of the Merauke Social Welfare Bureau, Herman Gipse, explained:

Because of the closure of localities in other areas, such as East Java and Jayapura, Merauke is "flooded" with sex workers who did not all go to localities. This makes it difficult for us. Before 2005, Social Welfare was responsible for collecting data on the health conditions of sex workers in bars and discotheques. But now it is done by the Tourism Bureau. We are worried about the spread of HIV because there is no regulation and the Tourism Bureau is not included in the coordination of the AIDS Commission.

Regulations, such as Merauke Regional Regulation No. 3 of 2013 and Papua Province Regulation No. 8 of 2010, may also criminalize women sex workers who

⁴² Studies include Universitas Atmajaya and Komisi Penanggulangan AIDS, *Studi Kualitatif Dampak Penutupan Lokalisasi/Lokasi Transaksi Seks Di Empat Kota* (Jakarta: UNIKA Atmajaya, 2016) and Organisasi Perubahan Sosial Indonesia, *Laporan Penelitian Penutupan Lokalisasi Gondang Legi Kota Malang dan Payosigadung Jambi*. (Jakarta: OPSI, 2016).

are positioned as the party responsible for the spread of HIV/AIDS. This criminal approach is suspected of further stigmatizing sex workers and blunting the response to HIV/AIDS.⁴³ In both regulations, sex workers are not limited to women, and managers of entertainment venues are obligated to monitor and return sex workers who test positive to their province of origin. In practice, this gender neutral regulation has a disproportionate impact on women. Entering the sexual services industry as worker, they must deal with unequal power relations with customers and pimps. Women sex workers have weak negotiating power for the use of condoms. If they are known to have HIV/AIDS, in addition to fines they are prohibited from working and even sent home to their place of origin.

These two regulations also burden women in terms of preventing transmission from mother to child. As informed by the participants in this study and others, it is difficult for women to negotiate the use of condoms with their domestic partners, even those who engage in unsafe sexual behaviour.⁴⁴ Requests to use condoms can risk both physical violence and neglect. Both regulations should address prevention of transmission from both parents to their children, complemented by support for women to prevent transmission by their partners, including through early treatment of domestic violence.⁴⁵

Since they focus on mothers, both regulations have the potential to criminalize pregnant and breastfeeding women. If a woman refuses to be tested for HIV/AIDS or refuses the advice of a medical officer regarding risk of transmitting HIV to child through pregnancy, then she is threatened with a sentence of up to six months in prison or a fine of Rp 50 million. Every mother who violates the obligation to be treated and follow instructions from health workers regarding the treatment of children with HIV/AIDS faces this threat of criminalisation. At the same time, we have found that a mother's ability to access treatment for her children may be impeded by the family of her former husband. She may be hesitant to be open about her health status due to the threat of violence.

(C) Access to Long-term Health Care

The local response coincided with two important developments: 1) special autonomy for the province of Papua, included special funding for HIV/AIDS; and 2) the launch of a national effort to provide universal health care, leading to the Papua Health Card, or KPS.⁴⁶ The KPS allowed people living with HIV/AIDS in Merauke and Jayapura to access ARV medication more easily because it reduce barriers in bureaucracy related to one's identity. Some participants mentioned other important support from the local government, such as transport subsidies and assistance for better nutrition.

43 Arinta Dea Dini Singgi and Naila Rizqi Zakiah, *Kajian Hukum dan Kebijakan HI V di Indonesia: Sebuah Tinjauan terhadap Peraturan Perundang-Undangan dan Implementasinya di Enam Kota/Kabupaten* (Jakarta: Lembaga Bantuan Hukum Masyarakat, Indonesian AIDS Coalition dan Global Fund, 2017), 33-34.

44 Ikatan Perempuan Positif Indonesia, *Voices from Indonesia: Stigma and Discrimination Against Pregnant Women and Mothers Living with HIV* (Jakarta: IPPI, 2013a) and Studi Kualitatif dan Pendokumentasian: Kasus Kekerasan terhadap Perempuan dengan HIV dan Aids di 8 (Delapan) Provinsi (Jakarta: IPPI, 2013b).

45 Changing approach from PMTCT to PPTCT is also raised by Ikatan Perempuan Positif Indonesia, *Laporan Akhir Penelitian Kualitas dan Rekomendasi Perbaikan Layanan PMTCT Bagi Perempuan Terinfeksi HIV di Empat Kota di Indonesia* (Jakarta: IPPI, 2018), 30.

46 In Indonesian, the *Kartu Papua Sehat* is also known by its acronym, KPS.

Our study did not cover rural and isolated areas, but some participants spoke about the difficulties they faced trying to access ARV drugs outside urban centres. Women living with HIV/AIDS and other stakeholders spoke of the lack of health care services in more isolated districts such as Intan Jaya, Nduga, and Mamberamo Raya.⁴⁷ One counselor described sending ARV drugs by bus to subdistricts outside of Merauke. Another counselor spoke about people who had to rent a speedboat to get to Merauke to access medical care and medications. Although the Provincial Health Ministry has appointed specific local health centres as satellite providers of ARV drugs, these units often lack medical personnel and supplies.⁴⁸

With the sub-division of districts, often along ethnic lines, there is a danger that local agencies will prioritise services for certain ethnic groups, while neglecting others. For example, in 2002 Merauke District was divided into four smaller districts associated with different ethnic groups: Merauke, Boven Digoel, Mappi, and Asmat.⁴⁹ Some local officials have been reluctant to provide services to persons in Merauke who belong to the Mappi or Asmat tribes, believing they should move back to “their” district. A number of respondents also expressed fear that free access to ARV medications will be affected when the special autonomy status and funding for Papua Province ends in 2021. However, the head of Animha Clinic stated that this fear is unnecessary because, free access to ARV drugs has been funded by the national government so far.

From Papua Health Card to National Health Card?

There is a plan to integrate the provincial-level health card, KPS, with the national health card that is overseen by the Social Security Implementation Agency (BPJS).⁵⁰ The Papua provincial government will then use the KPS funds to pay the insurance premium for Indigenous Papuans in accordance with Special Autonomy Regulation 17 of 2010. However, there is a concern that when this integration takes place the administrative requirements of BPJS (that include a national ID card as well as a family card) may prove to be insurmountable barriers for many Indigenous Papuans, particularly in remote areas. In practice, local governments have so far allowed Indigenous Papuans a three-day deadline to get their ID cards.⁵¹ Unless there are specific programmes to assist Papuan women in fulfilling administrative requirements, they will face barriers in accessing health care, including access to ARV medications, which is currently difficult to access through the national scheme on health service.⁵²

47 Evarianus Supar, “Dinkes: Layanan Pemeriksaan HIV-AIDS di Pedalaman Papua Terbatas,” 3 September 2018, <www.papua.antaranews.com/berita/470360/dinkes-layanan-pemeriksaan-hiv-aids-di-pedalaman-papua-terbatas>.

48 Ibid.

49 Nugie, “Profil,” 7 January 2018, <www.portal.merauke.go.id/news/3/profil.html>.

50 The National Health Guarantee-Healthy Indonesia Card, or *Jaminan Kesehatan Nasional Kartu Indonesia Sehat*, is known by its acronym JKN-KIS. The Social Security Implementation Agency, or *Badan Penyelenggara Jaminan Sosial*, is commonly known by its acronym, BPJS.

51 Papua Bangkit, “Pemprov Papua Siapkan Premi Rp 142 Milyar untuk KPS Tahun 2019,” 15 April 2019, <www.papuaangkit.com/2019/04/15/pemprov-papua-siapkan-premi-rp-142-miliar-untuk-kps-tahun-2019/>.

52 IPPI, 2013a, 11.

(D) Focus on Numbers and Ad Hoc Programming

Merauke District is considered a case study for a successful response to HIV/AIDS. In the 1990s, Merauke had the highest number of persons living with HIV/AIDS, now it ranks seventh in Indonesia.⁵³ However, with success there is a risk of complacency. Two decades later, much of the funding for HIV/AIDS programming throughout Indonesia, including Papua, has diminished. Many NGOs can no longer conduct education and outreach or provide needed assistance to those living with HIV/AIDS.

A Numbers Game?

With the decrease in funds to support long-term programmes that demonstrate a proven impact, several programmes now focus on reaching targeted numbers of people to be tested, without enough attention on counselling and follow-up.⁵⁴ An example of the shift to a target orientation, mentioned by resource persons in this study, is the “90-90-90” programme promoted by UNAIDS (i.e., 90% of the people living with HIV/AIDS know

their status, 90% take ARV drugs, and 90% of those can minimise the risk of infecting others).⁵⁵ A similar approach is the “three zeros” programme, also promoted by UNAIDS and adopted by the Indonesian Ministry of Health (0 infections, 0 deaths, 0 stigma).⁵⁶ Although this may be just a clever way to frame an approach, the emphasis on numbers creates a demand for quantitative targets as opposed to an approach that prioritises principles of empowerment and a nuanced understanding of social transformation and power dynamics.

In our study, local advocates for long-term HIV/AIDS responses raised concerns that the emphasis on reaching more people for testing will pressure vulnerable women to be tested without providing the support and care needed to make the test one step towards empowering themselves.

The Provincial AIDS Commission (KPA) has recently championed and funded two new interventions: a campaign for non-surgical male circumcision (using a contraption called pre-Pex) and stem cell therapy.⁵⁷ Since 2016, Papua Province has promoted male

53 MC Kab Merauke, “Kadinkes Provinsi Papua Sayangkan Keterlambatan Pembangunan Rumkit Rujukan,” 13 August 2019, <infopublik.id/kategori/nusantara/365792/kadinkes-provinsi-papua-sayangkan-keterlambatan-pembangunan-rumkit-rujukan>.

54 Kementerian Kesehatan Republik Indonesia, “Hari AIDS Sedunia, Momen STOP Penularan HIV: Saya Berani, Saya Sehat!,” accessed 2 September 2019, <www.depkes.go.id/article/view/18120300001/hari-aids-sedunia-momen-stop-penularan-hiv-saya-berani-saya-sehat-.html>.

55 UNAIDS, “90-90-90: An Ambitious Treatment Target to Help end the AIDS Epidemic,” accessed 10 August 2019, <www.unaids.org/sites/default/files/media_asset/90-90-90_en.pdf>.

56 UNAIDS, “Fast Track: Ending the AIDS Epidemic by 2030,” accessed 10 August 2019, <www.unaids.org/sites/default/files/media_asset/JC2686_WAD2014report_en.pdf>.

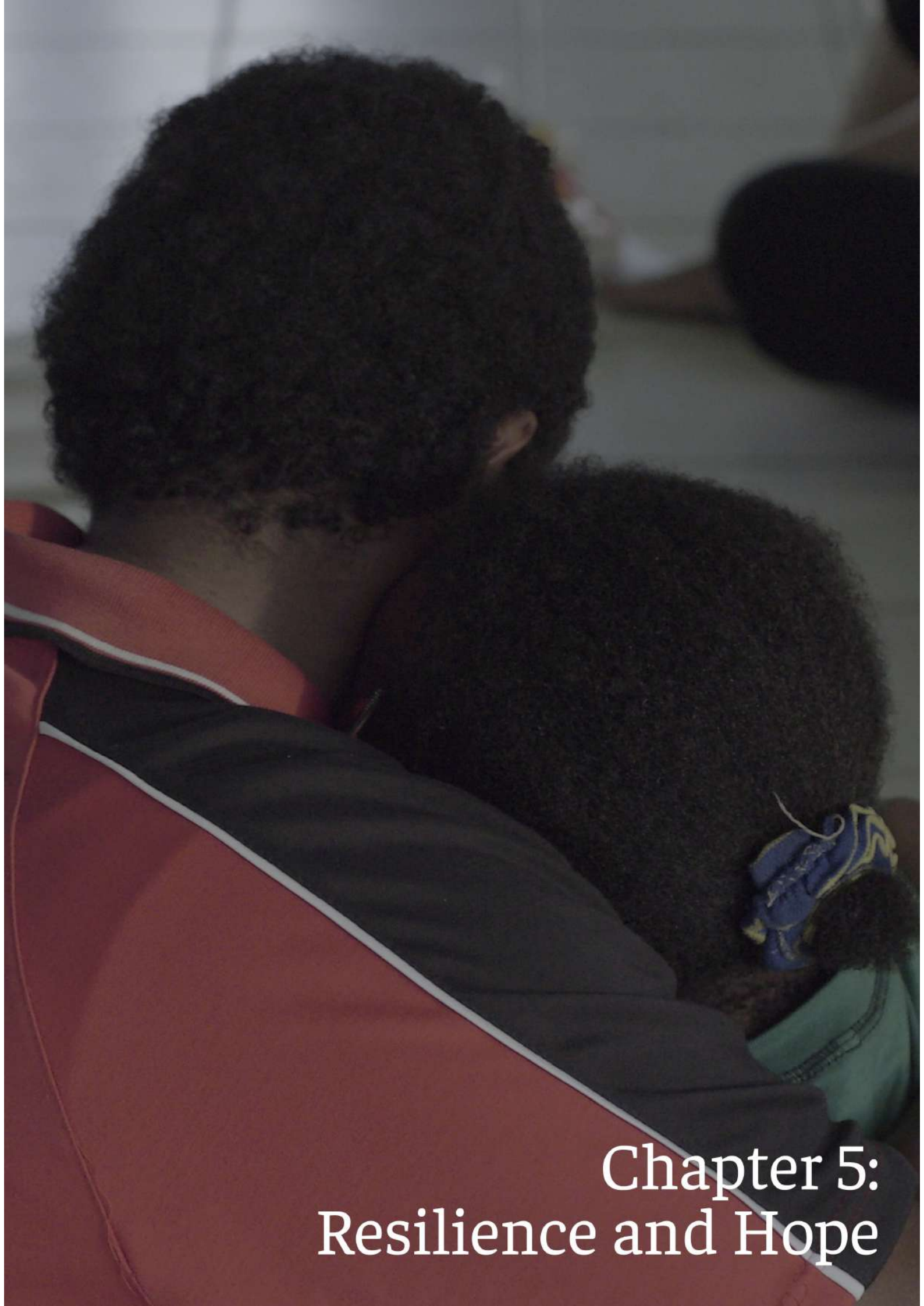
57 Komisi Penanggulangan AIDS, or Commission for AIDS Management, is known by its acronym KPA.

circumcision as a way to decrease the risk of HIV infection, based on research in Africa.⁵⁸ However, local advocates question the transparency of funding for this programme and are concerned that a misleading message is heard by the community; i.e., if you are circumcised, then you do not have to practice safe sex. This belief can make it harder for women to negotiate their partners' use of condoms and can lead to violence. The male circumcision campaign was terminated in 2019, but in its place the KPA has been promoting stem cell therapy (the cells are derived from animals) known as Purtier Placenta.⁵⁹ The KPA has entered into a partnership with a company distributing this medication to patients who volunteer.⁶⁰ This is a controversial programme, as there is not yet approval from WHO or the Ministry of Health for this therapy. A participant from our study commented: We want clarity about this information. If it's medicine, we also want to use it to get better. Don't make us guinea pigs to experiment with it.

58 Taiwo Akeem Lawal and E. Oluwabunmi Olapade-Olaopa, "Circumcision and its Effect in Africa," accessed 1 September 2019, <www.ncbi.nlm.nih.gov/pmc/articles/PMC5422680/>. WHO and UNAIDS have been promoting voluntary medical male circumcision (<www.who.int/hiv/topics/malecircumcision/fact_sheet/en/>) as one of the main strategies to prevent HIV based on scientific evidence.

59 Dr. John Manangsang endorsed the use of Purtier Placenta by the Papua Provincial KPA. Purtier Placenta is produced in New Zealand and distributed by Riway International in Singapore. One capsule consists of a 100-mg stem cell and 12 herbal elements. According to the doctor, Purtier Placenta can boost the immune system, recover damaged cells, and revive dead cells. He suggests consuming this product to complement ARV. See: Papua Satu, "Ini Penjelasan Dr. John Manangsang Terkait Purtier Placenta Yang Dikabarkan Akan Gantikan ARV," 11 May 2019, <www.papuasatu.com/peristiwa/ini-penjelasan-dr-john-manangsang-terkait-purtier-placenta-yang-dikabarkan-akan-gantikan-arv/>.

60 Papua Satu, "Yan Matuan: KPA Papua Akan Fight Selamatkan Ribuan Pengidap HIV," 8 March 2019, <www.papuasatu.com/kesehatan/yan-matuan-kpa-papua-akan-fight-selamatkan-ribuan-pengidap-hiv/>.



Chapter 5: Resilience and Hope

I was in a shelter for four months. Thanks to my caring friends, [I] am now able to walk and stand. I also thank Yasanto. My parents finally came to the shelter. They now know and accept [my condition]. I'm living at home now with my mom and younger siblings. My younger siblings already know. If there's an activity, I tell them and they'll take me to it. (HH, motorcycle washer, 37 years old)

Participants identified family support as the foundation for rebuilding lives after a positive test and after an incident of violence. Some women are able to find courage when they focus on the needs of their family members:

My partner hasn't beat me again since 2008 because I laid down my basic [position]. I told him to find another woman if he wanted to continue beating me. My priority is my family rather than him. The whole family lives in one house. (AB, peer supporter, 33 years old)

Yasanto was one of the first local civil society organisations that responded to the HIV/AIDS issue in Merauke in 1995. Yasanto was founded in the 1980s with a focus on the socio-economic development of Papuans. It was the only civil society organisation in South Papua that worked to remote villages. The massive spread of HIV/AIDS in the villages where Yasanto was working led to the formation of a special unit, the Public Health Development Agency, to address the epidemic.⁶¹

Our study confirmed the mutual reinforcement of two critical programmes to empower women who live with HIV/AIDS and suffer violence: (1) the availability of a shelter to provide care to suffering women; and (2) on-going solidarity and empowerment through peer support groups.

Twenty one of the 42 women affirmed a turning point in their lives when they were able to live in a shelter. A few stayed for as long as one year before their families were ready to accept them or they were able to live independently.

Even though I am sick, even though some of my family members rejected me, mama always supported [me]. Because my extended family rejected me, I stayed at the Yasanto shelter. Mama was willing to take care of my child. She brought my child to visit me at the shelter, brought food, supported me, encouraged me to revive my spirit. (SM, peer supporter, 32 years old)

I was treated for more than a month. The blood test showed I was sick with HIV. AB and Mama took me to the shelter in 2009 for several months and gave me ARV... After a year and I was better, I lived with my husband. (PR, sweet potato seller, 55 years old)

⁶¹ In Indonesian, Yasanto's *Badan Pengembangan Kesehatan Masyarakat* is known by its acronym, BPKM.

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I felt hopeless but got on a boat [to get home]. [I] called my mother to pick me up at the harbour in Merauke. I was very thin. I was taken to the shelter and lived there from 2013 until now. I have recovered and thank Yasanto. (PM, paramedic's assistant, 36 years old)

Yasanto has assisted more than 400 people living with HIV/AIDS. Operating a shelter since 1997, Yasanto has provided a space not only for palliative care, but to support healing and empowerment for those living with HIV/AIDS. Yasanto's shelter is a hub for support group meetings, counselling, creative therapy, skills training, distribution of food aid, and recreational activities.

Building on its experience developing people's independence, Yasanto created a programme of peer educators in schools (known by its acronym, KOMPAS) and in communities (KOMPAK) to support prevention and mitigation of HIV/AIDS. Yasanto is a pioneer in its integration of a rights-based approach in its community and school-based work that includes education on human rights and gender as well as environmental and health issues. Yasanto has trained more than 5,300 volunteers in 141 villages and urban neighbourhoods as facilitators for social change.

An important impact of Yasanto's work is the formation of a local response and leadership on the HIV/AIDS challenge, with Indigenous Papuans taking the helm. Leo Mahuze, the director of Yasanto, has played a key role in coordinating a multi-level, sustained response to the epidemic. In recent years, he has become dismayed by the decline in funds available for HIV/AIDS work. He stated:

For more than 20 years I have dedicated myself to supporting [those with] HIV/AIDS. The number of patients kept growing, the problem became increasingly complex, including how it is linked to violence against women. The government never showed it was serious in providing resources, while aid from other sources was also inadequate.

Yasanto has been at the forefront of developing good practices of case management for people living with HIV/AIDS. Although support services for people living with HIV/AIDS focus on Papuans, they may be accessed by anyone. Yasanto's programme has also provided training and opportunities for Papuan women. For example, the Katane Support Group (KSG) is led by Herlina Fonataba, one of the first HIV/AIDS counselors Yasanto trained in 1997. Moved by her own experience of surviving violence, she established KSG.



Rays of Hope for People Living with HIV/AIDS

*Interview with Herlina Fonataba of
Katane Support Group (KSG)*

“Katane Support Group was founded on 23 February 2012. At that time we saw people dying like chickens being slaughtered. One day a person would die in one place; the next day someone else in another place; and there was a lot of discrimination from families.

Katane means sun in the Marind language. This inspires us to be rays of hope to friends living with HIV/AIDS. This hope, in turn, is a positive strength for them to develop close bonds among themselves and with those around them.

Our vision is to reduce stigma and discrimination by distributing accurate information to the public, especially to a broad range of target groups that include school dropouts, women sex workers, male cross-dressers, pregnant women and their babies, children held in detention, children who sniff glue, boys who work on ships, construction workers, men who like men, those who glean trash dumps, church youth, families of people living with HIV/AIDS, and housewives. Our mission is to be a friend who provides comprehensive support to those living with HIV/AIDS because they are not just targets; each piece of statistical data is a human being. It is important that those living with HIV/AIDS take control of their own lives to achieve quality of life. They need to be empowered . . . have a fighting spirit.

Our programmes include non-formal education for boys and girls, 6 to 18 years old, who sniff glue, are trash recyclers, are living with HIV/AIDS, or are children of sex workers. Modules include information on reproductive health, body mapping, gender, and sexually-transmitted infections and disease, including HIV/AIDS, and drug addiction. Health outreach includes sharing information on treatment of sexually-transmitted infections and condom distribution to key populations (school dropouts, boys who work on ships, sex workers, etc.). Katane’s focus on accompaniment is expansive. Katane facilitates a discussion group for people living with HIV/AIDS; visits to those in the hospital, in detention centres, and home visits to encourage proper and regular use of ARV medication; referrals for needed services; fulfilment of spiritual and emotional needs; support and advice for families of those living with HIV/AIDS; and efforts to coordinate among stakeholders, such as the Commission on AIDS, clinics, and NGOs.

I get rice aid from the Social Bureau that I cook to feed the children who come to my house [for classes]. I teach them about hygiene: they eat well, they wash their hands, bathe

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well, and then they go to school. I give lessons. Those who don't read or write are in one group; the young children are in one group. My friends, volunteers who are HIV positive, help with the lessons and also help to cook to feed these children... Right now, I'm lobbying the district government to get access to more rice aid so that these children can continue going to school.

I also work with the Bureau of the Environment. I see these children in dumps to collect metal and plastic trash. They are child laborers, so I order them to pick up trash from the road every morning. They collect bottles and plastic trash, put it in large bags and bring it here. I weigh it and have a chart with their names... In general, their parents are dock workers who unload ships and don't get paid enough, so these children work to help their parents. After they've collected cans, metal and plastic trash I call the Bureau of the Environment [to exchange the trash with cash]."

In Jayapura, a local nurse, Sitti Soltief established a similar self-help group in 2001. Siti began to recognize cases of HIV/AIDS in 1998 when one of her friends was a patient in the hospital where she was assigned. Her first introduction to HIV/AIDS through this case made her realize that psychological support plays an important role in handling patients. This caused her to continue finding out more about HIV/AIDS, including how it relates to lung disease and tuberculosis. The need for mutual support, along with the increasing number of people infected, gave birth to the Jayapura Support Group (JSG). The first HIV/AIDS support group in Papua, it is run by unpaid volunteers.

At first, JSG was a space for the mutual support of friends living with HIV/AIDS to receive routine treatment, make peace with the disease, and face death calmly. At that time, ARV drugs were not available and life expectancy was less than six months. Besides conducting public education about HIV/AIDS, JSG also provides shelter for those who are infected but not accepted by their families. In 2004, the Papua Provincial Health Office designated the JSG shelter as an exemplary model of a shelter for people infected with HIV/AIDS. Although support for shelters was cut in 2009, JSG managed to continue operating its shelter until 2014. With funds from a humanitarian donor and the help of volunteers, JSG continues to provide key services such as peer group meetings, counselling, and support for those living with HIV/AIDS, including those with special needs.

At support group meetings, violence against women is often mentioned. JSG does not yet work with other organisations to address this issue. Usually, group members support each other to find solutions they can do independently, especially when the violence prevents them from accessing regular medical treatment. In trainings for counselors and

peer supporters, Sitti Soltief discusses the connection between violence against women and HIV/AIDS. This is especially important when training peer supporters and volunteers from the church community as they often put more emphasis on a pastoral approach that may not include adequate health and legal advocacy. Siti has also carried out counselling for women victims of rape and their perpetrators for voluntary counseling and testing, bearing in mind the risk of HIV infection due to this violence.

Other civil society groups that work on HIV/AIDS include Yayasan Cendrawasih Bersatu (United Paradise Foundation), Perkumpulan Keluarga Berencana Indonesia Papua (the Indonesian Family Planning Association in Papua), and Yayasan Pengembangan Kesehatan Masyarakat (Foundation for the Development of Public Health), as well as peer support groups such as the Indonesian League of Positive Women in Papua (Ikatan Perempuan Positif Indonesia Papua). Attempts to coordinate civil society efforts, for example by Forum Kerja Lembaga Swadaya Masyarakat Papua (the NGO Working Forum of Papua, or Foker) in Jayapura, remain weak.

In Merauke, a coordination platform has been established, but with the drying up of funds, member organisations have become inactive. The local AIDS commission in Merauke presents an opportunity to play such a role. Established by a local regulation, the KPA includes long-term HIV/AIDS workers and young people living with HIV/AIDS. Other agencies with a potential role include the Child Protection Agency and eL_AdPPer, an NGO that organises grassroots women and responds to cases of violence against women in Merauke. It has developed a strong working relationship with the local legal aid office, Pelita Kasih, and with community and faith leaders. eL_AdPPer has documented cases of violence, and provided training and referrals to government economic and health projects. Creating a mechanism for collective work will be important in sustaining a comprehensive approach to addressing violence against women and the needs of women living with HIV/AIDS.



Advocacy Association for Women's Care working to end violence against women in Merauke

The Advocacy Association for Women's Care (eL_AdPPer) is a non-governmental organisation started in Merauke in November 2002 by a number of Catholic women activists, along with the Diocese of Merauke. They were motivated by their experience from 1995 to 2001 addressing cases of violence against women in both public and private spheres. eL_AdPPer is one of the few NGOs that conducts critical education for women victims of violence regarding their rights. It also advocates for government policies in Merauke that are pro-women.

eL_AdPPer was originally situated under the Secretariat for Peace and Justice of the Merauke Archdiocese. In 2017, eL_AdPPer became an independent organization whose work is conducted by three staff and a few volunteers. Since 2013, eL_AdPPer broadened its focus from management of VAW cases to address women's economic issues, because the roots of the violence experienced by about 80% women served were economic in nature.

Over the years, eL_AdPPer has developed a number of local initiatives that have included discussions among village men and women to raise awareness on the impact of violence against women; taking part in the 16-day campaign to oppose VAW; in collaboration with others, assisting women victims of violence, including referrals to legal aid, police, urgent assistance for women and infants who are HIV positive; and facilitating economic empowerment programs.

Due to limited resources, eL_AdPPer has pulled back on some of its previous advocacy work, now referring VAW cases to legal aid organisations and other NGOs. Its work on women's economic empowerment focuses on the development of non-timber forest products in local villages, where the incidence of violence against women is high. In an interview focusing on eL_AdPPer's development over the years, Beatrix Gebze, head of the organisation, reflected:

From 2013, when we no longer limited our work to reporting cases to police and seeking mediation. At the time, I realised that the violence women suffer is not just physical violence. I thought about it, analysed the problem. There are a lot of things that influence violence. When the forests are all gone, the space for people to live has shrunk, the sources of their livelihoods are also diminishing... now when the kitchen fires no longer burn [due to poverty], that's when physical violence ignites."

Chapter 6: Recommendations



Ten Priorities and Three Key Recommendations for a Comprehensive Response to Women Living with HIV/AIDS and Victims of Gender-based Violence

This study indicates that the most effective way to address HIV/AIDS is to integrate efforts to overcome violence against women. Likewise, efforts to overcome violence against women will greatly benefit from adopting good practices in case management and empowerment approaches developed by advocates and people living with HIV/AIDS. By listening to the voices of women, we have formulated **ten priorities** to support women's empowerment in response to the double crisis of HIV/AIDS and violence. Based on our key findings on impact, these priorities can be grouped into **three main areas** for further work:

A. Supporting locally-driven initiatives that empower Papuan women to take part in understanding root causes and creating long-term solutions.

1. National and local government and other agencies should provide adequate funding and resources to develop comprehensive services to women in Papua at risk or impacted by HIV/AIDS and violence, including:
 - on-going support for local shelters and support groups to deal with the long-term needs of people living with HIV/AIDS, including counselling on domestic violence, non-violent communication, and anger management
 - ensuring the existence of women-only shelters for further referral when needed.
2. Service providers, both government and civil society, should strengthen referral processes, case management, counselling skills and coordination and integration of health and protection services. They should also increase the capacity of medical workers and HIV/AIDS counselors to be sensitive to violence against women, including how to initiate referrals and interventions.
3. National and local government, as well as other agencies in cooperation with local organisations, particularly women's organisations, should strengthen capacity for local engagement in policy making by:
 - Providing funding for women-led initiatives, leadership training and mentoring, and ensuring the involvement of Papuan women in decision-making forums relating to health, security, and law enforcement, including the local AIDS committee (KPA).
 - Strengthening capacity of local civil society groups to participate in government budgeting process and monitoring the use of funds.

4. Civil Society Organisations and academics should conduct an evaluation on development policies that have contributed to the transmission of HIV/AIDS and violence against women in Papua, including:

- Supporting a social history project or participatory inquiry to look at the long-term gendered impact of development policies, such as transmigration and extractive industries in Papua Province, and the closure of brothels, identifying lessons learned.
- Looking at good practices from other areas and countries that empower Indigenous women, transmigrants, and sex workers in leading efforts to protect themselves from HIV/AIDS, violence, and to access justice when violence takes place.
- Examining the impact of the security presence and developing codes of conducts and sanctions for security sector personnel in their interaction with civilian populations.

B. Investing in programmes addressing obstacles to accessing justice, including ways to connect advocates working on HIV/AIDS and violence against women.

5. Utilizing Special Autonomy Status, local government should reduce barriers to justice that women victims of violence face based on their marital status, by:

- ensuring that the lack of a marriage certificate does not hinder the duty to protect victims and to investigate alleged perpetrators of violence
- increasing education and outreach for law enforcement.

6. Relevant governmental institutions and advocacy organizations should develop an affirmative action framework for recovery and empowerment programmes for victims of gender-based violence that is sensitive to the risk of HIV/AIDS. This effort would include support for economic independence and help to access services for physical and psychological health, legal aid, and social assistance, including support for basic needs.

7. Local government and civil society organizations should audit and revise local regulations regarding HIV so that women in high-risk groups, particularly sex workers and mothers, are not criminalized or subjected to discrimination.

8. Service providers for women victims of violence, including police, should develop policy and practices to support initiatives for HIV/AIDS counselling and testing (both provider and client initiatives) in handling cases of sexual violence that include an assessment of risk of transmission. Counselling and testing initiatives for victims should be part of short- and long-term healing programmes for victims, including provision of prophylaxis for victims.

9. National and local governments, as well as other relevant agencies, should ensure adequate, ongoing support for peer supporters and counselors of women living with HIV/AIDS who are victims of violence:

- Protect peer supporters and counselors as part of witness and victim protection programmes and services
- Strengthen the capacity of peer supporters and counselors, including the sharing of knowledge and lessons based on the direct experience of peer support in Papua
- Develop programmes for collaboration and fundraising for peer support and counselling to ensure continual and beneficial programmes.

C. Strengthen the resilience of the young generation and all those affected by HIV/AIDS and violence

10. The Ministry of Education, in cooperation with local civil society organizations and with support from various parties, should conduct education activities with a focus on young people, to prevent and addressing HIV/AIDS and violence against women. This effort should include:

- Special attention to the vulnerability of youth, including initiatives to establish special clinics and programs for youth that includes sexual health, in cooperation with schools.
- Integration of an empowered self-concept and positive self-image of young Papuans in the development of education for reproductive health and prevention of violence.
- Revive the “Daku Papua!”⁶² initiative and other similar youth programmes as the basis for development of local and contextual curricula, implementation of student orientation, teacher training (particularly training of guidance counselors) and non-formal educational activities for youth.
- Support programs for self-actualization for Papuan women that covers, among other topics: knowledge of basic human rights, positive body image, reproductive health rights, negotiation skills and non-violent communication.

⁶² Daku Papua or “My Teenage World is Fun” was a training programme for teachers and other educators that was developed and implemented in Merauke from 2010 to 2012. Modules covered topics such as gender, changes in the body, friendships and other relationships, pregnancy, and HIV/AIDS. It was discontinued, mainly due to the lack of funds to support the program and changes in the school curriculum. See Papua government website, “Sekda: Pemprov Pertimbangkan Kembangkan Program DAKU Di Provinsi,” accessed 1 October 2019, <www.papua.go.id/view-detail-berita-2779/sekda-pemprov-pertimbangkan-kembangkan-program-daku-di-provinsi.html>; WPF Indonesia, “DAKU—Dunia Remajaku Seru”, accessed 1 October 2019; <crutgers.id/fokus-kami/pendidikan-seksualitas-komprehensif/daku-dunia-remajaku-seru/>



