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Research Report

INTEGRATING THE ROLES OF STAKEHOLDERS IN PREVENTING THE HIV/AIDS TRANSMISSION IN EAST JAVA, INDONESIA

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ABSTRACT

HIV/AIDS prevention is very important and absolutely necessary. HIV transmission is now entering a fairly alarming level, in which people with HIV/AIDS in certain subpopulations are emerging. Special steps and resources are thus needed to cope with the condition. There are some phenomena potentially encourage HIV transmissions, such as the increasingly common free sex, homosexuality, the use of unsafe and unsterile syringes in narcotics consumption, commercial sex workers and various high-risk sexual activities. One of the crucial concerns that arises when sending prostitutes back to their hometowns without any coordinated and holistic mechanism is that the prostitutes may cause the spreading of HIV/AIDS in their hometowns. The research objective is to provide the material (input) how the prostitutes themselves may cause the spreading of HIV/AIDS. The research employed descriptive method with a qualitative approach. The results showed that the implementation and the role division in the closure have been highly coordinated and holistic. The leading sector in the role division is the Social Welfare epartment of the Government in Surabaya. In terms of health aspects for the former prostitutes sent back to their hometowns, there has been no policies related to medical screening designed to identify the disease early. Screening is very important for early diagnosis during the post-closure phase. The screening mechanism is that the Provincial Health Department has to optimize the monitoring, coordination, cooperation, agreements and partnerships with stakeholders such as the Local Health Department and the National/Provincial/Distric AIDS Commission, NGOs that are concerned with the problems of HIV-AIDS, international organizations, professional organizations, community leaders, religious leaders and universities.

Keywords: *policy, prostitute reintegration, prostitution, HIV/AIDS countermeasure*

ABSTRAK

Penanggulangan HIV/AIDS sangat penting dan mutlak dilakukan. Saat ini, penularan HIV/AIDS telah memasuki fase yang cukup krusial. Munculnya penderita HIV/IDS pada komunitas tertentu memerlukan upaya khusus karena penularan HIV/AIDS dapat terjadi melalui berbagai cara. Satu hal penting yang dikhawatirkan saat pemulangan PSK kembali ke daerah asal tanpa adanya mekanisme yang terkoordinasi dan holistik adalah bahwa PSK tersebut justru dapat menyebarkan HIV/AIDS di daerah asal mereka. Penelitian ini mengkaji mekanisme reintegrasi PSK ke daerah asal yang telah dilakukan dan peran dari masing-masing dinas pemerintah ketika penutupan lokalisasi serta menjembatani kebijakan penanggulangan HIV/AIDS dengan kebijakan penutupan lokalisasi dalam kerangka sistem kesehatan daerah. Tujuan dari penelitian ini untuk bahan (input) penerapan dalam hal penanggulangan HIV/AIDS pasca penutupan lokalisasi. Penelitian ini menggunakan tipe penelitian deskriptif dengan pendekatan kualitatif. Hasil penelitian ini menunjukkan bahwa pelaksanaan pembagian peran pra dan saat penutupan enam lokalisasi di Surabaya di masing-masing dinas yang ditunjuk oleh pemerintah Kota Surabaya sangat terkoordinasi dan holistik. Dalam pembagian peran ini sebagai leading sectornya adalah Dinas Sosial kota Surabaya. Terkait dengan aspek kesehatan bagi PSK pada saat reintegrasi ke daerah asal, belum adanya kebijakan terkait dengan medical screening. Screening dirancang untuk mengidentifikasi suatu penyakit secara dini, supaya ada intervensi dari Dinas Kesehatan Provinsi, yang bertanggungjawab dalam penyebaran penyakit HIV/AIDS. Screening ini sangat dibutuhkan dan penting untuk diagnosis lebih awal bagi PSK pada saat reintegrasi ke daerah asal maupun pasca penutupan lokalisasi dengan melakukan

monitoring, koordinasi, kerjasama, kesepakatan-kesepakatan dan kemitraan dengan stakeholder seperti Dinas Kesehatan dan Komisi AIDS Nasional/Provinsi/Kabupaten, LSM yang peduli dengan masalah HIV-AIDS, organisasi internasional, organisasi profesi, tokoh masyarakat, pemuka agama dan perguruan tinggi.

Kata kunci: *kebijakan, reintegrasi Pekerja Seks Komersial (PSK), prostitusi, penanggulangan HIV-AIDS*

INTRODUCTION

HIV/AIDS prevention is very important and absolutely necessary. HIV transmission is now entering a fairly alarming level, in which people with HIV/AIDS in certain subpopulations are emerging. Special steps and resources are thus needed to cope with the condition. There are some phenomena potentially encourage HIV transmissions, such as the increasingly common free sex, homosexuality, the use of unsafe and unsterile syringes in narcotics consumption, commercial sex workers and various high-risk sexual activities.

The policy of closing red-light districts in Surabaya, Indonesia seems unable to resolve the issues of HIV/AIDS spreading due to the fact that risky sexual activities are still ongoing. The impacts of the policy implementation include uncontrolled transmission and spreading of HIV/AIDS from illegal prostitutions (illegal relocation), uncontrollable by government policy. HIV/AIDS countermeasure is heavily dependent on government policies in both national and local levels to reach the goal. The policy must be included in the health system prevailing in Indonesia. It has to be admitted that the conflicting policies above will greatly influence the policies and programs related to HIV/AIDS. Policies and programs on HIV/AIDS that will be developed cannot be separated from the debate on the red-light district closure.

It is already mentioned that the decrease of HIV/AIDS cases is one of the main targets of the Millennium Development Goals (MDGs). Thus, the research is expected to contribute to decrease AIDS-related deaths. Several studies about HIV have been conducted in other countries. In Africa, diagnosis of HIV caused grief, fear, anxiety, and despair.[1,2] Ugandan women were in denial, afraid, and felt isolated upon knowing their HIV status,[3] while Congolese women were ravaged and tormented over risk of dying and left their children orphaned; they puzzled why the infection had happened to them.[4] A number of Zimbabwean lived secret lives characterised by constant concern of relevation.[5]

Furthermore, HIV studies in patrilineal Zimbabwe have predictably centered on female prostitutes as dangerous disseminators of,[6] the risk of vertical transmission to their children,[7] and women as caregivers for orphans or people living with HIV (PLHIV).[8] In addition, Gona (2015) reports that Zimbabwean women area unit are at a high risk for HIV infection yet usually aren't the main focus of inquiry unless they're participants in controlled trials. In rural areas of Mexico, it has become progressively apparent that heterosexual transmission of HIV could be a growing problem.[9] Compared with the United States, Mexico continues to possess lower incidence rates of HIV and AIDS.[10] Traditionally, AIDS has been a disease of enormous urban areas and, till recently, the incidence of HIV infection in remote and rural regions of Mexico has been low. [9]

Researchers have contributed valuable data associated with the spread of HIV in migrant employees, particularly focusing on communities on the U.S.-Mexico border.[11–13] That migrant workers from Mexico working in the United States need culturally appropriate HIV education, access to HIV testing, and access to HIV care. Studies have shown a transparent association between poverty and health status.[14,15] Furthermore, the implications of HIV infection on the individual and also the resultant interventions required, as well as treatment, are well studied and understood.[16] Basavaraj (2010) stressed that it ought to benoted that for a well-rehabilitated and trained PLHIV with social and economic support, having access to quality health care makes a difference not solely in his/her personal life, but also for society in general.[17]

The framework suggests numerous support areas to help mitigate the impacts of HIV on commercial enterprise security.[18] Prostitutes and indigenous populations are found to be among the most vulnerable.[19] As seen in different countries, indigenous girls area unit overrepresented in statistics for new HIV infections, with the risk of dissemination for sex employees.[20] The prostitutes often resorted to drug abuse, a risk behavior that, in conjunction with social violence, made them a lot more suspectible to HIV and other Sexually Transmited Infections (STIs).[21] Strong relationships are found between sex work and drug abuse, with an exaggerated risk of getting HIV and other STIs, in addition to being victims of sexual and physical abuse.[22,23] There's a desire, therefore, to put culturally accepted interventions in place and to aim them at the women as well as their clients, whereas taking the issues featured by indigenous prostitutes under consideration.[20,24]

There is little analysis that explores how to prevent the HIV AIDS transmission related to sending prostitutes back to their hometowns. This study will observe the reintegration mechanisms of former prostitutes to their hometowns and to create a standardized medical screening policy to reduce HIV/AIDS transmission to fulfill the Tri Zero Programs in Indonesia, which are zero new HIV infections, zero AIDS-related death, and zero discrimination. This study examines how the reintegration mechanisms of former prostitutes

to their hometowns is conducted; what is the role of each agency; what the officers have done on the closure of red-light districts and how to relate the HIV/AIDS prevention policy with the policy of the red-light districts closure within the framework of the local health system.

MATERIAL AND METHOD

To obtain empirical data and information, this research applied descriptive research with qualitative approach. Several stages were applied, including: (1) Determining research locations by purposive, resulting in Dupak Bangunsari, Tambakasri, Moroseneng, Klakah Rejo, Jarak and Dolly in Surabaya, East Java, Indonesia. There are several considerations leading to the selection of six red-light districts in Surabaya for the research. The considerations are: first, East Java ranks second for HIV infection prevalence in Indonesia. Second, these six red-light districts are considered to be the "hotspot" red-light districts in Surabaya which had operated for years. Third, these six red-light districts are subjects of the East Java Governor policy for immediate closure. Fourth, these six red-light districts were considered by East Java Governor as the cause of increase of HIV/AIDS incidence in Surabaya. (2) Combining several techniques of data collections, including: (a) observation and (b) in-depth interview. (3) Selecting the informants for this study that consists of individuals who had the knowledge and experience of the problems studied, (4) Grouping and identifying the collected data by theme and then analyzing them to answer the research questions.

RESULT AND DISCUSSION

Former Prostitutes Reintegration Mechanism to Their Hometowns

The closure process of the red-light districts had actually been done by the Surabaya City Government in 2002, but it had the success rate of only 10% in reducing the number of prostitutes in Surabaya. This was due to the absence of actions and better coordination between Surabaya Social Affair Department, Surabaya Health Department, and the People Empowerment Department as well as government officials in the red-light districts either in the levels of sub-district, urban village, *Rukun Warga* (local non-formal officials) and also in the neighborhood.

Based on both Governor's Letters addressed to the mayors and head of regents throughout East Java, Surabaya City Government then immediately performed the closure. The red-light districts closure was completed using two approaches. The first approach was by persuasive approach, meaning that the Mayor invited the prostitutes, pimps, community leaders and religious leaders from six red-light districts in Surabaya in an event of *Ramadan Iftar* dinner. In the event, moral messages were delivered based on religious norms highlighting the fact that becoming prostitutes and the existence of red-light districts in Surabaya were great sins for both the prostitutes and the mayor herself as the leader in Surabaya. The mayor then called on the consciousness of the prostitutes, pimps and the people that relied their lives on the red-light districts to quickly realize that their actions were big sins.

In this event, a dialogue was held between the prostitutes, pimps, community leaders and religious leaders from six red-light districts in Surabaya. The dialogue covered problem identification and needs analysis. Indeed, some parties in the dialogue admitted that they did not want to be prostitutes and pimps, and their concern about the children in the areas around the red-light districts that could be affected. However, there were also many opposing remarks including the new prostitutes' contract with their pimps, meaning they were recruited by pimps and therefore indebted to the pimps. The debt must be paid off by serving "guests" or "costumers" where approximately 30% to 40% of the income goes to the pimps. This is how the prostitutes repaid their debts.

Should the first approach not be successful, the second approach was taken which was by repressive coercion. It is the utmost necessary to prevent and control prostitution and woman trafficking by closing of red-light districts.

In the closure, Surabaya City Government used strategic effort of gradually closing the red-light districts. 1) The plan started from Dupak Bangunsari, Tambakasri/Kremil, Klakah Rejo and Sememi (Moroseneng) and last Jarak and Dolly complex; 2) Providing skills training for prostitutes according to their interests, and providing venture capital; 3) Sending prostitutes from outside Surabaya back to their hometowns while keep coaching and mentoring in a continuous and sustainable manner; and 4) Transforming the red-light district sites into business hubs with opportunities for the surrounding community.

Before returning the prostitutes, spiritual guidance and vocational training were given to the prostitutes with the expectation that they could become more independent and accepted by the society. There were role divisions in the administration of the compensation fund. Before the prostitutes received compensation fund, officials from Surabaya Social Department would verify the data by matching the names and address in cooperation with the heads of RT and RW (local non-formal officials), urban heads of urban village and head of sub-districts in the red-light districts. In the data verification, the prostitutes must meet two requirements. The first requirement, the prostitutes were required to show their ID or work permit from the villages. The second requirement, they must fill out a Statement which explained that the prostitutes come from certain brothel houses and they promise not to return to be a prostitute anymore. The Surabaya Social Service could not disburse the financial compensation if these two conditions were not met.

In addition, the prostitutes would have voluntarily joined HIV counselling and test with local community

health centers in collaboration with Surabaya Health Department and RT & RW in the red-light districts. If there were prostitutes affected by HIV-AIDS disease, Surabaya Health Department will submit the case to the Provincial Health Department for further monitoring and coordination with the Local Health Department in the hometowns of the former-prostitutes. The Local Health Department in the prostitutes' prostitutes hometowns were expected to monitor and provide guidance for HIV/AIDS testing in the community health centers in the prostitutes' hometowns.

The Role of Each Government Department and Their Coordination in the Red-light District Closure

In reality, the program of red-light district closure was holistic and well coordinated to meet the targets of the Governor's Decree. All agencies were always linked to each other in running the programs. Most of these programs did not overlap among institutions. Regarding the post-closure HIV/AIDS countermeasure, the Provincial Health Department took the role as the leading sector. In addition, the leading sector in HIV/AIDS countermeasure in the East Java, Provincial Health Department also monitored and coordinated with the Local Health Department at the former prostitutes' hometowns, whether there were prostitutes infected with HIV by conducting voluntary counselling and testing (VCT) sessions. What are the forms of coordination and monitoring by the Local Health Department in the former prostitutes' hometowns? This is an issue related to the spreading of HIV/AIDS in East Java. As stated by Surabaya Social Department, after the closure of red-light districts, the Provincial Health Department would step in as the leading sector. If there were prostitutes affected by HIV/AIDS found in the red-light districts in Surabaya, the information would be submitted to the Provincial Health Department to follow it up with monitoring and coordination with the Local Health Department of the former prostitutes' hometowns. In terms of local budgets, some of the prostitutes in Surabaya red-light districts are from outside Surabaya. If this group were in fact infected with HIV and needed therapy, they would use the budget of Surabaya City and thus Surabaya City Government would be burdened with this problem.

Regarding the prostitutes affected by HIV/AIDS returning to their hometowns, the same case happened. The Local Health Department in the hometowns also faced similar issue. This is confirmed by the chairman of Embun Foundation's statement, explaining that prostitutes would rather check their venereal diseases and HIV/AIDS to hospitals or community health centers in Surabaya. The reason is that they trust them more than the NGOs that deal with the Local Health Departments. These prostitutes were familiar with the medical staff there, resulting in more confidence, better understanding and empathy. In addition, they were more familiar with the procedures when they checked themselves at the hospitals. This made the diagnosis and management easier, more understanding and more importantly, their secrets were kept discreet. On the other hand, however, the prostitutes were often not the citizens of Surabaya, meaning that the one who should be responsible on funding these problems of venereal disease and HIV-AIDS inspections were the health departments of the prostitutes' hometown.

The Hometown Local Health Departments of the former prostitutes seemed to be less prepared to accept this responsibility. Once these former prostitutes were sent back to their hometowns and were identified with HIV/AIDS disease, there seemed to be lack of attention without any follow up nor monitoring. There was no further guidance. This might be due to the human resource incapability concerning HIV/AIDS or the inability to budget the HIV/AIDS monitoring. The Provincial Health Department as the leading sector seemed to have less than the maximum effort in monitoring and coordinating this problem with the Local Health Departments of the former prostitutes' hometown. Worse still, the Local Health Departments of the former prostitutes' hometowns were not focused nor had any clear direction to support the need in the local health department level. As a result, the community health centers around the red-light districts in Surabaya still often received visits from former prostitutes who still lived in the area as well as those who had been sent back to their hometowns.

From all the explanation above, it seems that the Provincial Health Department as the leading sector has not been optimal in monitoring, coordinating and mutually supporting the Local Health Departments in the former prostitutes' hometowns. The lack of monitoring and coordination between the Provincial Health Department and the Local Health Departments had resulted the inaccurate surveillance data and thus it was difficult to intervene. Hence, the target was not reached. Data Surveillance is intended to strictly control the spreading of the infectious disease of HIV/AIDS, so that patients can immediately be isolated and control measures can be taken as early as possible. Thus, the need to plan programs is expected to have a successful result. From these programs, the disease countermeasures are then taken. If the target is not reached, the epidemic of sexually transmitted infections and HIV/AIDS cannot be controlled. In this case, the Provincial Health Department should cooperate and have agreements with Local Health Department on the former prostitutes' hometowns.

The issue of red-light districts closure was not an easy one. Prostitutes were experiencing extremely complex problems. Prior to being returned to their hometowns, former prostitutes were equipped with training to make culinary, sewing, handicrafts (mats, brooches), introduced to washing machine and manage budget spending. These former prostitutes and their families are also equipped with the knowledge and skills to survive in their hometowns.

In fact, some principle findings are found. One of the factors driving women to become prostitutes is that they came from poor families of farm labors, farmers, construction workers, small merchants, housewives, or being the family member of a prostitute. The result of this

study is similar to the one found in Bolivia that sex work has become a way of financial support.[25] The next factor is low education. Prostitutes generally have low education background. Likewise, the trafficking victims had less education in average. They only finished elementary school or do not even graduate. This is why they are easily deceived, seduced, and lured by pimps or brokers to become prostitutes.

Although skill trainings based on their interests and talents has been provided, the question lies on whether in a short time these former prostitutes would be able to survive. They come from poor families with poor education. Will they be able to survive with the existing conditions of poverty? There have been trainings for prostitutes before the red-light district closure such as cooking and salon business. Nevertheless, the government had made no effort to create jobs for these prostitutes. In the end prostitute remains a prostitute. This would have an impact on the spreading of HIV/AIDS.

The effects of the red-light district closure were very complex. Therefore, partnerships with stakeholders to interpret strategic plans into field implementation were highly required. Red-light district closure program should always be directed to build and maintain partnerships which involved all stakeholders comprising government agencies, community organizations, non-governmental organizations, international organizations, professional organizations, academics and universities, and the public in general.

The partnership is made to build understanding and a shared commitment to develop any necessary efforts in HIV/AIDS countermeasure. To make the process and objectives of the red-light district closure program successful, Surabaya Social Service took the role as the leading sector in the pre-closure and closure phases and the Provincial Health Department as the leading sector in the post-closure need to consider the partnership as a goal and the foundation to be applied in every implementation of HIV/AIDS countermeasure efforts by all stakeholders in Surabaya and East Java.

Surabaya Social Service has conducted partnership with RT, RW, urban village chiefs in the red-light districts both in terms of closure socialization, prostitute database collection and verification, and also assessment. Nevertheless, it has not made any partnership with NGOs, international organizations, professional organizations and colleges. This was confirmed by the statement of the head of Hotline Surabaya Surya that no partnership was made by Surabaya Social Service. Other NGOs that are concerned with the prevention of HIV/AIDS such as Obor foundation was not involved as well.

Likewise, after the closure, it seemed that no partnership was made by the Provincial Health Department as the leading sector. As the agency to coordinate and monitor the local health department when prostitutes infected with HIV AIDS were found, the Provincial Health Department seemingly made no coordination and monitoring. The former prostitutes could have become prostitutes in other brothel with a different format.

In general, the Local Health Service had relatively limited human resources and budget. Therefore, the concept of partnership was the most likely alternative for local governments (in this case involving the local health Department) to develop with non-governmental organizations, international organizations, professional organizations, community leaders, religious leaders and colleges. It was almost difficult to expect partnership without the involvement of all stakeholders. Some of the obstacles including: the inability of local governments to offer various forms of partnership and the concept being less feasible in conducting partnership which was offered by the local government in the prostitutes' hometowns.

Medical Screening Standardization as HIV-AIDS Countermeasure Efforts for Former Prostitute Reintegration at Their Hometowns

Although at the time of red-light district closure VCT had been conducted by Surabaya Health Department in cooperation with community health centers in six regions of red-light districts in Surabaya, it was still necessary to conduct VCT in the post-closure. It is the post-closure that the most important moment in HIV/AIDS countermeasure. Being the leading sector after the closure, it was up to the Provincial Health Department to maximize the monitoring, coordination, cooperation, and partnership agreements with stakeholders all the way to the local levels. Stakeholders in this study were the local health department, National/Provincial/Local AIDS Commissions, and NGOs that were concerned with the problem of HIV-AIDS, international organizations, professional organizations, community leaders, religious leaders and colleges. The monitoring, coordination, cooperation, and partnership agreements with the stakeholders should be right on target to gain an effective and efficient policy (fulfilling MDG target to reduce the number of people with HIV/AIDS until at least below 0.5 percent).

For further details, the reintegration mechanisms of former prostitutes to their hometowns as an effort to countermeasure HIV/AIDS for the former prostitutes needs to be standardized. The Provincial Health Department must have a national strategic plan to prevent, control, and cope with AIDS. This strategic plan can be in the form of counseling, prevention, nurturing, monitoring and controlling HIV/AIDS. Provincial Health Department needed to make an agreement with Provincial/Local AIDS Countermeasure Commission (KPA) to support the policy of HIV/AIDS prevention and controlling on the red-light district closure program.

The socio-cultural barriers and potentials (supports) in the policy model of medical screening standardization to countermeasure HIV/AIDS in the reintegration of prostitutes to their hometowns was highly dependent on the actors. The actors here means people, groups, organizations or networks that were capable of taking decisions and actions to cooperate in establishing and maintaining a specific rule/structure system. Conversely, this could also be conflicting due to different interests for example,

whether or not to accept government programs related to both the prevention of HIV/AIDS. The actors would then interact in forms of cooperation, competition, contradiction, use of coercive force and so on within the social system.

The policy process is the means of how policy was initiated, developed or formulated, negotiated, communicated, implemented and evaluated. There are two steps in the process of formulating policies that determines the preferred choice of a policy. At both of these stages, policy makers should ideally understand the situation in details to make implementable decisions.

Actors in policy model of medical screening standardization to reduce the number of people with HIV/AIDS during the prostitute reintegration process to their hometowns included NGOs which were concerned about the protection of women and children and HIV/AIDS spreading, colleges, community organizations, religious organizations, village/district government, counties, and local health departments. These agencies were the actors in formulizing policies on HIV/AIDS If these agencies have HIV/AIDS countermeasure policy, it could be said that they support Indonesia towards the Tri Zero condition. These actors are the supporters of the social system that had certain social movements to cooperate in building and maintaining specific rule system. Conversely, if these actors did not have any policy, on HIV/AIDS prevention or treatment, it could be said that they became the inhibitor in building a standardized medical screening. These actors can dispute with each other due to their different interests. This interest can be in the form of selfish sector interests.

The Provincial Health Department program may be obstructed/cannot be done, if no partnership was made with colleges, NGOs, religious organizations and community organizations including the village as government agency partners in realizing the closure. The goal of the partnership is the realization of red district closure and HIV/AIDS prevention. If this partnership were conducted by the Provincial Health Department in running the program, there would always be linkages with other stakeholders. Provincial Health department is not always capable of providing and implementing its own program. Therefore, it would require a partnership to support the government to implement the program of red-light district closure.

The participation of stakeholders as partners would provide a variety of programs that can be implemented better. The participation of stakeholder partners is expected by the government in terms of role division, access granting with the principle of equality and mutual benefit. In reality, however, this partnership is not always followed by a good coordination between the stakeholders and the red-light district closure had no clear focus nor a clear direction with overlaps so that they did not support each other. If the East Java Provincial Health Department were to make partnership with stakeholders, the principle of equality and mutual benefit should be implemented to realize the success of the closure and also the HIV/AIDS countermeasure.

CONCLUSION

The role distribution implementation of the pre-closure and closure stages of six red-light districts in Surabaya in the appointed departments within the Surabaya City Government has been highly coordinated and holistically implemented. In the role distribution, the Surabaya Social Service plays the role of the leading sector. During the post-closure phase, there are still role divisions in each service agencies where the East Java Health Department plays the role of the leading sector. The East Java Health Department is appointed by Surabaya City Government in accordance with HIV/AIDS prevention. However, the coordination with the East Java Health Department is apparently non-effective.

In terms of the health aspects for the former prostitutes during their reintegration to their hometowns, there has been no previous policies related to medical screening which is designed for early detection of the disease and this lack of intervention from the East Java Health Department may affect the spread of HIV/AIDS. Screening is very important for early diagnosis for former prostitutes at the time of reintegration into their hometowns and the red-light districts post-closure phase. The screening mechanism is that the Provincial Health Department has to optimize the monitoring, coordination, cooperation, agreements and partnerships with stakeholders such as the Local Health Department and the National/Provincial/Distric AIDS Commission, NGOs that are concerned with the problems of HIV-AIDS, international organizations, professional organizations, community leaders, religious leaders and universities. Monitoring, coordination, cooperation, and partnership agreements with stakeholders should be right on target so that an effective and efficient policy (fulfilling the targets of MDGs) can be made to reduce number of PLHIV to at least below 0.5 percent.

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REFERENCES

1. Doyal L, Anderson J. "My fear is to fall in love again…" How HIV-positive African women survive in London. Soc Sci Med. 2005 Apr; 60(8): 1729–38.
2. Ndirangu EW, Evans C. Experiences of African immigrant women living with HIV in the U.K.: Implications for health professionals. J Immigr Minor Heal. 2009; 11(2): 108–14.

3. Russell S, Seeley J. The transition to living with HIV as a chronic condition in rural Uganda: working to create order and control when on antiretroviral therapy. Soc Sci Med. 2010 Feb; 70(3): 375–82.
4. Maman S, Cathcart R, Burkhardt G, Omba S, Behets F. The role of religion in HIV-positive women's disclosure experiences and coping strategies in Kinshasa, Democratic Republic of Congo. Soc Sci Med. 2009 Mar; 68(5): 965–70.
5. Rayah F, Manchester J, Maposhere C. Positive Women: Voices and Choices – Zimbabwe Report. Vol. 2011. Zimbabwe: the International Community of Women Living with HIV/AIDS; 2002.
6. Bassett MT, Mhloyi M. Women and Aids in Zimbabwe: The Making of an Epidemic. Int J Heal Serv. 1991 Jan; 21(1): 143–56.
7. Humphrey JH, Marinda E, Mutasa K, Moulton LH, Iliff PJ, Ntozini R, et al. Mother to child transmission of HIV among Zimbabwean women who seroconverted postnatally: prospective cohort study. BMJ. 2010 Dec 22; 341(dec22 1): c6580–c6580.
8. Howard BH, Phillips C V, Matinhure N, Goodman KJ, McCurdy SA, Johnson CA. Barriers and incentives to orphan care in a time of AIDS and economic crisis: a cross-sectional survey of caregivers in rural Zimbabwe. BMC Public Health. 2006 Feb 9; 6: 27.
9. Zuniga PU, Rodriguez CM, Garcia EB. AIDS in Mexico. J Int Assoc Physicians AIDS Care. 1998 Nov; 4(11): 29–33.
10. Lewis J. How immigration spreads AIDS. The World Retrieved [Internet]. 2007. Available from: www.theworld.org/?q5node/8882
11. Parrado EA, Flippen CA, McQuiston C. Use of commercial sex workers among Hispanic migrants in North Carolina: implications for the spread of HIV. Perspect Sex Reprod Health. 36(4): 150–6.
12. Urizar GG, Winkleby MA. AIDS Knowledge among Latinos: Findings from a Community and Agricultural Labor Camp Survey. Hisp J Behav Sci. 2003 Aug 25; 25(3): 295–311.
13. Zambrana RE, Cornelius LJ, Boykin SS, Lopez DS. Latinas and HIV/AIDS Risk Factors: Implications for Harm Reduction Strategies. Am J Public Heal. 2004; 94(7): 1152–1158.
14. Sowell RL, Holtz CS, Velasquez G. HIV Infection Returning to Mexico With Migrant Workers: An Exploratory Study. J Assoc Nurses AIDS Care. 2008 Jul; 19(4): 267–82.
15. Greener R, Sarkar S. Risk and vulnerability: do socioeconomic factors influence the risk of acquiring HIV in Asia? AIDS. 2010 Sep; 24 Suppl 3: S3-11.
16. Gillespie S, Greener R, Whiteside A, Whitworth J. Investigating the empirical evidence for understanding vulnerability and the associations between poverty, HIV infection and AIDS impact. AIDS. 2007 Nov; 21 Suppl 7: S1-4.
17. Basavaraj K, Navya M, Rashmi R. Quality of life in HIV/AIDS. Indian J Sex Transm Dis AIDS. 2010; 31(2): 75.
18. Ismail SM, Eisa AA, Ibrahim F. HIV-infected People in Sudan Moving Toward Chronic Poverty: Possible Interventions. J Assoc Nurses AIDS Care. 2016 Jan; 27(1): 30–43.
19. García PJ, Bayer A, Cárcamo CP. The changing face of HIV in Latin America and the Caribbean. Curr HIV/AIDS Rep. 2014 Jun;11(2): 146–57.
20. Bingham B, Leo D, Zhang R, Montaner J, Shannon K. Generational sex work and HIV risk among Indigenous women in a street-based urban Canadian setting. Cult Health Sex. 2014; 16(4): 440–52.
21. Choudhury SM, Anglade D, Park K. From Violence to Sex Work: Agency, Escaping Violence, and HIV Risk Among Establishment-Based Female Sex Workers in Tijuana, Mexico. J Assoc Nurses AIDS Care. 2013 Jul; 24(4): 368–82.
22. Yao Y, Yang F, Chu J, Siame G, Lim HJ, Jin X, et al. Associations between drug use and risk behaviours for HIV and sexually transmitted infections among female sex workers in Yunnan, China. Int J STD AIDS. 2012 Oct; 23(10): 698–703.
23. Ulibarri MD, Strathdee SA, Patterson TL. Sexual and drug use behaviors associated with HIV and other sexually transmitted infections among female sex workers in the Mexico-US border region. Curr Opin Psychiatry. 2010 May; 23(3): 215–20.
24. Lawan UM, Abubakar S, Ahmed A. Risk perceptions, prevention and treatment seeking for sexually transmitted infections and HIV/AIDS among female sex workers in Kano, Nigeria. Afr J Reprod Health. 2012; 16(1): 61–7.
25. López Entrambasaguas OM, Granero-Molina J, Hernández-Padilla J, Fernández-Sola C. Understanding Sociocultural Factors Contributing to HIV Risk Among Ayoreo Bolivian Sex Workers. J Assoc Nurses AIDS Care. 2015 Nov; 26(6): 781–93.