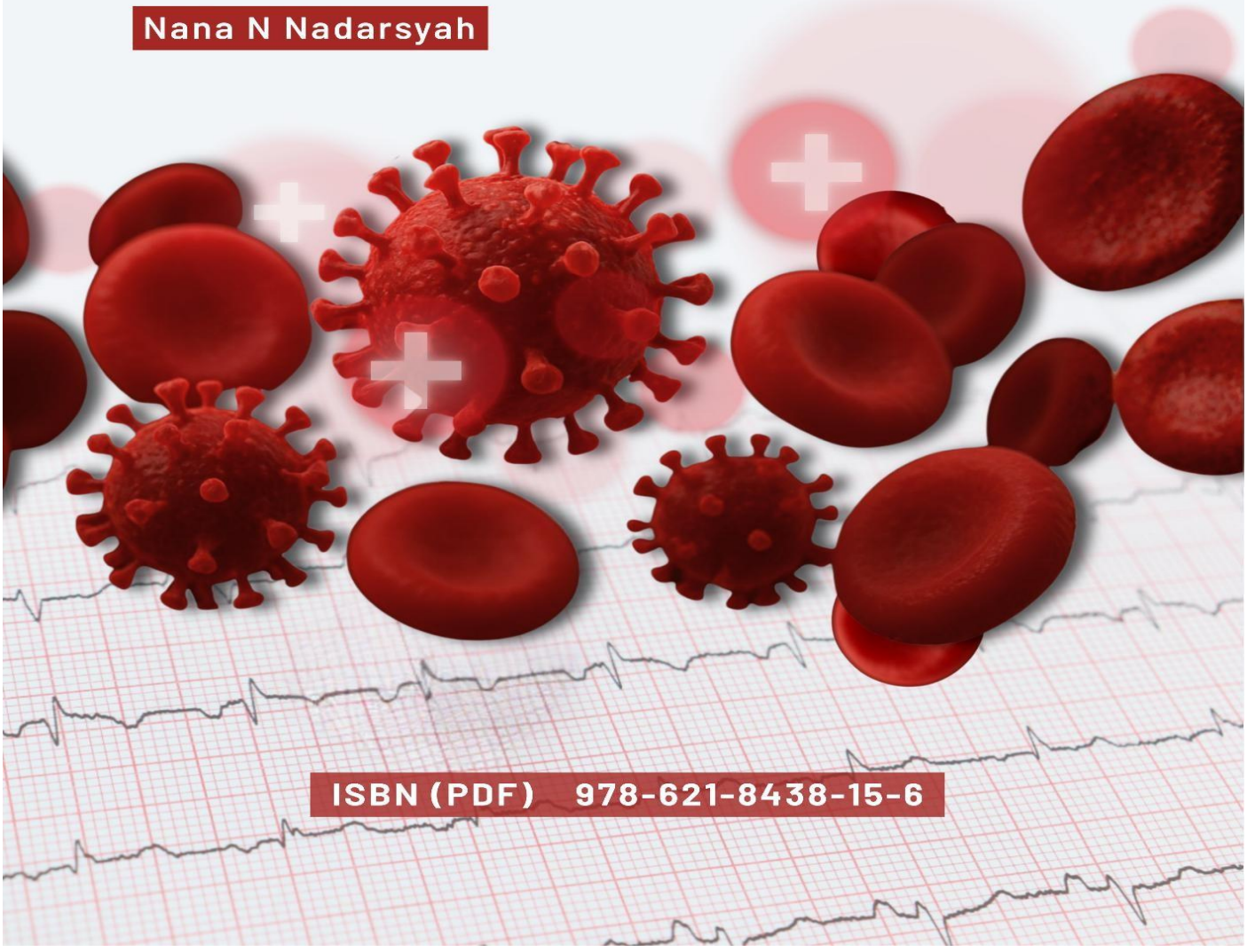
REGIONAL RESEARCH AND INNOVATION AGENCY
SOUTH KALIMANTAN PROVINCE

FSH-PH Publication

HIV-AIDS

HUMAN RESOURCE AND HEALTH POLICY

Nana N Nadarsyah



ISBN (PDF) 978-621-8438-15-6

PDF (downloadable)

ISBN 978-621-8438-15-6

Published by:

FSH-PH Publications

Block 4 Lot 6, Lumina Homes,

Pamatawan, Subic, Zambales

https://fsh-publication.com/

HIV/AIDS, HUMAN RESOURCE AND HEALTH POLICY

Nana N Nadarsyah

FOREWORD

Head of the Regional Research and Innovation Agency of South Kalimantan Province

All praise and gratitude be to God Almighty, because by His grace and blessings, this book "HIV–AIDS, Health Resources and Policy" has been completed and presented to stakeholders, researchers, academics, and health development observers.

On behalf of BRIDA, I express my deepest appreciation for the publication of this scientific work, which is a concrete manifestation of our commitment to strengthening the research and innovation ecosystem in the health sector. In the context of the dynamics of the HIV–AIDS epidemic, which remains a global, national, and regional challenge, the availability of up-to-date, evidence-based scientific references is a pressing need.

As we know, HIV–AIDS is a complex public health problem, with determinants involving medical, social, economic, and behavioral dimensions. Addressing it requires a comprehensive and integrated approach, ranging from the availability of health resources and appropriate service strategies to robust policies. Therefore, the contribution of literature that maps data, analyzes policies, and formulates research-based recommendations, as presented in this book, is crucial in supporting the planning and decision-making process at the regional level.

I hope this book can serve as an academic reference for policymakers, health workers, and relevant institutions in strengthening efforts to prevent, control, and mitigate the impact of HIV/AIDS. Furthermore, this publication is expected to encourage the development of regional innovation, improve the quality of health services, and strengthen cross-sector collaboration.

To the authors, partner institutions, and all parties who have contributed, I express my deepest appreciation and gratitude. I hope this book can make a significant contribution to our collective efforts to reduce the rate of HIV/AIDS transmission and encourage the realization of research-based, evidence-oriented, and sustainable health development.

Let us unite and work together with enthusiasm and optimism. The best results can be achieved with the cooperation and contribution of all parties. May all our efforts in this event receive the grace and blessings of Allah SWT.

Head of BRIDA

South Kalimantan Province

H. Thaufik Hidayat, S.Sos., M.Si

Foreword

Alhamdulillah, the author expresses infinite gratitude to the presence of Allah SWT, who has bestowed His blessings, mercy, guidance, and forgiveness, so that the author was able to complete the writing to perfect the book HIV/AIDS: Human Resources and Health Policy. Health policy is my concentration in my doctoral studies in public administration at Diponegoro University and is also my specialty as a health researcher. The author's strong determination to share knowledge and learn, based on the intention of worship, resulted in the completion of this book.

The author is fully aware that this book needs improvement. Therefore, the author humbly apologizes and hopes that this book can provide benefits, especially for the author himself and readers.

Banjarmasin, December 2023

Writer

Dr. Nana N Nadarsyah, S.ST, M.Kes,C.MT., CIQaR

A. CONCEPT OF HIV/AIDS

a. Understanding HIV/AIDS

HIV/AIDS is a slow-moving disease, and AIDS symptoms will appear around 5–10 years or even longer after infection occurs. HIV/AIDS is a disease that attacks the immune system, weakening the body's ability to fight infection. The virus enters the human body primarily through blood, semen, and vaginal fluids, with the majority (75%) of transmission occurring through sexual contact (Noviana, 2019).
According to data from the Indonesian Ministry of Health, the rate of increase in new HIV cases is accelerating.

Table: Number of HIV/AIDS Cases in Indonesia, 2009–2022.

Source: Directorate General of Infectious Disease Control & Environmental Health, March 2022

The increase in HIV/AIDS cases is an iceberg phenomenon, where it is not visible on the surface but spreads very rapidly. The development of HIV/AIDS cases in Indonesia shows an increasingly rapid increase with an increasingly worrying acceleration. The increasing prevalence of HIV/AIDS increases the risk that health workers working in health facilities will be exposed to infections that could potentially endanger their lives. This can happen when health workers provide care to patients so that there is direct contact with the patient's body fluids or blood. This can be a place where infectious agents can live and reproduce and then spread from one patient to another, especially if blood and body fluids are not administered to all patients.

In every action, health workers need to consider that all patients have the potential to be infected with HIV/AIDS or other infectious diseases. Because health workers who provide care to HIV/AIDS patients have a risk of infection, In order to avoid infection with HIV/AIDS and other diseases, it is necessary to apply universal precautions so that the risk of transmission can be minimized.

b. History of HIV and AIDS

The earliest cases of HIV infection were found in a blood sample taken in 1959 from a man in Kinshasa, Democratic Republic of the Congo (formerly Zaire), indicating that HIV had been present for more than two decades before the first CDC report. AIDS was first reported in 1981 by the United States Centers for Disease Control and Prevention (CDC), headquartered in Atlanta, Georgia. Nearly one million people in the United States were diagnosed with AIDS during the first 25 years. More than half a million Americans died from AIDS during the first quarter-century of the epidemic, and more than 400,000 Americans are currently living with AIDS. By 2006, more than 50,000 Americans were HIV-positive (CDC, 2008). AIDS is a disease found in many countries worldwide. In 2007, according to data collected by the United States Programme on HIV/AIDS (UNAIDS), 33 million people were living with HIV infection, nearly 3 million people were infected with HIV, and 2 million people had died (UNAIDS, 2007).

The HIV/AIDS case in Indonesia was first reported in 1987 in Bali. The highest number of cases was reported from DKI Jakarta, followed by Papua, East Java, Riau (Batam), and Bali. In the 10 years since AIDS was first discovered, at the end of 1996, the number of positive HIV cases reached 381, and 154 AIDS cases, respectively. The AIDS case received a response from the government after a Dutch patient died at Sanglah Hospital in Bali. This case was followed by reporting cases to the WHO, so Indonesia was the 13th country in Asia to report AIDS cases in 1987. In fact, in 1985, there were already patients at the Jakarta Islamic Hospital who were suspected of suffering from AIDS. Because the first case was found in a homosexual, there are suspicions that the pattern of AIDS spread in Indonesia is similar to that in other countries. In subsequent developments, AIDS symptoms were found in patients who had a background as female sex workers and their customers.(https://www.kebijakanaidsindonesia.net/id/49-general/1603-sejarah-hiv-aids).

The spread of HIV in Indonesia had two patterns after it arrived in 1987–1996. Initially, it only appeared in homosexual groups. In 1990, the model spread through

heterosexual sex. The largest percentage of HIV/AIDS sufferers is found in the productive age group (15–49 years): 82.9%, while the tendency for the most common mode of transmission is through risky sexual relations (95.7%), which is divided between heterosexuals (62.6%) and homosexual men (33.1%). (Stranas 1994).

c. THE SITUATION OF HIV AND AIDS IN INDONESIA

a) Development of HIV/AIDS Cases 1987–2019

HIV and AIDS are a public health issue that requires serious attention from all of us. This can be seen from the number of AIDS cases reported each year, which has increased significantly. The number of HIV cases reported by the Ministry of Health increases every year. Since it was first discovered in 1987 until June 2019, HIV/AIDS has been reported in 463 (90.07%) districts and cities in all provinces in Indonesia. The number of HIV cases reported from 2005 to 2019 has increased every year. The cumulative number of HIV cases reported up to June 2019 was 349,882 (60.7% of the 2016 estimated PLHIV of 640,443). There are 5 provinces with the highest number of HIV cases, namely DKI Jakarta (62,108), followed by East Java (51,990), West Java (36,853), Papua (34,473), and Central Java (30,257). Meanwhile, the number of AIDS cases reported from 2005 to 2019 was relatively stable every year. The cumulative number of AIDS cases from 1987 to June 2019 was 117,064 people. The age group with the highest cumulative percentage of AIDS was 20–29 years (32.1%), followed by 30-39 years (31%), 40–49 years (13.6%), 50–59 years (5.1%), and 15–19 years (3.2%). The most risk factors for transmission are heterosexual risky sexual intercourse (70.2%), use of non-sterile injection equipment (8.2%), followed by homosexuality (7%), and perinatal transmission (2.9%).

Apart from the increasing number of problems, the problems have become complex. This is because many people still view HIV/AIDS as a moral problem. People who are infected with HIV are seen as people who have behavior that is not 'normal'. So discrimination arises against PLWHA, who should also receive the same rights to health services, considering more substantial problems. However, with the increasing number of HIV cases reported each year, the number of AIDS cases is relatively stable. This shows that more and more PLWHA know their status at an early stage. Therefore, there needs to be support for PLWHA to immediately undergo treatment, both from health workers and family.

b) AIDS Case Discovery Period January – March 2021

The number of reported AIDS cases was 1,677 people. The five provinces with the most reported AIDS cases were Central Java, North Sumatra, East Java, West Java, and East Kalimantan. The 30-39 age group was the group with the highest percentage of AIDS (36%), followed by the 20-29 age group (29%) and the 40-49 age group (19%).

The percentage of AIDS in men was 59% and women 33%. Meanwhile, 8% did not report gender. The highest number of AIDS according to occupation/status were non-professional workers (employees) (21,249), housewives (18,848), self-employed/own business (16,963), farmers/livestock breeders/fishermen (6,484), and manual laborers (6,431)

The highest risk factors were risky sex in heterosexuals (51.5%), homosexuals (20%), and sharing needles (10.6%). There was a decrease in the number of AIDS cases reported in Quarter I (Jan – Mar) 2021 compared to Quarter IV (Oct-Dec) 2020 (from 1,867 people to 1,677 people).

c) Development of HIV Cases 2010-2021

1. Case Finding and HIV Treatment in January – March 2021

TB is the largest opportunistic infection in HIV and AIDS patients, and in 2010 was estimated that the prevalence of HIV among TB cases was 3.3% on a national scale.

The number of PLWHA found was reported as many as 7,650 people out of 810,846 people tested for HIV, and 6,762 people received ARV treatment. PLWHA infants ≤18 months seen in the January – March 2021 period were 7 out of 287 infants tested for HIV using PCR DNA (EID).

The highest percentage of PLWHA found in the January – March 2021 period was in the 25-49 year age group (71.3%), followed by the 20-24 year age group (16.3%), and the ≥ 50-year age group (7.9%). Based on gender, the percentage of PLWHA found in men was 69%, and in women was 31% with a male-to-female ratio of 5:3.

The percentage of PLWHA found in the period January - March 2021 based on risk factors in homosexuals 27.2%; heterosexuals 13.0%; and the use of shared injection needles 0.5%. The percentage of unknown risk factors is large (50.4%). The percentage of PLWHA found reported

in the FSW population group was 2.4%; MSM 26.3%; transgender 0.9%; injecting drug users 0.5%; WBP 0.7%; pregnant women 20.9%; TB patients 11.5%; and STI patients 0.8%.

2. HIV Case Discovery until March 2021

The number of HIV cases reported from 2005 to March 2021 tends to increase every year. The cumulative number of HIV cases reported until March 2021 was 427,201 (78.7% of the target of 90% estimated PLWHA in 2020 of 543,100).

The highest percentage of HIV infection was reported in the 25-49 age group (70.7%), followed by the 20-24 age group (15.7%), and the ≥ 50 age group (7.1%). (data available since 2010). The percentage of HIV cases in men was 62% and in women 38% with a male-to-female ratio of 5:3 (data available since 2008).

The percentage of HIV was found based on heterosexual transmission 30%; homosexual 17.5%; and the use of shared injection needles 4.1% (data available since 2010).

The five provinces with the highest number of PLHIV discoveries were DKI Jakarta (71,473), followed by East Java (65,274), West Java (46,996), Central Java (39,978), and Papua (39,419).

d) Trends in the number of HIV cases in the future

The trend in the number of new HIV infections in Indonesia is decreasing. According to the Ministry of Health's estimate for 2020, the number of PLHIV in 2020 was 543,100. Lower than the previous estimated calculation carried out in 2016. Meanwhile, the 2018 STBP noted that HIV prevalence in Indonesia varies greatly according to population: 25.8 percent among men who have sex with men, 28.8 percent among people who inject drugs (IDUs), 24.8 percent among the transgender population, and 5.3 percent among female sex workers (Indonesian Ministry of Health, 2022). Based on data from the Asian Epidemic Model (AEM), Indonesia's 2022 HIV incidence rate is 0.09 percent, smaller than the 2022 target of 0.19 percent. However, the incidence of deaths caused by AIDS is estimated to increase. Therefore, efforts are needed to find cases early, increase ARV initiation as early as possible, maintain treatment and compliance with ART, and increase the availability and distribution of better ARVs. (Indonesian Ministry of Health, 2022).

The National AIDS Commission and the Ministry of Health made estimates using a modeling system. Future trends in the HIV epidemic using modeling provide a clearer picture of current HIV transmission and future changes. The modeling process uses demographic, behavioral, and epidemiological data on key populations. The projection results predict the following:

o Increased HIV prevalence in the 15-49 age group from 0.21% in 2008 to 0.4% in 2014

o Increased number of new HIV infections in women, which will increase the number of HIV infections in children.

o Significant increase in new infections in all MSM groups

o There needs to be awareness of the potential for increasing new infections in sexual partners (intimate partners) of each key population

o Increase in the number of PLWHA from around 404,600 in 2010 to 813,720 in 2014. Increase in the need for ART from 50,400 in 2010 to 86,800 in 2014. The increase in the number of PLWHA requiring ART, above will increase further if there is a policy of changing the CD4 criteria in determining the need for ART, for example from 200 to 350 (https://kebijakanaidsindonesia.net/id/49-general/1603-sejarah-hiv-aids)

B. Transmission of HIV infection

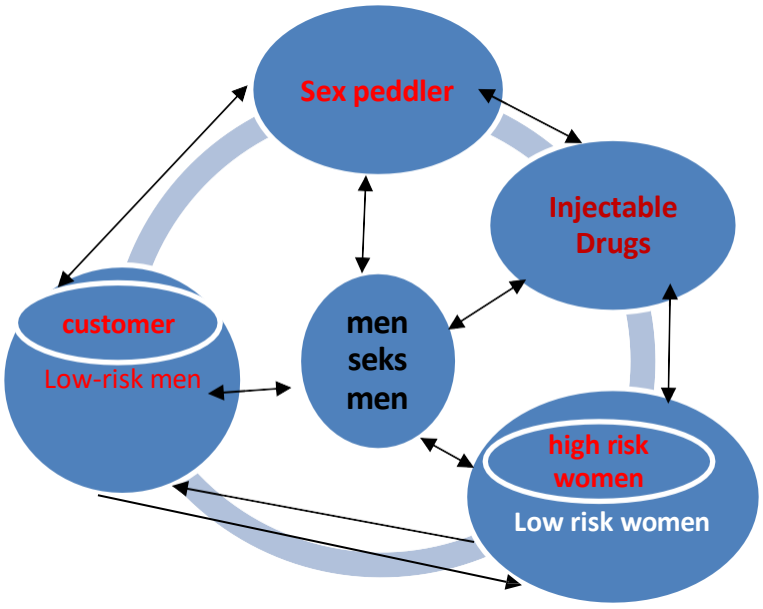
HIV transmission enters the human body in three ways, namely

a. vertically from HIV-infected mother to child.

Children are infected with HIV from their HIV-infected mothers to their fetuses during pregnancy, during labor, and after birth through the provision of breast milk (ASI). The transmission rate during pregnancy is around 5–10%, during childbirth 10–20%, and during breastfeeding 10–20%. The virus can be found in breast milk, so breast milk is an intermediary for postnatal transmission of HIV from mother to baby. If possible, giving breast milk to an infected mother should be avoided.

b. Transsexual (homosexual or heterosexual)

Chain of HIV Transmission



Sexual contact is one of the main ways of transmitting HIV in various parts of the world. This virus can be found in semen, vaginal fluid, and cervical fluid. The virus will concentrate in semen, especially if there is an increase in the number of lymphocytes in the fluid, such as in conditions of genital inflammation such as urethritis, epididymitis, and other disorders related to sexually transmitted diseases.

Sexual intercourse through the anus is an easier transmission of HIV infection because in the anus there is only a rectal mucous membrane, which is thin and easily torn, so that the anus is prone to lesions. If a lesion occurs, it will facilitate the entry of the virus, making it easier for infection to occur.

c. Horizontal, namely contact between infected blood or blood products

Blood and blood products are excellent mediums for HIV transmission. To be contagious, body fluids must enter directly into the bloodstream. HIV has been found in saliva, but until now, there has been no evidence that HIV can be transmitted through saliva. Likewise with breast milk from mothers who suffer from HIV/AIDS. HIV is also not found in urine, feces, or vomit.

This can occur in individuals who receive blood transfusions or blood products and bypass HIV screening tests. It is estimated that 90–100% of people who receive blood transfusions contaminated with HIV will develop an infection. This transmission can also occur in individuals who use intravenous narcotics by using syringes alternately or together in a group without paying attention to the principle of sterilization.

C. HIV infection

HIV enters the human body in various ways, namely, vertically, horizontally, and transsexually. So HIV can reach systemic circulation directly and indirectly through sharp objects that can penetrate blood vessel walls or indirectly through skin and mucosa that are not ingested, as occurs during sexual contact. Once it reaches or is in systemic circulation, 4–11 days after first exposure, HIV can be detected in the blood.

a. HIV is not transmitted through social contact, such as:

1) Sharing food, clothes, toilets, and cutlery
2) Touching, hugging, kissing (as long as there are no wounds or canker sores in the mouth or cavities), kissing the cheek, and shaking hands.
3) Saliva
4) Mosquito or insect bites; live in the same house as an HIV person.
5) Swimming with HIV people

b. HIV easily dies outside the body when exposed to hot water, soap, and cleaning agents.

c. The methods of sexual intercourse that are most vulnerable to HIV/AIDS transmission are as follows:

1) Passive anogenital. The penis of a sexual partner with HIV enters the partner's anus.
2) Active anogenital. The penis enters the anus of the sexual partner of the HIV sufferer.
3) Passive genetics. The penis of a sexual partner with HIV enters the vagina.
4) Active genetics. The penis enters the vagina of the sexual partner of the HIV sufferer.
5) Interrupted sexual intercourse with a partner who suffers from HIV/AIDS.
6) The relationship between the mouth of the sexual perpetrator and the genitals of the sexual partner of the HIV sufferer (orogenital) is not necessarily safe.

d. Signs of contracting HIV

Symptoms of people infected with HIV becoming AIDS can be seen from two symptoms, namely major symptoms (common) and minor symptoms (not common):
Major Symptoms:

1) Body weight decreases by more than 10% in 1 month
2) Chronic diarrhea that lasts more than 1 month
3) Prolonged fever for more than 1 month
4) Decreased consciousness and neurological disorders
5) Dementia/HIV encephalopathy

Minor Symptoms:

1) Cough persists for more than 1 month
2) Generalized dermatitis
3) The presence of multisegmental herpes zoster and recurrent herpes zoster
4) Oropharyngeal candidiasis
5) Chronic progressive herpes simplex
6) Generalized lymphadenopathy
7) Recurrent fungal infections of the female genitals
8) Cytomegalo viral retinitis

e. Opertunistic Infections

The opportunistic infections identified in establishing a diagnosis of AIDS are as follows:
1) Candidiasis of the respiratory tract, trachea, or lungs
2) Usophageal candidiasis
3) Invasive cervical cancer
4) Coccidioidomycosis spreads outside the lungs.
5) Cryptococcosis, extrapulmonary
6) Crytosporidiosis, a chronic intestinal disease (lasting more than one month)
7) Cytomegalovirus (other than liver, spleen, or nodes)
8) Cytomegalovirus retinitis (with loss of vision)
9) Encephalopathy, HIV-related
10) Herpes simplex; chronic ulcers (lasting longer than one month); or bronchitis, pneumonitis, or esophagitis
11) Histoplasmosis, disseminated or extrapulmonary.
12) Isosporiasis, chronic intestinal (lasting more than one month)
13) Kaposi's sarcoma

14) Lymphoma, the Burkitt (or equivalent term)
15) Lymphoma, immunoblastic (or equivalent term)
16) Lymphoma, primary, brain
17) Mycobacterium avium kansasii complex, or M, which is spread outside the lungs
18) Mycobacterium tuberculosis, any site (pulmonary or extrapulmonary)
19) Mycobacterium, other species, or unknown species, scattered or extrapulmonary
20) Pneumocystis carinii pneumonia
21) Pneumonia, recurrent
22) Progressive multifocal leukoencephalopathy
23) Salmonella septicemia, recurrent
24) Brain toxoplasmosis
25) Wasting syndrome due to HIV

f. Stages of Being Affected by HIV

An adult (>12 years old) is considered to have AIDS if they show a positive HIV test with an appropriate examination strategy with at least 2 major symptoms and 1 minor symptom, and these symptoms are not caused by other conditions that are not related to HIV infection. People who have been infected with HIV cannot immediately be seen physically. There are stages in which a person is infected with HIV.

1) Window Stage (Window Period)

That is the time from the entry of the virus until, when the test is carried out, the results are positive. The window period for some people is different, varying between 2 weeks and 6 months. During this window, even if the test result is negative, if someone is infected with HIV, they can transmit HIV to other people.

2) Periods without symptoms

This symptomless period ranges from 5 to 12 years, when a person is truly infected with HIV but there are no physical symptoms related to the infection.

3) Period of enlarged lymph nodes

At this stage, a PLWHA will experience swelling of the lymph glands. It usually occurs several times, repeatedly.

4) AIDS stage

In the final stage, or what is called full-blown AIDS, generally typical symptoms appear, namely major and minor symptoms. Major symptoms include prolonged fever, chronic diarrhea that recurs and persists, and weight loss of more than 10% in one month. Meanwhile, minor symptoms include: chronic cough, fungal infections of the mouth and throat, persistent swelling of the lymph nodes, cancer,

especially skin cancer known as Kaposi's sarcoma, and the appearance of Herpes zoster.

g. HIV Incubation Period

The time between HIV entering the body and the first symptoms of AIDS, also known as the HIV incubation period, varies from half a year to more than seven years. HIV (antigen) can only be detected for a short time, approximately half a month to 2.5 months after HIV enters the body.
The body needs time to produce antibodies. This time is an average of 2 months, which means that in a person with HIV infection in the first 2 months, the diagnosis cannot be confirmed by laboratory examination based on antibody determination. This 2-month period is called the window period. During this period, a person can be infected with HIV, but the HIV test can still give a negative result because the body has not produced enough antibodies for the test to detect. This period varies from person to person, depending on factors such as immunity and the type of test used. In general, this period lasts between 2 and 12 weeks after the infection. Therefore, if a person has been exposed to HIV or is at risk of becoming infected, it is important to wait until at least 12 weeks after exposure to test for HIV to ensure accurate results.

h. HIV/AIDS Prevention and Control Efforts

The most effective way to prevent HIV transmission is to break the chain of transmission. Prevention is linked to the ways in which HIV is transmitted. Because HIV/AIDS infection is a disease with a long journey and until now no effective cure has been found, prevention and transmission are very important, especially through health education and increasing correct knowledge regarding the pathophysiology of HIV and how it is transmitted.
Prevention is all efforts and activities carried out, including prevention, treatment, and rehabilitation activities. As is known, the HIV virus spreads through sexual intercourse, contaminated needles, blood transfusions, transmission from mother to child, blood donation, or organ donation.

a) Prevention of transmission through sexual contact

HIV infection mainly occurs through sexual intercourse, so AIDS prevention efforts need to focus on sexual intercourse. In order to avoid contracting HIV and

AIDS, a person must have safe and responsible sexual behavior. That is, only having sexual relations with your own partner (your own husband or wife). If one partner is infected with HIV, when having sexual intercourse, you must use a condom correctly. Carrying out safe sexual acts using the "ABCDE" concept to avoid transmission (Abstinent, Be faithful, Condom, Drug No., Education), namely not engaging in sexual activity (abstinent) is the safest method for preventing HIV transmission through sexual intercourse, not changing partners (be faithful), and using condoms (use condom), do not use drugs (Drug No.), and provide education and information regarding HIV/AIDS (Education).

b). Prevention of blood-borne transmission

1) Blood transfusion

To prevent HIV transmission, you must ensure that the blood used for transfusion is not contaminated with HIV.

2) Syringes and other tools that can injure the skin

Disinfect or clean tools such as needles, razors, piercing tools, and others with heating or a disinfectant solution.

3) Prevention of transmission from mother to child

Transmission of HIV from an infected mother can occur during pregnancy, during labor, or after birth through breast milk. It is estimated that 50% of babies born to HIV-positive (+) mothers will be infected with HIV before, during, and shortly after birth. Without any intervention, around 15% to 30% of mothers with HIV infection will transmit the infection during pregnancy and the birth process. Giving breast milk increases the risk of transmission by around 10–15%. This risk depends on clinical factors and may vary depending on the pattern and length of breastfeeding. Mothers suffering from HIV/AIDS need counseling. To prevent the spread of the HIV epidemic from the IDU group to the general population, mothers with HIV/AIDS need to consider getting pregnant, especially with IDU sexual partners and the babies they are carrying. To prevent the bad effects of narcotics (harm reduction), the strategy adopted is to help drug abusers stop using narcotics (abstinent), ensuring that they always use sterile syringes and are not independent.

D. HIV/AIDS PREVENTION AREAS

Risky behaviors within a community can influence the spread of HIV. Efforts include prevention through counseling, promoting healthy living, and education, as well as effective use of prevention tools, tailored to the specific goals of the prevention effort.

In packaging prevention programs, target groups are differentiated as follows:

• Infected groups (infected people)

The infected group is made up of those who are already infected with HIV. The prevention efforts aimed at infected groups are to slow the rate of HIV development, maintain individual productivity, and improve quality of life.

• Groups at risk of infection or prone to infection (high-risk people)

Those who behave in a way that puts them at high risk of contracting HIV are categorized as high-risk groups. Based on the literature, this group includes commercial sex workers, both female and male; clients of commercial sex workers; injecting drug users and their partners; transgender commercial sex workers and their clients; and men who prefer men. Due to their specific characteristics, prisoners are included in this group. Prevention efforts for vulnerable groups aim to change risky behaviors into safe ones.

• Vulnerable Groups

Vulnerable groups are groups of people who, due to their work environment, resilience, and/or family well-being, are prone to low and unstable health status, making them vulnerable to HIV transmission. Based on the literature, vulnerable groups include people with high mobility, both civilian and military, women, adolescents, street children, refugees, pregnant women, blood transfusion recipients, and health workers. Prevention efforts provided to vulnerable groups are aimed at preventing them from engaging in activities that put them at risk of contracting HIV (deterring at-risk groups).

• general population

Those not included in the three groups discussed above constitute the general public. Prevention efforts aimed at the general public aim to increase awareness, concern, and involvement in HIV/AIDS prevention and management efforts in their communities.

a. PREVENTION OF HIV INFECTION IN CHILDREN

Prevention of HIV/AIDS in children begins with prevention of HIV/AIDS for their mothers. As we know, it is estimated that 90% of children are infected through maternal transmission (during pregnancy, childbirth, or breastfeeding). Obviously, if a mother is not HIV positive, then no infection is passed on to her children. Hence the need to continue HIV/AIDS education worldwide; preventing one infection can save more than one life. However, if a mother is infected with HIV, preventive measures need to be taken to reduce the possibility of transmission to her child.

HIV/AIDS prevention methods can be accessed and utilized in various ways by a country, depending on its economic capacity. This will affect the resources required, such as costs for various therapies and treatments, knowledge, information, and skills. Transmission from mother to child can be reduced in the following ways:

• Treatment: It is clear that short-term preventive antiretroviral treatment is an effective and feasible method for preventing mother-to-child transmission of HIV. When combined with baby feeding support and counseling and the use of safer feeding methods, this treatment can reduce a child's risk of infection by half. ARV regimens are typically based on nevirapine or zidovudine. Nevirapine is given in one dose to the mother during labor and in one dose to the child within 72 hours of birth. Zidovudine is known to reduce the risk of transmission when given to the mother in the last six months of pregnancy, via infusion during labor, and to the baby for six weeks after birth. Even if zidovudine is given late in pregnancy or around the time of delivery, the risk of transmission can be reduced by half. In general, the effectiveness of a drug regimen will be lost if the baby continues to be exposed to HIV through breast milk. Antiretroviral drugs should only be used under medical supervision.

• Caesarean section: Of the number of babies infected through mother-to-child transmission, it is believed that about two-thirds are infected during pregnancy and around the time of delivery. Vaginal delivery is thought to increase the risk of mother-to-child transmission, while a caesarean section has been shown to reduce the risk. However, it is also necessary to consider the risk factors faced by the mother.

• Avoid breastfeeding: The risk of mother-to-child transmission increases when the child is breastfed. Even though breast milk is considered the best nutrition for children, for HIV-positive mothers, it is highly recommended to replace breast milk with formula milk to reduce the risk of infection in children. However, this is only recommended if

the formula milk can meet the child's nutritional needs, if the baby formula can be made in hygienic conditions, and if the cost of the baby formula is affordable for the family.

The World Health Organization (WHO, made the following recommendations: While replacement foods are acceptable, feasible, affordable, sustainable, and safe, it is strongly recommended that HIV-positive mothers not breastfeed their babies. If otherwise, then exclusive breastfeeding is recommended in the first month of the baby's life and should be stopped as soon as possible.

HIV prevention in children requires a comprehensive approach that includes various aspects such as health, education, socio-culture, parental roles, and applicable policies. The following are some preventive efforts that can be carried out in each of these aspects:

1. Health Aspect

a. Prevention of Mother-to-Child Transmission (PMTCT):

Prevention of Mother-to-Child Transmission (PMTCT) is a crucial step in preventing HIV in children. This involves providing antiretroviral therapy (ARV) to pregnant women who are infected with HIV, during pregnancy, childbirth, and breastfeeding. Effective use of ARVs can reduce the risk of HIV transmission from mother to child to below 2%.

b. HIV Screening and Testing for Pregnant Women:

All pregnant women should undergo HIV testing as part of routine antenatal check-ups. If a mother is known to be HIV positive, preventive measures can be taken immediately to protect her baby from HIV transmission.

c. Education and Counseling:

Health services must provide adequate education and counseling for pregnant women and their families about the risks of HIV transmission and how to prevent it. This information is important so that they can make informed decisions regarding pregnancy and childbirth.

d. Vaccination and Child Health Monitoring:

Children born to mothers with HIV need close health monitoring and complete immunizations to prevent other infections that can worsen their condition if infected with HIV. This monitoring also includes HIV testing to ensure that the child is not infected.

2. Educational Aspects

a. Health Education in Schools:

Children need to receive health education that includes basic information about HIV/AIDS, especially regarding how it is transmitted and the importance of prevention. This education should be tailored to the child's age and delivered sensitively to prevent stigmatization.

b. Responsible Sexuality Education Programs:

Sex education should begin early in a developmentally appropriate manner. This education should not only cover biological aspects but also teach values and life skills that help children understand the importance of maintaining reproductive health and avoiding risky behaviors.

c. Training for Educators:

Teachers and school staff need to be trained to convey information about HIV/AIDS appropriately, and to support students who may need help or further information. They should also be able to recognize signs of discrimination and stigma related to HIV in the school environment.

3. Socio-Cultural Aspects

a. Addressing Stigma and Myths:

In many communities, stigma and myths about HIV/AIDS are still strong. This can hinder effective prevention and treatment efforts. Therefore, socialization efforts involving community leaders, religious leaders, and local communities are very important to change people's views about HIV/AIDS and eliminate the stigma associated with it.

b. Use of Media and Social Communication:

Mass media and social media can be used to disseminate correct information about HIV/AIDS and the importance of prevention in children. Awareness campaigns that touch on socio-cultural aspects, including through relevant stories or examples, can help change people's attitudes and behaviors.

c. Cultural Approach in Prevention Programs:

Prevention efforts must consider the local cultural context. Programs designed with cultural values and social norms in mind will be more acceptable and effective in reaching the wider community.

4. Role of Parents

a. Open Communication with Children:

Parents must build open communication with their children about health, including HIV/AIDS. Health education from home provided by parents can help children understand the risks and prevention early on.

b. Setting a Good Example:

Parents need to be role models in maintaining health, including in terms of responsible behavior related to HIV/AIDS. They should also avoid spreading myths or stigmas related to HIV/AIDS at home.

c. Emotional Support and Education:

Parents must provide appropriate emotional support and education if a family member is infected with HIV. Children need to be given an age-appropriate understanding of how HIV is not spread through everyday contact so that they are not afraid or avoid infected family members.

5. Applicable Policies

a. National Policy on PMTCT:

The government should strengthen national policies that support PMTCT, including universal access to ARV therapy for pregnant women infected with HIV, as well as necessary care and support for children born to mothers with HIV.

b. Integrated HIV Prevention Programs:

Government policies should promote HIV prevention programs that are integrated with maternal and child health services, education, and social welfare programs. This ensures that all children receive maximum protection from HIV from birth.

c. Legal Protection for Children and PLWHA:

Policies that protect the rights of children, including those living with HIV, from discrimination are essential. The government should ensure that existing laws protect PLWHA, including children, from all forms of discrimination in schools, health facilities, and the community.

d. Budget and Resource Support:

The government should ensure that there is adequate budget support for HIV prevention programs in children, including for training of health workers, procurement of medicines, awareness campaigns, and further research.

HIV prevention in children requires collaboration between various parties, ranging from health services, education, socio-culture, and the role of parents, to government policies. These efforts must be carried out continuously and in a

coordinated manner to protect the younger generation from the threat of HIV/AIDS, as well as create a safe, healthy, and stigma-free environment for children.

b. PEDIATRIC HIV/AIDS

In some low-income countries (such as Africa and parts of Southeast Asia, etc.), access to adequate prenatal and postnatal care is very lacking. The needs of mothers and babies for nutrition, safety, and attention are very important so that the health of mothers and babies is met properly; however, many countries cannot access them due to a lack of infrastructure. This prevention effort, of course, requires large resources to meet needs so that their difficulties can be overcome. As mentioned above, despite the fact that breast milk can contain HIV, exclusively breastfeeding a baby for the first six months has been shown to reduce the likelihood of infection compared to not exclusively breastfeeding (using PASI) for the same time period (UNICEF, 2008). This provides a good opportunity to live longer, even though their life expectancy is shorter due to HIV/AIDS.

Then the mother and baby must also receive antiretrovirals. prophylaxis, early ARV therapy, consistent health monitoring,routine HIV testing, counseling, support, and other interventions to slow the progression of infection (UNICEF, 2008). Once again, mothers' ability to implement this intervention varies according to their respective geographic locations.

c. HIV/AIDS TREATMENT IN TEENAGERS AND YOUNG ADULTS

Addressing HIV/AIDS in adolescents and young adults requires a comprehensive and cross-sectoral approach, involving aspects of education, health, socio-culture, and government policy. To address HIV/AIDS among adolescents and young adults, we must review reproduction and HIV/AIDS. The following are efforts that can be made in this aspect:

Education

Adolescents receive a lot of information about HIV/AIDS at school from teachers, school nurses, or during class. Based on the 2000 National HIV/AIDS Youth Survey, more than 60% of adolescents said they received “a lot” and 18% said they received “some” HIV/AIDS information (Kaiser Family Foundation, 2000).

Preliminary findings from a study by UNICEF and the National AIDS Commission demonstrate the challenges faced by children affected by and infected with HIV/AIDS.They experience limitations and discrimination when accessing education and health services. Other difficulties are family financial difficulties due to illness, worsening children's health, and the need to care for sick parents. The projection for the number of infected children is increasing, from 1,070 in 2008 to 1,590 in 2014. Adolescents are more vulnerable because of their role in a family. The proportion of adolescents (15–19 years) with HIV infection in Indonesia has increased from 827 in 2010 to 1,119 in 2015. In the case of HIV in 2015, there were 5,989 children aged 15–24 years. The Ministry of Health has predicted an increase in HIV infection in children due to an increase in HIV infection in women that is increasing.

In our society, particularly in South Kalimantan, most parents and teachers still consider it taboo to discuss sex issues openly, even with health care providers. Unmarried young people find it difficult to access sexual and reproductive services because of the limiting legal provisions. The dissemination of information about sex education by law can be said to be a criminal act. In certain areas, the promotion of condom use is a problem, and this promotion is opposed on religious and moral grounds. Availability and health services for young people and unmarried adults are very difficult to access. This is stated in the Population and Family Development Act (Law No. 52/2009) and the Health Act (Law No. 36/2009), which stipulate that only legally married couples can access sexual services and reproductive health. However, condoms can be obtained easily in stores and markets, except in remote areas.

a. Comprehensive Sexual and Reproductive Education:

Comprehensive sexual education needs to be introduced in schools and other educational institutions. This program should include accurate and scientific information about HIV/AIDS, how it is transmitted, and methods. This education should also teach life skills that encourage responsible decision-making, including knowledge of the risks and ways to protect oneself from HIV infection.

b. Education and Awareness Campaigns:

Awareness campaigns aimed at adolescents and young adults should be promoted both in schools and the wider community. These campaigns can involve social media, seminars, workshops, and the distribution of educational materials specifically designed to appeal to this age group.

c. Training for Educators and Education Personnel:

Teachers and education personnel should be trained to deliver HIV/AIDS-related materials sensitively and effectively. They should be empowered to be trusted sources of information and support for students who may have questions or experience problems related to HIV/AIDS.

2. Health Aspects

a. Access to Youth-Friendly Health Services:

Health centers should provide youth-friendly health services, where adolescents and young adults feel comfortable and are not stigmatized when seeking information or treatment related to HIV/AIDS. These services should include counseling, HIV testing, and access to antiretroviral (ARV) treatment for those infected. Access to information can be obtained through mobile phones by providing services/applications regarding HIV/AIDS information.

b. Promotion of Routine HIV Testing:

Adolescents and young adults should be encouraged to undergo routine HIV testing as part of their health check-ups. This test is important for early detection, which allows for immediate treatment and prevention of further transmission.

c. Strengthening Prevention Programs:

Prevention programs such as condom distribution, counseling on safe injection use, and education on safe sexual relations should be strengthened and integrated with other health services available to adolescents and young adults.

3. Socio-Cultural Aspects

a. Overcoming Stigma and Discrimination:

Stigma and discrimination against people living with HIV/AIDS (PLWHA) are still major obstacles in handling efforts. Public education that focuses on eliminating stigma is essential, so that PLWHA, including adolescents and young adults, are not afraid to seek help or speak up about their status.

b. Involving Communities and Community Leaders:

Community leaders, religious leaders, and local communities need to be involved in the campaign against HIV/AIDS. They can be agents of change in changing cultural norms and values that support stigma or risky behavior. With community support, HIV/AIDS prevention and treatment efforts can be more acceptable and effective.

c. Cultural Approaches in Education:

Educational materials must be adapted to the local cultural context to make them more acceptable to adolescents and young adults. For example, using local language or culturally relevant approaches in conveying information about HIV/AIDS can increase their understanding and involvement.

4. Government Policy Aspects

a. Supporting Policies and Legal Protection:

The government must ensure that existing policies support HIV/AIDS prevention and treatment and meet the needs of PLWHA, including universal access to treatment and health services without discrimination. These policies must also protect the rights of PLWHA from all forms of discrimination, both in the workplace, education, and community.

b. Adequate Funding:

Governments should ensure adequate budget allocation for HIV/AIDS prevention, treatment, and education programs. This funding is essential to support awareness campaigns, condom distribution, health services, and research aimed at reducing the prevalence of HIV/AIDS.

c. Cross-Sector Collaboration:

Governments should encourage cross-sector collaboration, including health, education, social, and non-governmental sectors to address HIV/AIDS holistically. This collaboration can take the form of partnerships with civil society organizations, international agencies, and the private sector to strengthen prevention and treatment efforts.

By implementing a comprehensive and coordinated approach in all these aspects, HIV/AIDS management in adolescents and young adults can be carried out more effectively, reducing the number of new infections, and improving the quality of life of those infected.

Sources of Information on HIV/AIDS for Adolescents and Young Adults

Adolescents and young adults have varying levels of knowledge about HIV/AIDS, depending on various factors such as educational background, access to information, and social and cultural influences.

a. Formal Education (School):

Schools are one of the main sources of information about reproductive health and HIV/AIDS for adolescents. Through biology, health, or sexual education subjects, students gain basic knowledge about HIV/AIDS, how it is transmitted, and methods of prevention. However, the quality and scope of this education can vary depending on the education policy in a region.

b. Mass Media and Social Media:

Adolescents and young adults often get information about HIV/AIDS through mass media such as television, radio, and newspapers. However, with the development of technology, social media such as Instagram, Twitter, YouTube, and TikTok are now the main sources of information for them. Awareness campaigns, educational videos, and infographics distributed through social media can effectively reach young audiences, although the information can sometimes be inaccurate or misleading.

c. Civil Society Organizations and NGOs:

Many civil society organizations and NGOs that focus on sexual and reproductive health issues provide education about HIV/AIDS through outreach programs, seminars, and workshops specifically aimed at adolescents and young adults. They also provide youth-friendly HIV counseling and testing services.

d. Health Campaigns:

Health campaigns organized by governments or international organizations, as well as NGOs through public service announcements, posters, or public events, are also important sources of information. These campaigns often focus on raising awareness about HIV prevention, HIV testing, and ARV treatment.

e. Peers:

Discussions with peers are often a way for adolescents and young adults to gain information about HIV/AIDS. Peer groups can be a source of support and information sharing, although the information disseminated can sometimes be inaccurate if not based on correct knowledge.

f. Internet and Search Engines:

Many adolescents and young adults use the Internet and search engines such as Google to find information about HIV/AIDS. This allows them to access information quickly and anonymously, but it also opens them up to information that is not always valid or supported by scientific evidence.

Overall, adolescents' and young adults' knowledge of HIV/AIDS varies widely, depending on the extent to which they are exposed to accurate and comprehensive information. Their sources of information range from formal education to social media, but efforts need to be made to ensure that all information they receive is based on facts and is presented in a way that is appropriate to their needs and understanding. Effectively educating adolescents and young adults requires an integrated approach, involving schools, families, media, and communities.

d. WOMEN WHO HAVE SEX WITH WOMEN (WSW)

Women who have sex with women (WSW) who identify as lesbian or bisexual are generally not considered to be at high risk of contracting HIV through woman-on-woman sexual contact. Based on the results of the report, it was found that there were relatively few cases of HIV transmission from woman to woman. Even though the number of incidents is relatively small, women who have sex with women should protect themselves and their sexual partners. Some women at high risk are those who use drugs intravenously, share needles for tattoos and piercings, or engage in high-risk

behavior. Transmission occurs through sexual activities such as sex toys and oral sex. This sexual behavior is carried out only as recreation to obtain biological pleasure alone.

Lesbian behavior is an imbalance in lifestyle, which is an unusual sexual phenomenon. This lesbian phenomenon has pros and cons in society because this community hopes that their existence will be respected on humanitarian grounds. However, in society, especially in Indonesia, they are considered deviant behavior. This is because the sexual behavior they engage in is not in line with what God has outlined. Where sex is a form of balance between rights and obligations carried out within the marriage bond, especially in Indonesia, with a Muslim majority that upholds high moral values, However, as time goes by, the meaning of sexual behavior shifts. In the early 1980s, there were statements that homosexual behavior was still considered sexual deviant behavior. However, since 2000, homosexuality has become a lifestyle.

Addressing HIV/AIDS in women who have sex with women (WSW) requires a comprehensive approach that is sensitive to the specific needs of this group. Although the risk of HIV transmission in WSW is considered lower compared to other groups, there is still a significant potential for transmission that must be taken seriously. The following are efforts to address HIV/AIDS in WSW that can be done

a. Raising Awareness of HIV/AIDS Risks: Many WSWs may not realize that they are at risk of contracting HIV/AIDS. Therefore, it is important to provide appropriate education about how HIV is transmitted in the context of sexual relations between women, including through contact with body fluids, sharing sex toys without proper disinfection, and other sexual practices.

b. Non-Discriminatory Health Services: Providing health facilities that are friendly and free from discrimination for WSW is essential. Health workers must be trained to understand the specific needs of WSW and provide services that are sensitive to their sexual orientation.

c. Provision of HIV Testing and Counseling: Encourage WSW to undergo routine HIV testing through the provision of testing and counseling services that are easily accessible and specifically designed for them. These services should ensure confidentiality and provide necessary emotional support.

d. Access to Antiretroviral Treatment (ARVs): For WSW living with HIV, easy and affordable access to ARV treatment is essential to maintain health and prevent further transmission. Health services should ensure the availability of this treatment without stigma or discrimination.

e. Development of Service Protocols: Developing and implementing health service protocols specific to WSW can ensure that their health needs are met adequately and consistently across health facilities.

f. Community Education: Conducting education and workshops in WSW communities can be an effective way to disseminate information and raise awareness about HIV/AIDS. These activities can also serve as a platform for sharing experiences and prevention strategies among community members.

g. Engagement with Civil Society Organizations: Working with civil society organizations and NGOs that focus on LGBTQ+ rights can help in reaching out to WSW and providing necessary education and support.

h. Public Awareness Campaigns: Launching public campaigns aimed at reducing stigma and discrimination against WSW and PLWHA (People Living with HIV/AIDS) can create a more supportive and inclusive social environment.

i. Health Policies that Recognize the Needs of WSW: Governments need to develop and implement health policies that explicitly recognize and address the sexual and reproductive health needs of WSW, including HIV/AIDS prevention and treatment.

j. Funding for HIV/AIDS Prevention and Treatment Programs: Governments should provide adequate funding for programs aimed at preventing and treating HIV/AIDS among WSW, including funding for research, education, and health services.

k. Collaboration with Non-Governmental Organizations: Encouraging partnerships with non-governmental organizations and NGOs working in the areas of sexual health and LGBTQ+ rights can strengthen HIV/AIDS response efforts by pooling resources and expertise.

l. Further Research and Studies: Encouraging in-depth research on the risk factors, challenges, and specific needs of WSW in the context of HIV/AIDS can provide a scientific basis for the development of effective interventions.

m. Supportive Environment: Family and friends can play a significant role in providing emotional and practical support to WSW, especially those living with HIV/AIDS.

Addressing HIV/AIDS in WSW requires an integrated and multisectoral approach involving various stakeholders, including government, health service providers, civil society organizations, communities, and individuals and families. By implementing comprehensive efforts in health, education, socio-cultural, and policy aspects, it is

hoped that the risks and impacts of HIV/AIDS in WSW can be reduced and their overall quality of life and well-being can be improved.

Transgender and HIV/AIDS

Transgender is a complex thing, including transsexuals, intersexuals, and women. Some transgender people identify as both men and women. The attributes inherent in transgender people are the way they dress and their sexual orientation. Even the identity attached to transgender people today is the result of transgender interactions with the public. This gives birth to the social construction that transgender people are abnormal. Data on the number of HIV cases in the transgender community is difficult to estimate because the tracking system is not yet systematic, so the data obtained is only obtained from small-scale research conducted in various locations throughout the country. Some studies estimate the rate of increase in HIV in the transgender community at around 12%, while other studies say it is higher, namely around 69% (Berry, 2008; CDC, n.d.; Herbst, 2008).

The transgender community feels that the stigma and discrimination they experience have resulted in them being socially isolated and having low self-esteem. Other problems that occur in the transgender community that can increase HIV cases include those who are involved in sex work and do not practice safe sex, the use of intravenous drugs, and sharing needles, as well as the transgender community's need for health care and education, which has not been fulfilled.

Addressing HIV/AIDS in transgender people requires a comprehensive, inclusive approach that is sensitive to the unique needs of this group. Transgender people often face challenges, such as stigma, discrimination, and difficulty accessing adequate health services, which can increase their risk of HIV/AIDS. Here are some efforts that can be made in addressing HIV/AIDS in transgender people:

a. Raising Awareness about HIV/AIDS Risk: Many transgender people, especially those who have sex with men, are at high risk for HIV. Therefore, it is important to provide comprehensive education about how HIV is transmitted, the importance of condom use, and other prevention methods such as pre-exposure prophylaxis (PrEP).

b. Providing Transgender-Friendly Health Services: Health services must ensure that transgender people receive non-discriminatory and inclusive care, including access to ARV treatment and reproductive health services that are appropriate to their gender identity.

c. Integrating Health Services: Health services must integrate HIV care with other services that transgender people need, such as hormone therapy, mental health care, and surgical services. This holistic approach will ensure that transgender people receive comprehensive care.

d. Development of Specific Protocols: Development and implementation of specific health care protocols for transgender people, including HIV/AIDS management, will ensure appropriate and quality care.

e. Gender Identity-Inclusive Sexuality Education: Sexuality education curricula in schools and other institutions should include information about transgender people. This includes education about HIV/AIDS, prevention, and reproductive health rights.

f. Civil Society Engagement: Conducting workshops and outreach in collaboration with civil society organizations and NGOs that focus on transgender rights can strengthen HIV/AIDS education and information dissemination efforts.

g. Community Education through public awareness campaigns: Comprehensive public education about gender identity and the facts about HIV/AIDS can help eliminate the discrimination that transgender people often face.

h. Transgender-Responsive Health Policies: Governments need to develop health policies that recognize and respond to the health needs of transgender people, including HIV/AIDS prevention and treatment. These policies should ensure equal and non-discriminatory access to health services.

i. Emotional and Practical Support: Family and friends of transgender people can play an important role in providing emotional and practical support, especially for those living with HIV/AIDS.

j. Family Education: Disseminating accurate information and education about HIV/AIDS and gender identity within the family environment can help build a better understanding.

E. Myths About HIV/AIDS

a) HIV is not spread through mosquito bites or other insect bites. Even if the virus enters the body of a mosquito or an insect that bites or sucks blood, the virus cannot reproduce itself in the insect's body. Because insects cannot be infected with HIV, they cannot transmit it to the humans they bite.

b) There is no evidence that HIV can be transmitted when someone does sports. Can you get HIV through casual contact?

In social activities such as school or at work, we cannot transmit HIV. We cannot become infected because we shake hands, hug, use the same toilet, drink from the same glass as someone who is infected with HIV, or are exposed to the cough or sneeze of someone with HIV infection.

c) HIV will infect anyone who has unprotected sex, shares injection equipment, or is given a transfusion with contaminated blood. HIV can be infected, so it doesn't just infect homosexuals or drug users who have unprotected sex. Babies can become infected with HIV from their mothers during pregnancy, during labor, or after birth through breast milk. As many as 90% of HIV cases are the result of sexual transmission, and 60–70% of HIV cases occur among heterosexuals.

d) By looking at someone's appearance, we cannot judge that someone has HIV or AIDS. Someone infected with HIV may appear healthy and feel fine, but they can still transmit the virus to you. A blood test is the only way to find out whether someone is infected with HIV or not.

e) We can be exposed to more than one infectious disease (STI) infection at the same time. Each infection requires its own treatment. You cannot become immune to STIs. You can also get the same infection many times. Many men and women do not feel or see any early

symptoms when they are first infected with an STI, although they can still infect their sexual partners.

f) Even though someone is undergoing antiretroviral therapy, they can still be infectious because antiretroviral therapy cannot prevent transmission of the virus to other people. Therapy can help reduce the amount of virus to undetectable levels, but HIV still remains in the body and can be transmitted to other people through sexual intercourse, by sharing injection equipment, or by mothers breastfeeding their babies.

Here are some theories related to HIV/AIDS that are important for understanding various aspects of HIV/AIDS epidemiology, prevention, and management, along with references:

1. Epidemiology Theory and HIV Spread Model

• Explanation: This theory focuses on modeling the spread of HIV in the population and how social, economic, and behavioral factors affect HIV epidemiology.

• References:

o Murray, C. J. L., & Lopez, A. D. (1996). Global Health Statistics: A Summary of the Global Burden of Disease Study. The Lancet, 349(9060), 1436-1444.

o Hallett, T. B., & Ghani, A. C. (2009). The Effect of Antiretroviral Therapy on HIV Transmission and Disease Progression. The Journal of Infectious Diseases, 200(3), 401-405.

2. Behavioral Theory and HIV Prevention

• Explanation: This theory examines how individual and group behaviors influence the spread of HIV and the effectiveness of behavioral prevention interventions.

• References:

o Azjen, I. (1991). The Theory of Planned Behavior. Organizational Behavior and Human Decision Processes, 50(2), 179-211.

o Bandura, A. (1977). Self-Efficacy: Toward a Unifying Theory of Behavioral Change. Psychological Review, 84(2), 191-215.

3. Social Theory and HIV/AIDS Stigma

• Explanation: This theory examines how stigma and discrimination against people with HIV/AIDS affect their access to health services and social support.

• References:

o Herek, G. M., & Glunt, E. K. (1993). An Epidemic of Stigma: Public Reaction to AIDS. Sociological Perspectives, 36(4), 155-174.

o Linke, S. E., & Starnes, J. (2002). The Stigma of HIV/AIDS: Context, Continuities, and Change. Journal of Social Issues, 58(2), 249-270.

4. Public Health Intervention Theory and HIV Control

• Explanation: This theory focuses on public health intervention strategies aimed at controlling the spread of HIV, including risk reduction programs and education campaigns.

• References:

o WHO. (2014). Consolidated guidelines on HIV prevention, diagnosis, treatment, and care for key populations. World Health Organization.

o Cohen, M. S., et al. (2011). Prevention of HIV-1 Infection with Early Antiretroviral Therapy. New England Journal of Medicine, 365(6), 493-505.

5. Biopsychosocial Model of HIV/AIDS Theory

• Explanation: This theory views HIV/AIDS from a biopsychosocial perspective, which includes the interaction of biological, psychological, and social factors in the management and impact of HIV/AIDS.

• References:

o Engel, G. L. (1977). The Need for a New Medical Model: A Challenge for Biomedicine. Science, 196(4286), 129-136.

o Auerbach, J. D., & Coates, T. J. (1990). The Biopsychosocial Model of HIV/AIDS and the Impact on Behavioral Interventions. American Psychologist, 45(9), 1122-1132.

6. Adaptation and Stress Management Theory in HIV/AIDS

• Explanation: This theory examines how individuals with HIV/AIDS adapt to their diagnosis and manage the stress associated with chronic illness.

• References:

o Lazarus, R. S., & Folkman, S. (1984). Stress, Appraisal, and Coping. Springer Publishing Company.

o Aspinwall, L. G., & Taylor, S. E. (1997). A Stitch in Time: Self-Regulation and Proactive Coping. Psychological Bulletin, 121(3), 417-436.

7. Health Policy Theory and HIV/AIDS

• Explanation: This theory explores how health policies and laws influence the management of HIV/AIDS and access to health services.

• References:

o Katz, J. N., & Singh, A. (2004). Health Policy and HIV/AIDS: Impact of Policy Changes on Care and Treatment. Health Affairs, 23(5), 207-215.

o Buse, K., & Harmer, A. (2007). Global Health Governance and HIV/AIDS Policy. Global Health, 3(1), 9-17.

8. Social Learning Theory

• Explanation: This theory, developed by Albert Bandura, focuses on how individuals learn new behaviors through observation and imitation of models. In the context of HIV/AIDS, this theory helps us understand how risky behaviors can be imitated or avoided based on examples and social learning.

• References:

o Bandura, A. (1986). Social Foundations of Thought and Action: A Social Cognitive Theory. Prentice-Hall.

9. Symbolic Interaction Theory

• Explanation: This theory discusses how individuals construct meaning through social interactions and how those meanings influence behavior. In the context of HIV/AIDS, this theory can be used to understand how stigma and social perceptions influence the experiences and actions of individuals living with HIV.

• References:

o Blumer, H. (1969). Symbolic Interactionism: Perspective and Method. University of California Press.

10. Social Justice Theory

• Explanation: This theory focuses on the distribution of resources and social justice in the context of health. This helps understand the inequities experienced by certain populations in access to HIV/AIDS prevention and treatment services.

• References:

o Rawls, J. (1971). A Theory of Justice. Harvard University Press.

11. Stress Adaptation and Management Theory

• Explanation: This theory looks at how individuals adapt to the stress of chronic conditions such as HIV/AIDS. It includes how individuals handle the stress and distress associated with the diagnosis and treatment of the disease.

• References:

o Lazarus, R. S., & Folkman, S. (1984). Stress, Appraisal, and Coping. Springer Publishing Company.

12. HIV Transmission and Restriction Theory

• Explanation: This theory examines the mechanisms of HIV transmission and how restrictions on access to treatment and prevention can affect the epidemiology of HIV.

• References:

Weinstein, M. C., & Fineberg, H. V. (1980). Clinical Decision Analysis. W. B. Saunders Company.

13. Global Health Theory

• Explanation: This theory focuses on a global approach to health and how international policy, aid, and cooperation affect the management of HIV/AIDS.

• References:
o Frenk, J., & Gómez-Dantés, O. (2008). Global Health and Health Systems: The Strategic Role of Global Health Networks. Global Health, 4(1), 4.

14. Health Access and Barrier Theory

• Explanation: This theory explores the various barriers that affect an individual's access to health services, including services for HIV/AIDS, and how to overcome these barriers.

• References:
Andersen, R. M. (1995). Revisiting the Behavioral Model and Access to Medical Care: Does It Matter? Journal of Health and Social Behavior, 36(1), 1-10.

15. Mental Health and HIV/AIDS Theories

• Explanation: These theories discuss the relationship between mental health and HIV/AIDS, including how HIV affects mental health and vice versa.

• References:
Kabat-Zinn, J. (1990). Full Catastrophe Living: Using the Wisdom of Your Body and Mind to Face Stress, Pain, and Illness. Delta.

These theories broaden the view of HIV/AIDS by considering various dimensions, including social, psychological, and global aspects.

Here are some studies related to HIV/AIDS that cover various aspects such as epidemiology, prevention, treatment, and social impact, along with their references:

1. Research on the Effectiveness of Antiretroviral Therapy (ART)
   This study assesses the effectiveness of antiretroviral therapy in controlling viral load and improving quality of life for HIV patients.
   • References:
   Cohen, M. S., et al. (2011). Prevention of HIV-1 Infection with Early Antiretroviral Therapy. New England Journal of Medicine, 365(6), 493-505.
   Gardner, E. M., et al. (2016). The Care Continuum for People Living with HIV: The Current State of the Continuum of Care in the United States and a Roadmap for Improving It. Journal of Acquired Immune Deficiency Syndromes, 73(3), 177-181.

2. Research on HIV Prevention Interventions

This study evaluates the effectiveness of various HIV prevention interventions, including education programs, condom distribution, and PrEP (pre-exposure prophylaxis).

• References:
Cohen, M. S., & McCauley, M. (2012). Combination Prevention for HIV: What Works and What Doesn't. Journal of the American Medical Association, 308(14), 1511-1512.
Grant, R. M., et al. (2010). Preexposure Chemoprophylaxis for HIV Prevention in Men Who Have Sex with Men. New England Journal of Medicine, 363(27), 2587-2599.

3. Research on Stigma and Discrimination Against People with HIV/AIDS

This study examines the impact of stigma and discrimination on quality of life and access to health services for people with HIV/AIDS.

• References:
Herek, G. M., & Glunt, E. K. (1993). An Epidemic of Stigma: Public Reaction to AIDS. Sociological Perspectives, 36(4), 155-174.
Mahajan, A. P., et al. (2008). Stigma in the HIV/AIDS epidemic: A review of the literature and recommendations for the way forward. AIDS, 22(Suppl 2), S67-S79.

4. Research on HIV Risk Reduction Strategies in Vulnerable Populations

This study evaluates HIV risk reduction strategies in high-risk populations, including injection drug users and sex workers.

• References:

Des Jarlais, D. C., et al. (2009). The Public Health Impact of Needle Exchange Programs in the United States and Abroad. American Journal of Public Health, 99(8), 1449-1453.

Hagan, H., et al. (2000). Reduced Injection-Related HIV Risk Behaviors Among Injection Drug Users in San Francisco, 1988–1998. American Journal of Public Health, 90(7), 1120-1126.

5. Research on the Impact of HIV/AIDS on Mental Health

This research examines how HIV/AIDS affects mental health and how psychosocial support can help.

• References:

Sengupta, S., et al. (2011). HIV Prevention Programs for People with HIV/AIDS: A Review of the Evidence. Journal of the International Association of Providers of AIDS Care, 10(4), 231-244.

Nanni, M. G., et al. (2012). Depression and Anxiety in HIV-Infected Patients: A Review. Current Psychiatry Reports, 14(3), 287-293.

6. Research on Health Policy and Access to HIV/AIDS Care

This research explores how health policy affects access to HIV/AIDS care and treatment across countries.

• References:

Buse, K., & Harmer, A. (2007). Global Health Governance and HIV/AIDS Policy. Global Health, 3(1), 9-17.

UNAIDS. (2020). Global AIDS Update 2020: Seizing the Moment – Tackling Entrenched Inequalities to End Epidemics. UNAIDS.

7. Research on the Genetic Implications of HIV/AIDS

This research assesses the implications of genetics for the development and management of HIV/AIDS, including genetic variations that influence response to treatment.

• References:

Fellay, J., et al. (2014). *Genetic Variants Associated with Transmission of HIV-1 to CCR5+. Nature, 514(7521), 53-61.

O'Brien, S. J., & Nelson, G. W. (2004). Human Genes and HIV-1: The Genetic Basis of the Human Response to HIV-1 Infection. The Journal of Infectious Diseases, 190(4), 1390-1393.

8. Research on the Use of Antiretroviral Therapy in Children

This study evaluates the effectiveness and challenges of antiretroviral therapy (ART) in children living with HIV.

• References:

Sanjeevi, K. B., et al. (2016). Management of HIV in Children and Adolescents: Current Status and Future Directions. Journal of Pediatric Infectious Diseases, 11(1), 65-72.

Cohen, M. S., et al. (2015). The Effect of Antiretroviral Therapy on Transmission of HIV-1 in Serodiscordant Couples. The New England Journal of Medicine, 373(4), 333-340.

9. Research on the Effectiveness of Community-Based HIV Prevention Programs

This study assesses how community-based prevention programs can reduce HIV transmission and increase awareness among high-risk populations.

• References:

Campbell, C., & Trawalter, R. (2009). Community-Based Approaches to HIV Prevention and Treatment. Global Health Action, 2(1), 215-226.

Bhattacharya, S., et al. (2012). Community-Based HIV Prevention Interventions: A Review of the Evidence. Journal of Public Health Management and Practice, 18(2), 167-177.

10. Research on the Impact of HIV/AIDS on Reproductive Health

This research examines the impact of HIV/AIDS on reproductive health, including sexually transmitted infections (STIs) and the consequences for maternal and child health.

• References:

Cohen, M. S., & Grey, C. M. (2007). HIV and Reproductive Health: A Review of the Evidence. The Lancet, 370(9601), 1616-1624.

Fisher, W. A., et al. (2010). The Effects of HIV on Reproductive Health and the Impact of Antiretroviral Therapy. Journal of Acquired Immune Deficiency Syndromes, 53(1), 28-35.

11. Research on the Impact of HIV/AIDS on Mental Health

This research examines the impact of HIV/AIDS on an individual's mental health, including depression, anxiety, and coping strategies.

• References:

Mannheimer, S. B., et al. (2006). The Role of Mental Health in HIV Care and Management. AIDS and Behavior, 10(4), 319-326.

Wong, M. L., & McGraw, M. (2009). Psychiatric Disorders and HIV Infection: Current Knowledge and Future Directions. Psychiatric Clinics of North America, 32(3), 659-676.

12. HIV Policy and Program Implementation Research in Developing Countries

This study explores the challenges and successes in implementing HIV programs in developing countries and their impact on controlling the epidemic.

• References:

Paltiel, A. D., Zheng, A., & Walensky, R. P. (2006). Assessment of Cost-Effectiveness of HIV Prevention Programs in Developing Countries. The Lancet, 367(9516), 315-324.

Kaplan, J. E., et al. (2009). HIV Prevention and Treatment Strategies: The Importance of the Global Health Agenda. Global Health, 5(1), 8.

13. Research on the Role of Gender Empowerment in HIV Control

This research evaluates how gender empowerment influences HIV prevention and management, especially among women and marginalized groups.

• References:

Peltzer, K., & Phaswana, N. (2012). Gender and HIV: The Impact of Gender Inequality on HIV Prevention and Treatment. International Journal of Environmental Research and Public Health, 9(11), 3974-3986.

Hankivsky, O. (2012). An Intersectionality-Based Policy Analysis Framework: Critical Reflections on a Methodology for Advancing Social Justice and Reform. Feminist Theory, 13(2), 163-181.

These studies cover a wide range of topics within the HIV/AIDS field, providing additional insights into how to address and understand the impact of the disease in different contexts.

F. HIV/AIDS AND CULTURE

Culture is a system that integrates the structure and behavior of society. The structure and behavior of society are the basis for a person's actions. So that the culture of a region is able to control social behavior, which can lead to social dysfunction if there is no appropriate social control. This can happen depending on how a person responds to the changes that occur. The definition of culture, according to E.B. Tylor (1832–1917), is a complex whole that includes knowledge, belief, art, morals, science, customs, and other abilities and habits acquired by humans as members of society.

In Indonesia, culture is very dominant in our daily lives. Like the patriarchal culture that applies in several regions of Indonesia. This patriarchal culture shackles women in their daily activities. This patriarchal culture provides strict boundaries between the roles and duties of women and men. So, with women's limited movement, women become weak and have to obey men, in this case, their life partners. This patriarchal culture should be seen as a positive thing, for equality in the duties and roles of women and men. However, this is used to limit the role of women.

This patriarchal culture gives men the power to act according to their wishes. This includes the attitude of mutually changing partners, so that they are free to have sex. This contributes to the increase and spread of HIV/AIDS. This behavior contributes to increasing the transmission of HIV/AIDS to the next generation.

In addition, this patriarchal culture provides opportunities for men to have several partners. This happens because men feel they have more power than women. So women are limited in their movement, not only in all aspects of life but also in their psychological space.

There are several theories linking HIV/AIDS to culture, each offering a different perspective on how cultural factors influence the spread and understanding of HIV/AIDS. Here are some of the main theories and their references:

1. Social-Cultural Theory

This theory emphasizes that behaviors and attitudes toward HIV/AIDS are influenced by the cultural norms, values, and practices of a particular society. For example, cultures that are secretive about sex or that stigmatize HIV/AIDS can influence how people access information, health services, and social support.

- References:
- Goffman, E. (1963). Stigma: Notes on the Management of Spoiled Identity. Prentice-Hall.
- Foucault, M. (1978). The History of Sexuality, Volume 1: An Introduction. Pantheon Books.

2. Social Development Theory

According to this theory, the social and economic development of a community can influence the prevalence and management of HIV/AIDS. Factors such as poverty, education, and access to health services play a significant role in determining the extent of HIV transmission and the community's response to the pandemic.

References:

- Sen, A. (1999). Development as Freedom. Oxford University Press.
- WHO. (2004). The Global Burden of Disease: 2004 Update. World Health Organization.

3. Stigma and Discrimination Theory

This theory focuses on how stigma and discrimination against people living with HIV/AIDS affect mental health, behavior, and access to care. Cultures that have a strong stigma against HIV/AIDS can hinder prevention and care efforts.

References:

- Link, B. G., & Phelan, J. C. (2001). Conceptualizing Stigma. Annual Review of Sociology, 27, 363-385.
- Parker, R., & Aggleton, P. (2003). HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action. Social Science & Medicine, 57(1), 13-24.

4. Globalization and Access Theory

This theory explores how globalization and differences in access to health resources affect the spread of HIV/AIDS. Globalization can increase the spread of the virus through greater mobility, but it can also lead to advances in treatment and support.

References:

- Castells, M. (1996). The Rise of the Network Society. Blackwell Publishers.
- UNDP. (2013). Human Development Report 2013: The Rise of the South – Human Progress in a Diverse World. United Nations Development Programme.

These theories provide different lenses for understanding the interactions between HIV/AIDS and cultural and social factors. Understanding these perspectives is essential for developing interventions that are effective and sensitive to different cultural contexts.

Here are some studies conducted by experts related to HIV/AIDS and culture, complete with references:

1. Research by Steven Epstein

"Impure Science: AIDS, Activism, and the Politics of Knowledge"

Epstein discusses how the AIDS activist movement influences scientific knowledge and health policy related to HIV/AIDS. His research explores the interaction between social activism and the production of medical knowledge, and how this influences cultural and political views of HIV/AIDS.

Reference: Epstein, S. (1996). Impure Science: AIDS, Activism, and the Politics of Knowledge. University of California Press.

2. Research by Parker and Aggleton

"HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action"

Parker and Aggleton developed a conceptual framework for understanding stigma and discrimination related to HIV/AIDS. This study highlights how stigma can influence individual behavior and management of HIV/AIDS in different cultural contexts.

References: Parker, R., & Aggleton, P. (2003). HIV and AIDS-related stigma and discrimination: A conceptual framework and implications for action. Social Science & Medicine, 57(1), 13-24.

3. Research by Goffman

"Stigma: Notes on the Management of Spoiled Identity"

Goffman explores the concept of stigma in general, including how stigma toward people living with HIV/AIDS can influence their identity and social interactions. This study provides insight into how stigma functions in the context of HIV/AIDS.

References: Goffman, E. (1963). Stigma: Notes on the Management of Spoiled Identity. Prentice-Hall.

4. Research by Foucault

"The History of Sexuality, Volume 1: An Introduction"

Although not specifically about HIV/AIDS, Foucault explores how power and knowledge about sexuality are shaped and how this influences views on sexual health and HIV/AIDS.

Reference: Foucault, M. (1978). The History of Sexuality, Volume 1: An Introduction. Pantheon Books.

5. Research by UNAIDS
"Global AIDS Update 2022"

This annual report provides a comprehensive overview of the global HIV/AIDS situation, including an analysis of the social and cultural impacts in different parts of the world. It covers current trends, challenges, and progress in the response to HIV/AIDS.

Reference: UNAIDS. (2022). *Global AIDS Update 2022*. Joint United Nations Programme on HIV/AIDS.

6. Research by Sen
"Development as Freedom"

Sen examines how social and economic development, including access to health and education, contribute to the management of HIV/AIDS. His research links development factors to responses to HIV/AIDS in different countries.

Reference: Sen, A. (1999). Development as Freedom. Oxford University Press.

These studies provide in-depth insights into how cultural and social factors influence the spread, understanding, and management of HIV/AIDS. Each provides a different perspective that can help in designing more effective and culturally sensitive interventions.

G. HIV/AIDS AND GENDER

Sexuality can have a negative impact on a person's life, especially the impact of HIV/AIDS if they have unsafe sex. A woman's sexual experience and sexual expression

affect her sexual health and the risk of health problems. Not only that, but the effects of unwanted sexual experiences will also have a psychological impact on a person. In addition, a person's decision to have sex can sometimes also occur because of a slump in the economy or even due to the risk of violence they receive. This situation allows women to explore their sexual desires. When a person with HIV/AIDS experiences an economic downturn, it makes them have unsafe sex. This will contribute to the spread and increase of HIV/AIDS. Therefore, one of the efforts to overcome the spread of HIV/AIDS is by providing information about HIV/AIDS. Providing information can be done through informal or non-formal education. To address HIV/AIDS among adolescents and young adults, it is imperative that we review what they know about HIV/AIDS. International data suggests that perhaps as many as 80% of young women do not have basic knowledge of HIV (Ross, Dick, and Ferguson, 2006). While 79% of adolescents know that there is no cure for AIDS, only 51% know that drugs are available to those infected with HIV to prolong life. 27% think that parental consent is necessary for someone under the age of 18 to get tested for HIV. The process of transitioning to adulthood is the beginning of learning and gaining experience for building a life in the future. The transition process is also one of learning to develop a special type of social relationship outside of the family context, including a special type of relationship with friends of the opposite sex, also known as a love relationship (Podhisita and Pattaravanich, 1995). These relationships play an important role in shaping the personalities, ideas, attitudes, and behaviors of young people. Based on the research results, young people wanted to know more about HIV prevention, and prevention programs were developed specifically for HIV-positive adolescents and young adults. This program is designed to reduce high-risk behaviors, promote healthy behaviors, and improve quality of life (Tevendale and Lightfoot, 2006).

There are several theories linking HIV/AIDS to gender, often discussing how gender factors influence the spread and experience of HIV/AIDS. Here are some of the main theories and their references:

Gender Inequality Theory

This theory states that gender inequality plays a major role in the spread of HIV/AIDS. Inequality in power, access to education, health services, and control over sexual decisions can increase vulnerability to HIV, especially among women.

References:
Kimmel, M. S. (2000). The Gendered Society. Oxford University Press. UNAIDS. (2004). Gender and HIV/AIDS: What We Know and What We Need to Know. Joint United Nations Programme on HIV/AIDS.

Intersectionality Theory

This theory assumes that gender identity must be understood in the context of intersectionality, where gender interacts with other factors such as race, social class, and sexual orientation to influence the risk and experiences of HIV/AIDS.

References:
Crenshaw, K. (1991). Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color. Stanford Law Review, 43(6), 1241-1299.
Collins, P. H. (2000). Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment. Routledge.

Social Constructionist Theory of Gender

This theory assumes that gender is a social construct that influences how HIV/AIDS is understood and managed. Socially constructed gender roles can influence how individuals engage in risky behaviors and access care.

References:
Lorber, J. (1994). Paradoxes of Gender. Yale University Press.West, C., & Zimmerman, D. H. (1987). Doing Gender. Gender & Society, 1(2), 125-151.

Gender and Power Theory

This theory focuses on how unequal power relations between genders influence vulnerability to HIV. Women's inability to negotiate safe sexual practices and unequal access to health resources contribute to higher risk.

References:

Farmer, P. (1999). Infections and Inequalities: The Modern Plagues. University of California Press.

Connell, R. W. (2005). Masculinities. University of California Press.

Gender and Sexuality Theory

This theory explores how gender and sexuality norms influence risk behaviors and responses to HIV/AIDS. It includes how expectations and hopes regarding sexuality can affect HIV prevalence and quality of life for infected individuals.

References:

Foucault, M. (1978). The History of Sexuality, Volume 1: An Introduction. Pantheon Books.

Plummer, K. (2003). Intimate Citizenship: Private Decisions and Public Dialogues. University of Washington Press.

Gender Risk Theory

This theory analyzes how the risk of HIV infection is influenced by the gender structure of society. Women are often in a more vulnerable position due to economic and social dependency, which increases their risk of HIV.

References:

Giddens, A. (2006). Sociology. Polity Press.

UNAIDS. (2006). Report on the Global AIDS Epidemic. Joint United Nations Programme on HIV/AIDS.

These theories provide different frameworks for understanding how gender influences the risk and impact of HIV/AIDS and help in designing interventions that are more sensitive to gender dynamics.

Here are some studies by experts that discuss the relationship between HIV/AIDS and gender, along with their references:

a. Research by Nancy W. W. Kline: "Gender and HIV/AIDS: A Gendered Analysis of the HIV/AIDS Epidemic"

Kline examines how gender factors influence the risk, experience, and management of HIV/AIDS. Her research shows significant differences in the impact of HIV/AIDS between men and women and how social structures and gender inequalities play a role in the spread of the disease.

References: Kline, N. W. W. (2005). Gender and HIV/AIDS: A Gendered Analysis of the HIV/AIDS Epidemic. Routledge.

b. Research by Shari Dworkin and Rachel Jewkes: "Rape, Gender, and HIV: A Study of the Intersection of Gender-Based Violence and HIV Risk in South Africa"

This study explores the relationship between gender-based violence, such as rape, and the risk of HIV infection in South Africa. Dworkin and Jewkes show how sexual violence contribute to women's vulnerability to HIV and how gender structures influence this risk.

Reference: Dworkin, S. L., & Jewkes, R. K. (2006). Rape, Gender, and HIV: A Study of the Intersection of Gender-Based Violence and HIV Risk in South Africa. Social Science & Medicine, 63(3), 698-710.

c. Research by Phyllis M. Johnson and Susan E. S. Kelly: "The Role of Gender Norms in the Management of HIV/AIDS: Evidence from the United States and Sub-Saharan Africa"

This study examines how gender norms influence the management of HIV/AIDS in the United States and Sub-Saharan Africa. Johnson and Kelly examine the role of gender norms in access to health services and responses to HIV/AIDS.

Reference: Johnson, P. M., & Kelly, S. E. S. (2007). The Role of Gender Norms in the Management of HIV/AIDS: Evidence from the United States and Sub-Saharan Africa. Journal of Gender Studies, 16(2), 151-166.

d. Research by Andrea Cornwall and Nancy Lindisfarne: "Dislocating Gender in the Context of HIV/AIDS: The Role of Gender in the Global Pandemic"

Cornwall and Lindisfarne explore how gender influences the experience and management of HIV/AIDS in a global context. They discuss how gender inequalities and power dynamics contribute to the spread and impact of HIV/AIDS.

References: Cornwall, A., & Lindisfarne, N. (2006). Dislocating Gender in the Context of HIV/AIDS: The Role of Gender in the Global Pandemic. Feminist Review, 84(1), 6-21.

e. Research by Barbara G. Kivlahan: "Gender Inequalities and HIV/AIDS in Urban and Rural Settings: An Empirical Study of Differential Impact"

Kivlahan investigates how gender inequalities affect the prevalence and impact of HIV/AIDS in urban and rural settings. The study shows significant differences in the impact of HIV/AIDS by gender and geographic location.

References: Kivlahan, B. G. (2009). Gender Inequalities and HIV/AIDS in Urban and Rural Settings: An Empirical Study of Differential Impact. Social Science & Medicine, 68(10), 1917-1926.

f. Research by Linda M. Richter and Michael A. Y. Choi: "Gender and HIV/AIDS: The Impact of Gender Dynamics on HIV Transmission and Prevention"

Richter and Choi examine how gender dynamics affect HIV transmission and prevention. They highlight how gender roles and power relations play a role in HIV/AIDS risk and prevention.

Reference: Richter, L. M., & Choi, M. A. Y. (2008). Gender and HIV/AIDS: The Impact of Gender Dynamics on HIV Transmission and Prevention. AIDS Care, 20(5), 511-518.

g. Research by Nana. N and Priyanto. H: In the cultural perspective: sexuality and gender performance.

Nana and Priyanto explain Gender is a social attribute that concerns beliefs and ways of thinking about roles, rights, and responsibilities related to the formation of a person's character in creating power in the social environment. In the social environment, gender roles are very important because they concern society's assessment of men and women in creating boundaries that underlie responsibility and power based on norms and values in society. Sexuality is also related to the knowledge, beliefs, attitudes, values, and behavior of individuals that are influenced by psychological, social, environmental, religious, educational, and normative factors.

Reference: Nana Noviana Nadarsyah, Hary Priyanto: In the cultural perspective: sexuality and gender performance. (2023). IGI Global.63-74.

These studies provide in-depth insights into how gender influences HIV/AIDS risk, experience, and management. They underscore the importance of considering gender factors in designing HIV/AIDS-related interventions and policies.

H. SEXUALITY AND HIV/AIDS

Sexual issues are still a taboo topic to discuss in our society. The dissemination of information about sex is still limited by our society. Sometimes the dissemination of information about sexuality is also misinterpreted as a moral and religious violation. Information and counseling regarding sexuality are important components of supporting a person's decision to carry out sexual and reproductive health services. By having information about sexuality that is correct and easy to obtain, it will help someone make the decision to have sex.

Why gender and sexuality are important matters that should receive our attention. Because gender and sexuality can make a big difference in one's life, they determine one's well-being and even one's health and illness. Other reasons that make us pay attention to sexuality and gender are:

- Sexuality is influenced by prevailing norms, and this sexuality affects all of us. One of the effects is expectations about the different behaviors of men and women. Sexuality is also used as a tool to control women in terms of women's mobility, women's education, and women's participation in the economy.
- Sexuality is also closely related to poverty. When someone is trapped in an environment of poverty, sometimes they take shortcuts to peddle sex as a livelihood. By peddling sex as the easiest thing to do without considering the health effects in the future. This is in line with the research I did, which showed that to fulfill the family's economy, a woman made the decision to become a sex peddler in a shopping area. This happens because the inability to overcome poverty and the lack of knowledge and education also contribute to decision-making. (Noviana, 2019).

Sexuality can have a negative impact on a person's life, especially the impact of HIV/AIDS if he or she engages in unsafe sex. A woman's sexual experience and sexual expression affect her sexual health and the risk of health problems. Not only that, but the effects of unwanted sexual experiences will also have a psychological impact on a person. Apart from that, a person's decision to have sex can sometimes also occur due to economic downturns or even due to the risk of violence they receive. This situation allows women to explore their sexual desires.
When someone suffering from HIV/AIDS experiences an economic downturn that makes them engage in unsafe sex, this will contribute to the spread and increase of HIV/AIDS. Therefore, one effort to overcome the spread of HIV/AIDS is by providing information about HIV/AIDS. Providing information can be done through informal or non-formal education.

Here are some theories related to sexuality and HIV/AIDS along with their explanations and references:

1. Social Construction Theory

This theory argues that sexual identity and sexual behavior are shaped by social and cultural contexts. In the context of HIV/AIDS, stigma and discrimination can influence people's behavior in seeking health information and services.

References:

• Foucault, M. (1978). The History of Sexuality, Volume 1: An Introduction. Pantheon Books.

2. Theory of Planned Behavior

This theory states that individual behavior is influenced by their intentions, which are influenced by attitudes, subjective norms, and behavioral control. In the

context of HIV/AIDS, knowledge about the virus, social norms regarding condom use, and risk perceptions can influence decisions to engage in safe sexual behavior.

References:

• Ajzen, I. (1991). "The Theory of Planned Behavior." Organizational Behavior and Human Decision Processes, 50(2), 179-211.

3. Stress-Health Model

This model emphasizes that stress experienced by individuals, especially those related to stigma and discrimination due to their HIV-positive status, can negatively impact their mental and physical health, including sexual behavior.

References:

• Cohen, S. (1988). "Psychological Stress and Disease." JAMA, 259(18), 2722-2728.

4. Uncertainty Management Theory

This theory focuses on how individuals manage uncertainty related to their HIV/AIDS status and its impact on sexual relationships. This uncertainty can affect communication and decision-making in intimate relationships.

References:

• Afifi, W. A., & Weiner, J. L. (2004). "Managing Uncertainty in Health Communication." Health Communication, 16(1), 1-17.

5. Feminist Theory

This theory analyzes how gender and power influence experiences and responses to HIV/AIDS. Women are often at higher risk due to inequalities in relationships and access to education and health services.

References:

• Sontag, S. (1989). AIDS and Its Metaphors. Farrar, Straus and Giroux.

6. Social Transaction Theory

This theory views interpersonal relationships as transactions in which individuals seek to maximize benefits and minimize losses. In the context of HIV/AIDS, this may relate to how people make decisions about sexual behavior based on perceived risks and benefits.

References:

• Thibaut, J. W., & Kelley, H. H. (1959). The Social Psychology of Groups. Wiley.

These theories help us understand the complexity of sexuality and how social, psychological, and cultural factors play a role in the spread of HIV/AIDS. Understanding this context is essential to designing effective interventions in the prevention and treatment of HIV/AIDS.

Here are some studies related to sexuality and HIV/AIDS:

1. Stigma and Access to Health Services

This study examined how stigma experienced by individuals with HIV-positive status affects their access to health services and social support. The results showed that stigma can prevent individuals from getting the necessary testing and treatment.

References:

Herek, G. M. (1999). "AIDS and Stigma." American Behavioral Scientist, 42(7), 1106-1116.

2. The Influence of Knowledge on Sexual Behavior

This study explored the relationship between knowledge about HIV/AIDS and safe sexual behavior. Research showed that increased knowledge about how HIV is transmitted was positively associated with condom use among adolescents.

References:

Nsuami, M. J., et al. (2016). "Knowledge of HIV/AIDS and its Influence on Sexual Behavior among Young People in Cameroon." Health Education Research, 31(4), 487-497.

3. Risky Sexual Behaviors Among Adolescents

This study focused on risky sexual behaviors among adolescents and the factors that influence their decisions. Findings suggest that peer influence and lack of communication with parents contribute to dangerous behaviors.

References:

Chandra-Mouli, V., & Lane, C. (2015). "What Does Not Work in Sexual and Reproductive Health: A Systematic Review of Interventions." Global Health: Science and Practice, 3(3), 434-453.

4. Risk Perception and Condom Use

This study examined how individuals' risk perceptions of HIV/AIDS influence their decisions to use condoms. Results showed that individuals with higher risk perceptions were more likely to use condoms during sexual intercourse.

References:

Johnson, B. T., et al. (2000). "The Impact of HIV/AIDS Interventions on Sexual Risk Behaviors in Developing Countries: A Review of the Evidence." Journal of Acquired Immune Deficiency Syndromes, 24(Suppl 3), S76-S88.

5. Gender Roles in Responses to HIV/AIDS

This study explores how gender roles influence individuals' responses to HIV/AIDS, including access to information and services. The study found that women often experience more barriers than men in accessing HIV-related health services.

References:

Jewkes, R., et al. (2010). "Gender Inequalities and Gender-Based Violence in HIV and AIDS." AIDS Care, 22(Suppl 2), 205-216.

6. Impact of HIV on Mental Health

This study examined the relationship between HIV-positive status and mental health. The results showed that individuals living with HIV are more susceptible to depression and anxiety, which can affect their sexual lives and interpersonal relationships.

References:

Gonzalez, J. S., et al. (2011). "The Role of Psychosocial Factors in HIV Disease Progression." Journal of Clinical Psychology, 67(4), 338-350.

These studies demonstrate the complex relationship between sexuality and HIV/AIDS, underscoring the importance of interventions that are sensitive to social and cultural contexts.

I. LIFESTYLE SEXUALITY

Sexuality and its manifestations are influenced by several very complex components of human behavior, such as the expression of sexuality and intimacy, which are important throughout human life. Although the basic sexual drive is biological, its expression is determined by several factors, such as psychological, social, environmental, religious, and educational. Social factors play a role in the modulation of sexual expression. Various social aspects influence each other, even though ultimately people see and feel it in the form of sexual behavior. Learning about correct sexuality will give us many benefits, including preventing sexual problems, overcoming sexual problems, and becoming more sensitive and aware of human relationships.

The understanding of sexual lifestyle in a social context in a region is different and clearer, such as in marriage and sexual relations. As in the United States, lifestyle sexuality in a social context has variations in attitudes and behavior. As stated by social scientists

such as Alfred Kinsey and Masters and Johnson starting in the 1950s, the lifestyle in the United States that allows free sex represents a diversity of lifestyle views, so it is necessary to consider the impact it will have.

In society, there may be different variations in determining erotic power and reference; sexuality only exists in social forms and social organizations. The ways in which sexuality has been expressed, such as emotional desires and their relationships, are shaped by the culture of the society itself (Shaluhiyah, Z., The Pattern of Javanese Student Love Styles and the Socio-Sexual Lifestyles in the Era of LILY/AIDS).

In the lifestyle of sexuality, we know love. Love is recognized as an important aspect of close relationships and as a predictor of the stability of premarital relationships. Love has been described as a combination of attitudes or values as well as emotions.

Michael et al. (1994) divide individual attitudes and beliefs about sexuality into 3 categories:

1) Traditional: Traditionally, individuals' attitudes and beliefs about sexuality are based on religious beliefs, which are always used as guidelines for their sexual behavior. Thus, homosexuality, abortion, and premarital and extramarital sex are always considered wrong.
2) Relational: In relational, I believe that sex should be part of a loving relationship but not necessarily in marriage.
3) Recreational: While in recreation, Michael stated that the need for sex has nothing to do with love.

Hendrick and Hendrick (1992: p. 64-67) mention that there are six styles of love, which are explained as follows:

a. erotic/eros (romantic, passionate, showing verbally and physically).
   Eros is often described as passionate love. The value of Eros love is very high, and it has a definite image of the physical qualities desired in a partner. For example, if young

men tend to choose their dating partners who are tall, have long and straight hair, have light skin, and so on, then they are categorized as eros. These eros lovers tend to want to get involved very quickly when they meet someone who matches their mental image. The main characteristics of Eros are self-confidence and high self-esteem, all of which demonstrate an intense, exclusive focus on a partner but not jealousy or possessiveness.

b. Ludic love (playfulness, lack of commitment to partner, avoidance of involvement); Ludus is love played as a game for mutual enjoyment without any serious intentions. Ludus lovers have a love for just messing around with several partners at once, just for fun and to avoid the relationship becoming serious. Ludus lovers do not really look at their partner's physical appearance, but Ludus prefer all kinds of relationships and enjoy involvement in sex. A Ludus lover intends not to hurt; therefore, he sets a commitment at the beginning of the relationship. Cinta Ludus just wants to enjoy life and have other people enjoy it too

c. Storgic love (revelation of emotions muted, slow in developing love; intimacy is not important for the stability of the relationship). According to Lee (1973), it is a natural feeling of affection like you might have for a beloved brother or sister. Without passion and often without love, lovers, save this love in the case of drama works or romantic novels. Stoic love has its place in a friendly, safe, trusting relationship with a partner who is similar in attitudes and values. Sharing these values is much more important than loving because of physical appearance or because of sexual gratification. This stoic love orientation tends to seek long-term commitment rather than momentary excitement.

d. Pragmatic love (reasonable, practical, low emotionality). Pragma gives rise to the ideas of “pragmatic” and "practical,” and that is exactly what constitutes a love style. Pragma is love that understands its partner and knows what qualities he or she is looking for. Pragmatic lovers do not seek great excitement but rather playfulness, as for a suitable

partner, with whom they are satisfied and can build a worthwhile life. Pragma lover in pronunciation is almost similar to a storgic person but differs in difficulty in its ecstatic nature. Pragma people may grow up with someone without worrying excessively about the partner's financial prospects or family background.

e. manic love (conflicting feelings, possessiveness, and dependency). Mania has many similar qualities to our everyday concept of traditional romantic love. These jealous lovers, full of doubts about the partner's sincerity and commitment, are subject to physical symptoms such as the inability to eat and sleep, experiences of excitement, and easy depression. The manic lover tries to force commitment from the partner rather than waiting for it to develop naturally, and such forcing often brings the end of the relationship and confirms the manic lover's worst fear. Mania obsesses about the partner so that there is no real enjoyment in the relationship.

f. atypical love (giving, different attention). Agapic lovers are lovers who believe that the romantic world should be sacred. Agape is selfless and giving, and he cares about the welfare of the partner and that what he does does not interfere with himself. Agapic lovers do not form relationships because of what it can do for the lover. Because of the agape ideal, the quality of sex and sensual concerns are irrelevant. Agape functions more on a "spiritual level.".

The things that can influence young people's love style patterns are comfort behaviors or levels of social activity. This is thought to have a positive relationship with sexual behavior, which will influence young people's love style patterns. Most people consider sexual contact or the possibility of having sex to be one of the important characteristics of romantic love because there is a relationship that develops between romantic love and sexual expression. Therefore, Hendrick and Hendrick (1992 state that these sexual characteristics are related to intimate behavior and a sense of overall self-identity. In Javanese culture, perhaps such a connection between sexual expression and a sense of self does not exist because special personal expressions such as direct or

overt sexual expression are considered impolite, embarrassing, and a violation of other people's boundaries. But Javanese social norms are only acceptable in sexual behavior that occurs in Javanese culture, in the context of a committed loving relationship (a relationship before marriage).

The transition process to adulthood is the beginning of learning and gaining experience in building a life in the future. The transition process is also one of learning to develop special types of social relationships outside the family context, including special types of relationships with friends of the opposite sex, such as those known as love relationships (Podhisita and Pattaravanich, 1995). These relationships play an important role in shaping the personalities, ideas, attitudes, and behaviors of young people. When it comes to the relationship between love and sex, some people can argue and discuss the fact that love and sex are not automatically connected. Sex in the context of love makes for a very private experience because it connects two people and produces meaningful pleasure. In the context of Javanese youth, sex in the context of a romantic relationship not only means a very personal experience but also a strengthening commitment in a romantic love relationship that has a specific goal for their future life, including marriage. More abstractly, love with sex can be a form of communication, or communication, in a different language and beyond words that seem to require long-term dependence (Hendrick and Hendrick, 1992).

Nowadays, based on the author's analysis, there is a shift in the meaning of sex in the context of romantic relationships, no longer as a basis for strengthening commitment towards marriage but more simply as a form of communication in relationships. And this happens to both young men and women in relationships; there are similarities in sexual behavior and attitudes. Based on experimental studies that have been conducted to determine how a person's dating and desire to marry are influenced by their level of previous sexual experience, Study results indicate that a minority of respondents believe that extensive sexual experience is considered less desirable in a partner (Jacoby &

Williams, 1985; O'Sullivan, 1995; Sprecher, McKinney, & Orbuch, 1991, Sexuality, Culture, and Health series).

Here are some theories about lifestyle sexuality taken from the views of several experts along with their references:

Sigmund Freud's Theory of Sexuality

Freud viewed sexuality as an important part of an individual's psychological development. He introduced the concept of libido which is the main driver of human behavior. In the context of lifestyle sexuality, Freud argued that the way individuals express their sexuality can be influenced by the stage of psycho-sexual development and social influences.

Reference: Freud, S. (1905). Three Essays on the Theory of Sexuality.

Social Constructivism Theory

This theory suggests that sexual identity and sexual behavior are formed through social interaction and cultural norms. Experts such as Judith Butler argue that gender and sexuality are not fixed, but rather the result of repeated social practices.

Reference: Butler, J. (1990). Gender Trouble: Feminism and the Subversion of Identity.

Michel Foucault's Theory of Sexuality

Foucault in his works, especially The History of Sexuality, states that sexuality is influenced by power and social discourse. He argued that the control and regulation of sexuality in society shows the relationship between power and knowledge.

Reference: Foucault, M. (1976). The History of Sexuality, Volume 1: An Introduction.

Sexual Scripts Theory

This theory was developed by Gagnon and Simon who explained that sexual behavior is guided by "scripts" or social scripts that reflect cultural norms and values. These scripts can vary depending on the social context and the individual.

Reference: Gagnon, J. H., & Simon, W. (1973). Sexual Conduct: The Social Sources of Human Sexuality.

Biopsychosocial Theory

This theory integrates biological, psychological, and social aspects in understanding sexuality. Experts argue that genetic factors, life experiences, and social environments all contribute to shaping an individual's sexual behavior.

Reference: McCarthy, B., & Moller, N. (2008). "The Biopsychosocial Model and Sexuality".

Sexual Health Theory

This theory emphasizes the importance of sexual health in the context of lifestyle sexuality. The World Health Organization (WHO) defines sexual health as a state of complete physical, emotional, mental, and social well-being related to sexuality.

Reference: World Health Organization. (2006). Defining sexual health: Report of a technical consultation on sexual health, 28–31 January 2002.

These theories provide a useful framework for understanding the complexities of lifestyle sexuality from multiple perspectives.

Several studies by experts related to lifestyle sexuality and their references:

Research by Edward Laumann and Robert Michael

Their research in The Social Organization of Sexuality provides a comprehensive analysis of sexual behavior patterns in the United States, including how social and cultural factors influence sexual lifestyles.

Reference: Laumann, E. O., & Michael, R. T. (2001). The Social Organization of Sexuality: Sexual Practices in the United States. University of Chicago Press.

Research by the Kinsey Institute

Research conducted by the Kinsey Institute provides empirical data on sexual behavior across demographics, which helps understand lifestyle sexuality in a broader context.

Reference: The Kinsey Institute. (2020). The Kinsey Institute Research on Sexuality. Retrieved from the Kinsey Institute website.

These studies provide diverse insights into how lifestyle sexuality is shaped and influenced by various social, cultural, and individual factors.

J. THE LANGUAGE OF SEXUALITY

The language of sexuality is something that is very difficult to understand because sexuality itself is a multidimensional thing and covers various aspects of life. Many ambiguity problems arise when the language of sexuality is identified with the language of sex itself, for example, whether an action is included in the erotic category or not, or whether an action is considered sexual or not. The boundaries of sexual terminology actually do not exist, but socio-cultural concepts give it such a name (Plummer, 1975). The language of sexuality is not only a social product that can be felt but also shapes personality and life. The language of sexuality is also a historical construct involving a large number of biological and mental differences in various possible forms of culture and

gender identity. The language of sexuality relates to biological differences such as differences in body, reproductive capacity, needs, lust, fantasy, eroticism, practices, institutions, and values where the needs are not connected together. The language of sexuality is also not the same in other cultures. Every culture in other regions has its own characteristics regarding the language of sexuality.

The body and mind are the source of elements of sexuality, and it cannot be denied that there is biological or mental involvement in the process. Meanwhile, the capacity of the body and soul in the element of sexuality is given meaning only in social relationships. Because sexual language is difficult to understand, the regulation and restraint of sexuality are ambiguous. On the one hand, sexuality is treated as a private matter that cannot be interfered with by anything or anyone, nor does it need to be discussed at the public level because sexuality is taboo. On the other hand, it is treated as a public issue that must be regulated through a legal system complete with sanctions that are not only moral but also physical and material.

In eastern culture, the language of sexuality is considered an erotic concept so that it has moral implications in practice, which results in confusion for many parties. Sexuality is synonymous with feelings of the heart; sexuality is also the strongest identity, so it should not be revealed because it is considered sensitive and unethical. When a woman shows her love for a man, it is not an easy thing. Because liking is a very sensitive feeling for a woman to express, apart from that, for a woman to express her love for a man, she must drop her ego and put aside all feelings. So in eastern culture, expressing a woman's love for a man is taboo.

A person's sexuality is dominated by biological orders, so a person's sexuality cannot be changed by any influence. However, eroticism violates boundaries and is considered a deviation from sexual desire or is abnormal, such as masturbation, transsexuals, sexual workers, etc. This deviation from eroticism can occur due to social and cultural pressures that exist around them or even because of their ignorance of their

own sexuality because they are not aware of sexual health knowledge. The symptoms of this sexual phenomenon are increasingly susceptible to spreading due to the impact they cause, which cannot be identified. Apart from that, the spread of the phenomenon of sexuality is also partially seen as something that is unnatural, a verdict of disease, and so on.

Several theories about the "language of sexuality" proposed by experts, along with references:

Social Construction Theory by Judith Butler

Judith Butler in her work suggests that language has the power to shape gender identity and sexuality. Language is not just a means of communication, but also a tool that shapes social reality. Thus, the way people talk about sexuality can influence an individual's understanding and experience of sexuality itself.

References: Butler, J. (1990). Gender Trouble: Feminism and the Subversion of Identity.

Sexual Discourse Theory by Michel Foucault

Foucault argues that discourse—how we talk about sexuality—is how power operates in society. In the History of Sexuality, he shows that the regulation and control of sexuality takes place through social discourse that influences how individuals understand and express their sexuality.

References: Foucault, M. (1976). The History of Sexuality, Volume 1: An Introduction.

Sexuality and Language Theory by Eve Sedgwick

Eve Sedgwick examines how language shapes our understanding of sexual orientation. In her work, she explains how categories of sexuality, such as homosexuality and heterosexuality, are constructed and defined through language.

References: Sedgwick, E. K. (1990). Epistemology of the Closet.

Gender Role Theory and Language by R.W. Connell

Connell explores how language reflects and reinforces gender norms in society. In this context, the language used to discuss sexuality often reflects existing power structures between the genders.

References: Connell, R. W. (1995). Masculinities.

Sexual Communication Theory by Derlega and Grzelak

This research highlights how communication in a sexual context can influence interpersonal experiences and relationships. They emphasize the importance of open communication about sexuality in building healthy relationships.

References: Derlega, V. J., & Grzelak, J. (2008). "Communication and Sexuality: A Review of Research." Journal of Social Issues, 64(4), 705-720.

Sexual Narrative Theory by Jennifer Coates

Coates explains how the stories and narratives used in discussions about sexuality shape individuals' understandings of their sexual experiences. She argues that these narratives often reflect broader cultural and gender norms.

Reference: Coates, J. (2004). "Women, Men and Language: A Sociolinguistic Account of Gender Differences in Language." Routledge.

These theories highlight the importance of language in shaping understandings and experiences of sexuality, and how social discourses can influence identities and relationships.

Here are some studies related to the "language of sexuality" conducted by experts along with their references:

Research by Eve Sedgwick

In her seminal work, Sedgwick discusses how the language and terms used in discussions about sexuality influence the understanding and interpretation of sexual orientation. This research also explores how sexual categories are formed and maintained.

References: Sedgwick, E. K. (1990). Epistemology of the Closet. University of California Press.

Research by Michel Foucault

Foucault in The History of Sexuality explores the relationship between language, discourse, and power. He shows how ways of talking about sexuality shape social norms and individual experiences.

References: Foucault, M. (1976). The History of Sexuality, Volume 1: An Introduction. Vintage.

Research by Judith Butler

Butler examines how language shapes gender and sexual identity in a cultural context. In her analysis, she argues that language can dismantle or reinforce gender norms.

References: Butler, J. (1990). Gender Trouble: Feminism and the Subversion of Identity. Routledge.

Research by R.W. Connell

Connell investigates how language reflects and reinforces gender norms in sexual discourse. This research provides insight into how language can influence the understanding of masculinity and femininity.

References: Connell, R. W. (1995). Masculinities. University of California Press.

Research by Jennifer Coates

Coates examines how women and men talk about sexuality, and how the language they use can reflect and shape their sexual experiences. This research explores social interactions and gender roles in sexual communication.

References: Coates, J. (2004). Women, Men and Language: A Sociolinguistic Account of Gender Differences in Language. Routledge.

Research by Janelle L. Smith

This research highlights how the language used in the context of sex education can influence students' understanding of sexuality and sexual health. This research explores the terms and phrases frequently used in discussions about sex.

References: Smith, J. L. (2008). "Language and Sexuality: The Impact of Sex Education on Young People's Sexual Knowledge." Sex Education, 8(2), 161-174.

These studies provide important insights into how language plays a role in shaping understandings and experiences of sexuality, and how discourse can influence social norms.

K. SEXUAL ACTIVITY AND HEALTH

Sexual health requires a positive approach to shaping human sexual behavior. Because positive sexual behavior is the basis of sexual health and is very important for achieving a satisfying sexual life, A person's sexual health and sexual well-being can be influenced by a person's sexual expression. The condition of a person's sexual health and sexual well-being can put someone at risk or cause them to have reproductive system disorders.

Several epidemiological studies suggest that sexual activity can be beneficial for health. A follow-up study with male subjects showed that men who had two orgasms a week had a lower risk of death and also reduced the risk of heart disease. Sexual activity has been

proven to reduce stress because, in an orgasm, oxytocin and endorphins are produced, which have a calming effect and help people sleep.

Here are some theories related to lifestyle sexuality, complete with explanations and references:

1. Social Construction Theory

This theory argues that sexuality is the result of social and cultural construction. Views on sexuality can vary based on social context and individual experiences. This includes norms formed by society regarding sexual behavior, identity, and relationships.

References:

Foucault, M. (1978). The History of Sexuality, Volume 1: An Introduction. Pantheon Books.

2. Theory of Planned Behavior

This theory explains that sexual behavior is influenced by individual intentions, which are formed by attitudes, subjective norms, and perceived behavioral control. In the context of sexual lifestyle, these factors can influence an individual's decision to engage in certain sexual behaviors.

References:

Ajzen, I. (1991). "The Theory of Planned Behavior." Organizational Behavior and Human Decision Processes, 50(2), 179-211.

3. Social Identity Theory

This theory focuses on how an individual’s identity—including sexual identity—is shaped and influenced by the social groups with which they identify. Social identity can influence sexual behavior and lifestyle choices, including how individuals interact with others in sexual contexts.

References:

Tajfel, H., & Turner, J. C. (1986). “The Social Identity Theory of Intergroup Behavior.” In S. Worchel & W. G. Austin (Eds.), Psychology of Intergroup Relations (pp. 7-24). Nelson-Hall.

4. Risk and Protective Factors Theory

This theory identifies factors that increase or decrease the risk of unsafe sexual behavior. It includes individual, social, and environmental factors that influence sexual lifestyle and sexual health.

References:

Blum, R. W., & Rinehart, P. M. (1997). “Youth in a Changing World.” The Future of Children, 7(1), 67-86.

5. Feminist Theory

This theory explores how gender influences sexual experiences and choices. In the context of sexual lifestyle, feminist theory can help explain how power, control, and societal expectations about gender shape sexual behavior and identity.

References:

Tong, R. (2009). Feminist Thought: A More Comprehensive Introduction. Westview Press.

6. Heteronormativity Theory

This theory explains how heteronormative norms (the belief that heterosexual relationships are the norm) influence sexual understanding and expression. This has implications for how individuals from the LGBTQ+ community interact with society and their lifestyles.

References:

Warner, M. (1999). The Trouble with Normal: Postwar Youth and the Making of Heterosexuality. Harvard University Press.

These theories provide diverse perspectives on sexual lifestyle, describing how social, cultural, and psychological factors interact to shape individuals' sexual behavior and identity.

Here are some studies related to sexual lifestyle, complete with explanations and references:

1. The Influence of Social Media on Sexual Lifestyle

This study explores how social media use affects the sexual behavior of adolescents and young adults. The results show that social media can facilitate sexual exploration but also increase the risk of risky sexual behavior.

References:

Moreno, M. A., et al. (2013). "Sexual Behavior and Associated Risks Among Adolescents on Social Networking Sites." Pediatrics, 132(5), e1315-e1321. DOI: 10.1542/peds.2013-1206

2. Sexual Lifestyle and Mental Health

This study investigates the relationship between sexual lifestyle and mental health. Research shows that individuals who have a more free and diverse sexual lifestyle often report higher levels of happiness, but also higher mental health risks if there is no social support.

References:

Wilkins, R., & Pritchard, J. (2020). "Sexual Diversity, Health and Well-Being: Insights from a National Survey." BMC Public Health, 20(1), 1-12. DOI: 10.1186/s12889-020-08982-x

3. Risk Perception and Sexual Behavior Among Adolescents

This study analyzed how risk perceptions for sexually transmitted infections (STIs) influenced sexual behavior among adolescents. Results showed that adolescents who had a better understanding of risk were more likely to use protection during sex.

References:

Miller, K. S., et al. (2010). "The Role of Perceived Peer Norms in Sexual Risk Behavior Among Adolescents." American Journal of Public Health, 100(9), 1704-1708. DOI: 10.2105/AJPH.2009.183800

4. Social Factors Influencing Sexual Lifestyle

This study examined how social factors, such as family support and community norms, influence individuals' sexual lifestyle choices. The results showed that strong social support correlates with more responsible sexual behavior.

References:

Tabb, K. D., et al. (2013). "Family Support and Sexual Risk Behaviors Among Adolescents." Family Relations, 62(2), 253-266. DOI: 10.1111/j.1741-3729.2012.00751.x

5. The Influence of Sexual Lifestyle on Reproductive Health

This study investigated the relationship between sexual lifestyle and reproductive health among adult women. The findings suggest that a more sexually active lifestyle may be associated with increased risk of STIs, but also with a better understanding of reproductive health.

References:

Lewis, R. J., & Cummings, J. R. (2016). "Sexual Behavior, Health Outcomes, and the Role of the Health Care Provider: A Study of Women." Women's Health Issues, 26(5), 556-564. DOI: 10.1016/j.whi.2016.06.007

These studies suggest that sexual lifestyles are influenced by a variety of factors, including social media, risk perception, and social support. Understanding these aspects is important for developing effective sexual health education and intervention programs.

L. DIMENSIONS OF SEXUALITY

a. Biology and Sexuality

1. Sexual Development

The initial development of male and female sexual organs is the same, namely at 5–6 weeks of gestation. During the 7th week of pregnancy, differences between men and women appear in the structure of the internal reproductive organs. The external reproductive organs look the same until the 9th week, which is marked by changes in the external structure. Complete external structural differences at 12 weeks of gestation. During the fetal period, neither the ovaries nor the testicles function to produce the hormones estrogen and testosterone. Testosterone is a hormone that influences the development of male sexual organs, both internal and external. This hormone also influences the development of male sexual characteristics. Meanwhile, in women, the hormone estrogen initially does not affect the function of a woman's sexual development until she reaches sexual maturity.

In childhood, both male and female glands that influence the sexual organs (hypothalamus and pituitary) are inactive. When entering sexual maturity, the hypothalamus stimulates the pituitary gland to produce hormones. Next, this hormone will stimulate the production of sexual hormones in the ovaries and testicles. The period when the ovaries and testicles produce hormones is known as puberty, the period when the male and female sexual organs begin to function. Puberty is not a single event but a series of changes that occur over several years, from the end of childhood until early adulthood. The factors that influence sexual maturity are not well known, but the release of hormones from the hypothalamus, pituitary gland, and ovaries plays a role. The hypothalamus, via GnRH, stimulates the release of pituitary gonadotropin hormones. Hormones are released from these two glands to initiate puberty in childhood. In childhood, the production of low amounts of sexual hormones from the ovaries and testicles will inhibit the release of

hormones from the hypothalamus. Barriers to the release of these hormones are needed to prevent premature puberty. Sexual maturity can also be influenced by thoughts that stimulate the hypothalamus to release hormones.

The hypothalamus gradually increases GnRH production, starting in children aged 9 to 12 years, until it is enough to stimulate the pituitary gland to increase production of FSH (follicle-stimulating hormone) and LH (luteinizing hormone). Increased production of the hormones FSH and LH will stimulate the ovaries to produce the hormones estrogen and progesterone and also influence the development of secondary sexual organ characteristics.

2. Female reproductive organs

Figure 6.6: External female genitalia
(Source: Saladin, Anatomy & Physiology: The Unity of Form and Function, Third Edition (The McGraw-Hill Companies, 2003:1056).

a. Female reproductive organs

The female reproductive organs, or genital tract, consist of external and internal organs connected to the peritoneal cavity and mostly located in the pelvic cavity. The function of the female reproductive system is influenced by gonadotropin and steroid hormones from the thalamus, hypothalamus, pituitary, adrenal, and ovarian hormonal axes. Apart from that, there are extragonadal/extragenital organs and systems that are also

influenced by the reproductive cycle: the breasts, skin in certain areas, pigment, and so on.

a). External Genetalia

1) Vulva

The vulva is the external female reproductive organ, starting from the mons pubis to the edge of the perineum, consisting of the mons pubis, labia majora, labia minora, clitoris, hymen, vestibule, orificium urethrae externum, and glands in the vaginal wall.

2) Mons pubis or mons veneris

The mons pubis is formed by a layer of fat found in the anterior part of the pubic symphysis. During puberty, this area begins to grow pubic hair.

3) Labia majora

The labia majora is a layer of fat that continues from the mons pubis downward and behind, containing many venous plexuses. Embryological homologue to the scrotum in men. There are also blood vessels and glands that form the posterior labial commissure.

4) Labia minora

The thin folds of tissue behind the labia majora, the labia minora, do not have hair follicles. There are many blood vessels, smooth muscles, and nerve fiber endings. The labia minora extends from the clitoris obliquely downwards and along the back for 4 cm on the side of the vaginal orifice.

4) Clitoris

It consists of the head/glans clitoridis, which is located in the superior part of the vulva, and the corpus clitoridis, which is embedded in the anterior wall of the vagina. Embryological homologue to the male penis. There are also androgen receptors in the clitoris. Many blood vessels and nerve fiber endings are very sensitive.

5) Vestibule

The area has the upper border of the clitoris, the lower border of the fourchet, and the lateral border of the labia minora. The vestibule originates from the urogenital sinus. Inside there are six orifices, namely the external urethrae orifice, introitus vaginae, right-left Bartholin's glandular duct, and right-left Skene's duct. Between the fourchet and the vagina is the navicular fossa.

6) Introitus or vaginal orificium

Located at the bottom of the vestibule. In girls (Virgo), it is covered by a thin layer of mucosa, namely the hymen, intact without tears.

The normal hymen has a small hole for menstrual blood flow; it can be crescent-shaped, round, oval, cribriform, septum, or fimbriae. As a result of coitus or other trauma, the hymen can tear, and the shape of the hole becomes irregular with tearing. The shape of the postpartum hymen is called parous. Corrunculae myrtiformis are the remains of a torn hymen that appear in women who have given birth.

An abnormal hymen, for example, a non-perforated primary (imperforate hymen) that completely covers the vaginal opening, can cause menstrual blood to collect in the internal genital cavity.

7) Vagina

The musculomembranous cavity is tube-shaped from the lower edge of the symphysis to the promontory, and the front part measures 6.5 cm while the back a part measures 9.5 cm. The back wall of the vagina is longer and forms the posterior fornix, divided into 4 quadrants: the anterior fornix, the posterior fornix, and the right and left lateral fornix. The vagina has an elastic ventral wall and a dorsal wall. Lined with stratified squamous epithelium, it changes with the menstrual cycle.

Vaginal function: to remove uterine excretions during menstruation, for the birth canal, and for copulation (coitus).

The upper part of the vagina is formed from the Müllerian duct, and the lower part from the urogenital sinus. Clinically, the internal borders are the anterior, posterior, and lateral fornices around the uterine cervix. Grayenbergh's point (G-spot) is a sensory

area around the anterior 1/3 of the vaginal wall that is very sensitive to vaginal orgasmic stimulation.

8) Perineum

The area between the lower edge of the vulva and the anterior edge of the anus. The boundaries of the muscles of the pelvic diaphragm (musculus levator ani, musculus coccygeus) and urogenital diaphragm (musculus perinealis transverses profunda, musculus constrictor urethra). The perineum stretches during labor, sometimes needing to be cut (episiotomy) to enlarge the birth canal and prevent rupture.

b). INTERNAL GENITALIA

1) Uterus

A muscular organ shaped like a pear, covered by the peritoneum (serosa). During pregnancy, it functions as a site for implantation, retention, and nutrition of the conceptus. During labor, with contraction of the uterine wall and opening of the uterine cervix, the contents of the conception are expelled. Consisting of the corpus, fundus, cornu, isthmus, and uterine cervix. The main supports for the uterus are the pelvic diaphragm, levator ani muscles, and levator ani fascia.

2) Uterine cervix

The uterine cervix is the lowest part of the uterus, consisting of the pars vaginalis (bordering or penetrating the inner wall of the vagina) and the pars supravaginalis. It consists of three main components: smooth muscle, connective tissue (collagen and glycosamine), and elastin. The uterine cervix is cone-shaped, with the apex pointing downwards and backwards with a slight widening in the middle. The position of the cervix is directed caudally-posteriorly, at the level of the ischial spine.

Before giving birth (nullipara/primigravida), the external ostium hole is small and round; after giving birth (primipara/multigravida), it is transversely shaped. The mucous glands of the cervix produce cervical mucus containing carbohydrate-rich glycoproteins (mucin) and solutions of various salts, peptides, and water. The thickness of the mucosa and the viscosity of the cervical mucus are influenced by the menstrual cycle.

3) Uterine corpus

The uterine corpus consists of: the outermost layer of serosa/peritoneum, which is attached to the broad ligament of the uterus in the intra-abdomen; the middle layer of muscular/myometrium, in the form of three layers of smooth muscle (from the outside to the direction of the longitudinal, woven, and circular muscle fibers); and the inner layer of the endometrium, which is lining the walls of the uterine cavity and thickens and collapses according to the menstrual cycle due to the influence of ovarian hormones. The position of the intra-abdominal body is horizontal with flexion to the anterior; the uterine fundus is above the urinary bladder. The proportion of corpus size to the isthmus and uterine cervix varies during a woman's growth and development.

4) Ligaments that support the uterus

Wide uterine ligament, uterine rotundum ligament, cardinale ligament, ovarian ligament, propium sacrouterina ligament, infundibulopelvicum ligament, vesicouterina ligament, rectouterina ligament.

5) Uterine vascularization

Especially from the uterine artery branch of the internal hypogastric/illiaca artery, as well as the ovarian artery branch of the abdominal aorta.

6) Salping or Fallopian Tubes

The fallopian tubes are 11–14 cm long, and the fallopian tubes consist of left and right tubes, functioning as a way to transport ovum from the ovaries to the uterine cavity. The tube wall consists of three layers: serous, muscular (longitudinal and circular), and mucosa with ciliated epithelium.

It consists of pars interstitialis, pars isthmica, pars ampullaris, and pars infundibulum with fimbria, with different characteristics of cilia and wall thickness in each part. The fallopian tube consists of:

The pars interstitialis is the part of the tube that is inside the uterus. Pars isthmica (proximal/isthmus)

The part with the narrowest lumen is the uterine sphincter, which controls gamete transfer. Pars ampullaris (medial/ampulla)

The place where fertilization often occurs is the ampulla/infundibulum area, and in ectopic (pathological) pregnancies, implantation often also occurs in this part of the tube wall. Pars infundibulum (distal)

Equipped with fimbriae and abdominal tubae, the ostium is attached to the surface of the ovary. Fimbriae function to "catch" the ovum that comes out during ovulation from the surface of the ovary and carry it into the tube.

1) Ovaries

   The ovaries are oval-shaped endocrine organs located in the peritoneal cavity in a left-right pair. Lined with the mesovarium as connective tissue and a pathway for blood vessels and nerves. Consists of the cortex and medulla.

   The ovary functions in the formation and maturation of follicles into ovum (from primordial germ epithelial cells in the outer layer of the ovary epithelium in the cortex), ovulation (excretion of ovum), and the synthesis and secretion of steroid hormones

(estrogen by the follicle's theca interna, progesterone by the postovulatory corpus luteum). Connects to the Pars infundibulum of the fallopian tube through the attachment of fimbriae. Fimbriae “catch” the ovum released during ovulation. The ovaries are fixed by the ligamentum ovarii proprium, ligamentum infundibulopelvicum, and connective tissue of the mesovarium. Vascularization of the inferior abdominal aorta branches to the renal artery.

2) Endometrium

The inner layer of the uterine cavity wall functions as a potential place for implantation of the products of conception. During the menstrual cycle, the endometrial tissue proliferates, thickens, and secretes. If there is no fertilization or implantation, the endometrium falls off again and comes out in the form of menstrual blood or tissue. If fertilization or implantation occurs, the endometrium is retained as the site of conception. Endometrial physiology is also influenced by the cycle of ovarian hormones.

3) Breasts

The entire structure of the breast glands is under the skin in the pectoral area. It consists of a breast mass that mostly contains fat tissue, with lobes (20–40 lobes); each lobe consists of 10–100 alveoli, which, under the influence of the hormone prolactin, produce milk. From the lobes, milk flows through ducts that open in the papilla or nipple area.

The main function of the breasts is lactation, influenced by the postpartum hormones prolactin and oxytocin. The skin of the breast area is sensitive to stimuli, including being a sexually responsive organ.

4) Skin

In certain areas of the body, the skin has higher sensitivity and is sexually responsive, for example, the skin on the buttocks and inner thighs. Proteins in the skin contain pheromones (a type of steroid metabolite from the skin's epidermal keratinocytes), which function as a 'perfume' for sexual attraction (androstenol and androstenone are

made in the skin, axillary sweat glands, and salivary glands). Pheromones are also found in urine, plasma, sweat, and saliva.

b. Male reproductive organs

The reproductive system, also called the genital tract, is related to the urinary tract but is not connected. Most of the reproductive organs are located outside the pelvis. Testicles in men begin to grow early in fetal life, but their sexual characteristics are not yet known.

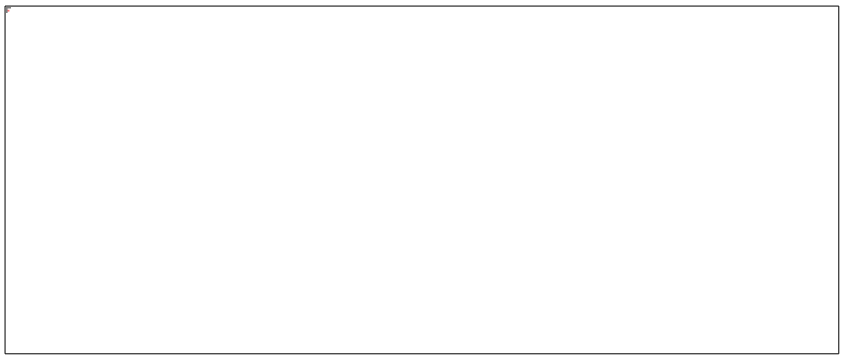


Figure 6.3: Male reproductive system.
(Source: Mader: Understanding Human Anatomy & Physiology, Fifth Edition, V. Reproduction and Development The McGraw-Hill Companies, 2004:343).

Figure 6.4
Anatomy of the inguinal region and external male genitalia.
(Source: Saladin, Anatomy & Physiology: The Unity of Form and Function,
Third Edition (The McGraw-Hill Companies, 2003:1027).

a. External Genetalia

1. Penis

The penis is round and long, located hanging in front of the scrotum between the two thighs. The penis consists of cavernosa and spongiosa tissue, which increases the cavity for blood vessels to flow.

If there is physical, emotional, or audio-visual stimulation, the veins will be filled with a lot of blood, which causes the penis to become erect, standing straight forward. This erection is really needed for sexual activities. Distributes and sprays sperm during ejaculation.

Inside the shaft of the penis, there is a urethral tube that opens at the head (glans) of the penis and is used for the excretion of urine and sperm.

2. Scrotum

A sac covered by brown, lean skin. Each sac contains one testicle. The skin of the scrotum is wrinkled and covered with coarse hair. Functions to protect the testicles from trauma or hot or cold temperatures. There are sacs containing the spermatic epididymisphenículus.

Scrotum layers:

-skin

-tunica dartos (smooth muscle layer)

b. Male Internal Genetalia

1. Testicles

There are two male testicles located in the scrotum. Oval shape, white, approximately 4 cm long, 2.5 cm wide, and 3 cm thick, weighs 10–14 g. Functions to produce or place sperm formation. Place of production of testesteromes, which play an important role in secondary sexual characteristics and virility.

2. Epididymis

It is a winding, pipe-shaped organ attached to the upper part of the testicle. Length is approximately 6 cm. The epidermis connects the testicles to the vas deferens. The epidermis produces fluid that contains lots of enzymes and nutrients whose function is to mature or perfect the shape of sperm. Medial to the epididymis there is a long cord-like structure, namely the funiculus spermaticus (in which there is the ductus deferens).

3. Ductus Deferens (VAS DEFEREN)

It is a channel that is 50–60 cm long. It is a continuation of the excretory duct from the epididymis. It functions to channel sperm from the epididymis to the seminal opticis, a place where some of the sperm is stored before being released.

4. Seminal Vesicles

The small pouch has an irregular shape. It consists of two sacs (bubbles) consisting of baga-baga (lobes) on the right and left, approximately 5 cm long, and located behind the dorsal surface of the urinary bladder. The opening of the ductus deferens and its lower part are continuous with the urethra. On the medial side, there is the ductus deferens, and on the dorsal side, there is the rectum. Its function is to secrete fluid that is alkaline or slightly alkaline and contains fructose and nutrients, which are a source of energy for spermatozoa.

5. Ejaculatory Duct

Formed from the union of the vas deferens with the seminal duct, it has a length of 2 cm.

6. Prostate Gland

The cone shape, 4 cm long, 3 cm wide, and 2 cm thick, weighs approximately 8 grams. A gland that has four lobes (anterior, posterior, lateral, and medial) is located under the bladder in the pelvis and surrounds the middle part of the urethra. Usually the size is the size of a walnut and will enlarge with age. The prostate and seminal vesicles produce fluid, which is a food source for sperm. This liquid is the largest part of cement. Other fluids that form semen come from the vas deferens and from the mucous glands in the head of the penis.

Its function is to secrete a thin, milky alkaline fluid that is useful for protecting spermatozoa against pressure in the urethra and contains citric acid, calcium, and several other substances. Prostate gland fluid will be emitted in addition to fluid released from the seminal vesicles.

Prostate fluid is very good for helping fertilization and sperm motility, as well as neutralizing the acidity of other fluids that inhibit sperm fertilization.

7. Bulbo urethral glands

Located under the prostate, the pjg gland duct is approximately 2.5–3 cm. It is round, small, and yellow in color. Its function is almost the same as that of the prostate gland, namely: secreting fluid that helps sperm survive better, allows them to move, and facilitates fertilization.

8. Urethrace

It is the urinary tract and ejaculatory tract. Regulates the function of urine output so that it does not come out at the same time as ejaculation.

9. Spermatogenesis

Spermatogenesis is the formation of sperm that occurs in all seminiferous tubules in the testicles during active sexual life, on average starting at the age of 13 years and

continuing throughout life. This spermatogenesis occurs due to stimulation of the hormones gonadotripin, FSH, and LH.

The first stage of spermatogenesis is the growth of several spermatogenia into very large cells called spermatocytes. Spermatocytes divide into two spermatocytes, each of which contains 23 chromosomes.

After that, the spermatocytes do not divide again but mature into spermatozoa. Of the 23 chromosomes, one will play a role in determining the sex of the offspring produced. There are two types of sex chromosomes produced by men, namely the X chromosome (female) and the Y chromosome (male).

After sperm are formed in the seminiferous tubules, the sperm enter the epididymis. In the epididymis, sperm are mature and perfected in shape, becoming complete with a head, neck, and tail within 18–10 days.

The sperm storage location is partly in the epididymis and partly in the vas deferens. Infrequent sexual activity means sperm can survive for several months. Normal and healthy sperm can usually move with their flagellum or tail through liquid at a speed of 1-4 mm per minute. The movements tend to be straight, not circular. Sperm activity can be more optimal in neutral and slightly alkaline fluids. Sperm die easily in acidic liquid media. Sperm can live for weeks in a woman's genital tract and can only live for 24 to 72 hours (1-3 days). The normal sperm count per 1 ml of sperm fluid contains 100–120 million sperm. This substance functions to make sperm fresher, stronger, and easier to move to reach the ovum. It functions as a storage place for spermatozoa before they are released through sexual activity.

Here are some theories from experts that discuss the relationship between biology and sexuality. Here are some of them along with their references:

- Sexual Evolution Theory - This theory was popularized by Charles Darwin and continued by Richard Dawkins in his book "The Selfish Gene". This theory explains how sexual selection influences sexual behavior and characteristics.
Reference: Dawkins, R. (1976). The Selfish Gene. Oxford University Press.
- Social Gender Theory - Judith Butler's book "Gender Trouble" suggests that gender identity and sexuality are shaped by social and cultural factors, not just biological factors.
Reference: Butler, J. (1990). Gender Trouble: Feminism and the Subversion of Identity. Routledge.
- Psychoanalytic Theory - Sigmund Freud developed a theory of sexuality that focuses on the psychosexual development of individuals and how early experiences influence sexual orientation.
Reference: Freud, S. (1905). Three Essays on the Theory of Sexuality. Basic Books.

Here are some studies by experts that discuss the relationship between biology and sexuality, namely:

- Research by Anne Fausto-Sterling - In her book "Sexing the Body," Fausto-Sterling critiques the binary view of gender and sexuality and examines the biological and social factors that influence gender identity.
Reference: Fausto-Sterling, A. (2000). Sexing the Body: Gender Politics and the Construction of Sexuality. Basic Books.

- Research by S. K. Markman and others - This study explores the relationship between biological factors and sexual behavior among men and women, showing significant differences in approaches to sexuality.
Reference: Markman, S. K., et al. (2014). "Biological influences on human sexual behavior: a review." Sexual and Relationship Therapy, 29(3), 275-284.

b. Psychology and Sexuality

The limits of sex in social psychology are not only on behavior or the urge to have sex, as in the definition of libido and sexuality in Freudian psychoanalysis. However, sex in the sense of social psychology includes everything related to sex (gender), such as gender roles, gender identity, and relationships between the genders.

Meanwhile, sex in the personality concept of social psychology is one of the most important factors because, from birth, each person will experience different treatment. These differences vary from place to place, from society to society, and from one culture to another. This sexual element of the personality is called psychosexual.

1. Gender Identity

Gender identity is a difference in sexual treatment that often occurs in our society. From the moment a child is born, gender identity is an important thing to pay attention to because the treatment of people around him will be different based on gender. A simple thing that we find in the surrounding environment regarding differences in treatment of gender is when a mother is pregnant with a female child. When a mother finds out that the gender of the baby she is carrying is a girl, all the baby's needs will be pink. Vice versa, if the child you are carrying is a boy, then all the baby equipment will be identical in shades of blue.
The birth of parents' treatment of their children is influenced by norms in the surrounding community, sizes and standards (sex-role standards), the treatment of each sex (sex role stereotypes), and the expected behavior of each sex (sex type behavior). . All things that influence the treatment of gender exist in every culture in the region and in other countries. Parents' treatment of their child's gender will have a psychological influence on the child's future development.

2. Gender Roles

Gender plays a very important role in shaping personality based on standard norms that apply everywhere, namely dominant, independent, competitive, and assertive. The role of gender in our society is very strong and dominant. This can be seen from the fact that a man is expected to play the role of breadwinner and protector for his family.

Meanwhile, a woman is expected to act as a wife to her husband and take care of the household and children.

3. The occurrence of identity and gender roles

There are several opinions regarding the occurrence of gender identities and roles, as expressed by Eysenck (1995), that gender identities and roles occur due to talent. It is proven in any culture that men are dominant, and this is a characteristic of almost every culture. These symptoms cannot be explained culturally or environmentally. In addition, Basow (1984) stated that differences in roles between the sexes are greatest in societies where the responsibility for educating children lies entirely with the mother, while economic life relies heavily on physical strength. Meanwhile, Montagu (1974) stated that it is biological differences (talents) that give rise to differences in gender roles.

Based on the opinions above, it can be concluded that a man has a greater opportunity to excel, get a job, and pursue his dreams. This is because men, apart from being physically strong, also have great opportunities because it is based on the prevailing cultural assessment that men are more dominant.

In addition, the formation of gender identity is explained simply by Bandura (1989). The formation process is explained in two ways: first, by being told directly by parents or adults, and second, by the child observing what the parents are doing. According to Kohberg (1966), from a cognitive theory perspective, gender identity develops according to the child's cognition. A child will understand gender and its impact on him after he reaches a certain level of cognitive development. A child will experience a shift in gender roles, indicating that he will behave in a feminist or masculine manner, following the example of his parents.

There is also an opinion that differentiates the cognitive structure between men and women with in-group or out-group schemas (in group or out group), according to Martin & Halverson (1987). This scheme explains that a child will place himself according to the attributes of his respective group. This is in accordance with the results of research

in the United States, which show that adult women's sexual behavior is shaped and directed by the sexual schema that develops in the person's cognition.

Here are some theories from experts that discuss the relationship between psychology and sexuality, namely:

- Psychoanalytic Theory (Sigmund Freud)

  Freud suggested that sexuality is an integral part of an individual's psychosexual development. He identified several stages, from oral to genital, and argued that early experiences can influence sexual behavior in adulthood.

  References: Freud, S. (1905). Three Essays on the Theory of Sexuality. Basic Books.
- Cognitive Theory (Albert Bandura)

  Bandura developed a social learning theory that explains that sexual behavior can be learned through observation and imitation. This shows how social and environmental contexts shape a person's sexual attitudes and behavior.

  References: Bandura, A. (1977). Social Learning Theory. Prentice Hall.
- Sexual Theory (Helen Singer Kaplan)

  Kaplan developed a sexual model that includes three phases: desire, stimulation, and orgasm. This theory emphasizes the importance of psychological components in sexual experience, including anxiety and hope.

  References: Kaplan, H. S. (1974). The New Sex Therapy: Active Treatment of Sexual Dysfunction. Brunner/Mazel.
- Gender Identity Theory (Judith Butler)

  Butler argues that gender identity is a social construct and not just a biological factor. In her book "Gender Trouble," she explains how social norms shape how individuals understand and express their sexuality.

  References: Butler, J. (1990). Gender Trouble: Feminism and the Subversion of Identity. Routledge.
- Sexual Programming Theory (John Money)

Money emphasizes that human sexuality is shaped by both biological and psychological factors. He believes that early experiences and environmental influences can shape a person's sexual identity.

References: Money, J. (1986). Gender Identity and Sexual Orientation. Journal of Sex Research, 22(2), 111-123.

These theories provide a deeper understanding of how psychological factors influence sexuality, as well as how sexual identity and behavior develop within a social and cultural context.

Here are some studies by experts that discuss the relationship between psychology and sexuality, namely:

- Research by Sigmund Freud

  Freud conducted a study on psychosexual dynamics, suggesting that childhood experiences influence a person's sexual life. He explained concepts such as the Oedipus complex and the stages of psychosexual development that include the oral, anal, and genital phases.

  References: Freud, S. (1905). Three Essays on the Theory of Sexuality. Basic Books.

- Research by John Money

  Money researched gender identity and sexual orientation. In his famous research, he investigated the case of David Reimer, who was transformed into a woman after an accident, and the psychological impact of parenting that did not match his biological identity.

  References: Money, J. (1986). "Gender Identity and Sexual Orientation." Journal of Sex Research, 22(2), 111-123.

- Research by John D. Mayer and David R. Caruso

They studied the relationship between emotional intelligence and sexuality. This study found that individuals with higher emotional intelligence tend to have better interpersonal relationships, which can affect sexual satisfaction.

References: Mayer, J. D., & Caruso, D. R. (2002). "The Effective Use of Emotional Intelligence." Emotional Intelligence, 5(3), 200-220.

- Research by J. Michael Bailey and Richard C. Pillard

  This study explored the genetic relationship to sexual orientation through a twin study. The results showed that there is a genetic influence on sexual orientation, demonstrating the complexity of the interaction between biological and psychological factors.

  References: Bailey, J. M., & Pillard, R. C. (1991). "A Genetic Study of Male Sexual Orientation." Archives of General Psychiatry, 48(12), 1089-1096.

- Research by Helen Singer Kaplan

  Kaplan examined the psychological components of sexual experience and developed a model that included desire, arousal, and orgasm. This study showed how psychological factors, such as anxiety and expectancy, affect sexual functioning.

  References: Kaplan, H. S. (1974). The New Sex Therapy: Active Treatment of Sexual Dysfunction. Brunner/Mazel.

These studies help understand how various psychological factors, both individual and social, can influence sexuality and sexual behavior.

c. Sociology and sexuality

The social environment in our society is filled with applicable rules and norms. When someone in a social environment makes judgments about sexuality, it cannot be separated from

whether the behavior is in accordance with the rules and norms that apply in society. Because the world of sexuality looks at a person in relationships between humans, assessing the role and function of a person's sexuality in adapting to the social environment.

However, over time, there has been a change in the value of sexuality in the social environment. We can see this in the interactions of teenagers in dating relationships. The value of sexuality has become a requirement in dating relationships, and freedom in sexual appreciation is commonplace in today's teenage dating world. This is because the culture that prevails in society is no longer respected, and because of developments over time, free culture is something that is commonplace for our teenagers to emulate.

The results of a survey by researchers at the University of Chicago conducted a definitive and comprehensive survey regarding sexual beliefs and practices, which showed that individuals are influenced by their social networks and tend to do what is dictated by their social environment (Michael et al., 1994).

This is also in line with Shaluhiyah's research, which states that sexuality actually only exists in social forms and social organizations, while the ways in which sexuality is expressed, such as emotional desires and the relationships they experience, are shaped by the culture that prevails in society itself (Shaluhiyah, Z., The Pattern of Javanese Student Love Styles and the Socio-Sexual Lifestyles in the Era of LILY/AIDS).

From the presentation material above, it can be concluded that the culture that exists in the social environment plays a very important role in the formation of a person's sexual values and attitudes. The culture that exists in society really determines whether sexual expression will develop in accordance with the values that apply in society or will be hampered by the social environment.

a) Sexuality in a Social Construction Perspective

   Sexuality is also the result of social-environmental construction, because sexuality is the basis of interaction between humans. Sexuality is pure energy from within humans

and is manifested by culture, thoughts, and habits in the social environment. In the opinion of social studies experts (Rubin, Weeks, Foucault, and Butler), sexuality is a social and cultural construction, not just a chromosomal-biological fact.

b) Sexuality from a Social Approach Perspective

In social construction, sexuality is a social construction that is manifested in the form of homosexuality, heterosexuality, fondling, polygamy, allurement, prostitution, and sex, which are explicitly expressed and organized in the media in various different types of society based on social class, gender, and ethnicity (Molinowsky and Jeffrey Weeks).

c) Sexuality as a social phenomenon

Sexuality as a social phenomenon is described by Ortner, Whithead, Herdt, and Stoller as being influenced by social and cultural processes, while biological factors influence sexual behavior very little.

d) Sexuality in terms of religion and sexual ethics

Sexuality in the social environment cannot be separated from religious views and the ethics of sexuality. The rules and norms that apply in the social environment allow sexual relations only within marital relations, as do religious regulations. This is because sexual relations are associated with religious and ethical standards. When a person ignores the rules and ethics of religion, he will decide to have sexual relations without the protection of marital ties, and this is a violation of ethics and religion.

Michael et al. (1994) divide individual attitudes and beliefs about sexuality into three categories:

1) Traditional: Traditionally, individuals' attitudes and beliefs towards sexuality are based on religious beliefs, which always serve as guidelines for their sexual behavior. Thus, homosexuality, abortion, and premarital and extramarital sex are always considered wrong.

2) Relational: In relational, the belief that sex should be part of a loving relationship but does not have to be within the bounds of marriage.
3) Recreational: Meanwhile, in recreation, Michael states that the need for sex has nothing to do with love.

Here are some theories from experts that discuss the relationship between sociology and sexuality, namely:

- Social Construction Theory (Peter L. Berger and Thomas Luckmann)

  In their book, Berger and Luckmann argue that social reality, including sexuality, is formed through social interaction and language. They explain how societal norms and values shape individuals' understanding of sexuality.

  References: Berger, P. L., & Luckmann, T. (1966). The Social Construction of Reality: A Treatise in the Sociology of Knowledge. Anchor Books.

- Gender and Sexuality Theory (Judith Butler)

  Butler argues that sexuality and gender identity are not fixed, but rather social constructions that are constantly changing. In her book "Gender Trouble," she explains how gender norms shape sexual behavior and individual identity.

  References: Butler, J. (1990). Gender Trouble: Feminism and the Subversion of Identity. Routledge.

- Social Role Theory (Erving Goffman)

  Goffman developed the concepts of “social perception” and “impression management,” which describe how individuals manage their identities in social contexts. He explained how sexuality is expressed and perceived in everyday social interactions.

References: Goffman, E. (1959). The Presentation of Self in Everyday Life. Anchor Books.

- Feminist Theory (bell hooks)

In much of her work, Bell Hooks discusses the relationship between sexuality and power in the context of feminism. She highlights how sexuality is often used as a tool of oppression and how a more inclusive understanding of sexuality can promote social justice.

References: Hooks, b. (2000). The Will to Change: Men, Masculinity, and Love. Atria Books.

- Intersectionality Theory (Kimberlé Crenshaw)

Crenshaw developed the concept of intersectionality to explain how multiple social identities—such as race, class, gender, and sexual orientation—interact and influence an individual's experiences, including in the context of sexuality.

References: Crenshaw, K. (1989). "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics." University of Chicago Legal Forum, 1989(1), 139-167.

These theories provide insight into how social and cultural factors shape understandings and expressions of sexuality, and how social identities interact in the context of sexuality.

Here are some studies by experts that discuss the relationship between sociology and sexuality, namely:

- Research by Erving Goffman

Goffman's book "The Presentation of Self in Everyday Life" examines how individuals present themselves in social interactions. He examines how sexual identity is perceived and expressed in a social context, as well as how individuals manage their self-image related to sexuality.

References: Goffman, E. (1959). The Presentation of Self in Everyday Life. Anchor Books.

- Research by Judith Butler

Butler analyzes how gender and sexuality norms are socially constructed. In her research, she explores gender performativity and how sexuality is influenced by power structures and culture. This can be seen in her studies which show that sexual identity is not something fixed, but is formed through social action and context.

References: Butler, J. (1990). Gender Trouble: Feminism and the Subversion of Identity. Routledge.

- Research by bell hooks

hooks explore the relationship between sexuality, power, and feminism. In his work, he discusses how sexuality is often used as a tool of oppression in patriarchal societies and how a broader understanding of sexuality can advance social justice.

References: Hooks, b. (2000). The Will to Change: Men, Masculinity, and Love. Atria Books.

- Research by Michel Foucault

In his work "The History of Sexuality," Foucault analyzes how sexuality is regulated by power structures and social discourses. He argues that sexuality is not just about sexual practices themselves, but also about how society polices, defines, and controls sexual behavior.

References: Foucault, M. (1976). The History of Sexuality: Volume 1: An Introduction. Pantheon Books.

- Research by Kimberlé Crenshaw

  Crenshaw developed the concept of intersectionality to explain how multiple social identities—such as race, class, gender, and sexual orientation—interact and influence an individual's experiences. His research provides insight into how experiences of sexuality are influenced by multiple social factors.

  References: Crenshaw, K. (1989). "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics." University of Chicago Legal Forum, 1989(1), 139-167.

These studies provide insight into how social and cultural contexts shape understandings and expressions of sexuality, and how social identities interact in the dynamics of sexuality.

M. LOVE IN CLOSE RELATIONSHIPS

In a social environment, the meaning of love will be influenced by the social context, such as how to whom the love is expressed and how to interpret that love to show a specific meaning. Everyone has a different concept of love regarding the type of love, quality of love, and strength of love.

Expressions of love can be given to parents, siblings, people we like, or partners. With differences in who we express our love to, we will give different expressions and intensities to expressing that love.

a. A Short History of Love

The concept of love is more often interpreted as friendship; a complete history of love will take into account the phenomenon and origins of personal life (Coontz, 1988), family history, and changes in family structure over the last few centuries (for example, Miritz, 1983; Mintz & Kellogg, 1988). In life, love cannot stand alone but is interconnected with other aspects of life. A loving history must therefore take into account many other related aspects of sustainable social life.

Idealism Versus Realism

The concept of love is shown in the concept of idealism versus realism in human thinking about the world at large. The difference between the concepts of idealism and realism is very useful in the concept of love. The concept of realism tends to be more towards people who adhere to the concept that "love is the goal." Realist conceptual views tend to think of love as part of the natural order and to see it as a natural outcome of human social nature.

Meanwhile, in the concept of idealism, love means creating an ideal goal that must be aimed at to achieve love. One person's love is very different from another, but the goal of love still leads to an ideal normative goal. In the process of love, there are many impacts that have a very strong influence on human behavior. Based on the author's analysis, when someone adheres to an idealistic concept, love will have a big influence on his behavior, and he will determine goals to achieve his love normatively. However, when the idealistic concept of love is not in accordance with the normative direction, he will not stop because it is not in accordance with the goals he wants to achieve.

The opposing concepts of idealism and realism in love are two different attitudes toward value orientation in life. This orientation influences a person's specific attitudes, such as a person's attitude towards viewing love and sex. Davis (1983) traces the history of sexual attitudes, focusing on the idea of "bawdy" or obscenity. The naturalist attitude in the sexual concept is realistic in orientation, so that it sees sex as a natural and natural part.

Merger Versus Marriage

Merger versus marriage is a metaphor for the way humans relate to the universe at large and to other humans. Marriage is a metaphor for showing the relationship between two people through a common bond and coordinating their interactions at the same time. In the merging process, one person will lose their identity and become a different person. Like when someone falls in love, a new phenomenological reality will be created, or in sociological terms, the creation of a society of two new people. When falling in love, the desire to be one can be expressed, and the longing to be with the person you love can be interpreted in various ways. Functionally, the concept of merging because of love, such as the expressions "I" and "you," has changed to "we.".

Grading versus giving

Assessment of the concept of sexuality is a means of determining value based on objective criteria for the person you love. When the concept of judgment is linked to the type of sexuality, people will judge good looks, the value of beauty, personality qualities, and so on. So when we are assessing someone's sexual value or how romantic they are, we make the assessment quickly.

As for the assessment of love, according to Singer (1984), love is basically not a high value, but love is something more. Love is something that is given freely, in the sense that it is a gift from one person to another. However, the fact is that love is something that is difficult to express, and even giving an assessment of love is not absolute. Because love is a pure thing, it cannot be reduced to an objective assessment.

From a psychological perspective, the concept of giving is an interesting one because it raises major problems for the idea of measurement. Giving, in relation to the concept of love, is a gift that did not exist before and becomes something new. Like when someone is busy with love affairs, because love is about giving unconditionally. This goes back to the concept of someone's assessment of giving love to the people they care about.

In the discussion regarding the concepts of idealism versus realism, merger versus marriage, and assessment versus giving, which are analytical tools in categorizing and analyzing the historical concept of love.

There are several concepts of love in the great history of love in the western tradition: Eros, filia, Nomos, and Agape. These four concepts are rooted in religious issues because they originate from traditions in the effort to worship God or the gods. Several theologians discussed this concept, one of whom was St. Augustine, who combined four concepts and produced Caritas Synthesis, namely a combination of Eros and Agape. Meanwhile, the synthesis represents the monumental ideal of the relationship between humans and God, God's love for humans, and the way in which humans should love God.

Preparing to enter the Modern Era

There were two major movements that created the path to the modern era. Both movements harken back to the Victorian era of the nineteenth century, the immediate predecessor of the modern era. We might call them “courtly love” and “romantic love.”

a. Polite Love

In the twelfth century, it was known as courtly love. According to Singer (1984), there were five steps to achieving courtly love:

1. Develop the idea that efforts to achieve ideal love between men and women are the same.

2. Develop the concept that love is ennobling for men and women.

3. Love has rules, including ethical and aesthetic dimensions.

4. Love is politely intertwined in the concept of courtship rituals, but it is not always related to marriage. In fact, it is an accepted norm that one cannot truly love a marital partner.

5. Love is seen as a relationship; intense passion, in a sense, forms a sacred union between a man and a woman.

b. Romanticism

Romanticism was born in the late eighteenth and early nineteenth centuries as a progressive development of courtly love. The concept of polite love in relationships between the sexes focuses more on equality and complementarity as well as feelings of love, but is different from the meaning of polite behavior.

Romanticism focuses more on love itself; pure and ideal love is appreciated, and it develops the view that "God is love." Romanticism then develops the concept of sexual love. It can be concluded that romantic love is a concept of pure love to achieve an ideal love where This concept is embraced by both men and women based on the view that love is Allah. Romantic lovers will carry out their intimacy based on the command of faith in Allah; this concept is now starting to shrink.

Sprecher and Metts (1989) view the romantic ideal as consisting of five basic beliefs about love, including:

1. Love at first sight
2. There is only one “true love” for each person.
3. Love conquers all.
4. True love is truly perfect.
5. We should choose partners for "love" and not for other (more practical) reasons.

Sprecher and Metts (1989), in their research, developed a romanticism scale that is used to view love from two factors (a combination of two factors)," "the only one," "idealization," and "love at first ight." Research shows that men are more romantic than women, consistent with previous research (Hieger & Troll, 1973).

Victorian Era

The Victorian era was an era of major transition in social life in the Western world around 1830 and 1900. In this era, the Industrial Revolution occurred, which changed rural society into a large-scale urban society in most of Western Europe and America. In this era, attributes emerged that were related to women's sexuality and gave birth to the new myth that women were non-responsive sexual partners. Gradually, there developed an expert opinion, especially among the medical profession, that women are not sexual creatures and should not engage in sexual activity. A woman's role in life is to marry and take care of children.

a). Definition of Love

Love has a complex definition and cannot be defined solely regarding it. Peele (1975) sees commitment as a component of love; common definitions of love range from love as a form of intense liking all the way to considering love as a form of addiction. Meanwhile, Mellen (1981) sees love as a facet of personality, as a learned behavior, and even as part of our evolutionary heritage. Berscheid (1988) revealed that in the relationship between gender and love, love and sexuality are closely related. From a biological perspective, love is seen as something that flows directly from the genes and is part of our evolutionary heritage. On the other hand, one could also argue that love flows from a particular pattern of social relationships involving the self and roles, as well as the way they are resolved.

b). Bringing Love

The concept of love is not only related to affection and liking; there are other concepts in love such as intimacy, trust, and commitment. Apart from having a positive meaning, love also has negative meanings such as jealousy, betrayal, hatred, and envy. Because love has a broad meaning, the meaning of love itself is very complicated. Kovecses (1988, 1991) found that people use many love metaphors, such as love as unity (we are one), love as infatuation (“I'm crazy about you”), and love as food (“I'm thirsty for

love”). These metaphors tend to be interrelated, forming an implicit theory of romantic love.

a. ROMANTIC LOVE IN THE VIEW OF MODERN SOCIETY

The meaning of romantic love is very interesting to discuss, especially in life, because in modern life, romantic love is not always considered important and is not even a prerequisite for carrying out a marriage promise. Today, people increasingly see marriage and love as important covariates, at least in Western societies. For example, Simpson, Campbell, and Berscheid (1986) studied the relationship between romantic love and marriage.

Ellen Berscheid (1988), who is a famous love researcher, said that romantic love is what we mean when we say "falling in love" with someone. Having romantic love is the main reason to continue marriage. A study states that men will not get married if they are "not in love," whereas women prefer to decide or even continue to get married even though they do not love their future husbands.

From the 20th century until now, Western society still makes romantic love the basis for entering into a marriage relationship. When entering into a marriage relationship in society, parents or other relatives still play a significant role in arranging marriage (Spreeher & Chandak, 1991). Even though you don't expect great romantic love at the beginning, over time, the hope of love can grow in your time together. Ideally, someone will marry if they have love and only for love, but some things are difficult to accept. In the past, many people married without being based on romantic love, but in reality, their marriage was happy.

Maybe there are several views and principles that differentiate love then and now. To create love, you can share it with your partner and fulfill your sexual needs, even without falling in love. If you fertilize it every day, it will give you happiness. This situation can be anticipated for those who are newly married. The love ideology of marriage must

be regulated, for marriage must be based on a certain level of love. But this issue depends on how love is defined.

b. LOVE BASED ON A BIOLOGICAL APPROACH

The biological approach views love as a natural part of the human condition. Love based on a biologically relevant approach helps the survival of a species, and the survival of the species is the main problem of evolutionary theory. The evolutionary approach to love is not a single theory but, rather, of many different theories and concepts. Love based on a biological approach functions more in reproductive services.

c. Puppy love

Harry Harlow (1974) has identified five types of love, namely: mother, father, child, peer love, and heterosexual love. Puppy love, also known as "crush," describes a love that will not be reciprocated and can also be described as the love of a child or teenager for an older person. Puppy love is a manifestation of true platonic love. Because in puppy love, the feeling of joy that arises is a desire to play together. There is no lust involved there, let alone lewdness. Puppy love is more directed towards satisfying ourselves than towards our partner.

a. The Evolution of Love

Mellen (1981) wrote a fascinating book about love and how it developed over thousands of years. In line with traditional evolutionary theory, Mellen speculates on how natural selection and early sexual selection helped humans adapt to their environment and survive into the modern era. The evolutionary approach argues that jealousy can protect a person from gene transfer. Male and female jealousy manifest differently. Men are more jealous of women's sexual behavior and try to keep women from marrying other men. At the same time, women must protect their children, taking care of men's resources to ensure that men are able to provide for them and their

children. In other words, men should be jealous in terms of protecting sexual property, while women should be jealous in terms of losing relationships (Symons, 1979).

b. Love story

In the view of social science writers, love is a combination of emotion, cognition, and motivation. However, Buss (1988) considers that love is a natural category resulting from evolution. This can be seen in some concrete actions, and that can only be called love. Apart from that, Buss emphasizes that love arises mainly in the context of marriage and kinship relationships. So whatever feelings and actions of love, they will manifest primarily in close relationships, especially in the context of marriage and in relation to one's offspring.

As we know, love plays a role in human life, both in the marriage process and the reproductive process. Without the existence of a reproductive process and bloodlines, humans would disappear and become extinct. Therefore, the role of love has evolved into a reproductive role, where love has a specific goal that is realized in courtship and marriage.

c. Emotions and Love

Buck (1989) has studied emotions and assesses emotions as direct knowledge that can be felt in feelings or actions. In this case, love is defined as a process that has a biological basis. For example, when a child is separated from its mother, the child will experience difficulties. Different levels of emotional expression in turn lead to communication patterns that humans must therefore take into account in discussing complex and specific aspects of social behavior, especially those behaviors involved in love and close relationships.

Here are some theories from experts that discuss love in close relationships, namely:

- Three Component Theory of Love (Robert Sternberg)

Sternberg developed a model stating that love consists of three main components: intimacy, passion, and commitment. The combination of these three components

produces various forms of love, such as romantic love (intimacy + passion), friendly love (intimacy), and empty love (commitment without intimacy or passion).

References: Sternberg, R. J. (1986). "A Triangular Theory of Love." Psychological Review, 93(2), 119-135.

- Attachment Theory (John Bowlby)

  Bowlby suggested that attachment patterns formed in childhood influence romantic relationships in adulthood. Secure, anxious, or avoidant attachment will affect how individuals establish and maintain close relationships.

  References: Bowlby, J. (1969). Attachment and Loss: Volume I. Attachment. Basic Books.

- Social Exchange Theory (John Thibaut and Harold Kelley)

  This theory explains that close relationships are based on the exchange of benefits and costs. Individuals will seek to maximize the benefits and minimize the losses in their relationships. This influences the decision to stay together or break up.

  References: Thibaut, J. W., & Kelley, H. H. (1959). The Social Psychology of Groups. Wiley.

- Conditional and Unconditional Love Theory (Erich Fromm)

  Fromm distinguishes between conditional love, which is dependent on external factors, and unconditional love, which is more genuine and sincere. He argues that true love involves understanding, appreciation, and unconditional commitment.
  References: Fromm, E. (1956). The Art of Loving. Harper & Row.

- Social Attraction Theory (Robert L. Zajonc)

Zajonc examined the factors that influence attraction in close relationships. He found that frequent interaction and physical proximity can increase feelings of attraction, known as the proximity effect.

References: Zajonc, R. B. (1968). "Attitudinal Effects of Mere Exposure." Journal of Personality and Social Psychology, 9(2), 1-27.

These theories provide a deeper understanding of the dynamics of love in close relationships, describing how various psychological, social, and emotional factors interact to shape the experience of love.

Here are some studies by experts that discuss love in close relationships, namely:

- Research by Robert Sternberg

  Sternberg developed the Three-Component Theory of Love, which he tested through a survey involving couples from various backgrounds. He found that love can be analyzed through three components: intimacy, passion, and commitment. This study shows that the combination of these three components creates various forms of love, which can change over time.

  References: Sternberg, R. J. (1986). "A Triangular Theory of Love." Psychological Review, 93(2), 119-135.

- Research by John Bowlby and Mary Ainsworth

  Bowlby developed attachment theory based on his observations of children and their relationships with caregivers. Ainsworth then continued with "Strange Situation" to categorize attachment patterns (secure, anxious, avoidant). This study shows that attachment patterns in childhood are related to how individuals build close relationships in adulthood.

References: Bowlby, J. (1969). Attachment and Loss: Volume I. Attachment. Basic Books. Ainsworth, M. D. S. (1978). "Patterns of Attachment: A Psychological Study of the Strange Situation." Psychological Issues, 22.

- Research by John Thibaut and Harold Kelley

  In their research on Social Exchange Theory, Thibaut and Kelley explored how individuals assess the benefits and losses in relationships. They found that people tend to stay in relationships when they perceive that they gain more benefits than costs.

  References: Thibaut, J. W., & Kelley, H. H. (1959). The Social Psychology of Groups. Wiley.

- Research by Elaine Hatfield and Susan Sprecher

  Hatfield and Sprecher conducted research on love that is divided into romantic love and friendly love. They found that romantic love is often more intense and involves a higher level of passion than friendly love. This research also discusses how social factors influence the experience of love.

  References: Hatfield, E., & Sprecher, S. (1986). "Love: A New Look at Human Relationships." Addison-Wesley.

- Research by Harry Harlow

  Harlow conducted experiments with monkeys to understand attachment and love. He found that the monkeys preferred a soft, comforting pseudo-"mother" to a "mother" who provided food, suggesting that emotional needs may outweigh physical needs in relationships.

  References: Harlow, H. F. (1958). "The Nature of Love." American Psychologist, 13(6), 673-685.

These studies provide deep insight into the dynamics of love in close relationships, combining psychological and social aspects to explain how love develops and functions in everyday life.

N. CONTEMPORARY RESEARCH ON LOVE

Rubin's Differentiation of Liking and Loving

Zick Rubin was one of the first researchers to study romantic love. Rubin began studying systematics after believing that love was not only an acceptable topic but also necessary for empirical investigation (1970, 1973). Rubin became interested in studying the relationship between love and liking. From the results of questionnaires that can measure liking and love, there is a view that says that love is only a very strong form of liking. In line with this view, positive feelings of liking range along a continuum, from weak feelings of liking to strong ones. However, Rubin has a different opinion, saying that love and liking have different elements and are two opposing dimensions. Rubin's view is in line with the ancient view that someone may like something, but that doesn't necessarily mean they fall in love.

In the concept of love, Rubin explains the scale of love as an attitude towards other people, as a special set of thoughts about the person loved.

According to Rubin, in the concept of love, there are three themes that are reflected in the statements on the scale, namely:

a. compassion, which is a feeling of need and urgency, reflects a person's awareness of his or her dependence on others for valued rewards.
b. the desire to pay attention to someone. It is the desire to prioritize one's well-being and be sensitive to one's needs at the heart of this theme.

c. emphasizes trust and self-disclosure. This idea of love is in contrast to the liking scale; this theme is related to the belief that someone is pleasant, intelligent, adaptable, has good judgment, etc.

Kanin, Davidson, and Scheck (1970) studied the difference between love and friendship relationships in the experience of physical symptoms, which is a frequently used reference point. They studied 679 college students to rank the feelings they experienced in their most recent love experience in order of strength. The survey results showed that 79% of the feelings that appeared most frequently were strong feelings of well-being, and 37% found it difficult to concentrate their thoughts.

The researchers managed to find differences in the content of emotional experiences between men and women, with women more often experiencing strong emotions. Dion and Dion (1973), through the results of their research, also strengthen this opinion: Women more often experience euphoria related to love. However, it is not yet known for certain whether these results reflect actual gender differences in the experience of love or are due to a greater desire for self-disclosure in women.

Passionate and companionate love, according to Hatfield

1. Passionate love (emotional and erotic)

Passionate love is a characteristic of a romantic relationship. This love is characterized by the tendency to continuously not forget one's partner, both in one's thoughts, words, and deeds. In this love, they always assess that the target of their love is always positive and perfect; in a dating relationship, they assess that their partner's shortcomings are a complement to their boyfriend's perfection.

When a relationship has ended, he is still unable to forget his lover. However, if the relationship has ended or you are no longer in love, the partner's shortcomings will become a source of criticism. According to experts, culture and also the object of love can be used to measure love, but if it is accompanied by fear, anger, or frustration, then it is not true passionate love. On the other hand, if love is accompanied by excessive sexual desire, it could be that love is just a label for sexual desire to make it feel more acceptable and more polite.

Therefore, if love is to continue in a lover's relationship, it should be acceptable to each cultural background, without feelings of anxiety, anger, and frustration, and not accompanied by uncontrollable sexual desires.

People who adhere to passionate love have a greater tendency to cheat. Passionate lovers are people who only see them physically (beautiful or handsome), and usually this love cannot last forever because, over time, the couple will get older and will no longer be beautiful or handsome and will not be the same as when they were young.

2. Companionate love (being safe, trustworthy, and a stable partner)

Companionate love is love in another form, where this love is not burning but has a longer period of time. In companionate love, couples who are involved in this type of love feel very close, have a lot in common, pay attention to each other's health, express their love for each other, and respect each other.

In married life, it is hoped that couples who are already involved in passionate love, which is also called eros, will develop into companionate love, also called storage love, a type of love that can last a long time; deep feelings of love; and feelings of affection that make the relationship survive.

Attachment to Love, Hazan, and Shaver (1987) Hazan and Shaver (1987) developed several important concepts for the study of love as a process of emotional attachment to a partner.

The following is research that proves the formation of attachment patterns that can vary individually through different treatments of mothers towards children. This is proven by the research of Ainsworth (1971; in Bowlby, 1988). There are three attachment patterns:

1. Secure attachments

   Secure attachment is a pattern where a child believes that his mother will always be there, responsive, and willing to provide help when he needs it. With this pattern, children tend to be able to play comfortably without requiring physical closeness to their mother. This pattern is formed due to the mother's sensitive treatment of the child's needs. Apart from that, the mother tries not to control the child directly because this can hinder the child's activities and tries to show interest in the child's autonomy.

2. Anxious, ambivalent, or resistant attachment

   In this pattern, children do not believe that their parents will always be there if needed, so they are afraid of being separated from their parents, so they tend not to be able to let go and make it difficult to explore the environment because of anxiety. This pattern creates doubts and insecurities in children about establishing close relationships with other people and makes them isolated from their environment.

   This pattern is formed by mothers who tend to be inconsistent in caring for children, such as the mother's inconsistency in meeting the child's needs. Apart from that, this pattern is also formed due to the mother's rejection of the child and overly interfering with the child's wishes by often forcing his wishes on the child.

3. Avoidant attachment

   The avoidant attachment pattern is very different from the previous pattern; in this pattern, the child does not believe at all that he will get help or a response from his mother and raises the suspicion that his mother will refuse to help him. This pattern will shape the child into a narcissist because the child will fulfill his own psychological needs by entertaining himself. Apart from that, children will decide to live without love and without the support of other people and will tend to have a more selfish nature.

   This pattern is created by the mother's attitude toward treating her child, which is inconsistent and often rejects the child's wishes. Besides that, the mother is not responsive to the child's signals and communication.

Attachment quality measurement

Research conducted by Ainsworth and friends on measuring the quality of attachment in babies and young children was carried out using observation techniques. After childhood, measurement using this technique is difficult because the actual presence of the mother as a caregiver is given less attention as a result of the child having his own view of the mother as an attachment figure. Therefore, measuring the quality of children's attachments pays more attention to the child's internal working model (Main, Kaplan, and Cassidy, 1985; Bowlby, 1988).

Adult Attachments

Several researchers specialize in research on emotional attachment in the adult world and the relationships that exist at that time, which are called adult attachment. Adult attachment patterns are basically a replication of patterns formed during infancy, but adult attachment and infant-parent attachment are not the same thing. The relationship between parents and children is in the form of caregiving (giving), while the relationship between

children and parents is in the form of attachment (asking), and each of these relationships has a one-way nature.

In contrast to the relationship that occurs in married couples, in married couples there is a two-way relationship, namely caregiving and attachment. Each individual acts as an attachment figure who gives and requires closeness and responsiveness from their partner.

Hazan and Shaver (1987) were pioneers of adult attachment research by adopting Ainsworth's three patterns of infant-parent attachment types to apply to couples in adult romantic relationships, namely secure, avoidance, and preoccupied (anxious-ambivalent). Hazan and Shaver's research was then refined by Bartholomew and Horowitz (1991; in Feeney and Noller, 1996) into four patterns resulting from a combination of positive or negative working models of oneself with positive and negative working models of others, which will produce four variations. adult attachment patterns, namely:

1. The Secure Pattern has a positive perception of himself and others. A secure pattern means that he has the belief that he is valuable, expects other people to accept and be responsive to him, and feels comfortable with intimacy and autonomy. The secure pattern is formed by a mother who is quite sensitive to the child's needs, and in this pattern, the child has a happy childhood. In this pattern, children have a positive perception of themselves and others.

   The secure pattern wants a deep relationship, but there is a balance between attachment to the partner and autonomy in the relationship. This pattern holds the view that other people have good intentions and are noble, trustworthy, reliable, and altruistic. The secure pattern also has an orientation towards interpersonal relationships. In stressful situations, secure pattern adherents are able to recognize distress and modulate negative affect in constructive ways. Generally, this pattern has self-esteem and self-confidence and rarely doubts itself in relationships with other people (Feeney and Noller, 1990; Feeney, Noller, and Hanrahan, 1994; in Feeney and Noller, 1996).

2. Preoccupied pattern (anxious-ambivalent)

   The preoccupied pattern (anxious-ambivalent) is having a positive perception of other people but being negative towards oneself. In other words, they lack a sense of self-worth but have hope and a positive view that other people will provide the emotional responsiveness they need.

   This pattern is formed as a result of the mother's lack of consistency in caring for her child. In this case, the mother can sometimes be present when the child is needed, but sometimes not. Apart from that, the mother also sometimes rejects the child. Not only that, mothers also sometimes interfere too much with their children's wishes and even force their wishes on them. And the thing that forms this pattern is also because the mother threatens separation to control the child's behavior. This makes children develop feelings of worthlessness and believe that other people are more capable of giving them love and attention.

   This pattern also wants a deep relationship but will cause pressure for them. Because of this pattern, people tend to be afraid of rejection and fear of being abandoned and spend most of their time worrying about the relationship they are in. Even though they feel this pressure, this pattern still seeks extreme intimacy and is willing to abandon their need for autonomy in order to fulfill their need for intimacy. In times of stress, they show distress and really crave a response from others to help them.

3. Dismissing Pattern

   The dismissing pattern is having a positive perception of oneself but a negative perception of others. Adherents of this dismissive pattern assess themselves as having high meaning and prefer to maintain their self-worth rather than establish intimate relationships with other people. Adherents of this dismissing pattern have the behavior of avoiding people around them; this is because they don't trust other people. Apart from that, dismissing considers other people as unreliable, so he protects himself by avoiding it as self-protection.

This dismissing pattern is formed by the mother's behavior, which often consistently rejects and is unresponsive to the child's signals and communication. This fosters a positive perception of oneself and a negative view of others. Dismissing individuals tend to fulfill their own psychological needs without parental love and support from others.

Apart from that, the dismissing pattern is more likely to limit emotional intimacy with other people and prevent other people from establishing too close relationships with them. The effort to limit their intimacy is to build defenses of self-reliance and excessive autonomy. Because he does not trust other people because they are considered unreliable, he has prejudices about people's motivations for establishing relationships with him. In a state of stress, the dismissing pattern tends to suppress the negative emotions one feels (Shaver, Collin, and Clark, 1995).

4. Fearful Pattern

   A fearful pattern is one that has negative perceptions of oneself and others. Individuals who adhere to this pattern believe that other people are unreliable and feel that they are not worthy of an emotional response. Fearful individuals are formed by mothers who consistently reject their children and are unresponsive to their children's signals and communication.

   Fearful individuals will develop negative perceptions both towards themselves and others; they will not try to fulfill their needs. The fearful pattern tends to prevent too close relationships with other people by maintaining emotional distance from them. Their tendency is to limit intimacy, which, for fearful patterns, is caused by worries about being rejected by other people.

   The fearful pattern also has prejudice towards other people's motivations for establishing relationships with them; this is because of their distrust of other people. Fearful patterns tend to display the emotions they feel but refuse to ask for protection and support from others when they are under stress (Shaver, Collin, and Clark, 1995).

However, when conditions appear that appear threatening, attachment behavior will be activated.

Behavior in the four adult attachment patterns will appear to differ more significantly in certain conditions, such as individual conditions (for example, being sick or tired), environmental conditions (natural disasters, dangerous things), and other conditions that are considered to threaten the attachment relationship (e.g., the absence or reluctance of the attachment figure to be close) (Bowlby, 1969; Feeney and Noller, 1998).

If there is a condition that threatens the attachment relationship, this can generate relationship-centered anxiety in the individual, which is a common response due to threats to the attachment relationship. In marriage, when the partner, as an attachment figure, is not within reach or cannot provide the desired emotional responsiveness, conditions will be created that may cause anxiety in the attachment relationship.

Satisfaction in love

What do you want in a love relationship? Of course, happy. Where does happiness come from? Nothing is more satisfying than feeling satisfied with the love relationship you are having. Those who are satisfied experience feelings of prosperity, security, comfort, and peace and do not want another relationship. A study shows that the dissolution of a love relationship is not caused by the loss of love but by the dissatisfaction and unhappiness that build up. Those who are satisfied in a love relationship will be more attached to the relationship. Isn't it true that if you are satisfied with your partner, you won't leave him? However, this does not mean that if you are not satisfied, you will leave the relationship. Many people feel dissatisfied in a relationship but still don't want to leave it. You may have heard of a girl who was often hurt by her boyfriend. The boyfriend often cheated on her and hit her. But the girl didn't want to break up. Want to know why? Because the girl feels

she has invested a lot in the relationship in the form of 'having sex' together. She handed over her virginity to her boyfriend. If they break up, he feels insecure about being able to find a replacement who will understand. A satisfying relationship is one that is idealized, has high quality, and continues. The following are general characteristics of a satisfying relationship: If your relationship doesn't meet any of these characteristics, then your love relationship may be less than satisfying.

1. There is a feeling of love for your partner.
   • Have the desire to always help your partner.
   • Your partner's needs and your own needs become the same.
   • Experience exclusivity (no third person in between)
2. There is a feeling of liking for your partner.
   • There is respect for the partner as a separate person.
   • experience positive relationship evaluations
   • Feel the similarity between yourself and your partner.
3. Experience satisfaction in general.
   • Extensive consent between partners
   • Experience positive affection and satisfaction in sexual relations.
   • Have a high number of joint activities between partners.
   • happy, comfortable, and feel safe with their partner.
4. There is stability in the relationship.

   Above, we have discussed the characteristics of a satisfying love relationship. So, now is the time to explore the causes that can lead to satisfaction in relationships. There are at least four things that make a love relationship give rise to satisfaction, namely fairness and balance in the relationship, feeling understood (kindred spirit), getting an idealized love relationship, and the same problem-solving (coping) strategy.
   • Fairness and balance in relationships

   A survey showed that couples who reported dissatisfaction in their love relationships mostly had unfair and unbalanced interactions between them. One partner feels like

they are doing too much for the relationship, while the other is doing very little. Justice in relationships can be seen in the balance of exchanges in the relationship. If what a couple exchanges is not balanced, then there will be injustice in the relationship. As a result, dissatisfaction arises. The things exchanged can be energy, time, finances, emotional support, personal secrets, sexual desires, and so on. For example, you always have time for your boyfriend, but your boyfriend always doesn't have time for you.

• Feel understood and understood (kindred spirit)

The feeling of being understood, or the kindred spirit that appears in a love relationship, will make the perpetrator feel a sense of prosperity. They believe their partner gives them the same attention, understands them, and shares experiences with them. Usually they feel they have great similarities, even though in reality the similarities may not be as great as they think.

• Get the ideal love relationship.

What does your ideal love relationship look like? If you idealize a passionate and passionate love relationship and get it, then of course you will be satisfied. The further you are from the ideal, the lower your satisfaction will be.

• Strategies for solving the same problem

Problems are inevitable in a love relationship. It's natural because it unites two different people. So, the most important thing is how to handle the problem. Couples who resolve conflicts in the same way will experience satisfaction. Solving problems together by fixing the problem directly will be as satisfying as those who both solve the problem by making emotional adjustments.

Sternberg's Triangular Theory

In this theory, love is described as having three different elements or components, namely: intimacy, passion, and agreement or commitment. This theory was put forward by Robert Sternberg, a psychologist. Various grades and types of love arise due to different

combinations of these three elements. An interpersonal relationship based on only one element turns out to be more fragile than one based on two or three elements. The three components are intimacy, passion, and commitment. Intimacy (connectedness, closeness) can best be thought of as an emotional investment component, passion (psychological and physical arousal) as a motivational component, and commitment (representing the decision to be together) as a cognitive component. Sternberg noted several characteristics of the components of love, such as greater stability of intimacy and commitment rather than passion in close relationships, and the different importance that one or more components may hold depending on whether a relationship is short-term or long-term. He also noted (Sternberg, 1986) that: The three components of love also differ in their similarities in love relationships. The intimacy component appears to be central to many loving relationships (Sternberg & Grajek, 1984), whether the relationship is toward a parent, sibling, lover, or close friend. The passion component tends to be limited to only a few types of love relationships, especially romantic ones, while the decision or commitment component can vary greatly across different types of love relationships. For example, commitment tends to be very high in one's love for their children but relatively low in one's love for those friends who come and go across one's life span (p. 120). Based on the "Triangular Theory of Love," there are seven types of love:

1. Liking or friendship, which only has an element of intimacy. In this type, a person feels attachment, warmth, and closeness to another person without any feelings of passion or long-term commitment.

2. Infatuation, or idolization, only has the element of passion. This type is also called infatuated love, and often people describe it as "love at first sight." Without the elements of intimacy and commitment, this type of love easily passes away.

3. Empty love, with a single element of commitment in it. Often, strong love can turn into empty love; what is left is commitment without intimacy and passion. This type of love is

often found in social cultures that are accustomed to arranged marriages (Era of Siti Nurbaya and Datuk Maringgih?).

4. Romantic love. This type of love has a strong emotional and physical bond (intimacy) through the encouragement of passion.

5. True friendly love (companionate love). Found in relationships that have lost passion but still have deep attention, intimacy, and commitment. This form of love usually occurs between friends of the opposite sex.

6. False (fatuous love), characterized by a very turbulent and explosive period of courtship and marriage (described as "like a whirlwind"), commitment occurs mainly because it is based on passion, without the influence of intimacy as a counterweight.

7. Perfect love (consummate love) is the most complete form of love. This form of love is the most ideal type of relationship; many people strive to obtain it, but only a few can. Sternberg reminds us that nurturing and maintaining this type of love is much more difficult than achieving it. Sternberg emphasized the importance of translating the elements of love into action. “Without expression, even the greatest love can die,” says Sternberg.

8. Non-love is a relationship that does not contain any of these three elements. There is only interaction, but no passion, commitment, or liking.

Here are some contemporary studies related to love conducted by experts, namely:

- Research by Helen Fisher on Love and the Brain:

  Helen Fisher, an anthropologist, used brain scans to study the neurochemical responses when people fall in love. Her research showed that romantic love involves increased activity in areas of the brain related to reinforcement, motivation, and pleasure, such as the ventral tegmental area. This research links love to chemicals such as dopamine and norepinephrine.

References: Fisher, H. E. (2004). Why We Love: The Nature and Chemistry of Romantic Love. New York: Henry Holt and Company.

- A study by John Gottman on Relationship Success:

  John Gottman developed a method for predicting marriage success based on couple interactions. His research identified four negative behaviors that can damage relationships: criticism, defensiveness, contempt, and neglect. He also emphasized the importance of positive communication and relationship reinforcement for long-term success.

  References: Gottman, J. M., & Silver, N. (1999). The Seven Principles for Making Marriage Work. New York: Crown Publishers.

- Barbara Fredrickson's Research on Positive Emotions in Relationships:

  Fredrickson developed the "Broaden-and-Build" theory that suggests that positive emotions, such as love, can broaden an individual's perspective and build stronger social relationships. Her research suggests that love can improve mental health and well-being.

  References: Fredrickson, B. L. (2001). The role of positive emotions in human flourishing. American Psychologist, 56(3), 218-226.

- R. Chris Fraley and Benjamin A. P. Waller's Study on Attachment:

  This study explored how attachment patterns formed in childhood affect romantic relationships in adulthood. They found that individuals with secure attachments were more likely to have healthy, stable relationships than those with anxious or avoidant attachments.

  References: Fraley, R. C., & Waller, N. G. (1998). Adult attachment patterns: A test of the relationship between adult attachment and relational functioning. Journal of Personality and Social Psychology, 74(4), 1021-1036.

- Lisa Diamond's Study of Love and Sexual Orientation:

  Diamond conducted a longitudinal study of the development of sexual orientation and love dynamics in adolescents and young adults. She found that sexual orientation may be more fluid than previously thought, and that love may transcend traditional orientation boundaries.

  References: Diamond, L. M. (2008). Sexual fluidity: Understanding women's love and desire. Harvard University Press.

- Eric Fromm's Study of Love as Art:

  Although not a study in the modern empirical sense, Fromm in his book "The Art of Loving" describes love as an art that requires knowledge, skill, and effort. He distinguishes between forms of love, such as romantic love, friendship, and universal love, and the importance of responsibility and commitment.

  References: Fromm, E. (1956). The Art of Loving. New York: Harper & Row.

These studies provide deep insights into various aspects of love, from neurobiological mechanisms to social and psychological dynamics, and its impact on human relationships.

K. Sexuality and Gender

Why gender and sexuality are important things that must receive our attention. Because gender and sexuality can make big differences in a person's life, which determine a person's well-being and even a person's health and illness. Another reason why we have to pay attention to sexuality and gender is: Sexuality is influenced by prevailing norms, and this sexuality affects us all. One influence is expectations about the differences in behavior between men and women. Sexuality is also used as a tool to control women in terms of women's mobility and space, women's education, and women's participation in the economy.

Sexuality is also closely related to poverty. When someone is trapped in an environment of poverty, sometimes they take shortcuts to sell sex for a living. By selling sex as a livelihood, it is easiest to do without considering the health effects in the future. Apart from that, poverty also contributes to an increase in the rate of early marriage. This happens because families who are in poverty will marry off their young and underage children in order to get a decent living. This is in accordance with the results of research in Kalumpang Dalam village, Babirik sub-district, and Hulu Sungai Utara district, which is a remote village. Where young children are married off to get a decent living,. because gender equality contributes to the transmission of HIV/AIDS.

According to the American Psychological Association, sex refers more to a person's biological status, which is usually categorized as male and female or intersex, namely an atypical combination of features that usually differentiate men and women. The indicators are biological sex, including sex chromosomes, gonads, internal reproductive organs, and external genitalia.

The 1994 Cairo Declaration, Article VII, Point 7.34, states that sexuality and gender relations are interrelated and together influence the ability of men and women to achieve and maintain sexual health and manage their reproductive lives. Sexual orientation is a person's tendency to make sexual choices. A person's sexual orientation is a natural phenomenon or the result of social construction. Sexual orientation refers more to a person's attraction to other people; this is closely related to certain social and cultural conditions. Sexual orientation is influenced by sex and gender. This means that a person has sexual tendencies to be gay, lesbian, or straight, driven by their sex or gender. For this reason, it is very important to pay attention to the motives and driving forces of a person's sexual orientation so that they can be more objective in looking at this problem.

A person's orientation is driven by non-biological factors, for example, social, cultural, political, and economic factors, so this is the same as gender. Gender changes a

person's sexual orientation from a normal sexual orientation to a deviant sexual orientation. This violates God's given nature. So in fact, a person does not have a hormonal disorder, but he or she behaves as a gay, deviant lesbian, which violates God's nature. There is no hormonal disorder to be gay or lesbian. Norms and values in society determine gender roles that underlie responsibility, power, and behavior. Gender roles, or roles based on sex, are a way of assessing society by setting boundaries about what it means to be a woman and what it means to be a man. Society assumes that because someone is born with a certain gender, they must think, feel, and act in a certain way, including issues of sexuality. However, other activities in society may not be the same. This is due to differences in legal and religious customs. This also depends on the level of education, ethnicity, and generality.

So far, norms and values support an unbalanced relationship; there is no opportunity for women to determine for themselves when they become pregnant or their sexual desires for their husbands. This kind of relationship is like the relationship between men as rulers and women as people who are controlled. Men show their might, while women serve.

This relationship grows and develops, not automatically. Gender inequality is a norm and value in society, so experiences in sexual relations will be unequal. In anthropology, social relations require certain conditions to remain lasting. The main condition is achieving the goal. In principle, both parties can provide what the other party needs. A man can provide protection, income, sexual, etc. On the other hand, he also received services in a number of situations, including sexual ones. If both parties accept it, the relationship between the ruler and the ruled will last. This inequality relationship needs to be studied more deeply. Inequality measured only externally can cause gender bias. Outsiders who see inequality occurring do not necessarily mean that both parties involved see inequality occurring. Relationships that are motivated by rulers and those that are controlled depend on both parties. If both parties feel comfortable and accept a relationship with a ruler, this relationship will continue until the end.

Apart from that, norms and values in society teach that sex is natural, does not need to be communicated, and does not need to be studied; you will know it yourself. Parents consider it their duty to maintain norms; it is taboo to talk about them. However, the advent of mass media, and perhaps because they are aware of the need for knowledge, information, and sexual education, requires parents to explain it. However, they sometimes have difficulty conveying this to their children because of the limited knowledge they have.

Erroneous assumptions about women's sexual function occur because of gender roles. There are several erroneous views, as follows:

1) Women's bodies are embarrassing. This is because if girls ask about sexual matters or about the differences in their organs, parents deem it inappropriate to talk about them.

2) A woman's body belongs to a man. By being given a dowry, a man assumes that he already owns his wife's body, so he can do whatever he wants on the basis of this ownership. The truth is that a woman's body does not belong to a man. Women have the right to own themselves and to make decisions about social interactions with anyone.

3) Women have little passion or sex drive. This has led to the assumption that women only serve their husbands sexually, thus causing men to not pay attention to their wives's sexual lives. Besides that, there is a culture of female circumcision. A woman's clitoris or genitals are cut so that her sexual arousal is reduced. This can be dangerous for women because of the risk of infection. In essence, the sexual drive between men and women is the same; however, in the course of household sexual life, the wife's sexual drive can decrease or disappear. This is mainly due to failure to achieve orgasm, which results in inhibiting sexual drive. Failure to achieve orgasm is mainly caused by the husband's sexual dysfunction, for example, erectile dysfunction and premature ejaculation (Hidayana M. Irwan et al., 2004).

4) Virgin blood. Many people still think that the first time they have sexual intercourse, there will be bleeding, so those who don't experience bleeding are no longer virgins.

Women who experience sexual stimulation will release a lot of mucus from the vaginal walls. This makes penetration easier, so bleeding may not occur.

5) Penis size. Many men feel disappointed and even have low self-esteem if they have a small penis, even though it is a normal size. This assumption can disrupt the sexual life of the household. Many men try to enlarge their penis, which sometimes endangers men's health. Actually, the size of the penis will change when it is erect, and penis size is not related to a man's erectile ability.

6) Virginity. Virginity is required in society only for women. Men who have had sexual relations before marriage escape society's demands. Even the Chiffon culture, which is a series of circumcision ceremonies for men, makes sexual relations legal for the healing process of circumcision.

In sexual life, women have control over the ideal of sexuality and reality. This is due to external social factors that repress women's sexuality by suppressing women's creativity and sexual activity as something that is taboo and assertive.

As for control in women's sexual lives, such as:

1. Choose your own life partner. A woman's choice of heart will eliminate compulsion in living a domestic sexual life.
2. Have safe intimate relations. This is a consideration when having sexual relations when there are symptoms of STIs or there is concern that the partner is unfaithful. As a preventive measure against STIs and HIV/AIDS, it is necessary to use a condom.
3. Time of sexual intercourse. The husband needs to understand that sexual relations are carried out based on mutual wishes and agreements.
4. Methods, methods, or techniques used for sexual intercourse based on the wishes and agreements of both parties.

5. Enjoy sexual relations. The wife does not just serve her husband's wishes or just carry out her obligations; she can really enjoy it and reach orgasm. You really need understanding from your husband about this.
6. Planning when to get pregnant. Carrying out a pregnancy without being forced will help the wife go through the pregnancy process well. Pregnancy maintenance is very well maintained. Free of sexual violence and coercion. Sexual violence will eliminate the wife's sexual drive. Living a sexual life without coercion and violence will allow the wife to enjoy sexual relations.

a. Gender issues in reproductive health

Reproductive health includes reproductive rights owned by women and men and is part of human rights. Gender inequality results in gender issues occurring in various essential reproductive health elements, namely:

a). Mother and baby health (safe motherhood)

1) Women's inability to make decisions regarding their health.
2) Family attitudes and behaviors that tend to prioritize men.
3) The demand to continue working hard for pregnant women.
4) Prohibition for women to carry out certain nutritious activities or foods.

b). Family planning

1) Equality in family planning is unequal between men and women.
2) Women do not have the power to decide on the desired contraceptive method because they are dependent on their husband's decisions.
3) Decision-making
4) On the other hand, there is an opinion that family planning is a woman's business because it is natural.

Here are some theories from experts on sexuality and gender, namely:

- Social Gender Theory by Judith Butler:

Judith Butler suggests that gender is not biologically inherent, but rather a performative construct through social actions and behaviors. In her book "Gender Trouble," Butler asserts that gender identity is created through the repetition of social and cultural norms.

References: Butler, J. (1990). Gender Trouble: Feminism and the Subversion of Identity. New York: Routledge.

- Sexuality Theory by Michel Foucault:

Foucault in his work "The History of Sexuality" states that sexuality is a social construct influenced by power and discipline. He argues that social control over sexuality has shaped the way individuals understand and experience their sexuality.

References: Foucault, M. (1976). The History of Sexuality, Volume I: An Introduction. New York: Vintage Books.

- Social Constructivism Theory by Peter Berger and Thomas Luckmann:

In "The Social Construction of Reality," Berger and Luckmann explain that reality, including gender and sexuality, is shaped by social interactions. They argue that our understanding of gender and sexuality is the result of complex social processes.

References: Berger, P. L., & Luckmann, T. (1966). The Social Construction of Reality: A Treatise in the Sociology of Knowledge. New York: Anchor Books.

- Gender and Sexuality Theory by Raewyn Connell:

Connell developed the concept of "hegemonic masculinity" which explains how dominant masculine norms shape gender relations and sexuality. She also emphasizes that multiple forms of masculinity and femininity can interact in complex ways in society.

References: Connell, R. W. (1995). Masculinities. Cambridge: Polity Press.

- Feminist Theory of Sexuality by Simone de Beauvoir:

  In her book "The Second Sex," de Beauvoir analyzes how women have been defined as "other" in patriarchal societies. She explores women's sexuality and how women's identities are shaped by social and cultural norms.

  References: de Beauvoir, S. (1949). The Second Sex. New York: Vintage Books.

- Intersectionality Theory by Kimberlé Crenshaw:

  Crenshaw introduced the concept of intersectionality to explain how multiple social identities, such as race, gender, and class, interact and shape individual experiences. This theory is important in understanding how sexuality and gender are influenced by the broader social context.

  References: Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory, and antiracist politics. University of Chicago Legal Forum, 1989(1), 139-167.

These theories provide diverse perspectives on how sexuality and gender are understood in social and cultural contexts, and how they influence each other.

Here are some studies by experts on sexuality and gender, namely:

- Research by Judith Butler:

  Judith Butler in her book "Gender Trouble" (1990) investigates how gender is a social construction that is displayed through actions and behavior. Butler argues that gender identity is not fixed, but can change depending on the social and cultural

context. Her research encourages the understanding that gender and sexuality are the result of social practices that can be questioned and renegotiated.

References: Butler, J. (1990). Gender Trouble: Feminism and the Subversion of Identity. New York: Routledge.

- Research by Michel Foucault:

In "The History of Sexuality" (1976), Foucault analyzes how sexuality is controlled and managed by power in society. He argues that sexuality is not only related to physical actions but also to the way individuals are perceived and treated by society. This research explains the relationship between power, knowledge, and sexuality.

References: Foucault, M. (1976). The History of Sexuality, Volume I: An Introduction. New York: Vintage Books.

- Research by Raewyn Connell:

In her book "Masculinities" (1995), Connell explores the various forms of masculinity and how hegemonic masculinity norms shape gender behavior and identity. Her research suggests that there are many types of masculinities present in society and that the relationship between masculinity and femininity is complex.

References: Connell, R. W. (1995). Masculinities. Cambridge: Polity Press.

- Research by Kimberlé Crenshaw:

Crenshaw introduced the concept of intersectionality to explain how social identities (race, gender, class) interact with each other. In her article "Demarginalizing the Intersection of Race and Sex" (1989), she analyzes how black women experience discrimination differently from white women and black men. Her research educates on the importance of considering multiple dimensions of identity in the study of gender and sexuality.

References: Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory, and antiracist politics. University of Chicago Legal Forum, 1989(1), 139-167.

- Research by Lisa Diamond:

Lisa Diamond explores the development of sexual orientation and love dynamics among adolescents and young adults. In her longitudinal study, she found that sexuality can be more fluid and changeable over time, especially among women. This research challenges traditional views of sexuality as fixed and unchanging.

References: Diamond, L. M. (2008). Sexual fluidity: Understanding women's love and desire. Harvard University Press.

- Research by Simone de Beauvoir:

In "The Second Sex" (1949), de Beauvoir analyzes how women are defined as "other" in patriarchal societies. She explores women's lived experiences and how social norms shape women's sexuality and identity. This research has become the basis for much modern feminist theory.

References: de Beauvoir, S. (1949). The Second Sex. New York: Vintage Books.

These studies provide insight into the complexities of sexuality and gender, and how they interact in social and cultural contexts.

N. Sexuality and Culture

Sexual behavior and human sexuality are parts of sexuality that are closely related to the culture prevailing in society. One form of manifestation of social formation in society is the aspect of sexual behavior. Sexual behavior in different regions varies; these differences vary from place to place, from society to society, and from one culture to another. Sexuality is also a form of social and historical interaction of a person in his attachment to the social environment, not just biological-physical interaction. Human

attachment to the social environment creates various rules for sexual activity. With the social formation of society, an understanding of social culture emerges. Attraction between humans is a human relationship in the social environment, while this attraction is in the form of attraction between humans and their partners (sexual partnership), sexual activity is not just procreation (perpetuating offspring), sexual activity is in the recreational dimension (enjoyment), sexual activity is in the form of relationships (relationships), and also institutions (institutions).

Some experts believe that a person's sexual orientation is determined in the womb, and then a person can determine whether to choose according to their sexual orientation or adapt to the surrounding environment.

Sexual orientation is not the same as sexual activity because sexual activity or behavior does not always reflect a person's sexual orientation. Individual sexual orientation is basically divided into three categories: heterosexual, homosexual, and bisexual.

Cultural Rejection of Sexuality

Sexuality is a continuous process that changes according to age, existing roles in society according to gender, and interactions with other people and the environment. Sexuality must be viewed as a whole in the context of human life and in various dimensions. Society's stigma and rejection of culture that deviates from religious traditions and values needs to be addressed. Society needs to be responsive to changes that occur urgently in its environment.

1) Sex and Culture

Culture is a system related to symbols, beliefs, attitudes, values, hopes, and norms for behavior. Sexuality has a complex (multidimensional) meaning. The many variations of sexuality and sexual behavior require a holistic perspective. Covers sociocultural, religious, ethical, psychological, biological, and even political and economic issues.

2) Cultural Rejection of Sexuality

The history of sexuality is not something that is easy to control, and it is also subject to cultural opposition and rejection. For example, cultural rejection comes from networks formed by sexual minorities, namely homosexuals, whose presence to this day is still opposed by the majority of our society. This is because their sexual orientation (as sexual minorities) is considered normal in society.

3) The actual problem of cultural rejection of sexuality

-Gender
-Polygamy
-Homosexual
-Abortion

Here are some important theories about sexuality and culture put forward by experts, namely:

- Social Constructionism Theory:

Peter Berger and Thomas Luckmann

This theory argues that social reality, including sexuality, is shaped by social interactions and cultural norms. Sexuality is seen not as purely biological, but as a social construction influenced by cultural and historical contexts.

References: Berger, P. L., & Luckmann, T. (1966). The Social Construction of Reality: A Treatise in the Sociology of Knowledge.

- Feminist Theory:

Judith Butler

Butler argues that gender and sexuality are performative, that is, formed through social actions and practices. In this context, culture is important in shaping sexual identity and related norms.

References: Butler, J. (1990). Gender Trouble: Feminism and the Subversion of Identity.

- Intersectionality Theory:

  Kimberlé Crenshaw

  This theory highlights how various social identities (such as race, gender, and class) interact to shape individual experiences, including in terms of sexuality. Culture influences how these identities are perceived and lived in a sexual context.

  References: Crenshaw, K. (1989). "Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics." University of Chicago Legal Forum.

- Social Identity Theory:

  Henri Tajfel

  This theory explains how individuals identify with certain groups, which can influence their views on sexuality. Culture plays a role in determining the norms and values associated with these groups.

  References: Tajfel, H., & Turner, J. C. (1979). "An Integrative Theory of Intergroup Conflict." In the Social Psychology of Intergroup Relations.

- Hegemony Theory:

  Antonio Gramsci

Gramsci explains how culture and power are intertwined, where certain sexual norms can be considered dominant and widely accepted in a society. Sexuality is influenced by the power relations that exist within a culture.

References: Gramsci, A. (1971). Selections from the Prison

Each of these theories provides a different perspective on how culture influences sexuality, and demonstrates the complexity of the relationship between identity, social norms, and cultural interactions.

Here are some studies by experts that discuss the relationship between sexuality and culture, namely:

- Research by Geert Hofstede, topic Cultural Dimensions and Sexuality

Hofstede researched cultural dimensions that influence individual behavior in organizational and social contexts. One relevant dimension is "masculinity vs. femininity," which influences values related to sexuality in a particular culture. For example, cultures with masculine values may place more emphasis on traditional gender roles.

Reference: Hofstede, G. (2001). Culture's Consequences: Comparing Values, Behaviors, Institutions, and Organizations Across Nations.

- Research by Edward Said, topic Orientalism and Representations of Sexuality

In his book Orientalism, Said explains how Western culture constructs an image of the "Orient," including representations of sexuality that are often stereotypical. This research shows how sexuality is influenced by power dynamics and different cultural perspectives.

Reference: Said, E. W. (1978). Orientalism.

- Research by Judith Butler: topic Gender Performativity

  Butler investigates how gender identity and sexuality are shaped through social and cultural practices. This research suggests that sexuality is not fixed, but rather the result of repeated actions influenced by cultural norms.

  References: Butler, J. (1990). Gender Trouble: Feminism and the Subversion of Identity.

- Research by Nancy Fraser, topic: Sexual Justice and Culture

  Fraser examines how struggles for social justice, including sexual rights, are influenced by cultural context. This research highlights the importance of understanding the dynamics between sexuality and power structures in society.

  References: Fraser, N. (1997). "Justice Interruptus: Critical Reflections on the 'Postsocialist' Condition."

- Research by Lisa Diamond, topic: Sexual Fluidity

  Diamond researches sexual fluidity, particularly among women, and how this experience is influenced by cultural and social context. This research suggests that sexual identity can change over time and is influenced by cultural norms.

  References: Diamond, L. M. (2008). "Sexual Fluidity: Understanding Women's Love and Desire." Each of these studies provides deep insights into how culture and social context influence understandings and experiences of sexuality.

O. SOCIAL REGULATIONS IN SEXUALITY

Sexuality is not just sexual activity but rather includes everything, not just the emotional aspects of sexual relations (Rosemary Hogan, 1980). Sexuality reflects human

characteristics, not only the genitals, meaning all human aspects related to men and women, which are a unified subject leading to dynamic and eternal change (Lion, 1982).

Apart from that, sexuality includes not only biological and psychological but also social and cultural dimensions of sexual identity and habits. Social roles are very closely related to their role in sexual activities. This is because the social environment is very closely related to the prevailing culture. Sexuality is influenced by cultural norms and regulations that determine whether behavior is acceptable or not based on the existing culture. Normal and cultural regulations in a region are different because they follow the previously prevailing culture.

Sexuality is a cultural space for humans to express themselves towards other people in a very complex sense, involving self-identity, sex acts, sexual behavior, and sexual orientation.

Society's assessment of sexuality can be said to discredit the position of women because it has positioned women in a condescending view and is considered a source of immorality. From this view, women are at a disadvantage and limit women's movement in their activities.

The social construction of sexuality is greatly influenced by unequal gender relations. Gender relations are still dominated by paternalistic patriarchal ideology and systems. The patriarchal system allows men to dominate, shackle, and control women's lives in all areas of life.

Sexuality that is considered good, normal, and natural is heterosexual, monogamous, reproductive, and non-commercial; any sex that violates these rules is considered bad, abnormal, and unnatural (Rubin, 1993). Sexuality is a social construction, not a chromosomal-biological fact; sexuality is not a biological phenomenon; it is a scientific reality that transcends social reality (Rubin, Foucault, and Butler).

An individual is influenced by their social network and tends to do what is dictated by their social environment (Michael et al., 1994). So the social environment has provided a vehicle for learning about sexual activity for all teenagers who are active in the world of social media. Not all learning in social networks has a positive impact; sometimes it can have a lot of negative impacts on the social environment. Therefore, serious and systematic efforts are needed to end all myths and misconceptions about sexuality.

a. Power and sexuality definition

Sexuality is not just sexual activity but rather includes everything, not just the emotional aspects of sexual relations (Rosemary Hogan, 1980). Sexuality reflects human characteristics, not only the genitals, meaning all human aspects related to men and women, which are a unified subject leading to dynamic and eternal change (Lion, 1982). Apart from that, sexuality includes not only biological and psychological but also social and cultural dimensions of sexual identity and habits. Social roles are very closely related to their role in sexual activities. This is because the social environment is very closely related to the prevailing culture. Sexuality is influenced by cultural norms and regulations that determine whether behavior is acceptable or not based on the existing culture. Normal and cultural regulations in a region are different because they follow the previously prevailing culture. Sexuality is a cultural space for humans to express themselves towards other people in a very complex sense, involving self-identity, sex acts, sexual behavior, and sexual orientation. Society's assessment of sexuality can be said to discredit the position of women because it has positioned women in a condescending view and is considered a source of immorality. From this view, women are at a disadvantage and limit women's movement in their activities. The social construction of sexuality is greatly influenced by unequal gender relations. Gender relations are still dominated by paternalistic patriarchal ideology and systems. The patriarchal system allows men to dominate, shackle, and control women's lives in all areas of life. Sexuality that is considered good, normal, and natural is heterosexual, monogamous, reproductive, and non-commercial; any sex that violates these rules is considered bad, abnormal, and unnatural (Rubin, 1993). Sexuality is a social construction, not a chromosomal-biological fact; sexuality is not a

biological phenomenon; it is a scientific reality that transcends social reality (Rubin, Foucault, and Butler). An individual is influenced by their social network and tends to do what is dictated by their social environment (Michael et al., 1994). So the social environment has provided a vehicle for learning about sexual activity for all teenagers who are active in the world of social media. Not all learning in social networks has a positive impact; sometimes it can have a lot of negative impacts on the social environment. Therefore, serious and systematic efforts are needed to end all myths and misconceptions about sexuality.

1. Dessemination of the idea of a true monosexed human being. Through medical science, law, and the courts, it is confirmed that every person must have one clear gender (everyone only has to have one and only one sex). (Foucault: 1988; viii). If you have female anatomy, then it must be feminine, and if you have male anatomy, then it must be masculine. There can be no mixing of the two, no in-between identities.
2. socialization of procreative behavior. Modern Western sexuality in the 19th century was oriented towards procreative goals, not pleasure, in contrast to the sexual discourse of ancient Greece and Rome. Foucault called this model scientia sexualis, while the ancient Roman sexual orientation towards pleasure, or aphrodisia, he called ars erotica. The aim of science is to maximize the strength, efficiency, and economy of the body, as well as the conjugal relations of marriage and heterosexuality.
3. Psychiatrization of pleasure (the psychiatrization of perverse pleasure). All forms of deviation from the principles of "normal procreative sexuality" are pathological; sexual pleasures are condemned; masturbation and homosexuality are considered abnormal, deviant, and in need of treatment. The reason is because non-procreative sexual practices weaken the body and make it susceptible to various diseases.
4. Hysterization of women's bodies. In this context, the definition of sexuality is broadened. Not just "having sex," but also includes experiences of masturbation, pregnancy, birth, and menopause. This hysterization demands the deregulation of women, making them legitimate objects of psychological and medical control. Thus, men and women receive different treatment in discursive practices.

5. Pedagogization of children's sexuality. In this strategy, children's sexual practices that are "potentially dangerous" are regulated in such a way because it is feared that they could cause physical and mental damage.

b. Power Factors that Influence Sexuality

a) Race Factor

Models of the evolution of sexuality put forward by late nineteenth-century theorists presented non-whites—"savages"—as ne necessarily lower on the evolutionary scale than whites. This view can be seen in the writings of anthropologist Margaret Mead, who states that in relativist and liberal cultures, the evolutionary model is visible. A most persistent myth is that of the dissatisfaction with the sexual needs of non-Europeans and the resulting threat they pose to the purity of the white race. Ethnic minorities, who are often the subject of racist practices, tend to be working-class or poor and socially excluded in various ways. Meanwhile, the definition of membership in an ethnic group can often depend on the gender of the performer and their successful sexual attributes. Power operates subtly through a complex and interrelated set of practices.

They were involved in the entire social network of contradictions and antagonisms that would shape the modern world. In the journal Perspectives on Sexual and Reproductive Health (2004), it was reported that there were large racial disparities between young people. For example, among US Job Corps entrants in the 1990s, the rate of HIV infection among young black women was 7 times higher than that of young white women.

Several studies suggest that the consistency and magnitude of covariation between risks associated with adolescent sexual and drug use behavior differ by race across

populations. In addition, high-risk sexual patterns, namely the characteristics of various cluster partners, namely men having sex with men, are typical in the black male cluster. This causes black men to have a higher risk of STDs than white men. These findings emphasize the importance of identifying distinct behavioral patterns across demographic groups. It can be concluded that it is necessary to identify behavior based on racial factors because racial factors play an important role in sexual behavior at risk of HIV/AIDS infection.

b) Gender Factor

If sex is a biological identity, gender is a social identity or social construction that is attached to men and women. Gender is a social attribute that is related to how we think and what we believe about what is permissible (can be done) or not (cannot be done) related to the social concepts of masculine and feminine. Gender means being male or female, which may differ according to the set of chromosomes a person has.

Gender is also related to the roles, rights, responsibilities, possibilities, and limitations that men and women have in a society. Men and women have different tasks, activities, and social environments. They are expected to behave differently. Men and women are expected to wear different clothes, games, interests, skills, competencies, and social mobility.

Gender is related to the position of women and men in the power structure. Gender is based on social characteristics through socialization, while sex is determined from the time a person is born. Sex is persistent, whereas gender (and gender roles) change over time and vary depending on culture.

Gender shapes a person to achieve opportunities in life, and gender roles are strengthened by social institutions, namely family, school, the workplace, and others. Gender is a very important part of power and sexuality. However, patterns of women's sexual abilities are historical products rooted in human power to define and categorize what is needed and desired. 'To be a woman'.

Sexuality is complex and does not allow for release because it is locked into gender structures, and the two are locked together by heterosexual assumptions. Women's sexuality has been limited by economic and social dependence, as well as human power. Because when a woman is trapped in a cycle of poverty, it will lead her to take steps as a sex worker to fulfill her economic needs. Likewise, social circles that are full of the glamor of life can sometimes make a woman fall into promiscuity.

Like other things, the relationship between other social determinants, such as poverty and health, and gender, sexuality, and health is complex and multi-dimensional. Not to mention the contribution of other macro factors that will influence the interaction of the three, such as culture and policy. This is like the case of HIV/AIDS, where in efforts to achieve health, other determinants are needed, such as gender, sexuality, culture, and policy. According to Feldman (1994) and Schoepf (2001), no other disease involves as many social, cultural, and political dimensions as AIDS. This creates a discourse where AIDS is seen as a disease of 'certain people' (Altman 2001). Sociological and anthropological analyses of HIV/AIDS mention the social construction of the disease as a social stigma. AIDS has also been seen as a'modern disease', and as a result, culturally based rituals such as siphoning or traditional circumcisions using non-sterile knives are considered risk-free because they are not associated with modernity.
Gender inequality is a key variable in the incidence of HIV/AIDS. If gender inequality worsens, the epidemic will result in more women suffering the negative consequences of gender inequality.

c. Economic Factors

When economic space plays a role in presenting women, not only in public space, women are still represented in body and beauty. The function of women's bodies, in terms of body and beauty, is increasingly shifting from organic, biological, and reproductive functions towards economic functions. The economic space represents the body, and desire is used as the central point of the product, which is called the 'libido economy'. As if'sexual

violence' against women were not enough, their bodies are still forced to be commoditized into goods of economic value.

According to Michel Foucault, in The History of Sexuality, the'sexual apparatus has a central role in shaping the construction of 'power'. Power in sexuality is the strongest reality of social existence and of all social relations. Through language, morality, and culture, sexuality has produced behavior, values, and ideologies. Therefore, according to Foucault, "the history of sexuality is the history of our discourses on sexuality." In other words, knowledge of sexuality is formed in real socio-historical conditions and does not exist in a vacuum. Knowledge in an abstract sense, including discourse about sexuality, has a material basis, namely social life.

Sexploitation, which exploits women for commercial purposes (or simply for money), has affected the image of women as individuals as well as their image as social creatures who are'marginalized' and considered 'despicable'. Therefore, efforts are needed to change society's mindset regarding the way they view and evaluate "sexuality" in paradigmatic ways.

d. Social status factors

Control of economic resources greatly determines men's social status, and this gives rise to differences in perspectives between men and women. Men who come from a high social class find it easier to get a job, continue their education, and get better skills.

It is a fact in developed and developing countries that men of lower social status experience difficulties getting decent work. The failure experienced will contribute to an increase in unemployment among men of low social status. The effects of unemployment will trigger frustration and increased aggressive behavior, increase violence and crime, and contribute to an increase in risky sexual behavior.

It is very difficult to change the way we view women because women have been seen as "female" for centuries. So this perspective makes women sexual objects, especially if they are powerless. Even though a woman has received an education and is more successful than a man, this point of view will not change, and she is even more vulnerable to sexual harassment, oblique comments, not getting a promotion, and so on.

A woman has the opportunity to convince others and gain respect as a human being when she has a high position and power. With a woman's high position, she will be able to overcome prejudice against her sexuality and increase her ability to negotiate with men.

e. Political Factors

In the western world, the propensity for sex has become a pleasurable activity and a highly favored issue of political debate. The 1920s and 1930s saw the complex relationship between sexual values and political power become clear. This is due to the rise and fall of the world sexual reform movement and its seemingly irresistible rise with the rise of authoritarianism and social fascism. This was conveyed by Wilhelm Reich in his writings, which connected the concepts of sex and politics—"sexual'politics'.

The development of sexual politics continues to develop; sexuality has become a battleground for competing political powers, a front line of contemporary politics. It seems that there are many struggles for the future; society must fight in the field of contemporary sexuality. As long as sexuality does not exist, so will society. On the contrary, as long as society does not exist, so does sexuality (Weeks, 1995). This preoccupation is intense with concomitant erotic growth and contributes to what Anthony Giddens has described as a 'transformation of intimacy' (Giddens 1992).

With social changes, there will be widespread criticism and greater challenges regarding sexuality in our culture, so it is necessary to struggle with sexual differences and gender division.

Several theories discuss social regulation in sexuality according to experts:

Social Construction Theory:

Peter Berger and Thomas Luckmann

This theory argues that social reality, including sexuality, is constructed through social interaction. Norms and values regarding sexuality are formed and maintained in a particular cultural context. For example, what is considered 'normal' or 'abnormal' sexual behavior varies across societies and over time.

References: Berger, P. L., & Luckmann, T. (1966). The Social Construction of Reality: A Treatise in the Sociology of Knowledge. Anchor Books.

Functionalism Theory:

Émile Durkheim

From a functionalist perspective, social regulation in sexuality maintains social stability and cohesion. For example, norms regarding monogamy or marriage are considered important for maintaining a stable family structure, which supports the larger social structure.

References: Durkheim, É. (1893). The Division of Labor in Society. Free Press.

Feminist Theory:

Michel Foucault

Foucault argues that sexuality is regulated through various discourses of power that exist in society. Sexuality is not only about individual practices but also about how power and knowledge are interrelated in controlling and defining sexual behavior.

References: Foucault, M. (1976). The History of Sexuality, Volume 1: An Introduction. Vintage Books.

Symbolic Interactionism Theory:

Erving Goffman

This theory emphasizes the importance of social interaction in the formation of sexual identity. Through interactions with others, individuals learn how to present their sexual identity and how social norms influence sexual behavior.
References: Goffman, E. (1959). The Presentation of Self in Everyday Life. Anchor Books.

Psychoanalytic Theory:
Sigmund Freud

Freud argued that social regulation of sexuality is related to the control of sexual urges and instincts. Social norms often aim to suppress these instincts to maintain social order and morality.
References: Freud, S. (1905). Three Essays on the Theory of Sexuality. Basic Books.

Each theory provides a different perspective on how sexuality is regulated and understood in a social context. This shows the complexity of understanding the social regulation of sexuality, which is influenced by culture, power, and social interaction.

P. HUMAN RESOURCE

a. HUMAN RESOURCES IN HEALTH SERVICES IN REMOTE AREAS

In Goggin et al., it is explained that resources are an important element in policy content. The things included in resources are money or budget, people, time, and expertise. The budget is a resource provided for possible arrangements for financing and/or providing other resources. An important aspect of resources is that while a variety of resources may be required to implement policy messages, not all available resources can be easily exchanged for other types of resources. The resources available through policy messages have a direct impact on implementation. Therefore, the greater the resources, the greater the likelihood that policy implementation will be faster.

b. HUMAN RESOURCES CAPABILITIES

An organization's capacity to carry out its duties to implement a policy is influenced by the amount of its human resources (Goggin et al., 1990) in Erwan (2012: 149). The number of human resources in an organization really depends on the tasks they have to carry out. The more complex a policy is, the more human resources must be provided to carry out the task of implementing it. The number of human resources an organization has depends on the tasks that must be carried out. HR's ability to meet organizational needs such as knowledge, skills, and personality.

Several theories about human resources according to experts, complete with references:

1. Maslow's Motivation Theory by Abraham Maslow

A hierarchy of needs theory states that individuals have five levels of needs: physiological, safety, social, esteem, and self-actualization. Fulfillment of lower needs is necessary before individuals can fulfill higher needs.

Reference: Maslow, A. H. (1943). "A Theory of Human Motivation." Psychological Review, 50(4), 370-396.

2. Herzberg's Two Factor Theory by Frederick Herzberg

Factors that influence job satisfaction are separated into two categories: motivator factors (which increase satisfaction) and hygiene factors (which can cause dissatisfaction if absent).

Reference: Herzberg, F. (1959). The Motivation to Work. John Wiley & Sons.

3. Social Learning Theory by Albert Bandura

Emphasizes the importance of observation and imitation in learning and how individuals can learn through social experiences and interactions.

References: Bandura, A. (1977). Social Learning Theory. Prentice Hall.

4. Human Resource Contingency Theory by John B. Miner

Proposes that human resource management strategies should be tailored to the organizational context and external factors that influence performance.

References: Miner, J. B. (2007). Organizational Behavior 1: Essential Theories of Behavior. M.E. Sharpe.

5. Organizational Behavior Theory by Douglas McGregor

Introduces Theory X and Theory Y, which describe two different views of employee management and motivation. Theory X assumes that employees tend to dislike work, while Theory Y assumes that employees will find work enjoyable.

References: McGregor, D. (1960). The Human Side of Enterprise. McGraw-Hill.

6. Competency Theory by Richard Boyatzis

Emphasizes the importance of competencies in determining individual success in a job and organization. Provides a framework for identifying, developing, and evaluating competencies.

References: Boyatzis, R. E. (1982). The Competent Manager: A Model for Effective Performance. John Wiley & Sons.

These theories provide different perspectives on how human resources can be managed and motivated to achieve organizational goals.

Several studies conducted by experts on human resources, complete with references:

1. Research on Employee Engagement by Kahn, W. A.

This study developed the concept of employee engagement, namely how individuals are involved in their work emotionally, cognitively, and physically.

Reference: Kahn, W. A. (1990). "Psychological Conditions of Personal Engagement and Disengagement at Work." Academy of Management Journal, 33(4), 692-724.

2. Research on Transformational Leadership by Bass, B. M.

This study explores the impact of transformational leadership on employee motivation and performance.

Reference: Bass, B. M. (1990). "From Transactional to Transformational Leadership: Learning to Share the Vision." Organizational Dynamics, 18(3), 19-31.

3. Research on Organizational Culture by Schein, E. H.

This study discusses the importance of organizational culture and how it affects employee behavior and performance.

References: Schein, E. H. (1992). Organizational Culture and Leadership. Jossey-Bass.

4. Research on Career Development by Savickas, M. L.

This research examines the importance of individual-focused career development and how individuals shape their career narratives.

References: Savickas, M. L. (2005). "The Theory and Practice of Career Construction." In Career Development and Counseling, ed. Steven D. Brown and Robert W. Lent. John Wiley & Sons.

5. Research on Employee Performance by Campbell, J. P.

This research develops a multidimensional model for assessing employee performance, including both measurable and qualitative dimensions.

References: Campbell, J. P. (1990). "The Role of Theory in Industrial and Organizational Psychology." In Handbook of Industrial and Organizational Psychology, ed. M. D. Dunnette. Consulting Psychologists Press.

6. Research on Conflict in Organizations by Thomas, K. W.

This research identifies conflict management styles and how they affect team dynamics and performance outcomes.

Reference: Thomas, K. W. (1976). "Conflict and Conflict Management." In Handbook of Industrial and Organizational Psychology, ed. M. D. Dunnette. Consulting Psychologists Press.

These studies provide valuable insights into understanding various aspects of human resource management and its application in organizations.

Q. HEALTH POLICY

a. PUBLIC POLICY

Public policy is related to various fields of science as a public field, while the field of science that is related to public policy is public health. In its development in the 19th century, public policy was used to discuss developing social problems, which is said to be the beginning of modern policy analysis (Parsons, 2014: 94). The health problem studied is the development of AIDS as a social problem by Anthony A. Vass (1986. Vass uses the Fuller and Myers model to explore social and medical conditions; although Vass feels that the model used is valid for studying AIDS, he gives several objections (Parsons, 2014: 101). Van Meter and Van Horn (1975) define public policy as actions carried out by the public and private sectors, both individually and in groups, aimed at achieving the goals set out in policy decisions. These actions are determined by policy decisions to convert decisions into operational actions in order to continue efforts to achieve large and small changes within a certain period of time. Goerge C. Edwards III and Ira Sharkansky in Suwitri (2008) state that public policy is government action in the form of government programs to achieve targets or objectives. So public policy is "what is stated and done or not done by the government, which can be stipulated in statutory regulations or in policy

statements in the form of speeches and discourses expressed by political officials and government officials, which are immediately followed up with government programs and actions.” Then Gerston 2010 states that public policies are created and implemented at all levels of government, ttherefore, the responsibilities of ppolicymakerswill differ at each level according to authority.

In this case, policy is the main decision, commitment and action made by the policy holder or authorized party. Apart from that, Gerston (2010) explains that policy is a combination of main decisions, commitments and actions made by influential holders or officials or authorized parties. Thomas R. Dye in Howlett and Ramesh (2005) stated that public policy concerns "what government does, why they do it, and what differences it makes". This means that public policy is everything the government does, why they do it, and the difference it makes.

Anderson stated that public policy is a policy determined by government agencies and officials. These policies have distinctive characteristics, namely: they have a goal, contain real actions, not just hopes, they may be positive or negative, and the policy is always stated in an authoritative regulation (Lubis, 2007). Apart from that, Birkland (2009) defines policy as "a statement by government of what it intends to do such as law, regulation, ruling, decision, order or a combination of these". This means that policy is a statement from the government regarding what it wants to do in the form of laws, regulations, decisions, orders or a combination of these aspects. The phenomenon explained above is based on several expert views regarding policy terminology that is appropriate to the context of HIV/AIDS control policy, which is Brikland's opinion regarding the form of policy. In the context of HIV/AIDS control policy, policy decisions take the form of Presidential Regulations, Ministerial Regulations, Regional Government Regulations, and Mayor Regulations. Based on the definitions above, it can be concluded that public policy is directed at solving public problems which contain objectives, values and implementation, where those who make public policy are government bodies, not the

private sector, and public policy concerns actions carried out by the government or not carried out. government

The characteristics of public policy are divided into 4 categories according to Anderson, J.E., Public Policy Making: An Introduction, Boston: Houghton Mifflin Company, 2006):

1. Substantive and procedural policies. Substantive policy is a policy carried out by the government by allocating profits and losses as well as costs and benefits directly to the community. Procedural policy is a policy carried out by the government relating to who will be given the authority to take action or how something will be done.
2. Distributive, regulatory, self-regulation and redistribution policies. Distributive policies are policies in allocating services or benefits to certain segments of society, namely individuals, groups, companies/institutions or society. Distributive policies usually involve the use of public funds to help specific groups, communities or institutions. Regulatory/regulative policies are policies that impose prohibitions on individual or group behavior, limit groups of individuals and institutions, or vice versa, force certain types of behavior. Usually this policy is protective or regulates competition. Self-regulatory policies are policies that limit or supervise a group which is carried out by giving the group the authority to regulate itself in order to protect or promote the interests of its group members. Redistributive policies are policies or programs created by the government with the aim of distributing wealth, ownership rights and other values among various social classes or ethnicities in society.
3. Material and symbolic policies. Material policy is a policy that provides complete resource benefits to the target group. Meanwhile, symbolic policies are policies that provide symbolic benefits to the target group.
4. Policies involving collective goods or private goods. Public goods policy is a policy that regulates the provision of public goods or services. Meanwhile, private goods policy is a policy that regulates the provision of goods or services for the free market.

Based on the division of categories above, we can identify which policy our proposed policy is. This is also important to do because the behavior of policy makers will also depend on the nature of the policy. There are several factors that influence policy-making behavior.

These factors are as follows (Nigro, F.A., and Nigro, L.G., Modern Public Administration, New York: Harper & Row Publishers, 5th ed., 1980: 207):

a). The influence of external pressures. Often, public officials have to make decisions because of external pressures. One type of policy making is based on rational assumptions (i.e., policy makers must consider alternatives to be chosen based on rational assessments), but the process and procedures for making policies cannot be separated from the real world, so external pressures also influence the process of making policies. This pressure could come from superiors or from other institutions.

b). The influence of old habits (conservatism). Old organizational habits tend to be followed by public officials even though, for example, these decisions have been criticized as wrong and need to be changed. These old habits are often inherited by new public officials, and they are often reluctant to openly criticize or blame the old habits that have been in effect or that were carried out by their predecessors.

c). The influence of personal characteristics. The various kinds of decisions made by policymakers are greatly influenced by their personal characteristics. For example, in the process of accepting or appointing new officials, the personal characteristics of the decision-maker often play a big role.

d). There is the influence of past circumstances. Previous experience sometimes influences policy-making. For example, people often decide not to delegate some of their authority and responsibility to other parties because they are worried that the delegated authority and responsibility will be misused.

b. POLICY PROCESS DISCOURSE

Policy implementation is a very important aspect of the entire policy process because, apart from involving the mechanism for translating decisions, it also involves decisions and who gets what in a policy that concerns conflict issues. Policy implementation has a broad understanding, namely that it is a public administration tool where actors, organizations, procedures, techniques, and resources are organized together to carry out policies to achieve the desired impact or goal. In an effort to improve service practices, a policy study was carried out to solve community problems that were increasingly developing in a better direction, based on the development of NPM and NPS theory.

Hupe & Hill in their book "Implementing Public Policy" (2016: 103–121) interpret implementation with five (five) meanings, namely: (a) carrying out instructions; (b) realizing something ideal; (c) adopting the legislator's directives; (d) carrying out mandates with certain institutions; (e) achieving variations in policy outcomes.

Apart from that, Hill & Hupe (2002:41–84) classify policy implementation into three types of approaches, namely: top-down approach, bottom-up approach, and synthesis approach (a combination of top-down and bottom-up). . Hill & Hupe (2002:193–194) review the theoretical views of those who see implementation from a governance perspective.

Table 2.2: Three approaches to policy implementation studies

Top-down	Bottom-up	Sintesis
Pressman & Wildavsky	**Lipsky**	**Elmore**
A policy is a set of goals to be achieved. Implementation is influenced by the cooperation of various government agencies	Implementation is influenced by street-level bureaucrats who	Implementation as system management, bureaucratic processes, organizational development, as well as conflict and bargaining.

Top-down	Bottom-up	Sintesis
connected to the implementation chain.	have discretion and work under pressure.	Introducing the term backward mapping
van Meter & van Horn Implementation is more successful if desired changes are low and consensus about goals is high. Implementation research should ideally be longitudinal and focus on six (six) variables, namely: policy standards and objectives, resources and incentives, quality of inter-organizational relationships, implementor characteristics, socio-economic-political environment, and implementor responses;	**Hjern** Implementation involves organizational networks. There must be an accountability mechanism that connects street-level bureaucrats with the public.	**Scharpf** Policy implementation is the result of the interaction of various actors who have different interests, goals, and strategies. Implementation is influenced by the network of actors and their ability to build collaborative networks.
Bardach Implementation is a political game and process that is strongly influenced by how the game scenario is created top-down and the ability of the actors to improvise to manage various obstacles in the field and outside the game scenario.	**Barrett & Fudge** Implementation is a political process involving various actors and characterized by negotiation and compromise.	**Ripley & Franklin** Implementation cannot be separated from the cultural and institutional context behind it. Policy implementation is influenced by the type of policy implemented. Implementation is considered successful if the desired performance and impact are achieved.
Sabatier & Mazmanian		**Sabatier**

Top-down	Bottom-up	Sintesis
Implementation is a matter of (a) consistency in the actions of implementers and target groups; (b) consistency of impact with policy objectives; (c) policies are reformulated based on the experience of implementers and target groups; Implementation is influenced by three factors, namely: problem tractability, non-statutory variables, and implementation structure.		Introducing the Advocacy Coalition Framework (ACF) as a lens for understanding policy implementation.
Hogwood & Gunn Implementation is influenced by: (a) environmental factors; (b) time and resources; (c) the policy fulfills the principle of cause and effect; (d) dependency relations between actors are minimal; (d) common understanding and agreement on policy objectives; (e) implementor tasks are clear, detailed, and sequential; (f) coordination and communication; and (g) implementors have authority.		**Lane** Implementation consists of two components: namely responsibility (the relationship between goals and results) and trust (the process of realizing policy effects).
		Goggin, Bowman, Lester & O'Toole, Jr

Top-down	Bottom-up	Sintesis
		Introducing the communication model as a lens for photographing policy implementation. They are called communication models because they focus on the communication aspects of government units at various levels.
		O'Toole, Jr Network-based implementation
		Palumbo & Calista Implementation is not a separate stage from all stages of public policy. It is a legitimate part of the public policy process. It exists at all existing stages.
		Stoker Three implementation approaches: authoritative approach (using power), exchange approach (using cooperation), and governance approach (collaboration between actors)
		Matland Explains the implementation with combines ambiguity and conflict variables. This combination produces four

Top-down	Bottom-up	Sintesis
		types of implementation, namely: administrative implementation (low ambiguity, low conflict), political implementation (low ambiguity, high conflict), experimental implementation (high ambiguity, low conflict), and symbolic implementation. (high ambiguity, high conflict).
		Kickert, Klijn & Koppenjan Further elaborating on policy implementation based on a network perspective. Implementation failure and success are determined by cooperation between actors and the structural attributes of the policy network.
		Rothstein Elaborating on accountability issues in policy implementation. Proposes six (six) ideal types of policy process models that encourage legitimacy, namely: legal-bureaucratic, professional, corporatist, user-oriented, politician-oriented, and lottery-based.

Source: Hill & Hupe (2002: 41-84)

a) Ripley, 1986

Health services are a distributive government policy for allocating services, one of which is HIV/AIDS control activities. This HIV/AIDS control policy is an effort to help the community control the transmission of HIV/AIDS as well as provide assistance to community groups suffering from HIV/AIDS by providing services, treatment, and others. Ripley stated that the programs or services provided by the government for the community or certain groups are distributive policies (Ripley in Erwan, 2012: 106). Implementation of these policies leads to a number of policies that are based on program objectives and the results desired by government officials.

If implementation can run according to the desired program, implementation must include actions by policy actors. Model Ripley's policy is seen as a cycle in which it is possible for an evolution of policy to occur within the policy stages. With this policy, it is possible that fundamental changes will emerge and more truth will be discovered. To assess the quality of output and performance results from the implementation of HIV/AIDS control policies, there are several indicators presented by Ripley (1986 in Erwan (2012): 106, namely:

1. Access

   The access indicator is the affordability of the services provided to the target group; this is so that the target group can easily reach the services provided. Apart from that, access to policies also makes it easier for the public to make a contact with the people responsible for implementing policies. Access also implies equal opportunities for all target groups without distinguishing their characteristics. So that by creating access to the policy, there will be no discrimination against those who implement or utilize it.
2. Coverage

This indicator is to assess how well the implemented policy has reached the target group.

3. Frequency

   To measure how often the target group receives the services promised in a policy, it is used to assess frequency indicators.

4. Bias

   When a policy or program has been implemented, there is the possibility of deviations in the services provided to the target group. For this reason, indicators are needed.

Assessing deviations in the policy or program, namely by assessing the bias indicators of the policy or program.

1. accuracy of service (service delivery)

   In implementing a policy or program, it will provide an output. The output of the policy or program needs to be assessed regarding the timeliness provided by a policy or program that is time-sensitive.

2. Accountability

   The implementation of a policy or program will produce an output, for which the output must be held accountable. Therefore, this accountability indicator is an assessment of responsibility for the output produced by a policy or program.

3. Suitability of the Program for Needs

   When implementing a policy or program, you must truly understand the group that is the target of the policy. Apart from understanding the target group, policies or programs are needed that suit the needs of the target group. Therefore, an indicator is needed that assesses whether the policy or program is in accordance with the needs of the target group or not.

In implementing a policy, so that the policy runs well, implementation elements need to be fulfilled. The implementation elements that must be fulfilled are:
1. Implementor

Implementors or implementing elements, in this case administrative units or bureaucratic units, are the parties who have the main obligation to implement public policies (Sharkansky in Tachjan, 2006). This was also stated by Ripley and Grace A. Franklin (Tachjan, 2006: 27):

> *"Bureaucracies are dominant in the implementation of programs and policies and have varying degrees of importance in other stages of the policy process. In policy and program formulation and legitimation activities, bureaucratic units play a large role, although they are not dominant".*

In the public policy process, these administrative units, or bureaucratic units, are vehicles for various administrative activities. Based on the authority and administrative capacity he has, he carries out various actions, starting with "determining organizational goals and objectives, analyzing and formulating organizational policies and strategies, making public policy implementation processes and decisions, planning, programming, organizing, mobilizing people, implementing activities and operations, supervision, and assessment" (Dimock & Dimock in Tachjan, 2006; Noviana, 2019).

2. Program to be implemented

In implementing policies such as administrative policies, it is necessary to explain operational programs in the form of general statements containing goals, objectives, and various means. This was also stated by Grindle (1980): "Implementation is that set of activities directed toward putting a program into effect.". Operational programs should be easy to understand and implement, have clear goals and targets, detailed resource allocation, clear work procedures and methods, and have clear standards.

This was conveyed by Terry in Tachjan (2006):

> *"A program can be defined as a comprehensive plan that includes future use of different resources in an integrated pattern and established a sequence of required actions and time schedules for each in order to achieve stated objectives. The makeup of a program can include objectives, policies, procedures, methods, standards, and budgets"*

This means that the program is a comprehensive plan that describes the resources that will be used and is integrated into one unit. The program describes goals, policies, procedures, methods, standards, and costs.

3. Target Groups

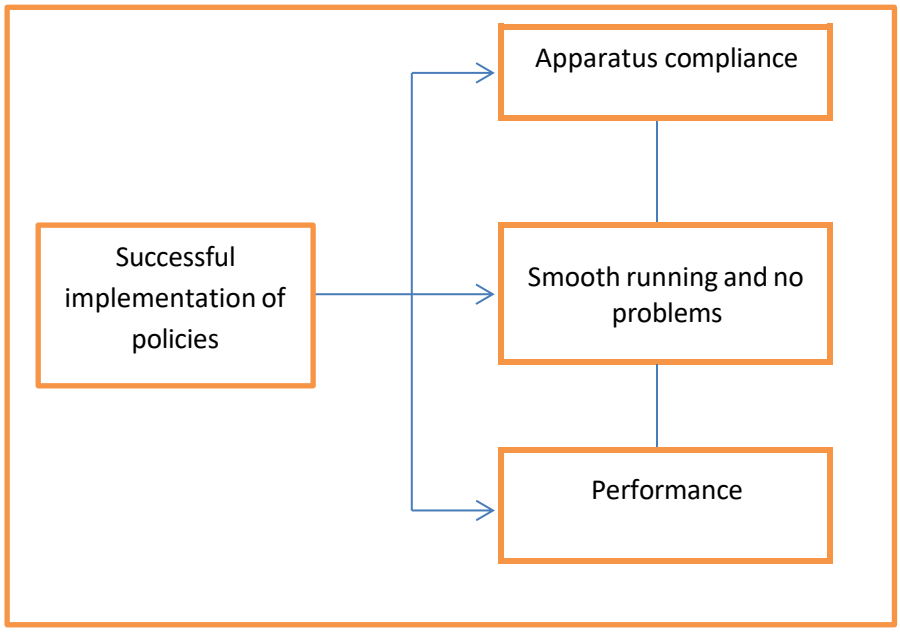
Target group, namely a group of people or organizations in society who will receive goods and services or whose behavior will be influenced by the policy. The target group has characteristics such as gender, target group size, education level, age, experience, and socio-economic conditions that influence the effectiveness of implementation. These characteristics are partly influenced by the geographical environment and socio-cultural environment in which they live.

Apart from that, Ripley and Franklin (1982) stated in their book Policy Implementation and Bureaucracy that the success of program policy implementation can be seen from:

1. compliance perspective,

The level of compliance of subordinates with superiors or implementers regarding the implementation of policies or regulations contained in policy implementation documents will influence the level of success of policy implementation. This compliance is carried out in accordance with the standards and procedures set out in the policy.

The following is the policy implementation model according to Rippley and Franklin:



Source.2.1 Policy implementation model according to Rippley and Franklin (1990)

The indicators of the compliance approach presented by Ripley are the implementor's behavior and the implementor's understanding of the policy. Ripley explains that there are several indicators to explain this approach:

- Many actors are involved.

Ripley explained that the more complex a program is, the more actors the policy implementation process involves. Apart from that, policy implementers in implementing

programs must have skills, and policy implementation will be hampered if the number of policy-implementing personnel is insufficient. Apart from that, this indicator is also supported by other indicators such as number and identity, the role of interested parties, and the absence of hierarchy.

- Clarity of purpose

Clarity of policy content is the clarity and consistency of objectives that can be understood so that they are easy to implement. Clear policy content will make it easier for implementers to understand and translate the policy's implementation into real action. On the other hand, if the content of the policy is not clear, it will give rise to distortions in policy implementation.

- Program Development and Complexity

To see the complexity of a program, you can look at the level of complexity of the program rules in question. The success or failure of implementing a program will be seen in the dynamic implementation instructions that will be created.

- Participation in all government units

Participation in all government units in question is the participation of all actors involved in policy implementation.

- Uncontrollable factors affecting implementation

The uncontrollable factors that can influence policy implementation are non-technical factors that have exceeded the implementor's control limits, which are indirectly related to program implementation, and this can hinder or even thwart the implementation of programs that have been previously designed.

2. smooth routine with no problems.

Smooth routines and the absence of problems in policy implementation are key to successful implementation.

3. performance that satisfies all parties, especially the recipients of the expected benefits. Successful policy implementation refers to the realization of the desired performance and impact (benefits) of all policy objectives.

b) Van Meter and Van Horn Theory, (1975)

A policy or program must be implemented to have the desired impact or goal. This shows that the role of public administrators is in determining whether a policy formulated and ratified by police makers can be implemented or not through a conducive and intensive approach, and it is hoped that this will act as a link between the state's mandate and the interests of society. The following is a chart of the policy implementation model developed by Van Meter and Van Horn:

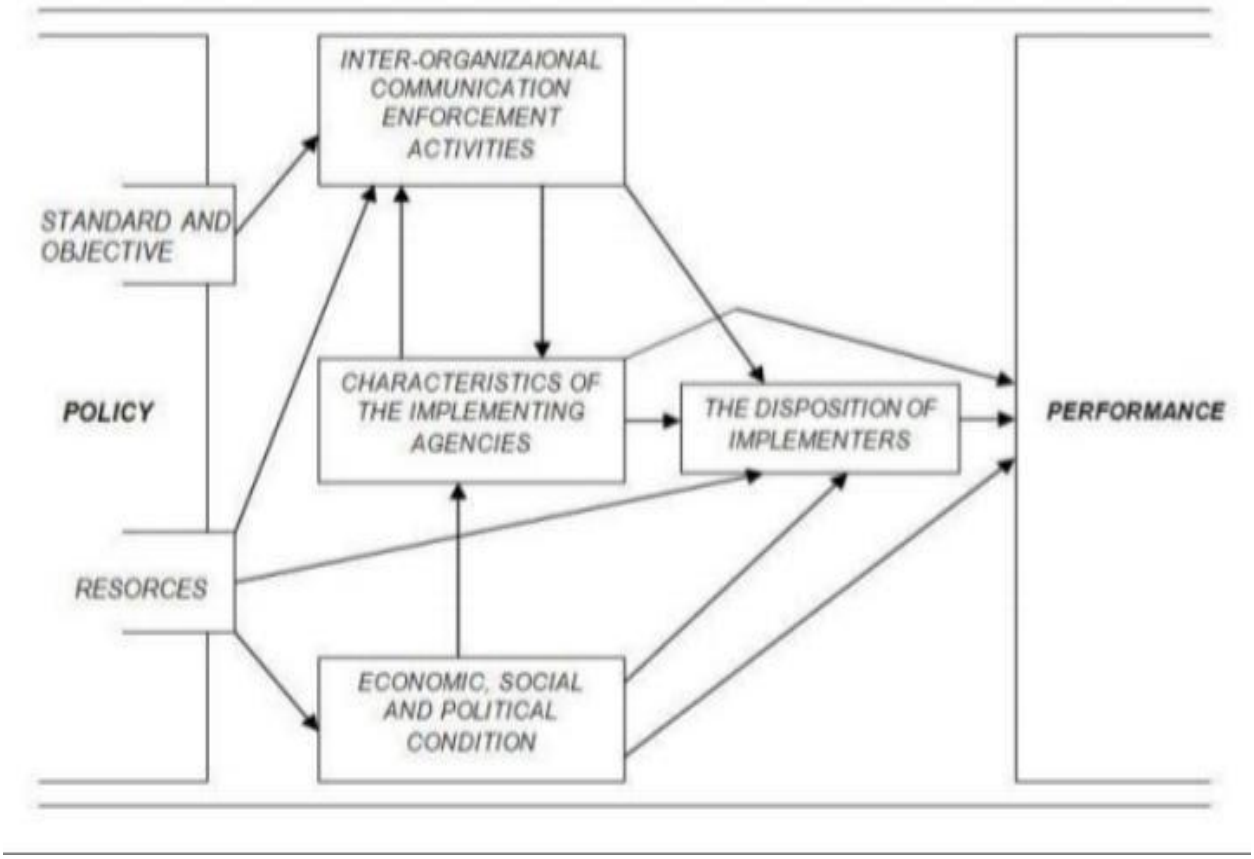


Figure 2.2: Van Meter and Van Horn (1975) Policy Implementation Model

The theory put forward by Van Meter and Van Horn (1975) in Leo Agustino, 2012: 141: as a model of the policy implementation process, by proposing six variables that form the bond between policy and achievement (six variables that shape the linkage between policy and performance) for successful policy implementation by paying attention to the concepts of change, control, and compliance, namely:

(a) Policy size and objectives;

In order for a policy to be realized, the standards and targets must be clear and measurable. Besides that, the achievement of a policy must have indicators to assess the

extent to which the policy objectives have been realized. Measures and objectives are useful in describing in detail overall policy decisions so that they can be easily measured against the program. However, if the goals of a policy are too ideal to be realized at the citizen level, then it is quite difficult to realize the policy to the point of success; likewise, if the standards and targets of the policy are vague, this will lead to conflict due to multiple interpretations among implementing agents.

(b) Resources

Policy implementation needs resource support, both human and non-human resources. Policy-implementing resources must have competence in implementing policies. The competence of policy-implementing resources to understand, absorb, and translate the contents of the policy. Van Metter and Van Horn mentioned that apart from human resources, there are financial resources and time resources.

(c) Communication

The ability of an implementor to respond to and understand policies in order to be able to communicate the contents of the policy both in terms of understanding, absorbing, and translating the meaning contained in the policy. An implementor must have motivation so that he is able to communicate the contents of a policy to achieve the policy objectives.

(d) Interorganizational and inaugural activities;

In order for a policy or program to be successful, coordination or support from various agencies is needed in implementing the policy.

(e) Characteristics of implementing agents;

The characteristics of implementing agents can influence the implementation of a program; these characters are bureaucracy, norms, and relationship patterns that occur within the bureaucracy, all of which will influence the implementation of a program. Apart from that, it is also necessary to consider the scope and area of policy implementation in determining implementing agents, because the wider the scope of policy implementation, the more agents should be involved.

(f) social, economic, and political conditions, as well as the character of the implementer. To assess the performance of public implementation, according to Van Metter and Van Horn, the extent to which the external environment contributes to the success of public policies that have been established. Failure to implement policies can occur if the social, economic, and political environment is not conducive.

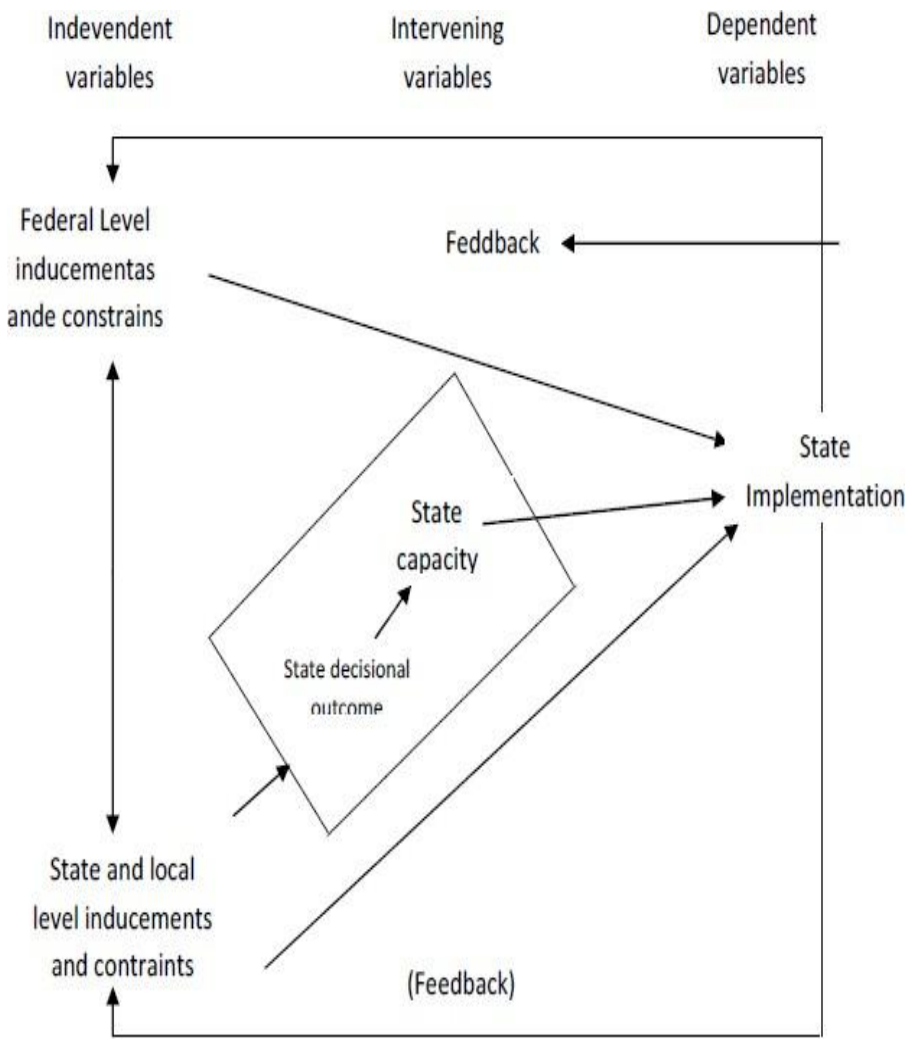
The Van Meter and Van Horn policy model provides a quite relevant reference for studying policy implementation. With this model, it is easier to identify influential variables and see the obstacles faced during the policy implementation process.

c) Goggin, Bowman and Lester Theory (1990)

Goggin et al. (1990), in Hill, 2002:66, are one of the advocates who are trying to develop implementation studies in a more scientific direction. They try to bridge the gap between top-down and bottom-up approaches so as to avoid the conceptual weaknesses of both approaches. They encourage implementation research to further improve the quality of indicators for measuring. For this reason, they established a "communication model" for analyzing the implementation of messages between layers of government regarding the acceptance or rejection of messages. However, critics say implementation studies should be developed with a more "intuistic" (qualitative) approach in order to provide space to explore explanations of implementation phenomena more comprehensively. This is based on the fact that the factors for successful implementation are very complex in a positivistic

logic involving various levels of different units of analysis, namely organizations, policies, individuals, and communities, so that an intuitive approach can provide space for researchers to further explore these factors.

The communication theory offered by Goggin is an understanding of the relationship between government policy implementation and The implementor here is the implementation target, who must be able to interpret the backlog of messages. Goggin et al. (1990:40) consider implementation a dynamic process of learning various things related to policy and reformulating the policy. This generation contributes to the complexity of the phenomenon of policy implementation. Goggin's model can be adapted for policy in Indonesia to assess the extent of policy effectiveness. The following is Goggin et al.'s model:



Source. Implementation model according to Goggin (1990) ,

Goggin et al.'s model implicitly implies three important things in the implementation of public policy, namely: message content, message form, and perception of state leadership. The translation of the Goggin et al. model into eleven Goggin indicators (1990: 77), namely:

a. Resource

In Goggin et al., it is explained that resources are an important element in policy content. The things included in resources are money or budget, people, time, and expertise. The budget is a resource provided for possible arrangements for financing and/or providing other resources. An important aspect of the resource aspect is that while a variety of resources may be required to implement a policy message, not all available resources can be easily exchanged for other types of resources. The resources available through policy messages have a direct impact on implementation. Therefore, the greater the resources, the greater the likelihood that policy implementation will be faster.

b. Credibility of the message as a solution

The credibility of the message as a solution or the trustworthiness of the policy message among potential implementers is not a simple problem, but it is an important one. Some messages can identify policy goals that are even technically impossible to achieve.

c. Policy Efficacy

All policies, except symbolic ones, are designed to address some public problem. But some issues are easier to address, whether in technical or political terms, than others. Some policies are based on a set of very well-tested principles of cause and effect and thus provide hope for stability. A large part of the implementation process for this policy has been reduced to a matter of engineering, thereby providing ease and certainty for the implementers charged with achieving national goals.

d. Community participation

Community participation is a viable means for policy development. The more actors added to the implementation network, the greater the opportunity for blockages or pitfalls for the program to be converted into action. This effect clearly undermines some levels of certainty in the implementation process. Pressman and Wildavsky emphasized that the chances of successful implementation are inversely proportional to the number of actors and decision points (1984: 87–124). Mazmanian and Sabatier also reached the same conclusion in their famous theory as an empirical work (1983: 27).

e. Policy type

The type of policy contained in the policy message can also be important for the implementation patterns that are likely to emerge. The notion of policy type here has a specific meaning: not to designate substantive differences. One important reason is that complex implementation processes often require a lot of time, energy, expertise, and organizational capacity.

f. Policy clarity

In everyday life, they are more likely to be acted upon wisely if they are communicated clearly. The same applies to policy messages from officials. Clarity can be defined in terms of two final elements: meaning and ending.

Messages that contain direct statements about their standards or targets—especially those without qualifications, contradictory, or ambiguous language—are clear and unambiguous regarding the goals. Messages that set out specific procedures" (Montjoy and O'Toole, 1979: 468) must be followed by implementers, especially those with deadlines and/or instructions regarding mandated patterns of interdependence and formal authority among implementing actors (individual or organization), specific and clear with respect to the means. A policy that includes clarity with respect to both means and ends should be considered clearer than one that is unclear in one respect and unambiguous in another.

g. Policy consistency

Policies can, individually or cumulatively, be clear but inconsistent. Because if we understand policy as a message or as a flow of messages, it may come from several officials. Social science findings about the effects of messages with the characteristics just mentioned—complexity and ambiguity—are fairly straightforward. Recipients of such messages are more likely to receive messages selectively (Simon and Dearbom, 1958). Selective perception means that such policy messages are less likely to stimulate direct implementation in federally determined directions.

h. Message repetition frequency (policy)

Clarity and consistency help in the process of communicating through a series of inducements and constraints for actors. Communication theory points to an additional factor: messages are transmitted periodically, and when their content is consistent, they are more likely to be received and acted upon.

i. Policy recipient

The world's most brilliant policies are meaningless if left untranslated into administrative regulations.

j. Legitimacy of regional policy-making leaders

How state and local governments view the legitimacy of federation officials is not an all-or-nothing affair. In contrast, some national government actors are seen as authoritative in certain policy arenas or on certain issues.

k. credibility of leadership at the central level.

The analysis omits coverage of one additional item that may influence the message's impact on the implementer: sender credibility. Certain policy elements can affect credibility. These elements of our communication model can also be influenced by the interaction itself. Because it essentially requires complex patterns of coordination over time, a prudent course of action encourages cooperative action (OToole and Montjoy, 1984). Implementation incorporated between trust periods after removing key components that may be different from the message recipient on a problem can increase bargaining opportunities. Whatever means are used to produce policy, the point is that credibility can be a resource that actors can bring to the context of implementation or can develop within that context because of the dynamics of the process that unfolds. Credibility is not just a matter of cooperative trust; trustworthiness can always help implementation in several situations by convincing potential implementers.

According to Goggin et al. (1990:46), there are four types of policy implementation:

a. Deviance

A type of deviation is the delay or even cancellation of implementation by the implementer accompanied by changes, both to objectives, target groups, and implementation mechanisms, resulting in the objectives not being achieved.

b. Delay

That is a delay without modification. Implementation is postponed by the implementer but does not change the content of the policy.

c. Strategic delay

Postponement, accompanied by modifications aimed at increasing the success of implementation

d. compliance

Implementation is carried out by the implementor without any changes to the content or implementation mechanism of the policy.

Policy implementers' compliance with policy implementation mechanisms can give rise to fraud, which can harm other people. One of the frauds that occurs is an error in presenting facts, where the facts presented are detrimental to other people but are beneficial to the implementer, although not materially.

Achieving successful policy implementation is also influenced by organizational capacity, actors in policy implementation, and coordination and interaction between actors in policy implementation.

The success of the bureaucracy is greatly influenced by organizational capacity, which plays a very important role in implementing policies. Even though there are various implementing agencies involved in implementing policies, the bureaucracy still has a dominant position.

Goggin et al. (1990) in Erwan, 2002: 128 define organizational capacity as a unit of organizational elements that involves:

a) structure;

So that organizational goals can be achieved well, a forum for cooperation from various elements of the organization is needed in order to achieve policy implementation goals, namely the organizational structure. Organizational structure is a system of formal relationships between tasks and authority that controls and coordinates resources to achieve goals (Jones, 2014) in Erwan (2012: 130).

The organizational structure must be prepared in accordance with the objectives and complexity of the policy so that the organizational structure mandated to implement the policy can work effectively. Goggin et al. (1990), in Erwan (2012: 131), stated that the preparation of the implementation organizational structure is also influenced by the approach used to implement a policy.

Theoretically, implementing policies with a simple structure will have a higher chance of success than with a complex structure. However, reality shows that most policy implementations use complex structures involving multiple organizations, such as government, non-governmental organizations, and the private sector (cf. Hjern & Porter, 1981) in Erwan (2012: 133).

The capacity of implementing organizations in the regions to carry out their duties is greatly influenced by the dynamics of the relationship between the central government and regional governments. The role of the central government can provide support or put obstacles to the efforts of implementing organizations. The capacity of regional implementing organizations is also influenced by variables in the regional government itself, which are called organizational environmental variables (state ecology). This environmental variable has many aspects, such as economic, political, social, physical, and others (Goggin et al., 1990) in Erwan (2012: 139).

b) work or coordination mechanisms between units involved in implementation Another factor that supports organizational capacity is work teams. An effective work team model is formed from several elements, namely: context, composition, work design, and process.
c) human resources existing in the organization

An organization's capacity to carry out its duties to implement a policy is influenced by the amount of its human resources (Goggin et al., 1990) in Erwan (2012: 149). The number of human resources in an organization really depends on the tasks they have to carry out. The more complex a policy is, the more human resources must be provided to carry out the task of implementing it. The number of human resources an organization has depends on the tasks that must be carried out. HR's ability to meet organizational needs such as knowledge, skills, and personality.

d) financial support and resources that the organization needs to work.
The four elements that Goggin has conveyed must be involved so that a policy can be achieved well. These four elements must be in optimal conditions and support each other in order to achieve a policy with the right organizational structure design.

Goggin (in Erwan, 2002: 70) also states that to determine the success of implementation, the questions that need to be asked are:

(a) Strategic questions:

- Who and what are the conditions and distribution of the target group?
- Does the program comply with policy objectives, and what is the likelihood of success in implementation?

(b) Questions about compliance:

- Whether program activities are able to reach the planned people, households, or community groups

- Does the program provide resources, services, or other benefits as desired?

(c) Questions about impact:

Whether the program achieves its objectives effectively Are there any undesirable effects?

(d) Question of efficiency.

How much does it cost to provide services and benefits for the target group? Is this program more efficient compared to other programs?

In the process of implementing public policy, the involvement of actors, implementors, and stakeholders is very necessary, but the large number of actors involved in implementing the policy is one of the causes of the complexity of implementing public policy in developed countries.

Actor terminology in the policy process, based on Knoepfel et al. (2007), is:

> *"either an individual (a minister, member of parliament, specialist journalist etc), several individuals (constuting for example an office or a section of an administration), a legal entity (a private company, an association, a trade union and so on) or a social group (farmers, drug users, the homeless etc)"*

Coordination is understood as the process of integrating the goals and activities of separate work units to achieve organizational goals effectively. The organizational structure for implementing policies mostly has multi-organizational characteristics, which means that policy implementation has the consequence that coordination is carried out with many organizations and actors. In order for the collaboration process to run smoothly, supporting factors are needed for this coordination to occur.

O'Toole and Montjoy (1984) in Erwan (2012 put forward three supporting factors so that the collaboration process can be carried out well, namely: authority, common interest, and exchange. Even though these three factors are very important in successful coordination, coordination will be difficult when there are more work units involved in a policy (Jening, 1998; Erwan, 2012: 153).

Meanwhile, Howlett and Ramesh (1995) classify policy actors into 4 categories, namely: 1) policy sub-systems; 2) community organizations; 3) state organizations; and 4) international systems organizations.

1) Actors in the Policy Subsystem

   Hawlett and Ramesh (1995) stated that actors in the policy process are divided into 5 categories, namely:

   a. Elected Officials

Elected officials in the policy process are divided into two categories, namely: executive and legislative and political members. The role of executive members is to control and influence social actors such as interest groups and mass media. The role of the legislature is to provide supervision to the government so that it is responsible to the public in making and implementing a policy. Meanwhile, the role of politics is as an "aggregation of interests," where sometimes actors in the policy sub-system are influenced by political parties.

b. appointed official

Officials appointed in public policy are often referred to as bureaucracy, which is an important source of government power. Bureaucratic actors have a role in helping executives carry out their duties. According to Howlett and Ramesh (1995), bureaucratic actors have influence and power because of the extensive resources available to them, such as the law, which provides certain important functions in making decisions for the state. The bureaucracy also has extraordinary access to material resources to achieve their goals and the bureaucracy is also a place for people who have skills and expertise, which become resources for bureaucratic organizations in society.

c. Interest Groups

Interest groups have an articulation of interests; that is, they function to provide demands, provide alternative policy actions, and provide information to public officials. Hawlett and Ramesh (1995) state that an interest group's most important resource is knowledge, especially information that may not be available or not owned by other actors.

d. Research Organization

Other social actors who have a significant role in the policy process are researchers working in universities and think tanks. Think tanks are linked to political parties, interest groups, and private companies as non-governmental institutions. Think tanks often act as a bridge between academics and the policy-making community to serve the public interest.

e. Mass media

The mass media has a role in the policy process by combining the roles of passive reporters and active analysts as advisors to problem solvers, and this mass media is needed to influence the policy process.

a) State Organization

   Public policy makers are the prerogative of the government and key actors in the policy sub-system. The state will be able to make and implement policies supported by autonomy and capacity.

b) Community Organization

   A country needs the support of social groups and their actions in implementing policies effectively. This is because a country's capability is determined by how it is run, how it relates to society, and how a policy is used to solve public problems.

c) International Systems Organization

   The role of international organizations has a strong influence in the policy sector, such as in trade and defense. International institutions influence public policy by shaping actors' choices and providing facilities where they can.

d) Fraud Donald R. Cressey Theory (1935)

Fraud theory was first introduced by Donald R. Cressey (1935) and called the Fraud Triangle. The Fraud Triangle explains three factors that are always present in fraud situations, namely:

a. pressure, namely the presence of pressure, incentive, or need to commit fraud. Pressure that can give rise to fraud covers almost everything, including lifestyle, economic demands, and other non-financial matters. It is stated that there are four types of general pressure conditions that result in fraud, namely: financial stability, external pressure, personal financial needs, and financial targets.

b. opportunity, namely a situation that provides an opportunity to allow fraud to occur. This usually occurs due to weak internal controls, a lack of supervision, and abuse of authority. Opportunity is the element that is most likely to be minimized through the implementation of processes, procedures, and early detection efforts for fraud.
c. Rationalization: the existence of an attitude, character, or set of ethical values that allows certain parties to commit acts of fraud, or people who are in a sufficiently stressful environment that makes them rationalize acts of fraud.

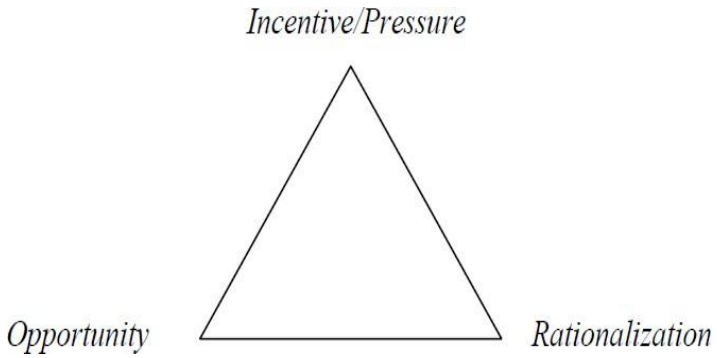


Figure 2.4: Fraud Triangle by Donald R. Cressey (1935)

Albercht et al. (2011) also stated that fraud is a general thing and has many meanings, where fraud occurs because of human ingenuity. Fraud is intended by one party to gain profit by presenting false data. To define fraud, there are no specific rules that can be used as a reference. Fraud can take the form of surprise, deception, cunning, and unnatural methods used to deceive other people, and this can damage human morals.

e) Three-term contingency Skinner Theory (1938)

The A-B-C theory, known as three-term contingency (A-B-C), was developed by Skinner (1938) in his book entitled "The Behavior of Organisms." This theory explains how a stimulus functions to increase the effect of consequences on behavior in the future. These consequences can strengthen or weaken certain behaviors in the future.

Skinner's explanation of this theory is:

a. Antecedence: an environmental event that forms a stage or trigger for behavior (Holland & Skinner, 1961). I can explain that antecedence is an event that causes someone to behave or is a trigger for someone's behavior.

   The antecedent process is divided into two, namely, as follows:

   1. Natural antecedents (naturally occurring antecedents)
   Behavior that arises because it is triggered by environmental events that have already occurred.
   Example: The increase in HIV/AIDS cases encourages people to take steps to prevent HIV/AIDS.
   2. Planned Antecedents
   Health behaviors that have no natural antecedents.
   Example: An HIV/AIDS sufferer whose condition has deteriorated because he did not take ARV medication will, in the future, continue to take ARV medication so that his condition does not decline again.

b. Behavior:
   Behavior is a person's response or reaction to a stimulus (external stimulation). This was explained by Skinner (1938): this behavior occurs through the process of a stimulus to an organism, and then the organism responds, so this theory is called S-O-R (Stimulus-Organism-Response). The response itself is divided into two types, namely:
   1. Responses that occur naturally due to stimuli from the external environment or unintentional responses

2. Instrumental response or operant response, namely a response that arises and develops and is then followed by a certain stimulus or stimulus.

Judging from the type of response to this stimulus, behavior can be divided into two categories, namely:

1. Covert behaviour

   Closed behavior is when a person's response to a stimulant is in a closed or disguised form. This means that the response is still limited to the reaction of attention, perception, knowledge, awareness, and attitude of the recipient of the stimulus, so that this cannot be observed clearly.

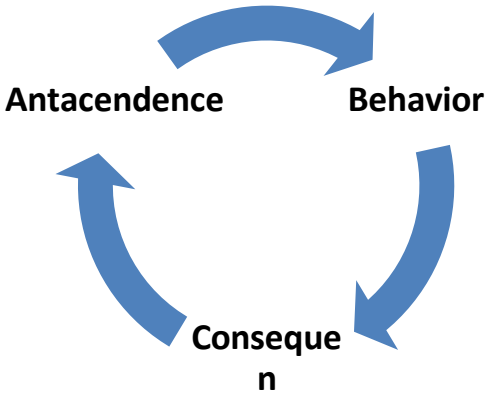
2. Overt Behavior

   Meanwhile, overt behavior is a person's response to a stimulus in the form of real or overt action. In open behavior, the actions that arise from the given stimulus are clearly visible so that they are easy to observe.

c. Consequences:

Consequences are environmental events that follow a behavior and also strengthen, weaken, or stop it. Consequences can strengthen or even weaken behavior. When someone feels they can take advantage of the benefits, the consequences will strengthen the behavior, but when the behavior does not provide benefits and is unpleasant or even scary, the consequences will weaken the behavior.

And this situation applies to all initial behavioral attitudes, whether they are negative or positive. Thus, a person can change after experiencing an event. And it can change from a negative attitude to having a pleasant event, then strengthening it to behaving positively, and vice versa.

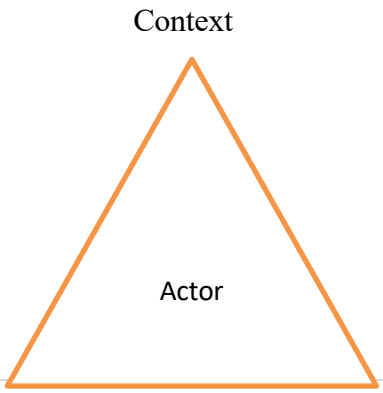


Source. Three-term contingency Skinner theory (1938)

e) Walt and Gilson Theory (1974)

Walt and Gilson (1994) developed the concept of health policy, which, to simplify its practice, is described in the "policy triangle." According to Walt, health policy is an open offer to people who influence policymaking, how they exercise this influence, and on what terms, and this is similar to politics.

This policy triangle helps to think systematically about policy actors who might influence policy.



content Procces

Figure : Adopting Walt and Gilson, 1994

In Walt and Gilson's theory, it is explained that there are several components in the policy triangle, namely:

a. Policy Actors/Policy Drafting Actors are individuals, organizations, and even countries, along with actions that influence policy. There are a variety of different actors and ways to differentiate them. This is so that we can examine who has influence in the policy process. Political scientists consider them to be interest groups and pressure groups. These actors seek to influence the political process at various levels. Understanding how much influence actors have in the policy process means we understand the concept of power as well as how power is used. Power can be categorized based on personal wealth, personality, level of or access to knowledge, or authority, but it is closely related to the organization and structure in which the individual actor works and lives.

b. Policy context/context of policy are systematic factors such as political, economic, social, and cultural, both nationally and internationally, that can influence health policy. Therefore, to examine the context in which the policy is made and assess the extent to which the types of factors influence the resulting policy, it is necessary to understand how health policies change or not and the ability to review policies.

c. Policy content is the substance of a policy, which explains in detail the parts of the policy.

d. Process is a policy process that refers to the way in which policies are initiated, developed, drafted, negotiated, communicated, implemented, and evaluated. The Heuristic Stages by Sabatier and Jenkins-Smith (1993) are known as an approach used to understand

the policy process. The series of stages helps to understand policy formulation in different stages:

- Identify the problem and its content.
- Policy formulation
- Implementation of policies
- Policy evaluation

4. DELIBERATIVE ANALYSIS OF PUBLIC POLICY

The development of policy analysis has ushered in a change from government terminology to governance. This change was widely proclaimed and supported in the political science and policy science communities (Pierre, 2000). This shows dissatisfaction with authoritarian top-down government intervention and one-sided bureaucracy in the creation and implementation of political problems (Hajer and Wagenaar, 2003). Understanding governance is a concept from Mark Warren in the journal American Political Science Review entitled Democratic Theory and Self-Transformation (1992), which has an expanded meaning of democracy.

The birth of this governance mode is seen by scholars and policy analysts as a logical change in world life. Hajer and Wagenaar (2003), in their book "Deliberative Policy Analysis," state that "deliberative approaches to policy analysis are relevant here" (3002:13).

In Frank Fisher et al. (2015), Hajer and Wagenaar (2003) stated that the analytical model of public policy deliberation has become an important discourse in the literature on public administration and public policy. The development of public policy studies has also penetrated the social sciences by providing a better understanding of the policy-making process by including scientific knowledge in policy decision-making.

The deliberative model, also known as the argumentative policy model, was initiated by Fisher and Forester (1993) in "The Argumentative Turn in Policy Analysis and Planning." This argumentative analysis model is a method that uses interpretative analysis, discourse and narrative policy analysis, socio-linguistic analysis, or careful description and interpretation in deliberative policy.

Hajer and Wagenaar (2003: 8–12) propose a deliberative policy analysis model where they distinguish five concrete challenges for policymaking and politics:

a. New space in politics

In the classical-modernist conception, political institutions obey the implicit conceptual 'Matrouchka' system. This model loses its heuristic power: politics and policymaking often occur in configurations that do not fit the old format (Dryzek, 1999; Held, 1995; Eriksen & Fossum, 2000). Politics in network society is characterized by the image of "multi-level governance","regimes," or "transnational policy discourses" (Hajer, 2000). In terms of the recovery of political life, it can be observed at all levels of government, both in international politics, within national borders, and regionally. Characteristically, these new political spaces initially exist in an “institutional void”: there are no predetermined rules that determine who is responsible, who has authority over whom, or what kind of accountability is expected. But when politics occur between two organizations, everyone brings their own institutional expectations and routines with them. And, because different participants follow their own “logic of appropriateness” (March & Olsen 1995),

b. Politics and Policy Making under Conditions of Radical Uncertainty.

Policymakers must be sensitive to the limitations of knowledge in conditions of radical uncertainty. Concrete problem solving, shared responsibility, performance-based

learning, and learning together become strong and potential building blocks for viable alternative strategies.

c. The Importance of "Differences" in Political Understanding

Modern society is becoming more culturally complex. This phenomenon of cultural differences is not new, and eventually scholarship has addressed the problem in policy analysis (Yanow 1996, 2000), but the increasing importance of differences magnifies problems of translation: between languages, between discourses, and ultimately between people (cf. Yanow, this book; Torgerson, this volume). Solving these public problems increasingly requires the cooperation of different groups.

d. Act based on awareness of interdependence

A fourth feature of policymaking and politics in networked societies is an increasing awareness of interdependence. If conditions of difference radically change the nature of the policymaking process by posing problems of translation, interdependence gives rise to the need to overcome these very real discursive barriers. Traditional forms of government are no longer able to provide services due to a lack of legitimacy and the existence of jurisdictional territory, so it is hoped that actor networks will be able to create capacity for interaction and communication. This awareness facilitates new creativity in solving "new modes of conflict resolution," which suggests that the essence of dealing with policy conflicts may be a more substantial process of deliberation and solving public problems together by collaborating.

e. Policy making, dynamics of trust, and identity.

The concept of community networks helps in understanding why there is interest in "trust", "interdependence," and “institutional capacity." In this case, there is a problem that the government cannot solve, and when the government still wants to solve the problem, "trust" is the key to the solution.

Hajer and Wagenaar (2003:16) state that policy science is involved with modern democracy, which lies in three pillars, namely: interpretation, practice, and deliberation.

a). Policy analysis is interpretive.

Meanstream policy analysis lies in philosophical realism, which assumes that the observational data that forms the input for analytical techniques is non-problematic, such as Kalokowski's statement (1968:3) that "there is no real difference between 'essence' and 'phenomenon'.

b). Policy analysis is practice-oriented.

The responsibility to address the situation at the level of job-defining characteristics rests with policymakers and public administrators.

c). Policy analysis is deliberative.

When talking about community, we are not thinking about abstract or ideal theoretical buildings, but rather living entities that can be identified in space and time. And think that social society is made up of people who are connected to their environment.

Ines and Booher (2003) are people who put forward the importance of interdependence in society, as stated by Hajer and Wagenaar (2003). Ines and Booher proposed the concept of "authentic dialogue," which is a new approach that states that policies will be achieved if there is diversity and interdependence between actors.

In social science, the term "network" was first used in the 1940s and 1950s to analyze and map relationships, interconnections, and personal dependencies (see Bolt, 1957; Frankenburg, 1966) (Parsons, 2014: 187). In the case of policy making, this term gives meaning to how policies emerge and interplay between people and organizations and provides a more informal description of how "real" policies are implemented (Parsons, 2014; 187).

Rhodes applied the theory of resource dependency and exchange and the idea of policy networks to the study of local-central relations (see Rhodes 1981, 1986, 1988). And following Benson in defining policy networks in terms of "complexes of organizations linked to each other through resource dependencies" (Benson, 1982: 148), Parsons (2014). Michael M. Atkinson and William D. Coleman, in their article "Policy networks, Policy communities, and the Problem of Governance," reviewed and evaluated the network literature in 1992. They argue that this approach is an important attempt to understand broader policy processes than the bureaucratic-political model.

According to Hajer and Wagenaar (2003), network societies are characterized by multi-level governance. The form of deliberation in the policy process of the idea of multi-level governance first introduced by Mark (1993; 392) is 'a system of continuous negotiation among nested governments at several territorial tiers'. This definition describes domestic political analysis, especially the policy network approach, by describing how, under the concept of multi-level governance, both supranational, national, regional, and regional governments are connected in territories that encompass the policy network.

4. HEALTH POLICY REGARDING HIV/AIDS

Policy on HIV/AIDS includes a series of decisions and actions that affect institutions, organizations, the role of stakeholders, service provider systems, and funding related to HIV/AIDS. HIV/AIDS prevention policies in Indonesia have changed from a centralized government system to a decentralized system (regional autonomy). The

fundamental weakness in the regional response to HIV/AIDS is that it relies on policy and institutional action alone, namely the formation of regional KPAs, but is weak in terms of policy implementation capacity (Australian Aid, 2015). In general, health development programs in Indonesia still face two challenges. First, internally within the health sector, namely the lack of integration between policy, planning, budgeting, and implementation. Second, in relation to other sectors, namely, weak synergy in preparing cross-program activities (Australian Aid, 2015). Based on Minister of Health Regulation No. 21 of 2013 concerning HIV/AIDS control, Article 12 states that controlling HIV transmission can be achieved effectively by implementing a safe and risk-free lifestyle. The prevention in question is: b. prevention of HIV transmission through sexual contact; c. preventing HIV transmission through non-sexual relations; and D. preventing HIV transmission from mother to child. Based on Banjarmasin City Regional Regulation No. 11 of 2012 concerning HIV-AIDS Control in Banjarmasin City, efforts to prevent and control HIV-AIDS are as follows:

(1) Prevention of HIV-AIDS can be done by:

a. not engaging in unhealthy and deviant sexual relations;

b. being loyal to one partner;

c. using condoms for every sexual contact that poses a risk of contracting HIV-AIDS.
d. the transfused blood must be free of HIV; e. use of sterile and disposable syringes;
f. use of sterile medical equipment;

g. PLWHA mothers are obliged to prevent HIV transmission to their unborn babies;
h. the transfer of organs and body tissues must be HIV-free;

(2) To prevent the potential for HIV transmission through injection drug use, every person who uses injection equipment during injection drug use activities is required to use sterile syringes and/or replace injectable drugs with substitute substances.

(3) The use of injectable drugs, as referred to in paragraph (2), is part of treatment or healing as regulated in the laws and regulations in the field of narcotics.

(4) Efforts to organize communication, information, and education (KIE) to:

- increase healthy behavior and healthy and responsible sexual relations;

- use of condoms for all sex workers and their clients, as well as PLWHA and their partners;

- reduce sexually transmitted infections (STIs) caused by injecting drug abusers through harm reduction activities;

- utilize the dual function of condoms in the family.

In the Regulation of the Minister of Health of the Republic of Indonesia number 74 of 2014, it is stated in the attachment to the guidelines for implementing HIV counseling and testing that the national policy and strategy have proclaimed the concept of universal access with the vision of getting to zero, namely zero new HIV infections, zero discrimination, and zero AIDS-related deaths.The vision of getting to zero is an ambitious target for controlling HIV/AIDS, which is outlined in the implementation of the fast-track approach. The efforts to control HIV/AIDS that have been implemented globally by UNAIDS convey the importance of efforts to control HIV transmission, as conveyed by UNAIDS in On the Fast-Track to End AIDS to end the AIDS epidemic without leaving anyone behind. On the Fast Track to End AIDS is an approach that utilizes innovation to expand services so that the services provided are closer to the community and focus more on areas and populations that have the highest burden of HIV.

The Fast-Track approach is to encourage the achievement of the 90-90-90 target, namely that by 2020, 90% of people living with HIV know their HIV status, 90% of people who know their status are undergoing treatment, and 90% of those undergoing HIV

treatment experience viral load suppression so that their immune system remains strong and they no longer transmit HIV. This fast-track approach is a meaningful and ambitious target for accelerating HIV services over the next five years. Fast-Track is a new way to reach those who need these services. The program is focused on areas and population groups where the service will have the greatest impact. On the Fast Track to End AIDS is a fast-track approach to changing how we work.

UNAIDS Indonesia, 2014 Apart from that, efforts to overcome HIV/AIDS have been outlined in the details of the HIV/AIDS prevention strategy for the period 2015–2019, which are as follows:

a. Determining geographic target priorities: in this case, attention to areas that are the epicenter of the epidemic, where there is also local regional infrastructure readiness to produce optimum response impacts.
b. Utilizing combination prevention as a leverage strategy: combination prevention is an approach that combines the prevention of new infections with treatment programs as prevention in order to support the provision of comprehensive services. Combination prevention not only focuses on prevention through behavior change interventions but also on biomedical interventions through treatment, positive prevention, treatment as prevention, pre- and post-exposure prophylaxis, reducing the harm of drugs, PMTS, circumcision, counseling, gender equality, supportive policies, strengthening a conducive environment, as well as social mobilization of communities and society.
c. Strengthening sustainable comprehensive services: aims to strengthen an integrated health service system with community-based prevention such as PMTS through close collaboration between district and city governments, health service managers, civil society, as well as communities, key populations, and PLWHA.
d. Decentralization and integration of HIV services: HIV activities need to be immediately better integrated into community-based activities.

e. Developing and expanding impact mitigation: The focus of developing and expanding impact mitigation in the future is so that children infected and affected by HIV and AIDS can access services that provide social protection, education, and health.
f. Creating a supportive environment for key populations and PLWHA: Stigma, discrimination, and human rights violations are widely recognized as barriers to an effective national response to HIV. In order to realize effective HIV prevention, services, and support programs, these human rights barriers must be addressed by integrating the protection and promotion of human rights and gender equality into the HIV response, improving existing programs that address these human rights barriers, and ensuring that HIV programs do not have the potential to or do not violate human rights. This integration must be carried out from the planning stage to monitoring the implementation of the HIV program.
g. Evaluation of processes and quality standards to strengthen quality interventions: Quality improvement needs to be carried out by paying attention to the details of program implementation as regulated in activity guidelines or procedures. One of the quality improvements that will be the focus in the future is searching for and finding cases of HIV or STIs and ensuring that treatment and care meet the standards set by the Ministry of Health.
h. Supporting the strengthening of community systems: Community involvement and empowerment are two of the principles of dealing with HIV and AIDS. Community System Strengthening (CSS) in the fight against AIDS aims to achieve better health outcomes with the active participation of affected populations and community-based organizations in planning, implementing, monitoring, and evaluating services and activities related to control, treatment, and care. and support for PLWHA.
i. Managing knowledge and skills between districts and cities: Improving knowledge management is one of the priorities of SRAN 2015–2019, especially knowledge management of AIDS prevention efforts at the district or city level to facilitate horizontal learning between districts and cities in Indonesia.

j. Encourage the allocation of funds for AIDS control at the district or city level. The sustainability of HIV and AIDS control depends on adequate levels of funding. With the decline in foreign funding support for AIDS prevention efforts in Indonesia, it is necessary to encourage adequate funding allocation not only at the national level but also at the provincial and district/city levels.
k. Strengthening research and data quality and accelerating the use of innovation and new technology
l. Strengthening international partnerships: bilateral and multilateral. HIV/AIDS prevention activities are managed by the KPA (AIDS Prevention Commission), located in provinces and districts. KPA also coordinates with various sectors and NGOs at the policy level.

Referring to the Presidential Regulation of the Republic of Indonesia Number 124 of 2016 in Article 17a, it is explained that:

(1) The National AIDS Commission completes its duties no later than December 31, 2017. (2) After the end of the term of office of the National AIDS Commission as intended in paragraph (1), the duties and functions: a. the determination of policies, national strategic plans and strategic steps, dissemination of information, national regional cooperation, as well as control, monitoring and evaluation carried out by the National AIDS Commission are the responsibility of the minister who handles government affairs in the health sector; and b. Coordination carried out by the National AIDS Commission is the responsibility of the minister who carries out coordination, synchronization and control of ministerial affairs in the administration of government in the fields of human development and culture.

(3) At the end of the term of office of the National AIDS Commission, as intended in paragraph (1), all assets of the National AIDS Commission will become state-owned assets, which will then be handed over to the ministry that carries out government affairs in the

health sector after an audit is carried out in accordance with the provisions of the laws and regulations. invitation. Based on Minister of Home Affairs Regulation Number 20/2007, it is stated that the duties of the district or city KPA include:

a. Coordinate the formulation of policies, strategies, and steps needed to overcome HIV and AIDS in accordance with the policies, strategies, and guidelines set by KPAN.

b. lead, manage, control, monitor, and evaluate the implementation of HIV and AIDS prevention in the region or city;

c. Collect, mobilize, provide, and utilize resources from the central, regional, community, and foreign aid effectively and efficiently for HIV and AIDS prevention activities;

d. Coordinate the implementation of the duties and functions of each agency that is part of the Regency/City KPA membership;

e. Organizing regional cooperation in the context of combating HIV and AIDS;
f. Disseminate information regarding efforts to control HIV and AIDS to officials and the community;

g. Facilitate the implementation of the tasks of sub-district heads and village/district governments in dealing with HIV and AIDS.

h. Encourage the formation of NGOs or groups concerned about HIV and AIDS;
i. Supervise and evaluate the implementation of HIV and AIDS control and submit regular and tiered reports.

4. Discourse on the Substance of HIV/AIDS Policy

a. Control of HIV/AIDS

The continuing high level of the AIDS epidemic in Indonesia has weakened the role of infected teenagers so that they are no longer productive. With the condition of teenagers going through this transition period, they will be easily influenced by the environment and behavior at risk of contracting HIV/AIDS, so there is a need for efforts to control HIV/AIDS so that they can save productive human resources for development.

HIV (Human Immunodeficiency Virus) is a virus that attacks and weakens the human immune system to fight infections so that the body is easily infected with various diseases, while Acquired Immunodeficiency Syndrome (AIDS) is a syndrome caused by decreased immunity due to HIV infection. A person infected with HIV does not immediately suffer from AIDS but may take 5–10 years before suffering from AIDS (Ministry of Health, 2014).

The HIV/AIDS control strategy is the main thing that must be done, because control means making every effort to break the chain of transmission so that preventing HIV transmission becomes effective. HIV/AIDS infection is a disease with a long journey. By providing health education and increasing knowledge, we can improve efforts to prevent and transmit HIV/AIDS. Control is all efforts and activities carried out, including mitigation, handling, and rehabilitation activities. As is known, HIV is transmitted from someone infected with HIV to another person through blood and body fluids (sperm fluid, vaginal fluids, and breast milk).

Control is carried out with the aim of:

a. Improving the level of public health so that it is able to prevent and overcome the transmission of HIV/AIDS.

b. fulfilling the community's need for adequate, safe, quality, and affordable information and health services for all levels of society so as to be able to overcome the transmission of HIV/AIDS.
c. protecting the community against all possible events that could lead to HIV/AIDS transmission.
d. providing convenience in order to support increased efforts to control HIV/AIDS.
e. Improving the quality of human resources in dealing with HIV/AIDS (Banjarmasin City Regulation, No. 11 of 2012).

The prevention and countermeasures carried out are:

- Controlling transmission through sexual contact

- Control of transmission through blood

- Controlling transmission from mother to child

- Reducing the Negative Impact of HIV Infection

HIV/AIDS control methods can be accessed and utilized in various ways by a country, depending on its economic capacity. This will affect the resources required, such as costs for various therapies and treatments, knowledge, information, and skills. This control effort, of course, requires large resources to meet needs so that their difficulties can be overcome. To address HIV/AIDS among teenagers and young adults, it is very important that we review what they know about HIV/AIDS.

Efforts to control HIV/AIDS sometimes experience problems, as is the case in several developing countries in Africa, Asia, and Latin America. These problems, as mentioned by Condon & Sinha (2008, are:

a. Weak finances in prevention and treatment
b. Failure to limit costs is related to a lack of epidemic or ideological information, as well as limitations in using donor aid.
c. Limited capacity to manage increasing costs.
d. Failure to integrate HIV control into schools, workplaces, and other health care programs
e. There is stigma and discrimination against HIV sufferers and vulnerable groups, thus hindering testing and control services.

Crisovan (Australian Aid, 2015) suggests that HIV/AIDS education programs in Indonesia will be more effective if they are able to recognize:

a. the identity of the person targeted by the program
b. the prevailing culture and the religious ideology they adhere to, as well as complex situations
c. that cultural and programmatic definitions of "risk" are often inconsistent.

The cultural concept in this case makes it possible to develop policies and programs that are culturally appropriate and sensitive in various places in Indonesia.

Apart from that, Faulk and Usunier (2009) stated that the factors that facilitate the spread of HIV/AIDS in developing countries are economic, social, and cultural factors, including:

a. countries with low income and high-income disparities;
b. Living and working conditions risk HIV infection, namely high labor migration;
c. The large number of unemployed people of productive age

d. Government actions in providing facilities when security threats and instability occur
e. There is a strong stigma to marginalize someone infected with HIV/AIDS from receiving education, control, testing, and treatment.
f. Lack of HIV/AIDS information provided
g. High disparities between women and men in education and income place women in a position that is more vulnerable to infection.

HIV/AIDS Management Policies and Programs

Policy on HIV/AIDS includes a series of decisions and actions that affect institutions, organizations, the role of stakeholders, service provider systems, and funding related to HIV/AIDS. HIV/AIDS prevention policies in Indonesia have changed from a centralized government system to a decentralized system (regional autonomy). The fundamental weakness in the regional response to HIV/AIDS is that it relies on policy and institutional action alone, namely the formation of regional KPA, but is weak in terms of policy implementation capacity (Australian Aid, 2015).

In general, health development programs in Indonesia still face two challenges. First, internally within the health sector, namely the lack of integration between policy, planning, budgeting, and implementation. Second, in relation to other sectors, namely, weak synergy in preparing cross-program activities (Australian Aid, 2015). Based on Minister of Health Regulation No. 21 of 2013 concerning HIV/AIDS control, Article 12 states that controlling HIV transmission can be achieved effectively by implementing a safe and risk-free lifestyle.

The prevention in question is:

a. prevention of HIV transmission through sexual contact;

b. preventing HIV transmission through non-sexual relations; and

c. preventing HIV transmission from mother to child;

Based on Banjarmasin City Regional Regulation No. 11 of 2012 concerning the control of HIV/AIDS in Banjarmasin City, efforts to prevent and control HIV/AIDS are as follows:

(1) Prevention of HIV/AIDS can be done by:

a. not engage in unhealthy and deviant sexual relations;
b. loyal to one partner;
c. use condoms for every sexual contact that carries a risk of contracting HIV/AIDS.
d. the transfused blood must be free of HIV;
e. use of sterile and disposable syringes;
f. use of sterile medical equipment;
g. PLWHA mothers are obliged to prevent HIV transmission to their unborn babies;
h. the transfer of organs and body tissues must be HIV-free;

(2) To prevent the potential for HIV transmission through injection drug use, every person who uses injection equipment during injection drug use activities is required to use sterile syringes and/or replace injectable drugs with substitute substances.

(3) The use of injectable drugs, as referred to in paragraph (2), is part of treatment or healing as regulated in the laws and regulations in the field of narcotics.
(4) Efforts to organize communication, information, and education (KIE) to:
a. increasing healthy behavior and healthy and responsible sexual relations;

b. use of condoms for all sex workers and their clients, as well as PLWHA and their partners;
c. reducing sexually transmitted infections (STIs) caused by injecting drug abusers through harm reduction activities;

d. utilization of the dual function of condoms in the family.

In the Regulation of the Minister of Health of the Republic of Indonesia number 74 of 2014, it is stated in the attachment to the guidelines for implementing HIV counseling and testing that the national policy and strategy have proclaimed the concept of universal access with the vision of getting to zero, namely zero new HIV infections, zero discrimination, and zero AIDS-related deaths.The vision of getting to zero is an ambitious target for controlling HIV/AIDS, which is outlined in the implementation of the fast-track approach.

The efforts to control HIV/AIDS that have been implemented globally by UNAIDS convey the importance of efforts to control HIV transmission, as conveyed by UNAIDS in On the Fast-Track to End AIDS to end the AIDS epidemic without leaving anyone behind. On the Fast Track to End AIDS is an approach that utilizes innovation to expand services so that the services provided are closer to the community and focus more on areas and populations that have the highest burden of HIV. The Fast-Track approach is to encourage the achievement of the 90-90-90 target, namely that by 2020, 90% of people living with HIV know their HIV status, 90% of people who know their status are undergoing treatment, and 90% of those undergoing HIV treatment experience viral load suppression so that their immune system remains strong and they no longer transmit HIV.

Implementation of HIV/AIDS Control Policy (Case Study in Banjarmasin)

Efforts to combat HIV/AIDS in the City of Banjarmasin will not be separated from the national HIV/AIDS response, while the national government's HIV/AIDS prevention efforts have been

included in the National Strategy for Combating AIDS for 2015–2019. Apart from that, the national government has also made efforts to accelerate HIV/AIDS prevention. AIDS through an accelerated or fast-track program, which is an intensive and comprehensive control effort suitable for high-prevalence areas.

The government's commitment to efforts to control HIV/AIDS can be seen in the formation of the AIDS Control Commission with the issuance of Presidential Regulation Number 76 of 2005. Although in the course of this policy change, it was notified that the validity period of the National AIDS Commission (KPAN) had expired based on Presidential Regulation. Noor 124 of 2016 on December 31, 2017. However, efforts to control HIV/AIDS by KPAN continue to operate under the auspices of the Ministry of Health under the Director General of P2P of the Ministry of Health.

The National HIV/AIDS Management Strategy is proof of the government's commitment to tackling HIV/AIDS, and this is the blueprint for fighting HIV/AIDS in Indonesia. Therefore, government policies, both national, provincial, and global, are the basis for consideration in efforts to control HIV/AIDS in the City of Banjarmasin.

The Banjarmasin City Government's response to efforts to control HIV/AIDS was to issue regional regulation Number 11 of 2012 concerning HIV/AIDS control in the City of Banjarmasin. The response to issuing this regional regulation is a top-down model policy because it is assumed to be the government's own initiative and implemented by the government (Van Meter and Van Horn, 1975). In its application, this top-down model policy sometimes makes policy decisions not in line with the wishes of the community. This misalignment is because top-down model policies make it difficult for the government to uncover new problems because policies are made on an ongoing basis. Apart from that, top-down model policies give rise to undemocratic public policies (Sabatier in Subarsono, 2005). Apart from that, this analysis assumes that the relationship between policies and results tends to ignore the impact of implementers on policy delivery (Parson in Frank Fischer, 2015: 130).

Principles and Goals of HIV/AIDS Control

Implementation is an important process in policy; to achieve a goal that has been set in the policy, it needs to be implemented. In HIV/AIDS control policies, it is very important to clearly distribute policy outputs that have been implemented by implementers to target groups as an effort to realize policy objectives (Van Meter and Van Horn, 1975). HIV/AIDS control policy actions are continued with operational actions as an effort to continue HIV/AIDS control efforts to achieve change by suppressing HIV/AIDS cases.

The principles and objectives of HIV/AIDS control policy in Banjarmasin City are stated in Regional Regulation Number 11 of 2012 in Article 3, namely that HIV/AIDS control is carried out based on the principles of humanity, justice, gender equality, togetherness, integration, sustainability, confidentiality, and voluntary. The principles and objectives of this policy in its implementation have not been properly socialized and have not reached the community optimally. When the principle of togetherness is in controlling HIV/AIDS, it should be togetherness in controlling HIV/AIDS. However, the fact is that the agencies involved in controlling HIV/AIDS have not implemented HIV/AIDS control together. Several agencies carry out control efforts based on programs derived from central policy. This explains why the principle of togetherness is not yet clear in its implementation.

Policy implementers need clear objectives for a policy as a source and understanding for its implementation in the field. The clearer the objectives of a policy in providing guidance, the greater the possibility of achieving the goals set by the policy. As stated by Goggin et al. (1990), policy messages that contain direct statements about their standards or targets—especially those without qualifications, contradictory, or ambiguous language—are clear and unambiguous regarding the goals. In this case, the policy language written is still ambiguous because the appointment of agencies involved in implementing HIV/AIDS control policies is clearly stated in Regional Regulation Number. 11 of 2012,

but no explanation was given regarding the basis for its implementation, such as mayoral regulations and so on.

Ripley et al. (1986) also stated that clarity of policy content is the clarity and consistency of objectives that can be understood so that they are easy to implement. Having clear policy objectives will make it easier for implementers to implement policies. In efforts to implement HIV/AIDS control policies in the City of Banjarmasin, there are no supervisors or juknis (technical instructions) to implement HIV/AIDS control efforts, so it is not clear where the objectives of this HIV/AIDS control policy will be taken. Relevant agencies carry out HIV/AIDS control efforts based on previous programs, which are central programs. Such as the Health Service in carrying out efforts to control HIV/AIDS by using references or technical instructions from the Ministry of Health's program. Likewise with social services, one of whose main tasks is HIV/AIDS prevention. In the absence of a supervisor or technical guide for implementing HIV/AIDS control, this is an obstacle to implementing the policy.

Several related agencies that have been mentioned in Regional Regulation Number 11 of 2012 have never been aware of and have never even received socialization regarding these regional regulations. Even though the relevant agencies are open to making efforts to control HIV/AIDS if there is a guardian as the basis for implementation. Policy implementation does not only contain routine procedural mechanisms but also regarding decisions, who implements the policy, and what they get; apart from that, it also contains conflicting issues in its implementation. To achieve successful policy implementation, it is not only necessary to have accurate objectives but also to support resources. In this case, an active role is needed from bureaucrats to socialize regional regulations so that they achieve their goals appropriately.

The principles and objectives of Regional Regulation Number 11 of 2012 cannot achieve the expected objectives. The majority of informants stated that the principles and benefits of HIV/AIDS control had not been properly socialized, so that the objectives and

benefits of the Banjarmasin City Regional Regulation had not been optimally felt by policy recipients. This is because the agencies related to efforts to control HIV/AIDS as stated in Regional Regulation Number 11 of 2012 do not know about this, then there is no socialization regarding these regional regulations so that the majority of informants do not know about these regional regulations, apart from the content and the objectives of these regional regulations are unclear and not detailed so that it is difficult to translate their aims and objectives, the unclear role of bureaucrats in implementing HIV/AIDS control and then the absence of perwali (mayor regulations) or juknis (technical instructions) to follow up on Regional Regulation Number 11 of the Year 2012 so that the regional regulations cannot be implemented optimally. This cannot answer strategic questions to determine the success of policy implementation regarding policy objectives and program suitability (Goggin, 1990). In this case, HIV/AIDS control policies have not been able to significantly change the fate of the target group as idealized in the stated policy objectives.

Several theories regarding health policy put forward by experts, along with explanations and references:

Health System Theory by Donabedian (1980)

This theory explains that the health system has three main components: structure, process, and outcomes. Structure includes the facilities and resources available, the method includes how services are delivered, and outcomes include the impact of health services on the population.

Reference: Donabedian, A. (1980). "Explorations in Quality Assessment and Monitoring."

Health Behavior Theory by Rosenstock (1974)

This theory suggests that an individual's health behavior is influenced by their understanding of the risks and benefits of certain health actions. This model emphasizes the importance of health education to increase awareness and change behavior.

Reference: Rosenstock, I. M. (1974). "The Health Belief Model and Health Behavior."

Social Justice Theory by Rawls (1971)

This theory puts forward that health policies should be designed to ensure that all individuals have fair access to health services. Social justice requires governments to address the needs of marginalized groups.

References: Rawls, J. (1971). "A Theory of Justice."

Stakeholder Theory by Freeman (1984)

This theory emphasizes the importance of considering all parties involved in health policy, including patients, providers, and the government. Involving stakeholders in the decision-making process can increase the effectiveness of policies.

References: Freeman, R. E. (1984). "Strategic Management: A Stakeholder Approach."

Policy Implementation Theory by Pressman and Wildavsky (1973)

This theory focuses on how health policies are implemented in the field. They explain that successful policy implementation is often hampered by a variety of factors, including coordination between agencies and budget support.

References: Pressman, J. L., & Wildavsky, A. (1973). "Implementation."

Each of these theories provides a different perspective on how health policies are formulated, implemented, and evaluated, and the factors that influence their success.

Here are some studies by experts on health policies along with explanations and references:

Study on Universal Health Coverage Policy by the World Health Organization (WHO)

Research by WHO shows that implementing universal health policies can increase access to health services and reduce health disparities in society. This study analyzes various countries that have successfully implemented the policy and its impact on public health.

Reference: World Health Organization. (2010). "The World Health Report 2010: Health Systems Financing: The Path to Universal Coverage."

Research on the Impact of Anti-smoking Policies by Chaloupka, F. J., & Laixuthai, A.

This study examines the effects of anti-smoking policies, including cigarette taxes and smoking bans in public places, on smoking behavior and public health. The results show that these policies can significantly reduce the prevalence of smoking and related diseases.

Reference: Chaloupka, F. J., & Laixuthai, A. (1996). "Cigarettes, Taxes, and Health: The Impact of Tax Policies on Smoking Behavior."

Mental Health Policy Analysis by Thornicroft, G., et al.

This study explores the effectiveness of mental health policies across countries. Research suggests that policies that focus on integrating mental health services into the general health system can improve access and outcomes for people with mental health problems.

References: Thornicroft, G., et al. (2016). "The British Mental Health Policy and Its Impact on the Quality of Care: A Systematic Review."

Health Inequity Studies by Marmot, M.

This study examines inequities in health and how socioeconomic factors affect the health of individuals and populations. The results suggest that policy interventions targeting social determinants of health can reduce health disparities.

References: Marmot, M. (2005). "Social determinants of health inequalities." The Lancet.

Immunization Program Evaluation by Gavi, The Vaccine Alliance

This study evaluates the effectiveness of the global immunization program supported by Gavi in increasing vaccination coverage in developing countries. Findings suggest that appropriate financial and technical support can improve vaccine access and uptake.

References: Gavi, The Vaccine Alliance. (2020). "Gavi's Role in Global Immunization: Achievements and Future Directions." These studies provide in-depth insights into various aspects of health policy, from access and equity to the impact of specific policies on public health.

R. IMPLICATIONS OF HIV-AIDS, RESOURCES, AND HEALTH POLICY

The increase in HIV-AIDS cases is not only a problem in Indonesia but has become an international one. HIV (Human Immunodeficiency Virus) attacks the human immune system, leading to a decline in immunity and increased susceptibility to opportunistic infections. The HIV-AIDS response is highly dependent on the availability and distribution of health resources. The availability and distribution of these health resources include:

• Human resources (HR): such as trained health workers, HIV counselors, social workers, and laboratory technicians.

• Financial resources: national funding and global donors (e.g., The Global Fund, PEPFAR).

• Physical and technological resources: laboratories for viral load testing, ARV drug supply chain systems, primary care infrastructure.

• Social and community resources: civil society organizations, support groups for people living with HIV, the media, and advocacy networks.

Unequal distribution of resources leads to disparities in access to HIV services, particularly in low-

and middle-income countries. Therefore, resources are needed for the sustainability of HIV/AIDS response programs. Furthermore, for long-term sustainability, HIV programs must be integrated into national health systems.

HIV-AIDS is not only a health issue, but also a social, economic, and public policy issue. One of the most powerful social factors exacerbating the HIV epidemic is stigma and discrimination against people living with HIV. People living with HIV often experience social exclusion, job loss, and denial of health services. Furthermore, women are often the most socially impacted group, as in patriarchal societies, women have limited access to health information and reproductive decisions. Women also experience gender-based violence, which can increase the risk of HIV transmission. The HIV epidemic also has a significant impact on labor productivity and national economic development, particularly in developing countries. This increases mortality rates among productive-age individuals, reducing economic output. Furthermore, the cost of long-term HIV treatment places a fiscal burden on governments. Households with members living with HIV often face income losses and high healthcare costs, exacerbating poverty.

Public policy determines the extent to which communities can access prevention, treatment, and social support services. Countries with inclusive, human rights-based policies that are non-discriminatory have better epidemiological outcomes.

The effectiveness of HIV/AIDS policy implementation depends heavily on health system capacity, which includes: Availability of resources (human, financial, and social). The availability and adequate distribution of these three elements are key structural determinants of the success of HIV/AIDS prevention, care, and control programs. The World Health Organization (2007) describes six health system building blocks, three of which (human, financial, and social governance) are the foundation of effective health policies, including HIV. The availability of health workers (doctors, nurses, HIV counselors, laboratory personnel, and field workers) influences: Access to HIV diagnostic services, the quality of ARV counseling and therapy, patient monitoring, and the coverage of community-based interventions. When human resources are limited or distributed unevenly, HIV policies (e.g., free ART or early detection) will be ineffective at the field level.

In addition, HIV policies require long-term funding for:

- Provision of antiretroviral drugs (ARVs),
- Prevention programs (PrEP, condoms, education),
- Surveillance and laboratory work,

• Training of health workers, and

• Social support for people living with HIV/AIDS (PLWHA).

When funding is unstable, for example, due to reduced international donor assistance, policy effectiveness will be hampered.

Social resources include community networks, civil society support, and social and cultural norms that influence health behaviors. PLWHA communities and NGOs play a crucial role in policy advocacy, implementation oversight, and public education. Policies that do not involve community participation often fail because they are not appropriate to the local social and cultural context. Parker (2002) emphasized that structural social and political inequalities are at the root of the ineffectiveness of global HIV policies.

HIV/AIDS remains one of the world's greatest public health problems. Since 2016, the world has committed to Sustainable Development Goal (SDG) 3.3, which aims to end the AIDS epidemic as a public health threat by 2030.

However, global progress faces significant challenges: unequal access to services, donor dependency, and fragmented health systems. Therefore, experts believe that integrating HIV services into Universal Health Coverage (UHC) systems is the most sustainable strategy for achieving AIDS elimination.Universal Health Coverage (UHC) is defined by the WHO as a situation where all people have access to quality health services without experiencing financial hardship.UHC consists of three main dimensions: service coverage, population coverage, and financial coverage. Integrating HIV into UHC means integrating HIV programs into national health systems, not as vertical or separate programs, but as an integral part of primary health care, national financing, and social security.

HIV programs over the past two decades have relied heavily on global funding, such as the Global Fund. As aid declines, middle-income countries face service sustainability risks. Integration into the UHC system allows for domestic-based financing through national insurance or government budget allocations. Integrating HIV into UHC means HIV services, including testing, ART, and counseling, are available in primary health facilities that also treat other diseases.

This increases efficiency and expands reach to the general population and vulnerable groups.

Integrating HIV into UHC promotes synergies between health programs, for example, with TB, hepatitis, or reproductive health. A study by The Lancet Global Health (2021) showed that integrating HIV and TB services increased cost efficiency by up to 20% compared to a vertical model.

UHC emphasizes equity, ensuring that no one is left behind in accessing services. Integrating HIV into the UHC framework also strengthens the pillars of the health system: human resources for health, sustainable financing, integrated health information, and community participation of people living with HIV.

Thus, HIV policy is no longer seen solely as a disease program, but as part of the national welfare system.

REFERENCES

Andrew, Gilly. 2009. Buku Ajar Kesehatan Reproduksi Wanita (Women sexual Health). Jakarta: EGC

Andrea Parrot & Harold Feldman, (1984). *Human Sexuality – Contemporary Controversies*, Sage Publications, Inc, Beverly Hills, California.

American Psychological Association. Excerpt from: The Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients, adopted by the APA Council of Representatives, February 18-20, 2011. The Guidelines are available on the APA website at http://www.apa.org/pi/lgbt/resources/guidelines.aspx

Allan Rosenfield and Mahmoud F. Fathalla, 1990. *Reproductive Health, Global Issues*. The Parthenom Publishing Group, Casterton Hall, Carnforth, LA – Park Ridge, USA.

***Behavior*. www.guttmacher.org/pubs/journals/2818602.html**

Butler, Judith (1999) **Gender Trouble, Feminism and the Subversion of Identity**, London: Routledge.

Campbell, et al, 1999 . *Biology, Fifth Edition*, terjemahan Safitri, Amalia, 2004. Erlangga, Jakarta.

Carolyn Tucker Halpern, Denise Hallfors, Daniel J. Bauer, Bonita Iritani, Martha W. Waller, Hyunsan Cho. 2004. Perspectives on Sexual and Reproductive Health, Nov-Dec.

EB Tylor, (1871), Primitive Culture, London

Feldman. H & Parrot.A, (1984). *Human Sexuality, Contemporary Controversies*. Sage Publication. Beverly Hills/London/ New Delhi

Female Genital Piercings, http://piercingbible.com/female-genital-piercings

Gearon Christopher J. *(2010.) Pernikahan Dan Sek.* Diunduh Dari http://health.discovery.com. Pada tanggal 20 April 2010.

Glasier A, Gulmezoglu AM, Schmid GP, Moreno CG, Van Look PF. 2006. Sexual and reproductive health: a matter of life and death. Lancet vol 368(9547):1595- 1607.

Guttmacher Institute. 2011. *Reproductive Choices for Asian Adolescents: A Focus on Contraceptive*

Henshaw, Finer, 2006. Disparities in Rates of Unintended Pregnancy In the United States, 1994 and 2001.

Jacoby & Williams, 1985; O'Sullivan, 1995 ; Sprecher, McKinney, & Orbuch, 1991 , Sexuality, Culture and Health series

Jeffrey Weeks.2003. Sexuality, Second Edition, ISBN

Jennifer Ting**,** *The Power of Sexuality*, Journal of Asian American Studies - Volume 1, Number 1, February 1998, pp. 65-82

James R. Browning , Debra Kessler , Elaine Hatfield , Patricia Choo . 1999.Journal of Sex Research, *Power Jender, dan Perilaku Seksual* Journal of Sex Research.

Jane Ogden, 1996. *Health Psychology*. Open University, Buckingham, Philadelphia.

Lloyd,C.B,1996. "Family And Gender Issue For Populations Policy", Population on Women, New York: United Nations Publication, 1996

Michel Foucault (1980) Herculine Barbine; Being The Recently Discovered Memoirs of a Nineteenth-Century French Hermaphrodite, Sussex: The Harvester Press

Noviana, N. Priyanto, H.2023. In Cultural Perspective: Sexuality and Gender Performance. In Handbook of Research on Diversity and Gender Differences in Spiritual Experiences. e IGI Global book series Advances in Religious and Cultural Studies (ARCS) (ISSN: 2475-675X; eISSN: 2475-6768)

Noviana.N, Sri Suwitri, Bambang Supriyono, Sutopo Patria Jati. 2019. Suitability of the HIV/AIDS Control Program in the HIV/AIDS Control Policy in Banjarmasin to Achieve "Getting to Zero". Journal of Social and Development Sciences (ISSN 2221 -1152) Vol. 10, No. 3, pp. 22-29, September 2019

Noviana, N. 2013. Kesehatan Reproduksi & HIV/AIDS. Trans Info Media, Jakarta

Noviana, N. 2018. Edisi Revisi: Kesehatan Reproduksi Untuk Mahasiswa Kebidanan. Trans Info Media, Jakarta

Noviana. N, Sri Suwitri, Bambang Supriyono, Sutopo Patria Jati. 2023. HIV/AIDS CONTROL IN THE CONTEXT OF HEALTH POLICY. Penerbit Synsto. https://www.synsto.com/book/hivaids-control-in-the-context-of-health-policy

Nagel Joane. 2004. *Race, Ethnicity, and Sexuality*, Intimate Intersections, Forbidden Frontiers**,** Canadian Journal of Sociology Online May-June 2004 Canadian Journal of Sosiologi Online Mei-Juni 2004

Pinar Ilkkaracan and Susie Jolly. January, 2007. Gender and sexuality. Bridge, development-gender.

Shaluhiyah, Z. The Pattern Of Javanese Student Love Styles And The Socio-Sexual Lifestyles In The Era Of LIlY/AIDS.

Suzane Everett, 2004. *Handbook of Contraseption & Reproductive Sexual Health, 2 nd.* Terjemahan Nike Budhi, 2005. Penerbit buku kedokteran EGC, P.O. Box 4276, Jakarta.

Susan Sprecher, Kathleen McKinney. (1989). *Sexuality*, Sage Publications, International Educational and Profesional Publisher, Newbury Park, London, New Delhi.

Sonea correa at all ,Sexuality, Culture and Health series

Sarah Grogan, Body image : understanding body dissatisfaction in men, women, and children, East Sussex, Routledge, 2008 (http://piercingbible.com/female-genital-piercings)

World Health Organization.2002. Defining sexsual health, report of a technical consultation on sexual health. Geneva

HIV-AIDS
HUMAN RESOURCE AND HEALTH POLICY

Author's Biography

Dr. Nana Noviana, S.ST, M. Kes, C.MT., ClQaR

Born in Banjarmasin on January 10, 1977. The author currently works at the Regional Research and Innovation Agency of South Kalimantan Province as a researcher with expertise in public health and is a non-permanent lecturer. Previously, the author had worked in health services, both at the Community Health Center and at the Government Hospital. The author completed a master's degree in health promotion at Diponegoro University, Semarang, with a specialization in reproductive health and HIV/AIDS in 2012. In 2019, the author completed a doctoral degree in public administration at Diponegoro University, Semarang. In 2021, the author received scientific research awards from the Research Culture Society/Scientific Research Association Global Awards, and in 2022, the research proposal received the Brennaff Premium 1 billion Grant for Researchers Awards.