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Article

A critical documentary analysis on HIV/AIDS policies in Indonesia

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Abstract: The new cases of HIV/AIDS are being reported in Indonesia tend to increase. for over two decades, the Indonesian government has issued policies to reduce the number of cases through several ministries and local governments, but the results have not indicated signs of success. Therefore, this research aims to analyze the failure of prevention policies to improve policymaking in the future. It focuses on policy and institutional substance aspects using a qualitative design with documentary analysis approach. The results show that the policy failure in dealing with cases is caused by inappropriate rationalization, medicalization, and weak institutional and regulatory roles. Based on these descriptions, stakeholders are expected to emphasize a multi-perspective and holistic approach and rationalize policy objectives with institutional capacity. Moreover, the government needs to increase public and community involvement, strengthening the role of religious leaders and the media, and increase public literacy regarding HIV/AIDS.

Keywords: HIV/AIDS; policy failure; prevention policies; implementation; institutional

1. Introduction

According to World Health Organization (WHO), the Human Immunodeficiency Virus (HIV) attacks the immune system and reduces people's defenses against many infectious diseases (Rahman, 2020; WHO, 2016). For Infected individuals become immunocompromised when the virus destroys immune cells and impairs their function. HIV has been declared a global public health challenge since it was first discovered in 1981 and required a global response from the UN Security Council resolution in 2000 (UNAIDS, 2021a). Meanwhile, Acquired Immune Deficiency Syndrome (AIDS) is the most advanced stage of the infection caused by an extremely weakened immune system, which can take years to develop without treatment in some individuals (Baleanu et al., 2023). AIDS is the development of particular cancer, infection, or other long-term severe clinical manifestation (WHO, 2021). Since it was first discovered in Sub-Saharan Africa, this virus has become an epidemic disease (Jacobson, 2020; Martial et al., 2021). Even, HIV/AIDS can affect human development (Tian et al., 2023).

Increasing number of people living with HIV/AIDS (PL-HIV), it has become a global public health challenge (Khodayari-Zarnaq et al., 2021; Wanni Arachchige Dona et al., 2021). Globally, 37 million people were infected in 2021, and approximately 5.8 million people in the ASIA-Pacific region have HIV/AIDS. Indonesia is one of Asia's countries with the fastest addition of cases, with an estimated increase in infection rates of more than 36%. Indonesia's epidemic is growing faster than in other Asian countries, including Pakistan and the Philippines (UNAIDS, 2021b). To overcome this, WHO has a global commitment to achieve 95-

95-95. This means that firstly, 95% of people who are estimated to be living with HIV will know their HIV status (testing), secondly, 95% of people who already know their HIV status are receiving ARV treatment and HIV care, and 95% of people who have received Anti-Retroviral Drug therapy (ARV) experiences viral suppression which can be determined through a Viral Load (VL) test (WHO, 2023).

In low- and middle-income countries, the epidemic continues to spread among the most vulnerable groups, especially the poor, sex workers, and women (Apenteng et al., 2020; Golomski, 2023; Hardon et al., 2009; Khodayari-Zarnaq et al., 2021; Naqvi and Ibrar, 2017; Ongaga and Ombonga, 2012). This is exacerbated by a weak health care system, which impacts unresolved epidemic control (Beck et al., 2007). In the Indonesian case, much research has explained the increasing trend of cases in several regions (Ford et al., 1997; Kartono et al., 2022; Lestari, 2013; Moeliono et al., 1998; Olii et al., 2021; Pohan et al., 2011; Putra et al., 2021; Rahman, 2020; Resubun et al., 2021; Sahiddin and Resubun, 2018; Waluyo et al., 2015). However, research that discusses evaluation of policy failure analysis nationally is limited, especially the gap between determined targets and their implementation. Therefore, political and policy approaches to HIV/ADS prevention are necessary to mitigate the epidemic (Dworkin, 2010; Kaboyakgosi and Mpule, 2008).

According to Waluyo et al. (2015), the increasing number of HIV cases is due to injecting drugs, free sex, and the ignorance of survivors. According to Indonesian Health data released by the Ministry of Health as of July 2021, the estimated number of people with HIV in 2020 is 543,100, with 29,557 new infections and 30,137 deaths. **Figure 1** shows that yearly reported HIV-positive cases tend to increase. However, in 2020, the number of cases was the lowest in the last four years, totaling 41,987. Compared to the average of the previous 8 years, the number of new AIDS cases tends to decrease but has increased compared to the previous year, namely 8639 cases in 2020.

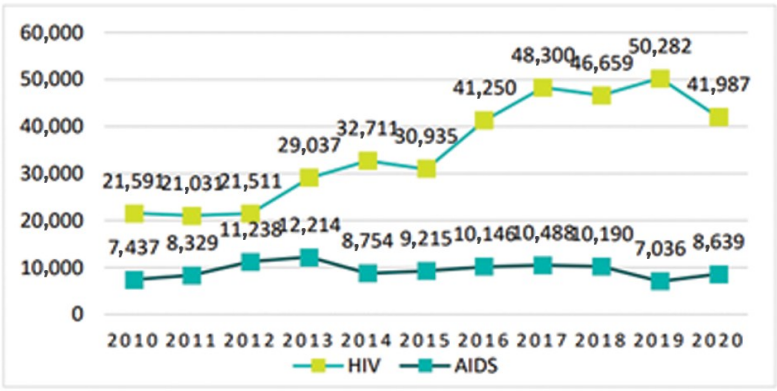

Figure 1. Number of reported HIV/AIDS cases in 2010–2020 in Indonesia.
Source: Indonesian Minister of Health (2021).

In contrast to the number of reported cases, the latest data until March 2021 by the Directorate General of Disease Prevention and Control, Indonesian Ministry of Health, on May 25, 2021, shows that the cumulative number of cases is 558,618 consisting of 427,201 HIV and 131,417 AIDS.

Since it was first discovered and continues to spread, the government has been committed to implementing the policies resulting from international agreements in controlling HIV/AIDS by promoting multilateral and bilateral cooperation as well as expanding cooperation with neighboring countries in the AIDS Control Program. The Indonesian government has implemented a total of 10 international policies. Furthermore, 66 national and 21 provincial and regency/city-level policies exist. Despite the many international, national, and local policies, the tendency for cases is still very high. This condition is undoubtedly a danger alarm for essential actors of the state/government (Kartono et al., 2022).

This research examines policy impacts that control cases in Indonesia, especially at the implementation of prevention level. This section presents a theoretical framework for public policy and failure, HIV/AIDS policy, and subsequent policies. The methodological and data collection systems are presented, followed by an empirical discussion of the prevention failure and its analysis. The last section draws some conclusions and suggests some theories without referring to Indonesia's failure of prevention policies.

2. The approach to documentary analysis

Public policy in social sciences is complex and multidisciplinary (Kreis and Christensen, 2013; Wilder, 2017) due to the nature of the public policy seen from various aspects and sides (Wang and Wei, 2009). In simple terms, public policy is interpreted by Dye (1998) as "anything selected to be implemented or not" or the output of government (Provis, 2007). Public policy cannot be separated from human life in the form of micro and macro levels in the life of society and the state. In this context, some dimensions are interrelated between public policy as a choice of legal or official action, hypothesis, and purposes (Althaus et al., 2004; Barclay and Birkland, 1998).

A policy is created as a government response to resolving a public issue (de Leon, 1992; Roziqin et al., 2021). The policy is a meeting room between politics and bureaucracy (Wang and Wei, 2009). According to Hogwood (1995), several approaches to describe the policy framework include (1) Studies of policy content, (2) Studies of policy processes, (3) Studies of policy outputs, (4) Evaluation studies, (5) Information for policymaking, (6) Process advocacy, concentrated with improving the policy process, (7) Policy advocacy, (8) The critical appraisal of the assumptions, methodology, and validity of policy analysis. These eight approaches are used by policy to analyze a complex public issue (Buick et al., 2016; Lieberman, 2012). HIV/AIDS control is a public concern that policymakers should address.

According to Kaboyakgosi and Mpule (2008) and Khodayari-Zarnaq et al. (2021), a typical HIV/AIDS control policy is made in a multi-actor way. Therefore, many actors are involved and influence the failure or success of the policy. Increasing cases in a country is a policy challenge by considering the policy actors involved in context, content, and process (Spicer et al., 2011). Public policy formulated is a form of control instrument for HIV/AIDS problems in a country (Ayiro, 2012; Pope, 2012). The focus of the policy considered the most strategic and important is at the prevention and stigma stage (Kerr and Jackson, 2016). However, it covers economic, political, and

socio-cultural dynamics at the international, national, and regional levels. The implementation will be seen from how the policy can be initiated, formulated, developed, communicated, and evaluated.

2.1. Global policy about HIV/AIDS

The Joint United Nations Program on HIV/AIDS (UNAIDS) has targeted the UN 90-90-90 Treatment for All Targets for HIV control worldwide (UNAIDS, 2017). Since January 2018, a guideline has been in effect to ensure that 90% of people living with HIV know their status, 90% diagnosed can receive antiretroviral therapy (ART), and 90% of HIV-infected individuals take ART can suppress their viral load. The guidelines are expected to be revisited for further amendments in 2023 (Shimizu, 2021), and each country has a varied strategy for controlling HIV/AIDS. For example, in America, Kerr and Jackson (2016) focused on the policy aspect due to injustice in society caused by the drug war.

Akukwe (2001) suggested that the focus of handling HIV/AIDS in America is to use preventive efforts, poverty alleviation programs, and intensive public health services. In Pakistan, Naqvi and Ibrar (2017) criticized the weak role of social workers in the national strategy and policy framework for dealing with cases. Furthermore, Khodayari-Zarnaq et al. (2021) realized that the many actors involved in managing HIV/AIDS in Iran impact the weak coordination between stakeholders. This was confirmed by Lieberman (2012) in South Africa, where political actors and leaders have a preference interest in policies dealing with the infection. In several Asia-Pacific countries, adolescents or adults are vulnerable to the risk of transmission (Sileo and Sileo, 2001). The facts from previous research indicate that political and policy approaches can be a strategy in dealing with HIV/AIDS in a country.

2.2. Assessment of policy impact

Understanding a policy is a complex and multidimensional work (Donadelli, 2020). A policy almost always involves many actors from the formulation stage to the evaluation (de Leon and Varda, 2009). This allows policy failure to occur at every stage. Policy failures are not always easy to identify because they are contested constructs, both in practically and scholarly investigation. Policy failure is not a complete or absolute phenomenon, meaning that a policy can fail in some areas but succeed in others. Additionally, policy failure has multiple dimensions, meaning that it varies in terms of duration, extent, visibility, intensity, and avoidability (Howlett, 2012).

A well-organized policy fails to achieve the objectives due to several internal and external factors inseparable from the complexity of policy making (Busenberg, 2004; Fawcett et al., 2018). Failure connotes betrayal of a value, aim, or objective. Policy failure means the government's inability to provide the best public services to the community (Begley et al., 2019) due to a poor understanding of the stakeholders involved (McConnell, 2016). According to McConnell (2016), the phenomenon is caused by the non-fulfillment of standards in the implementation process as follows:

(1) The existence of multiple standards for failure. The term failure denotes something undesirable, like failing to meet a goal, aim, or objective.

(2) Failure to achieve the primary purposes of government. Evaluation of policy against the goals of the government is a common practice in policy analysis, particularly in the rationalist–scientific paradigm.
(3) Failure to manage interests or groups. Policies might not have helped the specific target group or groups that the original policy's explicit aim was supposed to assist.
(4) Failure to produce benefits more significant than the costs. A standard tool in economic analysis, cost-benefit analysis weighs the pros and cons of various outcomes to be utilized in political discourse and policy evaluations.
(5) Failure to match moral, ethical, or law standards. Many of the protagonists argue that the failure of policy is a violation of underlying values, regardless of what the government purports to have accomplished or sets out to do.
(6) Failure to improve on what went before. The idea that we are "worse off" as a result of what the government has done (or failed to accomplish) is a typical element of "failure" discourse.
(7) Failure to perform better than others in dealing with similar issues. The standard used here is when a government's response to a problem is deemed inferior to that of another jurisdiction (often a country) handling a substantially identical issue.
(8) Failure to garner sufficient support from actors. Policies may be deemed unsuccessful if they failed to garner enough support from individuals who were either strategically involved in the process of putting them into effect or whose backing was essential to the policies legitimacy.

To understand the pattern of policy failure, this research develops a framework as follows:

Figure 2 shows the assessment of policy impact or error in the implementation stage. The community, as the subject and target of the policy group, has characteristics difficult to support policy (Roziqin et al., 2021). The characteristics are incremental, as emphasized by (Harvey, 2002) that HIV/AIDS policy is often patchy (past work) because it is constrained by complicated bureaucracy and administration. In contrast, effective policy implementation will impact the success of achieving goals. According to Begley et al. (2019), all stakeholders expressed their concern about the process of formulating and implementing policies. Moreover, the central and regional regulatory mechanisms overlap in the case of state strategic policies (Kaboyakgosi and Mpule, 2008).

In handling HIV/AIDS, overlapping and multi-actor issues will be included in every policy stage consisting of agenda setting, formulation, implementation, monitoring, and evaluation (Kaboyakgosi and Mpule, 2008). In developing countries such as Indonesia, the number of actors and overlapping authorities can interfere with organizational performance in achieving goals. According to Khodayari-Zarnaq et al. (2021), HIV/AIDS control in a country is part of a political issue and a multidimensional phenomenon where stakeholders with different interests and political incentives can play an essential role in disease control. This is coupled with a pluralistic and multicultural society structure (Bredström, 2009). Therefore, a strong commitment by the government and public awareness have an essential role in the control (Rahman, 2020).

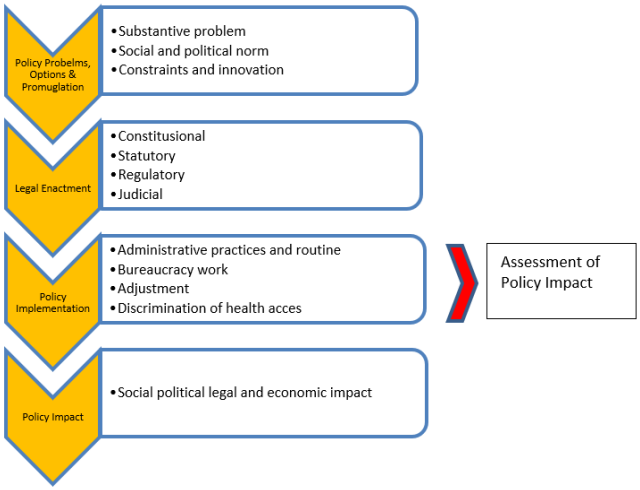

Figure 2. Level of policy and its context, adopted from Kreis and Christensen (2013).

3. Specification of documentary analysis

This research employs qualitative approach (Creswell, 2013), by collecting data through literature review (Snyder, 2019) and documentary analysis (Kayesa and Shung-King, 2021), which used to support data present. These two approaches are considered the most comprehensive in explaining the social phenomena studied related to the topic of social-health research. Documents that have the most vital relationship were selected with 3 critical phenomena, such as "HIV/AIDS," "prevention policies," and "policy failure." The literature review approach is carried out by looking for peer-reviewed articles from reputable publisher and sources such as ScienceDirect, Emerald Insight, Taylor and Francis, Wiley Online Library, Springer, MDPI, and Sage.

The second approach, document analysis is carried out to collect data/reports issued by universities, research institutes, WHO, UNAIDS, and other relevant government official reports. These data are analyzed in an explanatory manner to answer research questions by prioritizing the 5W + 1H principle. According to Kayesa and Shung-King (2021), document analysis in social health research, especially health policy, aims to validate the various documents obtained, considering the process that goes through several stages. This approach is also considered appropriate considering the characteristics of health policy, especially HIV/AIDS, which is often contained in different documents.

The results of the two data obtained from scientific and documentary analysis are reviewed using a technique adopted from Snyder (2019), which starts from designing, conducting the review, analyzing, and writing the review. For the analysis stage, data is summarized and synthesized from various sources according to the questions to be answered. This research tends to be more nuanced in an explanatory narrative, following the findings and phenomena of HIV/AIDS policy failure. The results and discussions are divided into 2 significant subsections, namely pathways and failure analysis of HIV/AIDS policy in Indonesia.

4. Documentary analytical results and discussion

4.1. Policy pathway

The spread of HIV/AIDS has increased since it was first discovered in 1987. Based on **Figure 1**, the trend of people living with this virus has increased. This condition is certainly quite worrying for a nation and needs the government's attention as a public agenda (Jacobson, 2020). The Indonesian government has issued several regulations or policies to reduce the spread and treatment of the survivors. The first step is establishing a special commission as stipulated in Presidential Decree Number 36/1994 on the Establishment of the National AIDS Commission (NAC) and the Regional AIDS Commission (RAC) as government agencies that coordinate the implementation of AIDS prevention.

The establishment of the AIDS Commission (AC) is carried out at the central and regional levels. This strategy is an essential response to public policy, where AC has coordinated control efforts by non-governmental organizations, the government, and other sectors. The policy objective should reduce the increase in new cases and deaths. One strategic step is strengthening the AIDS Commission (AC) at all local government levels, both provincial and regency/city. Based on this national strategy, many international partners support the implementation of prevention in Indonesia. Furthermore, several ministries issue regulations related to the prevention efforts, such as the Minister of Education Regulation Number 9 of 1997 concerning the prevention through education, followed by the Minister of Education Regulation Number 303 of 1997 concerning the implementation guidelines.

According to the 2015–2019 National Targets and Action Plan for Combating HIV/AIDS 2015–2019, the financing budget requirement is $720 million, whereas the funding capacity is just 401 million dollars. International funds, such as those awarded in 2018, have dominated funding for countermeasures thus far. The Global Fund established new award monies for the 2018–2020 term, totaling USD 264,225,834. Dependence on international financing is aggravated by the fact that coverage of ARV (Antiretroviral) treatment in Indonesia is just 17% of the entire 640 thousand people living with HIV/AIDS (PLWHA), implying that only 140 thousand are receiving ARV medication, while the remaining 500 thousand are still not. International donors contribute grants to help pay the government's low budget. However, the data from the Indonesia AIDS Coalition (IAC) show that HIV/AIDS prevention remains poor. The same is true at the regional level, with HIV/AIDS prevention and control budgets remaining modest in Districts and Provinces. Indonesia's HIV/AIDS control budget remains dependent on foreign donor organizations, which is decreasing year after year.

The budget from the government sector is also expected to increase in line with the complexity of the problems faced. The national health system as regulated in Article 1 Number 2 Article 4 Paragraph (1) Presidential Regulation Number 72 of 2012 concerning the National Health System as a follow-up to Law Number 36 of 2009 concerning Health emphasizes that all components of the Indonesian nation conduct health management in an integrated and mutually supportive manner. This is to ensure the achievement of the highest degree of public health in stages from the central and local governments and the community.

The responsibility of the central government has also been stated in Article 6 Letters a-c of the Minister of Health Regulation Number 21 of 2013 concerning HIV and AIDS Prevention. The duties and responsibilities in dealing with HIV/AIDS include making policies and guidelines in promotive, preventive, diagnosis, treatment/care, support, and rehabilitation services, cooperating with local governments in implementing policies, monitoring and evaluating the implementation, and ensuring the availability of medicines and medical equipment needed in the national prevention. The Indonesian government conducts these responsibilities through several Ministries and Institutions such as the Ministry of Health, Ministry of Law and Human Rights, Ministry of Women's Empowerment and Child Protection, Ministry of Religion, Ministry of Social Affairs, Ministry of Communication and Information, Manpower and Transmigration, Ministry of Home Affairs, Ministry of Defence, AIDS Commission, and several other institutions coordinated by the Coordinating Ministry for Human Development and Culture. For more detail, see **Figure 3**.

Public policy and strategies at the regional level in dealing with HIV/AIDS are contained in Law Number 23 of 2014 concerning Local Governments ("Law 23/2014") and the amendments. Therefore, they have a broad policy space to address various problems, including health problems faced by the community, by forming regional regulations adapted to developing aspirations. Based on Law 23/2014 and the amendments, regional regulations are recognized as a means of accelerating the success of development and the welfare of the people in the regions.

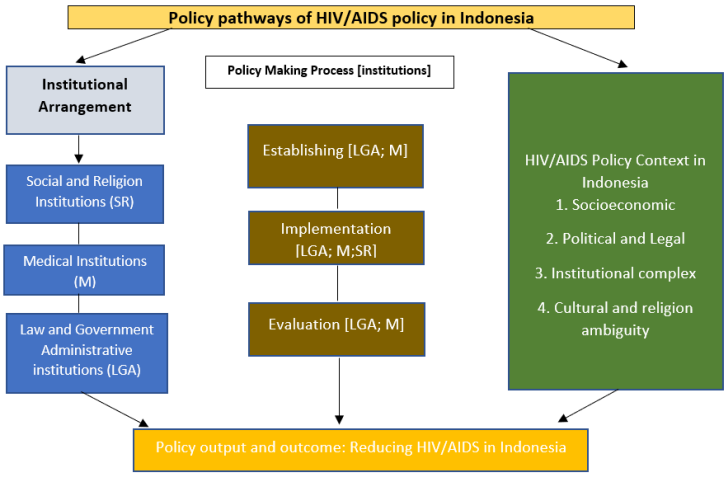

Figure 3. Policy pathway framework on HIV/AIDS policy in Indonesia.

The involvement of local governments is also stated in Article 2 of the Minister of Home Affairs Regulation Number 20 of 2007 concerning General Guidelines for the Establishment of an AIDS Commission and Community Empowerment in the Context of Controlling HIV and AIDS ("Minister of Home Affairs Regulation 20/2007") stating that:

(1) In the context of dealing with HIV and AIDS in the Province, a Provincial AIDS Commission has been established.

(2) In the context of dealing with HIV and AIDS in the Regency/City, the Regency/City AIDS Commission has been formed.

(3) A Governor's Decree stipulates the Provincial AIDS Commission as in paragraph (1).
(4) The Regency/City AIDS Commission, as referred to in paragraph (2), is stipulated by the Regent/Mayor Decree.

At the provincial level, Article five of the Minister of Home Affairs Regulation 20/2007 stipulates that the Provincial AIDS Commission, as referred to in Article 2 paragraph (1), has the task of coordinating the formulation of policies, strategies, and steps needed in the context of HIV and AIDS prevention according to the policies, strategies, and guidelines set by the National AIDS Commission, leading, managing, controlling, monitoring, and evaluating the implementation of HIV and AIDS prevention in the Province, as well as collecting, mobilizing, providing, and utilizing resources from the central, regional, community, and foreign aid effectively for the prevention activities.

Table 1. Government policies concerning HIV/AIDS in the three periods.

No	Period	Government Policies	Crucial points of HIV/AIDS Prevention	Policy Impact
1	1987–1996	10 international policies, 66 national policies, as well as 21 provincial and regency/city level policies	Building institutionalism and job description Initiating decentralization of HIV/AIDS handling	Institutionalism approach to overcome HIV/AIDS cases
2	1997–2007	2 international policies related to HIV AIDS, 7 national policies for prevention, and 7 national policies for Care Support and Treatment • Ministerial Decree 339/IV/88 establishes the HIV AIDS Commission based on Ministerial Decree Number 301. / IV / 1989 • Minister of Health Instruction Number 72 /ii/1988 concerning the Obligation to Report People with Symptoms of AIDS and MZ RI 2/6/1988 • Presidential Decree Number 26 of 1994 concerning the establishment of the National AIDS Commission (NAC), followed by AIDS Commission in several provinces	Strengthening institutions by establishing national and provincial HIV/AIDS Commissions	Centralized policy pattern
3	2007–2013	Coordinating Minister for People's Welfare Regulation Number 7/PER/MENKO/KESRA/III/2007 concerning the National Strategy for AIDS Prevention 2007–2010 Coordinating Minister for People's Welfare Regulation Number 2/PER/MENKO/KESRA/I/ of 2007 concerning AIDS Prevention Policy in 2007 General Guidelines for the Establishment of an AIDS Commission and Community Empowerment in the Context of Controlling HIV and AIDS in HOT Regions National Strategy and Action Plan (NSAP) 2010–2014	Strengthening the role of local governments as well as public or community involvement	Decentralize policies while still following directions from the center

Source: Author analysis.

An explanation of Indonesia's policy pathway can be seen in **Table 1** above, divided into 3 periods. According to Australian Aid (2015), the first, second, and third periods are sexual relations, the use of syringes, and the return of sex relations as the main transmission factor.

Based on **Table 1**, the formulation of policies for handling HIV/AIDS is carried out in stages by establishing formal institutions, division of job desks, policy diffusion at the regional level, and community involvement. This research argues that this step is appropriate, but in practice, many local governments do not have strategic planning documents and regional action plans used as a reference for implementation (Dewi, 2014). This condition becomes a gap in handling HIV/AIDS in the regions, and the issue depends on the sensitivity of regional leaders to be included in priority problems to be resolved.

4.2. Assessment of policy impact

Since it was first discovered in Bali in 1987, HIV/AIDS cases have spread in various parts of Indonesia and become a severe problem for the government. The government has issued various policies to overcome the disease in several areas and scopes, but these policies do not seem optimal. Therefore, this research compiles an analysis of several factors causing the failure of policy regarding HIV/AIDS as follows:

4.2.1. Policy rationalization

By 2030, in line with commitments at the global level, the Indonesian government is targeting Three Zero (zero new infections, zero AIDS-related deaths, and zero stigmas and discrimination) through the Coordinating Ministry for Human Development and Culture. Several strategies carried out to achieve this include developing a 90-90-90 fast track strategy launched in 2017, which includes accelerating the achievement of 90% of people knowing their HIV status through testing or early detection, 90% of PLWHA (People living with HIV/AIDS) knowing their status through ARV therapy, and 90% of PLWHA on ARV (Antiretroviral) therapy succeed in suppressing the number of viruses, reducing the possibility of transmission and eradicating negative stigma and discrimination against PLWHA.

The number of cases continues to grow, and policy interventions have not been achieved until now. The failure of the policies is caused by high targets with limited potential resources (Begley et al., 2019; Haapanen et al., 2014). As stated in the legislation, the health budget ceiling gets a minimum of 5% of the State Budget at the central government and 10% of the Regional Budget at the local level. The government does not provide a balanced budget to support policies for handling HIV/AIDS, especially local governments. The lack of a budget is evidenced by the available 2019 budget of US$ 75.59 million, while the need for funding is US$ 184.71 million, hence there is a shortage of US$ 109.12 million.

According to an informant from the Ministry of Health, the budget for handling HIV/AIDS in 2019 reached 2.5 trillion rupiahs, but 1.1 trillion was used to purchase drugs. Based on the data, it can be described that policy budgeting is not allocated much for the region's prevention and derivative aspects of policies. Therefore, local governments spearhead HIV/AIDS prevention in Indonesia. Research conducted by an NGO found that some budgets in city governments such as Medan, Palembang, Bandung, Semarang, Denpasar, Makassar, Sorong, and Jayapura were not more than 1.4 billion rupiahs. Efforts to achieve policy objectives are irrational with the capacity of the allocated budget resources.

The achievement of the policy objectives for dealing with HIV/AIDS even

experienced a setback after the National AIDS Commission (NAC) dissolution based on Presidential Regulation Number 124/2016, which ended on December 31, 2017. NAC indicated that Indonesia's AIDS prevention efforts could not proceed as planned owing to Presidential Regulation 124 of 2016. Foreign aid of around 150 billion rupiahs from the Global Fund and the United States Agency for International Development (USAID) cannot be disbursed. Therefore, when the AIDS Commission is disbanded, HIV cases will explode, and the cost of treatment will significantly burden the state's finances.

The substance of HIV/AIDS policy is also more on prosecution and identification of survivors (Moeliono et al., 1998; Olii et al., 2021). However, aspects of prevention and improvement of public morality are still limited (Pohan et al., 2011; Wammes et al., 2012). Policies regarding the virus do not lead to technical problems in the field and tend to adopt an institutional approach. Therefore, the current number of cases could be like the Iceberg phenomenon, meaning that the invisible could be more significant than estimated.

4.2.2. Medicalization

Medicalization is the process of defining and treating a non-medical problem (Cacchioni and Tiefer, 2012). Medicalization is based on a biomedical disease model, considering behavior, conditions, and disease as a direct result of malfunctions (Beard, 2002). Commercial and market interests are the main drivers of medicalization due to recent advances in biotechnology, genomic medicine, consumer focus, and managed care (Conrad, 2005). The medicalization of the disease has influenced the social construction of HIV/AIDS as a disease. This is one of the reasons for neglect and dissatisfaction with the care received in diagnostic and treatment centers. Therefore, it is a factor for interventions and modifications to reduce abandonment rates for such services (Reinado et al., 2012). However, medicalization can have a negative connotation because it focuses unnecessarily on biomedical language, explanations, and solutions to cultural, psychological, relational, and social problems (Tiefer, 2012).

HIV/AIDS is a social and medical disease (Osborn, 1986) due to its transmission mode, implications, and connotations. It is a medical disease caused by a retrovirus that causes immune deficiency and opportunistic infections, and the disease responds well to ARV treatment (Weiss, 1993). Handling HIV/AIDS tends to only focus on the medical approach or the health sector, not balanced with a social approach to educate and provide an understanding of the virus in the community. According to Reinado et al. (2012), The medicalization of the disease has influenced how society views HIV as a sickness and is a contributing factor to patient discontent and abandonment from diagnostic and treatment facilities. As a result, it is something that should be changed and intervened in order to lower the rates at which these services are abandoned.

Based on the practices of other nations, HIV/AIDS is being treated with medicalization in Indonesia and African countries (Sub-Saharan Africa). According to Gitome et al. (2014), the medicalization of various HIV prevention and treatment aspects has become the norm in Kenya, Sub-Saharan Africa, and other parts of the world. Successful social mediation, such as family, communication, integration, and community systems, strengthens and generates business income complementing medical solutions such as ART, microbicides, PrEP, and the search for an HIV vaccine.

The medicalization of HIV/AIDS cases in Indonesia is not entirely incorrect. However, as a result of this medicalization, stakeholders become overly concentrated and disregard other factors, such as psychological. As a result, many policy-related activities are of a medical nature. According to Dr. Afriana—*Subdit AIDS P2P* (Directorate General of Disease Prevention and Control), the Ministry of Health of the Republic of Indonesia stated;

> "*HIV/AIDS is a major issue since it is transmitted mostly through risky conduct, such as unprotected sexual practices, the use of non-sterile and numerous injection needles, and the transfer of HIV positive mothers to their babies. HIV/AIDS control policies must be comprehensive, encompassing promotional, preventative, curative, and rehabilitative initiatives. It is vital to include all connected sectors, civil society organizations, including the commercial sector, and community leaders."*

4.2.3. Stigma

Most HIV/AIDS survivors get a bad stigma in society. According to The People Living with HIV Stigma Index Indonesia (2020), the stigma and discrimination in the form of exclusion from social, religious, and family activities are very low. About 97% of PLWHA report that they have not experienced such a bad thing. Despite the very low proportions, female and transgender PLWHA at 2.1% and 2.7% reported a more significant proportion of exclusion from family activities more than 12 months ago. There is no recent experience compared to their male counterparts, who reported slightly 0.6% and 0.8% for the two figures, respectively.

In connection with the stigma of Dr. Afriana—*Subdit AIDS P2P*, Ministry of Health of the Republic of Indonesia stated;

> *"stigma and discrimination continue to be major issues for persons living with HIV/AIDS, so efforts must be made to eliminate stigma and discrimination by increasing information, increasing access, and establishing clinical mentor teams in every province. Another name is Continuous Comprehensive Services."*

People Living with HIV(PLHIV) has hesitated to take action on witnessed breaches, as evidenced by the small number of people who reported and sought help. Even though these interventions are rare, they were only performed by men living with HIV and reportedly resolved the problem in 70.1% of people recently affected by the infringement. The main reason these people did not take financial-related actions for men living with HIV is to prevent additional resources. Transgender people are associated with insufficient knowledge and HIV. About 44% of people living with HIV have confirmed that Indonesia has a law protecting them from discrimination (The AIDS Research Center of Atma Jaya, 2020).

Disclosure to family members or relatives is considered a "slow and difficult process," but some informants are expected to gain social support. However, attempts to obtain this support are interpreted differently concerning disclosure. First, the decision not to disclose the HIV status of their parents, spouse, children, or siblings to some informants was motivated to protect themselves from adverse reactions, hence it does not interfere with the existing relationship. This interpretation of social support undermines disclosure and potential benefits in exchange for the status quo as a model of social relationships. Second, at the opposite end are those who disclose to (selected)

family members in the hope that they will receive additional support to augment their existing relationship, which will help them to accept their HIV status and act positively towards health and personal improvement (Mi et al., 2020). However, disclosure is not always met with positive reactions within the household, such as discriminatory treatment in the form of ostracism, verbal abuse, humiliation, or blackmail. All of these are present at least in the early post-disclosure stages. The uncertainty surrounding the form and duration of this discriminatory treatment is seen as a major trade-off significantly devaluing disclosure. The risk of adverse reactions and further loss of much-needed existing support outweigh the benefits. Recent evidence investigating the psychological pathways of disclosure suggests potential alternative avenues for promoting social support and self-efficacy (Mi et al., 2020).

Survivors feel self-guilt, remorse, shame, or self-deprecation after realizing they have become HIV-positive. This belief translates into overcoming psychological effects such as loss of self-confidence, previous desires for romantic relationships and having children, or fear that others may already know their status (Tran et al., 2019). Fatally, they will spread the virus to several people deliberately to increase and satisfy their interests. This belief is formed in a group of people living with HIV who strongly view their infection as the result of risky behavior because of their gender or sexual identity. Indonesia's increasingly gender-unfriendly policy environment and sexual minorities may have reinforced this belief (Manalastas et al., 2017). It represents a mechanism by which complex interactions with others mediate the impact of HIV-related stigma and discrimination on health and well-being.

Eradication of Seasonal Affective Disorder (SAD) has been pursued on a global agenda to create an environment that maximizes the health and well-being of people living with HIV (UNAIDS, 2016). SAD presents a significant barrier to care and support (Tran et al., 2019) and disincentives engagement in programs and activities essential to maintain or improve the standard of health (Katz et al., 1996), with adverse consequences for public health. The low prevalence of enacted stigma should not justify complacency for several reasons. In countries like Indonesia, where marginalization is readily accepted as a social norm among disadvantaged groups, PLWHA can adapt to stigma and other discriminatory behaviors, such as health workers.

The burden of stigma and discrimination is unequal among gender groups and may be another sociodemographic marker indicating a social marginalization determinant. National programs have expanded the scope of interventions beyond the current biomedical focus to address these determinants, from the medical sector to infectious disease management and the non-medical sector. Bridging the gap in this program will expand ART coverage and increase efforts to improve the health of people living with HIV. The Ministry of Health can incorporate a public reporting system into the services and issue non-discriminatory policies as part of professional, ethical norms. Close community monitoring of service delivery and reporting deviations from standards can be effective tools.

4.2.4. The weak role of HIV/AIDS institutions and regulations in Indonesia

Handling HIV/AIDS is still centered on regulations governing the virus and the institutions responsible. Therefore, it has not become the collective responsibility of

all elements of state institutions. The results are still far from the target, namely 90-90-90, to solve HIV/AIDS in Indonesia by 2030. Furthermore, the autonomy granted by the government seems to be only a formality, including budget autonomy. This is because the mechanism for dealing with the virus remains within the central government's legitimacy.

Local governments have a wide range of dedication to combating HIV/AIDS. This can be seen in 37 provinces in Indonesia, only 17 or 46% have a local regulation on the virus. Out of 416 regencies and 98 cities, only 27 or 6% and 11 or 11.5% have prevention regulations. Therefore, the response policy in Indonesia is still lacking in support from the local government. The prevention program has not become an important issue and development priority for most local governments.

Institutionally, handling HIV/AIDS is carried out using horizontal and vertical approaches. The vertical approach relies on the technical capabilities of centralized and tight control, while the horizontal emphasizes multisectoral and decentralized control. Decentralization is difficult since it often necessitates the synchronization of public affairs, particularly medical administration. In the health sector, alignment extends to both policies and health services. In this situation, innovative medical systems need to be developed to improve public health. The two most common steps are institutional response and enforcement of regulations/policies. These two steps are believed to ensure the program's sustainability, hence the government can continue to invest with donors. The research shows that the arrangements/policies and institutions formed rely on the effectiveness of their implementation on existing health systems and governance. The health sector provides comprehensive answers to inherit skills in sectors outside the scope of HIV and AIDS (Goyena and Fallis, 2015).

There are many cases in the field where these two steps reflect the normative aspect. There are regulations and institutions, but they are ineffective because of the poor quality of implementation. Almost all provinces have established Regional AIDS Commissions (RAC), but their role is limited to fulfilling their obligations. The enforcement of local regulations on HIV/AIDS is also considered ineffective due to the lack of adequate resources and sanctions. This is because they often overlap or conflict with regulations in other public sectors. The fundamental weakness in the local response is that it relies on the "procurement" of policies and institutions (RAC) but little attention to capacity for implementation. This weakness is expected in the health sector and has become a classic problem.

Local governments only enforce policies such as local regulations to combat HIV and AIDS, with encouragement from the National AIDS Commission (NAC) and financial support from donors. Therefore, existing local regulations are policy documents and are not followed by precise funding mechanisms or programs appropriate to the local situation. Several RAC shows different reactions and developments at the tissue level. They are more active in areas of active civil society, such as East Java, North Sumatra, and Bali. The implementation issue often encountered in the visitor area is the synergistic effect of the NAC policy and priority public health programs. Separating the fight against HIV and AIDS from the regional political and economic context is challenging. On the one hand, integrating or incorporating local context into a policy can be time-consuming and costly from a program effectiveness perspective. Local governments are often inconsistent, for

example, when empowered to screen for sexually transmitted diseases.

The government's use of Civil Society Organizations (CSOs) is also not maximized. CSOs collaborating have not provided significant input data in HIV/AIDS treatment decision-making. Furthermore, the partner with the government is not well targeted, meaning that their competencies and networks are not extensive. This condition is undoubtedly complex to make CSOs strategic partners in handling HIV/AIDS.

5. Conclusion

The case of HIV/AIDS in Indonesia is like an iceberg, where the detected and reported cases are only a small part of a significant phenomenon that data cannot prove. The development of this virus is due to the government's failure to draw up policies, especially in prevention. Policies for handling HIV/AIDS involve multi-actor and multi-sector. The decentralization also has an impact on increasingly complex institutional arrangements. Therefore, the role is weak and not optimal, especially for local governments as the spearhead in suppressing the spread of cases. This research has the limitation that it only focuses on the role of government and its policies.

Policy failure refers to efforts to achieve goals and manage interests and actors. It is caused by several factors, such as weak policy rationalization, approaches that focus on medicalization, stigma, and the weak role of institutions and regulatory substances. The actors involved need to reformulate the national action plan using a multi-perspective and holistic approach, especially emphasizing active society and community involvement, as well as involvement of non-government organizations. For community involvement, the government should select and have a track record in handling HIV/AIDS as the basis for effective decision-making. The government needs to review the policy objectives of handling the cases to be more rational with the conditions and capacities of formal institutions. The community's literacy and comprehension should be increased to minimize negative stigma and serve as a support structure for HIV/AIDS legislation in Indonesia. Meanwhile, the role of NGOs can help and act as a means of controlling government policy if the policy deviates from the initial goal. Therefore, the future research direction that other researchers can carry out is regarding the role of NGOs in handling HIV/Aids in a country.

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References

Akukwe, C. (2001). The Need for an Urban HIV/ AIDS Policy in the United State. Journal of Health & Social Policy, 12(2), 37–41. https://doi.org/10.1300/J045v12n03

Althaus, C., Ball, S., Bridgman, P., et al. (2004). The Australian Policy Handbook. Allen and Unwin.

Apenteng, O. O., Osei, P. P., Oduro, B., et al. (2020). The impact of implementing HIV prevention policies therapy and control strategy among HIV and AIDS incidence cases in Malaysia. Infectious Disease Modelling, 5, 755–765. https://doi.org/10.1016/j.idm.2020.09.009

ASHA. (2020). April 2020. The ASHA Leader, 25(3), 26–27. https://doi.org/10.1044/leader.ppl.25042020.26

Australian Aid. (2015). Study of HIV/AIDS Policy Documents and the Health System in Indonesia (Indonesian). INSIST Press.

Ayiro, L. (2012). HIV/AIDS and its impact on education in sub-Saharan Africa: Policy initiatives and challenges. International Perspectives on Education and Society, 18(2012). https://doi.org/10.1108/S1479-3679(2012)0000018004

Baleanu, D., Hasanabadi, M., Mahmoudzadeh Vaziri, A., et al. (2023). A new intervention strategy for an HIV/AIDS transmission by a general fractional modeling and an optimal control approach. Chaos, Solitons & Fractals, 167, 113078. https://doi.org/10.1016/j.chaos.2022.113078

Barclay, S., & Birkland, T. (1998). Law, Policymaking, and the Policy Process: Closing the Gaps. Policy Studies Journal, 26(2), 227–243. Portico. https://doi.org/10.1111/j.1541-0072.1998.tb01896.x

Beard, R. L., Estes, C. L. (2002). Medicalization of aging. Available online: https://www.encyclopedia.com/education/encyclopedias-almanacs-transcripts-and-maps/medicalization-aging (accessed on 7 October 2023).

Beck, E. J., Mays, N., Whiteside, A. W., & Zuniga, J. M. (2007). The HIV Pandemic: Local and Global Implications. Oxford University Press. https://doi.org/10.1093/acprof:oso/9780199237401.001.0001

Begley, P., Bochel, C., Bochel, H., et al. (2019). Assessing policy success and failure: targets, aims and processes. Policy Studies, 40(2), 188–204. https://doi.org/10.1080/01442872.2018.1557134

Buick, F., Blackman, D., O'Flynn, J., et al. (2016). Effective Practitioner-Scholar Relationships: Lessons from a Coproduction Partnership. Public Administration Review. https://doi.org/10.1111/puar.12481

Busenberg, G. (2004). Wildfire management in the United States: The evolution of a policy failure. Review of Policy Research, 21(2), 145–156. https://doi.org/10.1111/j.1541-1338.2004.00066.x

Cacchioni, T., & Tiefer, L. (2012). Why medicalization? Introduction to the special issue on the medicalization of sex. Journal of Sex Research, 49(4), 307–310. https://doi.org/10.1080/00224499.2012.690112

Conrad, P. (2005). The shifting engines of medicalization. Journal of Health and Social Behavior, 1(46).

Creswell, J. W. (2013). Qualitative Inquiry and Research Design: Choosing Among Five Approaches, 3rd ed. Sage Publication.

de Leon, P. (1992). The Democratization of the Policy Sciences. Public Administration Review, 52(2), 125. https://doi.org/10.2307/976465

de Leon, P., & Varda, D. M. (2009). Toward a theory of collaborative policy networks: Identifying structural tendencies. Policy Studies Journal, 37(1), 59–74. https://doi.org/10.1111/j.1541-0072.2008.00295.x

Dewi, E. H. (2014). A Decade of Regional Regulations for Controlling HIV & AIDS in Indonesia (Indonesian). Available online: https://kebijakanaidsindonesia.net/id/artikel/artikel-tematik/146-satu-dekade-peraturan-daerah-penanggulangan-hiv-aids-di-indonesia (accessed on 22 October 2023).

Donadelli, F. (2020). When evidence does not matter: The barriers to learning from science in two cases of environmental policy change in Brazil. Science and Public Policy, 47(3), 313–321. https://doi.org/10.1093/scipol/scaa006

Dworkin, S. L. (2010). Emerging and concentrated HIV/AIDS epidemics and windows of opportunity: Prevention and policy pitfalls. Advances in Medical Sociology, 11(2010). https://doi.org/10.1108/S1057-6290(2010)0000011010

Dye, T. R. (1998). Understanding public policy. Prentice Hall

Fawcett, P., Legrand, T., Lewis, J. M., et al. (2018). Governance, public policy and boundary-making. Australian Journal of Political Science, 53(4), 480–489. https://doi.org/10.1080/10361146.2018.1519776

Ford, N., Siregar, K., Ngatimin, R., & Maidin, A. (1997). The hidden dimension: Sexuality and responding to the threat of HIV/AIDS in South Sulawesi, Indonesia. Health and Place, 3(4), 249–258. https://doi.org/10.1016/S1353-8292(97)00018-X

Gitome, S., Njuguna, S., Kwena, Z., et al. (2014). Medicalization of HIV and the African response. African Journal of Reproductive Health, 18(3), 25–33.

Golomski, C. (2023). Interrogating traditionalism: gender and Swazi Culture in HIV/AIDS policy. Journal of Contemporary African Studies, 41(2), 183–198. https://doi.org/10.1080/02589001.2019.1701184

Goyena, R., & Fallis, A. (2015). DAN HIV-AIDS Policy and the Health System in Indonesia (Indonesian). Journal of Chemical Information and Modeling, 53(9).

Haapanen, M., Lenihan, H., & Mariani, M. (2014). Government policy failure in public support for research and development. Policy Studies, 35(6), 557–575. https://doi.org/10.1080/01442872.2014.971728

Hardon, A. P., Oosterhoff, P., Imelda, J. D., et al. (2009). Preventing mother-to-child transmission of HIV in Vietnam and Indonesia: Diverging care dynamics. Social Science and Medicine, 69(6), 838–845. https://doi.org/10.1016/j.socscimed.2009.05.043

Harvey, D. C. (2002). Towards empowering social workers and consumers as HIV/AIDS policy makers: An editorial opinion. Journal of HIV/AIDS and Social Services, 1(3), 3–6. https://doi.org/10.1300/J187v01n03_02

Hogwood, B. W. (1995). Public Policy. Public Administration, 73(1), 59–73. https://doi.org/10.1111/j.1467-9299.1995.tb00817.x

Howlett, M. (2012). The lessons of failure: Learning and blame avoidance in public policy-making. International Political Science Review, 33(5), 539–555. https://doi.org/10.1177/0192512112453603

Indonesian Minister of Health. (2021). Indonesia Health Profile 2021 (Indonesian). Available online: https://www.kemkes.go.id/id/profil-kesehatan-indonesia-2021 (accessed on 12 December 2023).

Jacobson, L. E. (2020). President's Emergency Plan for AIDS Relief (PEPFAR) Policy Process and the Conversation around HIV/AIDS in the United States. Journal of Development Policy and Practice, 5(2), 149–166. https://doi.org/10.1177/2455133320952210

Kaboyakgosi, G., & Mpule, K. P. (2008). Beyond public administration? HIV/AIDS policy networks and the transformation of public adminstration in Botswana. Public Administration and Development, 28(4), 301–310. https://doi.org/10.1002/pad.505

Kartono, R., Astutik, J., & Negoro, A. B. A. R. (2022). Prosocial Behavior of Peace Support Groups in Overcoming Problems of People Living With HIV/AIDS in Malang Raya. Journal of Local Government Issues, 5(1), 63–79. https://doi.org/10.22219/logos.v5i1.19763

Katz, I. T., Ryu, A. E., Onuegbu, A. G., et al. (1996). Impact of HIV-related stigma on treatment adherence: systematic review and meta-synthesis. SAE Technical Papers, 16(Suppl 2), 18640. https://doi.org/10.4271/961745

Kayesa, N. K., & Shung-King, M. (2021). The role of document analysis in health policy analysis studies in low and middle-income countries: Lessons for HPA researchers from a qualitative systematic review. Health Policy OPEN, 2(November 2019), 100024. https://doi.org/10.1016/j.hpopen.2020.100024

Kerr, J., & Jackson, T. (2016). Stigma, sexual risks, and the war on drugs: Examining drug policy and HIV/AIDS Inequities among African Americans using the Drug War HIV/AIDS Inequities Model. International Journal of Drug Policy, 37, 31–41. https://doi.org/10.1016/j.drugpo.2016.07.007

Khodayari-Zarnaq, R., Ravaghi, H., Mosaddegh-rad, A. M., et al. (2021). HIV/AIDS policy-making in Iran: A stakeholder analysis. International Journal of Health Planning and Management, 36(6), 2351–2365. https://doi.org/10.1002/hpm.3313

Kreis, A. M., & Christensen, R. K. (2013). Law and Public Policy. Policy Studies Journal, 41(Suppl 1), 38–52. https://doi.org/10.1111/psj.12011

Lestari, T. R. P. (2013). HIV / AIDS Control Policy in Denpasar Control Policy of HIV/AIDS in Denpasar (Indonesian). Jurnal Kesehatan Masyarakat Nasional, 8(1), 45–48.

Lieberman, E. S. (2012). Descriptive representation and AIDS policy in South Africa. Contemporary Politics, 18(2), 156–173. https://doi.org/10.1080/13569775.2012.674337

Manalastas, E. J., Ojanen, T., Torre, B., et al. (2017). Homonegativity in Southeast Asia: attitudes toward lesbians and gay men in Indonesia, Malaysia, the Philippines, Singapore, Thailand, and Vietnam. Asia-Pacific Social Science Review, 1(17).

Martial, N. T., Mubarik, S., & Yu, C. (2021). The trend of HIV/AIDS incidence and risks associated with age, period, and birth cohort in four central African countries. International Journal of Environmental Research and Public Health, 18(5), 1–12. https://doi.org/10.3390/ijerph18052564

McConnell, A. (2016). A public policy approach to understanding the nature and causes of foreign policy failure. Journal of European Public Policy, 23(5), 667–684. https://doi.org/10.1080/13501763.2015.1127278

Mi, T., Li, X., Zhou, G., et al. (2020). HIV disclosure to family members and medication adherence: role of social support and self-efficacy. AIDS and Behavior, 1(24), 45–54. https://doi.org/10.1007/s10461-019-02456-1

Moeliono, L., Anggal, W., & Piercy, F. (1998). HIV/AIDS-risk for underserved Indonesian youth: A multi-phase participatory

action-reflection-action study. Journal of HIV/AIDS Prevention and Education for Adolescents and Children, 2(3–4), 41–61. https://doi.org/10.1300/J129v02n03_04

Naqvi, R. H., & Ibrar, M. (2017). Need for social work education and practice in the prevention of HIV/AIDS: A case study of Pakistan. Journal of HIV/AIDS and Social Services, 16(1), 20–33. https://doi.org/10.1080/15381501.2015.1112334

Olii, N., Arifin, H., Kurniawati, Y., et al. (2021). The utilization profile of place for HIV testing in Indonesia: A nationwide study. Journal of HIV/AIDS and Social Services, 20(4), 319–329. https://doi.org/10.1080/15381501.2021.1988026

Ongaga, K., & Ombonga, M. (2012). HIV/AIDS education programs in Kenya: Contexts of implementation in secondary schools in kisii county. International Perspectives on Education and Society, 18. https://doi.org/10.1108/S1479-3679(2012)0000018005

Osborn, J. E. (1986). The AIDS epidemic: multidisciplinary trouble. The New England Journal of Medicine, 12(314), 779–782.

Pohan, M. N., Hinduan, Z. R., Riyanti, E., et al. (2011). HIV-Aids prevention through a life-skills school based program in Bandung, West Java, Indonesia: Evidence of empowerment and partnership in education. Procedia - Social and Behavioral Sciences, 15, 526–530. https://doi.org/10.1016/j.sbspro.2011.03.135

Pope, C. (2012). Therapeutic Imaginaries in the Caribbean: Competing Approaches to HIV/AIDS Policy in Cuba and Belize. Annals of the Association of American Geographers, 102(5), 1157–1164. https://doi.org/10.1080/00045608.2012.659971

Provis, C. (2007). Ethics and Issues in Public Policy. Policy and Society, 26(3), 21–33. https://doi.org/10.1016/s1449-4035(07)70113-3

Putra, D. S., Atmadani, R. N., & Hidayati, I. R. (2021). Relationship between knowledge level of HIV/AIDS patient with antiretroviral adherence in primary healthcare service in Malang City. Journal of HIV/AIDS and Social Services, 20(3), 228–245. https://doi.org/10.1080/15381501.2021.1961651

Rahman, F. (2020). Factors affecting the implementation of HIV/AIDS prevention programs: A literature review. Enfermeria Clinica, 30, 321–324. https://doi.org/10.1016/j.enfcli.2020.06.072

Reinado, C. R., Blasco, T., Jesus, H., & Esono, N. (2012). The medicalization of disease as a factor of abandonment and dissatisfaction with HIV treatment services. Retrovirology, 9(S1), 4690. https://doi.org/10.1186/1742-4690-9-s1-p91

Resubun, T. F., Amiruddin, R., Palluturi, S., et al. (2021). Qualitative analysis of financing HIV and AIDS program in Health Office of Jayawijaya District, Papua Province. Gaceta Sanitaria, 35, S64–S66. https://doi.org/10.1016/j.gaceta.2020.12.018

Roziqin, A., Mas'udi, S. Y. F., & Sihidi, I. T. (2021). An analysis of Indonesian government policies against COVID-19. Public Administration and Policy, 24(1), 92–107. https://doi.org/10.1108/PAP-08-2020-0039

Sahiddin, M., & Resubun, T. (2018). Human Resources in the Hiv/Aids Control Program in Jayawijaya Regency, Papua (Indonesian). Jurnal Keperawatan Tropis Papua, 1(1), 1–7. https://doi.org/10.47539/jktp.v1i1.16

Shimizu, K. (2021). A SWOT analysis of the guidelines on prevention of HIV/AIDS in Japan in the context of COVID-19. Infectious Disease Reports, 13(4), 949–956. https://doi.org/10.3390/idr13040087

Snyder, H. (2019). Literature review as a research methodology: An overview and guidelines. Journal of Business Research, 104(July), 333–339. https://doi.org/10.1016/j.jbusres.2019.07.039

Spicer, N., Harmer, A., Aleshkina, J., et al. (2011). Circus monkeys or change agents? Civil society advocacy for HIV/AIDS in adverse policy environments. Social Science and Medicine, 73(12), 1748–1755. https://doi.org/10.1016/j.socscimed.2011.08.024

Tian, X., Chen, J., Wang, X., et al. (2023). Global, regional, and national HIV/AIDS disease burden levels and trends in 1990–2019: A systematic analysis for the global burden of disease 2019 study. Frontiers in Public Health, 11. https://doi.org/10.3389/fpubh.2023.1068664

Tiefer. (2012). Medicalizations and demedicalizations of sexuality therapies. Journal of Sex Research, 4(49), 311–318.

Tran, B. X., Phan, H. T., Latkin, C. A., et al. (2019). Understanding global HIV stigma and discrimination: Are contextual factors suffciently studied? (Gap research). International Journal of Environmental Research and Public Health, 16(11). https://doi.org/10.3390/ijerph16111899

UNAIDS. (2016). Fast-Track Commitments To End AIDS by 2030. Available online: https://www.unaids.org/sites/default/files/media_asset/fast-track-commitments_en.pdf (accessed on 9 January 2024).

UNAIDS. (2017). 90-90-90—An Ambitious Treatment Target to Help end the AIDS Epidemic. Available online: https://www.unaids.org/en/resources/documents/2017/90-90-90 (accessed on 9 January 2024).

UNAIDS. (2020). The People Living with HIV Stigma Index Indonesia. Available online: https://www.aidsdatahub.org/resource/people-living-hiv-stigma-index-indonesia-april-2020 (accessed on 7 January 2024).

UNAIDS. (2021a). 40 Years Of The Aids Response. Available online: https://www.unaids.org/sites/default/files/40-years-of-the-AIDS-response_en.pdf ().

UNAIDS. (2021b). UNAIDS Data Reference. Available online: https://www.unaids.org/en/resources/documents/2021/2021_unaids_data (accessed on 8 October 2023).

Waluyo, A., Culbert, G. J., Levy, J., & Norr, K. F. (2015). Understanding HIV-related Stigma Among Indonesian Nurses. Journal of the Association of Nurses in AIDS Care, 26(1), 69–80. https://doi.org/10.1016/j.jana.2014.03.001

Wammes, J. J. G., Siregar, A. Y., Hidayat, T., et al. (2012). Cost-effectiveness of methadone maintenance therapy as HIV prevention in an Indonesian high-prevalence setting: A mathematical modeling study. International Journal of Drug Policy, 23(5), 358–364. https://doi.org/10.1016/j.drugpo.2012.06.009

Wang, J., Wei, F. (2009). Distortions in Implementing Public Policy. Transnational Corporations Review, 1(4), 67–71. https://doi.org/10.1080/19186444.2009.11658214

Wanni Arachchige Dona, S., Bohingamu Mudiyanselage, S., Watts, J. J., et al. (2021). Added socioeconomic burden of non-communicable disease on HIV/AIDS affected households in the Asia Pacific region: A systematic review. The Lancet Regional Health—Western Pacific, 9, 100111. https://doi.org/10.1016/j.lanwpc.2021.100111

Weiss, R. A. (1993). How Does HIV Cause AIDS? Science, 260(5112), 1273–1279. https://doi.org/10.1126/science.8493571

WHO. (2016). Global Health Sector Strategy on HIV 2016–2021: Towards Ending AIDS. WHO Document Production Services.

WHO. (2021). HIV Data and Statistics. Available online: https://www.who.int/teams/global-hiv-hepatitis-and-stis-programmes/hiv/strategic-information/hiv-data-and-statistics (accessed on 19 January 2024).

WHO. (2023). HIV and AIDS. Available online: https://www.who.int/news-room/fact-sheets/detail/hiv-aids?gad_source=1&gclid=CjwKCAjw1K-zBhBIEiwAWeCOFzkwOqCGs8ezzn7NhCyMzyrfOeKNUJjcqx5GSe4Hj-lmBP-R-ZWYrhoCpDwQAvD_BwE (accessed on 8 October 2023).

Wilder, M. (2017). Comparative Public Policy: Origins, Themes, New Directions. The Policy Studies Journal, 45, 47–66.