Family Barriers in Preventing HIV/AIDS Among Young People in Indonesia

Romanus Beni

Abstract. *Most studies on HIV/AIDS revealed that young people are highly at risk to that epidemic mainly because of their physical, psychological, social, and economical attributes. AIDS is incurable but preventable disease. HIV, the virus causes of AIDS, spreads through unique means and preventable. A significant effort on preventing HIV/AIDS among young people may come from the family who generally has big influences over them and that influence can last a lifetime. In other words, working with families as early as possible in young people's lives could help solidify their healthy behaviors on HIV/AIDS, and prevent the risk before it happens. Yet, studies found that families in Indonesia have unique barriers in preventing their teen's to escape from the HIV/AIDS epidemic. This paper aims to explore family barriers in preventing HIV/AIDS in the context of Indonesia. Qualitative method with in-depth interview and focus group discussion was employed. The results of the study found at least five cultural barriers faced by family: (1) cultural constraints, (2) lack of understanding about the extend of HIV/AIDS problem; its causes and its solution, (3) lack of understanding about how to resolve the HIV/AIDS problem, (4) lack of awareness of the HIV/AIDS problem, and (5) lack of support and encouragement.*

Keywords: *Family, barriers, young people, HIV/AIDS, Indonesia.*

1. INTRODUCTION

1.1 Why Focus on Family

The epidemic of HIV/AIDS may be considered as an individual case, but its impacts will certainly include families or households. In fact, households and families bear most of the burdens since they are the primary unit in coping with the disease and its consequences. A family in which the infected person is a breadwinner will suffer financially both from the loss of earnings and the increase in expenditure for medical care. In the long period of illness, the loss of income and the increase in cost of caring for a family member impoverish households (United Nations, 1987). Many empirical studies documented the impact that drawn families into poverty (Ainsworth and Filmer, 2002; Bechu, 1997; Haworth *et al.*, 1991). Considering this great impact, therefore, families should be included in preventing their children or young people from HIV/AIDS and eliminate the barriers.

Regarding the close relationship among family members, it is expected that families can help their members to protect themselves especially children from risky sexual and drug using behaviors. Family connectedness and parent-child communication are the key factor to ensure healthy behaviors. Likewise, when families are not connected and young peoples feel they can not talk to the adults in their lives, there is a greater risk of unhealthy behavior. Two key aspects of parenting that are influential to adolescents are they believe that their parents know to whom they spend time with (either they stay at home or in school). Second, some families also have strong ties with the community, making the community a strong influence too.

Traditionally, families in Indonesia have a key role in preventing many diseases from their children including HIV/AIDS. Koentjaraningrat (1957; 1985) and Geertz (1961) describe that in the Javanese family[1] children as a source of warmth, joy, and happiness. The principles of social harmony and respect guide Javanese social behavior outside the family. Parents begin to teach their children in a very early age about the concepts of *isin* (shyness), *wedi* (fear), and *sungkan* (respectful politeness). This would encourage social harmony and respect in their outside relationships. These three concepts are considered appropriate to situations demanding respectful behavior (Geertz 1961). According to Magnis-Suseno (1988), the Javanese strive to control their natural impulses in order to maintain social harmony. Therefore, the only

place where the Javanese are relatively free from such tensions are inside the family and Javanese relationships among family members should be based on unconditional love (*tresna*) (Magnis-Suseno 1988). Feelings of *isin* and *sungkan* should not be felt among members of the family; rather, family members can express their emotions freely, without fearing the loss of family support, especially that of the parents (Magnis-Suseno 1988).

In any other cultures and ethnics in Indonesia there are undocumented family guide like Javanese families have which lead the family in creating social harmony. In term social harmony they could complete their role to take care their children. Other evolution, such as the increasing the level of education, particularly for women, and the availability of work opportunity for women to work outside their home, has slightly altered this role. But at the same time, the culture of nucleus family has also blossomed. These phenomena are the actual practice of parents including the mother spending more time outside the home. Communication and relations between parent and children are getting rare even in time when young people need more attention from others, particularly their parents. Most young people spend more time with their peers who are the consumer global trendsetter of modern culture. This situation causes constraint for the family to apply traditional values in their lives meanwhile they are also confused in applying and adopting modern culture. Their background of education, behavioral attitude, poverty, and many social and cultural burdens throw them in a family turbulence. They are very vulnerable by this outside influenced hitting them. This situation has also occurred when HIV/AIDS hits their family member. It is assumed that the families have many barriers to avoid the HIV/AIDS epidemic, but little study has been done to identify the existing barriers.

Families in Indonesia are now in the stage of transition process. As regards to this paper, the transitions are identified from two factors, namely the number of family members and the family value. From the number side, there is a family size transition from a big family to a small family. Evidences from the statistics shows that the Indonesian total fertility rate (TFR) has decreased from 5.6 children per woman in 1971 to 2.6 in 2003 (BPS and ORC Macro, 2004a). It means that currently each family has only three children (comparing to 6 children each family in 1971). The second type of transition is that most of the traditional value of the Indonesian family has changed. There are many aspects caused by these changes, such as the evolution of tradition itself against any other tradition affecting the Indonesian family. These transitions influenced the family (parents and child) in how to response to any other problem, including in response to HIV/AIDS epidemic. This condition has also influence their preventing effort in hampering HIV/AIDS

problem. The Indonesian family transition and its impact have created barriers for the family in preventing HIV/AIDS among their children. The question is what barriers Indonesian family faces in preventing HIV/AIDS. This paper tries to answer this question. An effort to acknowledge the barriers is the first phase to create comprehensive program on preventing HIV/AIDS infecting young people.

Most prevention programs of HIV/AIDS on young people in Indonesia, has not yet considered family as a focal point in combating HIV/AIDS spread whereas families are known to have great influence over these age groups, and in the end this influence can last a lifetime. Families working as early as possible in their children's lives helps solidify healthy behaviors and relationships, thus preventing risk before it happens. The family has a great influence on how an individual responds to the epidemic. They are instrumental in decreasing or increasing the vulnerability of an individual due to HIV/AIDS (Kalibala, 2003). Yet, HIV/AIDS prevention in Indonesia dominantly has focused on the high risk group and not yet in the family. The National Family Planning Coordinating Board (NFPCB/BKKBN) is the only institution with an initiative program that invites families to prevent their members from HIV/AIDS (NFPCB, 1995).

This paper defines families as groups related by kinship, residence, or close emotional attachments. It displays four systemic features- intimate interdependence, selective boundary maintenance, ability to adapt to change and maintain their identity over time, and performance of the family tasks. The tasks include physical maintenance, socialization and education, control of social and sexual behaviors, maintenance of family morale and of motivation to perform roles inside and outside the family, the acquisition of mature family members by the formation of sexual partnerships, the acquisition of new family members through procreation or adoption, and the launching of juvenile members from the family when mature (Mattessich and Hill 1987).

However, the working definition of family in this paper is a small group of community consists of fathers, mothers, brothers and sisters, uncles, aunts, cousins, grandparents or foster parents with mutual kinship and emotion.

It is important to note that the active promotion and implementation of community care and continuum-of-care measures in the HIV/AIDS management has not been translated into researchers' attention to the family experience of HIV/AIDS (Bharat, *et al.* 1998). Undoubtedly, the family

experience of care and support in HIV/AIDS is similar to that of other chronic diseases. Yet there are other unique effects, specific to the distinguishing features of the infection. Bor *et al.* (1993) list some of these effects, namely (a) HIV challenges traditional definitions of the family and concepts of normative family functioning, (b) family is an important source of emotional, practical support, and care for the seropositive individual, which makes relevant to study the patterns of care and support including their consequences for the family, (c) the family experiences similar problems as seropositive individuals does, including stigma and isolation, (d) HIV infection on one family member is a signal of the possibility of HIV infection on others, while puts other family members at risk, both of which have implications for care, support, and household environment, and (e) the relationship between family support and the occurrence of clinical and psychological symptoms on the person with HIV are disturbed. Further, since the pandemic has struck mainly young adults, its presence would threat the family role. Yet, in terms of empirical investigations, it remains one of the least studied areas.

1.2 HIV/AIDS and Young People

HIV (human immunodeficiency virus) is the most popular virus in the world that causes AIDS (acquired immunodeficiency syndrome). HIV/AIDS was recognized as a global crisis by the mid-1980s (Kiragu, 2001). HIV/AIDS also was globally recorded as the fourth cause of death and the leading cause of death in Africa (WHO, 1999). By the end of 2003, 40 million people was living with HIV/AIDS and 3 million of them have died (UNAIDS, 2003a). UNAIDS also reported that over 1 million people in Asia and the Pacific acquired HIV in 2003, bringing to an estimated 7.4 million people living with the virus. A further 500,000 people are estimated to have died of AIDS in 2003 (UNAIDS, 2003b).

Young people are at the center of the global HIV/AIDS epidemic. While not recognized at the onset, the global HIV/AIDS epidemic is now clearly worsen among young people[2]. They also are the world's greatest hope in the struggle against this fatal disease. Young people have inherited a lethal legacy that is killing them and their friends, their brothers and sisters, parents, teachers, and role models. An estimated 11.8 million young people aged 15 to 24 are living with HIV/AIDS. Each day, nearly 6,000 young people between the ages of 15 and 24 become infected with HIV. Yet only a fraction of them know that they are infected (UNICEF, UNAIDS, and WHO, 2002). New UNAIDS reported that the rate of HIV infection among young people worldwide is growing rapidly and 67% of newly infected individuals in the

developing world are young people aged between 15 and 24 years. The escalating risk occur especially found among young women and girls (15-24 years), who make up 64% of the young people in developing countries living with HIV or AIDS (UNAIDS, 2004).

Although young people suffer the most from HIV/AIDS, the epidemic among youth remains largely invisible (Macdonald *et al.*, 1994; Mboy, 2004; Mohamad, 2004), both to young people themselves and to the society as a whole. Young people often carry HIV for years without knowing that they have been infected. As a consequence, the epidemic spreads beyond high-risk groups to the broader population of young people, making it even harder to control. As the AIDS epidemic spreads, younger and more younger age groups are becoming exposed to the risk of HIV (Hitchcock and Fransen, 1999; UNAIDS and WHO 1998; Rahmat, 2004). Infection spreads to the younger age groups as men increasingly choose younger sexual partners.

Principally, AIDS is incurable but a preventable disease. HIV spreads through a unique means such as unprotected sex, transfusion of unscreened blood, contaminated needles and syringes, and from an infected woman to her child during pregnancy, childbirth or breastfeeding. All of these transmissions are preventable.

Indonesia by the end of 2003 has 4,091 people living with HIV/AIDS with contains 1371 AIDS cases and 2,720 HIV infections as well as 479 of whom have died had been reported to the Department of Health (MOH, 2004). Since testing has been limited in, however, the number of HIV infections is undoubtedly much larger than reported (NFPCB and UNFPA, 2002).

HIV/AIDS prevalence of young people in Indonesia has risen rapidly. Based on the current data, cumulative AIDS cases to the 15-19 years and 20-29 years reached 53.5 %. As much as 42 % of AIDS occurred at the aged group 20-29 years and 30.7 % of AIDS occurred at the aged group of 30-39 years. What does it mean to the young people? It means that HIV has infected them at the age 10-24 years or below. The same pattern might occur in the AIDS/IDU cases. Injecting drug is almost related to the young people's behavior. As much as 74.3 % of AIDS cases came from IDUs for the aged group of 15-19 years and 20-29 years. On average cumulative HIV/AIDS data showed that about 50% of the cases were young people aged below 29 years (MOH, 2004)

The government's response to HIV/AIDS on young people seems quite late. Although first National AIDS Strategy (NAS)[3] was launched in 1994 (Dharmaputra, et al 1997), no specific target and programs was addressed to young people. Much attention in the early years of HIV/AIDS cases in Indonesia focused on the high-risk behaviour group such as female sex workers and their male clients (Zubairi, 2000; DI-FEUI, 2003). The response to young people is considered when many young people was recorded infected by HIV. In the new NAS in 2003, Ministry of National Education (MNE) has been commissioned to undertake it among young people (NAC 2003).

Some programs were conducted to prevent young people to suffer from this epidemic. Educating young people on HIV/AIDS is one of the common activities. But, there are some barriers to implement HIV/AIDS education in Indonesia. Studies reported by UNICEF (2000) found that respondents mentioned several barriers to getting reproductive health programs in schools. They were, first, a strong resistance from teachers to discuss questions relating to sexual health. Second, teachers have no guidance about how to deliver reproductive health education. Third, pressure from parents and religious organizations to *not* deliver reproductive health education. Fourth, in the peer education program, there is a section about religious and moral aspects of HIV prevention, but hardly anyone can deliver it, especially in the provinces. Fifth, there is reluctance among government and other institutions to recognize young people as sexual beings, and sex is thought to be a private matter. These barriers in some extent have met with the development of peer education programs.

Fonseka (1998) stated that the vulnerability of young people on HIV/AIDS includes child or adolescent experiencing sexual abuse, children trafficking, adolescent with lack of reproductive health information, female young people who work in factories, young people with drugs particularly injecting users, street children, and children in prisons. Young people vulnerable to HIV/AIDS accordingly should be prevented immediately in the early time. Giving thorough and complete HIV/AIDS information to the vulnerable young people as well as full intervention of the government program should be created to solve this problem.

The knowledge and perception of young people about HIV/AIDS in Indonesia varied. There are several quantitative studies released in Indonesia focused on young people's showing this fact. A study conducted in 2002 in four provinces (South Sumatra, West Kalimantan, East Nusa Tenggara, and West Java) found an interesting fact of young people's knowledge and

perception in Indonesia (Demographic Institute, 2002). This study found that more than 63 percent of young people aged 15-24 ever heard about the term of STDs. The rest, i.e. 36. 2 percent never heard about STDs. This study also found that the best-known of STDs among the young people was HIV/AIDS. HIV/AIDS was ever heard by 85 percent of young people.

A study conducted by IPPA (Indonesian Planned Parenthood Association-*Perkumpulan Keluarga Berencana Indonesia*-PKBI) found some sights (Tanjung *et al.*, 2001). This study found that 52.67 percent respondent's knowledge on basic reproductive health was inadequate. Their knowledge on HIV/AIDS, syphilis, gonorrhea as sexually transmitted diseases was good. But they had inadequate knowledge on how these diseases were transmitted. They felt that to avoid this disease was simply done by not having sexual intercourse (65.2%). Most of the respondents pointed out that pre-marital sex was caused by the influence of social environment (58.14%).

The Baseline Survey of Young Adult Reproductive Welfare conducted by the Demographic Institute, Faculty of Economics University of Indonesia also found interesting findings regarding knowledge and perception on STDs and HIV/AIDS in Indonesia (Demographic Institute, 1999). This survey found that the percentage of males who ever heard about HIV/AIDS and other sexually transmitted diseases were 81.7 percent. For females, the percentage of those who ever heard about HIV/AIDS and other sexually transmitted diseases were 78.8 percent. But only 40.9 percents of males and 42.6 percent of females knew well the meaning of HIV/AIDS.

The above study also found that in general, the knowledge about HIV/AIDS spread was relatively low. Young peoples' knowledge regarding how other sexually transmitted diseases are spread was also relatively low; most young people even had a tendency to say that the spread of other sexually transmitted diseases is mostly due to sexual contact with prostitutes. The percentage of male youths who said that the people who are most likely to get infected with HIV/AIDS are those who often have sexual contact with prostitutes was recorded to be 61.9 percent; meanwhile the percentage of female youths was only 40.5 percent. The percentage of youths who said that each person has the same risk to get infected with HIV/AIDS and other sexually transmitted diseases was still very low, only 2.8 percent and 2.6 percent respectively.

Meanwhile the Baseline KAP (Knowledge, Attitude, and Practice) on STDs and HIV/AIDS among teenagers in Blok M Area, Jakarta, conducted by Yayasan Pelita Ilmu (YPI) found that the respondent's knowledge about

reproductive health was still low. More than half (65.8%) claimed that it was necessary to understand about reproductive health and 60 percent said that their friend did not know much of reproductive health problem. This study also found that more than 50 percent of respondent never knew about any well-known STDs. More than 80 percent of respondents worried for getting infected by STDs and HIV/AIDS and said that they still need to gain more knowledge (Wahyuningsih, et al, 1999).

The 2002 Reproductive Health Baseline Survey in South Sumatra, West Java, West Kalimantan, and East Nusa Tenggara found that the respondents aged 15-20 years were already aware about reproductive health issues and also about HIV/AIDS. However, the degree of understanding between respondents in these provinces and among gender groups varied. Misperceptions still persisted. Therefore specific information on sexuality and safe sexual behavior are needed. Regardless of the quality of their information, male respondents seemed to be better informed on STI (Sexually Transmitted Infections) and AIDS compared to female respondents. Those living in urban areas also had better information compared to the respondents living in rural areas. Their sources of information came mostly from friends, school, the mass media and TV, novels and accessible pornographic materials. Most respondent agreed that ARH services were needed to help young people, but such services were not yet available in their localities (CHR-UI 2002).

The 2002-2003 Indonesia Young Adult Reproductive Health Survey (IYARHS) carried out by Badan Pusat Statistik (BPS--Central Board of Statistics Indonesia) have comprehensive information on knowledge and perception of young people about HIV/AIDS. Regarding the knowledge and perception of HIV/AIDS, the 2002-2003 IYARHS found that nine in ten women and eight in ten men ever heard of AIDS. The majority (67 percent of women and 64 percent of men) said that AIDS can be avoided. Older respondents, who lived in urban areas, and with better education, had more knowledge about HIV/AIDS than other respondents. The most significant difference in knowledge was by the respondent's education. For example, nine in ten women with secondary or higher education believed that there is a way to avoid getting the disease compared with two in ten (22 percent) of women with no education (BPS-Statistics Indonesia and ORC Macro, 2004b).

Based on above studies, it seems that knowledge and perception of young people in Indonesia on HIV/AIDS is low. Education plays as a key role in enhancing young people's knowledge and perception. Many studies revealed that the higher of education level, the higher the young people's knowledge and perception on STDs and HIV/AIDS. Due to their physical and

social factors, young people must understand the long-term consequences of unsafe sexual practices and feel confident to practice healthy behaviors.

Frankly, at the beginning (at the 1990s), with the time constraint, resource and level of HIV/AIDS epidemic in Indonesia, the priorities of the advocacy efforts for HIV/AIDS prevention mostly are addressed to the high-risk behaviour group, which have a great and magnify potential to the widespread of the HIV/AIDS. Yet, young people might be covered on these efforts if their behaviour is high-risk. At that time, young people was not yet considered to be the target in HIV/AIDS prevention program.

The advocacy for HIV/AIDS prevention among young people in Indonesia is also covered in the Adolescent Reproductive Health (ARH) program, which has been currently introduced. HIV/AIDS prevention is part of this ARH program. BKKBN as the government agency has been holding this program in the current decade in collaboration with YPI and PKBI. Although HIV/AIDS prevention among young people has been introduced in some cities, particularly Jakarta City by YPI and PKBI, the concern about HIV/AIDS prevention among young people is currently introduced as a national policy. The new NAC strategy already concerns about putting the young people in the high priority (NAC 2003). Only today, political commitment and budget strategy for HIV/AIDS prevention among young people are clearly formulated (MOH 2004). Recently, the Ministry of National Education has prepared a manual on Life Skills Education for senior high school students to foster the awareness, attitudes, beliefs, values, behavior, and norms about HIV/AIDS to the young people.

The objective of this paper is to identify some barriers among Indonesian families in preventing HIV/AIDS. The family transition, inadequate knowledge and perception on HIV/AIDS of young people, and lack of long plan program on HIV/AIDS addressed to the young people has burdened Indonesian families to avoid HIV/AIDS from their home. Barrier is faced by Indonesian families in their effort to drive out HIV/AIDS.

2. METHOD

Besides literature research, this paper utilizes data derived from the Need Assessment Study on Advocacy for HIV/AIDS Prevention among Young People in Indonesia which was conducted in June-August 2003 in South Jakarta and Bogor. This study was a need assessment research that aimed to identify the priority needs and gaps in HIV/AIDS information and

services for young people. In spite of several urban areas having high exposure to HIV/AIDS, this assessment only selected one urban area i.e Jakarta. Jakarta was chosen of its highest exposure to HIV/AIDS cases. Bojong Gede village in Bogor District was selected for rural area (DI-FEUI, 2003).

Table 1
SELECTED RESEARCH AREAS FOR FGDS AND IN-DEPTH INTERVIEWS IN URBAN AND RURAL AREAS

Area	Urban		Rural
District	South Jakarta	South Jakarta	Bogor
Sub-district	Setiabudi	Jagakarsa	Bojong Gede
Village/*Kelurahan*	Menteng Atas	Lenteng Agung	Bojong Gede

In addition, qualitative method is applied by using focus group discussions (FGDs) and in-depth interviews. FGDs were conducted among young people aged 10-24 years and in-depth interview was conducted among key informants. For FGD, three age groups were covered (i.e. 10-14, 15-19, and 20-24 years) and it was distinguished between urban-rural, male-female, in school-out of school, and single-married. The total FGD conducted is this study was 32 FGDs (Table 2). Respondents were selected among young adults who were willing to participate in the discussions. Since the purpose of the study was to look for gaps on advocacy of prevention on HIV/AIDS among adolescent, the selection process of FGD's participants was only base on their sex, age, level of schooling and marital status. After being identified base on these characteristics, they were invited to participate in the FGD. The in-depth interview was conducted among 16 key informants that consisted of government officers, health services providers, media executives, teachers, parents, community or religious leaders, HIV infected persons, and drug users.

Table 2
NUMBER OF FOCUS GROUP DISCUSSION PARTICIPANTS BY SEX, AGE, AREA, SCHOOL STATUS, AND MARITAL STATUS

Sex	Age	Area	School Status	Marital Status	Number of Participants in FGD
Female	10-14	Urban	In-school		8
			out-school		11
		Rural	In-school		10
			out-school		7
	15-19	Urban	In-school		10
			out-school	Single	10
				Married	7
		Rural	In-school		12
			out-school	Single	9
				Married	10
	20-24	Urban	In-school		8
			out-school	Single	8
				Married	9
		Rural	In-school		6
			out-school	Single	8
				Married	10
Male	10-14	Urban	In-school		10
			out-school		9
		Rural	In-school		12
			out-school		8
	15-19	Urban	In-school		10
			out-school	Single	10
				Married	8
		Rural	In-school		9
			out-school	Single	11
				Married	2
	20-24	Urban	In-school		10
			out-school	Single	10
				Married	9
		Rural	In-school		7
			out-school	Single	10
				Married	6

There were several groups of respondent/informant interview for this study. The group consisted of: a) young people aged 10-24, b) parent, c) teacher, d) community or religious leader, e) health service provider, f) media executive, g) infected HIV/AIDS, and h) drug user.

Since the method used in the Need Assessment Study was not designed for the objectives of this paper, I would like to reorganize several constraints and assumptions. First, as regard to the concepts of family used in this paper, respondent from the Need Assessment Study were divided in two groups: children and parents. Hence, all information collected by 32 FGD from young people is assumed as children perspectives on family barriers in preventing HIV/AIDS. Hence, information collected by the in-depth interview from parents, teachers, and community or religious leaders are assumed as parent's perspectives on family barriers in preventing HIV/AIDS.

The topics of young people's FGD were sexually transmitted diseases and HIV/AIDS, sexual behavior, condom use and availability, and pregnancy. While the topics of in-depth interview with key informants were HIV/AIDS, sexual behavior, and condom use and availability. Although all information collected from the Need Assessment Study was considered to be analyzed as information related to HIV/AIDS, this is also the focus in this paper. Content analysis was used to find out the barriers among Indonesian families in preventing HIV/AIDS among young people.

3. FINDINGS

3.1 General Findings

Although the setting of this study was located in Jakarta as the urban area with the highest exposure place to HIV/AIDS cases, most informants reported that they had no experience with people living with HIV/AIDS in their family. The same situation was found in Bojong Gede as rural area and a satellite area of Jakarta. It should be understood that the needs assessment study utilized in this research was designed to the common people or common family as in opposition to the high-risk people or high-risk family which was always the target of the treatment of HIV/AIDS campaign and program intervention. However, most informants had ever heard about HIV/AIDS. This situation was suitable to the concept of preventing. Young people should be prevented before HIV infected them or other family members.

Informants believed that in preventing HIV/AIDS, young people should be provided by complete information on HIV/AIDS. Informants (community leaders, teachers, parents) agreed that information should be given to the students at school. But, their age and education's level should differentiate due to the given information. The HIV/AIDS information is very important to be provided at school and it might be attached to some subject such as the biology or in counseling activities. They also agreed that since it overburdens the curricula, no specific subject covered the HIV/AIDS curricula, so it must be embedded in closed related subject.

> "Information on HIV/AIDS is needed to be provided at school, particularly among the students who attend the second level of junior high school to the second level of senior high school...but it is not in a special subject. The curricula is already overburden in school. Existing subjects, such as biology, religions, counseling activities, and sport, can deliver this information"
> *"Informasi mengenai HIV/AIDS sangat dibutuhkan untuk diberikan di sekolah, terutama untuk siswa antara kelas 2 SMP sampai kelas 2 SMA... tetapi tidak menjadi mata pelajaran khusus. Kurikulum kita sudah terlalu padat. Mata pelajaran tertentu seperti biologi, agama, bimbingan dan konseling, dan olah raga bisa digunakan untuk menginformasikan hal ini". (Rn, parent, male, teacher, 43 years old, Lenteng Agung, 25 June 2003)*

> "It is much needed. But, it should be adjusted for the age group and class in school"
> *"Itu sangat dibutuhkan. Tapi, harus disesuaikan dengan kelompok umur dan kelas di sekolah". (Yf, community leader, male, 39 years old, Lenteng Agung, 19 June 2003)*

However, it is hard to implement this idea. There are so many pre conditions that should be provided and set up. An informant stressed on the readiness of the teacher in school to teach this subject and perception of the students related to HIV/AIDS information. According to the informants, teaching HIV/AIDS material is more difficult than teaching other subject in school. Teaching this subject needs more attention, empathy, hospitality, friendly, comfort, honest, and other things from the teacher. It should be presented in relax situation in both teacher and students. In turn, it would build trust between teacher and students. Hence, the condition of students should also be prepared by the professional teacher to engage in this matter.

The informant, stated that the gaps in the readiness of teacher and students' condition is the common situation in school.

> "The teacher's knowledge to teach the HIV/AIDS materials is very little. So, the teachers should be trained first. They also should be trained on how to teach this material to the students."
> *"Pengetahuan guru untuk mengajarkan materi HIV/AIDS sangat sedikit. Jadi, guru-guru ini harus dilatih terlebih dahulu. Mereka juga harus diajarkan bagaimana mengajarkan materi ini kepada siswa".* (Rn, parent, male, teacher, 43 years old, Lenteng Agung, 25 June 2003).

> "I have experience when counselors give HIV/AIDS information in our school. Only few students paid attention to it, and most did not. It was not interesting; especially the language used was not interesting, monotone, and boring to be listened."
> *"Saya punya pengalaman ketika konselor memberikan informasi HIV/AIDS di sekolah kami. Hanya sedikit siswa yang mendengarkannya, dan banyak yang tidak mendengarkan sama sekali. Hal itu tidak menarik, terutama bahasa yang digunakan tidak menarik, monoton, dan membosankan untuk didengar".* (FGD, 20-24, in-school female student, urban).

Furthermore, other gaps go to the situation of teaching in Indonesia. Mostly, teaching activities in school are done in a formal situation. According to informants, informing HIV/AIDS could be successfully done in an informal way, friendly, and comfort situation. This method is chosen because the adolescents tend to be embarrassed or worry to speak out their problems, since talking HIV/AIDS is taboo and perceived as a result of dirty behavior in the community.

> "...HIV/AIDS information should be presented in an informal discussion out of class. ... providing open discussion for adolescent enable them to talk in ease without the burden of embarrassment or worries/"
> *"...informasi HIV/AIDS sebaiknya disampaikan dalam diskusi informal di luar kelas. ...penyediaan diskusi terbuka untuk remaja memungkinkan mereka berbicara dengan leluasa tanpa ada beban malu atau takut".* (FGD, 15-19, in-school male student, urban)

An informant addressed the role of parents in family to distribute information about HIV/AIDS in the informal situation. According to this

informant, parents should be trained to guide their teen in their family in any informal ways.

> "Teenagers should first get the first information from the family. ...by using guidance, story telling about HIV, and its impact if someone has been infected. The parents should also be trained... How can the parents tell their teens if they themselves don't know how to guide their teens in regards in teaching HIV/AIDS information"
> *"Remaja terlebih dahulu harus diinformasikan di keluarga...dengan bimbingan, menceritakan sejarah tentang HIV, dan dampaknya bila seseorang terinfeksi. Para orangtua juga harus dilatih... Bagaimana orangtua dapat menceritakannya kepada remaja mereka jika mereka sendiri tidak tahu bagaimana membimbing remaja mereka dengan informasi HIV/AIDS".* (Rn, parent, male, teacher, 43 years old, Lenteng Agung, 25 June 2003).

> "Parents tend to know little about HIV/AIDS. Accordingly, it is hard for parents to guide their teens without any intervention in dealing with them."
> *"Orang tua tidak tahu banyak tentang HIV/AIDS. Hal itu menyulitkan orangtua untuk membimbing remaja mereka tanpa adanya intervensi untuk menjangkau mereka"* (Ai, parent, male, teacher, 37 years old, Bojong Gede, 3 July 2003).

Most young people in this study were reluctant to seek openly information on HIV/AIDS or any other sexual information. Their reluctance come mainly from their fear to be called as rascal (*"anak nakal or bad children"*) and identified as having experiences in sexual activities. As a matter of fact, they were already exposing to some information related with HIV/AIDS including posters that were plastered at the health centers and clinics. Those posters were frequently placed near the cashier, but they were afraid to read it intensively. Despite their reluctant to talk with the official authority (health providers, teachers, community or religious leaders), many young people were willing to talk openly about HIV/AIDS with their peers (friends at school or neighborhood). The main problem is that the peers itself has no complete and good information on HIV/AIDS.

The only information that they get is from TV in the news format. Television programs provide talk show that discusses topics on sexuality as well as HIV/AIDS. These programs provide information for the young people. Resource persons filling these programs are reputable medical doctors that specialized in field of obstetric-gynecology, andrology, psychology, and

sexual diseases. These programs are often presented in late evenings. Young adults are curious to hear this program. But they are also reserved and recoil if known by other family members.

Lack of information for these young people on HIV/AIDS caused to their ignorance on the dangerous of HIV/AIDS and the misinformation on how HIV/AIDS were infected; they did not know methods of prevention. They could not tell the difference between HIV and AIDS. They only knew that HIV/AIDS is a dangerous and deadly disease. Place for treatment for HIV/AIDS that they knew was in health center and medical doctor.

3.2 Family Barriers

Frankly, families give response and desire to take an effort to prevent their members, particularly young people from serious diseases like HIV/AIDS. All informants believed that young people had to escape from unwanted conditions including HIV/AIDS. But, some barriers hampered this response, effort, and desire. Findings from this study summed up five barriers in the families in preventing HIV/AIDS from young people in Indonesia. They were cultural constraints, lack of understanding about the extent of HIV/AIDS problems, lack of understanding about how to resolve the HIV/AIDS problem, lack of awareness of the HIV/AIDS problems, and lack of support and encouragement.

3.2.1 Cultural constraints

Cultural constraints are the first source and starting points of the sequel in any emerging family barriers. The dominant cultural constraint is taboo to talk about sex. Sex in most ethnic and culture in Indonesia is perceived as a private matter. It is banned to speak it out publicly and openly. Talking about sex is merely for married people at specific and private place, not for public consumption nor for young people. Taboo to talk about sex is now still perceived by most Indonesian families. As a result, it is hard to find those speaking freely about sex or sexual behavior in family communication as well as in the public, even speaking good information about sex or sexual behavior. Although most young people easily get sexual information from irresponsible media (stencil or pornography magazine or pornography site in internet) they are also reluctant to speak freely about sex or sexual behavior. The topic of sex or sexual behavior is a forbidden subject to talk and to

discuss in most families. This cultural barrier is so strong, even among few families who want and know that informing sexual reproductive health to young people is necessary. They are also reluctant to do this matter in their family.

> "Most people and families in our culture still perceive that speaking sex is taboo. It is a forbidden subject to family. I ever practice sex, but not to discuss to my teen. I really don't know how to talk about it to my children."
> *"Banyak orang dan keluarga dalam budaya kita masih menerima bahwa membicarakan seks adalah hal tabu. Ini merupakan hal yang dilarang dalam keluarga. Saya telah mempraktekkan berhubungan seks tapi tidak untuk didiskusikan dengan remaja saya. Saya sama sekali tidak tahu bagaimana membicarakan hal tersebut dengan anak-anak saya"* (Ai, parent, male, teacher, 37 years old, Bojong Gede, 3 July 2003).

> "...We never talk about this, we are still young and it's taboo to talk about it..."
> *Kami tidak pernah membicarakan hal ini, kami masih muda dan tabu untuk membicarakan hal tersebut* (FGD, 10-14, in-school male student, urban).

What is the relation between taboo to talk sex and HIV/AIDS? HIV/AIDS in Indonesia is known as part of the Sexual Transmission Diseases (STDs). Mass media tend to report HIV/AIDS as sexual based, such as the mode of transmission through heterosexual, homosexual and bisexual, HIV/AIDS is a disease of commercial sexual worker, and AIDS is vulnerable for high risk sexual behavior[4]. This tendency and reports brings HIV/AIDS as a similar subject to sex. Therefore sex is taboo to talk, and then HIV/AIDS is also taboo to talk both in public and inside the family. Most informants said that the family is embarrassed to discuss the phenomena of HIV/AIDS among their children or among other family members. As a result, young people are also taboo to talk about HIV/AIDS. If young people look at poster or advertising about HIV/AIDS they are embarrassed and reluctant to find out more information about it. Since it is taboo to talk, an effort to give HIV/AIDS information in school are also being restricted. Until today, sex education that includes HIV/AIDS information is not yet perceived as a national program in school. This cultural constraint causing all effort in giving HIV/AIDS information to young people facing hard challenges, as the family is faced.

"HIV/AIDS information was scarce to be spoken in the family. Something like sex, is still taboo to be spoken and discussed. It does not seem to be a problem of their family but the problem of other families where their husbands go to commercial sexual worker. I know a little about this problem from newspaper"
"*Informasi HIV/AIDS jarang dibicarakan dalam keluarga. Hal semacam seks, itu masih tabu untuk dibicarakan dan didiskusikan. Hal seperti itu seperti bukan masalah dalam keluarga mereka tapi masalah keluarga lain yang suaminya suka jajan dengan pekerja seks komersial. Saya tahu sedikit dengan masalah ini dari surat kabar*" (Yf, parent, community leader, male, 39 years old, Lenteng Agung, 19 June 2003).

"...never looked for this information, because I had no experience it ..."
...tidak pernah mencari informasi tersebut, karena saya tidak berpengalaman...(FGD, 15-19, out-school, male student, married, urban)

3.2.2 Lack of understanding about the extent of HIV/AIDS problem; its causes and its prevention

As the results of the above cultural constraints, most families have lack of understanding about the extent HIV/AIDS problem; its causes and its solution. Most families do not know the nature and fundamental problem of HIV/AIDS, the cause, the mode of transmission, and the ways to avoid from HIV/AIDS. Their knowledge about HIV/AIDS is superficial and sometimes is misunderstood. Their source of information is merely from newspaper, magazine, television, or advertisement. When asked about the mode of transmission of HIV/AIDS, most informants and children only knew heterosexual as a main mode of transmission and primary cause of HIV/AIDS problem. They do not know other mode of transmission such as homo-bisexual, injecting drug use (sharing needles without sterilization), blood transfusion, hemophiliac, and prenatal transmission. However, they only knew one solution to avoid suffering HIV/AIDS through doing sex with one partner. Moreover, certain solution they stated was misleading. An informant said that the means to avoid HIV/AIDS was the family should practice good faith. According to this informant, the best solution to fight HIV/AIDS is by practicing good faith and let God helps us. Other wrong perception was that

most of the family kept their mind shut down and closed their self from any information about HIV/AIDS. These understandings influenced their solution to avoid HIV/AIDS.

3.2.3 Lack of understanding about how to prevent the HIV/AIDS

Young people's understanding about how to resolve the HIV/AIDS problem tend to be low. Lacking the necessary knowledge and skills to prevent from HIV/AIDS, younger adolescent are less likely to protect themselves from HIV than those in their early 20s. Since young people are sexually active, their understanding to resolve HIV/AIDS by the ABC (Abstain from sex/delay the first sexual experience, Be faithful to one partner, and Consistently use a latex condom properly) prevention are still low.

Condom or using condom is one of the means to resolve the HIV/AIDS problem. But, information about condom in Indonesia is contaminated with the pro and contra of condom use. People that are pro or agree to use condoms believe that using condoms is the best way to prevent and protect from sexual transmitted diseases including HIV/AIDS. While people that are contra said that condom is taboo so that it is not necessary to provide information about condom. An informant said that condom was prohibited by all religion and promoting condom was similarly to promoting free sex. It is caused by the stigma that condom was more known for people in prostitution and localization of commercial sex activities. An informant believed that if the pros and cons and the stigma of condom use remained, no complete and right information about condom could be given to families and their youth.

Most family still think condom is taboo. The main barrier for young people to buy condom is the judgment that condom is taboo. There is ashamed feeling for youth to buy condom. Sometimes, drugstores keepers ask the youth regarding the aim to buy condom. This is a psychological barrier for youth to use condom in preventing them from HIV/AIDS. There is a stigma that using condom is associated with free sex. Traditional society perceives that promoting condom use for young people means promoting free sex.

3.2.4 Lack of awareness of the HIV/AIDS problems

Because of the existing cultural constraints, lack of understanding about the extent of HIV/AIDS problems, and lack of understanding about how to prevent from the HIV/AIDS, the families have lack of awareness of the HIV/AIDS problems. Families are not aware that HIV/AIDS may infect them. If they have information, they perceive that the problem does not exist among them; it is other families' problem with high-risk behavior. HIV/AIDS is not serious for them, but serious for other families.

According to informants, the seriousness of HIV/AIDS epidemic were just only for high-risk behavior people and families or people who practice free sex, particularly people in localization (prostitution) areas and all around recreation place. The informants perceived and believed that by having a strong faith, the young people could avoid HIV infection.

> "...the seriousness of HIV/AIDS problems is only for the people who practiced free sex like in localizations (for prostitution) and recreation places. As long as we have a faith, we cannot be infected by HIV."
> " *...keseriusan persoalan HIV/AIDS hanya untuk masyarakat yang menganut seks bebas seperti di lokalisasi dan tempat rekreasi. Sepanjang kita punya iman, kita tidak akan terinfeksi HIV* (Gn, parent, religious leader, male, 46 years old, Bojong Gede, 5 July 2003).

Are HIV/AIDS serious to young people? Informants said that HIV/AIDS was just a matter of a disease. There are so many diseases causing death. HIV/AIDS is just one, and only occurs among people with high risk sexual behavior. An informant said that there were so many priority problems to overcome and need to be solved. At current situation, to deal with HIV/AIDS problem had not been recognized as a priority program, both for the government and non-government organization. There are so many other programs priorities that have are more serious to be considered by decision-makers. HIV/AIDS for young people tend to be blown up.

> "In Indonesia, many young people have not yet considered HIV/AIDS as an important problem. There are so many other problems that are more serious to be solved first."
> *"Di Indonesia, HIV/AIDS untuk pemuda belum dianggap sebagai masalah penting. Ada begitu banyak masalah dan lebih serius untuk ditangani terlebih dahulu* (Yf, parent, community leader, male, 39 years old, Lenteng Agung, 19 June 2003)

"HIV indeed is not a problem should be blown up. ...the spread of HIV/AIDS does not take place in the general society but more localized in specific places."
"HIV sesungguhnya, bukan sebuah masalah yang harus dibesar-besarkan. ... penyebaran HIV/AIDS bukan di masyarakat umum, tapi terlokalisasi di tempat khusus (Tg, parent, male, entrepreneur, 40 years old, Menteng Atas, 22 June 2003).

3.2.5 Lack of support and encouragement

In preventing HIV/AIDS, families and youth need support and encouragement from relevant institution both government and non-government institution. Families are in need of the support and encouragement to enhance their capabilities, awareness, and commitment to combat HIV/AIDS. Young people should also be provided with information, skill, and counseling in preventing HIV/AIDS by support centers and services. What has been done to support and to encourage the prevention of HIV/AIDS among families in Indonesia? Informants and children from this study said that there was little support and encouragement in preventing HIV/AIDS form the government and non-government organizations that exist in this country. Families were also lack of support and encouragement to young people to find information and services about HIV/AIDS.

There are only few centers for counseling and support services for youth that require consultation and advice to solve their problem related to HIV/AIDS. Informants recognized it. The center was hard to find by students. Even, informant in rural area did not know the existing centers of counseling and support services for youth.

The availability of service for youth on HIV/AIDS in urban areas is better than in rural areas. Some informants said YPI and PKBI had services for youth. Informants said that most counseling centers established in urban are YPI and PKBI. Unfortunately, the youth was difficult to access these services. There was a stigma, if someone came to the centers, he/she was suspected to be infected or there was any symptom closed to HIV/AIDS for the persons. Hence, youth tended to postpone their visit to the center. This stigma should be changed therefore which can encourage youth to go to the center freely and easily. Mostly, for the first time they used hotline services provided by centers and if they trusted the counselor they continued to meet in a face-to-face counseling.

Informants said that the main barriers of youth who need the services was not caused by the distance to the centers or lack of support services nor by lack of information to find the center. The main barrier existed inside themselves. They were always embarrassed or worried to discuss their problem that was related to HIV/AIDS. Community perceived that talking about HIV/AIDS was taboo and HIV/AIDS was a result of dirty behavior. This condition occurred in youth. But, for youth with no problem related to HIV/AIDS or the youth that believed that their behavior was far away from high-risk to be infected by HIV/AIDS, no initiative or effort was done to reach the services. An informant admitted that there were hidden barriers to prevent care of the HIV/AIDS spreading.

Sadly, this study also found out that some informants said that they did not know about governments support and encouragements related to HIV/AIDS prevention as well as the centers for counseling and support services from the NGOs.

> "I don't know if there are any government's supports and encouragements that have been done to prevent the HIV/AIDS spreading to young people"
> *"Saya tidak tahu jika ada dukungan dan upaya-upaya dari pemerintah yang telah dilakukan untuk mencegah penyebaran HIV/AIDS kepada pemuda"*. (Gn, parent, religious leader, male, 46 years old, Bojong Gede, 5 July 2003)

The barriers in information dissemination, HIV/AIDS material, counseling and services, availability and accessibility of services, barriers of young people to reach the services, and governments program on HIV/AIDS prevention for youth were admitted by the informants. They suggest that the government and civil society should give more attention and care to overcome these problems. All informants believed that young people are the resources of the nation in the future. Prevention programs to young people from HIV/AIDS accordingly are the nation investment on building capacity for the future.

4. CONCLUSION

This study has summed up five barriers of Indonesian family in preventing HIV/AIDS for young people, such as cultural constraints, lack of understanding about the extend of HIV/AIDS problem, lack of

understanding about how to resolve the HIV/AIDS problem, lack of awareness of the HIV/AIDS problem, and lack of support and encouragement. These barriers should be resolved. The proposed programs of action are breaking taboos to talk about sex as well as HIV/AIDS, providing information and services on HIV/AIDS to families in an interesting ways, using the mass media and/or person to person communication and advocacy to raise awareness of HIV/AIDS problem, helping families to discuss and identify solution and support development to resolved the HIV/AIDS problems, and providing support and encouragement both from government and non-government institutions.

Other solutions should go to the National Family Planning effort in preparing prosperous family in Indonesia. The institution has been avowed it success in creating small family culture in Indonesia. The institution has also established eight family functions toward prosperous family in Indonesia. This function has been collected by experts from values of family tradition in Indonesia. In the small family condition, the program of preventing HIV/AIDS in the family should be created.

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NOTES

1. Javanese family used in this paper referred to big ethnic in Indonesian country. Principally each ethnic in Indonesia have own concept on family relation. But, hypothetically in general have some similarities regarding to the role in preventing disease including HIV/AIDS. Studies on this matter were limited.
2. The terms of "young people", "youth", and "adolescent" are defined variously. WHO refers to people aged 10 to 19 years as adolescents and the larger age group 10 to 24

as young people (WHO. 1986). The three terms are often used interchangeably; a practice that this paper follows.

3. Recognizing the threat that a widespread of HIV/AIDS epidemic would pose to national development, a Presidential Decree number 36 in 1994 was implemented by establishing a National AIDS Commission (NAC). The NAC formulated the first National AIDS Strategy (NAS) in 1994 and the National AIDS Program 1995-2000. On May 2003, the NAC launched new NAS. In the NAS 2003, the Ministry of National Education (MNE) has been commissioned by the NAC to undertake the 2003 NAS for young people (NAC 2003).
4. According to Sciortino (1994), based on the reports of mass media in Indonesia during the period of 1983-1993 there were four paradigms of HIV/AIDS, namely non-existent of AIDS in Indonesia, AIDS is disease of west people, AIDS is disease of gay, and AIDS is disease of commercial sex worker.

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Romanus Beni, Researcher, Demographic Institute, Faculty of Economic University of Indonesia. E-mail: Romanus@ldfeui.org