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Determinants of Stigma Attitude Among People Living with HIV

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Abstract

Objective: Human immunodeficiency virus / acquired immunodeficiency syndrome (HIV/AIDS) is still a stigma in the community and becomes a barriers in dealing with HIV. This study aimed to identify the determinants of stigma attitude among people living with HIV/AIDS (PLWHA).Methods: This study used a cross-sectional design. Sample collection was carried out by simple random sampling involving 135 Housewife suffered by HIV in Surabaya. The independent variables were policy support, patient characteristics (including age, sex, education level, marital status, occupation, HIV status, first being diagnosed with HIV), family factors (including family burden and family resilience). The dependent variables were stigma. Data were collected using a questionnaire. The analysis used binary logistic regression with a significance level of $p \leq 0.05$. Results: The results showed there are five factors related to stigma in PLWHA, namely policy support ($p = 0.019$), marital status ($p = 0.039$), first being diagnosed with HIV ($p = 0.006$), family burden ($p = 0.000$) and family resilience ($p = 0.041$). Out of five variables, only four had a significant effect on stigma, namely marital status (OR = 0.009; 95% CI 0.000 – 0.697), first being diagnosed with HIV (OR = 7,464; 95% CI 1,820 - 30,617), family burden (OR = 0.075; 95% CI 0,017 - 0.329), and family resilience (OR = 0.010; 95% CI 0.000 - 0.381).Conclusion: The determinants of stigma attitude among PLWHA include policy support, marital status, first being diagnosed with HIV, family burdens and family endurance. Tackling stigma on HIV which involves various sectors including society, family, private and government.

Keywords: *HIV/AIDS; PLWHA, Stigma attitude.*

Introduction

Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) continues to be one of the main global public health problems [1].In 2018, 37.9 million people were living with HIV, with 1.7 million newly infected with HIV and 770 thousand people dying of AIDS-related illnesses [2].The trend of HIV/AIDS in Indonesia is increasing, because all groups and age ranges can be at risk of contracting HIV/AIDS [3].The majority of HIV / AIDS sufferers in Indonesia came from the group of housewives, followed by employees and entrepreneurs [4].

Housewive often at risk of HIV infection mainly due to women's general inability to negotiate condom use with their partner [5].People living with HIV/AIDS (PLWHA) not only face physical health problems but are also accompanied by the burden of stigma which is a social phenomenon that develops both in the social and care environment [6].Stigma against patients with HIV / AIDS continues to be an urgent problem related to the nature of endemic and long-term care which has a negative impact on the health and well-being of people living with HIV, with adverse effects on their quality of life [7,8].HIV stigma is one of the leading issue in reducing and eliminating HIV prevalence in the world [9].

Many women living with HIV report anticipated high-level stigma, resulting in a desire to hide their status from family and friends for fear of discrimination [10]. The stigmatization experienced is related to the quality of life of HIV patients so that it affects the well-being of living a life that can result in hampered access to care and treatment as well as poor social relations with friends, family members and the

community [11,13]. Corno (2013) reported that HIV/AIDS stigmatizing attitudes are negatively associated with education and wealth of patient. However, the perceived stigma is positively related to the idea of suicide in HIV-positive patients [14]. In addition, non-optimal fulfilment of well-being can worsen the assessment of the immune system and decline resistance towards diseases (including infectious diseases) [15].

There are various efforts that can be done to reduce the stigma against PLWHA. The struggle against HIV-AIDS must lead to empowerment and decisive steps for solutions by the community [16].Public policy must focus on empowering and reducing stigma related to HIV / AIDS [17].Increasing the empowerment of people living with HIV can be done through social self-value interventions [18].

Education seems to play a major role in society with regard to HIV stigma and discrimination against PLWHA, so educating the population with factual information about HIV / AIDS is needed to reduce stigma and discrimination against PLWHA in the community [19].Family support is the most helpful for PLWHA who can increase their optimism in facing life [20].HIV related stigma attitude can be happened at public and self-stigma which is defined as unacceptable behaviour in social context [9].

Research related to stigmatization attitudes of HIV-AIDS patients has been conducted but has not yet explored the influence of policy support, patient characteristics (including age, sex, education level, marital status, occupation, HIV status, first being diagnosed with HIV), family factors (including family burden and family resilience) on the stigma. This study aims to analyze the factors that influence stigmatization attitudes toward PLWHA.

Therefore, this research emphasizes the policy and family support related to stigmatization attitudes.

Materials and Methods

To determine the factors the stigmatization attitudes toward PLWA, we analyzed data from a cross-sectional survey [21].This research was conducted in January-February 2019. The population was HIV-AIDS patients in two hospitals located in Surabaya. This research was conducted in out-patients ward. The sample in this research consisted of 135 Housewifes suffered of HIV/AIDS in Surabaya generated from simple random sampling. The participants were recruited based on ethical principles. Eligible participants involved in this study have previously received a written explanation regarding the purpose of study, procedures, rights and obligation, benefit and disadvantages during the study. Only participants who have given informed consent were involved in the study.

The independent variables were policy support, patient characteristics (including age, sex, education level, marital status, occupation, HIV status, first being diagnosed with HIV), family factors (including family burden and family resilience). The dependent variables were stigma.

The instruments used in collecting data were questionnaires developed by authors to obtain more contextualized questionnaire used in Indonesian culture. The data were analyzed using binary logistic regression with a significance level of $p \leq 0.05$. Descriptive analysis is presented in the form of frequencies and percentages. Data analysis was performed using SPSS software version 24.1. This study had obtained ethical approval from the Ethical Committee of Faculty of Nursing, Airlangga University with the number 1233-KEPK.

Results

Table 1: Characteristics of participants (n=135)

No	Respondents characteristics	Category	N	%
1	Age	10-16	1	0.7
		17-23	9	6.7
		24-30	20	14.8
		31-37	35	25.9
		38-42	41	30.4
		43-50	24	17.8
		51-57	4	3.0
		58-64	1	0.7
		Total	135	100.0
2	Sex	Male	62	45.9

No	Respondents characteristics	Category	N	%
		Female	73	54.1
		Total	135	100
3	Education level	Elementary school	27	20.0
		Junior high school	26	19.3
		Senior high school	69	51.1
		Higher education	13	9.6
		Total	135	100.0
4	Marital status	Single	36	26.7
		Married	73	54.1
		Divorced	26	19.2
		Total	135	100.0
5	Occupation	Civil servant	2	1.5
		Private	73	54.1
		Entrepreneur	21	15.6
		Unemployed	39	28.9
		Total	135	100.0
6	HIV Status	Asymptomatic	65	48.1
		Symptomatic	49	36.3
		AIDS	21	15.6
		Total	135	100.0

Table 1 shows the respondent's characteristics. The majority of respondents is in the age range of 38-42 years as many as 41 respondents (30.4%). Most respondents were female, as many as 73 respondents (54.1%). A total of 73 respondents (54.1%) were at the high school education level. The majority of marital status is married, with 73 respondents (54.1%), working in the private sector, 73 (54.1). The majority of HIV experienced was asymptomatic, as many as 65 respondents (48.1%)

Table 2: Determinant of stigma attitude among people with HIV/AIDS

Variable	OR	95% CI		*p*-value
		Lower	Upper	
Policy support				
Supportive	2.601	.337	20.058	.019
Less supportive	.266	.041	1.711	
Not supportive	Ref	Ref	Ref	
Marital status				
Single	.009	.000	.697	.039
Married	.530	.034	8.186	
Divorced	Ref	Ref	Ref	
First being diagnosed with HIV				
< 1 year	7.274	1.778	29.754	.006
≥ 1 year	Ref	Ref	Ref	
Family burden				
Mild	.002	.000	.155	.000
Moderate	.075	.017	.329	
Severe	Ref	Ref	Ref	
Family resilience				
Good	.010	.000	.381	.041
Moderate	.009	.000	.368	
Less	Ref	Ref	Ref	

There were five factors statistically significant in the analysis, namely policy (p = 0.019), marital status (p = 0.039), first being diagnosed with HIV (p = 0.006), family burden (p = 0.000) and family resilience (p = 0.041). Out of five variables, only four had a significant effect on stigma, namely marital status (OR = 0.009; 95% CI 0.000 – 0.697), first being diagnosed with HIV (OR = 7,464; 95% CI 1,820 - 30,617), family burden (OR = 0.075; 95% CI 0,017 - 0.329), and family resilience (OR = 0.010; 95% CI 0.000 - 0.381). (Table 2)

Discussion

The results showed that policy support related to the stigma attitude among PLWHA. Those who accept a policy that supports are more likely to have a positive attitude in dealing with stigma than those who accept a policy that does not support it. Community stigma has a negative impact on efforts to improve the psychological condition of respondents and HIV / AIDS patients [22].Health workers, health institutions, trusted health organizations, and government agencies must provide motivation and direction to the community to eliminate stigma [23]. The government has a role not only to help the lives of PLWHA, but also to act to prevent transmission through various programs that involve all parties [16]. Indonesia has established a National AIDS Commission that plays a role in increasing efforts to prevent and manage AIDS that are more intensive, comprehensive, integrated, and coordinated. Government activities put PLWHA not in a discriminatory position so that PLWHA can empower themselves optimally in life. With a supportive policy, individuals will feel protected and cared for by the government which allows the policy to influence the public's view of PLWHA. The results showed that marital status was related to the stigma attitude among PLWHA. Those who are not married are less likely to have a positive

attitude in the face of stigma than divorced people.

This is in line with research by Li *et al.* (2018) who reported that marital status was related to personalized stigma. PLWHA with unmarried status will feel a higher stigma [25]. HIV is believed to be related to a history of bad behavior, especially related to sexual relations so that PLWHA tend to be seen as having unhealthy sexual behavior such as being unfaithful to a partner even though unmarried PLWHA are generally exposed to little sexual activity. With this view, PLWHA will feel higher pressure related to stigma so that it will be difficult to respond positively. The results showed that the first being diagnosed with HIV was related to the stigma attitude among PLWHA. Those who are diagnosed <1 year are more likely to have a positive attitude in the face of stigma than those who are diagnosed with HIV ≥ 1 year.

The results of this study differ from Loutfy *et al.* (2012) which states that a longer duration of HIV diagnosis is associated with lower stigma because PLWHA can develop coping strategies and social support networks over time to help reduce stigma. This can happen because people living with HIV have a high religious value in the form of trust, thereby increasing acceptance of HIV. Spirituality / religiosity generally increases after being diagnosed with HIV [27].Acceptance of each individual is different, the possibility in this study is greater. So PLWHA will surrender to God more to their condition. In addition, individuals newly diagnosed with HIV will try to keep the disease a secret so that it is not known to the public so it tends to accept a little stigma.

The results showed that the family burden was related to the stigma attitude among PLWHA. PLWHA who have a family burden in the moderate category are less likely to have a positive attitude in dealing with stigma than PLWHA who have a heavy family burden. For families living with HIV / AIDS, shame is a shared burden, where HIV / AIDS causes the whole family to lose face in the community [28].However, family burdens are considered to be more changeable, controlled, or managed than stigmatized, and this may give rise to more adaptive coping [29].PLWHA families have an effort to prevent transmission and reduce the emotional, social and economic burden on families and protect their families from the consequences of HIV and stigma stigma [30].In this study, the possibility of the family not being so involved in caring for members with HIV / AIDS, so they do not feel burdened. The results showed that family resilience was related to the stigma attitude among PLWHA. PLWHA with good family resilience are less likely to have a positive attitude in dealing with stigma than those who have less family resilience. Families are expected to reduce the burden of stigma and lead to increased support and better health outcomes for PLWHA [31].

Family support without or little discrimination is found to contribute to quality of life among people infected with HIV [32].Resilience is related to exposure and experience, which is the possibility of families exposed to stigma. Good family resilience will support family care in caring for and provide support to PLWHA to live better quality and face exposure to stigma. But in this study, even though families have good resilience, PLWHA is less likely to have a positive attitude towards stigma. This can occur because of a lack of closeness of people living with HIV with members of his family so it has no impact on the attitude of people living with HIV face stigma.

Conclusion

Factors associated with stigma attitude among people living with HIV/AIDS include policy support, marital status, first being diagnosed with HIV, family burden and family resilience. Unresolved self-stigma will affect the quality of life of patients and continue to happen along the individual life cycle. Therefore, there needs to be a fundamental improvement in dealing with stigma that involves various elements including family, community, private, government and individual.

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