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ORIGINAL RESEARCH

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STIGMA TOWARDS PEOPLE LIVING WITH HIV/AIDS AMONG COUNSELING OFFICERS IN SOUTH SULAWESI, INDONESIA

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Abstract

Background: Human Immunodeficiency Virus (HIV) / Acquired Immunodeficiency Syndrome (AIDS) has been a global problem nowadays. To reduce its spread, Voluntary Counseling and Testing (VCT) and Provider-Initiated Testing and Counseling (PITC) have been provided. However, these interventions remain ineffective to discover new cases, as the stigma among health officers may exist.

Objective: To compare the stigma towards people living with HIV/AIDS between VCT and PITC officers.

Methods: This was a descriptive comparative conducted in Makassar City, Parepare City and Sidenreng Rappang Regency, South Sulawesi Province Indonesia. There were 139 samples were selected using convenience sampling technique, which consisted of 66 VCT counseling officers and 73 PITC officers. The questionnaire from Health Policy Project in Thailand was used to measure the HIV/AIDS related-stigma. Data were analyzed using descriptive analysis and Mann Whitney test.

Results: Findings show that there was a statistically significant difference in stigma between the group of VCT and PITC on people living with HIV/AIDS (PLWHA), which the mean of stigma in the PITC group (73.07) was higher than the mean value in the VCT group (66.61).

Conclusion: There is a significant difference in stigma between VCT and PITC officers towards PLWHA. It is suggested that PITC curriculum should be evaluated and supervision and monitoring in both VCT and PITC groups should be implemented regularly to reduce the stigma towards PLWHA.

Keywords: Stigma, HIV/AIDS, VCT, PITC

INTRODUCTION

Currently the Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS) has spread across the world. In 2016 the World Health Organization (WHO) estimated that people living with HIV/AIDS (PLWHA) had been at the number of 36.7

million people, in both adults and children ([UNAIDS, 2017](#)). The African continent is the first rank with the highest case of 25.6 million ([UNAIDS, 2017](#); [WHO, 2016](#)). UNAIDS reports that, in the continent of Asia and the Pacific, Indonesia has been ranked third after

India and China ([UNAIDS, 2017](#)). AIDS cases in Indonesia in 2016 were at 86,780 people while HIV infections in South Sulawesi Province were 993 people with a cumulative number of 6,296 people ([MOH, 2017](#)).

The discovery of HIV/AIDS coverage in Indonesia until December 2016 has increased with a cumulative number of 232,323 people. This is still far from the estimated target for 2016 which should reach 785,621 people ([MOH, 2014a, 2017](#)). This is certainly very worrying because the discovery of HIV/AIDS cases has not been optimal in health services as expected. HIV transmission will certainly continue to occur with the pattern of HIV/AIDS transmission which has shifted from initially focused on risky populations including women sex workers, transvestites, injecting drug users to housewives and men who have sex with other men, so the pattern of the spread of HIV/AIDS is now in the general public and no longer centered on the at-risk population, especially for housewives and there will be transmission from mother to child/baby ([MOH, 2014c; Risal & Gunawan, 2018](#)).

Study ([Wagner, Girard, McShane, Margolese, & Hart, 2017](#)) explained that one of the obstacles to the low coverage of people who would like to test and know their HIV status is that there are concerns of the stigma and discrimination from health workers so that it affects the access of PLWHA to health services. Another study ([Kumar et al., 2017](#)) explained that HIV-related stigma and discrimination are factors that drive this epidemic, despite advances in medical care and increased patient awareness of this disease. It is also explained that there is an increasing stigma as an obstacle to access in the HIV treatment series ([Nyblade et al., 2017](#)).

Stigma is a negative presumption in a group including PLWHA ([Wagner, Hart, McShane, Margolese, & Girard, 2014](#)). The stigma of PLWHA is reflected in cynicism, feelings of excessive fear and negative perceptions ([Paryati, Raksanagara, & Afriandi, 2012](#)).

PLWHA report negative experiences they receive by health workers related to interaction or communication, irrelevant questions, harsh treatment, sympathy or pity, excessive precautionary measures through the use of different personal protective equipment for each patient, refusal of treatment, non-referral health needed, delays in hospital care, inadequate psychosocial support and violations of the confidentiality of patients' HIV status ([Arrey, Bilsen, Lacor & Deschepper, 2017](#)).

Stigma and discrimination are the main factors that influence the ability of nurses to treat PLWHA patients. Nurses are well aware of the stigma and discrimination caused by HIV/AIDS so as to make adjustments in providing nursing care to reduce the manifestation of AIDS stigma. However, although it is stated that PLWHA are treated equally by applying the use of universal prevention consistently ([Mill et al., 2013](#)), many health workers are still afraid of dealing with PLWHA as one of the factors related to stigma and discrimination ([Wodajo, Thupayagale-Tshweneagae, & Akpor, 2017](#)).

Previous study ([Paryati et al., 2012](#)) explained that the occurrence of stigma and discrimination to PLWHA by health workers is influenced by several things including knowledge about HIV/AIDS, perceptions of PLWHA, level of education, length of work, age, training, gender, institutional support and adherence to religion. If the stigma and discrimination among health workers is not reduced, the patients will not have the desire, fear, or delay to check HIV status.

Global HIV/AIDS control refers to three things known as three zero, namely reducing the number of new HIV cases as low as possible, reducing AIDS mortality and reducing the level of stigma and discrimination ([MOH, 2014a, 2015](#)). One of the programs implemented by the Ministry of Health based on WHO recommendations to increase the scope of HIV counseling is through counseling and testing conducted by health workers / personnel trained to handle HIV/AIDS patients through both Voluntary Counseling and

Testing (VCT) and Provider-Initiated Testing and Counseling (PITC) ([MOH, 2014a](#), [2014b](#); [WHO, 2009](#)). The program was initially implemented in Makassar City and Parepare since 2005 for VCT and 2010 for PITC and expanded its implementation after the rule of law through the Health Minister Regulation of the Republic of Indonesia in 2013.

VCT is the main model of HIV testing services at the patient's initiative to seek HIV screening services performed before the test, after the test, and during HIV treatment by a trained counselor ([MOH, 2013](#); [WHO, 2009](#)). VCT counseling aims to prevent HIV transmission through assessing risk factors, reducing risk factors, changing risk behavior, improving the quality of life of patients and further counseling for PLWHA ([MOH, 2014a](#)). While PITC is a counseling approach that aims to discover HIV diagnosis, early treatment and comprehensive care for PLWHA ([Kennedy et al., 2013](#); [Roura, Watson-Jones, Kahawita, Ferguson, & Ross, 2013](#); [Topp et al., 2012](#)). VCT has an approach strategy with patient activity and is implemented both in health care institutions and outside health services, for example in the community. While the PITC strategy carried out by health professionals including nurses is only carried out in health care institutions. VCT and PITC also help achieve self-efficacy of health workers both individually and in groups so as to increase the coverage of people doing HIV testing ([Leidel, Leslie, Boldy, & Girdler, 2017](#)). However, as there is a lack of information about stigma and discrimination among health care officers, therefore this study aims to explore the stigma and discrimination between VCT and PITC Counseling Officers towards people living with HIV/AIDS as well as to compare the perception related stigma and discrimination between the two officer groups.

METHODS

Study Design

This was a descriptive comparative study to compare the stigma towards people living with HIV/AIDS between VCT and PITC officers.

Setting

This research was conducted in Makassar City, Parepare City and Sidenreng Rappang Regency, South Sulawesi Province Indonesia.

Sample

There were 139 samples were selected using convenience sampling technique, which consisted of 66 VCT counseling officers and 73 PITC officers. The inclusion criteria in this study are health workers (doctors, nurses or midwives) who have been trained in VCT and PITC training and include continuous comprehensive services (LKB), willing to be a respondent. Exclusion criteria in this study are health workers who have been trained in VCT and PITC but are not active in their implementation for at least the last year, officers who have been trained in VCT and PITC training but not from the health profession for example (NGOs) and officers who are not present at the time of the research.

Instrument

Data were collected using a questionnaire to measure HIV-related stigma among health facility staff adopted from the Health Policy Project in Thailand ([Health Policy Project, 2013](#)) on the recommendation of UNAIDS and WHO. Validity and reliability tests have been carried out with the Cronbach's Alpha value of 0.707. The questionnaire has been translated to Indonesian language. This questionnaire is to measure stigma and discrimination. Based on the operational definition of stigma research that is looking at or negative connotation, labeling and can cause discrimination against PLWHA. The process that is passed to produce a stigma includes the actual stigma of stigma that is experienced if there is a person or community that takes concrete actions, both verbal and non-verbal, which causes others to be distinguished and excluded. The potential or perceived stigma is that if the stigma does not occur yet there is a sign or feeling of discomfort so that people tend not to access health services. Internal stigma or self-stigmatization is that someone judges himself as "not entitled" and "disliked by society" ([MOH, 2012](#)). The scale used is numerical, with objective criteria using the

median value of good value if it is less or equal to the median value, less if more than the median value. The highest score is 14 and the lowest score is 1. The stigma instrument in this study is there are six questions namely Q6, Q8, Q9, Q10, Q11 and Q12.

Ethical Consideration

This research has been approved by the Research Ethics Committee of Faculty of Medicine of Hasanuddin University with number approval 427/ H4.84.5.31/PP36-Kometik/2018. The study permission was also obtained from Regional Development Planning Board in Makassar City, Parepare City and Sidenreng Rappang Regency, South Sulawesi Province as well as from the Community Health Centers for data collection. Before the research was conducted the researcher explained the purpose of the research that would be carried out further if the respondent were willing to be asked for approval from the respondent by signing an informed consent.

Data Collection

Data were collected by the researchers assisted with three research assistants with a minimum education of Bachelor degree in nursing and also worked as a counselor in the study setting. Prior to data collection, the research assistant was trained about objective and procedures of data collection. Data collection used single

blind, the main researcher does not know the respondent's data and to get accurate information and prevent answers that are not in accordance with the respondent's condition this is because researchers are facilitators of VCT and PITC counseling training

Data Analysis

Data were analyzed using univariate (frequency distribution) and bivariate (Mann Whitney test) analysis. Mann Whitney test to examine the difference in mean rank (ordinal data) from two different independent groups and if the data distribution is not normal ([Dharma, 2011](#)).

RESULTS

Table 1 shows that the majority of respondents was female (119%) and married (88.5%). Most of the respondents were nurses (38.8%) and midwives (33%) followed by physician (15.1%). Majority of respondents had bachelor degree in nursing & ners profession (33.8%) and Diploma III. Bachelor degree and Master degree in this study refer to the degree in all majors. It also shows that PITC group have joined the training about stigma and discrimination (63%) more than VCT group (45.5%).

Table 1 Frequency distribution of respondents' characteristics

Characteristics of respondents	VCT		PITC		Total		p
	f	%	f	%	f	%	
Gender							
Male	15	22.7	5	6.8	20	14.4	0.008 ^a
Female	51	77.3	68	93.2	119	85.6	
Total	66	100	73	100	139	100	
Age							
Mean	38.55		34.67		36.51		0.263 ^a
SD	8.123		9.042		8.843		
Education							
Diploma III	7	10.6	37	50.7	44	31.7	0.000 ^a
Diploma IV	6	9.1	5	6.8	11	7.9	
Bachelor degree	23	34.8	10	13.7	33	23.7	
Bachelor of Nursing & Profession	27	40.9	20	27.4	47	33.8	
Master Degree	3	4.5	1	1.4	4	2.9	
Total	66	100	73	100	139	100	

Marital Status							
Married	62	93.9	61	83.6	123	88.5	
Single	4	6.1	12	16.4	16	11.5	0.056 ^a
Total	66	100	73	100	33	100	
Profession							
Physician	12	18.2	9	12.3	21	15.1	
Nurse	35	53	19	26	54	38.8	
Laboratory personnel	4	6	7	9.6	11	7.9	0.000 ^a
Midwifery	10	15.2	36	49.3	46	33	
Public health	5	7.6	0	0	5	7.6	
Others	0	0	2	2.7	2	2.7	
Total	66	100	73	100	139	100	
Training of stigma & discrimination							
No	36	54.5	27	37.0	63	45.3	
Yes	30	45.5	46	63.0	76	54.7	0.147 ^a
Total	66	100	73	100	139	100	

^aChi Square Test

Table 2 shows that there was a statistically significant difference in stigma between the group of VCT and PITC on people living with

HIV/AIDS, which the mean of stigma in the PITC group (73.07) was higher than the mean value in the VCT group (66.61).

Table 2 Difference of stigma between VCT and PITC groups on PLWHA using Mann-Whitney

	Median (min-max)	Mean (CI95%)	p-value
VCT (n= 66)	1 (1-4)	66.61 (0.95-1.14)	0.027*
PITC (n= 73)	1 (1-4)	73.07 (1.06-1.35)	

DISCUSSION

Findings of this study revealed there was a significant difference in mean value of stigma between VCT and PITC counseling officers towards PLWHA. The mean of stigma in the PITC group was higher than the mean value in the VCT. This result supports the previous study that majority of patients prefer VCT (66.1%) which is initiated by patients themselves compared with PITC initiated by health workers (11.6%) and independent testing (22.3%) (Van Dyk, 2013). This occurs with the reason that VCT approach prioritizes patient autonomy, no human rights violations, and keeps confidentiality of the testing results (Van Dyk, 2013). In addition, the VCT approach increases the scope of case discovery and reduces the level of HIV/AIDS stigma (Mall, Middelkoop, Mark, Wood, & Bekker, 2013). This is in line with previous study (Misir, 2013) stated that counseling through

the VCT approach is significantly correlated with a decrease in stigma.

However, the result of our study is also in contrast with another study (Ogbo et al., 2017) indicated that the PITC strategy is very acceptable and feasible, and increases the number of patients tested for HIV by 5% compared to VCT. It is also said that the utilization of HIV testing increases after PITC compared to VCT, therefore PITC must be expanded and evaluated rigorously (Kennedy et al., 2013).

On the other hand, another study (Silvestri et al., 2011) indicated that there was no significant difference VCT and PITC approaches in finding new cases. However, Wanyenze said that both VCT and PITC counseling approaches show the results of good counseling practices including the process of patient approval, confidentiality

aspects, counseling processes, and referrals for follow-up care, so that both can be used to increase the coverage of HIV/AIDS cases (Wanyenze et al., 2013). But, this is certainly supported by trained counseling officers in both VCT and PITC by not stigmatizing patients, especially in at-risk populations including man who have sex with man, female sex workers, drug users, transgender, etc. As a consequence, it will lead to the improvement of HIV testing coverage and help patients to get subsequent treatment interventions.

Based on the results of this study, the evaluation of the PITC implementation curriculum and training for health workers are necessary. Study stated that stigma reduction training programs carried out for health workers in Bangladesh showed a substantial decrease in stigma among health workers in men who have sex with men, young people who are active sexual or involved in immoral behavior (Geibel et al., 2017). Therefore, stigma reduction training materials can be included in the PITC training curriculum. Additionally, monitoring and supervision from professional counselors is needed to evaluate the performance of PITC officers related to stigma and discrimination.

CONCLUSION

There is a significant difference in stigma between VCT and PITC officers towards PLWHA. It is suggested that training curriculum in PITC should be evaluated and supervision in both VCT and PITC groups should be implemented regularly to reduce the stigma in PLWHA.

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