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Original Research Article

HIV-related stigmatized attitudes among health care providers in Aceh, Indonesia: The findings from a very low HIV case-load region☆

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ABSTRACT

Introduction: Study of HIV-related stigmatized and discriminatory attitudes is predominantly conducted in the regions with high HIV prevalence; therefore, understanding about stigmatized and discriminatory attitudes dynamic in the region with a very low HIV prevalence is needed.

Aim: To identify the levels of stigmatized attitudes toward people living with HIV (PLHIV) and their predictors among health care providers (HCPs) in Aceh, the lowest HIV prevalence province in Indonesia.

Material and methods: A cross-sectional study was conducted in seven regencies in Aceh. Structured questionnaires were used to collect data from 589 HCPs (doctors, nurses, midwifes and supporting staffs). Univariate analyses including one-way analysis of variance, *t*-test and correlation test were performed according to data type. Multiple linear regression was conducted to identify the predictors of stigmatized attitudes.

Results and discussion: The level of HIV-stigmatized attitudes among HCPs in Aceh was high. Univariate analysis revealed that location, experience of direct contact with PLHIV, knowledge on HIV transmission and prevention, value-driven stigma and overestimated risk to HIV transmission were associated significantly with stigmatized attitudes levels ($P < 0.05$).

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A multiple linear regression model identified that high level of value-driven stigma and high level of overestimated risk to HIV transmission were robust predictor factors for stigmatized attitudes ($R^2 = 0.212$; $F = 14.113$; $P < 0.001$).

Conclusions: This study demonstrates that the value-driven stigma and overestimated risk to HIV transmission are the major predictors of stigmatized attitudes toward PLHIV among HCPs in Aceh. Therefore, programs to reduce value-driven stigma and overestimated risk are needed.

1. Introduction

HIV-related stigmatized and discriminatory attitudes are negative factors in the crusade to diminish the prevalence and the effects of HIV/AIDS pandemic. They are the major barriers to effective and sustainable prevention, care, treatment, and support programs.[1] As a consequence they create a HIV hidden epidemic.[2] HIV-related stigmatized and discriminatory attitudes also cause people living with HIV (PLHIV) feel anxiety, depression, guilt, isolated, low self-esteem, physical and emotional violence, intensification of grief, and loss of social support[3–5] which in turn affect PLHIV in seeking voluntary counseling and testing, accessing HIV treatment and care, adhering to antiretroviral therapies and accessing education and information on preventive behaviors.[5–8] In addition, HIV-related stigmatized attitudes tend to build and reinforce negative connotations through the association of HIV and AIDS with already-marginalized behaviors, such as prostitution, drug usage, homosexuality, and transgender sexual practice.[9]

Studies on stigmatized and discriminatory attitudes toward PLHIV among health care providers (HCPs) have been conducted in some countries.[3,10–15] Some studies found that the levels of stigmatized and discriminatory attitudes were high among HCPs, including HIV testing without informed consent, verbal abuse/gossip, designating patients as HIV positive on charts or in wards, verbally harassing, isolating HIV-positive patients, denial of treatment and using gloves during all interactions.[2,11,14,15]

Studies from different countries found that various factors affect stigmatized and discriminatory attitudes toward PLHIV among HCPs. Studies in Bangladesh demonstrated that the factors associated with high level of stigmatized and discriminatory attitudes among the HCPs were irrational fears of HIV transmission, working in teaching hospital rather than in non-teaching hospital and diagnostic centers, low level of education, and being male.[11,16] A study in Malaysia found that the key factors affecting stigmatized and discriminatory attitudes were high-risk taking behavior, individuals related to stigmatized identities, sources of HIV infection, stage of the disease, relationship with PLHIV, and ethnicity and urban–rural locality.[17] Additionally, another study indicated that stigmatized attitudes in health care setting related to the fact that HIV/AIDS has strong connection with social or moral problems, such as promiscuity, homosexuality, drug addiction, or prostitution.[18]

In 2009, the number of PLHIV in Indonesia was 310 000.[19] Although the national HIV prevalence is less than 0.2%, in a particular province, Papua, HIV prevalence is approximately 2.4%.[20] Aceh has the lowest HIV prevalence among other provinces in Indonesia. In 2012, there were 33 PLHIV cases only in Aceh.[21] However, recently, HIV prevalence is increasing significantly. Up to date, there is no data available regarding HIV-related stigmatized attitudes either in public or in health care setting in Aceh. In addition, research related to HIV-related stigmatized and discriminatory attitudes was predominantly conducted in the regions with high HIV prevalence.[2,4,10,12–15,22] Therefore, the objective of this study was to identify the levels of stigmatized attitudes among HCPs toward PLHIV and their explanatory factors in Aceh.

2. Aim

The aim of this present study was to provide scientific evidence of HIV-related stigmatized attitudes dynamic among HCPs toward PLHIV as a basic strategy to design intervention programs to decrease stigma and discrimination toward PLIHV in health care settings in Aceh.

3. Material and methods

3.1. *Study design*

This study was a part of the study designed to identify the dynamics of stigmatized and discriminatory attitudes in health care settings. Discriminatory attitudes report has been published elsewhere.[23] In this paper, the stigmatized attitudes report is presented. This study was cross-sectional, conducted in seven regencies (Bireuen, Sigli, Sabang, Lhokseumawe, Tamiang, Langsa, and Takengon) of Aceh which have affiliation teaching hospital with School of Medicine, Syiah Kuala University. HCPs (doctors, nurses, midwifery, and support staffs) were recruited from teaching hospital of those regencies. Data were collected from October 2012 to January 2013. This study was approved by the Institutional Review Board (IRB) School of Medicine, Syiah Kuala University, Banda Aceh, Indonesia and Provincial Health Office No. 050/3080/X/2012.

The experimental procedure used in this study is based on US Agency for International Development (USAID) recommendation.[24] Briefly, the interviewers read a prepared script that consisted of the study aims, risks, and benefits and obtained informed consent from all who participated. Each informed consent form and its questionnaire were assigned a unique