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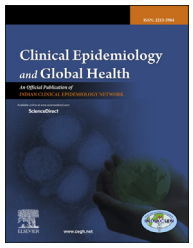

Original Article

Discriminatory attitudes toward people living with HIV among health care workers in Aceh, Indonesia: A vista from a very low HIV caseload region

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ABSTRACT

Background: The aim of this study was to identify the level of discriminatory attitudes towards people living with HIV (PLHIV) among health care workers (HCWs) and the factors influencing discriminatory attitudes in very low HIV load region.

Methods: This research was conducted at seven regencies in Aceh, Indonesia. A cross-sectional study design was adopted and 589 HCWs selected purposively were included in this study. Research was conducted from October 2012 to January 2013. Correlation analysis, analysis of variance and independent sample t test analysis were used according to the type of data. Multiple linear regression models were used to identify the predictor factors.

Results: It was observed that the level of discriminatory attitudes is high. Bivariate analysis showed that regency, education, type of HCW, religion, direct contact experience with PLHIV, HIV/AIDS-related training, knowledge on transmission and prevention of HIV, value-driven stigma, overestimated risk to HIV transmission, and facility profile were significantly related to the level of discriminatory attitudes ($p < 0.05$). A multiple linear

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regression model identified the following correlate to discriminatory attitudes: being Muslim, low-level of knowledge on transmission and prevention of HIV, and high level of value-driven stigma and overestimated risk to HIV transmission ($R^2 = 0.205$).

Conclusions: Our study found that knowledge on transmission and prevention of HIV, value-driven stigma and overestimated risk to HIV transmission are the only significant predictors of discriminatory attitudes towards PLHIV among HCWs in Aceh. Therefore to reduce those factors, trainings on HIV-related discrimination to HCWs and clear guidelines and protocols related to PLHIV care are urgently needed.

1. Introduction

In 2009, there were 33.3 million people living with HIV (PLHIV) around the globe, about 1.8 million AIDS-related deaths happen every year and 2.6 million people are newly infected with HIV.[1] In the same year, there were 3,10,000 PLHIV in Indonesia. Although national HIV prevalence is less than 0.2%, in some area, for instance Papua, HIV prevalence is 2.4%.[1,2] Aceh is one of region that has the lowest HIV prevalence in Indonesia. In mid 2009, there were 29 PLHIV cases only registered in Aceh Provincial Health Office.[3]

Discrimination is an aspect of stigma – a dynamic process of devaluation that 'significantly discredits' an individual in the eyes of others thus reducing that individual's status in the eye of society – defined as a form of exclusion, restriction of expression, marginalization, or prevention from access to something or services.[4,5] Discrimination is described as a behavior in which a distinction that is made about a person that results in their being treated unfairly or unjustly on the basis of their belonging or being perceived to belong to a particular group.[6] HIV-related discrimination refers to any forms of arbitrary distinction, exclusion, or restriction affecting PLHIV.[7] HIV-related discrimination is the major barrier to effective and sustainable prevention, care, treatment, and support efforts in HIV/AIDS control program.[8,9] It tends to create a hidden epidemic of the disease based on socially-shared ignorance, fear, misinformation, and denial.[7,10] Studies found that experience of discrimination or fear of being discriminated produce anxiety, depression, guilt, isolation, low self-esteem, disruption of family dynamics, physical and emotional violence, intensification of grief, and loss of social support, which in turn influence the PLHIV to accessing voluntary counseling and testing, HIV treatment, care and support services, low adherence to antiretroviral therapies, all of which have a great impact on public health.[8,11]

Discriminatory attitudes toward PLHIV do not exist only among the general public, several studies from developing and developed countries have indicated that the existence of high levels of discriminatory attitudes amongst health care workers (HCWs) also.[12–15] HCWs' discriminatory attitudes include providing differential treatment, refused of treatment, testing and disclosing HIV status without consent, giving verbal abuse/gossip, designating patients as HIV positive on charts or in wards, verbally harassing patients, avoiding and isolating HIV-positive patients, referring patients for HIV testing without counseling and using gloves during all interactions.[9,16]

Studies from different countries found that various factors affect discriminatory attitudes toward PLHIV amongst HCWs and that vary among countries.[8,13,17–19] The study on HIV/AIDS-related discrimination is important from both public health and human rights perspectives.[7] Therefore, understanding the magnitude and causes underlying HIV/AIDS-related discrimination amongst HCWs is necessary to develop anti-discrimination strategies and programs. However, recently, there has been no study of HIV/AIDS-related discrimination amongst HCWs in Aceh, Indonesia. In Banda Aceh, a small-scale research has been conducted by Harapan et al,[20] but that study did not represent the general situation in Aceh. In this context, this study was conducted to explore discriminatory attitudes towards PLHIV amongst HCWs in Aceh. Most of the described research was conducted in regions with high HIV prevalence; with this work we tried to understand discrimination dynamic in region with very low HIV prevalence.

2. Methods

2.1. Study design and participants recruitment

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. HCWs (doctors, nurses, midwifery, and support staff) were recruited from teaching hospital of those regencies. A total of 589 HCWs was interviewed face-to-face. All HCWs were asked to participate and there was no incentive was given to the participants. HCWs were selected purposively.

2.2. Procedure

The procedure used in this study was based on USAID recommendation.[21] Briefly, interviewers read a prepared script that provided an overview of the study aims, risks, and benefits and obtained an informed consent from the HCWs. Each informed consent form and its matching questionnaire were assigned a unique three-digit identifier. To protect confidentiality, these numbers were used in all analyses. Once informed consent was obtained, the interviewer conducted a structured interview.