

ORIGINAL ARTICLE

**'BETWEEN US AND THEM' - UNDERSTANDING STIGMA
AND STIGMATIZATION AMONG PEOPLE WITH HUMAN
IMMUNODEFICIENCY VIRUS (HIV) / ACQUIRED
IMMUNE DEFICIENCY SYNDROME (AIDS) IN
SUMATERA ISLAND, INDONESIA**

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Abstract

Objective: People living with HIV/AIDS have been the targets of stigma. For those with HIV/AIDS, stigma has created dire circumstances in the workplace, healthcare and in social settings. There is limited information on stigma among people living with HIV/AIDS West Sumatera in Sumatera Island Indonesia. The purpose of this research is to understand how stigma and stigmatisation among people living with HIV/AIDS in their daily lives. **Methods:** The study design was Charmaz's Constructivist Grounded Theory. Data was collected by semi-structured interviews, document reviews, and field notes and memos of 25 participants at Ahmad Muchtar Hospital Sumatera. Data analysis used Paillé. **Results:** The research found 4 categories: (1) denial, (2) low self-esteem, (3) rejection and isolation, and (4) fear. HIV AIDS stigma becomes another life obstacle of people who are already faced with social and economic obstacles. **Conclusions:** The findings provide some useful information to be incorporated into healthcare education directed toward enabling current and future providers of health services to help people with HIV/AIDS in Sumatera Island Indonesia. Stigma remains a clinical and social justice priority to provide ongoing support for people with HIV/AIDS, to develop and evaluate both general and more targeted anti-stigma interventions. Further researches are needed to understand the stigma toward people with HIV/AIDS in Sumatra Island from families' and communities' perspectives. *ASEAN Journal of Psychiatry, Vol. 18 (1): January – June 2017: XX XX.*

Keywords: Stigma, HIV/AIDS, Grounded theory, Sumatra Island, Indonesia

Introduction

According to the Joint United Nations Programme on HIV/AIDS [UNAIDS] (2016), there were approximately 36.7 million people worldwide living with HIV/AIDS at the end of

2015; and an estimated 2.1 million individuals worldwide became newly infected with HIV in 2015 [1]. HIV/AIDS is one of the world's most serious health and development challenges [2]. Forty six percent of people living with HIV were receiving antiretroviral

treatment in 2015 [3]. HIV/AIDS is one of the world's most serious health challenges globally. From 36.9 million people living with HIV globally, 17.1 million do not know they have the virus. Around 22 million of people with HIV/AIDS do not have access to HIV treatment, including 1.8 million children [4]. In addition, most of the people living with HIV do not have access to prevention, care, and treatment.

In the last 15 years, HIV/AIDS had become an epidemic in Indonesia. This epidemic is one of the fastest growing among HIV/AIDS in Asia. In Indonesia, a case of HIV/AIDS was first known in Bali province. The highest concentration areas of HIV/AIDS are in Papua, Jakarta, East Java, West Java, Bali and Riau and all are considered to be zones that need immediate attention[5]. According to The United Nations Children's Fund UNICEF Indonesia (2012), every 25 minutes one person is newly infected by HIV in Indonesia. The two provinces of Papua and West Papua, Jakarta and Bali lead in the rate of new HIV cases per 100,000 people, and Jakarta province has the highest number of new cases (4,012) in 2011 [6].

The word "stigma" in ancient Greek and Roman societies described marks that were tattooed or burned into the flesh of criminals or slaves, a visible testament to their marginal social status or deviance [7]. Erving Goffman defined stigma as an "attribute that is deeply discrediting and that reduces the bearer from a whole and usual person to a tainted, discounted one." A person's stigma "makes him different from others in the category of persons available for him to be and of a less desirable kind." Thus, the stigmatized are perceived as having a "spoiled identity" (p. 3) [8]. Ahmedani (2011) defines three specific levels of stigma: self, social, and professional. Self-stigma is stigma internalized by an individual, who results in low self-confidence and self-esteem that may lead to altered behaviour. Social of public stigma results from a society's endorsement of a particular stereotype, which leads to prejudice and discrimination against, and can influence a person to feel guilty and inadequate about his or her condition. The third level of stigma is the stigma held by healthcare professionals

[9]. Patients have reported labeling and marginalizing by health professionals [10].

HIV/AIDS-related stigma refers to prejudice, discrediting, and discrimination directed at people perceived to have HIV/AIDS, and the groups and communities with whom they are associated [11]. HIV/AIDS stigma is related to HIV- risk behaviour among gays [12]. It also extends to other groups such as ethnic minority women at risk for HIV/AIDS [13]. The consequences of HIV/AIDS stigma are to be a loss of income and livelihood, loss of marriage and childbearing options, poor care within the health sector, withdrawal of care giving in the home, loss of hope and feelings of worthlessness and loss of reputation [14]. It also creates restrictions on education, employment, housing and health care accesses. Stigma can drive a person to have preconceived ideas, behaviours, and or actions conducted by employers, healthcare providers, coworkers, family, friends, society, and government [15]. According to Savvakis, Alexias & Stratopoulou (2015), HIV/AIDS significantly influence the lived experiences of the individuals infected by HIV/AIDS, as well as their partners, family, friends and social relations [16]. The sense of social inferiority and potential devaluation has been connected with significant impacts on psychology and quality of life as: ambivalence, low self-esteem, decreased psychosocial functioning and disruption of erotic and sexual life [17, 18], depression, feeling of shame [19, 20].

In Indonesia, several studies show that HIV/AIDS stigma is a problem experienced by the patient, family, community, and healthcare professionals. According to UNICEF Indonesia (2012), fear, stigma and discrimination against people living with HIV still pose formidable barriers. In two Papua provinces, only 20.2 percent of young people in school and 15 percent of out-of-school young people had accepting attitudes towards people living with HIV. Also, sex remains a taboo subject that is not openly discussed with parents, teachers, and even with health providers. Legal restrictions make it difficult for unmarried young people to access sexual and reproductive health services. Other legal provisions criminalize the dissemination of information on sex education [21]. People

living with HIV/AIDS are stigmatized on multiple levels. The high stigma against people living with HIV/AIDS causes much discrimination in their work, health care treatment, education etc. [22]. Stigmatized people are usually considered bad. They are humiliated, avoided, discredited, and rejected. In addition, they are often detained by the police. Stigma against people with HIV/AIDS affects the community's acceptance. Label from the community makes people with HIV/AIDS find that they do not have places to share their feelings. People look at sufferers as people who need to be avoided. They believe that people with HIV/AIDS will transmit their disease to other healthy people. Also, people in society think that HIV/AIDS is a very fearful, contagious and lethal illness [23].

A research on stigma among with HIV/AIDS in Kalimantan Island showed that 72% of well-educated people do not accept people who have HIV/AIDS, and only 5% of respondents can accept the sufferers [24]. A study conducted in Papua Indonesia revealed that people living with HIV/AIDS experience stigma from various sources. This HIV/AIDS stigma has impacts on rejection to education and health services access [25]. In fact, in many cases health care providers do not treat their patients with dignity or respect. They also do not provide optimal protection and treatment for people with HIV/AIDS. Inability of healthcare providers to provide treatment for people with HIV/AIDS leads to stress, frustration and depression among patients [26].

The aim of this paper is to present the results of a qualitative constructivist grounded theory research that explored how people with HIV/AIDS in West Sumatera Indonesia perceive their illness and how they respond to stigmatization. Also, this research sought to understand the relationships between stigmatization and HIV/AIDS and how they affect access to treatment and their daily life. In addition, this research examined the role of community members in social life and practice of healthcare providers in healthcare settings.

Methods

The objective of the research was to explore stigma among people with HIV/AIDS in West Sumatera Indonesia. This research may be one of the few studies to theorize the experiences of stigma and HIV/AIDS among Indonesian adults using a constructivist grounded theory. The constructivist grounded theory research approach was introduced first by Kathy Charmaz (2006). Charmaz's grounded theory design is consistent with a constructivist epistemology and ontology by placing priority on the phenomena of study and seeing both data and analysis as created from shared experiences and relationships with participants and other sources [27]. It is a more objectivist approach, where the investigator's role is to discover the truth that lies within the object of investigation, diminishes "the power of a constructivist approach by treating experience as separate, fragmented and atomistic [17]. Data that are assumed to be objective facts and already exist in the world are, with an objectivist approach, to be discovered by the researcher to determine the theories they imply.

Setting and Participants

This research was conducted at RSUD Dr. Ahmad Muchtar Hospital in West Sumatera province Indonesia. Ethical approval was from the University of Andalas Indonesia West Sumatera. A total of 25 participants were recruited and all participants provided consent to participate. They were recruited by the researchers and only adults who self-identified themselves as Indonesian citizens, had the ability to read and write, were at least 18 years of age or older, and admitted that they had experienced HIV/AIDS and stigma, were included in the study. All participants provided consent to participate. Twenty to thirty participants are enough to ensure data saturation [27, 28]. Interviews with participants were conducted at the hospital and at the participants' home. During the 30-60 minute interviews, participants were asked a series of questions. No participant received any direct benefit from his or her participation in this research project.

Data collection

Semi-structured interviews were the primary method of data collection used with 25 participants on a one-to-one basis. Interviews are a common method for collecting data in qualitative research studies and are used to elicit information about what people do, think or believe about a particular topic [29]. Also, mute evidence or document review is a way of collecting data by reviewing existing documents. Documents or mute texts comprise a variety of written, visual, and physical material that 'document' human activity over time [30]. Along with interviews, memos and field notes, mute evidence was part of our data collection strategy and formed the triangulation of data that served to improve the probability that interpretations of the data will be found credible. Mute evidence collected was both hard copy and electronic, including nursing reports and logs, nurse performance ratings, meeting minutes (pre-and post-conferences), and other materials. In addition, field notes and memos were written during the interviews. Memo writing includes the interviewers' thoughts and interpretations about the interview, ideas about the emerging theory, and the research process including questions, gaps, as well as the analytic progress of the research. Memos are essentially a way to document thoughts and create a tangible paper trail that explains the researcher's thinking process throughout the research project. Written accounts provide insight into the meanings, perspectives, practices, and events not obtained in interviews. Field notes were written into a notebook after each interview to construct a context for making sense of the data later in analysis. They allowed us to collect information on important nonverbal communication, and to make general observations of participants' sights, sounds, interpretations, and gestures.

Data analysis

In this study, twenty-five semi-structured interviews with patients living with HIV/AIDS were conducted and used as the primary source of data for analysis. Paillé's (1994) method of data analysis was used to organize and manage data [31]. Paillé adapted the basic

principles of Charmaz's constructivist grounded theory and displayed the data analysis in a sequential. Paillé's (1994) data analysis can be divided into three stages: codification and categorization (initial coding), linking categories and integration (intermediate phase), conceptualization and theorization (final development) [31]. Although Paillé's data analysis steps are presented as separate entities, the researcher must not view them as mutually exclusive, nor assume that the progression between each step is linear. It is a system process of analysis. This analytical process, which included the codification of interviews and gradual categorization and integration of emergent concepts, produced four mutually exclusive categories: (1) denial; (2) low self-esteem; (3) rejection/isolation; and (4) fear. Each of them will be presented in results section.

Ethical considerations

Ethics approval for this study was obtained from the Universitas Andalas Research Ethics Board West Sumatera Indonesia and follows the Tri-Council Policy Statement on ethical conduct for research involving humans. As such, we ensured that all participants in the study were able to give an informed consent to participate to the study and were informed that they could withdraw from the study at any time without any prejudice. Prior to each interview, participants were required to read and sign two copies of a consent form and were given one of the copies. Confidentiality and data protection were also ensured throughout the research process. Each participant was attributed a random, alphanumeric code in order to make it impossible for anyone to link a transcription to a particular participant (participant 1, 2 etc). All digitally recorded interviews were downloaded into a private password-protected computer. All confidential data and materials were kept locked at the Universitas Andalas West Sumatera Indonesia.

Results

Category I: Denial

Participants who are diagnosed having HIV/AIDS refuse or deny their illness and

their conditions. As the study results indicated that participants were denial to their disease:

I just shocked.... Why? I cannot accept this disease.... Why.... I should have it? I am a home person. I am not the people who often go out from my home at night. I never do exchange my partner. I was just stress....I did not know what I had to do? Still, I cannot accept it ... I do not believe every time a wake in the morning. I still do not believe so. Why I get this disease? Why others cannot have this disease? (Participant 11).

Other participants do not believe and accept their condition. For example a participant mentioned:

Actually, I was so afraid and did not receive it ... my condition. I cannot believe... why can have this disease? Yes, I do not accept. Every time, I sit alone, I always ask myself... why is this kind of disease with me? (Participant 5).

Category 2: Low Self-Esteem

Low self-esteem (patient)

The results of this study showed that patient with HIV/AIDS and their families have a problem related to self-esteem. A participant suffers indicates that he has low self-esteem because of HIV/AIDS:

I do not know what should I do else? I am ashamed of myself. I am in low self-esteem... I really feel shy... And, I'm afraid to tell my family about this. What will be their reaction when they find out or know? What will they say? I have this disease (crying) (Participant 13).

Ashamed and Low Self-Esteem (family members)

Some participants said that their family members are ashamed and they also have low self-esteem. Two participants indicate this issue:

In the community, I was difficult to adapt. Moreover, if I get together with them, I

feel that I have limitations to adapt in my family and society orI am with them because of my illness....I feel shy. I do not feel confident with them. I feel better to be quiet and silent in my room than join with them (Participant 7).

What they said about this ... about my illness, an infectious and dangerous disease. Later on, people in society will know of my illness. We, all family members will feel shy. What would we explain to the people about this disease? Do not let them know [community members]; let us know... only families know about it (Participant 11).

Category 3: Isolation and rejection

Self-Isolation (patient)

Self-isolation was also experienced by participants. Some said that they isolate themselves. They do want to get along or interact with the other people in community. The following participants indicate this self-isolation:

Mom [interviewer].... Therefore, I like to be just staying at home. I am lazy to leave home and to go outside. I prefer to be alone and I do not want to hang out at the community surrounding. I do not believe myself to hang out with them. I am a sick person ... I am a sick, mom (Participant 16).

I am embarrassed [interviewer].... I graduated IAIN [an Islamic university], a religious school.... Moreover, with the community where I live... I often just stay myself in the house. If I want to go out, I will do it in the evenings only. I was discomfort and insecure. I prefer be alone with myself And, I did not want anyone to know my illness (Participant 13).

Family Isolation and rejection

Isolation also conducted by the family toward participants. Some participants said that they were expelled, rejected and shunned by their families:

My family did not accept me. I was isolated by families and put away from home by my mother. I was told by them to stay in the *cabins* [a small house away from home] where there is no light there. I stayed in the *cabins* until now. None of my families want to close and come to look me. I'm so sad mom [interviewer] (Participant 18).

A participant also indicates that her brothers and sisters want him to go away from home and stay in a remote house:

My brothers and sisters are away from me. My sister drove and pushed me away from my house. She told me to stay at my grandma's small house in the remote village, which it was never inhabited. Until now, I live there.... I do not live in my own house. I just stay away ... "I'm afraid you'll spread your illness, you just stay in the grandmas' remote house," she said....There is no light there [remote house] (Participant 25).

Other participants revealed that she has been told to stay outside home because family members are fear because of her infectious disease. A participant indicates that the reason he is isolated by his family because of having HIV/AIDS.

Yeah, it is true. I feel sosad. I was ordered by my family to stay out of my home. Yes, it is very sad for me because I was told to stay away from home. They [family members] are fear of my HIV/AIDS. It is a contagious illness. Therefore, I am living away from my home (Participant 17).

Social/Community Isolation and Avoidance

Study participants are also isolated by people in their community. A participant indicates that he was shunned and avoided by other people in her village. People are afraid of deadly HIV/AIDS disease:

Sad ... People are away from me. I was just avoided in the village. They are scared because of this deadly disease. They say that there is no cure for this disease and you are better to die... they said that. They

do not want to close to me. The community is like that... I was eschewed from the society because I have this contagious illness. Nobody cares. From thatIt is stigma... very sad, nobody wants to care and come to see me...they avoid me (Participant 1).

I was just avoided, mom.... A person who sold beverages did not want to make me a drink. "You have that the disease (HIV/AIDS), right? I am scared of your disease which will stick in my glass, he said. Later, other people who come here will have the disease from you". Therefore, we were shunned. They [other people] do not want to shake hands with us. They feel disgusted to see us. I am stress because I have a little boy. Where will I bring my son, mom [interviewer] (Participant 15).

Isolation conducted by health professionals

Research participants indicate that they were isolated by healthcare professionals. In the hospital, they are set aside and placed in isolation room. The clothes were burned or disposed immediately:

At that time, the nurses... yes mom [interviewer], I knew that they were afraid of contracting with my disease. At that time, I was ever ... I was cared for in a ward [hospital]. There, I get treated badly, mom [interviewer]. The nurse who wasstanding next to me told another nurse: "all clothes used by patients should be discarded or burned, ok... yes, I am in bed, my bed should be placed there and here [exchange frequently]. I did not have the same treatment with the other women with different illness who are hospitalized with me. I was entered and put in the room that has never been used. It was like an isolation room. I was placed and isolated there.....The room was not mopped.... it was not swept by cleaning service (Participant 12).

Category 4: Fear

People's fear of the disease

Some participants said that other people feel fear of HIV/AIDS. Others are afraid of contracting with HIV/AIDS:

The first, my family called and blamed me, "from where did you get this illness? "Do not live in this house, we are afraid of contagious illness", he said. "Just stay at the shack and away from us". Yes, I was told by them to stay away from home. Until now, I am still living away from home (Participant 7).

Yes, they are afraid of my contagious disease. Many of my family told me to go abroad, away from my family. In the near future, this disease will be as an infectious to the others. They were afraid. "Just go out from this house", they said (Participant 14).

Patients' fear toward others

Study participants also indicate that they are afraid to other people. They are afraid that other people will be contracted by their HIV/AIDS illness:

I am so afraid because this disease can affect other people. What others will say? "We are afraid of your disease". Hence, I am afraid that this illness will infect people in my house and family. I did get the disease..... And other people will have it as well. I am afraid other people in my home and village will be contracting with my HIV/AIDS disease (Participant 12).

Discussion

Study results in West Sumatera Indonesia indicated the ways people with HIV/AIDS encounter stigmatization in multiple settings, whether in a personal interaction, or within broader contexts such as family, community and the healthcare system. HIV/AIDS is also a threat to individuals, families and communities because of their impact. Many people also still believe that HIV/AIDS is a bad, lethal, and sinful disease. A similar study also indicates that HIV/AIDS stigma was found to exert a direct negative impact on the health of those who have the disease [32, 33]. The study results also showed that the patients with

HIV/AIDS are denial of their condition related to HIV/AIDS disease. Other words, they refuse to admit the truth or reality about their conditions. In addition, family members and society deny the condition of people with HIV/AIDS. This study indicates that there is a denial or rejection among people diagnosed with HIV/AIDS related to their illness in community setting. Other words, people with HIV/AIDS cannot believe that they were exposed to HIV/AIDS. Similar to this result, there had been a rejection and denial of the diagnosis of African-American women living with HIV and discomfort to express that they suffer from HIV/AIDS [34]. Also, a study in Canada indicates that due to denial, many people from immigrant communities may be discouraged from taking advantage of testing, early care and treatment of HIV/AIDS [35]. Also, Furthermore, in Toronto Canada, Caribbean and African communities are located in specific geographic areas, creating a sense that 'everyone knows everyone,' and that news about HIV illness will travel to their home countries. A perceived lack of personal privacy may contribute to the denial of HIV and the fear of disclosure [36]. According to a study result, denial has engendered serious and often tragic consequences, denying people living with HIV/AIDS access to treatments, services and support, as well as making it hard for prevention work to take place [37].

The study findings also showed that patients with HIV/AIDS and their family have problem related to self-esteem or low self-esteem. People with HIV/AIDS experience low self-esteem because of stigma conducted by the people around them. According to a study, low self-esteem is related to the concept of oneself and influenced by the way he/she is seen by others [38]. Similar to this study result, people with HIV/AIDS experienced a low self-esteem [39]. Also, HIV/AIDS sufferers have lower self-esteem when compared to individuals living with other different chronic illnesses [40]. In India, a study that evaluated the self-esteem and quality of life of people living with HIV/AIDS indicates that a significant positive correlation between low self-esteem and of quality of life of people living with HIV/AIDS [41]. The sense of social inferiority and potential devaluation has been connected with significant impacts on low self-esteem [18].

In addition, among HIV-positive men, there was a positive relationship between self-esteem and disclosure to receptive anal sex partners [42].

Study results revealed that HIV/AIDS stigmatization appeared in a variety of contexts. HIV/AIDS is seen as bringing shame upon the family and community. People with HIV/AIDS in Sumatera Indonesia experienced rejection and isolation from their family, community, and health professionals. According to a study, central among those are the family and local community, employment and the workplace, and the health care system [37]. Family's isolation by means patients are kept away to stay outside away from home. HIV/AIDS is associated with stigma, ostracism, repression and discrimination, as individuals affected (or believed to be affected) by HIV [37]. Similarly, a study of Dutch people living with HIV found that stigma in family settings - in particular, avoidance, exaggerated kindness and being told to conceal one's status - actively contributed to psychological distress [43]. Also, Furthermore, a study in Cambodia indicates that family members reject seropositive members not only because of the stigma associated with HIV/AIDS, but also because of the connotations of homosexuality, drug use and promiscuity that HIV/AIDS carried [44]. Stigma also take forms within community settings. Stigma experienced by people living with HIV/AIDS is shunned, rejected from the community. They are not allowed to use public transportation [45]. People living with HIV/AIDS are also considered repulsive and fired in their workplace. Stigma is perceived as a major limiting factor in primary and secondary HIV/AIDS prevention and care, and has interfered with voluntary testing and counseling, and access to care and treatments [46].

Stigmatizing against people with HIV/AIDS is also common in healthcare settings. Healthcare providers have some negative attitudes and beliefs toward patients with HIV, and that they fear becoming HIV infected while providing health services to such patients. Healthcare professionals feel unsafe in providing services to HIV/AIDS patients;

some amount of discrimination is likely to remain. The study results revealed that participants experienced isolation is also conducted by healthcare providers. A similar study indicates that patients feel stigmatized and despised by health teams suffering from HIV/AIDS [47]. Furthermore, the impact is a lot of patients who does not get treatment well. A study finds that some patients are reluctant to come to the hospital. Educational background of health providers influences stigma and discrimination against people with HIV/AIDS [47]. Treatment is greatly influenced by the regularity of the patient came to the hospital. Patients' attendance is influenced by healthcare team who is against patients with HIV/AIDS and their families. Healthcare professionals can assist someone infected or affected by HIV, and provide life-saving information on how to prevent it. However, sometimes healthcare providers are not confidential, contains the judgment about a person's HIV status, behaviour, sexual orientation or gender identity. In some Asian countries, 34% of respondents reported breaches of confidentiality by health workers [48]. This situation can prevent people with HIV/AIDS from being honest to healthcare workers when they seek medical help and fear discrimination [49]. People with HIV may suffer the stigma from their co-workers and employers, such as social isolation and ridicule, or experience discriminatory practices, such as termination or refusal of employment [50]. Specifically, a study revealed that nurses conducted stigma against them. Nurses do not provide nursing care to the patient with a maximum of HIV/AIDS and more frequent rejection of them [26].

Study participants indicated that people living with HIV/AIDS are afraid. They are afraid of what it was, afraid of the unknown, and afraid of what it could be possibly due to them. Study participants were afraid of their disease because HIV/AIDS was always associated with fear associated with death. A study finds that self-stigma and fear of a negative community reaction can hinder efforts to address the HIV epidemic by continuing the wall of silence and shame surrounding the virus and after excommunicated; the next stage is the patient experienced the fear about

the disease [51]. Fear of a negative community reaction can hinder efforts to address the HIV epidemic by continuing the wall of silence and shame surrounding the virus. Fear related to stigmatization conducted by society may mean that a person's HIV/HIV status is not revealed outside their home. People who are already marginalized and rejected may fear negative or violent reactions from other people. A study finds that fears of patients with HIV/AIDS have been reported by sex workers and injecting drug users [52]. HIV/AIDS is always associated with behaviour that is transmitted through sex, which is a taboo subject in Indonesian cultures. It is the result of personal irresponsibility or moral fault (such as infidelity) that deserves to be punished. These issues make people living with HIV/AIDS are fear. Fear of rejection and stigmatization within their home and community may prevent them revealing their sero status to family members [53]. A study result found that 35% of participants feared losing family and friends if they disclosed their HIV status [54]. In Jamaica, people living with HIV/AIDS become suicidal when they first receive their diagnosis and self-destructive tendencies are often rooted in the fear of isolation and discrimination that will come as a result of having others find out about the disease [55]. In addition, study results indicated that the fear surrounding the emerging HIV/AIDS persists. People are fearful of those infected with HIV due to fear of contagion. Some participants felt that other people are afraid of contracting HIV/AIDS. Many factors contribute to HIV/AIDS stigma, and the fact that people are afraid of contracting HIV. Excessive fear of society is related with the lack of public knowledge about HIV/AIDS. According to a study, stigma against people living with HIV/AIDS is a reflection of the fear associated with the deadly and contagious disease [11]. A study also indicates that, 38% of respondents feel they are being judged by others and nearly half of respondents had encountered someone who was afraid to have casual contact with them because of their HIV/AIDS. In addition, 25% reported that someone would not share food or a drink because their HIV/ AIDS and 24% reported that someone would not kiss them due to their HIV/AIDS [54].

Conclusion

This study in West Sumatera Indonesia has shown that HIV/AIDS stigma was found to have a negative impact on the health of those who have the disease. The price societies pay for HIV/AIDS stigmatization, its impact upon family and community, healthcare systems, labor and productivity. The findings provide some useful information to be incorporated into healthcare education directed toward enabling current and future providers of health services to help people with HIV/AIDS in Sumatera Island Indonesia. Stigma remains a clinical and social justice priority to provide ongoing support for people with HIV/AIDS, to develop and evaluate both general and more targeted anti-stigma interventions. Efforts to understand the problems wrought by stigma and to develop programs that will diminish its impact will greatly advance the goals of people with HIV/AIDS. For the public, education and information resources regarding HIV/AIDS are fundamental to prevent HIV/AIDS stigma. Healthcare professionals and students are expected to have expertise in providing a support group for people with HIV/AIDS and socialization to provide information to the public about HIV/AIDS. It is vital to challenge society's myths, stereotypes and judgments and HIV/AIDS stigma. In addition, efforts should be made to address not only risks of HIV/AIDS infection but also their vulnerability to the social stigma associated with HIV/AIDS. This stigma needs to be given priority in healthcare education to improve students' knowledge and sensitivity-related stigma against people with HIV/AIDS. Stigma subjects associated with HIV/AIDS need to be included in health education curriculum.

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