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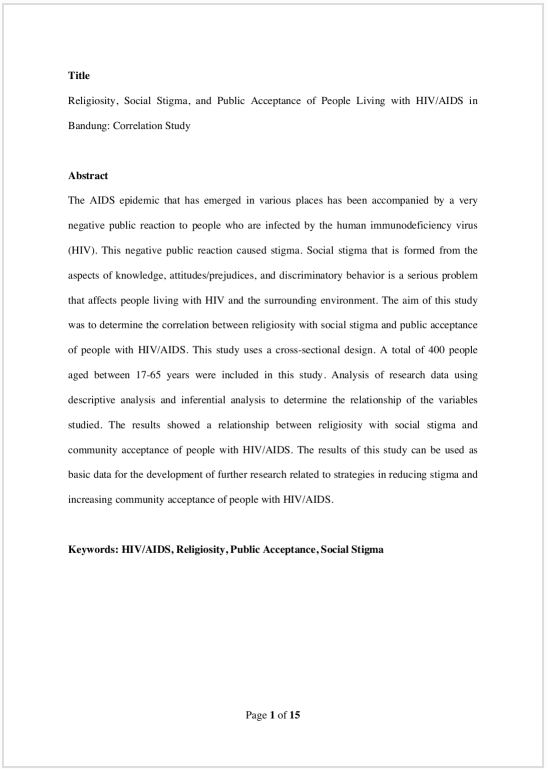

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Religiosity, Social Stigma, and Public Acceptance of People Living with HIV/AIDS in Bandung: Correlation Study

Abstract

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Keywords: HIV/AIDS, Religiosity, Public Acceptance, Social Stigma

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INTRODUCTION

Human immunodeficiency virus (HIV) infection cases in Indonesia are increasing every year. The number of HIV cases from 2016 to 2017 has increased by 17.1%. In 2016, the number of cases reported was 41,250, increasing to 48,300 cases at the end of December 2017. Meanwhile, from October to December 2017 the number of people infected with HIV was reported to have reached 14,640 people (Kementerian Kesehatan RI, 2017).

West Java Province occupies the fourth position after DKI Jakarta, East Java, and Papua as the provinces with the highest number of HIV infections in Indonesia, which is 28,964 cases (Kementerian Kesehatan RI, 2017). Meanwhile, Bandung is the city with the highest HIV cases compared to other cities in West Java.

The AIDS epidemic occurs accompanied by negative reactions or social stigma against people with HIV infection. Social stigma that is formed from the aspects of knowledge (labeling), attitudes (prejudice), and behavior (discrimination) (Thornicroft, Rose, Kassam, & Sartorius, 2007) is a serious problem. So that the stigma that occurs to people living with HIV/AIDS (PLWHA) can be a form of excessive prejudice, negative attitudes, and bad treatment directly from the people around them.

The stigma against HIV disease threatens the physical and psychological well-being of PLWHA. This also impacts on the ability and willingness of the community to provide treatment and care for PLHIV and the prevention of further HIV transmission. Stigma is also a major barrier to accessing prevention, care and care services (Bond, Chase, & Aggleton, 2002; Nyblade, Stangl, Weiss, & Ashburn, 2009).

Skinner and Mfecane (2004) also revealed that stigma causes reluctance of HIV sufferers not to disclose their HIV positive status, thereby delaying access to treatment. Stigma can damage a person's identity and capacity to cope with the disease. Fear of discrimination limits the possibility of disclosing status and discourages potential

endorsements such as family and friends. With the existence of stigma, people who are infected by HIV and people who are thought to be infected with HIV experience social exclusion, discrimination, and even violence. Zierler et.al (2000) in their study, reported that people with HIV positive status experienced acts of physical violence from the time they were diagnosed..

The impact of the social stigma that arises from the community makes it difficult for PLWHA to reach broadly into the community, disrupts community functions, and makes HIV prevention and treatment difficult. This HIV-related stigma is considered a sustainable and destructive problem in every aspect of community, social and economic life. The social stigma against PLWHA not only makes life more difficult, but is related to the development of the HIV/AIDS epidemic at large. This situation occurs as a result of systematic stigma emerging from households, communities, work environments, health services and the government.

When a disease is stigmatized, various ways and approaches must be taken to suppress the development of stigmatization of the disease. Although there is a lot of stigma that appears against HIV from a group of people who have a good level of education, economy, and religious knowledge. A disease that has been stigmatized will complicate the acceptance of the sufferer.

Religion and spirituality in relation to the life of a person with HIV are expected to play a big role. Relationship between religiosity and reduced risk of disease linking religious values and beliefs to factors of protection against disease and survival (Aldridge, 2000; Matthews, Berrios, Darnell, & Calhoun, 2006). People living with HIV/AIDS combine religiosity as a way to solve problems, help reorganize lives, and get meaning and purpose in life. Religious experiences help them to interpret the problems and situations that arise due to HIV disease, where the situations they encounter are often situations that are considered

unfavorable for them such as incidents of stigmatization. (Siegel & Schrimshaw, 2002).

However, it is different from the research results of Muturi and An (2010) who found that people who have high religiosity show a high stigma against people with HIV / AIDS. This high stigma is associated with the assumption that HIV/AIDS is a curse and punishment from God. Verbal responses to open-ended questions also reveal that widespread prejudice comes from a religious point of view. This shows that religiosity is a significant factor in determining the high stigma of people living with HIV/AIDS.

Thus, it is important to examine the relationship between perceived religiosity by society and the social stigma that may occur in society towards PLWHA. So that it can also be seen the relationship between the level of religiosity with public acceptance of PLWHA. The purpose of this study is to determine the correlation between religiosity with social stigma and public acceptance of people living with HIV/AIDS.

METHODS

Participant and Procedure

The research design used was cross-sectional. This design is used to identify whether there is a relationship between religiosity, social stigma, and public acceptance of people with HIV / AIDS. The respondents involved were 400 people living in the city of Bandung. Respondents aged between 17 years to 65 years and recorded as resident who already have a National Identity Card. The sampling technique used purposive sampling which was carried out using an online forms.

The research instrument used was the Indonesian HIV/AIDS Social Stigma (I-HSS) Scale. (Wilandika & Sari, 2020). The I-HSS scale is used to measure the social stigma that occurs in society. The I-HSS scale measures social stigma based on three stigma domains such as neglect/labeling, prejudice, and discrimination. This scale has proven validity and reliability values. Meanwhile, the measurement of the aspect of public acceptance of people with HIV/AIDS uses the scale of public acceptance of people with HIV/AIDS. The public acceptance scale assesses aspects of treatment, support, cooperation and public trust. In addition, this study also uses The Centrality of Religiosity Scale (CRS) (Huber & Huber, 2012) to know the level of someone's religiosity.

The correlation test used to answer the research hypothesis used the non-parametric test, the Spearman Rank, both for the correlation test of the religiosity variable with social stigma, or the correlation test for the variable of religiosity with public acceptance. This test was carried out because one of the variables tested with an interval scale was not normally distributed. The study was approved by the Health Research Ethics Committee at Sekolah Tinggi Ilmu Kesehatan 'Aisyiyah Bandung Nomor 19/KEP.02/STIKes-AB/VII/2019.

FINDINGS AND DISCUSSION

Findings

Sample description

The characteristics of the community members who participated in this research can be seen in Table 1. below.

Table 1. Sociodemographic Characteristics

	Frequency (*f*)	Percentage (%)
Gender		
Male	134	33.5
Female	266	66.5
Age (in years)		
17-25	142	35.5
26-45	229	57.2
46-65	27	6.8

	Frequency (*f*)	Percentage (%)
> 65	2	0,5
Religion		
Muslim	367	91,8
Catholic	10	2,5
Protestant	12	3,0
Buddhist	4	1,0
Hindu	3	0,7
Konghuchu	4	1,0
Marital Status		
Married	270	67,5
Never married	123	30,7
Divorced/separated/widowed	7	1,8
Employment		
Civil servants	60	15,0
Private officers	94	23,5
Housewife	24	16,5
Entrepreneur	28	7,0
Nurse	32	8,0
Midwife	3	0,8
Lecturer	31	7,8
Teacher	17	4,3
Factory workers	4	1,0
Frelancer	5	1,3
College student	66	16,5
student	26	6,5
Unemployment	10	2,5
Exposure to HIV Information		
Yes	380	95,0
No	20	5,0

The residents in this study are all people who live in Bandung City, aged between 17 -> 65 years, where most of the people involved are adults (57.2%). Most of the community members are female (66.5%) and almost all are Muslim (91.8%). In addition, most of the community members are married (67.5%). A small proportion of the community members involved in this study worked as private employees (23.5%). Almost all members of the community who participated in this study said they had been exposed to information about HIV (95%) (Table 1).

Tabel 2. Distribution of Average Score of Religiosity, Social Stigma, and Public Acceptance of Citizens

	Average Score (*mean* ± SD)	*f*	%
Religiosity	**38.4 ± 5.3**		
Religious		386	96.5
Less religious		14	3.5
Social Stigma	**80.1 ± 24.0**		
High		235	58.7
Low		165	41.3
Public Acceotance	**35.1 ± 10.2**		
Good		181	45.3
Not good		219	54.7

Tabel 3. Spearman Correlation Coeficient Rho and P-Value for Correlation between Religiosity with Social Stigma and Public Acceptance (n = 400)

	Religiosity	
	Correlation coefficient	*P-value*
Social Stigma	*r* = -.325	.001
Public Acceptance	*r* = .506	.001

Based on the above results, the results of the Spearman test between the variables of religiosity and social stigma, obtained a correlation coefficient *(r)* = -.325 and p value = .001. The results of this test found that there was a significant relationship between religiosity and stigma. The relationship between religiosity and social stigma shows a moderate relationship and a negative pattern. This means that the higher the religiosity, the higher the social stigma of the community.

Meanwhile, in the correlation test between religiosity and public acceptance, the correlation coefficient (r) = .506 and p value = .001. The results of statistical tests showed that there was a significant relationship between religiosity and public acceptance. The relationship between religiosity and acceptance shows a moderate and positive pattern. This means that the higher the religiosity, the higher public acceptance.

Discussion

Community Religiosity

The people of Bandung City are dynamic societies, developing along with the changing times. Various cultures mingle with each other and interact with the citizens of the city of Bandung. The variety of cultures brought by newcomers to Bandung City is also a distinctive color that makes Bandung City more attractive. Likewise, the various religions practiced by the citizens of the city of Bandung make the atmosphere of the city of Bandung more lively. Even though the majority of residents embrace Islam, other religions can still develop and carry out their worship peacefully.

Religion is a belief or faith that is held firmly by its adherents. Religion is also a system and rituals of worship that regulate individual relationships with God Almighty. Religion is also able to move someone to behave and act. The indicator of someone having a strong religion is assessed by the level of piety or religiosity. A society that has a good level of religiosity has an impact on the development of that society in a better direction.

The results of this study indicate that almost all residents of Bandung City have a good level of religion or are in the religious category (96.5%). Even though in this study, the majority of people involved are Muslim (91.8%), this does not change the fact that in general the citizens of Bandung with various religions involved in this study are religious.

Religiosity is multidimensional. Religiosity has five dimensions, namely religious belief, religious practice, experience of appreciation, consequential, and observance of worship. (Hassan, 2005). Religiosity is not only the activity which is manifested in the activities visible to the eye, but the activities that are not visible and must be characterized as personal or can only be felt in one's heart. In other words, religiosity does not only appear in the form of rituals and physical worship but there are many invisible forms of worship that are related to belief and obedience to God Almighty.

Religiosity is also closely related to one's views, perceptions, interpretations and behavior of a case. As stated by Hallahmi (2014) religion aims to measure a person's religious thoughts and their meaning. In psychological terms it refers to hypotheses, explanations, religious ideas and actions. Religiosity encompasses various human activities in various fields of life, be it the social, economic, and even health fields. Religiosity has a dominant impact on changes in health behavior. People with citizens who have a high level of religiosity tend to be more careful in responding to various problems or activities that are prohibited by their religion. So that the various problems faced or that arise in the midst of the community will be

able to be faced by relying on their religious strength. In other words, various worldly problems can be resolved by placing religion as a reference or reference for solving these problems.

Social Stigma and Public Acceptance of People Living with HIV/AIDS

The HIV infection epidemic, raises health and social problems that are difficult to treat. This problem is the stigma of people living with HIV/AIDS (PLWHA). Goffman (2009) say that the term stigma comes from Greek. Stigma is a term that refers to signs from the body to reveal something unusual or not good as a marker of a person's moral status. Like a sign of an incision scar or a burn on the body, it is identical as a sign of a slave or a criminal or even someone with deviant behavior in the midst of society. So that stigma is interpreted as an attribute that greatly discredits someone so that it becomes tarnished or dirty.

Initially, HIV/AIDS, which mostly occurs in perpetrators of unhealthy sexual relations, has become a marker for society to think that HIV/AIDS is something dirty. People who are exposed to this information, the longer they will believe and be convinced of this assumption. This is called stigmatization. As stated Goffman (2009) that the stigmatization of society occurs on the basis of so-called "differences" or "deviations," and results in a "bad identity".

Meanwhile, Thornicroft et al. (2007) stated that stigma is an act of giving social labels or signs that give rise to negative attitudes and aim to discredit someone. In addition, stigma is also defined as a negative perception that is used by a person or group in perceiving a different situation in a negative sense and then it will be used as a norm for a person or group. Stigma is closely related to neglect, prejudice and discrimination.

The results of study on social stigma and public acceptance of PLWHA among the citizens of Bandung City showed that the social stigma of HIV was mostly high (58.7%) with a mean score of 80.1 ± 24.0. Meanwhile, the acceptance of community members to PLWHA is lower. Most of the community members do not accept the presence of PLWHA in the midst of their environment (54.7%). The stigma of HIV/AIDS which is measured in Bandung City residents is seen from three aspects of the problem, namely the problem of knowledge (neglect/labeling, the problem of negative attitudes (prejudice), and the problem of rejection behavior (discrimination).

Knowledge problems that give rise to stigma in PLWHA are neglect or labeling. Ignoring or labeling is someone's action in ignoring people with HIV disease and giving a negative label. This action occurs on the basis of the person's knowledge of HIV. HIV/AIDS

infection which is considered to be a disorder occurs due to the wrong conception of knowledge and is misunderstood by most people. This will broaden and assume that people with HIV/AIDS infection are something different. This attitude, if believed by the majority of the community, will lead to labeling and stereotyping of groups of people with HIV/AIDS.

This misconception of knowledge arises from incorrect beliefs about the transmission of HIV infection. Most people understand that HIV is transmitted through unsafe sexual relations and sharing needles with drug users. However, not many people know how HIV infection is transmitted and not many people also know that HIV infection is not easily transmitted. This is supported by Herek, Capitanio, and Widaman (2002) that the stigma of HIV occurs because of wrong beliefs about the disease. This HIV stigma is also strengthened by the emergence of negative feelings towards HIV/AIDS sufferers, discomfort and avoidance, and the wrong conception of knowledge related to HIV transmission.

In addition, the understanding that is widely developed in society is that HIV/AIDS sufferers come from groups that are considered socially deviant, such as commercial sex workers, transgender women, men who have sex with men (MSM), and other abnormal behaviors. This gives rise to a broad judgment from society. The majority of people think that PLWHA deserves to be infected with HIV as a reward for their deviant actions. All of this arises as a result of inaccurate information about HIV/ IDS.

Prejudice which is a problem of negative attitudes towards PLWHA is a burden that can affect the psychosocial status of PLWHA and will develop into discriminating behavior towards PLWHA. Nelson (2002), expressing prejudice is believed to have an important contribution to disparities in health services for PLWHA. Meanwhile, Stuber, Meyer, and Link (2008) said that experiences of prejudice include exposure to negative attitudes, interpersonal discrimination, unfair treatment and violence experienced by a group of people who are considered different.

Prejudice can be defined as a negative perception that develops from a person to someone with HIV disease. Prejudice against PLWHA in various areas is characterized by negative emotions and feelings. Prejudice is higher in areas with the most HIV epidemics. This HIV-related prejudice will raise behavioral problems, namely discrimination against PLWHA and have an impact on more serious health problems (Parker, 2012).

Meanwhile, discrimination which includes behavioral problems is the act or behavior of a person in discriminating against HIV disease sufferers at every possible opportunity. Discrimination appears as a behavioral response due to stereotypes and excessive prejudice in

groups that are considered socially different by the majority group. There are many incidents of discrimination against PLWHA, both by the general public and by health workers.

The stigma of people living with HIV/AIDS is indeed a social problem, however, this stigma affects the health problems of HIV sufferers and the overall treatment of HIV infection. The stigma against HIV has the impact of changing the life habits of PLWHA and reducing their health status. Several studies have revealed various cases of stigma affecting health practices (Kurien et al., 2007; Li et al., 2007).

The stigma against HIV affects PLWHA's access to care facilities. Stigmatized PLWHA will be reluctant to seek treatment for fear of confronting society. Moreover, the unfriendly attitude of health workers and sometimes rejecting HIV care makes it an unpleasant experience for PLWHA. This fear and feeling of discrimination caused PLWHA to stop the treatment process. Meanwhile, discontinuation of antiretoviral therapy experienced by PLWHA will increase the potential for further transmission (Giordano et al., 2007; Quinn et al., 2000).

In addition, stigma is a complex problem and a major obstacle in the complete response to HIV / AIDS. If not controlled, the stigma that appears as a social response to rejection of HIV / AIDS infection can have a wide impact on the deterioration of the quality of health care for HIV sufferers and the prevention of HIV infection. However, Mahajan et al. (2008) stated that efforts to reduce stigma against PLWHA are on average at the lowest priority. This is because the characteristics of stigma problems are very complex, involving a number of fields and various elements. However, if efforts to reduce the stigma are not optimal, it can hamper the effectiveness of combating HIV/AIDS infection.

Relation of Religiosity, Social Stigma and Public Acceptance of PLWHA

The assumption regarding the link between HIV and immoral behavior arises from a religious perspective. The assumption that HIV infection is a consequence of committed sins still appears in society. Even in some societies, religious and moral values make people think that HIV infection is the result of moral wrongdoing (such as promiscuity or deviant sex) and deserves punishment. This shows that there are times when a high level of religiosity can lead to high stigmatization of HIV infection as well.

When people make religious attributes based on the assumption of sinful and immoral behavior, the stigma on HIV becomes higher which causes public acceptance of PLWHA to decrease. Such stigma based on religiosity would not only discredit PLWHA, but justify their suffering in the name of "punishment," or "curse."

However, on the other hand, the involvement of religiosity in the health sector cannot be denied. The relationship of religiosity with HIV disease is also very close. Religious activities (such as prayer, spiritual studies, and reading religious literature) were found to be significantly associated with immunity status in patients with HIV as indicated by an increase in CD4 + counts in the body (Woods et al., 1999). Likewise, religiosity with social stigma and public acceptance of HIV have significant links.

The role of religiosity in relation to the life of someone who has a serious illness is quite large. Religiosity has an impact on reducing the risk of illness that a person may suffer. There are even studies that reveal that people diagnosed with HIV experience an increase in spirituality and religion (Coleman & Holzemer, 1999). Ironson et al. (2006) stated that high spirituality results in decreased cortisol levels, thus reducing levels of depression and hopelessness. In addition, it also causes smoking habits that tend to decline and an increase in the quality of life is better.

The results of the research on the relationship between religiosity and social stigma among PLWHA showed a value of p = .001 and r = -.325, which means that there is a significant relationship between religiosity and social stigma. Meanwhile, if seen from the relationship between religiosity and public acceptance of PLWHA, it shows a value of p = .001 and r = .506, which means that there is a significant relationship between religiosity and public acceptance. Even though the assessment shows that the level of community religiosity is almost entirely religious (96.5%). Meanwhile, the social stigma of society is mostly high (58.7%), but the public acceptance is mostly low (54.7%).

The results of this study indicate the opposite pattern of the effect of religiosity on stigma. The higher the religiosity, the higher the social stigma against PLWHA. The results of this study are similar to research by Muturi and An (2010), where religiosity and stigma have a significant relationship, but have a negative direction. People with high religiosity show a much higher stigma. This high stigma is associated with curses and punishment from God for people with HIV/AIDS. In addition, there was also a deep prejudice against HIV/AIDS from a religious perspective.

CONCLUSION

The social stigma and public acceptance of PLWHA among the citizens of Bandung City shows that the social stigma of community members is high with low public acceptance in accepting PLWHA in their environment. Although religiosity with social stigma and public acceptance of HIV have a significant relationship. This stigma is a complex problem and is a major obstacle in the complete response to HIV/AIDS. If not controlled, the stigma that appears as a social response to rejection of HIV/AIDS infection can have a wide impact on the deterioration of the quality of health care for HIV sufferers and the prevention of HIV infection.

However, efforts to reduce stigma against PLWHA based on the aspect of religiosity must be a priority. This is because the characteristics of stigma problems are very complex, involving a number of fields and various elements. Suggestions for further research are the need to develop strategies or interventions for reducing social stigma in society as an effort to reduce social stigma in HIV and increase public acceptance.

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