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STIGMA TOWARD PEOPLE LIVING WITH HIV (PLHIV) AND ITS RELATED FACTORS IN URBAN COMMUNITIES

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ABSTRACT

One of the 2030 Sustainable Development Goals (SDGs) targets is to end the AIDS epidemic with Three Zeros; no new cases of HIV/AIDS, no deaths from HIV/AIDS, and no stigma and discrimination toward people living with HIV (PLHIV). This study aims to identify factors associated with stigma in PLHIV in urban areas. A cross-sectional study was conducted during September – October 2022 on 204 urban residents in Jakarta, Bogor, Depok, Tangerang, and Bekasi who were over 18 years old to measure stigma toward PLHIV, gender, age, education level, marital status, health profession, and knowledge about HIV/AIDS. Data were analyzed descriptively, and analytically with bivariate and multivariate analysis using multiple logistic regression. It was found that 90.5% of the subjects had a stigma toward PLHIV. The results of the multivariate analysis found that gender [adjusted OR: 2.850, (95% CI: 0.936 – 8.675)] and health professions [adjusted OR: 4.126, (95% CI: 1.516 – 11.225)] were significantly associated with stigma toward PLHIV. Meanwhile, age, education level, marital status, and level of knowledge were not significantly associated with stigma toward PLHIV. Specific interventions are needed for urban women and non-health workers to reduce the stigma toward PLHIV.

Keywords: health profession; HIV/AIDS; PLHIV; Stigma

INTRODUCTION

The number of HIV cases in the world in 2021 was 38.4 million people over the age of 15 years as many as 36.7 million. By gender, 54% of people with HIV are women. Then, the number of new HIV cases in 2021 was 1.5 million. A total of 650.000 people died of AIDS in 2021[1]. In Indonesia, there were 36,902 new cases of HIV in 2021, and as many as 30,160 people received ARV treatment. Most people living with HIV are in the age group of 25-49 years (69.7%). The cumulative number of HIV cases reported in 2021 was 456,453 people, while the cumulative number of AIDS cases reported in 2021 was 135,490 people [2]. Some of the provinces with the highest number of HIV cases in 2021 include DKI Jakarta (74,867), West Java (51,218), and Banten (12,764), the majority of which are urban areas [2].

The vision of the global HIV response is to achieve three zeros: zero new HIV infections, zero AIDS-related deaths, and zero discrimination [3]. The Ministry of Health and its partners want to invite all levels of society to achieve success in achieving Three Zero by 2030 [4]. HIV testing and service targets of 95–95–95 are achieved in all subpopulations and ages. As many as 95% of women of reproductive age suffer from HIV and their sexual and reproductive health service needs are met; 95% of pregnant and lactating women live with burden-suppressed HIV; 95% of those exposed to HIV are children and tested by 2030 [5]. The Ministry of Health is accelerating ARVs, with a target of 258,340 PLHIV treatments in 2020. Currently, only 50% or 17 provinces have achieved the target, namely: Aceh, Jambi, South Sumatra, Bengkulu, Lampung, Bangka – Belitung, West Java, Banten, Bali, NTB,

NTT, West Kalimantan, South Kalimantan, East Kalimantan, Central Kalimantan, North Sulawesi and Gorontalo [4]. Public stigma toward PLHIV is one of the factors that prevent PLHIV from testing themselves in health facilities and getting treatment.

HIV stigma is negative attitudes and beliefs about people living with HIV. The prejudice that comes with labeling individuals as part of a group is believed to be socially unacceptable [6]. According to Corrigan and Kleinlein, stigma has two perspectives, namely community stigma, and self-stigma. Community stigma occurs when the general public agrees with a person's bad stereotypes (e.g., mental illness, addicts, etc.) and self-stigma is a consequence of stigmatized people applying stigma to themselves. In 25 out of 36 countries with the latest data according to UNAIDS, >50% of 15-49-year-olds have discriminatory attitudes toward PLHIV [7]. Stigma and discrimination toward PLHIV cause a major barrier for PLHIV who want to access treatment, care, education, and information to prevent HIV transmission [8].

The stigma of HIV arises from the fear of HIV. There are still misconceptions about how HIV is transmitted and what it means to live with HIV today. The lack of information and awareness coupled with outdated beliefs makes people afraid of contracting HIV. In addition, many people consider HIV to be a disease that only infected certain groups. This leads to negative value assessments of people living with HIV [6]. When stigma and discrimination occur in PLHIV, the suffering of PLHIV will be even greater. A study involving data from 19 countries revealed that 1 in 5 (20%) PLHIV are afraid to come to the clinic because of the stigma and discrimination they receive within society. When PLHIV waits until they fall into the condition of AIDS, then the treatment they seek often does not produce satisfactory results [9].

Many factors have been studied to be related to community stigma toward PLHIV. Previous research on students aged 20-23 years at one of the universities in Sukoharjo found a relationship between age and stigma toward PLHIV [10]. Research conducted by Wahyuni and Ronoadmodjo (2016) on the Indonesian society 2012 Demographic and Health Survey's Advanced Analysis found that there was no relationship between sex and community stigma toward PLHIV [11].

Another factor is that education is related to the stigma toward PLHIV which has good education with a stigma of PLHIV of 69.9% and education that is less with no stigma of PLHIV of 30.1% [11]. Another study in Kupang City found that there was no relationship between marital status and community stigma toward PLHIV [12]. Research conducted by Situmeang, Syarif, and Mahkota (2017) among adolescents 15-19 years in Indonesia obtained the results of knowledge about HIV/AIDS having a relationship with community stigma toward PLHIV with p-value = 0.000; sufficient knowledge (64.75%) with heavy stigma and non-stigma (21.23%); lacked knowledge with severely stigmatized (78.77%) and non-stigmatized (35.25%) [13]. Based on some of the results of these studies, there are still inconsistencies in the relationship between several factors and community stigma toward PLHIV. For this reason, this study aimed to find out the picture of community stigma toward PLHIV and the factors related to it.

RESEARCH METHODS

This study was conducted with a cross-sectional design. The research was conducted in September - October 2022 in the cities of Jakarta, Bogor, Depok, Tangerang, and South Tangerang, Bekasi, and its surroundings. The study population is urban people aged 18 years and over. The sample consisted of 204 respondents with inclusion criteria; living in urban

areas, and having never been diagnosed with HIV/AIDS until the time of data collection. Samples were collected by purposive sampling using an online questionnaire with a Google form. The dependent variable is the stigma toward PLHIV. The independent variables were gender, age, education level, marital status, health profession, knowledge of HIV/AIDS, and HIV test service.

Stigma and knowledge about HIV were measured using the 2017 Indonesian Demographic Health Survey (IDHS) questionnaire [14]. Stigma was measured by 9 closed questions regarding attitude statements toward PLHIV with yes/no/don't know answer choices. Knowledge about HIV/AIDS was measured by 13 closed questions about HIV/AIDS, knowledge of how to prevent HIV/AIDS, comprehensive knowledge about HIV/AIDS, knowledge about prevention of mother-to-child transmission, and knowledge about HIV/AIDS service facilities with the answer choices yes/ don't/don't know. Data are presented descriptively, with bivariate and multivariate analysis using multiple logistic regression. The strength of the relationship is seen based on the odds ratio (OR) value.

RESULTS AND DISCUSSIONS

The results of the analysis of participants' stigma, characteristics, and knowledge level about HIV of are descriptively presented in table 1. While the details of the stigma component can be seen in table 2. Table 3 showed a cross-tabulation between independent variables and stigma. The last, multivariate analysis modeling was presented in table 1.

Table 1. Stigma and Characteristics of Respondents

Variables	F	%
Stigma		
Yes	191	90.5
No	20	9.5
Age		
19 – 29	123	58.3
30 – 39	68	32.2
40 – 49	15	7.1
50 – 54	5	2.4
Sex		
Female	186	88.2
Male	25	11.8
City		
Bekasi	10	4.7
Depok	17	8.1
Bogor	19	9.0
West Jakarta	2	0.9
Central Jakarta	4	1.9
South Jakarta	28	13.3
East Jakarta	59	28.0
North Jakarta	2	0.9
Tangerang	18	8.5
South Tangerang	25	11.8
Others	27	12.8
Educational level		
Elementary school	2	0.9
Junior high school	1	0.5
Senior high school	43	20.4
Diploma/bachelor degree	150	71.1
Master/Doctoral degree	15	7.1
Educational level		
Low (Elementary – Senior High school)	46	21.8
High (Diploma – Doctoral degree)	165	78.2
Marriage status		
Not married	122	57.8
Married	86	40.8
Divorced	3	1.4
Health profession		
Yes	83	39.3
No	128	60.7
Knowledge about HIV		
Less	25	11.8
Enough	186	88.2

The main results of this study found that 90.5% of participants had a stigma toward PLHIV. The details of the questions and answers about the stigma can be seen in table 2. Based on its characteristics, the average age of participants was 27.89 years with the youngest age being 19 years and the oldest 54 years. Meanwhile, according to their age range, most respondents were aged 19-29 years (58.3%) and at least 50 – 54 years old (2.4%). As many as 88.2% of participants were women, 28.0% lived in East Jakarta and lived the most in West and North Jakarta. There were 71.1% of participants with a diploma or bachelor's degree and 0.9% with a primary school education. In general, 78.2% of participants were highly educated, and unmarried 57.8%. Based on their job category, 60.7% of participants were non-health workers. In general, 88.2% of participants had a sufficient level of knowledge about HIV.

The details of participants' questions and answers about HIV-related knowledge are as follows; 99.1% of them had heard of a disease called HIV/AIDS, and 80.6% knew that the risk of being infected with HIV can be reduced by having one sexual partner who was not infected with HIV. As many as 76.8% knew that HIV cannot be transmitted through mosquito bites. They also knew (74.4%) that the chances of getting infected with HIV could be reduced by using condoms every time they had sex, 59.7% knew that HIV could not be transmitted through sharing food with an infected person, and 94.8% knew that HIV was not caused by witchcraft.

In addition, 97.6% had learned that HIV could be transmitted through the joint use of non-sterile syringes, 89.6% answered that HIV-positive people might have looked healthy, 73.5% knew that HIV could be transmitted by the mother to her child during the gestation period, during childbirth (68.7%), and during breastfeeding (64.5%). There were 86.7% of participants knew about HIV testing and only 68.7% knew where HIV testing facilities were located.

Table 2. Questions and answers about stigma

Stigma Questions	Answers	F	%
Would you buy fresh vegetables from a shopkeeper or vendor if you knew that this person had the HIV-AIDS virus?	Yes	54	25.6
	No	54	25.6
	DK/Not sure/Depends	103	48.8
If a member of your family got infected with the HIV-AIDS virus, would you want it to remain a secret or not?	Yes	60	28.4
	No	74	35.1
	DK/Not sure/Depends	77	36.5
If a member of your family became sick with HIV-AIDS, would you be willing to care for her or him in your household?	Yes	129	61.1
	No	14	6.6
	DK/Not sure/Depends	68	32.2
Do you think children living with HIV-AIDS should be allowed to attend school with children who do not HIV-AIDS	Yes	114	54.0
	No	39	18.5
	DK/Not sure/Depends	58	27.5
Do you think people hesitate to take an HIV test because they are afraid of how other people will react if the test result is positive for HIV?	Yes	178	84.4
	No	13	6.2
	DK/Not sure/Depends	20	9.5
Do people talk badly about people living with HIV, or who are thought to be living with HIV?	Yes	125	59.2
	No	33	15.6
	DK/Not sure/Depends	53	25.1
Do people living with HIV-AIDS, or thought to be living with HIV-AIDS, lose the respect of other people?	Yes	94	44.5
	No	50	23.7
	DK/Not sure/Depends	67	31.8
Do you agree or disagree with the following statement: I would be ashamed if someone in my family had HIV-AIDS.	Yes	40	19.0
	No	125	59.2
	DK/Not sure/Depends	46	21.8
Do you fear that you could get HIV-AIDS if you come into contact with the saliva of a person living with HIV-AIDS?	Yes	128	60.7
	No	55	26.1
	DK/Not sure/Depends	28	13.3

In table 2 we can see the details of questions related to participant stigma toward PLHIV. Only 25.6% of participants were willing to buy fresh vegetables from traders who were HIV-positive. 35.1% of participants would make no secret if one of their family members was infected with HIV, but 61.1% were willing to take care of them at home. They argued that HIV-positive children should go to school together with other healthy children (54%), and 84.4% of them rated that people would be afraid to get tested for HIV because they imagined how society would react if they found the test result was positive.

They also thought (59.2%) that people would talk bad things about PLHIV, and people living with PLHIV, and both would be disrespected by society (44.5%). However, 59.2% said they were not ashamed if any of their family members were infected with HIV. Sadly, 60.7% of participants were afraid of being infected if they were exposed to saliva from PLHIV.

Table 3. Cross-tabulation between independent variables and stigma

Variables	Category	Stigma toward PLWH		OR 95% CI	p-value
		Yes (%)	No (%)		
Age	< 40	171 (89,5)	20 (10.5)	-	0.228
	≥ 40	20 (100,0)	0 (0,0)	<i>Reff</i>	
Sex	Female	171 (91,9)	15 (8,1)	2.850 (0.936 – 8.675)	0.069
	Male	20 (80,0)	5 (20,0)	<i>Reff</i>	
Educational level	Low	44 (95,7)	2 (4,3)	2.694 (0.602 – 12.063)	0.257
	High	147 (89,1)	18 (10,9)	<i>Reff</i>	
Marriage status	Unmarried	107 (87,7)	15 (12,3)	0.425 (0.148 – 1.215)	0.162
	Married	84 (94,4)	5 (5,6)	<i>Reff</i>	
Health professional	No	122 (95,3)	6 (4,7)	4.126 (1.516 – 11.225)	0.007
	Yes	69 (83,1)	14 (16,9)	<i>Reff</i>	
Knowledge about HIV-AIDS	Less	25 (100,0)	0 (0,0)	-	0.140
	Enough	166 (89,2)	20 (10,8)	<i>Reff</i>	

Furthermore, a bivariate analysis with chi-square was carried out to see the cross-tabulation between dependent and independent variables. In table 3 we can see that 89.5% of participants aged <40 years, and 100% aged 40 years and over have a stigma toward PLHIV. Meanwhile, based on gender, 91.9% of women and 80% of men have a stigma toward PLHIV. The proportion of participants who were poorly educated was 95.7% and those highly educated was 89.1% who had a stigma toward PLHIV. There are 87.7% who are not married/divorced and 94.4% of those who are married have a stigma toward PLHIV. according to their job category, 95.3% of non-health workers and 83.1% of health workers have a stigma toward PLHIV. All respondents with a low level of knowledge and 89.2% with a sufficient level of knowledge about HIV had a stigma toward PLHIV.

After a cross-tabulation analysis, the researchers decided to include all independent variables in multivariate modeling with multiple logistic regression analysis given the importance of all variables in the context of stigma toward PLHIV. In multivariate modeling, interaction and confounding tests were carried out. The interaction test was carried out on variables that were substantially suspected to have interactions, they are the level of education with the level of knowledge and the health profession with the level of knowledge. After the interaction test was done, it was found that there was no interaction between these variables. So that the final model of the analysis was listed in table 4 below:

Table 4. Multivariate analysis

Variables	OR	CI 95%	p-value
Age	0.000	0.000 - ~	0.998
Sex	5.522	1.508 – 20.222	0.010
Educational level	2.090	0.417 – 10.462	0.370
Marriage status	0.550	0.178 – 1.696	0.298
Health profession	3.303	1.068 – 10.216	0.038
Knowledge about HIV	-	-	0.998

The results of the final model of the multivariate analysis found that gender and health professions were significantly associated with stigma toward PLHIV with p values of 0.001 and 0.038 respectively. Women had 5.522 times greater odds of stigmatizing PLHIV than men (95% CI: 1,508 – 20,222). Furthermore, participants with non-health professions had 3.303 times greater odds of stigmatizing PLHIV than participants who worked as health workers (95% CI: 1,068 – 10,216). In addition, the study found that participants' age, level of education, marital status, and level of knowledge about HIV were not significantly associated with stigma toward PLHIV.

The main results of this study found that 90.5% of participants in urban areas had a stigma toward PLHIV. This is in line with and even higher results than the findings of the 2017 SDKI which found that 80% of the Indonesian population has a stigma toward PLHIV [14]. When compared to the results of the 2017 SDKI in DKI Jakarta Province, the findings of this study are also in line with the high stigma of the community toward PLHIV (81-88%) [15]. The stigma of urban communities found in this study is higher than in non-urban areas. A study conducted in Grobongan Regency, Central Java found that respondents still stigmatized PLHIV [16]. The high stigma that still occurs in urban areas today is certainly a big challenge if it is associated with the target of three zero AIDS elimination by 2030 [17].

The results of the multivariate analysis found that gender and professional status were factors that were significantly related to stigma in PLHIV. The problem of women living with HIV is very close to gender discrimination. In addition to the more dominant partner, women and children who end up being victims, bear a lifelong stigma, especially from their environment, lose their future, and lose their reproduction rights. Women are more vulnerable because of their traditional role in society, especially in terms of their role in the household. This triggers the stigma toward PLHIV that arises in women who are not infected with HIV [18]. Considering that women are the figures who have the most role in daily activities that have the potential to intersect with PLHIV such as caring for HIV-positive family members, taking care of children's schools, shopping for groceries, etc., and who are most affected if they are infected with HIV.

This study found that most urban communities already had sufficient knowledge related to HIV, but the stigma that arises toward PLHIV is still very high. So it was found that there was no significant relationship between the level of knowledge and stigma. Some of the factors that influence the stigma toward PLHIV are HIV/AIDS is a life-threatening disease, people are afraid of being infected with HIV, the disease was associated with behaviors that have been stigmatized in society, PLHIV is often considered as responsible if there is an infection, moral or religious values make people believe that HIV / AIDS as a result of moral violations [23]. So in this context, it is very possible that people whose knowledge is quite good still have a stigma toward PLHIV.

Another finding in this study is that there was a significant difference between those who are health workers and non-health workers with a stigma toward PLHIV. Participants who are not health workers are more likely to stigmatize PLHIV than those who are health workers. This happens because health workers get more exposure to comprehensive knowledge related to HIV compared to non-health workers. In addition, health workers can socialize with PLHIV more often. So they are more accepting of the existence of PLHIV in the community. Studies comparing stigma toward PLHIV by health workers and non-health workers are still limited. Most of the studies found examined specifically the population of health workers [19], [20]. The stigma of health workers in PLHIV is still happening, and this is a big problem because it is health workers who play an important role in the success of HIV testing and treatment target achievements. PLHIV which receives stigma from health workers tended to be reluctant to get checked up and seek ARV therapy regularly [21], [22].

This study had some limitations. First, this study used a cross-sectional design so that causal relationships cannot be inferred from the results of this study. Second, the technique of collecting samples was purposive. So that there is a possibility that the study results cannot be fully drawn in general representing the population conditions of urban communities in Jabodetabek. Third, the independent variables in this study are limited to characteristics and levels of knowledge. There are several variables related to the stigma that was not included in this study. So, it is necessary to conduct further studies in a comprehensive manner that includes other important variables related to stigma toward PLHIV.

CONCLUSION

The stigma in urban communities toward PLHIV is still very high. This is a tough challenge to achieve the target of zero stigmas and discrimination by 2030. Women and non-health workers are shown to have the potential to have a higher stigma toward PLHIV than men, and health workers. For this reason, it is necessary to make efforts to reduce stigma in society specifically, especially for women and non-health workers by all parties (government, private sector, and the community itself) in the form of comprehensive education, and other inclusive activities that involve the general public to realize their important role in efforts to reduce community stigma toward PLHIV.

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REFERENCES

- [1] UNAIDS, “Global HIV & AIDS statistics — Fact sheet,” UNAIDS Website. 2022. [Online]. Available: <https://www.unaids.org/en/resources/fact-sheet#:~:text=38.4>
- [2] Kementerian Kesehatan Republik Indonesia, “Laporan Eksekutif Perkembangan HIV AIDS dan Penyakit Infeksi Menular Seksual (PIMS) Triwulan IV Tahun 2021.” 2021. [Online]. Available: https://siha.kemkes.go.id/portal/files_upload/Laporan_TW4_2021_OK_OK.pdf
- [3] UNAIDS, “Advancing toward the three zeros,” UNAIDS Website. 2020. [Online]. Available: <https://aids2020.unaids.org/chapter/chapter-1-advancing-toward-the-three-zeros/#:~:text=The>
- [4] Kemenko PMK, “Menuju Indonesia Bebas AIDS 2030,” Kemenko PMK Website. 2020. [Online]. Available: <https://www.kemenkopmk.go.id/menuju-indonesia-bebas-aids-2030>

- [5] UNAIDS, “2025 AIDS Targets.” pp. 1–38, 2020. [Online]. Available: https://www.unaids.org/sites/default/files/2025-AIDS-Targets_en.pdf
- [6] Centers for Disease Control and Prevention, “HIV Stigma and Discrimination,” CDC Website. 2021. [Online]. Available: <https://www.cdc.gov/hiv/basics/hiv-stigma/index.html#:~:text=HIV>
- [7] UNAIDS, “HIV and Stigma and Discrimination.” pp. 1–6, 2021. [Online]. Available: https://www.unaids.org/sites/default/files/media_asset/07-hiv-human-rights-factsheet-stigma-discrimination_en.pdf
- [8] UNAIDS, HIV and AIDS-related stigmatization, discrimination and denial: forms, contexts, and determinants. 2000. [Online]. Available: https://data.unaids.org/publications/irc-pub01/jc316-uganda-india_en.pdf
- [9] UNAIDS, “UNAIDS warns that HIV-related stigma and discrimination is preventing people from accessing HIV services,” UNAIDS Website. 2017. [Online]. Available: https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2017/october/20171002_confronting-discrimination
- [10] B. A. Sholekhah, T. A. K. Indah, and S. R. S. Putri, “Hubungan Karakteristik Responden dan Interaksi Bersama Orang dengan HIV/AIDS (ODHA) Terhadap Stigma Mahasiswa pada ODHA,” *Publ. Ilm. UMS*, pp. 354–372, 2019.
- [11] A. S. Sri Wahyuni and S. Ronoatmodjo, “Hubungan Antara Pengetahuan HIV/AIDS dengan Sikap Penolakan Terhadap Orang Dengan HIV/AIDS (ODHA) Pada Masyarakat Indonesia (Analisis Lanjut Survei Demografi dan Kesehatan Indonesia 2012),” *J. Kesehat. Reproduksi*, vol. 8, no. 1, pp. 41–52, 2017, doi: 10.22435/kespro.v8i1.5222.41-52.
- [12] K. Hati, Z. Shaluhiah, and A. Suryoputro, “Stigma Masyarakat Terhadap ODHA di Kota Kupang Provinsi NTT Konstantinus,” *J. Promosi Promosi Kesehat. Indones.*, vol. 12, no. 1, pp. 62–77, 2017.
- [13] B. Situmeang, S. Syarif, and R. Mahkota, “Hubungan Pengetahuan HIV/AIDS dengan Stigma terhadap Orang dengan HIV/AIDS di Kalangan Remaja 15-19 Tahun di Indonesia (Analisis Data SDKI Tahun 2012),” *J. Epidemiol. Kesehat. Indones.*, vol. 1, no. 2, pp. 35–43, 2017, doi: 10.7454/epidkes.v1i2.1803.
- [14] BKKBN, BPS, Kemenkes, and ICF, “Indonesia District Health Survey 2017,” p. 588, 2018, [Online]. Available: <https://dhsprogram.com/pubs/pdf/FR342/FR342.pdf>
- [15] Badan Pusat Statistik, “Survei Demografi Dan Kesehatan : Kesehatan Reproduksi Remaja 2017. In Badan Kependudukan dan Keluarga Berencana,” *Survei Demogr. Dan Kesehat.*, p. 271, 2017, [Online]. Available: <http://www.dhsprogram.com>.
- [16] Z. Shaluhiah, S. B. Musthofa, and B. Widjanarko, “Stigma Masyarakat terhadap Orang dengan HIV/AIDS,” *Kesmas J. Kesehat. Masy. Nas. (National Public Heal. Journal)*, vol. 9, no. 4, pp. 333–339, May 2015, doi: 10.21109/KESMAS.V9I4.740.
- [17] K. Ibrahim, R. Kombong, and A. Sriati, “The Difference of Perceived HIV Stigma between People Living with HIV Infection and Their Families,” *Nurse Media J. Nurs.*, vol. 9, no. 2, pp. 117–127, 2019, doi: 10.14710/nmjn.v9i2.24256.
- [18] K. Perempuan, “Risalah Kebijakan Perempuan dengan HIV dan AIDS: ‘Lingkaran Kekerasan Seksual dan Kerentanan Atas Hak Hidup,’” pp. 1–10, 2019.
- [19] R. Sofia, “Stigma Dan Diskriminasi Terhadap Odha (Studi Pada Tenaga Kesehatan Di Puskesmas Tanah Pasir Aceh Utara),” *AVERROUS J. Kedokt. dan Kesehat. Malikussaleh*, vol. 2, no. 1, p. 79, 2018, doi: 10.29103/averrous.v2i1.423.
- [20] L. Nyblade, P. Mingkwan, and M. A. Stockton, “Stigma reduction: an essential ingredient to ending AIDS by 2030,” *Lancet HIV*, vol. 8, no. 2, pp. e106–e113, 2021, doi: 10.1016/S2352-3018(20)30309-X.

- [21] K. L. Stringer et al., "HIV-Related Stigma Among Healthcare Providers in the Deep South," *AIDS Behav.* 2015 201, vol. 20, no. 1, pp. 115–125, Dec. 2015, doi: 10.1007/S10461-015-1256-Y.
- [22] H. Oktaviannoor, A. Herawati, N. Hidayah, M. Martina, and A. S. Hanafi, "Pengetahuan dan stigma masyarakat terhadap pasien Covid-19 dan tenaga kesehatan di Kota Banjarmasin," *Din. Kesehat. J. Kebidanan Dan Keperawatan*, vol. 11, no. 1, pp. 98–109, 2020, doi: 10.33859/dksm.v11i1.557.
- [23] F. Maharani, "Faktor -Faktor Yang Berhubungan Dengan Stigma Terhadap Orang Dengan Hiv Dan Aids (Odha)," *J. Endur.*, vol. 2, no. 2, p. 158, 2017, doi: 10.22216/jen.v2i2.1300.