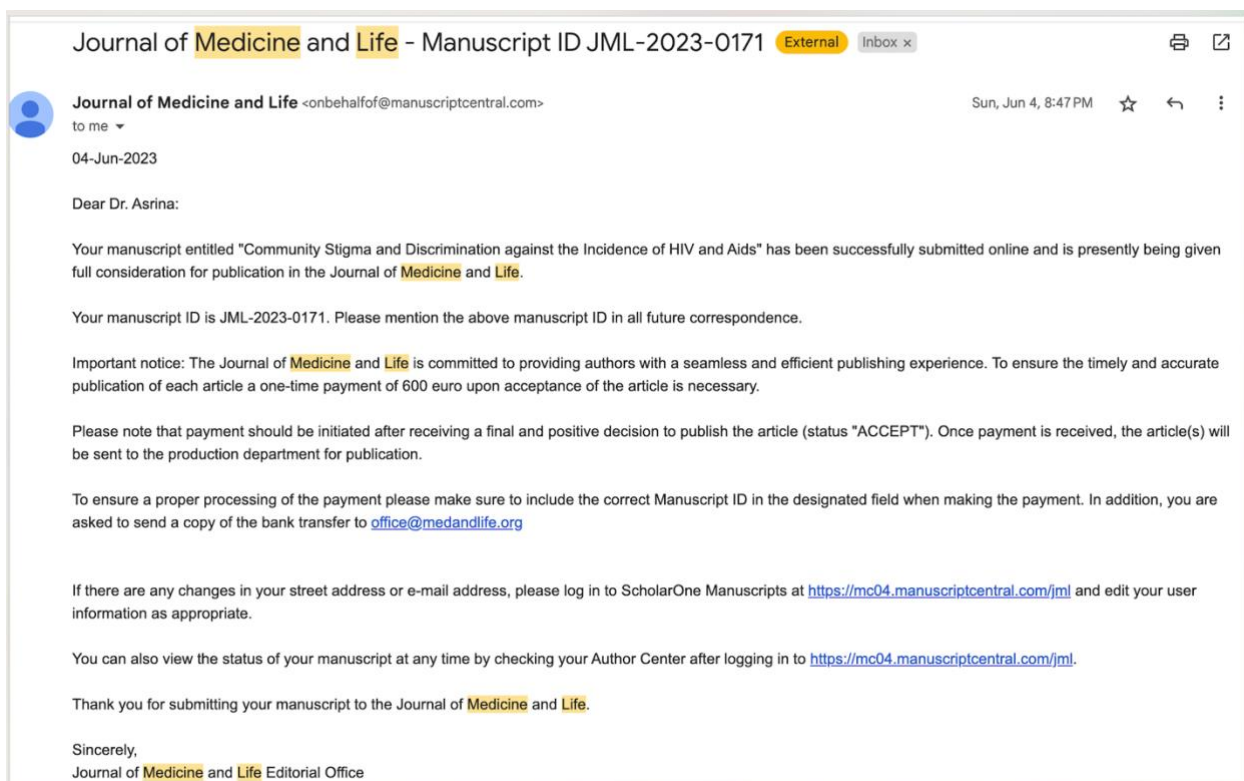
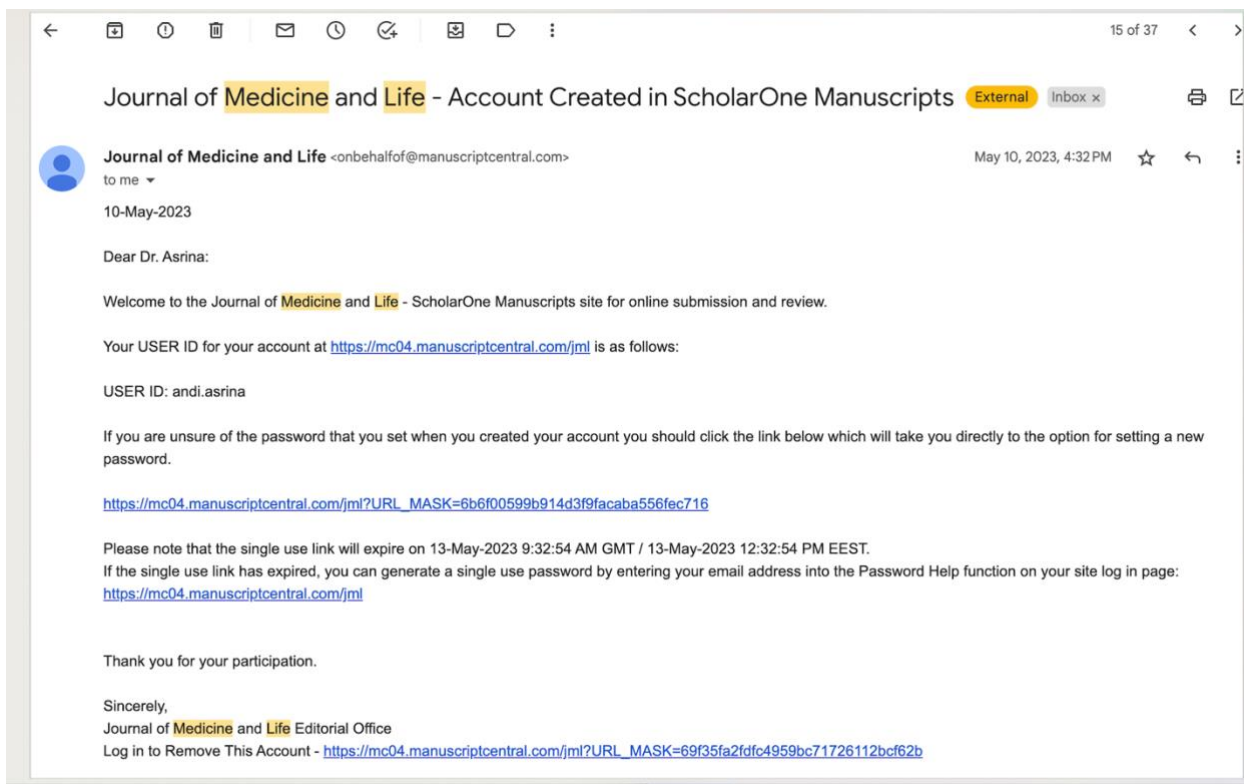




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Dafin Muresanu <onbehalf@manuscriptcentral.com>

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Mon, Jul 17, 3:34 PM



17-Jul-2023

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The reviewer(s) have recommended publication, but also suggest some revisions to your manuscript. Therefore, I invite you to respond to the reviewer(s)' comments and revise your manuscript.

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Once again, thank you for submitting your manuscript to the Journal of **Medicine** and **Life** and I look forward to receiving your revision.

Sincerely,
Prof. Dafin Muresanu
Editor-in-Chief, Journal of **Medicine** and **Life**
dafinm@ssnn.ro

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Reviewer(s)' Comments to Author:

Reviewer: 1

Comments to the Author
Comments to authors

OVERALL

There is a need to improve the English and clarity of the sentences throughout the manuscript.

INTRODUCTION:

- Introduction is weak. A substantial missing point in the introduction is the synthesis of the existing literature/the previous findings on HIV stigma and discrimination: what kind of HIV stigma and discrimination has happened to PLHIV, and what are the supporting factors? Presenting these aspects will support the authors' position to convincingly formulate the novelty or knowledge gap they wanted to bridge through their study/this paper. There have been studies and publications on these aspects in Indonesia, Asia and globally. Here are some current resources on HIV stigma in Indonesia and low- and middle-income countries in Asia that you may consult and cite to support your statements:

- HIV Stigma and Moral Judgement: Qualitative Exploration of the Experiences of HIV Stigma and Discrimination among Married Men Living with HIV in Yogyakarta. Int. J. Environ. Res. Public Health 2020, 17, 636. <https://doi.org/10.3390/ijerph17020636> <https://www.mdpi.com/1660-4601/17/2/636>
- Stigma and Discrimination towards People Living with HIV in the Context of Families, Communities, and Healthcare Settings: A Qualitative Study in Indonesia. Int. J. Environ. Res. Public Health 2021, 18, 5424. <https://doi.org/10.3390/ijerph18105424> <https://www.mdpi.com/1660-4601/18/10/5424>
- HIV Stigma and Discrimination: Perspectives and Personal Experiences of Healthcare Providers in Yogyakarta and Belu, Indonesia. Frontiers in **Medicine**. Volume 8 - 2021 | <https://doi.org/10.3389/fmed.2021.625787> <https://www.frontiersin.org/articles/10.3389/fmed.2021.625787/full>
- Psychological and Social Impact of HIV on Women Living with HIV and Their Families in Low- and Middle-Income Asian Countries: A Systematic Search and Critical Review. Int. J. Environ. Res. Public Health 2022, 19, 6668. <https://doi.org/10.3390/ijerph19116668> <https://www.mdpi.com/1660-4601/19/11/6668>
- HIV-related challenges and women's self-response: A qualitative study with women living with HIV in Indonesia. PLoS ONE 17(10): e0275390. <https://doi.org/10.1371/journal.pone.0275390> <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0275390>
- Risk factors and The Impact of HIV among Women Living with HIV and Their Families in Yogyakarta and Belu District, Indonesia (see Section 5.3.1 and 6.3.1). https://www.researchgate.net/profile/Nelsensius-Fauk/publication/361886192_Risk_factors_and_the_impact_of_HIV_among_women_living_with_HIV_and_their_families_in_Yogyakarta_and_Belu_district_Indonesia/links/62cab6a400d0b4511046b7a9/Risk-factors-and-the-impact-of-HIV-among-women-living-with-HIV-and-their-families-in-Yogyakarta-and-Belu-district-Indonesia.pdf?utm_source=nationaltribune&utm_medium=nationaltribune&utm_campaign=news

- The novelty/knowledge gap of this study/paper is provided. What is the selling point of this manuscript? In other words, what's new? Authors need to provide this aspect in the last paragraph of the introduction section.

- Authors need to use current HIV data in Indonesia; the 2022 report has been available online: see SIHA website.

- In the last paragraph of the introduction, the authors stated that they used the social construction theory by Peter L. Berger and Thomas Luckmann as an analytical tool, but nowhere to find in the manuscript the explanation of the theory and how they used it. You need to walk the readers through the theory to help them understand how you have used the theory to guide your research, data analysis and discussion of the findings. Provide a section on the theory.

METHODS:

I suggest the authors consult the COREQ checklist to guide their report on the methodology used in this study.

RESULTS

The findings currently presented in this paper are poor.

Causes of Stigma and Discrimination for People with HIV and AIDS

- I would suggest the authors read several resources I have provided in the introduction section above to help them identify causes of or contributing factors for HIV stigma and discrimination.

Forms of Stigma and Discrimination for People with HIV and AIDS

- When you talk about forms of stigma, that means you present whether it is enacted/external stigma or perceived stigma or anticipated stigma or self-stigma. None of these forms of stigma were explored in the findings. Again, please read the references I provided above to help you clearly understand these types of stigma and revisit your data to improve the presentation of your findings.

The Impact of Stigma and Discrimination on People with HIV and AIDS

- Similar to the two sub-sections above, this is very poor, please make it rich.

DISCUSSION

DISCUSSION

Once you have improved the above sections, I would be happy to look at the discussion section in the second round of the review because this section will depend upon your result section.

Reviewer: 2

Comments to the Author

This article does not present adequate methodology and therefore its results are poorly presented. The discussion and conclusion are not based on scientific methods and therefore are not eligible for publication.

Reviewer: 3

Comments to the Author

The paper contains in material, methods and results sections only general statements and does not provide specific characteristics of the authors research, such as specified in the instructions for authors.

Materials and methods - please include the following, as specified in the instructions for authors:

- sample size,
- inclusion/exclusion criteria, sampling method
- study setting (multicenter, single center, national, local, online),
- timeline (prospective/retrospective, between month(s) and year(s)),
- type (randomized control trial, observational, longitudinal, case-control, cross-sectional, descriptive, exploratory, ecological, intervention studies (on effectiveness of preventive measures/treatments, cohort, epidemiological, viral shedding study, community study),
- descriptive statistics of the sample,
- statistical tests,
- variables used,
- primary and secondary endpoints
- statistical software (SPSS, R, STATA, SAS, Medcalc, or others).

Results should contain the:

- number of participants
- key demographics (age, sex)

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	- Major Revision (17-Jul-2023) - a revision has been submitted				
	view decision letter				

Journal of Medicine and Life

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Community Stigma and Discrimination against the Incidence of HIV and Aids

Journal:	<i>Journal of Medicine and Life</i>
Manuscript ID	JML-2023-0171
Manuscript Type:	Original Article
Date Submitted by the Author:	19-Jun-2023
Complete List of Authors:	Asrina, Andi; Universitas Muslim Indonesia, Faculty of Public Health Ikhtiar, Muhammad ; University of Muslim Indonesia, Faculty of Public Health Idris, Fairus ; University of Muslim Indonesia, Faculty of Public Health Adam, Arlin; Universitas Pejuang Republik Indonesia, Faculty of Public Health Alim, Andi; Universitas Pejuang Republik Indonesia, Faculty of Public Health
Keywords:	HIV and AIDS, People with, Stigma, Discrimination

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INTRODUCTION

The 2030 global target for HIV and AIDS prevention is three zeros, namely zero new HIV infections, zero deaths due to AIDS cases, and zero acts of stigmatization and discrimination. Zero stigma and discrimination targets for PLWHA are likely to experience obstacles due to a lack of public understanding accompanied by a prejudiced attitude towards those living with them. Human Immunodeficiency Virus (HIV) is by definition a virus that attacks the human immune system and weakens the body's ability to fight all kinds of diseases. Acquired Immune Deficiency Syndrome (AIDS) is a collection of symptoms of a disease caused by a decrease in the immune system due to infection with HIV. AIDS is often referred to as a disease of deviant behaviour because the factors that trigger this event were previously only found in at-risk groups such as commercial sex workers, homosexuals, injecting drug users, and men who become sex customers.

However, currently, the attack of HIV and AIDS has occurred among the general public (generalised epidemic level) such as those infected in housewives and children. HIV and AIDS do not recognize social stratification such as age, gender, occupation, ethnicity, nation and others. It is in this view that HIV and AIDS then become a sociological and health problem that threatens the lives of all social strata of society. It is estimated that there will be 543,100 people with HIV and AIDS (PLWHA) in 2020. The number of PLHIV found in the April-June 2022 period was 11,100 of the 986,288 people who were tested for HIV, and as many as 8,972 people received ARV treatment [1,2].

Cumulatively, HIV and AIDS cases in Indonesia, based on the 2017 report, had 41,250 HIV and 9,280 AIDS with a total of 948 deaths [3]. Southeast Sulawesi is one of

55 the provinces that has experienced an increase in the findings of new HIV AIDS cases
56
57 every year. According to data, cases of HIV and AIDS in Southeast Sulawesi Province
58
59 between 2012-2017 have increased. Report on the Development of HIV and AIDS and
60

1 Sexually Transmitted Diseases. Quarter I 2021 for Southeast Sulawesi, as many as 3,795
2
3
4 people who were tested for HIV found 16 new cases, while in the April-June 2022 period,
5
6 5,678 people were tested for HIV and found 95 cases of people with HIV/ PLHIV [2].
7

8 The numbers obtained are only for people who take the test voluntarily. HIV cases
9
10 can occur in any area, as well as in Wakatobi District which has experienced an increase
11
12 in the number of new cases. Data owned by the Wakatobi Regional AIDS Commission in
13
14 2021, there were 13 new cases of HIV and in 2022 as many as 16 new cases were found
15
16 [4]. Of course, the actual cases are much more because HIV and AIDS are included in this
17
18 phenomenon. iceberg (iceberg phenomenon). The underlying cause is the existence of
19
20 stigma and discrimination against people living with HIV and AIDS so that the population at
21
22 risk tends to shut down to remain untested. In effect, new infections occur in the form of a
23
24 silent epidemic. Incidents of stigma and discrimination often occur in families,
25
26 communities, schools, places of worship, places of work, and places of legal and health
27
28 services.
29
30
31
32
33

34 The process of silent transmission will be further strengthened by the characteristics
35
36 of the at-risk population such as working as an overseas trader who leaves his wife for a
37
38 long time, thus allowing risky sexual contact to occur. People with HIV and AIDS consist of
39

various ages, genders, groups and statuses. People who suspect they are infected with sexually transmitted diseases as well as those living with HIV usually withdraw from themselves and are afraid of stigma and discrimination, making it difficult to develop prevention, care and treatment practices.

The epistemology of this research is constructivism using social construction theory by Peter L. Berger and Thomas Luckmann as an analytical tool. In explaining the constructivist paradigm, social reality is a social construction created by individuals through a process of social interaction. The individual becomes a determinant in the social world which is constructed based on his will. Individuals are not victims of social facts but

of creative production and reproduction media in constructing their social world [5]. Individuals continuously create a reality that is subjectively owned and experienced together [6]. There is a dialectic between individuals creating society and society creating individuals through a process of externalization, objectivation and internalization [7]. The purpose of this study was to analyze the causes, forms and impacts of stigmatization and discrimination of people living with HIV and AIDS.

MATERIAL AND METHODS

This study uses a qualitative method with a case study technique which intends to explore in depth the phenomena of stigma and discrimination against people living with

27 HIV and AIDS. This research is located in Wakatobi District with the consideration that
28
29 there are additional cases from year to year and in this area a mentoring and monitoring
30
31 program is currently underway for suspected and living HIV, making it easier to obtain
32
33 informants and information.
34
35

36 The informants for this study were HIV and AIDS Programmers at the Wakatobi
37
38 Health Office as key informants, representatives of the Wakatobi Regional AIDS
39
40 Commission as supporting informants and key informants who were selected purposively,
41
42 namely communicative and willing to be interviewed. The main instrument of this research
43
44 is the researcher himself who is equipped with tools used for data collection such as
45
46 interview guides, observation sheets, field notes, cameras, recorders, and other supporting
47
48 tools.
49
50

51 Data collection techniques namely by observation, in-depth interviews and
52
53 documentation. There are three components in qualitative research which are called social
54
55 situations, namely places, actors, and activities. Observations were made to observe
56
57 informants' activities on the phenomena being investigated, either directly or indirectly.
58
59
60

1
2 Meanwhile, in-depth interviews explored invisible phenomena by tracing information from
3
4 all informants regarding stigma and discrimination. Documentation relevant to the review is
5
6 a source triangulation approach to ensure the validity of the qualitative findings.
7

8 Qualitative data analysis was carried out using the Miles and Huberman model,
9
10 namely data reduction is defined as a process of categorizing and selecting data,
11
12

namely data reduction is defined as a process of categorizing and selecting data, displaying data to compile information that has been collected in drawing conclusions and taking action, then drawing conclusions and verifying, will then be presented in narrative form.

RESULTS AND DISCUSSION

RESULTS

Causes of Stigma and Discrimination for People with HIV and AIDS

Based on the results of the study, it was found that stigma and discrimination can arise if the incidence of HIV AIDS, both from the family environment, work, social environment or health services in general, is the same, namely fear, as expressed by the following informants:

"If someone gets (HIV)? it's dangerous to be able to move around, that's how naughty people will get sick like that"

Preliminary information from one of the residents who was randomly asked about his response if someone was known to be infected with HIV. Community responses were very common so a sense of concern was felt by the informants as disclosed below:

1
2 *"I was sentenced to B20 in 2019, of course, I was shocked... what if someone finds*
3 *out later, but now I have been taking medication for 3 years. If anyone asks what's*
4 *wrong, I answer that if I have TB, I have to take medicine."*
5
6
7
8
9

10
11 *"At first my wife was also surprised but now we are no longer the only ones who*
12 *know because if other people know, they will be shunned, blamed, and told and no*
13 *one wants to meet let alone shake hands"*
14
15
16
17
18

19
20 The lack of knowledge from the community about HIV AIDS is considered a
21
22 punishment for sufferers who have behaved not according to societal norms, even though
23
24 the entrance to HIV is not only through free sex and injecting drugs.
25
26
27
28

29 **Forms of Stigma and Discrimination for People with HIV and AIDS**

30
31
32
33

34 Perceptions that arise from the family and social environment of people living with
35
36 HIV are generally negative, as stated by the following informants:
37
38
39
40

41 *"At first my wife was also surprised but now we are no longer the only ones who*
42 *know because if other people know, they will be shunned, blamed, and told and no*
43 *one wants to meet let alone shake hands"*
44
45
46
47
48

49
50 Concerns about the attitude of the surrounding environment were also felt by other
51
52 informants as disclosed below:
53
54
55
56

57 *"The people here still don't understand, so if someone is found to be infected with*
58 *HIV, they will stay away, swear at them, and not leave their room because other*
59
60

people don't want to meet them"

The Impact of Stigma and Discrimination on People with HIV and AIDS

The occurrence of stigma and discrimination certainly has an impact on PLWHA so some are afraid to seek treatment. Here's the quote:

"As I said, if it is known that HIV will be shunned, talked about carelessly, blamed so don't have the courage to check it"

This information was corroborated by local health officials, as follows:

"Indeed, most people here generally do not know what HIV AIDS is, the causes of which are widely known are infectious diseases due to free sexual behaviour, injecting drugs, so we need information, so we are educating school children. It is really necessary to provide information widely because this disease occurs in all places. Stigma and discrimination exist because of people's ignorance."

DISCUSSION

Causes of Stigma and Discrimination for People with HIV and AIDS

The occurrence of cases of stigma and discrimination against people living with HIV and AIDS can be seen from the causes of the occurrence of the stigma and discrimination itself. The community's minimal knowledge of the pattern of HIV transmission can lead to stigma that has an impact on at-risk populations not being open to prevention, screening and treatment. The impact of stigma and discrimination causes low awareness to seek

1
2 information and utilize health services and even tend to hide so that PLWHA face
3
4 problems not only about health but also social pressure which worsens their condition [8,
5
6 9, 10, 11].
7

8
9 According to Goffman (2009), the cause of stigma is due to various discriminations
10
11 that result in social rejection of individuals and groups starting from fear [12]. Fear is the
12
13 main cause of the stigma of living with HIV and AIDS especially since there is an
14
15 assumption that HIV/AIDS is only contracted by people who behave at risk such as drug
16
17 users and have multiple sexual partners and can be transmitted by touch, fear of being
18
19 infected is the main source of discrimination by families and even by health workers [13,
20
21 14].
22
23

24
25 The above concept is to the results of this study that fear is the initial cause of the
26
27 stigma experienced by people living with HIV and AIDS. The fear experienced by people
28
29 living with HIV and AIDS arises from how people living with HIV and AIDS understand HIV
30
31 as a deadly infectious disease and that there is no cure. This makes people living with HIV
32
33 and AIDS think that when someone is infected with HIV, that person must be kept away so
34
35 they don't catch the disease. The fear experienced by people with HIV and AIDS in this
36
37 study comes from within the sufferers themselves so people with HIV prefer to hide their
38
39 status due to lack of self-confidence and lack of information about HIV. Excessive fear,
40
41 cynicism, social isolation, verbal abuse, dissemination of the status of people infected with
42
43 HIV and rejection in all fields make it increasingly difficult to detect the number of HIV
44
45 cases and affect access to and adherence to HIV prevention and treatment efforts [15, 16,
46
47 17, 18].
48
49
50

51
52 Stigma against people living with HIV and AIDS is also caused by their unattractive
53
54 appearance. Several conditions can cause people to be considered unattractive,
55
56 especially in cultures where external beauty is highly valued, stigma occurs when there are
57
58 attributes that create a gap in the acceptance of others because of the social identity
59
60

1
2 carried as a person with HIV [19, 20]. The unattractive assumption for people living with
3
4 HIV and AIDS is that negative treatment arises from fear of being infected, where a person
5
6 feels uncomfortable when in direct contact with PLHIV, as well as with objects used by
7
8 PLHA [14].
9

10
11 The research findings indicate that sufferers are worried about their appearance that
12
13 is different from other people. Generally, this feeling occurs in people with HIV and AIDS
14
15 who have shown symptoms of opportunistic infections, such as red rashes on the skin,
16
17 itching and so on and in people with AIDS who have reached the stage. Another cause of
18
19 stigma is anxiety. In view Goffman (2009), anxiety is a disability because the HIV and
20
21 AIDS viruses make sufferers uncomfortable, so they don't have the confidence to socialize
22
23 and appear in dealings with other people, hindering several processes including social
24
25 relationships [19, 21]. Having a negative view of oneself and feeling rejected by the
26
27 environment [22].
28
29
30

31
32 This study found that the anxiety experienced by people living with HIV and AIDS
33
34 causes discomfort in themselves after learning that they are HIV positive. This anxiety then
35
36 makes people with HIV and AIDS not know how to behave with the people around them.
37
38 Finally, people living with HIV and AIDS tend to avoid, be alone, close themselves off, and
39
40 feel unworthy to be in the middle of a family and feel different because they have HIV and
41
42 AIDS.
43
44

45
46 People with HIV and AIDS first realize that the reason they are infected is the result
47
48 of the behaviour they have done and it is a consequence that must be accepted. In
49
50 addition, society generally understands that HIV and AIDS are caused by immoral
51
52 behaviour associated with people who practice deviant behaviour, such as Commercial
53
54 Sex Workers, LGBT, and Drug Users. This becomes a natural thing when people living
55
56 with HIV are people who carry out deviant behaviour. Socially negative judgments from
57
58 ordinary people are also triggered by religious thinking that free sex outside of marriage,
59
60

1
2 let alone changing sexual partners is unlawful and a sin so infection with a sexual disease
3
4 is a consequence that must be accepted [23, 24].
5

6
7 Government policy instruments are also the cause of the stigma experienced by
8
9 people living with HIV and AIDS, especially about separate treatment policies for people
10
11 living with HIV and AIDS in hospitals or other health services. The government's policy of
12
13 separating health services then makes people living with HIV and AIDS feel differentiated
14
15 among patients, resulting in opportunities for opening up a person's HIV status and
16
17 opportunities for stigma and discrimination in society to increase. Stigma and
18
19 discrimination that is felt when seeking treatment at health services such as labelling
20
21 identifying as living with HIV, gestures, excessive use of personal protective equipment,
22
23 and patient confidentiality is not guaranteed until treatment is refused [25, 26]. The
24
25 patient's status is confidential, as is the case with people living with HIV, so it is important
26
27 to protect it and not spread it because it creates stigma. The motives of PLWHA to cover
28
29 their status outside their community are because of the stigma and discrimination they get,
30
31 such as exclusion and even expulsion from their environment [27, 28, 29].
32
33
34
35

36
37 While the causes of discrimination are found in various causes including
38
39 disappointment, feeling insecure and withdrawn, as well as competition and exploitation. If
40
41 this fact is related to the process of social construction, the disappointment that arises in
42
43 families ultimately makes people living with HIV and AIDS the scapegoat for various
44
45 existing problems, even though many people are infected with HIV, not because of free
46
47 sex but are transmitted by their partners who have risky behaviour. That is why people
48
49 with HIV will only open up to their in-group and feel safe telling their condition and feelings.
50
51 Someone will open up if they have something in common because they feel more
52
53 comfortable and safe sharing personal information about themselves [30].
54
55

56
57 Social construction is formed through the process of internalization experienced by
58
59 individuals in the form of interpretation, then produces an objectivation process after the
60

individual understands his interpretation according to the standard norms. Furthermore, individuals develop externalization processes in the form of actions. As well as the causes of stigma and discrimination in society against people living with HIV and AIDS in this study are a social construction built by the community itself from the way it sees, interprets, understands what is happening, and implements certain actions. Therefore, after contracting HIV and AIDS a person will carry out social construction of the conditions experienced by people who previously had a healthy body condition to experience HIV and AIDS by externalizing or adjusting themselves to living with HIV and AIDS and adjusting themselves in the face of societal stigma and discrimination against people living with HIV and AIDS.

Forms of Stigma and Discrimination for People with HIV and AIDS

Analysis of the findings of researchers in the field shows the forms of stigma and discrimination against people living with HIV and AIDS that are experienced, such as public stigma and self-stigma. While the forms of discrimination are: verbal discrimination and avoidance as shown in the (Table 1) below:

Based on Table 1, public stigma comes from the family itself and the social environment. The exaggerated initial reaction given to people living with HIV and AIDS after hearing the words HIV and AIDS elicited a response in the form of verbal stigma. Stigma can arise because society always associates HIV as an infectious disease due to sex outside of marriage and drug use, so if someone is known to be infected with HIV then they are given that label. Social stigma due to excessive fear of people living with HIV because it is considered a scary disease, embarrassing and a violation of social norms so they are ostracized and shunned [31, 32]. Stigma is an unfair prejudice that tends to be generalized to all people living with HIV, this is a manifestation of the lack of information

and understanding about HIV and AIDS and errors in interpreting the information received.

Another form of stigma is self-stigma where self-esteem and self-confidence are reduced for people living with HIV. In this study, a form of self-stigma is often found in people living with HIV and AIDS after being declared positive for HIV, in the form of negative thoughts, distancing themselves from their families, despair, shame, anger and withdrawal from their social environment. Negative self-stigma, because they feel rejected by others, causes a low quality of life, anxiety and depression occur and even the desire to commit suicide [33].

The results of research on forms of discrimination obtained several forms including verbal discrimination, avoidance, and ostracism. Verbal discrimination is discrimination that occurs through words such as insulting (verbal abuse) people with HIV and AIDS. The method is done by cornering people living with HIV and AIDS through words due to ignorance of information about HIV and AIDS. Discrimination in the form of avoidance is practised by avoiding or staying away from a person or group of people who are not liked. Status changes experienced by people living with HIV and AIDS lead to changes in the behaviour of the people around them. People with HIV and AIDS feel this, such as people who used to be close and then it seems they don't know them, who used to have good relations suddenly become tenuous, don't want to be close, let alone touch, stay away and avoid.

The Impact of Stigma and Discrimination on People with HIV and AIDS

The status of HIV and AIDS will arise from the impact of stigma and discrimination in society against people living with HIV and AIDS. The impact of social stigma and discrimination against people living with HIV and AIDS can be: it is difficult to seek help, it is difficult to restore life, and it causes discrimination. People who have experienced

1 stigma and discrimination will find it difficult to seek help. This difficulty can come from
2
3 family, friends and the environment around people living with HIV and AIDS. This research
4
5 is supported by research conducted by Darak et al. (2019), who stated that there are
6
7 mental disorders experienced by people who are not infected with HIV who live in the
8
9 same house as people with HIV [34].
10
11
12

13 It will be difficult for people living with HIV and AIDS to improve their quality of life if
14
15 stigma and discrimination continue. This becomes a social and mental burden that is felt
16
17 which further worsens his health. Stigma is a stereotyped activation of certain individuals
18
19 or groups that always has a negative impact causing a decrease in self-esteem in the form
20
21 of poor self-efficacy [35, 36]. Not many PLHIVs can go through this difficult phase after
22
23 knowing their HIV status because the stigma and discrimination they receive are greater
24
25 than the social support they receive. This condition causes PLWHA to close themselves
26
27 and not want to socialize and not utilize health services for their treatment. People who
28
29 experience discrimination have an impact on non-compliance with treatment and hinder
30
31 the healthcare process for PLHIV [37].
32
33
34
35

36 The impact of stigma will lead to discrimination experienced by people living with HIV
37
38 and AIDS. Discrimination makes it difficult for people with HIV and AIDS to find
39
40 accommodation and work. Discrimination that occurs starts from the family environment
41
42 which separates cutlery and toiletries for people with HIV and AIDS. Then it happened in
43
44 health services that differentiated other patients from patients living with HIV and AIDS and
45
46 also happened in public services such as prisons which separated prisoners living with
47
48 HIV and AIDS. If stigma continues, then discrimination will take place and develop in
49
50 society. This makes people living with HIV afraid, they don't take advantage of health
51
52 services, making it even more difficult to get exact data on people living with HIV and
53
54 AIDS.
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CONCLUSION

Based on the results of the study, it can be concluded that the cause of stigma is ignorance of the community due to minimal information regarding the pattern of transmission and handling of HIV and AIDS, which causes fear, worry, low self-esteem, anxiety, associations, and feelings of insecurity as a person living with HIV. While the causes of discrimination are a disappointment, the perception of security and low self-esteem. The forms of stigma and discrimination against people living with HIV and AIDS are public stigma and self-stigma. While the form of discrimination is verbal discrimination and avoidance. The impact of stigma and discrimination on people living with HIV and AIDS is that it is difficult to seek help, it is difficult to restore life, and they are reluctant to take advantage of health services. It is recommended to intensify HIV and AIDS education programs in the general public to minimize stigma and discriminatory attitudes.

Table 1. Forms of stigma and discrimination against people living with HIV and AIDS

Acquired Forms of Stigma	
Theme	Sub Themes
Public Stigma	• Labeling • Stereotypes • Exclusion • Lost status • Minimal social support from family and community
Self-Stigma	• Powerlessness • Low self-efficacy • Withdraw • Emotional responses such as fear, anger, disappointment, shame • Hopeless • Loss of appreciation/self-esteem
Forms of Discrimination	
Verbal expression	Avoidance/shunning
Avoidance	

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The authors have put a lot of work into improving the manuscript. I would like to give general comments that need their attention for improvement:

1. There is a need to conduct thorough English editing and improve the flow of ideas throughout the manuscript
2. When using abbreviations/acronyms for the first time, you need to write the full sentence.
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5. The discussion section needs to be condensed

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Journal of Medicine and Life

Community Stigma and Discrimination against the Incidence of HIV and Aids

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Keywords:	HIV and AIDS, People with, Stigma, Discrimination

INTRODUCTION

The 2030 global target for HIV and AIDS prevention is three zeros, namely zero new HIV infections, zero deaths due to AIDS cases, and zero acts of stigmatization and discrimination. Zero stigma and discrimination targets for PLWHA are likely to experience obstacles due to a lack of public understanding accompanied by a prejudiced attitude towards those living with them. Human Immunodeficiency Virus (HIV) is by definition a virus that attacks the human immune system and weakens the body's ability to fight all kinds of diseases. Acquired Immune Deficiency Syndrome (AIDS) is a collection of symptoms of a disease caused by a decrease in the immune system due to infection with HIV. AIDS is often referred to as a disease of deviant behaviour because the factors that trigger this event were previously only found in at-risk groups such as commercial sex workers, homosexuals, injecting drug users, and men who become sex customers.

However, currently, the attack of HIV and AIDS has occurred among the general public (generalised epidemic level) such as those infected in housewives and children. HIV and AIDS do not recognize social stratification such as age, gender, occupation, ethnicity, nation and others. It is in this view that HIV and AIDS then become a sociological and health problem that threatens the lives of all social strata of society. Based on the Report on the development of HIV, AIDS and Sexually Transmitted Diseases in Indonesia until September 2022, the cumulative number of PLHIV found was 338,760, while the cumulative number of AIDS reported until June 2022 was 140,024 and the cumulative number of HIV and AIDS cases up to June 2022 was 478,784 [1].

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number of HIV and AIDS cases up to June 2022 was 478,784 [1].

Commented [WU1]: Reviewer 1:
Authors need to use current HIV data in Indonesia; the 2022 report has been available online: see SIHA website.
It has been adjusted to the latest link
https://siha.kemkes.go.id/login_index.php based on suggestions from reviewers

Southeast Sulawesi is one of the provinces that has experienced an increase in the findings of new HIV and AIDS cases every year. According to data, cases of HIV and AIDS in Southeast Sulawesi Province between 2012-2017 have increased. Report on the Development of HIV, AIDS and Sexually Transmitted Diseases Quarter I 2021 for

1

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Southeast Sulawesi, as many as 3,795 people who were tested for HIV found 16 new cases, while in the April-June 2022 period, 5,678 people were tested for HIV and found 95 cases of people with HIV/ODHA [2].

The numbers obtained are only for people who take the test voluntarily. HIV cases can occur in any area, as well as in Wakatobi District which has experienced an increase in the number of new cases. Data owned by the Wakatobi Regional AIDS Commission in 2021, there were 13 new cases of HIV and in 2022 as many as 16 new cases were found [3]. In general in all regions, of course, there are far more actual cases because HIV and

AIDS are included in the iceberg phenomenon. The basic cause is the presence of stigma and discrimination against people living with HIV and AIDS so that the population at risk tends to withdraw from taking the test. In effect, new infections occur in the form of silent epidemics. Incidents of stigma and discrimination often occur in families, communities, schools, places of worship, workplaces, and places of legal and health services.

The process of silent transmission will be further strengthened by the characteristics of the at-risk population such as working as an overseas trader who leaves his wife for a long time, thus allowing risky sexual contact to occur. People with HIV and AIDS consist of various ages, genders, groups and statuses. People who suspect they are infected with sexually transmitted diseases as well as those living with HIV usually withdraw from themselves and are afraid of stigma and discrimination, making it difficult to develop prevention, care and treatment practices.

Various studies have been carried out, as the results of research conducted by Mahamoro et al. (2020), Participants experience external stigma in health facilities, communities, and families, which is expressed through discriminatory attitudes and behaviour [4]. They also experience anticipatory stigma as a result of other PLWHA's experiences of stigma and discrimination. Individual moral judgments related to HIV status and negative self-assessment are determinants of perceived stigma. Similar research was

also conducted by N. K. Fauk, Ward, et al. (2021), that stigma and discrimination against PLHIV still exist in the family, community, and health services. This is reflected in negative labelling, segregation of personal belongings, avoidance, treatment refusal, and rejection of PLWHA by healthcare providers, families, and community members. Some healthcare providers even admit that they are also involved in stigmatizing and discriminating against PLHIV [5].

A similar study was also conducted by N. K. Fauk, Hawke, et al. (2021), which found that participants experienced stigma and discrimination in various places, including in the family, community, and healthcare settings. Factors such as lack of knowledge about HIV, fear of contracting HIV, and social and moral perceptions about HIV and PLHIV are considered drivers of stigma and discrimination [6]. Follow-up research conducted by N. K. Fauk, Mwanri, et al. (2022), HIV causes negative psychological consequences for WLHIV, such as stress, fear, worry, anxiety, and depression, as well as social impacts including stigma, discrimination, and family separation [7]. In addition, N. Fauk (2022) stated that the impact of HIV on WLHIV and MLHIV and their families included: (i) stigmatization and discrimination, (ii) psychological impact, (iii) family conflict and separation, and (iv) physical impact [8].

According to N. K. Fauk, Gesesew, et al. (2022), psychological challenges, stigma, and discrimination faced by WLHIV. However, they show an extraordinary capacity to adopt effective strategies and supports to protect themselves and educate themselves and those around them. With this, they seek to rebuild trust, gain respect and acceptance. These findings highlight the need for policies and practices that help WLHIV better address HIV-related psychological and social challenges [9].

Many studies have reported that stigma and discrimination occur within one's own family such as siblings, relatives and even parents because of fear of being infected and to this day it is still a global problem in reducing infection [10, 11, 12, 6]. The fear of

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- Introduction is weak. A substantial missing point in the introduction is the synthesis of the existing literature/the previous findings on HIV stigma and discrimination: what kind of HIV stigma and discrimination has happened to PLHIV, and what are the supporting factors? Presenting these aspects will support the authors' position to convincingly formulate the novelty or knowledge gap they wanted to bridge through their study/this paper. There have been studies and publications on these aspects in Indonesia, Asia and globally. Here are some current resources on HIV stigma in Indonesia and low- and middle-income countries in Asia that you may consult and cite to support your statements:

- HIV Stigma and Moral Judgement: Qualitative Exploration of the Experiences of HIV Stigma and Discrimination among Married Men Living with HIV in Yogyakarta. *Int. J. Environ. Res. Public Health* 2020, 17, 636. <https://doi.org/10.3390/ijerph17020636>
- Stigma and Discrimination towards People Living with HIV in the Context of Families, Communities, and Healthcare Settings: A Qualitative Study in Indonesia. *Int. J. Environ. Res. Public Health* 2021, 18, 5424. <https://doi.org/10.3390/ijerph18105424>
- HIV Stigma and Discrimination: Perspectives and Personal Experiences of Healthcare Providers in Yogyakarta and Belu, Indonesia. *Frontiers in Medicine*. Volume 8 - 2021 | <https://doi.org/10.3389/fmed.2021.625787>
- <https://www.frontiersin.org/articles/10.3389/fmed.2021.625787/full>
- Psychological and Social Impact of HIV on Women Living with HIV and Their Families in Low- and Middle-Income Asian Countries: A Systematic Search and Critical Review. *Int. J. Environ. Res. Public Health* 2022, 19, 6668. <https://doi.org/10.3390/ijerph19116668>
- <https://www.mdpi.com/1660-4601/19/11/6668>
- HIV-related challenges and women's self-response: A qualitative study with women living with HIV in Indonesia. *PLoS ONE* 17(10): e0275390. <https://doi.org/10.1371/journal.pone.0275390>
- <https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0275390>
- Risk factors and The Impact of HIV among Women Living with HIV and Their Families in Yogyakarta and Belu District, Indonesia (see Section 5.3.1 and 6.3.1). https://www.researchgate.net/profile/Nelsensius-Fauk/publication/361886192_Risk_factors_and_the_impact_of_HIV_among_women_living_with_HIV_and_their_families_in_Yogyakarta_and_Belu_district_Indonesia/links/62cab6a400db4511046b7a9/Risk-factors-and-the-impact-of-HIV-among-women-living-with-HIV-and-their-families-in-Yogyakarta-and-Belu-district-Indonesia.pdf?utm_source=nationaltribune&utm_medium=nationaltribune&utm_campaign=news

The above references have been added to the writing of this article based on suggestions from journal reviewers

contracting HIV stems from a lack of knowledge about HIV and is a driving factor for stigma and discrimination against people living with HIV [13, 14, 9]. Responses as a result of immoral, dirty, embarrassing and inappropriate behaviour further increase the stigma and discrimination against PLHIV [15, 16, 4].

Various studies on stigma and discrimination against PLWHA are generally based on a positivistic paradigm that views events of stigmatization and discrimination as objective facts. This study rests on the constructivism paradigm by focusing on the meanings constructed by the community that shape their knowledge and actions towards PLHIV. Epistemology of constructivism research uses social construction theory by Peter L. Berger and Thomas Luckmann as analytical tools. In explaining the constructivist paradigm, social reality is a social construction created by individuals through a process of social interaction. Knowledge is seen as a picture that is formed from objective reality in itself, the individual becomes a determinant in the social world that is constructed based on his will. Individuals are not victims of social facts, but of creative production and reproduction media in constructing their social world [17, 18, 19, 20].

Individuals continuously create a reality that is subjectively owned and shared and forms standards, and values that are recognized by society [21, 22, 23]. There is a dialectic between individuals creating society and society creating individuals through a process of externalization, objectivation and internalization [24]. This study aimed to analyze the causes, forms and impacts of stigmatization and discrimination of people living with HIV and AIDS as a product of dialectical social interactions.

MATERIAL AND METHODS

Epistemologically, this study uses the perspective of Peter L. Berger and Luckmann's Social Construction Theory which views social reality as relative and is a reality created by

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- In the last paragraph of the introduction, the authors stated that they used the social construction theory by Peter L. Berger and Thomas Luckmann as an analytical tool, but nowhere to find in the manuscript the explanation of the theory and how they used it. You need to walk the readers through the theory to help them understand how you have used the theory to guide your research, data analysis and discussion of the findings. Provide a section on the theory.

It has been added based on suggestions from reviewers

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- The novelty/knowledge gap of this study/paper is provided. What is the selling point of this manuscript? In other words, what's new? Authors need to provide this aspect in the last paragraph of the introduction section.

It has been added based on suggestions from reviewers

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10 individuals. This paradigmatic foundation then determines the choice of research methods,
11 data collection techniques, methods of data analysis and interpretation, to conclude. Thus,
12 this research approach uses a qualitative approach because it emphasizes the reality
13 created by individuals with a case study method that intends to explore in depth the
14 phenomena of stigma and discrimination against people living with HIV and AIDS as a
15 result of a social construction process. This research is located in Wakatobi District with
16 the consideration that there are additional cases from year to year and in this area a
17 mentoring and monitoring program is currently underway for suspected and living HIV,
18 making it easier to obtain informants and information.
19

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21 The informants for this study were HIV and AIDS programmers at the Wakatobi
22 Health Office as key informants, representatives of the Regional AIDS Commission as
23 supporting informants and key informants who were selected purposively, namely
24 communicative and willing to be interviewed. The selection of informants was based on
25 consideration of their direct involvement in the social world which reflects the reality of
26 stigmatization and discrimination of people living with HIV and AIDS as the basic
27 assumptions of the constructivism paradigm which forms the basis of this research. The
28 main instrument of this research is the researcher himself who is equipped with tools used
29 for data collection such as interview guides, observation sheets, field notes, cameras,
30 recorders, and other supporting tools.
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33 Data collection techniques namely by observation, in-depth interviews and
34 documentation. In using this data collection technique, based on the constructivism
35 paradigm, the values, ethics and morals of the researcher cannot be separated because
36 the findings of the data in the form of meaning come from the researcher's subjective
37 relationship with the social world of actors who experience the phenomenon of
38 stigmatization and discrimination due to HIV and AIDS. There are three components in
39 qualitative research which are called social situations, namely places, actors, and
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activities. Observations were made to observe informants' activities on the phenomena being investigated, either directly or indirectly. Meanwhile, in-depth interviews explored invisible phenomena by tracing information from all informants regarding stigma and discrimination. Documentation relevant to the review is a source triangulation approach to ensure the validity of the qualitative findings.

Qualitative data analysis was carried out using the Miles and Huberman model guided by constructivist reasoning. Miles and Huberman direct the stages of analysis, namely data reduction is defined as the process of categorizing and selecting data, displaying data to compile the information that has been collected in drawing conclusions and taking action, then drawing conclusions and verifying, then will present in a narrative form, while constructivism directives are applied using a reasoning process at each stage of analysis developed based on the creative results of the researcher in providing explanations of the findings or in constructing the reality of the findings.

RESULTS AND DISCUSSION

RESULTS

Based on Table 1, it can be described that the informants in this study were at a productive age which based on the data is the age group most infected with HIV. The level of education in the middle and above does not mean that education is linear with the knowledge possessed about HIV, as well as with the work of informants that do not

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Reviewer 2:

This article does not present adequate methodology and therefore its results are poorly presented. The discussion and conclusion are not based on scientific methods and therefore are not eligible for publication.

Reviewer 1:

I suggest the authors consult the COREQ checklist to guide their report on the methodology used in this study.

Reviewer 3:

The paper contains in material, methods and results sections only general statements and does not provide specific characteristics of the authors research, such as specified in the instructions for authors.

Materials and methods - please include the following, as specified in the instructions for authors:

- sample size,
- inclusion/exclusion criteria, sampling method
- study setting (multicenter, single center, national, local, online),
- timeline (prospective/retrospective, between month(s) and year(s)).
- type (randomized control trial, observational, longitudinal, case-control, cross-sectional, descriptive, exploratory, ecological, intervention studies (on effectiveness of preventive measures/treatments, cohort, epidemiological, viral shedding study, community study),
- descriptive statistics of the sample,
- statistical tests,
- variables used,
- primary and secondary endpoints
- statistical software (SPSS, R, STATA, SAS, Medcalc, or others).

48 necessarily fortify themselves with HIV prevention efforts and openness to accept status
49 as living with HIV which can lead to stigma and discrimination.

52 Causes of stigma and discrimination in the incidence of HIV and AIDS

the reviewer

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The findings currently presented in this paper are poor.

Reviewer 3:

Results should contain the:

- number of participants
- key demographics (age, sex)
- details on their clinical attributes
- results of primary and secondary outcome measurements

It has been added about the characteristics of the informant

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11 Based on the results of the study, it was found that stigma and discrimination can
12 arise due to fear of HIV and AIDS. This fear is experienced in the same way, both in the
13 family environment, work, social environment or health services in general, which is fear
14 as expressed by the following informants:
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20 "If someone is exposed to (HIV)? That's the danger of being able to move around,
21 that's how naughty people will get sick like that" (Mr., 54 years)
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The views of these informants understand that HIV is a danger that the virus can move around easily, and can even be transmitted through ordinary social relationships. This point of view grows and develops as a result of the internalization process received in social interaction which generally has a wrong understanding of how HIV is transmitted. This means that there is a process of social construction created by individuals which is understood collectively and then develops into general knowledge.

Misunderstandings that have been objectivated by society are used as a basis for externalization in the form of stigmatizing and discriminating against sufferers. Because of that, people with HIV also experience construction in the form of fear due to their HIV-positive status. The implication is that sufferers must be forced to lie and cover up the disease they suffer from, as revealed by the following informants:

■

"I was sentenced to B20 in 2019, of course, I was shocked...what if someone finds out later, but now I have been taking medication for 3 years...If someone asks me what's wrong, I answer that I have TB so I have to take medicine" (Kj, 40 years)

■

"At first my wife was also surprised but now we are no longer the only ones who

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know because if other people know, they will be shunned, blamed and told stories and no one wants to meet let alone shake hands" (Kj, 40 years)

The behaviour of people with HIV and their families who cover their HIV status is a way of dealing with the response of society which tends not to provide reasonable social acceptance for people living with HIV. For sufferers, the treatment of society in the form of being shunned, blamed, and not even wanting to shake hands is much more painful than the physical suffering caused by the disease.

In line with what was experienced by the previous informant, another informant also revealed:

"As soon as they know HIV, it's so hard for the people here that they even prefer another way than passing in front of the house of someone who is known to have HIV" (Ra, 37 years).

According to an informant, the community's strong response to HIV sufferers is practised in the form of avoiding walking in front of the house, let alone meeting people with HIV because they consider it a disgrace. This means that social sufferers are already isolated in the process of interaction because society perceives them as violators of social norms that should be avoided socially. The sufferers experience difficulties in accessing services, especially medical services that they must undergo routinely. The further implication is that sufferers do not implement adherence to taking medication due to the difficulty of building interactions with the social environment.

Forms of Stigma and Discrimination for People with HIV and AIDS

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Causes of Stigma and Discrimination for People with HIV and AIDS
- I would suggest the authors read several resources I have provided in the introduction section above to help them identify causes of or contributing factors for HIV stigma and discrimination.
An informant's statement has been added based on suggestions from reviewers

Perceptions that arise from the family and social environment of people living with HIV are generally negative, as stated by the following informants:

■

"We sufferers are thought to be sinners because we are infected through commercial sex, so people often tell negative stories when they are together. We finally think we have no value in the eyes of society"(Ni, 35 years old)

■

The label of a sinner is the impression captured by the person with the community's response to him. Generally, people understand that HIV is only transmitted through sexual intercourse with multiple partners. Because of that society uses its moral basis in treating people living with HIV. The construction of this knowledge comes from the religiosity of society which is the principle of developing daily behavior.

Another form of stigma accepted by sufferers is that society views sufferers as a dangerous source of transmission. Because of that, there are no social spaces for sufferers to live, including living with their families. This feeling was experienced by the informants below:

■

"I and the sufferer are considered to be the ones who transmit HIV, that's why society doesn't give us the slightest chance to live. What's worse, our family also feels the same way so we are forced to not be accepted by our family" (Zn, 41 years old)

■

The public's partial understanding of the mode of transmission that only understands sexuality has implicated a dangerous response for the future life of sufferers. Society closes itself which in turn affects the attitude of families with people who also participate in treating family members who have HIV.

This social process clearly shows the existence of a reality created by individuals who are socially accepted and then socialized in everyday life to form norms in the form of

rejection for people living with HIV and AIDS.

The Impact of Stigma and Discrimination on People with HIV and AIDS

The occurrence of stigma and discrimination certainly has an impact on PLWHA so some are afraid to seek treatment. Here's the quote:

■

"As I said, if HIV is known, they will be shunned, talked about carelessly, blamed so they don't dare to get tested" (AI, 23 years)

■

The discriminatory treatment due to the negative social stigma was responded to by the sufferer in the form of a delay in carrying out HIV testing. The further impact is the possibility of people who behave at risk of suddenly experiencing opportunistic infections that should not have happened if their status could be known through testing at an early stage. Another impact is that the HIV iceberg phenomenon will continue to mount due to the attitude of delaying testing due to fear of being avoided by the public if their HIV-positive status is known by the public.

Another type of impact that was found was the behaviour of the sufferer's quality of life being ignored due to the loss of life expectancy, as expressed by the informant below:

■

"It's useless to take medicine all the time because our families don't think we're humans anymore and it seems that society doesn't want to hang out anymore...Why else live when it's like this" (Wu, 28 years)

■

The absence of reasonable life opportunities in society makes people despair, some even experience symptoms of mental disorders. The impact is that sufferers no longer pay

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Forms of Stigma and Discrimination for People with HIV and AIDS

- When you talk about forms of stigma, that means you present whether it is enacted/external stigma or perceived stigma or anticipated stigma or self-stigma. None of these forms of stigma were explored in the findings. Again, please read the references I provided above to help you clearly understand these types of stigma and revisit your data to improve the presentation of your findings.

An informant's statement has been added based on suggestions from reviewers

attention to the behaviour of taking the medication regularly and regularly and other healthy living behaviours. This will have an impact on the quality of life of sufferers who will experience a decrease until they experience imminent death. Even though ideally, when the sufferer maintains his healthy behaviour, the sufferer has the opportunity to live a productive life, the same as people who do not have HIV.

This information was corroborated by local health officials, as follows:
"The latter was a case of a woman who was depressed because she could not accept her HIV status, in the end, the collaboration was treated by a psychiatrist...Indeed, some people here generally don't know what HIV and AIDS is, the causes of which are widely known are infectious diseases due to free sexual behaviour, and injecting drugs, so we need information, so we are educating school children...It is really necessary to provide information widely because this disease occurs in all places...Stigma and discrimination exist because of people's ignorance" (Ni, 35 years)

DISCUSSION

Causes of Stigma and Discrimination in HIV and AIDS

The occurrence of cases of stigma and discrimination against people living with HIV and AIDS in research is caused by misunderstanding, excessive fear, disgrace to society, and people with HIV and AIDS are considered to violate religious and social norms.

The lack of public knowledge about the pattern of HIV transmission can lead to stigma and discrimination for sufferers. The results of this study are similar to those stated by N. K. Fauk, Hawke, et al. (2021), who see erroneous knowledge as a driver of stigma.

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The Impact of Stigma and Discrimination on People with HIV and AIDS

- Similar to the two sub-sections above, this is very poor, please make it rich.

An informant's statement has been added based on suggestions from reviewers

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Once you have improved the above sections, I would be happy to look at the discussion section in the second round of the review because this section will depend upon your result section.

It has been adjusted based on the direction of the journal reviewer

Erroneous knowledge in the context of this study was created by the community together through the process of daily social interaction to form a pattern of general knowledge. This is then used as the basis for developing the externalization process as stated by Peter L. Berger regarding the process of social construction which takes place in three concurrent moments, namely the process of internalization, objectivation, and externalization [6].

This erroneous knowledge also later gave rise to fears of excessive public fear, which led to stigmatization and discriminatory attitudes. Fauk, et al also found that an attitude of fear can lead to stigma and discrimination against sufferers, but research localizes community fear as an implication of the objectivation process that has been built in society according to the social construction theory of Peter L. Berger. Within society, the moral perspective in understanding HIV and AIDS has undergone a process of institutionalization (objectivation) which is often used as a basis for society to develop external actions. The basis of this morality cannot be separated from the typology of the Wakatobi people who are the focus of this research, which are indeed religious. Fear is the main cause of the stigma of living with HIV and AIDS especially since there is an assumption that HIV and AIDS is only contracted by people who behave at risk such as drug users and have multiple sexual partners and can be transmitted by touch, fear of being infected is the main source of discrimination by families and even by health workers [25, 26].

The above concept is by the results of this study that fear is the initial cause of the stigma experienced by people living with HIV and AIDS. The fear experienced by people living with HIV and AIDS arises from how people living with HIV and AIDS understand HIV as a deadly infectious disease and there is no cure. This makes people living with HIV and AIDS think that when someone is infected with HIV, that person must be kept away so they don't catch the disease. The fear experienced by people with HIV and AIDS in this study comes from within the sufferers themselves so people with HIV prefer to hide their status due to lack of self-confidence and lack of information about HIV. Excessive fear,

cynicism, social isolation, verbal abuse, dissemination of the status of people infected with HIV and rejection in all fields make it increasingly difficult to detect the number of HIV cases and affect access to and adherence to HIV prevention and treatment efforts [27, 28, 29, 6].

Another cause of stigma is the perspective of AIDS as a disgrace, causing anxiety. In Goffman's view (2009), anxiety is a disability because the HIV and AIDS viruses make sufferers uncomfortable [30]. So that you don't have the confidence to socialize and appear in front of other people, hindering several processes including social relations [31, 32]. Having a negative view of oneself and feeling rejected by the environment [33].

This study found that the anxiety experienced by people living with HIV and AIDS because they are considered a disgrace causes them to feel uncomfortable after learning that they are HIV positive. This anxiety then makes people with HIV and AIDS not know how to behave with the people around them. Finally, people living with HIV and AIDS tend to avoid, be alone, close themselves off, and feel unworthy to be in the middle of a family and feel different because they have HIV and AIDS.

People living with HIV and AIDS first realize that the reason they are infected is not because of free sex, but the people's assumption that it is difficult to break, which always thinks that HIV is caused by free sex. In addition, society, in general, understands that HIV and AIDS are caused by immoral behaviour associated with people who practice deviant behaviour, such as prostitutes, LGBT, and drug users. This becomes a natural thing when people living with HIV are people who carry out deviant behaviour. Socially negative judgments from ordinary people are also triggered by religious thinking that free sex outside of marriage, let alone changing sexual partners is unlawful and a sin so infection with a sexual disease is a consequence that must be accepted [34, 35].

Another reason is that people with HIV and AIDS are seen as violators of social and religious norms. The social norms in question are rules that are mutually agreed upon by

the community, especially about sexual behaviour which is only tolerated when the sexual relationship is bound by marriage. The same thing is also adhered to in religious norms which prohibit sexual relations outside of marriage. Society considers that people living with HIV and AIDS are people who do not comply with norms so they get problems in the form of disease. The sufferers are labelled as violators of the norm. Because of that society is obliged to provide evasion so that individually, they are also not ridiculed. This social process clearly illustrates the existence of a reality that is constructed by the community itself based on the prevailing social order.

Social construction is formed through the process of internalization experienced by individuals in the form of interpretation, then produces an objectivation process after the individual understands his interpretation according to the standard norms. Furthermore, individuals develop externalization processes in the form of actions. As well as the causes of stigma and discrimination in society against people living with HIV and AIDS in this study is a social construction built by the community itself from the way it sees, interprets, understands what is happening, and implements certain actions. Therefore, after contracting HIV and AIDS a person will carry out social construction of the conditions experienced by people who previously had a healthy body condition to experience HIV and AIDS by externalizing or adjusting themselves to living with HIV and AIDS and adjusting themselves in the face of societal stigma and discrimination against people living with HIV and AIDS.

Forms of Stigma and Discrimination for People with HIV and AIDS

Analysis of the findings of researchers in the field shows the forms of stigma and discrimination against people living with HIV and AIDS that are experienced, such as public stigma and self-stigma. While the forms of discrimination are: verbal discrimination

and avoidance as shown in the table below:

Based on Table 2, public stigma comes from the family itself and the social environment. The exaggerated initial reaction given to people living with HIV and AIDS after hearing the words HIV and AIDS elicited a response in the form of public stigma. Stigma can arise because society always associates HIV as an infectious disease due to sex outside of marriage and drug use, so if someone is known to be infected with HIV then they are given that label. Social stigma due to excessive fear of people living with HIV because it is considered a scary disease, embarrassing and a violation of social norms so they are ostracized and shunned [36, 37]. Stigma is an unfair prejudice that tends to be generalized to all people living with HIV, this is a manifestation of the lack of information and understanding about HIV and AIDS and errors in interpreting the information received.

Another form of stigma is self-stigma where self-esteem and self-confidence are reduced for people living with HIV. In this study, a form of self-stigma is often found in people living with HIV and AIDS after being declared positive for HIV, in the form of negative thoughts, distancing themselves from their families, despair, shame, anger and withdrawal from their social environment. Negative self-stigma, because you feel rejected by others, causes a low quality of life, anxiety and depression occur and even the desire to commit suicide [38].

The results of research on forms of discrimination obtained several forms including verbal discrimination, avoidance, and ostracism. Verbal discrimination is discrimination that occurs through words such as insulting (verbal abuse) people with HIV and AIDS. The method is done by cornering people living with HIV and AIDS through words due to ignorance of information about HIV and AIDS.

Discrimination in the form of avoidance is practised by avoiding or staying away from a person or group of people who are not liked. Status changes experienced by people living with HIV and AIDS lead to changes in the behaviour of the people around them.

9
10 People with HIV and AIDS feel this, like people who used to be close and then it seemed
11 they didn't know them, those who used to have good relations suddenly became tenuous,
12 don't want to be close, let alone touch, stay away and avoid.
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14

15 16 **The Impact of Stigma and Discrimination on People with HIV and AIDS** 17

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19
20 Stigma and discrimination against people living with HIV and AIDS are not inherent
21 but are the result of a social process in which meanings and norms are built and
22 maintained. Society collectively creates stigmatization of HIV and AIDS through various
23 mechanisms, such as stereotypes, moral judgments, and negative assumptions about
24 people who are infected. Stigma is a stereotyped activation of certain individuals or groups
25 that always has a negative impact causing a decrease in self-esteem in the form of poor
26 self-efficacy [39, 40].
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29 Social construction theory emphasizes the role of symbols, language and narratives
30 in shaping social reality. In the context of HIV and AIDS, the use of certain words and
31 terms, such as referring to a person with HIV as "a person with AIDS" or using other
32 derogatory words, can reinforce stigma and discrimination. The media, popular culture,
33 and misleading narratives can also influence people's perceptions of HIV and AIDS.
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37 Community perceptions that are constructed from media narratives influence patterns
38 of social interaction between people and people living with HIV. If society generally avoids
39 contact with people living with HIV and AIDS or isolates them, the stigma will be
40 strengthened and make those who are infected feel isolated. This research was similar to
41 that conducted by N. K. Fauk, Ward, et al. (2021), that stigma and discrimination against
42 PLHIV still exist in the family, community, and health services. This is reflected in negative
43 labelling, segregation of personal belongings, avoidance, treatment refusal, and rejection
44 of PLWHA by healthcare providers, families, and community members. Some healthcare
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providers even admit that they are also involved in stigmatizing and discriminating against PLHIV [5].

Institutions such as government agencies, health services, and workplaces can also influence the reproduction of stigma and discrimination. If some policies or practices discriminate against people living with HIV and AIDS, this can cause people with HIV to be reluctant to seek support or access health services, including HIV testing. To the results of research conducted by Mahamboro et al. (2020), Participants experience external stigma in health facilities, communities, and families, which is expressed through discriminatory attitudes and behaviour. They also experience anticipatory stigma as a result of other PLWHA's experiences of stigma and discrimination. Individual moral judgments related to HIV status and negative self-assessment are determinants of perceived stigma [4].

The impact of stigma and discrimination on people living with HIV and AIDS can make them reluctant to take an HIV test. Fear of rejection, isolation and discrimination can lead them to hide their health conditions and avoid testing for HIV. This phenomenon causes many cases of HIV and AIDS to go undiagnosed or to be detected too late, thus forming a bigger iceberg of the incidence of HIV and AIDS.

When people with HIV and AIDS feel afraid or embarrassed to reveal their condition or take tests, this stigma will continue to form in society. This creates a vicious circle in which stigma and discrimination continue to grow and affect newly infected people, hindering efforts to fight HIV and AIDS effectively. The growing iceberg phenomenon is an opportunity for new infections to emerge in the future.

The negative impact of stigma and other discrimination against people living with HIV is mental health problems for people living with HIV and AIDS in the form of shame, depression, anxiety, and feelings of inferiority. These mental disorders are perceived by sufferers as a result of symptoms of social rejection shown by society. Poor mental health conditions can reduce the ability of sufferers to care for themselves properly, including

maintaining their physical health, thus increasing the risk of developing opportunistic infections. Sufferers may feel that there is no need to take precautions or check their health because they feel worthless or unappreciated by society. This can lead to behaviour that increases the risk of increasing virulence levels so that it can reduce the sufferer's immunity in a short time.

Stigma and discrimination against HIV and AIDS can have a serious impact on the mental health of sufferers. People who experience discrimination and social rejection tend to feel stressed, anxious, and depressed. This poor mental health condition can cause sufferers to feel hopeless and lose enthusiasm for maintaining their health. This research is supported by research conducted by Darak et al. (2019), who stated that there are mental disorders experienced by people who are not infected with HIV who live in the same house as people with HIV [41].

Stigma and discrimination also have an impact on the difficulty of accessing people living with HIV and AIDS to health services. If sufferers feel afraid or embarrassed to seek medical care because they are afraid of experiencing discrimination in health facilities, they may delay or avoid the treatment they need. This increases their risk for opportunistic infections, due to the weakened immune system caused by HIV. This research is in line with the results of research conducted by N. K. Fauk, Hawke, et al. (2021), who found that participants experienced stigma and discrimination in various places, including in the family, community, and healthcare settings. Factors such as lack of knowledge about HIV, fear of contracting HIV, and social and moral perceptions about HIV and PLHIV are considered drivers of stigma and discrimination [6].

The act of stigma in healthcare facilities is a symptom of objectivation in social construction theory. People with it are increasingly legitimizing themselves as people who are not accepted because even credible healthcare facilities have shown negative attitudes and perceptions. Feelings of being ignored, unacknowledged and rejected by

healthcare facilities can cause sufferers to lose motivation to live a healthy lifestyle. They may feel that the pursuit of health is no longer relevant because of persistent feelings of sadness and hopelessness. This condition causes PLWHA to close themselves and do not want to socialize and not utilize health services for their treatment. People who experience discrimination have an impact on non-compliance with treatment and hinder the healthcare process for PLHIV [42].

Stigma and discrimination can affect a person's attitude towards medical care and healthy behaviour. Feelings of hopelessness and mental disorders can cause them to refuse to seek necessary treatment or to neglect preventive measures that are important to maintain their health. This research is in line with the results of research conducted by N. K. Fauk, Mwanri, et al. (2022), HIV causes negative psychological consequences for WLHIV, such as stress, fear, worry, anxiety, and depression, as well as social impacts including stigma, discrimination, and family separation [7].

In addition to the stigma received from society, people living with HIV and AIDS can also internalize this stigma, which is known as "internal stigma". They may experience feelings of shame, guilt, or low self-esteem because they have HIV and AIDS. This internal stigma can prevent sufferers from taking positive steps in maintaining their health.

To overcome the phenomenon where healthy behaviour is ignored by people living with HIV and AIDS due to the impact of stigma and discrimination, a social construction theory approach can help by changing people's perceptions and attitudes towards HIV and AIDS. Accurate education about HIV and AIDS, strong anti-stigma campaigns, positive social support, and reduction of internal stigma can help reduce the negative impact of stigma and discrimination so that sufferers can feel more supported and motivated to take positive steps to maintain their health.

According to N. K. Fauk, Gesesew, et al. (2022), psychological challenges, stigma, and discrimination faced by WLHIV. However, they show an extraordinary capacity to

adopt effective strategies and support to protect themselves and educate themselves and those around them. With this, they seek to rebuild trust, gain respect and acceptance. These findings highlight the need for policies and practices that help WLHIV better address HIV-related psychological and social challenges [9].

CONCLUSION

The stigmatization and discrimination of HIV and AIDS result from the process of community construction caused by an attitude of fear due to the erroneous understanding of the society in interpreting HIV events based on interpretations of morality and religion so that sufferers are labelled as disgraceful and violators of social and religious norms who have committed deviant behaviour. The forms of stigma and discrimination that occur are public stigma, self-stigma, and verbal avoidance. The impact of stigma and discrimination on sufferers is the decision not to take the test, to stop using health services, to ignore healthy behaviours, and to develop mental disorders that worsen the quality of life for people with HIV and AIDS. It is recommended to involve key people such as health workers and sufferers in actively carrying out the process of social reconstruction. Health workers apply friendly behaviour in providing health services and sufferers dare to disclose their status and actively campaign for the social support they need.

Table 1. Characteristics of Informants

No	Informant Initials	Age (years)	Gender	Education	Work	Information
1	Ni	35	Woman	3-Year Diploma	Civil Servant	Key Informants
2	Kj	40	Man	Senior High School	Honorary	Common Informant
3	Ra	37	Woman	Senior High School	Housewife	Common Informant
4	Al	23	Man	Student	-	Common Informant
5	Zn	41	Man	Senior High School	Private	Common Informant
6	Wu	28	Woman	3-Year Diploma	-	Common Informant
7	Tn	54	Man	Senior High School	Private	Supporting Informants

Table 2. Forms of stigma and discrimination against people living with HIV and AIDS

Acquired Forms of Stigma	
Theme	Sub Themes
Public Stigma	• Labeling • Stereotypes • Exclusion • Lost status • Minimal social support from family and community
Self-Stigma	• Powerlessness • Low self-efficacy • Withdraw • Emotional responses such as fear, anger, disappointment, shame • Hopeless • Loss of appreciation/self-esteem
Forms of Discrimination	
Verbal expression	Avoidance/shunning
Avoidance	

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Dear Dr. Asrina:

It is a pleasure to accept your manuscript entitled "Community Stigma and Discrimination against the Incidence of HIV and Aids" in its current form for publication in the Journal of **Medicine and Life**. The comments of the reviewer(s) who reviewed your manuscript are included at the foot of this letter.

Thank you for your fine contribution. On behalf of the Editors of the Journal of **Medicine and Life**, we look forward to your continued contributions to the Journal.

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Original article

Community stigma and discrimination against the incidence of HIV and AIDS

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ABSTRACT

The problem of HIV and AIDS is increasingly complex, apart from being related to health problems but also rampant stigma and discrimination which further exacerbate the health and social conditions of the sufferers. This study aims to examine the triggers of stigma and discrimination in the incidence of HIV and AIDS in Wakatobi, Southeast Sulawesi. This type of research is quasi-qualitative with a case study approach with the stages of reducing data, displaying data, and drawing conclusions. The results of the study found that the triggers for stigma and discrimination of people living with HIV and AIDS were: causes of stigma: fear, unattractiveness, anxiety, association and lack of confidentiality. Causes of discrimination: disappointment, experiencing insecurity and low self-esteem, and competition and exploitation. The forms of stigma for people living with HIV and HIV are in the form of public stigma, self-stigma, forms of verbal discrimination, and avoidance. Meanwhile, the impact of stigma and discrimination on people living with HIV and AIDS is: it is difficult to find help, it is difficult to restore life and discrimination. Stigmatizing attitudes and discriminatory acts of people living with HIV and AIDS worsen the quality of life of PLWHA which has the potential to cause new infections. Therefore, it is hoped that the government will be more massive in programming education about HIV and AIDS to increase public knowledge so that there is no stigma and discrimination in people's social life.

KEYWORDS: HIV and AIDS, people with, stigma, discrimination

INTRODUCTION

The 2030 global target for the prevention of Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS) aims for zero new HIV infections, zero AIDS-related deaths, and zero stigmatization and discrimination [add reference]. The goal of achieving zero stigma and discrimination targets People Living with HIV/AIDS (PLWHA) who are likely to experience obstacles due to a lack of understanding in society, accompanied by prejudiced attitudes towards those living with it [add reference]. HIV is by definition a virus that attacks the human immune system and weakens the body's ability to fight all types of disease. AIDS is a collection of disease symptoms caused by a decrease in the immune system caused by HIV infection [add reference]. AIDS is often referred to as a disease of deviant behaviour because the factors that trigger this event were previously only found in at-risk groups such as commercial sex workers, individuals with diverse sexual orientations, injecting drug users, and men who engaged in risky sexual behavior [add reference].

However, currently, the attack of HIV and AIDS has occurred among the general public (generalised epidemic level) such as those infected in housewives and children. HIV and AIDS do not recognize social stratification such as age, gender, occupation, ethnicity, nation and others. This underscores the sociological and public health significance of HIV and AIDS, influencing all societal strata. According to the Report on HIV, AIDS and Sexually Transmitted Diseases in Indonesia up to September 2022, there were 338,760 of People Living with HIV (PLHIV), with 140,024 AIDS cases by June 2022, bringing the total HIV and AIDS cases to 478,784 by June 2022 [1].

Southeast Sulawesi has witnessed an increase in the findings of new HIV and AIDS cases every year. According to data, cases of HIV and AIDS in Southeast Sulawesi Province between 2012-2017 have increased. According to the Report on the Development of HIV, AIDS and Sexually Transmitted Diseases for the first quarter of 2021 in Southeast Sulawesi, 16 new HIV cases were detected among 3,795 individuals tested. During the April-June 2022 period, out of 5,678 people tested for HIV, 95 cases of people with HIV/ODHA were identified [2].

These figures only represent individuals who take the test voluntarily. Furthermore, Wakatobi District has also experienced an increase in the number of new cases. Data from the Wakatobi Regional AIDS Commission indicates 13 new cases of HIV in 2021 and 16 new cases in 2022 [3]. In reality, the actual number of cases is significantly higher in all regions due to the underreported cases of HIV/AIDS, driven by stigma and discrimination against those affected. Subsequently, the population at risk tends to withdraw from taking the test. In effect, new infections occur in the form of silent epidemics. Incidents of stigma and discrimination often occur in families, communities, schools, places of worship, workplaces, and places of legal and health services.

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Currently, HIV and AIDS have become a generalized epidemic, affecting individuals across diverse demographics, including individuals from various backgrounds and children, without regard to age, gender, occupation, ethnicity, or nationality, highlighting the sociological and public health significance of these diseases, influencing all societal strata [add reference].

Reply

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INTRODUCTION

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The process of silent transmission can be facilitated by various factors within at-risk populations. For example, individuals engaged in long-term overseas work may face an increased risk of engaging in risky sexual behavior, which can contribute to silent transmission. People living with HIV and AIDS consist of various age groups, gender, groups and statuses. Both people who suspect they may be infected with sexually transmitted diseases and those already living with HIV usually withdraw from themselves and are afraid of stigma and discrimination, making it difficult to develop prevention, care and treatment practices. Numerous studies, including research by Mahamoro et al. [4], have found that individuals with HIV/AIDS face external stigma in healthcare facilities, communities, and

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Reply

Andreea Strlicuc To maintain a more formal tone, you could replace "iceberg phenomenon" with "underreporting" or "hidden cases," which are more straightforward terms often used in academic and scientific writing to describe the same concept

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MATERIAL AND METHODS

Epistemological foundation and research approach

This study adopts the perspective of Peter L. Berger and Luckmann's Social Construction Theory which views social reality as relative and created by individuals. This paradigm determined the choice of research methods, data collection, data analysis and interpretation. Consequently, we used a qualitative approach because it emphasized the reality created by individuals, using a case study method to explore in depth the phenomena of stigma and discrimination against people living with HIV and AIDS as a result of a social construction process.

Study location and participants

The research was conducted in the Wakatobi District, due to the increasing cases of HIV and AIDS in the region and the ongoing mentoring and monitoring programs for suspected and confirmed HIV cases. This environment facilitates access to relevant informants and information.

The informants for this study were HIV and AIDS personnel at the Wakatobi Health Office as key informants, representatives of the Regional AIDS Commission as supporting informants and key informants. The selection of these informants was purposeful, targeting individuals who had strong communication skills and a willingness to participate in interviews. The selection of informants was based on consideration of their direct involvement in the social world which reflects the reality of stigmatization and discrimination of people living with HIV and AIDS as the basic assumptions of the constructivism paradigm which forms the basis of this research.

Data collection

This research used various tools for data collection, including interview guides, observation sheets, field notes, cameras, recorders, and supplementary materials. Data was collected through observation, in-depth interviews and documentation. In using this data collection technique, based on the constructivism paradigm, the values, ethics and morals of the researcher cannot be separated because the findings of the data in the form of meaning come from the researcher's subjective relationship with the social world of actors who experience the phenomenon of stigmatization and discrimination due to HIV and AIDS. There are three components in qualitative research which are called social situations, namely places, actors, and activities. Observations were made to observe informants' activities on the phenomena being investigated, either directly or indirectly. Meanwhile, in-depth interviews explored invisible phenomena by tracing information from all informants regarding stigma and discrimination. Documentation relevant to the review is a source triangulation approach to ensure the validity of the qualitative findings.

Data analysis

Qualitative data analysis was carried out using the Miles and Huberman model guided by constructivist reasoning. Miles and Huberman direct the stages of analysis, namely data reduction is defined as the process of categorizing and selecting data, displaying data to compile the information that has been collected in drawing conclusions and taking action, then drawing conclusions and verifying, then will present in a narrative form, while constructivism

directives are applied using a reasoning process at each stage of analysis developed based on the creative results of the researcher in providing explanations of the findings or in constructing the reality of the findings.

RESULTS

Table 1. Characteristics of Informants

No	Informant Initials	Age	Gender	Education	Work	Information
1	Ni	35 years	Woman	3-Year Diploma	Civil Servant	Key Informants
2	Kj	40 years	Man	Senior High School	Honorary	Common Informant
3	Ra	37 years	Woman	Senior High School	Housewife	Common Informant
4	Ai	23 years	Man	Student	-	Common Informant
5	Zn	41 years	Man	Senior High School	Private	Common Informant
6	Wu	28 years	Woman	3-Year Diploma	-	Common Informant
7	Tn	54 years	Man	Senior High School	Private	Supporting Informants

As shown in Table 1, the informants in this study were at a productive age which based on the data is the age group most infected with HIV. The level of education in the middle and above does not mean that education is linear with the knowledge possessed about HIV, as well as with the work of informants that do not necessarily fortify themselves with HIV prevention efforts and openness to accept status as living with HIV which can lead to stigma and discrimination.

Causes of stigma and discrimination in the incidence of HIV and AIDS

The study revealed that stigma and discrimination can arise due to fear of HIV and AIDS. This fear is experienced in the same way, both in the family environment, work, social environment or health services in general, as expressed by the following informants:

"If someone is exposed to (HIV)? That's the danger of being able to move around, that's how naughty people will get sick like that" (Mr., 54 years)

These perspectives depict HIV as a virus that can move around easily, and can even be transmitted through ordinary social relationships. This point of view grows and develops as a result of the internalization process received in social interaction which generally has a wrong understanding of how HIV is transmitted. This means that there is a process of social construction created by individuals which is understood collectively and then develops into general knowledge.

Misunderstandings that have been objectivated by society are used as a basis for externalization in the form of stigmatizing and discriminating against sufferers. Because of that, people with HIV also experience construction in the form of fear due to their HIV-positive status. The implication is that sufferers must be forced to lie and cover up the disease they suffer from, as revealed by the following informants:

"I was sentenced to B20 in 2019, of course, I was shocked...what if someone finds out later, but now I have been taking medication for 3 years...If someone asks me what's wrong, I answer that I have TB so I have to take medicine" (Kj, 40 years)

"At first my wife was also surprised but now we are no longer the only ones who know because if other people know, they will be shunned, blamed and told stories and no one

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Due to the constructivist paradigm guiding this research, the researcher's values, ethics and morals played a role in interpreting the data. This recognition is essential because it acknowledges that the data's meaning is influenced by the researcher's subjective interaction with individuals who have experienced stigma and discrimination related to HIV and AIDS.

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wants to meet let alone shake hands" (Kj, 40 years)

The behaviour of people with HIV and their families who cover their HIV status is a way of dealing with the response of society which tends not to provide reasonable social acceptance for people living with HIV. For sufferers, the treatment of society in the form of being shunned, blamed, and not even wanting to shake hands is much more painful than the physical suffering caused by the disease.

In line with what was experienced by the previous informant, another informant also revealed:

"As soon as they know HIV, it's so hard for the people here that they even prefer another way than passing in front of the house of someone who is known to have HIV" (Ra, 37 years).

According to an informant, the community's strong response to HIV sufferers is practised in the form of avoiding walking in front of the house, let alone meeting people with HIV because they consider it a disgrace. This means that social sufferers are already isolated in the process of interaction because society perceives them as violators of social norms that should be avoided socially. The sufferers experience difficulties in accessing services, especially medical services that they must undergo routinely. The further implication is that sufferers do not implement adherence to taking medication due to the difficulty of building interactions with the social environment.

Forms of Stigma and Discrimination for People with HIV and AIDS

Perceptions that arise from the family and social environment of people living with HIV are generally negative, as stated by the following informants:

"We, the sufferers, are thought to be sinners because we are infected through commercial sex, so people often tell negative stories when they are together. We finally think we have no value in the eyes of society" (Ni, 35 years old)

The label of a sinner is the impression captured by the person with the community's response to him. Generally, people understand that HIV is only transmitted through sexual intercourse with multiple partners. Because of that society uses its moral basis in treating people living with HIV. The construction of this knowledge comes from the religiosity of society which is the principle of developing daily behavior.

Another form of stigma accepted by sufferers is that society views sufferers as a dangerous source of transmission. Because of that, there are no social spaces for sufferers to live, including living with their families. This feeling was experienced by the informants below:

"The general opinion is that people with HIV are the ones who transmit HIV, that's why people don't give people the opportunity to socialize. What's worse, the family is also of the same opinion so that the sufferer is forced not to be accepted by the family" (Zn, 41 years old)

The public's partial understanding of the mode of transmission that only sees sexuality has implicated a dangerous response for the future life of sufferers. Society closes itself which in turn affects the attitude of families with people who also participate in treating family members who have HIV.

This social process clearly shows the existence of a reality created by individuals who are socially accepted and then socialized in everyday life to form norms in the form of rejection for people living with HIV and AIDS.

The Impact of Stigma and Discrimination on People with HIV and AIDS

The occurrence of stigma and discrimination certainly has an impact on PLWHA, and some are afraid to seek treatment.

"As I said, if HIV is known, they will be shunned, talked about carelessly, blamed so they don't dare to get tested" (Al, 23 years)

The discriminatory treatment due to the negative social stigma was responded to by the sufferer in the form of a delay in carrying out HIV testing. The further impact is the possibility of people who behave at risk of suddenly experiencing opportunistic infections that should not have happened if their status could be known through testing at an early stage. Another impact is that the HIV iceberg phenomenon will continue to mount due to the attitude of delaying testing due to fear of being avoided by the public if their HIV-positive status is known by the public.

Another type of impact that was found was the behaviour of the sufferer's quality of life being ignored due to the loss of life expectancy, as expressed by the informant below:

"It's useless to take medicine all the time because our families don't think we're humans anymore and it seems that society doesn't want to hang out anymore... Why else live when it's like this" (Wu, 28 years)

The absence of reasonable life opportunities in society makes people despair, some even experience symptoms of mental disorders. The impact is that sufferers no longer pay attention to the behaviour of taking the medication regularly and regularly and other healthy living behaviours. This will have an impact on the quality of life of sufferers who will experience a decrease until they experience imminent death. Even though ideally, when the sufferer maintains his healthy behaviour, the sufferer has the opportunity to live a productive life, the same as people who do not have HIV.

This information was corroborated by local health officials, as follows:

"The latter was a case of a woman who was depressed because she could not accept her HIV status, in the end, the collaboration was treated by a psychiatrist... Indeed, some people here generally don't know what HIV and AIDS is, the causes of which are widely known as infectious diseases due to free sexual behaviour, and injecting drugs, so we need information, so we are educating school children... It is really necessary to provide information widely because this disease occurs in all places... Stigma and discrimination exist because of people's ignorance" (Ni, 35 years)

DISCUSSION

Causes of Stigma and Discrimination against individuals living with HIV/AIDS

Cases of stigma and discrimination against people living with HIV and AIDS were caused by misunderstanding, excessive fear, social disgrace, and the notion that people with HIV and AIDS violate religious and social norms. The lack of public knowledge about the pattern of HIV transmission can lead to stigma and discrimination. This study is in line with the findings of Fauk, *et al.*, who identified erroneous knowledge as a driver of stigma. This erroneous

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knowledge is formed through the process of daily social interaction, which becomes the basis for the process of externalization as explained by Peter L Berger about the process of social construction which involves the process of internalization, objectivation and externalization [6].

Wrong knowledge creates excessive fear, which causes stigmatization and acts of discrimination. Fauk, et al stated that fearful attitudes can lead to stigma and discrimination against people living with HIV and AIDS, by focusing on the implications of the objectivation process in Peter L. Berger's social construction theory. Within the Wakatobi community, the moral perspective on HIV and AIDS has undergone a process of institutionalization (objectivation) and has become the basis for external actions. The typology of the Wakatobi religiosity community also influences this basis of morality. Fear is the main cause of stigma and discrimination against people living with HIV and AIDS. The community thinks that HIV and AIDS is only experienced by people at risk, such as drug users and multiple sexual partners, and can be transmitted through touch. Fear of infection is also a source of discrimination, even by families and health workers [25, 26].

Fear is the initial cause of stigma in people living with HIV and AIDS. These individuals often perceive HIV as an incurable, life-threatening infectious disease, leading them to believe that they must isolate themselves to prevent transmission. This feeling of fear is rooted in a lack of understanding about HIV, causing those affected to conceal their status due to insufficient information and lack of self-confidence. This leads to social isolation, dissemination of HIV status, and rejection, which in turn makes it difficult to detect the number of HIV cases and hinders access to and adherence to HIV prevention and treatment efforts [27, 28, 29, 6].

AIDS stigma occurs due to the belief that AIDS is a disgrace that causes anxiety and discomfort. Goffman, stated that this anxiety is considered a disability due to the HIV and AIDS virus, so sufferers feel insecure in interacting and dealing with other people, inhibit social relations, and have negative views of themselves and feel rejected by the surrounding environment [30; 31; 32; 33].

This study found that people living with HIV and AIDS feel uncomfortable because of anxiety and the view that this disease is a disgrace. This makes it difficult for them to behave with the people around them. The social implication is that people with HIV and AIDS tend to avoid, be alone, close themselves off, and feel they don't deserve to be in the midst of their family because they feel different due to their HIV and AIDS conditions.

People living with HIV and AIDS realize that even though the cause of their infection is not free sex, it is difficult for society to change the common belief that HIV is caused by free sex. Society also tends to understand that HIV and AIDS is caused by immoral behavior associated with groups such as Commercial Sex Workers, Lesbians, Gays, Bisexuals, and Transgenders (LGBT), and Drug Users. Religious thinking that considers free sex and multiple partners to be unlawful and a sin also triggers negative evaluations from society towards people with HIV [34, 35].

Based on an understanding of morality, people with HIV and AIDS are also labeled as violators of social and religious norms. Social norms relate to rules of sexual behavior which are only accepted if within a marriage bond, and religious norms prohibit sex outside of marriage. Society considers that people living with HIV and AIDS do not comply with this norm, so they get disease as a consequence. People with it are considered as violators of norms, and society provides avoidance so as not to be ridiculed. This social process reflects the construction of reality by society based on the existing social order.

Social construction is formed through the process of internalization, in which individuals interpret and understand according to standard norms. Then, the objectivation process produces externalization actions. In this study, stigma and discrimination against people living with HIV

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and AIDS are the result of social constructions based on people's perspectives, interpretations, and understanding of these conditions. After contracting HIV and AIDS, a person will make adjustments as a person with HIV and face stigma and discrimination that arise from society.

Forms of Stigma and Discrimination for People with HIV and AIDS

The research found two forms of stigma and discrimination against people living with HIV and AIDS: public stigma and self stigma. Forms of discrimination include verbal discrimination and avoidance as shown in the following table:

Table 1. Forms of stigma and discrimination against people living with HIV and AIDS

Acquired Forms of Stigma	
Theme	Sub Themes
Public Stigma	• Labeling • Stereotypes • Exclusion • Lost status • Minimal social support from family and community
Self-Stigma	• Powerlessness • Low self-efficacy • Withdraw • Emotional responses such as fear, anger, disappointment, shame • Hopeless • Loss of appreciation/self-esteem
Forms of Discrimination	
Verbal expression	Avoidance/shunning
Avoidance	

Based on table 2, public stigma occurs from the family and social environment. Overreaction to the words HIV and AIDS causes public stigma. Society often associates HIV with sexual behavior outside of marriage and drug use, so that someone infected with HIV can be labeled negatively. People living with HIV face social stigma because it is considered a disease that is scary, embarrassing, and a violation of social norms, which causes them to be ostracized and shunned [36, 37]. This stigma is an unfair prejudice that is often generalized to all people living with HIV, due to the lack of information and understanding about HIV and AIDS and misinterpretation of the information received.

Self stigma is another form of stigma in which people with HIV experience decreased self-esteem and self-confidence. In this study, self-stigma was often found in people living with HIV and AIDS after being declared HIV positive. They face negative thoughts, distance themselves from their families, feel hopeless, ashamed, angry, and withdraw from social circles. This self-stigma keeps their quality of life low, causing anxiety, depression, and even suicidal ideation [38]

The results of research on discrimination found several forms, including verbal discrimination, avoidance, and exclusion. Verbal discrimination occurs through insulting words for people living with HIV and AIDS. This often happens due to a lack of information about HIV and AIDS, causing sufferers to be ostracized through words that demean them.

Discrimination in the form of avoidance is carried out by avoiding or staying away from people or groups that are disliked. Changes in the status of people living with HIV and AIDS

families, leading to discriminatory attitudes and behaviors [4]. They also experience anticipatory stigma as a result of other PLWHA's experiences of stigma and discrimination. Individual moral judgments related to HIV status and negative self-assessment are determinants of perceived stigma. Similar research was also conducted by Faulk, Ward *et al.*, that stigma and discrimination against PLHIV still exist in the family, community, and health services. This is reflected in negative labelling, segregation of personal belongings, avoidance, treatment refusal, and rejection of PLWHA by healthcare providers, families, and community members. Some healthcare providers even admit that they are also involved in stigmatizing and discriminating against PLHIV [5].

Faulk *et al.*, found that participants experienced stigma and discrimination in various places, including the family, community, and healthcare settings. Factors such as lack of knowledge about HIV, fear of contracting HIV, and social and moral perceptions about HIV and PLHIV are considered drivers of stigma and discrimination [6]. Follow-up research conducted by Faulk *et al.*, found that HIV causes negative psychological consequences for WLHIV, such as stress, fear, worry, anxiety, and depression, as well as social impacts including stigma, discrimination, and family separation [7]. In addition, Faulk stated that the impact of HIV on Women Living with HIV (WLHIV) and Men Living with HIV (MLHIV) and their families included: (i) stigmatization and discrimination, (ii) psychological impact, (iii) family conflict and separation, and (iv) physical impact [8].

According to Faulk *et al.*, psychological challenges, stigma, and discrimination faced by WLHIV. However, they show an extraordinary capacity to adopt effective strategies and supports to protect themselves and educate themselves and those around them. With this, they seek to rebuild trust, gain respect and acceptance. These findings highlight the need for policies and practices that help WLHIV better address HIV-related psychological and social challenges [9].

Many studies have reported that stigma and discrimination occur within one's own family such as siblings, relatives and even parents because of fear of being infected and to this day it is still a global problem in reducing infection [10, 11, 12, 6]. The fear of contracting HIV stems from a lack of knowledge about HIV and is a driving factor for stigma and discrimination against people living with HIV [13, 14, 9]. Responses as a result of immoral, dirty, embarrassing and inappropriate behaviour further increase the stigma and discrimination against PLHIV [15, 16, 4].

Various studies on stigma and discrimination against PLWHA are generally based on a positivistic paradigm that views events of stigmatization and discrimination as objective facts. This study rests on the constructivism paradigm by focusing on the meanings constructed by the community that shape their knowledge and actions towards PLHIV. Epistemology of constructivism research uses social construction theory by Peter L. Berger and Thomas Luckmann as analytical tools. In explaining the constructivist paradigm, social reality is a social construction created by individuals through a process of social interaction. Knowledge is seen as a picture that is formed from objective reality, in itself. The individual becomes a determinant in the social world that is constructed based on his will. Individuals are not victims of social facts, but of creative production and reproduction media in constructing their social world [17, 18, 19, 20].

Individuals continuously create a reality that is subjectively owned and shared and forms standards, and values that are recognized by society [21, 22, 23]. There is a dialectic between individuals creating society and society creating individuals through a process of externalization, objectivation and internalization [24]. This study aimed to analyze the causes, forms and impacts of stigmatization and discrimination of people living with HIV and AIDS as a product of dialectical social interactions.

result in changes in behavior in the surrounding environment. People with HIV and AIDS feel that people who used to be close now seem like they don't know them, good relationship patterns become tenuous, they don't want to be close to or touch, and tend to stay away and avoid.

The Impact of Stigma and Discrimination on People with HIV and AIDS

Stigma and discrimination against people living with HIV and AIDS are not inherent, but the result of a social process in which meanings and norms are built and maintained. Society co-creates stigmatization of HIV and AIDS through mechanisms such as stereotypes, moral judgments and negative assumptions about people who are infected. This stigma is a stereotyped activation of certain individuals or groups which always has a negative impact, causing a decrease in self-esteem and poor self-efficacy in sufferers [39, 40]. Social construction theory emphasizes the role of symbols, language and narratives in shaping social reality. In the context of HIV and AIDS, the use of certain terms such as "AIDS sufferers" or other derogatory words can reinforce stigma and discrimination against people with HIV.

Community perceptions of symbols in the form of words influence patterns of social interaction with people living with HIV. If society generally avoids or isolates them, the stigma will get stronger and make sufferers feel alienated. This study is in line with the findings of Faulk, Ward, *et al.*, who found that stigma and discrimination against people with HIV and AIDS still exist within the family, community, and health services. This is reflected in negative labeling, separation of personal belongings, avoidance, resistance to treatment, and rejection by health care providers, families, and communities. Some health care providers even admit to being involved in stigmatizing and discriminating against people living with HIV and AIDS [5].

Institutions such as government agencies, health services, and workplaces can influence the reproduction of stigma and discrimination. Discriminatory practices against people living with HIV and AIDS can make them reluctant to seek support from health services, including HIV testing [6]. Research by Mahamboro *et al.*, shows that informants experience external stigma in health facilities, communities, and families, which is expressed through discriminatory attitudes and behavior. They also experience anticipatory stigma because of their experiences of stigma and discrimination from other people with HIV and AIDS. Individuals' moral judgments regarding HIV status and negative self-assessments contribute to perceived stigma [4]. When the sufferer does not seek health service support, there is difficulty in knowing a person's HIV status so that the iceberg phenomenon can grow which has implications for the opportunity for new HIV infections to emerge.

Stigma in health care facilities is a symptom of objectivation in social construction theory. People with it increasingly feel that they are not accepted because credible health services show negative attitudes and perceptions. Feelings of being ignored, unacknowledged and rejected by health care facilities can cause sufferers to lose motivation to live a healthy lifestyle. This condition causes PLWHA to withdraw and are reluctant to socialize and do not utilize health services for their treatment. This discrimination has an impact on non-compliance with treatment and hinders the health care process for PLHIV [41].

Stigma and discrimination against HIV and AIDS also have a serious impact on the mental health of sufferers. People who experience discrimination and social rejection tend to feel stressed, anxious, and depressed, which can cause them to feel hopeless and lose their enthusiasm to take care of their health. This research is supported by the study of Darak *et al.*, which states that people who live in the same house as people with HIV who are not infected also experience mental health problems [42].

Stigma and discrimination affect the attitude of sufferers towards medical care and healthy behavior. Feelings of hopelessness and mental disorders can cause them to refuse to

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Despite facing psychological challenges, stigma, and discrimination, WLHIV demonstrated resilience in adopting effective coping strategies and seeking support to educate themselves and their communities. These findings underscore the importance of policies and practices that assist WLHIV in addressing HIV-related psychological and social challenges

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seek necessary care or to neglect preventive measures that are essential to maintaining health. This research is in line with the results of research by Fauk, Hawke, *et al.* which shows that HIV causes negative psychological consequences in people with HIV, such as stress, fear, worry, anxiety, and depression, as well as social impacts including stigma, discrimination, and family separation [7].

To overcome the negative impact of stigma and discrimination that causes healthy behavior to be ignored by people living with HIV and AIDS, a social construction theory approach can help. Accurate education about HIV and AIDS, strong anti-stigma campaigns, positive social support, and reduction of internal stigma can help reduce the negative impact of stigma and discrimination. Thus, sufferers can feel more supported and motivated to take positive steps in maintaining their health.

Fauk, Gesesew, *et al.* noted the psychological challenges, stigma, and discrimination faced by WLHIV. However, they demonstrate an extraordinary capacity to adopt effective strategies and supports to protect themselves and educate themselves and those around them. These findings highlight the need for policies and practices that help WLHIV better address HIV-related psychological and social challenges [9].

CONCLUSION

The stigmatization and discrimination faced by individuals living with HIV and AIDS result from the process of community construction. This process is primarily caused by societal fear rooted in misconceptions about HIV events and based on interpretations of morality and religion. Consequently, individuals living with HIV are often unfairly labelled as disgraceful and violators of social and religious norms who have committed deviant behaviour. The forms of stigma and discrimination that occur are public stigma, self-stigma, and verbal avoidance. These harmful consequences include decisions to avoid HIV testing, stop using health services, ignore healthy behaviours, and develop mental disorders that worsen the quality of life for people with HIV and AIDS. It is recommended to involve key people such as health workers and individuals with HIV/AIDS in actively carrying out the process of social reconstruction. Health workers apply friendly behaviour in providing health services and individuals with HIV/AIDS dare to disclose their status and actively campaign for the social support they need.

ACKNOWLEDGMENTS

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Conflict of interest

The authors declare no conflict of interest.

Ethical approval

The study was conducted according to a protocol approved by the Health Research Ethics Committee, Faculty of Public Health, University of Pejuang Republic Indonesia (No: 462-KEPK-FKM-UPRI)

Consent to participate

All participants provided their informed consent prior to their participation in the study.

Written informed consent was obtained from participants or their legal guardians if they were under the age of 16.

Data availability

The data is available from the corresponding author upon reasonable request.

Authorship

AAS, MI, and AAD contributed to conceptualizing the study and the methodology. AAS and AAL contributed to writing the original draft and data curation. AAS, AAL, and FPI contributed to editing the manuscript and data analysis. FPI, AAD, and MI contributed to data collection. AAS, MI, and AAD reviewed the manuscript.

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Community stigma and discrimination against the incidence of HIV and AIDS

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ABSTRACT

The problem of HIV/AIDS is increasingly complex, including not only health-related concerns problems but also rampant stigma and discrimination, further exacerbating the health and social conditions of the affected individuals. This study aimed to examine the triggers of stigma and discrimination among individuals with HIV/AIDS in Wakatobi, Southeast Sulawesi. We employed a quasi-qualitative design with a case study approach involving data reduction, presentation, and drawing conclusions. Triggers of stigma and discrimination experienced by individuals living with HIV/AIDS encompassed a range of factors. Stigma was rooted in various causes, including fear, perceptions of unattractiveness, anxiety, associations with the disease, and lack of confidentiality. Discrimination, on the other hand, was caused by disappointment, feelings of insecurity, diminished self-esteem, and factors like competition and exploitation. The forms of stigma for people living with HIV/AIDS were in the form of public stigma, self-stigma, forms of verbal discrimination, and avoidance. Meanwhile, the impact of stigma and discrimination on individuals living with HIV and AIDS are substantial. They encounter difficulties in finding help, restoring their lives, and discrimination. Stigmatizing attitudes and discriminatory acts of people living with HIV/AIDS worsen the quality of life of PLWHA which has the potential to cause new infections. Therefore, the government should undertake extensive educational initiatives regarding HIV and AIDS. By enhancing public knowledge and awareness, society can work towards eradicating stigma and discrimination from social interactions.

Keywords: HIV/AIDS, stigma, discrimination

INTRODUCTION

The 2030 global target for the prevention of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) aims for zero new HIV infections, zero AIDS-related deaths, and zero stigmatization and discrimination [1]. The goal of achieving zero stigma and discrimination targets people living with HIV/AIDS (PLWHA) who are likely to experience obstacles due to a lack of understanding in society, accompanied by prejudiced attitudes [2]. HIV is by definition a virus that attacks the human immune system and weakens the body's ability to fight all types of disease. AIDS is a collection of disease symptoms caused by a decrease in the immune system resulting from HIV infection [3]. AIDS is often referred to as a disease of deviant behaviour because the factors that trigger this event were previously only found in at-risk groups such as commercial sex workers, individuals with diverse sexual orientations, injecting drug users, and individuals who engaged in risky sexual behaviors [4].

Currently, HIV and AIDS have become a generalized epidemic, affecting individuals across diverse demographics, including individuals from various backgrounds and children, without regard to age, gender, occupation, ethnicity, or nationality, highlighting the sociological and public health significance of these diseases, influencing all societal strata [5]. According to the report on HIV, AIDS and sexually transmitted diseases in Indonesia up to September 2022, there were 338,760 of people living with HIV (PLHIV), with 140,024 AIDS cases by June 2022, bringing the total HIV and AIDS cases to 478,784 by June 2022 [6].

Southeast Sulawesi has witnessed an increase in the findings of new HIV/AIDS cases every year. According to data, the number of HIV/AIDS cases in Southeast Sulawesi Province between 2012-2017 have increased. According to the Report on the Development of HIV, AIDS and Sexually Transmitted Diseases for the first quarter of 2021 in Southeast Sulawesi, 16 new HIV cases were detected among 3,795 individuals tested. Out of 5,678 people tested for HIV during April-June 2022, 95 cases of HIV/AIDS were identified [7].

These figures only represent individuals who take the test voluntarily. Furthermore, Wakatobi District has also experienced an increase in the number of new cases. Data from the Wakatobi Regional AIDS Commission indicates 13 new cases of HIV in 2021 and 16 new cases in 2022 [8]. In reality, the actual number of cases is significantly higher in all regions due to the underreported cases of HIV/AIDS, driven by stigma and discrimination against those affected. Subsequently, the population at risk tends to withdraw from taking the test. In effect, new infections occur in the form of silent epidemics. Incidents of stigma and discrimination often occur in families, communities, schools, places of worship, workplaces, and places of legal and health services.

The process of silent transmission can be facilitated by various factors within at-risk populations. For example, individuals engaged in long-term overseas work may face an increased risk of engaging in risky sexual behavior, which can contribute to silent transmission. People living with HIV/AIDS consist of various age groups, gender, groups and statuses. Both people who suspect they may be infected with sexually transmitted diseases and those already living with HIV usually withdraw from themselves and are afraid of stigma and discrimination, making it difficult to develop prevention, care, and treatment practices.

Numerous studies, including research by Mahamboro *et al.*, found that individuals with HIV/AIDS face external stigma in healthcare facilities, communities, and families, leading to discriminatory attitudes and behaviors [9]. They also experience anticipatory stigma as a result of other PLWHA's experiences of stigma and discrimination. Individual moral judgments related to HIV status and negative self-assessment are determinants of perceived stigma. Similar research was also conducted by Fauk *et al.*, suggesting that stigma and

is reflected in negative labelling, segregation of personal belongings, avoidance, treatment refusal, and rejection of PLWHA by healthcare providers, families, and community members. Some healthcare providers even admit that they are also involved in stigmatizing and discriminating PLHIV [10].

Fauk *et al.*, found that participants experienced stigma and discrimination in various places, including the family, community, and healthcare settings. Factors such as lack of knowledge about HIV, fear of contracting HIV, and social and moral perceptions about HIV and PLHIV are considered drivers of stigma and discrimination [11]. Follow-up research conducted by Fauk *et al.*, found that HIV causes negative psychological consequences for WLHIV, such as stress, fear, worry, anxiety, and depression, as well as social impacts including stigma, discrimination, and family separation [12]. In addition, Fauk stated that the impact of HIV on women living with HIV (WLHIV) and men living with HIV (MLHIV) and their families included: (i) stigmatization and discrimination, (ii) psychological impact, (iii) family conflict and separation, and (iv) physical impact [13].

Despite facing psychological challenges, stigma, and discrimination, WLHIV demonstrated resilience in adopting effective coping strategies and seeking support to educate themselves and their communities. These findings underscore the importance of policies and practices that assist WLHIV in addressing HIV-related psychological and social challenges [14].

Many studies have reported that stigma and discrimination occur within one's own family such as siblings, relatives and even parents. This often results from the fear of HIV transmission and remains a persistent global challenge in efforts to reduce infection rates [10-12, 6]. The fear of contracting HIV occurs from a lack of knowledge about HIV and is a driving factor for stigma and discrimination against people living with HIV [13,14,9]. Responses as a result of immoral, dirty, embarrassing and inappropriate behaviour further increase the stigma and discrimination against PLHIV [15,16,4].

Various studies on stigma and discrimination against PLWHA are generally based on a positivistic paradigm that views events of stigmatization and discrimination as objective facts. This study rests on the constructivism paradigm by focusing on the meanings constructed by the community that shape their knowledge and actions towards PLHIV. The epistemology of constructivism research uses the social construction theory by Peter L. Berger and Thomas Luckmann as analytical tools. In explaining the constructivist paradigm, social reality is a social construction created by individuals through a process of social interaction. Knowledge is seen as a picture that is formed from objective reality in itself. The individual becomes a determinant in the social world that is constructed based on his will. Individuals are not victims of social facts, but of creative production and reproduction media in constructing their social world [17-20].

Individuals continuously create a reality that is subjectively owned and shared and forms standards, and values that are recognized by society [21-23]. This intricate interplay involves individuals creating society and society creating individuals through a process of externalization, objectivation and internalization [29]. This study aimed to analyze the causes, forms and impacts of stigmatization and discrimination of people living with HIV/AIDS as a product of dialectical social interactions.

MATERIAL AND METHODS

Epistemological foundation and research approach

This study adopts the perspective of Peter L. Berger and Luckmann's Social Construction Theory which views social reality as relative and created by individuals. This paradigm

determined the choice of research methods, data collection, data analysis and interpretation. Consequently, we used a qualitative approach because it emphasized the reality created by individuals, using a case study method to explore in depth the phenomena of stigma and discrimination against people living with HIV and AIDS as a result of a social construction process.

Study location and participants

The research was conducted in the Wakatobi District, due to the increasing cases of HIV/AIDS in the region and the ongoing mentoring and monitoring programs for suspected and confirmed HIV cases. This environment facilitated access to relevant informants and information. The informants for this study were HIV and AIDS personnel at the Wakatobi Health Office as key informants, representatives of the Regional AIDS Commission as supporting informants and key informants. The selection of these informants was purposeful, targeting individuals who had strong communication skills and a willingness to participate in interviews. The selection of informants was based on consideration of their direct involvement in the social world which reflects the reality of stigmatization and discrimination of people living with HIV/AIDS as the basic assumptions of the constructivism paradigm which forms the basis of this research.

Data collection

This research used various tools for data collection, including interview guides, observation sheets, field notes, cameras, recorders, and supplementary materials. Data was collected through observation, in-depth interviews and documentation. Due to the constructivist paradigm guiding this research, the researcher's values, ethics and morals played a role in interpreting the data. This recognition is essential because it acknowledges that the meaning of data is influenced by the researcher's subjective interaction with individuals who have experienced stigma and discrimination related to HIV/AIDS. There are three components in qualitative research which are called social situations, namely places, actors, and activities. Observations were made to observe informants' activities on the phenomena being investigated, either directly or indirectly. Meanwhile, in-depth interviews explored invisible phenomena by tracing information from all informants regarding stigma and discrimination. Documentation relevant to the review is a source triangulation approach to ensure the validity of the qualitative findings.

Data analysis

The qualitative data analysis in this study followed the Miles and Huberman model, guided by a constructivist approach. This model outlines several key stages of analysis. First, data reduction involved categorizing and selecting relevant data to compile the collected

information. Next, data were displayed to facilitate the drawing of conclusions and informing subsequent actions. Following this, conclusions were drawn and verified. Ultimately, the findings were presented in a narrative form. Throughout these stages, constructivist principles were applied, involving a reasoning process informed by the researcher's creative insights. This approach was essential for providing comprehensive explanations of the findings and constructing a nuanced understanding of the research.

RESULTS

Table 1. Informants' characteristics

No	Informant Initials	Age	Gender	Education	Work	Information
1	Ni	35 years	Woman	3-Year Diploma	Civil Servant	Key Informants
2	Kj	40 years	Man	Senior High School	Honorary	Common Informant
3	Ra	37 years	Woman	Senior High School	Housewife	Common Informant
4	Ai	23 years	Man	Student	-	Common Informant
5	Zn	41 years	Man	Senior High School	Private	Common Informant
6	Wu	28 years	Woman	3-Year Diploma	-	Common Informant
7	Tn	54 years	Man	Senior High School	Private	Supporting Informant

As shown in Table 1, most of the informants were between the ages of 23 and 54, with varying levels of education and occupations, and HIV positive. Despite having higher levels of education, some informants lacked knowledge about HIV, and their occupations did not necessarily involve efforts to prevent HIV transmission or promote openness about their HIV status, which can lead to stigma and discrimination.

Causes of stigma and discrimination against HIV and AIDS

The study revealed that stigma and discrimination can arise due to fear of HIV and AIDS. This fear is experienced in the same way, both in the family environment, work, social environment, or health services in general, as expressed by the following informants:

"If someone is exposed to (HIV)? That is contagious, it's because they've engaged in risky behavior, and that's why they get infected like that" (Mr., 54 years)

These perspectives depict HIV as a virus that can move around easily and can even be transmitted through ordinary social relationships. This point of view grows and develops as a result of the internalization process received in social interaction which generally has a wrong understanding of how HIV is transmitted. This means that there is a process of social construction created by individuals which is understood collectively and then develops into general knowledge.

Misunderstandings that have been objectivated by society are used as a basis for externalization in the form of stigmatizing and discriminating against those affected. Because of that, people with HIV also experience construction in the form of fear due to their HIV-positive status. The implication is that individuals affected must be forced to lie and cover up

positive status. The implication is that individuals affected must be forced to lie and cover up the disease, as revealed by the following informants:

"I was diagnosed HIV positive in 2019, of course, I was shocked...what if someone finds out later, but now I have been taking medication for 3 years...If someone asks me what's wrong, I answer that I have TB, so I have to take medicine" (Kj, 40 years)

"Initially, my wife was surprised. Now, others know too, and they avoid us, gossip about us, and refuse to interact. No one wants to shake hands" (Kj, 40 years)

The behaviour of people with HIV and their families who cover their HIV status is a way of dealing with the response of society which tends not to provide reasonable social acceptance for people living with HIV. For those affected, the treatment of society in the form of being shunned, blamed, and not even wanting to shake hands is much more painful than the physical suffering caused by the disease.

In line with what was experienced by the previous informant, another informant also revealed:

"As soon as they know someone is HIV positive, they avoid walking in front of the house of those known to have HIV" (Ra, 37 years).

According to an informant, the community's strong response to HIV sufferers is practised in the form of avoiding walking in front of the house, let alone meeting people with HIV because they consider it a disgrace. This means that individuals affected are already isolated in the process of interaction because society perceives them as violators of social norms that should be avoided. These individuals experience difficulties in accessing services, especially medical services that they must undergo routinely. Furthermore, they do not adhere to medication due to the difficulty of building interactions with the social environment.

Forms of stigma and discrimination against people with HIV/AIDS

Perceptions that arise from the family and social environment of people living with HIV are generally negative, as stated by the following informants:

"We, the sufferers, are thought to be sinners because we are infected through commercial sex, so people often tell negative stories when they are together. We finally think we have no value in the eyes of society"(Ni, 35 years old)

The label of a sinner is the impression captured by the person based on the community's response to him. Generally, people understand that HIV is only transmitted through sexual intercourse with multiple partners. Because of that society uses its moral basis in treating people living with HIV. The construction of this knowledge comes from the religiosity of society which is the principle of developing daily behavior.

Another form of stigma accepted by individuals with HIV/AIDS is that society views

them as a dangerous source of transmission. Because of that, there are no social spaces for them to live, including their families. This feeling was experienced by the informant below:

"The general opinion is that people with HIV are the ones who transmit HIV, that's why people don't give people the opportunity to socialize. What's worse, the family shares the same opinion so that the sufferer is forced not to be accepted by the family" (Zn, 41 years old)

The partial understanding of the public regarding the mode of transmission that only sees sexuality has perpetuated a dangerous response for the future life of individuals living with HIV. Society closes itself, subsequently influencing the attitudes of families caring for their HIV-positive members. This social process clearly shows the existence of a reality created by individuals who are socially accepted and then socialized in everyday life to form norms in the form of rejection for people living with HIV/AIDS.

The impact of stigma and discrimination on people with HIV/AIDS

The occurrence of stigma and discrimination certainly has an impact on PLWHA, and some are afraid to seek treatment:

"As I said, if HIV is known, they will be shunned, talked about carelessly, blamed so they don't dare to get tested" (Al, 23 years)

The discriminatory treatment resulting from negative social stigma can lead individuals to postpone undergoing HIV testing. This delay can have several consequences, including an increased risk of individuals engaging in risky behavior developing preventable opportunistic infections that could have been detected early through testing. Furthermore, such delays contribute to the persistence of the HIV iceberg phenomenon, as individuals fear public

avoidance upon disclosing their HIV-positive status. Another impact found the neglect of the affected individual's quality of life due to their reduced life expectancy, as highlighted by the following informant:

"It's useless to take medicine all the time because our families don't think we're humans anymore, and it seems that society doesn't want to hang out anymore...Why else live when it's like this" (Wu, 28 years)

The absence of reasonable life opportunities in society makes people despair, some even experience symptoms of mental disorders. Consequently, people with HIV/AIDS may neglect taking their medication regularly and fail to engage in other healthy behaviors. This neglect has a detrimental impact on the quality of life of those with HIV/AIDS, leading to a decline in health until they face imminent death. Even though ideally, when individuals with HIV maintain healthy behaviors, they have the opportunity to live productive lives, similar to those without HIV.

English translation of the text in Portuguese: 11 11 11 11 11 11 11 11 11 11

DISCUSSION

Causes of stigma and discrimination against individuals living with HIV/AIDS

Stigma and discrimination against people living with HIV/AIDS were caused by misunderstanding, excessive fear, social disgrace, and the notion that people with HIV and AIDS violate religious and social norms. The lack of public knowledge about the pattern of HIV transmission can lead to stigma and discrimination. This study is in line with the findings of Fauk *et al.*, who identified erroneous knowledge as a driver of stigma. This erroneous knowledge is formed through the process of daily social interaction, which becomes the basis for the process of externalization as explained by Peter Berger regarding the process of social construction which involves the process of internalization, objectivation and externalization [11].

Wrong knowledge creates excessive fear, which causes stigmatization and acts of discrimination. Fauk *et al.* stated that fearful attitudes can lead to stigma and discrimination against people living with HIV and AIDS, by focusing on the implications of the objectivation process in Peter Berger's social construction theory. Within the Wakatobi community, the moral perspective of HIV/AIDS has undergone a process of institutionalization (objectivation) and has become the basis for external actions. The typology of the Wakatobi religiosity community also influences this basis of morality. Fear is the main cause of stigma and discrimination against people living with HIV and AIDS. The community thinks that HIV and AIDS is only experienced by people at risk, such as drug users and multiple sexual partners, and can be transmitted through touch. Fear of infection is also a source of discrimination, even by families and health workers [25, 26].

Fear is the initial cause of stigma in people living with HIV and AIDS. These individuals often perceive HIV as an incurable, life-threatening infectious disease, leading them to believe that they must isolate themselves to prevent transmission. This feeling of fear is rooted in a lack of understanding about HIV, causing those affected to conceal their status due to insufficient information and lack of self-confidence. This leads to social isolation, dissemination of HIV status, and rejection, which in turn makes it difficult to detect the number of HIV cases and hinders access to and adherence to HIV prevention and treatment efforts [27-29, 6].

AIDS stigma occurs due to the belief that AIDS is a disgrace that causes anxiety and discomfort. Goffman, stated that this anxiety is considered a disability due to the HIV and AIDS virus, so sufferers feel insecure in interacting and dealing with other people, inhibit social relations, and have negative views of themselves and feel rejected by the surrounding environment [30-33].

This study revealed that individuals living with HIV/AIDS often experience discomfort, anxiety, and a sense of shame associated with their condition. These feelings hinder their interactions with others. Consequently, the social implication is that people with HIV and AIDS tend to isolate themselves, withdraw from social activities, and believe they do not deserve to be part of their families or communities due to their perceived differences arising from their HIV and AIDS status.

Individuals living with HIV and AIDS are aware that despite the actual cause of their infection not being related to unprotected sex, it is challenging for society to shift the prevailing belief that HIV is primarily transmitted through sexual promiscuity. Misconceptions and stereotypes sometimes associate HIV and AIDS with what some consider 'immoral' behavior, including activities associated with groups such as commercial sex workers, LGBTQ+ individuals, and drug users. Religious thinking that considers free sex and multiple partners to be unlawful and a sin also triggers negative evaluations from society towards people with HIV [34, 35].

Based on an understanding of morality, people with HIV and AIDS are also labeled as violators of social and religious norms. Social norms relate to rules of sexual behavior which are only accepted if a marriage bond exists, and religious norms prohibit sex outside of marriage. Society considers that people living with HIV and AIDS do not comply with this norm, so they get the disease as a consequence. Therefore, they are considered violators of norms, and often face societal avoidance to avoid ridicule. This social process reflects the construction of reality by society based on the existing social order.

Social construction is formed through the process of internalization, in which individuals interpret and understand according to standard norms. Then, the objectivation process produces externalization actions. In this study, stigma and discrimination against people living with HIV and AIDS are the result of social constructions based on people's perspectives, interpretations, and understanding of these conditions. After contracting HIV and AIDS, a person will make adjustments as a person with HIV and face stigma and discrimination that arise from society.

Forms of stigma and discrimination against people with HIV and AIDS

The research found two forms of stigma and discrimination against people living with HIV and AIDS: public stigma and self stigma. Forms of discrimination include verbal discrimination and avoidance as shown in Table 2.

Table 2. Forms of stigma and discrimination against people living with HIV and AIDS

Acquired forms of stigma	
Theme	Sub Theme
Public Stigma	• Labeling
	• Stereotypes • Exclusion • Loss of status • Minimal social support from family and community
Self-Stigma	• Powerlessness • Low self-efficacy • Withdrawal • Emotional responses such as fear, anger, disappointment, shame • Hopelessness • Loss of appreciation/self-esteem

Forms of Discrimination	
Verbal expression	Avoidance/shunning
Avoidance	

Public stigma occurred from the family and social environment. Overreaction to the words HIV and AIDS caused public stigma. Society often associates HIV with sexual behavior outside of marriage and drug use, so that someone infected with HIV can be labeled negatively. People living with HIV face social stigma because it is considered a disease that is scary, embarrassing, and a violation of social norms, which causes them to be ostracized and shunned [36, 37]. This stigma is an unfair prejudice that is often generalized to all people living with HIV, due to the lack of information and understanding about HIV and AIDS and misinterpretation of the information received.

Self stigma is another form of stigma in which people with HIV experience decreased self-esteem and self-confidence. In this study, self-stigma was often found in people living with HIV and AIDS after being declared HIV positive. They faced negative thoughts, distanced themselves from their families, felt hopeless, ashamed, angry, and withdrew from social circles. This self-stigma keeps their quality of life low, causing anxiety, depression, and even suicidal ideation [43].

The research results on discrimination revealed several forms, including verbal discrimination, avoidance, and exclusion. Verbal discrimination involves the use of insulting words directed at people living with HIV and AIDS. This often happens due to a lack of information about HIV/AIDS, leading to the use of demeaning words that isolate and devalue individuals with the condition.

Discrimination in the form of avoidance involves actively avoiding or staying away from people or groups that are disliked. Changes in the status of people living with HIV and AIDS result in changes in behavior in the surrounding environment. People with HIV and AIDS feel that people who were once close now act like as if they do not know them. Previously good relationships become tenuous, they do not want to be close to or touch, and tend to stay away and avoid.

The Impact of stigma and discrimination on people with HIV and AIDS

Stigma and discrimination against people living with HIV and AIDS are not inherent, but the result of a social process in which meanings and norms are built and maintained. Society co-creates stigmatization of HIV and AIDS through mechanisms such as stereotypes, moral judgments and negative assumptions about people who are infected. This stigma is a stereotyped activation of certain individuals or groups which always has a negative impact, causing a decrease in self-esteem and poor self-efficacy in people affected [39, 40]. Social

construction theory emphasizes the role of symbols, language and narratives in shaping social reality. In the context of HIV and AIDS, the use of certain terms such as "AIDS sufferers" or other derogatory words can reinforce stigma and discrimination against people with HIV.

Community perceptions of symbols in the form of words influence patterns of social interaction with people living with HIV. If society generally avoids or isolates them, the

stigma will get stronger and make sufferers feel alienated. This study is in line with the findings of Fauk *et al.*, who found that stigma and discrimination against people with HIV and AIDS still exist within the family, community, and health services. This is reflected in negative labeling, separation of personal belongings, avoidance, resistance to treatment, and rejection by health care providers, families, and communities. Some health care providers even admit to being involved in stigmatizing and discriminating people living with HIV and AIDS [10].

Institutions such as government agencies, health services, and workplaces can influence the reproduction of stigma and discrimination. Discriminatory practices against people living with HIV and AIDS can make them reluctant to seek support from health services, including HIV testing [11]. Research by Mahamboro *et al.*, shows that informants experience external stigma in health facilities, communities, and families, which is expressed through discriminatory attitudes and behavior. They also experience anticipatory stigma because of their experiences of stigma and discrimination from other people with HIV and AIDS. Individuals' moral judgments regarding HIV status and negative self-assessments contribute to perceived stigma [9]. When individuals affected by HIV do not seek health services and support, it becomes challenging to determine their HIV status. This lack of awareness can contribute to the HIV iceberg phenomenon, wherein a significant number of undiagnosed cases exist. Consequently, this situation increases the risk of new HIV infections emerging within the population.

Stigma in health care facilities is a symptom of objectivation in social construction theory. People experiencing stigma increasingly feel that they are not accepted because credible health services show negative attitudes and perceptions. Feelings of being ignored, unacknowledged and rejected by health care facilities can cause individuals affected to lose motivation to live a healthy lifestyle. This condition causes PLWHA to withdraw and become reluctant to socialize or utilize health services for their treatment. This discrimination has an impact on non-compliance with treatment and hinders the health care process for PLHIV [46].

Stigma and discrimination against HIV and AIDS also have a serious impact on the mental health of people with HIV/AIDS. Those who face discrimination and social rejection often experience heightened stress, anxiety, and depression, leading to feelings of hopelessness and a loss of motivation to prioritize their health. This finding is supported by Darak *et al.*, which states that people who live in the same house with people with HIV who are not infected also experience mental health problems [47].

Moreover, stigma and discrimination can influence the attitudes of people with HIV/AIDS towards medical care and healthy behavior. Feelings of hopelessness and mental disorders can lead to a reluctance to seek necessary medical attention and a neglect of preventive measures essential for maintaining health. This research is in line with the results of Fauk *et al.*, which shows that HIV causes negative psychological consequences among people with HIV, such as stress, fear, worry, anxiety, and depression, as well as social impacts including stigma, discrimination, and family separation [12].

To overcome the negative impact of stigma and discrimination which often lead individuals living with HIV and AIDS to neglect healthy behaviors, an approach rooted in social construction theory can help. Accurate education about HIV and AIDS, strong anti-

CONCLUSION

The stigmatization and discrimination faced by individuals living with HIV and AIDS result from the process of community construction. This process is primarily caused by societal fear, rooted in misconceptions about HIV events and based on interpretations of morality and religion. Consequently, individuals living with HIV are often unfairly labelled as disgraceful and violators of social and religious norms who have committed deviant behaviour. The forms of stigma and discrimination that occur are public stigma, self-stigma, and verbal avoidance. These harmful consequences include decisions to avoid HIV testing, stop using health services, ignore healthy behaviours, and develop mental disorders that worsen the quality of life for people with HIV/AIDS. It is recommended to involve key people such as health workers and individuals with HIV/AIDS in actively carrying out the process of social reconstruction. Health workers apply friendly behaviour in providing health services and individuals with HIV/AIDS dare to disclose their status and actively campaign for the social support they need.

ACKNOWLEDGMENTS

Conflict of interest

The authors declare no conflict of interest.

Ethical approval

The study was approved by the Health Research Ethics Committee, Faculty of Public Health, University of Pejuang Republic Indonesia (No: 462-KEPK-FKM-UPRI)

Consent to participate

All participants provided their informed consent prior to their participation in the study. Written informed consent was obtained from participants or their legal guardians if they were under the age of 16.

Data availability

The data is available from the corresponding author upon reasonable request.

Personal thanks

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Authorship

AAS, MI, and AAD contributed to conceptualizing the study and the methodology. AAS and

6850 words



Indonesian



Focus





Andi Asrina <andi.asrina@umi.ac.id>
to andreea ▾

Sep 29, 2023, 6:27 AM ☆ ↶ ⋮

Dear.
Editor of the Journal of **Medicine and Life**

Dear Editor-in-Chief

Regarding our article entitled "Community Stigma and Discrimination against the Incidence of HIV and Aids" which was submitted for publication in the Journal of **Medicine and Life**, we have included all references in numerical form in the main text as attached to this email. Thank You

Please.

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>

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> Editor of the Journal of **Medicine and Life**

>

> Dear Editor-in-Chief

>

> Regarding our article entitled "Community Stigma and Discrimination

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I. Authorship and publication declaration

We approve the submission of this paper to *Journal of Medicine and Life* for publication. We confirm that neither the manuscript submitted nor any part of it has been published nor is being considered for publication elsewhere in any language or any form (abstracts < 250 words excepted). We understand that this also applies to tables and figures as well as the publication of symposia, proceedings, preliminary communications, books and invited articles. We also confirm that our (co-) authorship is based upon the following conditions:

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Each of us declares the following current or past (within the last 12 months) interest in relationship with a company/organization* that could benefit financially from the publication of the data in our manuscript.

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Community stigma and discrimination against the incidence of HIV and AIDS

Q1

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ABSTRACT

The problem of HIV/AIDS is increasingly complex, including not only health-related concerns problems but also rampant stigma and discrimination, further exacerbating the health and social conditions of the affected individuals. This study aimed to examine the triggers of stigma and discrimination among individuals with HIV/AIDS in Wakatobi, Southeast Sulawesi. We employed a quasi-qualitative design with a case study approach involving data reduction, presentation, and drawing conclusions. Triggers of stigma and discrimination experienced by individuals living with HIV/AIDS encompassed a range of factors. Stigma was rooted in various causes, including fear, perceptions of unattractiveness, anxiety, associations with the disease, and lack of confidentiality. Discrimination, on the other hand, was caused by disappointment, feelings of insecurity, diminished self-esteem, and factors like competition and exploitation. The forms of stigma for people living with HIV/AIDS were public stigma, self-stigma, verbal discrimination, and avoidance. Meanwhile, the impact of stigma and discrimination on individuals living with HIV and AIDS is substantial. They encounter difficulties in finding help, restoring their lives, and discrimination. Stigmatizing attitudes and discriminatory acts of people living with HIV/AIDS worsen the quality of life of PLWHA, which can potentially cause new infections. Therefore, the government should undertake extensive educational initiatives regarding HIV and AIDS. By enhancing public knowledge and awareness, society can work towards eradicating stigma and discrimination from social interactions.

KEYWORDS: HIV/AIDS, stigma, discrimination

INTRODUCTION

The 2030 global target for the prevention of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) aims for zero new HIV infections, zero AIDS-related deaths, and zero stigmatization and discrimination [1]. The goal of achieving zero stigma and discrimination targets people living with HIV/AIDS (PLWHA) who are likely to experience obstacles due to a lack of understanding in society, accompanied by prejudiced attitudes [2]. HIV is, by definition, a virus that attacks the human immune system and weakens the body's ability to fight all types of disease. AIDS is a collection of disease symptoms caused by a decrease in the immune system resulting from HIV infection [3]. AIDS is often referred to as a disease of deviant behavior because the factors that trigger this event were previously only found in at-risk groups such as commercial sex workers, individuals with diverse sexual orien-

tations, injecting drug users, and individuals who engaged in risky sexual behaviors [4].

Currently, HIV and AIDS have become a generalized epidemic, affecting individuals across diverse demographics, including individuals from various backgrounds and children, without regard to age, gender, occupation, ethnicity, or nationality, highlighting the sociological and public health significance of these diseases, influencing all societal strata [5]. According to the Report on HIV, AIDS, and Sexually Transmitted Diseases in Indonesia up to September 2022, 338,760 people were living with HIV (PLHIV), with 140,024 AIDS cases by June 2022, bringing the total HIV and AIDS cases to 478,784 by June 2022 [6].

Southeast Sulawesi has witnessed an increase in the findings of new HIV/AIDS cases every year. According to data, the number of HIV/AIDS cases in Southeast Sulawesi Province between 2012 and 2017 has increased. According to the Report on the Development of HIV, AIDS, and Sexually Transmitted Diseases, for

the first quarter of 2021 in Southeast Sulawesi, 16 new HIV cases were detected among 3,795 individuals tested. Of 5,678 people tested for HIV during April-June 2022, 95 cases of HIV/AIDS were identified [7].

These figures only represent individuals who take the test voluntarily. Furthermore, Wakatobi District has also experienced an increase in the number of new cases. Data from the Wakatobi Regional AIDS Commission indicates 13 new cases of HIV in 2021 and 16 new cases in 2022 [8]. In reality, the actual number of cases is significantly higher in all regions due to the underreported cases of HIV/AIDS, driven by stigma and discrimination against those affected. Subsequently, the population at risk tends to withdraw from taking the test. In effect, new infections occur in the form of silent epidemics. Stigma and discrimination often occur in families, communities, schools, places of worship, workplaces, and legal and health services.

The process of silent transmission can be facilitated by various factors within at-risk populations. For example, individuals engaged in long-term overseas work may face an increased risk of engaging in risky sexual behavior, which can contribute to silent transmission. People living with HIV/AIDS consist of various age groups, genders, groups, and statuses. Both people who suspect they may be infected with sexually transmitted diseases and those already living with HIV usually withdraw from themselves and fear stigma and discrimination, making it challenging to develop prevention, care, and treatment practices.

Numerous studies, including research by Mahamboro *et al.*, found that individuals with HIV/AIDS face external stigma in healthcare facilities, communities, and families, leading to discriminatory attitudes and behaviors [9]. They also experience anticipatory stigma due to other PLWHA's experiences of stigma and discrimination. Individual moral judgments about HIV status and negative self-assessment are determinants of perceived stigma. Similar research was also conducted by Fauk *et al.*, suggesting that stigma and discrimination against PLHIV still exist in the family, community, and health services. This is reflected in negative labeling, segregation of personal belongings, avoidance, treatment refusal, and rejection of PLWHA by healthcare providers, families, and community members. Some healthcare providers even admit that they are also involved in stigmatizing and discriminating PLHIV [10].

Fauk *et al.* found that participants experienced stigma and discrimination in various places, including the family, community, and healthcare settings. Factors such as lack of knowledge about HIV, fear of contracting HIV, and social and moral perceptions about HIV and PLHIV are considered drivers of stigma and discrimination [11]. Follow-up research conducted by Fauk *et al.* found that HIV causes negative psychological consequences for WLHIV, such as stress, fear, worry, anxiety, and depression, as well as social impacts, including stigma, discrimination, and family separation [12]. In addition, Fauk stated that the impact of HIV on women living with HIV (WLHIV) and men living with HIV (MLHIV) and their families included (i) stigmatization and discrimination, (ii) psychological impact, (iii) family conflict and separation, and (iv) physical impact [13].

Despite facing psychological challenges, stigma, and discrimination, WLHIV demonstrated resilience in adopting effective coping strategies and seeking support to educate themselves and their communities. These findings underscore the importance of policies and practices that assist WLHIV in addressing HIV-related psychological and social challenges [14].

Many studies have reported that stigma and discrimination occur within one's family, such as siblings, relatives, and even parents. This often results from the fear of HIV transmission and remains a persistent global challenge in reducing infection rates [11, 15-17]. The fear of contracting HIV occurs from a lack of knowledge about HIV and is a driving factor for stigma and discrimination against people living with HIV [14, 18, 19]. Responses resulting from immoral, dirty, embarrassing, and inappropriate behavior further increase the stigma and discrimination against PLHIV [9, 20, 21].

Various studies on stigma and discrimination against PLWHA are generally based on a positivistic paradigm that views events of stigmatization and discrimination as objective facts. This study rests on the constructivism paradigm by focusing on the meanings constructed by the community that shape their knowledge and actions towards PLHIV. The epistemology of constructivism research uses the social construction theory by Peter L. Berger and Thomas Luckmann as analytical tools. In explaining the constructivist paradigm, social reality is a social construction individuals create through social interaction. Knowledge is seen as a picture that is formed from objective reality in itself. The individual becomes a determinant in the social world constructed based on his will. Individuals are not victims of social facts but of creative production and reproduction media in constructing their social world [22-25].

Individuals continuously create a reality that is subjectively owned and shared and forms standards and values recognized by society [26-28]. This intricate interplay involves individuals creating society and society creating individuals through externalization, objectivation, and internalization [29]. This study aimed to analyze the causes, forms, and impacts of stigmatization and discrimination of people living with HIV/AIDS as a product of dialectical social interactions.

MATERIAL AND METHODS

Epistemological foundation and research approach

This study adopts the perspective of Peter L. Berger and Luckmann's Social Construction Theory, which views social reality as relative and created by individuals. This paradigm determined the choice of research methods, data collection, data analysis, and interpretation. Consequently, we used a qualitative approach because it emphasized the reality created by individuals, using a case study method to explore the phenomena of stigma and discrimination against people living with HIV and AIDS due to a social construction process.

Study location and participants

The research was conducted in the Wakatobi District due to the increasing cases of HIV/AIDS in the region and the ongoing mentoring and monitoring programs for suspected and confirmed HIV cases. This environment facilitated access to relevant informants and information. The informants for this study were HIV and AIDS personnel at the Wakatobi Health Office as key informants, representatives of the Regional AIDS Commission as supporting informants, and key informants. The selection of these informants was purposeful, targeting individuals with strong communication skills and a willingness to participate in interviews. The selection of informants was based on consideration of their direct

involvement in the social world, which reflects the reality of stigmatization and discrimination of people living with HIV/AIDS as the basic assumptions of the constructivism paradigm, which forms the basis of this research.

Data collection

This research used various tools for data collection, including interview guides, observation sheets, field notes, cameras, recorders, and supplementary materials. Data was collected through observation, in-depth interviews, and documentation. Due to the constructivist paradigm guiding this research, the researcher's values, ethics, and morals played a role in interpreting the data. This recognition is essential because it acknowledges that the meaning of data is influenced by the researcher's subjective interaction with individuals who have experienced stigma and discrimination related to HIV/AIDS. There are three components in qualitative research called social situations: places, actors, and activities. Observations were made to observe informants' activities on the phenomena being investigated, either directly or indirectly. Meanwhile, in-depth interviews explored invisible phenomena by tracing information from all informants regarding stigma and discrimination. Documentation relevant to the review is a source triangulation approach to ensure the validity of the qualitative findings.

Data analysis

The qualitative data analysis in this study followed the Miles and Huberman model, guided by a constructivist approach. This model outlines several key stages of analysis. First, data reduction involved categorizing and selecting relevant data to compile the collected information. Next, data were displayed to facilitate drawing conclusions and informing subsequent actions. Following this, conclusions were drawn and verified. Ultimately, the findings were presented in a narrative form. Throughout these stages, constructivist principles were applied, involving a reasoning process informed by the researcher's creative insights. This approach was essential for comprehensively explaining the findings and constructing a nuanced understanding of the research.

RESULTS

As shown in Table 1, most informants were between the ages of 23 and 54, with varying education and occupations, and HIV

positive. Despite having higher levels of education, some informants lacked knowledge about HIV, and their occupations did not necessarily involve efforts to prevent HIV transmission or promote openness about their HIV status, which can lead to stigma and discrimination.

Causes of stigma and discrimination against HIV and AIDS

The study revealed that stigma and discrimination can arise due to fear of HIV and AIDS. This fear is experienced in the same way, both in the family environment, work, social environment, or health services in general, as expressed by the following informants:

"If someone is exposed to (HIV)? That is contagious, it is because they've engaged in risky behavior, and that's why they get infected like that" (Mr., 54 years)

These perspectives depict HIV as a virus that can move around easily and even be transmitted through ordinary social relationships. This point of view grows and develops due to the internalization process received in social interaction, which generally has a wrong understanding of how HIV is transmitted. This means that individuals create a process of social construction, which is understood collectively and then develops into general knowledge.

Misunderstandings that have been objectivated by society are used as a basis for externalization in the form of stigmatizing and discriminating against those affected. Because of that, people with HIV also experience construction in the form of fear due to their HIV-positive status. The implication is that individuals affected must be forced to lie and cover up the disease, as revealed by the following informants:

"I was diagnosed HIV positive in 2019; of course, I was shocked... what if someone finds out later, but now I have been taking medication for 3 years...If someone asks me what's wrong, I answer that I have TB, so I have to take medicine" (Kj, 40 years)

"Initially, my wife was surprised. Now, others know too, and they avoid us, gossip about us, and refuse to interact. No one wants to shake hands" (Kj, 40 years)

The behavior of people with HIV and their families who cover their HIV status is a way of dealing with society's response,

Table 1. Informants' characteristics

No	Informant Initials	Age	Gender	Education	Work	Information
1	Ni	35 years	Woman	3-Year Diploma	Civil Servant	Key Informants
2	Kj	40 years	Man	Senior High School	Honorary	Common Informant
3	Ra	37 years	Woman	Senior High School	Housewife	Common Informant
4	Ai	23 years	Man	Student	-	Common Informant
5	Zn	41 years	Man	Senior High School	Private	Common Informant
6	Wu	28 years	Woman	3-Year Diploma	-	Common Informant
7	Tn	54 years	Man	Senior High School	Private	Supporting Informants

which tends not to provide reasonable social acceptance for people living with HIV. For those affected, the treatment of society in the form of being shunned, blamed, and not even wanting to shake hands is much more painful than the physical suffering caused by the disease.

In line with what was experienced by the previous informant, another informant also revealed:

"As soon as they know someone is HIV positive, they avoid walking in front of the house of those known to have HIV" (Ra, 37 years).

According to an informant, the community's strong response to people living with HIV is practiced by avoiding walking in front of the house, let alone meeting people with HIV, because they consider it a disgrace. This means that individuals affected are already isolated in the interaction process because society perceives them as violators of social norms that should be avoided. These individuals experience difficulties accessing services, especially medical services that they must undergo routinely. Furthermore, they do not adhere to medication due to the difficulty building interactions with the social environment.

Forms of stigma and discrimination against people with HIV/AIDS

Perceptions that arise from the family and social environment of people living with HIV are generally negative, as stated by the following informants:

"We, the sufferers, are thought to be sinners because we are infected through commercial sex, so people often tell negative stories when they are together. We finally think we have no value in the eyes of society" (Ni, 35 years old)

The label of a sinner is the impression captured by the person based on the community's response to him. Generally, people understand that HIV is only transmitted through sexual intercourse with multiple partners. Because of that, society uses its moral basis in treating people living with HIV. The construction of this knowledge comes from the religiosity of society, which is the principle of developing daily behavior.

Another form of stigma accepted by individuals with HIV/AIDS is that society views them as a dangerous transmission source. Because of that, there are no social spaces for them to live, including their families. This feeling was experienced by the informant below:

"The general opinion is that people with HIV are the ones who transmit HIV. That's why people don't give people the opportunity to socialize. What's worse, the family shares the same opinion so that the sufferer is forced not to be accepted by the family" (Zn, 41 years old)

The partial understanding of the public regarding the mode of transmission that only sees sexuality has perpetuated a dangerous response for the future lives of individuals living with HIV. Society closes itself, subsequently influencing the attitudes of families caring for their HIV-positive members. This social process clearly shows the existence of a reality created by socially accepted individuals and then socialized in everyday life to form norms in the form of rejection for people living with HIV/AIDS.

The impact of stigma and discrimination on people with HIV/AIDS

The occurrence of stigma and discrimination certainly has an impact on PLWHA, and some are afraid to seek treatment:

"As I said, if HIV is known, they will be shunned, talked about carelessly, blamed, so they don't dare to get tested" (Al, 23 years)

The discriminatory treatment resulting from negative social stigma can lead individuals to postpone undergoing HIV testing. This delay can have several consequences, including an increased risk of individuals engaging in risky behavior and developing preventable opportunistic infections that could have been detected early through testing. Furthermore, such delays contribute to the persistence of the HIV iceberg phenomenon, as individuals fear public avoidance upon disclosing their HIV-positive status. Another impact found the neglect of the affected individual's quality of life due to their reduced life expectancy, as highlighted by the following informant:

"It's useless to take medicine all the time because our families don't think we're humans anymore, and it seems that society doesn't want to hang out anymore... Why else live when it's like this" (Wu, 28 years)

The absence of reasonable life opportunities in society makes people despair; some even experience symptoms of mental disorders. Consequently, people with HIV/AIDS may neglect medication regularly and fail to engage in other healthy behaviors. This neglect has a detrimental impact on the quality of life of those with HIV/AIDS, leading to a decline in health until they face imminent death. Even though ideally, when individuals with HIV maintain healthy behaviors, they can live productive lives similar to those without HIV.

This information was corroborated by local health officials as follows:

"The latter was a case of a woman who was depressed because she could not accept her HIV status; in the end, the collaboration was treated by a psychiatrist... Indeed, some people here generally don't know what HIV and AIDS are, the causes of which are widely known as infectious diseases due to free sexual behavior and injecting drugs. So we need information, that's why we are educating school children... It is really necessary to provide information widely because this disease occurs in all places... Stigma and discrimination exist because of people's ignorance" (Ni, 35 years)

DISCUSSION

Causes of stigma and discrimination against individuals living with HIV/AIDS

Stigma and discrimination against people living with HIV/AIDS were caused by misunderstanding, excessive fear, social disgrace, and the notion that people with HIV and AIDS violate religious and social norms. The lack of public knowledge about the pattern of HIV transmission can lead to stigma and discrimination. This study aligns with the findings of Fauk *et al.*, who identified erroneous knowledge as a driver of stigma. This erroneous knowledge is formed through the process of daily social interaction, which becomes the basis for the process of

externalization, as explained by Peter Berger regarding the process of social construction, which involves the process of internalization, objectivation, and externalization [11].

Wrong knowledge creates excessive fear, which causes stigmatization and acts of discrimination. Fauk *et al.* stated that fearful attitudes can lead to stigma and discrimination against people living with HIV and AIDS by focusing on the implications of the objectivation process in Peter Berger's social construction theory. Within the Wakatobi community, the moral perspective of HIV/AIDS has undergone a process of institutionalization (objectivation) and has become the basis for external actions. The typology of the Wakatobi religiosity community also influences this basis of morality. Fear is the main cause of stigma and discrimination against people living with HIV and AIDS. The community thinks HIV and AIDS are only experienced by at-risk people, such as drug users and multiple sexual partners, and can be transmitted through touch. Fear of infection is also a source of discrimination, even by families and health workers [30, 31].

Fear is the initial cause of stigma in people with HIV and AIDS. These individuals often perceive HIV as an incurable, life-threatening infectious disease, leading them to believe they must isolate themselves to prevent transmission. This feeling of fear is rooted in a lack of understanding about HIV, causing those affected to conceal their status due to insufficient information and lack of self-confidence. This leads to social isolation, dissemination of HIV status, and rejection, making it difficult to detect the number of HIV cases and hindering access to and adherence to HIV prevention and treatment efforts [11, 32-34].

AIDS stigma occurs due to the belief that AIDS is a disgrace that causes anxiety and discomfort. Goffman stated that this anxiety is a disability due to the HIV and AIDS virus, so sufferers feel insecure in interacting and dealing with other people, inhibit social relations, have negative views of themselves, and feel rejected by the surrounding environment [35-38].

This study revealed that individuals living with HIV/AIDS often experience discomfort, anxiety, and a sense of shame associated with their condition. These feelings hinder their interactions with others. Consequently, the social implication is that people with HIV and AIDS tend to isolate themselves, withdraw from social activities, and believe they do not deserve to be part of their families or communities due to their perceived differences arising from their HIV and AIDS status.

Individuals living with HIV and AIDS are aware that despite the actual cause of their infection not being related to unprotected sex, it is challenging for society to shift the prevailing belief that HIV is primarily transmitted through sexual promiscuity. Misconceptions and stereotypes sometimes associate HIV and AIDS with what some consider 'immoral' behavior, including activities associated with groups such as commercial sex workers, LGBTQ+ individuals, and drug users. Religious thinking that considers free sex and multiple partners to be unlawful and a sin also triggers negative evaluations from society toward people with HIV [39, 40].

Based on an understanding of morality, people with HIV and AIDS are also labeled violators of social and religious norms. Social norms relate to rules of sexual behavior, which are only accepted if a marriage bond exists, and religious norms prohibit sex outside of marriage. Society considers that people living with HIV and AIDS do not comply with this norm, so they get the disease. Therefore, they are considered violators of norms and often face societal avoidance to avoid ridicule. This social

process reflects the construction of reality by society based on the existing social order.

Social construction is formed through internalization, in which individuals interpret and understand according to standard norms. Then, the objectivation process produces externalization actions. In this study, stigma and discrimination against people living with HIV and AIDS result from social constructions based on people's perspectives, interpretations, and understanding of these conditions. After contracting HIV and AIDS, a person will adjust as a person with HIV and face the stigma and discrimination that arise from society.

Forms of stigma and discrimination against people with HIV and AIDS

The research found two forms of stigma and discrimination against people living with HIV and AIDS: public stigma and self-stigma. Forms of discrimination include verbal discrimination and avoidance, as shown in Table 2.

Public stigma occurred from the family and social environment. Overreaction to the words HIV and AIDS caused public stigma. Society often associates HIV with sexual behavior outside of marriage and drug use so that someone infected with HIV can be labeled negatively. People living with HIV face social stigma because it is considered a disease that is scary, embarrassing, and a violation of social norms, which causes them to be ostracized and shunned [41, 42]. This stigma is an unfair prejudice often generalized to all people living with HIV due to the lack of information and understanding about HIV and AIDS and misinterpretation of the information received.

Self-stigma is another form of stigma in which people with HIV experience decreased self-esteem and self-confidence. In this study, self-stigma was often found in people living with HIV and AIDS after being declared HIV positive. They faced negative thoughts, distanced themselves from their families, felt hopeless, ashamed, angry, and withdrew from social circles. This

Table 2. Forms of stigma and discrimination against people living with HIV and AIDS

Acquired forms of stigma	
Theme	Sub Theme
Public Stigma	- Labeling - Stereotypes - Exclusion - Loss of status - Minimal social support from family and community
Self-Stigma	- Powerlessness - Low self-efficacy - Withdrawal - Emotional responses such as fear, anger, disappointment, shame - Hopelessness - Loss of appreciation/self-esteem
Forms of Discrimination	
Verbal expression	Avoidance/shunning
Avoidance	

als with HIV/AIDS dare to disclose their status and actively campaign for the social support they need.

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Conflict of interest

The authors declare no conflict of interest.

Ethical approval

The study was approved by the Health Research Ethics Committee, Faculty of Public Health, University of Pejuang Republic Indonesia (No: 462-KEPK-FKM-UPRI)

Consent to participate

All participants provided their informed consent before they participated in the study. Written informed consent was obtained from participants or their legal guardians if they were under the age of 16.

Data availability

The data is available from the corresponding author upon reasonable request.

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Authorship

AA, MI, and AAD contributed to conceptualizing the study and the methodology. AA and AnAl contributed to writing the original draft and data curation. AA, AnAl, and FPI contributed to editing the manuscript and data analysis. FPI, ArAd, and MI contributed to data collection. AA, MI, and ArAd reviewed the manuscript.

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self-stigma keeps their quality of life low, causing anxiety, depression, and even suicidal ideation [43].

The research results on discrimination revealed several forms, including verbal discrimination, avoidance, and exclusion. Verbal discrimination involves insulting words directed at people living with HIV and AIDS. This often happens due to a lack of information about HIV/AIDS, leading to demeaning words that isolate and devalue individuals with the condition.

Discrimination in the form of avoidance involves actively avoiding or staying away from people or groups that are disliked. Changes in the status of people living with HIV and AIDS result in changes in behavior in the surrounding environment. People with HIV and AIDS feel that once close people now act as if they do not know them. Previous good relationships become tenuous, and they do not want to be close to or touch and tend to stay away and avoid.

The impact of stigma and discrimination on people with HIV and AIDS

Stigma and discrimination against people living with HIV and AIDS are not inherent but the result of a social process in which meanings and norms are built and maintained. Society co-creates stigmatization of HIV and AIDS through stereotypes, moral judgments, and negative assumptions about infected people. This stigma is a stereotyped activation of certain individuals or groups, which always has a negative impact, causing a decrease in self-esteem and poor self-efficacy in people affected [44, 45]. Social construction theory emphasizes the role of symbols, language, and narratives in shaping social reality. In the context of HIV and AIDS, the use of certain terms such as "AIDS sufferers" or other derogatory words can reinforce stigma and discrimination against people with HIV.

Community perceptions of symbols in the form of words influence patterns of social interaction with people living with HIV. If society generally avoids or isolates them, the stigma will get stronger and make sufferers feel alienated. This study is in line with the findings of Fauk *et al.*, who found that stigma and discrimination against people with HIV and AIDS still exist within the family, community, and health services. This is reflected in negative labeling, separation of personal belongings, avoidance, resistance to treatment, and rejection by healthcare providers, families, and communities. Some healthcare providers even admit to being involved in stigmatizing and discriminating against people living with HIV and AIDS [10].

Institutions such as government agencies, health services, and workplaces can influence the reproduction of stigma and discrimination. Discriminatory practices against people living with HIV and AIDS can make them reluctant to seek support from health services, including HIV testing [11]. Research by Mahamboro *et al.* shows that informants experience external stigma in health facilities, communities, and families, expressed through discriminatory attitudes and behavior. They also experience anticipatory stigma because of their experiences of stigma and discrimination from other people with HIV and AIDS. Individuals' moral judgments regarding HIV status and negative self-assessments contribute to perceived stigma [9]. When individuals affected by HIV do not seek health services and support, it becomes challenging to determine their HIV status. This lack of awareness can contribute to the HIV iceberg phenomenon, wherein many undiagnosed cases exist. Consequently, this situation increases the risk of new HIV infections emerging within the population.

Stigma in healthcare facilities is a symptom of objectivation in social construction theory. People experiencing stigma increasingly feel unaccepted because credible health services show negative attitudes and perceptions. Feeling ignored, unacknowledged, and rejected by healthcare facilities can cause individuals to lose motivation to live a healthy lifestyle. This condition causes PLWHA to withdraw and become reluctant to socialize or utilize health services for their treatment. This discrimination impacts non-compliance with treatment and hinders the healthcare process for PLHIV [46].

Stigma and discrimination against HIV and AIDS also seriously impact the mental health of people with HIV/AIDS. Those who face discrimination and social rejection often experience heightened stress, anxiety, and depression, leading to hopelessness and a loss of motivation to prioritize their health. This finding is supported by Darak *et al.*, which state that people who live in the same house as people with HIV who are not infected also experience mental health problems [47].

Moreover, stigma and discrimination can influence the attitudes of people with HIV/AIDS towards medical care and healthy behavior. Feelings of hopelessness and mental disorders can lead to reluctance to seek medical attention and neglect preventive measures essential for maintaining health. This research is in line with the results of Fauk *et al.*, which shows that HIV causes negative psychological consequences among people with HIV, such as stress, fear, worry, anxiety, and depression, as well as social impacts, including stigma, discrimination, and family separation [12].

To overcome the negative impact of stigma and discrimination, which often lead individuals living with HIV and AIDS to neglect healthy behaviors, an approach rooted in social construction theory can help. Accurate education about HIV and AIDS, strong anti-stigma campaigns, positive social support, and reduction of internal stigma can help reduce the negative impact of stigma and discrimination. Thus, individuals with HIV/AIDS can feel more supported and motivated to take positive steps in maintaining their health.

Fauk *et al.* noted the psychological challenges, stigma, and discrimination faced by WLHIV. However, they demonstrate an extraordinary capacity to adopt effective strategies and support to protect and educate themselves and those around them. These findings highlight the need for policies and practices that help WLHIV better address HIV-related psychological and social challenges [14].

CONCLUSION

The stigmatization and discrimination faced by individuals living with HIV and AIDS result from community construction. This process is primarily caused by societal fear, rooted in misconceptions about HIV events and based on interpretations of morality and religion. Consequently, individuals living with HIV are often unfairly labeled as disgraceful and violators of social and religious norms who have committed deviant behavior. The forms of stigma and discrimination are public stigma, self-stigma, and verbal avoidance. These harmful consequences include decisions to avoid HIV testing, stop using health services, ignore healthy behaviors, and develop mental disorders that worsen the quality of life for people with HIV/AIDS. It is recommended to involve key people such as health workers and individuals with HIV/AIDS in actively carrying out the process of social reconstruction. Health workers apply friendly behavior in providing health services, and individu-



Andi Asrina <andi.asrina@umi.ac.id>
to alexandra@medandlife.org

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Dear,
Editor of the Journal of **Medicine and Life**

Dear Editor-in-Chief

Regarding our article entitled "Community Stigma and Discrimination against the Incidence of HIV and Aids" which was submitted for publication in the Journal of **Medicine and Life**, we have read it, the names of the authors are as stated in the article sent by the journal editor, authorship form, the transfer of copyright which has been signed by the authors and including proof of payment is attached to this email. Thank You

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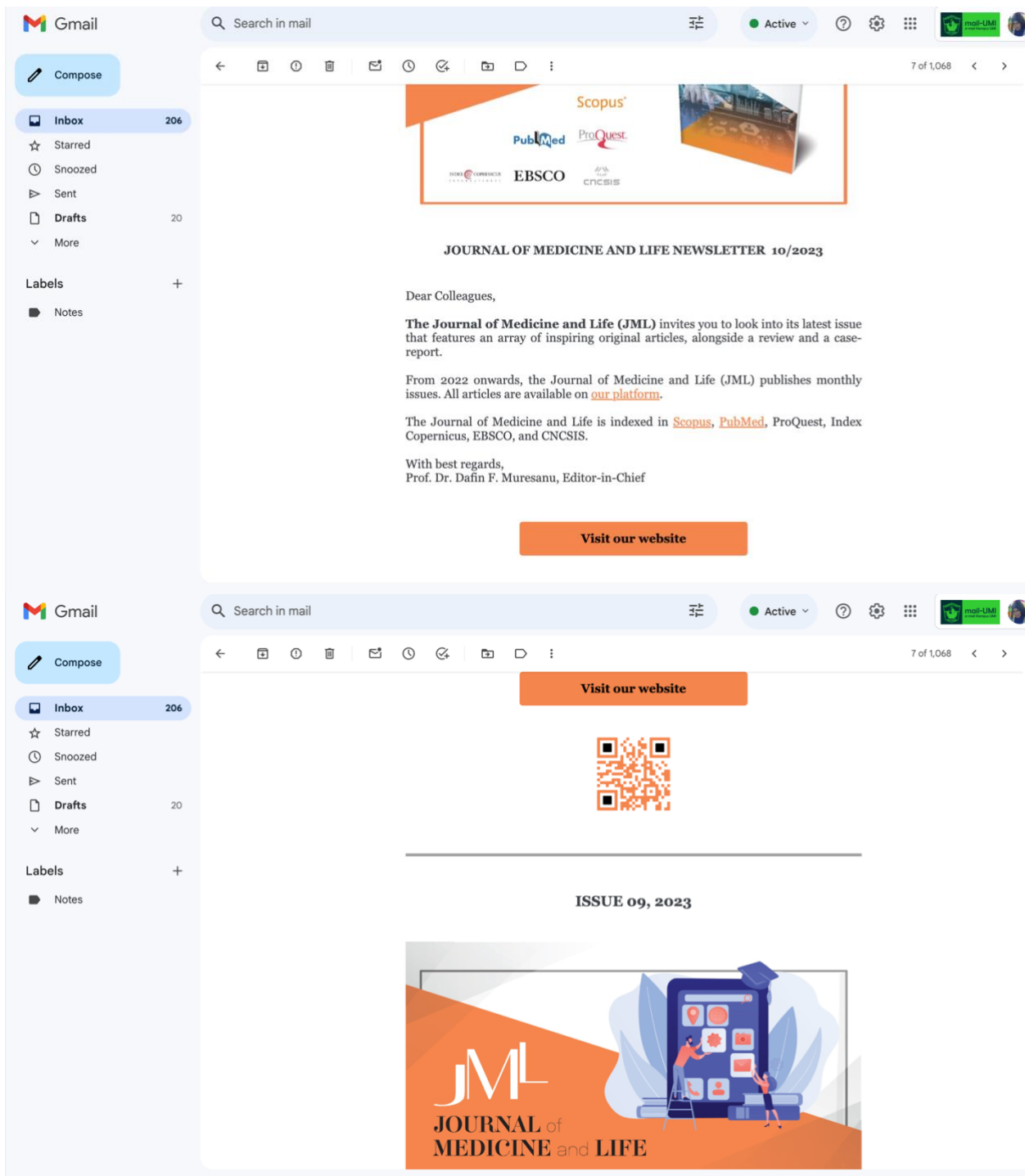
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