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Barriers for nurses provided nursing care for gay clients living with HIV/AIDS in Indonesia☆

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Abstract
Objective: This study aims to explore the barriers Indonesian nurses face when providing care for gay clients with HIV/AIDS.
Method: This study uses a descriptive qualitative approach by utilizing a purposive sampling technique. The research was carried out in two leading hospitals in Jakarta, with one government and one private hospital included. The research data were analyzed using a thematic analysis.
Results: The contents of this research resulted in three main themes: client-based barriers to nursing care, family-based barriers to nursing care, and care constraints that are derived from the nurses themselves.
Conclusion: Nurses need to be open, to involve clients and families to discuss problems encountered. Also, nurses need to be equipped with specific knowledge and skills of how to handle gay clients through trainings especially related to sexuality knowledge and communication skills.

Introduction

There are more than 34 million people infected with HIV/AIDS globally[1] Between January–March 2017, the number of people living with HIV in Indonesia was reportedly 242,669.[2] Moreover, as many as 87,453 people live with AIDS, with the majority of AIDS cases occurring in men compared to women (2:1 ratio). In Indonesia, the percentage of men with AIDS is 56%, and the risk for AIDS in gay men is as high as 28%.[2] Men who have sex with men contribute substantially to the HIV epidemic.[3]

The increase in the incidence of HIV/AIDS in gay clients is closely correlated with risky sexual activity, such as oral sex, anal sex, unprotected sex, and alternating sexual partners. Anal sex is the primary risk factor for gay men.

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Research indicates that the majority of gay men report having had oral sex (99%) or unprotected anal sex (90%) within their lifetime, two-thirds of men (68%) reported that they have participated in group sex, and 58% reported that they have had sex with a stranger in their lifetime. Even men engaged in monogamous relationships sometimes reported free sexual activity.[4,5] In a study regarding gay men who identified as having HIV/AIDS in Ontario, Canada, 51% of cases were reported as occurring in clients who had protected anal sex, 33% of cases indicated anal sex without a condom, and 16% of cases reported having oral sex.[6]

When a client is infected with HIV/AIDS, they require treatment and care. For this type of treatment, the client will go to healthcare facilities such as hospitals. Within the hospital setting, nurses act as healthcare professionals and are involved with clients directly. In Indonesia, nurses have difficulty identifying gay clientele, as homosexuality is still widely debated in both religion and human rights and psychology.[7] Because of this, nurses who provide treatment to this type of client can run into trouble in caring for them. Based on the results of a quantitative research study conducted in Japan regarding the experiences of public health nurses, 52.8% of 1.535 valid questionnaires, the study respondents reported difficulty in implementing HIV/AIDS treatment services. These difficulties were caused by a shortage of nurses, as well as a lack of training related to meeting with homosexual clients and those with HIV/AIDS. These difficulties were coupled with a poor knowledge of sexuality and diverse sexual orientation, as well as a lack of training on sexual diversity and education in public health nursing. Nurse respondents who participated in this study said it was difficult for caring gay men or client with HIV/AIDS.[8]

Gay clients have assessed that healthcare workers do not have enough knowledge about meeting their healthcare needs.[9] This is manifested in the attitudes of healthcare workers, some of whom are less than comfortable in dealing with gay clientele and place an undue level of negative attention on gay identity. These attitudes result in a lack of objectivity and client privacy. Gay clients want to be respected, treated as human beings, given treatment when they get sick, receive professional care, and have the expected disclosure of privacy regarding their identity and sexual orientation.[9]

Due to the lack of specific guidelines and relevant studies, the competency of healthcare providers and nurses when performing treatment for gay clients with HIV/AIDS is less developed. As such, nurses experience difficulties and obstacles when identifying client care needs. Based on the above-described problems, this study explores the barriers of providing Indonesia nursing care to gay clients with HIV/AIDS.

Methods

This study uses a qualitative descriptive approach. Qualitative descriptive research method involves findings that approaching real data.[10] The aim of this study is to explore the issues related to the phenomenon, experiences, views, and perspectives obtained directly from those who have experienced that happened.[11–13] This study is suitable for use in the field of environmental health.[14] This is because it provides factual responses to questions regarding the feelings and reasons behind why healthcare services are used, as well as their benefits and inhibitors.[14] Participants of this study included nurses who care for gay clients with HIV/AIDS, and a purposive sampling technique was employed to conduct the research. Purposive sampling is a suitable method for qualitative research as it requires closeness as part of the sample criteria and reason for decision-making.[15]

In order to determine the eligibility of the selected study participants, the following inclusion criteria was applied: the participant must have been a nurse who cared for gay clients with HIV/AIDS in the inpatient unit and have a minimum education equivalent to a Diploma of Nursing because that is a level of Nursing education that has the aim of producing beginner nurses. This research was conducted in two leading Jakarta hospitals, one government and one private. The recruitment process involved several key informants who searched nurses that counselled HIV/AIDS clients in the two hospitals. There were 15 nurses in total who were successfully recruited to participate in this study, with 8 participants deriving from a government hospital and 7 participants deriving from a private hospital. This is consistent with the target range of recommended research participants, which was between 12–60 participants.[16] Data collection was conducted over two months from May-June in 2018. This study has been approved by the Ethics Committee of the Faculty of Nursing at Universitas Indonesia. Ethical principles have been applied to this research, among which is the principle of autonomy wherein informed consent was given to prospective participants to make a decision within 1×24 h. The principle of beneficence was implemented by explaining the advantage of the research confidentiality is done by offering participants a pseudonym when interviewing and providing coding using initials (P1, P2, P3, etc.) when documenting. Justice provides equal opportunities for participants to be involved in research and clear information related to the fair research procedures for the nurses who are participants.[17,18]

The study participant interviews ranged from 30 to 77 min in length. The research instruments used within this study included a tape recorder, semi-structured interview guidelines, and field notes hand written.[18] Data were analyzed using several steps of thematic analysis: data introduction, the production of codes, placing codes into subthemes, revising the themes, naming the themes, and producing reports.[19]

Results

Characteristics of participants

Participants in this study were nurses working in the inpatient unit. There were 15 nurse participants, 11 of which were female and 4 of which were male. The ages of the participants ranged between 26–49 years. The education level of the participants also varied, with eight who completed a Diploma of Nursing, six who graduated with a Bachelor of Nursing, and one who has received accreditation from a professional (Nurse) programme.

The three themes identified by the researchers in this study include the client, family, and caregiver barriers during the nursing care process. These themes are based on the statements of almost all of the study participants. Obstacles occur from three main sources, namely the client, a family member, or barriers of the nurses themselves.

Theme 1: Client-based barriers to nursing care

Nurses are presented with several obstacles, many of which come from clients who are not open to dealing with the conditions of status. This is described by three participants (P1, P7 and P9) in the following statements:

''The only barrier is if they do not want to open up (coming out).'' (P1)

''Just be sure that their experiences of gay. Yes, sometimes they hide this status from the family. This was the most difficult.'' (P7)

''Gay men, especially with a couple, are very difficult. They are more closed and not open to others.'' (P9)

Another obstacle comes from a lack of client knowledge regarding HIV/AIDS. This is expressed by the following participant remark:

''Average does them because of a lack of knowledge, but often come here finally their knowledge increases.'' (P15)

Five of the 15 participants stated that resistance sometimes comes from the client's awareness of the disease:

''Clients stop only when they are sick, and, I found out that he is doing a risky sexual behavior again.'' (P3)

''At first, they want for example introspection. It has been reprimanded by such diseases, should they desire to quit, but it does not exist.'' (P5)

''They actually know about the risk, but can't stop it'' (P7)

''Experience in treatment does. Such clients tend to be more difficult (eyes while looking up) for education, for aaa, with their behaviur still being high risk. So, much more difficult arghh.'' (P7)

''So, they know but never move on to learn more about it.'' (P8)

Theme 2: Family-based barriers to nursing care

The second theme identifies that barriers to the provision of nursing care to gay clients with HIV/AIDS can also be derived from the client's family. Obstacles coming from the family include exclusion from the family in nursing care, and the neglect of ethical and legal aspects such as sign an agreement on medical and nursing actions.

Family exclusion becomes an obstacle to the provision of optimal nursing interventions. This is expressed by P5, P7, and P11 as follows:

''They are not treatment at home because the family rarely tends to care.'' (P5)

''The difficulty is yes, family. There are some families in which informed consent does not exist. Some will have to wait.'' (P7)

''Obstacles with the family are sometimes present in nursing action. Usually, patients accompanied not by their family but by people, friends, their boyfriend. Well, I waited by people like this for 24 hours. We're not able to assist them 24 hours. When they have nothing that they need, no family beside them.'' (P11)

Family exclusion during the process of nursing care will ultimately have an impact on the client. The legal aspects of ethical neglect become an obstacle in the process of nursing care, which is expressed by nurses in the following statements:

''Most of them who are delivered to administration are not from the same family, for example, as a responsible family should. So, sometimes whoever found him sick is not family, but his partner who brought him in.'' (P6)

''We need a signature from the family. If no one comes, it sometimes hinders the process and medical measures. This is because usually at the hospital, the presence of family or a representative is required. It must be done legally, so most were just obstacles.'' (P10)

Theme 3: Care constraints that are derived from the nurses themselves

The third theme that emerges is a bottleneck in the provision of nursing care that comes from the nurses themselves. This includes the poor treatment of clients and nursing constraints stemming from the judgement associated with a nurse's impression of a client. Excerpts related to these barriers were expressed by P3, P5, and P13:

''In the average visit, she had him sign over there complications, it is helpless. Anyway, yes. We will help to aaa daily living activity, although there is no family. There is also sometimes when the family is not waiting. If not waiting, all they need is a nurse.'' (P3)

''And it's usually clients who tend to be helpless, physically weak. That is, if his own family, the tendency often left at the family. I cannot help ya nurse in charge. Yes, sometimes he is upset too. But the nurse yes just done, hehehe (laugh).'' (P5)

''Clients have entered with organic mental disorders. So already there is an infection in the brain. Sometimes with organic mental disorders, we cannot examine now.'' (P5)

''Except that have been really bad, but we cannot examine because his situation is not possible.'' (P13)

Aside from these barriers, bad impressions of a client's condition can cause the nurse to fear contracting HIV/AIDS from their client. This was expressed by P5 in the following way:

''Just because they are paranoid, not all people are scared. They are paranoid that if they are exposed to the liquids of clients with HIV/AIDS they will contract is

his HIV virus, whereas this is not necessarily right. The principle is actually already known. Yes, it is transmitted through anywhere. But yes, it is being too protective. It still seems like overkill, I think anyway. There is nothing like it.'' (P5)

''This impression of the client and what his behavior is. Yeah, we sounded bad, hehehe (laugh). Because of the disease, the term sought after themselves.'' (P5)

The barriers that occur for the client, the family, and the nurses are therapeutic obstacles to nursing. Therapeutic obstacles are impediments to the progress of the relationship between nurses and clients.[20] Specifically, these obstacles are divided into four categories: resistant, transference, countertransference, and deviation limits.[20]

Barriers are derived from clients who does not coming out, and can include a client's health status, their lack of knowledge related to their health, and the results of a systematic review on transgender clients.[21] Furthermore, the client's awareness of HIV can lessen these inhibiting factors if explained to them theoretically that the barriers in question are resistance. It occurs when the client refuses to change their behaviours, despite knowing why these changes need to be made. Some examples of resistance include suppression, repression, self-setbacks, despair, intellectual indolence, intellectual inaction, irrational behaviour, and the rejection of normality. Resistance can also be expressed in the form of depression or lack of motivation.[20]

Coming out client is a form of psychosocial-spiritual adaptation response, which is undertaken by clients to cope with their stressor responses. These clients are usually identified as having difficultly opening up, and they often tend to isolate themselves.[20,22] This is done as a coping mechanism to protect themselves so that their identity may remain anonymous. Clients express the fear that if their identity is revealed, people around them like family, friends, and society will exclude them. This is because being gay is considered a sin.[23] In addition to isolation, clients also experience a negative feelings of sadness, despair, the fear of death, rejection, and discrimination.[24] With no exception being made for nurses, clients sometimes show transference characterized by inappropriate levels of response intensity. For example, clients can be hostile to nurses. Such behaviour is seen when the client interacts with the nurse, as the client will usually try to keep a distance from them.

Barriers sourced from family members include family disengagement in nursing care. Family disengagement is usually triggered by the client hides the gay and HIV status from family. Clients assume that they will be a source of stress for their family if they knew their status. Because of this, clients rarely involve their families in the process of nursing care. Some study participants revealed that their clients attempt to open up regarding the situation of being excluded from their family. This happens because of a lack of information, as well as the fear of stigma associated with the state of the client. The lack of information pertaining to HIV/AIDS can cause problems that aggravate the conditions experienced by the client as clients become increasingly closed.[25] With such conditions, gay clients are prone to have worsening attitudes, as well as participate in increasingly risky sexual behaviour. Moreover, emerging mental disorders such as anxiety, loneliness, depression, social isolation, and suicidal behaviours have been reported.[26]

Acceptance, support, and family involvement in the process of providing nursing care can be a coping resource for clients. Some potential parental or relative roles include: assigning a positive family role model to help learn new treatment methods, reducing the risk of HIV transmission by having communications about sex between parent and client, having a two-way discussion between parent and client about sex and sexuality, and support and ongoing treatment when the client returns to their family environment.[27] Parental involvement will aim to raise a client's self-awareness in controlling and preventing the spread of HIV, as well as to help clients accept and realize their status.

As expressed by several of the study participants, barriers originating from nurses exist, such as a nurses' bad impression having an impact on the status of a client. Based on the statements made by the study participants, it can be claimed that nurses show obstacle countertransference intervention. Countertransference occurs when transference is shown by a nurse to stop their emotional response to their client.[20] In accordance with the study results, countertransference was shown nurses through their reaction of excessive disgust in relation to their impression of their clients. As a result, they treated their clients badly. Countertransference is associated with the perception of nurses who consider the deviation of sexual orientation by clients to be taboo, which creates maltreatment of gay clients and a misunderstanding of the client's needs.[21]

A qualitative study conducted in the Netherlands indicates that there are additional difficulties faced by nurses who treat gay clientele with HIV/AIDS. These difficulties are associated with the emerging discomfort of shame felt by nurses when discussing issues related to sexual behaviours.[28] Nurses then do not trust themselves when discussing topics related to sexuality, which is linked to a lack of knowledge and practical communication skills. Because of this, many nurses decide not to converse about sexuality, which in the end, does not address client issues appropriately.[28]

Several strategies can be implemented by nurses to address the barriers of treating gay clients with HIV/AIDS. By increasing knowledge through training that discusses sexuality, especially for novice nurses, the quality of client consultations regarding sexual behaviour will greatly improve. Knowledge improvement will begin by nurses encouraging open questions on a regular basis, nurses actively attempting to not patronize clients, and nurses becoming facilitators so that they are able to carry out their duties professionally.[28,29]

Conclusion

Barriers can be sourced from either clients, families, or nurses during the process of nursing care. The implications of these barriers reveal that nurses do not currently provide optimal nursing care in Indonesia. Thus, nurses must involve clients in providing nursing care, be open to dealing with clients, and actively discuss the barriers they experience in

order to overcome these obstacles. This can be achieved by providing training and specialized skills for nurses who deal with gay clients with HIV/AIDS. For example, efforts to increase knowledge through training pertaining to sexuality will allow nurses to have confidence when discussing sex-related issues with their clients. Furthermore, nurses should be expected to master the good communication techniques and strategies to overcome nursing obstacles. Appropriate communication techniques can be achieved through regular practice, which will in turn allow the client to feel more comfortable with their nurse. This will close the interaction gap between nurses and clients.

Conflict of interests

The authors declare no conflict of interest.

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