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The relationship between stigma, religiosity, and the quality of life of HIV-positive MSM in Medan, Indonesia☆

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Abstract
Objective: This study aims to determine the relationship between stigma, religiosity, and the quality of life of HIV-positive men who have sex with men (MSM) in Medan.
Methods: This is an analytical observational study with a cross-sectional approach. Data in demographics, stigma, religiosity, and quality of life were obtained directly from the participants. Data were taken from April to May 2018. There were 175 subjects who met the criteria which; (i) HIV-positive MSM; (ii) aged ≥ 18 y.o.; and (iii) able to read and write.
Results: Bivariate analysis found that there is a negative relationship between stigma and quality of life (p-value = 0.007), and there is a positive relationship between religiosity and quality of life (p-value = 0.000).
Conclusion: These findings suggest that stigma is an indicator of poor quality of life, while higher religiosity is associated with better quality of life. An interdisciplinary approach is needed in health care planning and social services, to improve the quality of life of HIV-positive MSM.

Introduction

In recent years, HIV infection trends show that the number of men who have sex with men (MSM) increases each year significantly. In Indonesia, HIV infections with MSM risk factors have been increasing in the last 5 years: there were 1514 cases in 2012; 3287 in 2013; 3858 in 2014; 4241 in 2015; and the most cases was reported in 2016; 13,063 cases. Thus, MSM has become the second-most at-risk group after heterosexuals which make up 17,754 cases in 2016. The latest reports obtained in the first quarter of 2017 show that MSM has the highest risk factor for HIV infection, with 2867 cases followed by heterosexual with 2448 cases. Data from North Sumatera's Board of Health show an increased percentage of HIV-positive MSM, from 4% in 2012 to 10% in 2015.[1]

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The MSM population is predicted to continue to increase, which means that there will be an increase in HIV risk prevalence in this particular group. Many other countries have also reported a high occurrence of HIV in MSM groups. Generally, it is evident that MSM is 28 times more at risk for HIV than the general population.[2] The increasing risk of HIV infection in MSM groups has been related to their risky sexual attitudes and behaviors, such as frequently switching partners, unprotected sexual intercourse, flexibility of sexual roles between MSM, and legal factors, according to a May 2016 tally by the International Lesbian, Gay, Bisexual, Trans, and Intersex Association (ILGA), which reports that 73 countries still criminalize same-sex conduct. In 13 countries homosexuality is punishable by the death penalty. As a result, MSM is less likely to access HIV services for fear of their sexual orientation and identity being revealed.

MSM with HIV faces various kinds of stigma regarding their status. Besides HIV status-related stigma, they are also facing stigma due to their sexual orientations. This hinders them in revealing their HIV status and tends to cause them to avoid HIV-related issues.[3] In some cultures, aggressiveness and hostilities are shown by the general population toward same-sex practices; they claim that HIV is a form of punishment for same-sex practices,[4] or they claim that MSM do not behave with normative masculinity, and they do not act according to social norms regarding gender roles, e.g., she-males. These sorts of attitudes cause MSM to be stigmatized and directly discriminated against, which triggers marginalization of MSM, which contributes to sexual vulnerability[5] and also causes an increase in risky sexual behaviors.[6] HIV-positive MSM not only are stigmatized by the general population, but also by HIV-negative MSM communities.[7] The stigma toward MSM also occurs in healthcare services, where 54% of the respondents in research in San Salvador reported high discrimination from healthcare services regarding their sexual orientation and gender identities.[8]

Religion and religiosity are considered to have a connection with stigmatization toward people living with HIV/AIDS (PLWHA), because many religions adhere to the values that prohibit HIV transmission-related behaviors.[9] As for PLWHA, religiosity may have an advantageous or harmful impact. Higher religiosity is related to lower psychological pressure, less pain, higher energy, and motivation toward life, and better social and cognitive functions. Higher religiosity may cause PLWHA to feel a better life after being diagnosed as HIV-positive.[10–13] However, higher religiosity may also cause a negative impacts Antri. In a particular qualitative study, there was a noticeable finding that religion has the potential to cause a negative impact, where several youths seemed to rely more on divine intervention rather than biomedical treatment. There is still no clear explanation of the spreading of this problem, although it may have an impact on the obedience to antiretroviral therapy (ART).[14]

Since HIV AIDS has developed into a chronic disease, quality of life is a multidimensional concept that is recognized as a significant indicator used to assess health in various aspects of the life of PLWHA. The stigmas and discrimination toward AIDS are still significantly impacting the quality of life of PLWHA in all stages. Compared with HIV-negative individuals, PLWHA in every phase of the disease shows poorer quality of life in every aspect, especially in psychological and social aspects.[15,16] Previous studies on MSM populations indicated that surveys regarding their quality of life might provide information relating to physical, social, psychological, and cognitive functions, based on their perception of health.[11–13]

Method

This research employed an analytic observational research design with a cross-sectional study approach. The sample collection in this research employed non-probability sampling, with a purposive-sampling technique. The inclusion criteria in this research were: (i) MSM PLWHA (based on initial screening questionnaires); (ii) aged $\geq$ 18 years old; and (iii) able to read and write. There were 175 people who filled the requirements. This research was conducted in four places: Rumah Sakit Umum Pusat Haji Adam Malik, Rumah Sakit Umum Pirngadi, Puskesmas Teladan, and Puskesmas Padang Bulan, in Medan. The period of the research ranged from 21 April to 24 May 2018.

This research employed a questionnaire as a data collection instrument. The questionnaire used was comprised of respondents' characteristics; the Berger HIV Stigma Scale, which has 40 questions; a religious-level questionnaire made up of 20 questions; and the World Health Organization Quality Of Life-HIV questionnaire, which is made up of 31 questions. The validity of the instrument test results was >0.3, and the reliability was >0.6.

Results

The bivariate analysis results show that stigma has an association (p-value = 0.007) to the quality of life, and religiosity is (p-value = 0.000) related to the quality of life in HIV-positive MSM in Medan, Indonesia. A socio-demographic factor that has a significant relationship with the quality of life of HIV-infected MSM with HIV in Medan is income (Tables 1 and 2).

Discussion

The relationship between stigma and quality of life of HIV-positive MSM

In this research, higher stigmas were reported by 90 respondents (51.4%). This is in accordance with the results of research conducted on HIV-positive MSM in China, where respondents were reported to experience higher stigmas.[17]

Statistics obtained in this research show that there is a meaningful relationship between stigma and the quality of life of HIV-positive in Medan. These results are consistent with several previous studies, which reported that there is a significant negative relationship between stigma and quality of life, where higher stigmas are correlated with poor quality of life.[18–22] A study in Cape Town South Africa, compared the stigmas toward HIV-positive MSM and PLWH non-MSM. The results reported that HIV-positive MSM received higher stigmas, compared to heterosexual men. These findings indicate that multi-faceted stigmas occur toward homosexual behavior and HIV-positives.[23]

Table 1 Demographic characteristics.

Characteristic	Total	
	n = 175	%
Age		
<40 years old	160	91.4
≥40 years old	15	8.6
Education		
Lower (high school)	111	63.4
Higher (undergraduate)	64	36.6
Employment		
Unemployed	14	8
Employed	161	92
Marital status		
Single	158	90.3
Married	17	9.7
Income		
Higher	86	49.1
Lower	89	50.9
Duration of diagnosis		
≥12 months	124	70.9
<12 months	51	29.1
Stigma		
High	90	51.4
Low	85	48.6
Religiosity		
High	91	52
Low	84	48
Quality of life		
Poor	81	46.3
Good	94	53.7

Table 2 Variables associated with quality of life.

Variables	*p*-Value	OR (95% CI)
Age	0.399	–
Young adults		
Adults		
Education	0.107	–
Higher		
Lower		
Employment	0.991	–
Employed		
Unemployed		
Marital status	0.850	–
Married		
Single		
Income	0.001	3.050 (1.643–5.661)
Higher		
Lower		
Duration of diagnosis	0.482	–
<12 months		
≥12 months		
Stigma	0.007	4.368 (2.248–8.487)
High		
Low		
Religiosity	0.000	3.847 (2.053–7.209)
High		
Low		

p-Value <0.005.

MSM PLWHA faces various kinds of stigmas, or ''layered stigmas'' including stigmas related to their HIV-status and their identity as MSM.[19] Higher stigmas have been reported as a hindrance for MSM PLWHA in revealing their status and also in seeking information and help for treatment.[3] Similar views were expressed by other research in which stigmas toward MSM PLWHA are also related to silence, denial, self-accusation, rejection, violence, isolation, and procrastination in testing and seeking treatment.[24] Stigmas and discrimination related to MSM are the main obstacles for MSM to seek medical help. Stigmas related to HIV may cause depression and poor obedience to medication, which will lead to poor quality of life.[25]

Stigmas related to HIV-status in PLWHA are still reported as high in Indonesia. Stigmas related to HIV occur not only because of regarding HIV as a fatal disease, but also because of views that regard this disease as happening through behaviors that are not in accordance with moral, social, and religious values. Stigmas may occur in the form of resistance in purchasing foods that are sold by PLWHA, not allowing children to play along with PLWHA, avoiding toilets that were used by PLWHA, family members refusing to share one bed with other PLWHA members, and refusing to take care of PLWHA family members.[26] Several studies have shown that stigmas toward PLWHA not only occur in society but also in healthcare services.

In Indonesia, society's cultural norms and perspectives make it difficult for MSM to confess and to be accepted. Studies had indicated that being gay in Indonesia may be seen as sexual deviation and corruption of Indonesian culture.[27] Moreover, if certain people are considered deviant from the dominant normative heterosexuality, they may not only be considered as sick (as in having a mental health issue) and sinful but also be considered as not adequate to be Indonesian citizens. Such societal norms and perspectives often lead to stigmatization toward MSM, along with discrimination, judgments, rejection, and violent threats. This causes MSM to hide their status and hesitate to discuss sexual health issues with other people, including family members and healthcare professionals. Such clandestine behavior regarding their HIV status may cause MSM to lack information or to prevent themselves from accessing HIV/AIDS-related services, such as voluntary counseling and testing, and postpone seeking medications.

The relationship between religiosity and the quality of life of MSM PLWHA

In this research, 52% of the respondents reported having a high rate of religiosity. This is in accordance witha previous study, which reported that 65.1% of its respondents had a goodrate of religiosity. Respondents considered religion an

important part of their life.[28] The bivariate analysis results showed a statistically significant relationship between the religiosity of respondents and their quality of life.

In several studies, religiosity is related to better mental and general health in PLWHA. Better mental health will impact better obedience toward medications, better income, and higher social satisfaction. The absence of the symptoms of depression and higher satisfaction with social support are related to better general health. The existence of religion, prayer, and religiosity rates contribute to the increase in comprehension of the meaning of life, peace, lifestyle alteration, healthier self-confidence, self-perception, and social support, all of which lead to improvement in the quality of life.[29]

Sexual orientation is one of the key factors in the relationship between religiosity and the test results of PLWHA. A comparison study between religious practices and the bio–psycho–social results (e.g., emotional states, social support) of homosexuals and heterosexuals reported that religiosity had a positive relationship with social support between homosexual PLWHA groups, but religiosity was not able to mediate the bio–psycho–social results among heterosexual PLWHA.[30]

High stigmatization of HIV-positive MSM is still found in Indonesian society. Higher stigmas may decrease the quality of life of PLWHA. However, higher religiosity may contribute to a better quality of life. Religiosity has a significant impact on health among MSM. Further research may be advisable, to comprehend the way to maximize religiosity, which may have an impact on better health for PLWHA and minimize harmful factors. Religious aspects may be put into consideration for inclusion in HIV-disease management as a way to handle and improve physical and mental health results.

Conflict of interests

The authors declare no conflict of interest.

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