ORIGINAL ARTICLE

Understanding Health Workers' Stigma Towards Hiv/Aids Patients In West Sumatra Through Grounded Constructivist Theory

Amira Esti, Yenni, Yade Kurnia Sari, Septa Nely

Faculty of Nursing, University Of West Sumatra, Km 32 Lubuk Alung, Jalan Padang-Bukit Tinggi, 25581 Sumatera Barat, Indonesia

ABSTRACT

Introduction: HIV/AIDS remains a major global public health challenge, with an estimated 36.9 million people living with HIV worldwide, many of whom lack awareness of their status or access to adequate treatment. In Indonesia, HIV/AIDS cases have increased rapidly in recent years, placing significant pressure on the healthcare system. Despite advances in HIV prevention and treatment, access to comprehensive and stigma-free HIV care remains uneven, particularly in low- and middle-income settings. The growing HIV burden in Indonesia highlights persistent gaps in service delivery that cannot be fully explained by epidemiological data alone. Examining healthcare workers' experiences is therefore critical to understanding how HIV care is enacted in practice. **Methods:** This qualitative study employed thematic analysis to explore how healthcare workers construct meaning from their experiences in caring for people living with HIV/AIDS. Data were collected through in-depth interviews with health professionals from several healthcare facilities in West Sumatra, supported by direct clinical observations. Thema develompment were used to identify stigma-related themes. **Results:** Stigma among healthcare workers was shaped Fear-Based Negative Judgment and Patient Devaluation, Restricted Access to Comprehensive Healthcare Services, Patient Labeling and Social Othering and Fear-Driven Overuse of Personal Protective Equipment. **Conclusion:** Targeted education and training programs are needed to reduce stigma and improve the quality of HIV/AIDS care.
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Corresponding Author:
Amira Esti, M. Kep
Email: Amira.esti@yahoo.co.id
Tel: +62 81266012129

INTRODUCTION

According to UNAIDS, an estimated 36.9 million individuals were living with HIV/AIDS globally in 2023. Although antiretroviral therapy coverage is projected to reach 61–89% by 2024, HIV/AIDS remains a major health and development concern. Approximately 17.1 million people are still unaware of their HIV status, and nearly 22 million—including 1.2 million children—lack adequate access to treatment, preventive services, and routine clinical monitoring. Over the past fifteen years, Indonesia has experienced a rapid increase in HIV/AIDS cases, positioning it as one of the fastest-growing epidemics in Asia. Provinces such as Papua, Jakarta, East Java, West Java, Bali, and Riau have become high-priority areas due to their substantial case burden (1).

Historically, stigma in ancient Greek and Roman societies referred to physical marks used to denote social exclusion. Goffman later conceptualized stigma as an attribute that deeply discredits individuals, separating them from socially accepted categories and damaging their personal, social, and professional identities (2). In the context of HIV/AIDS, stigma remains a critical barrier to effective prevention, diagnosis, treatment, and long-term care.

In Indonesia, inadequate pre- and post-test counseling, limited public awareness of voluntary counseling and testing (VCT), breaches of confidentiality, and occasional refusal of care persist within healthcare settings (3). HIV/AIDS stigma manifests through discriminatory attitudes, negative labeling, and social exclusion, restricting access to healthcare, education, employment, and housing. Previous studies highlight that insufficient HIV-related knowledge among healthcare workers—particularly nurses—regarding transmission and management significantly contributes to stigmatizing practices (4).

Despite extensive evidence documenting stigma at the community and individual levels, empirical studies examining how stigma is constructed and enacted within healthcare services—particularly from the perspective of healthcare workers—remain limited in Indonesia. Existing research largely focuses on epidemiological patterns, patient experiences, or general attitudes, leaving a critical gap in understanding the institutional and professional processes through which stigma is reproduced in everyday clinical practice. This gap is particularly concerning given evidence that healthcare-related stigma directly undermines trust, service utilization, and treatment adherence.

Therefore, this study seeks to address this gap by investigating stigma within healthcare services through an in-depth qualitative exploration of healthcare workers' experiences and meaning-making processes. By moving beyond descriptive accounts toward a theoretically informed analysis, this research offers a novel contribution to the literature by illuminating how stigma is embedded in care practices and organizational contexts. Such insights are essential for developing targeted interventions to reduce stigma and improve the quality and equity of HIV/AIDS care in Indonesia.

MATERIALS AND METHODS

This study aimed to explore stigma among health workers who provide care for individuals with HIV/AIDS in West Sumatra, Indonesia. It represents one of the few studies examining stigma through a thematic analysis approach in this context. Consistent with the framework proposed by Braun and Clarke (2006), thematic analysis was conducted as an iterative and reflexive process aimed at identifying, analyzing, and reporting patterned meanings across the dataset. Rather than generating formal theory, this approach focuses on capturing shared and divergent experiences of stigma as articulated by healthcare workers. Data interpretation acknowledges the active and reflexive role of researchers in theme development, while remaining firmly grounded in participants' accounts and the sociocultural context of HIV/AIDS care (6).

The research was carried out in the jurisdiction of the Padang Pariaman District Health Office, West Sumatra Province. Ethical approval was granted by the University of West Sumatra. Twenty adult participants who had cared for HIV/AIDS patients and had observed or enacted stigma were recruited. Each participant provided informed consent. Interviews were conducted in hospitals and primary health centres, lasting 30–45 minutes, using a semi-structured format.

Data collection included individual interviews as the primary method, along with document reviews. Silent or documentary evidence—such as nursing reports, performance evaluations, meeting minutes, field notes, and memos—was incorporated as part of data triangulation (7). Memo writing involved recording reflections, analytical ideas, and theoretical insights emerging during data collection. Field notes captured contextual information, non-verbal cues, and situational observations to support deeper interpretation of the data (4).

Statistical Analysis

Analysis In this study, twenty semi-structured interviews Interviews were conducted flexibly, with follow-up probes used when necessary to clarify or deepen participants' responses:1.What emotions do you experience when providing care to patients living with HIV/AIDS? 2. How do fear or anxiety influence your interactions with these patients? 3. Despite understanding HIV transmission, have you ever felt reluctant or emotionally distant when delivering care? 4. Can you describe a situation in which fear affected your professional attitude or commitment? 5.How do you determine the type and scope of healthcare services provided to patients living with HIV/AIDS? 6. Have you ever hesitated to provide certain examinations or treatments? What influenced that decision? 7. What are your views on follow-up care for patients with HIV/AIDS? 8. How and why are referrals to specialized HIV clinics usually made in your workplace? 9. How are patients perceived or categorized when they are suspected of having HIV/AIDS? 10.Have you observed labeling or assumptions made prior to diagnostic confirmation? 11.How do such labels influence interactions between healthcare workers and patients? 12.In your opinion, how does labeling affect patients' sense of inclusion or exclusion in healthcare settings? 13. What personal protective equipment do you usually use when caring for patients living with HIV/AIDS? 14.What factors influence decisions to use additional or excessive PPE? 15. How do you think patients perceive PPE use during their care? 16. In your view, how does PPE use reflect fear or stigma related to HIV transmission?

With health workers who had treated patients with HIV/AIDS were conducted and used as the main data source for analysis. A thematic analysis approach was used to organize and manage the qualitative data. Data analysis was conducted through an iterative and systematic process consistent with the phases of thematic analysis as outlined by Braun and Clarke (2006). The analysis progressed through several interconnected stages: familiarization with the data, initial coding, searching for patterns across codes, reviewing and refining themes, and defining and naming final themes. In the initial phase, interview transcripts were coded systematically to capture meaningful units relevant to healthcare workers' experiences of stigma in HIV/AIDS care. During the intermediate phase, related codes were compared and clustered to identify recurring patterns and relationships across the dataset. In the final phase, these patterns were refined and consolidated into coherent, conceptually

distinct themes that captured shared meanings across participants' accounts. Although these analytic phases are presented sequentially, the process was not linear. Analysis involved constant movement back and forth between data, codes, and emerging themes, allowing for reflexive refinement throughout. This iterative analytic process resulted in the identification of four distinct and non-overlapping themes that represent key dimensions of stigma within healthcare settings.1. Fear-Based Negative Judgment and Patient Devaluation.2. Restricted Access to Comprehensive Healthcare Services 3. Patient Labeling and Social Othering 4. Fear-Driven Overuse of Personal Protective Equipment. These stigmatizing practices were reinforced by interconnected factors that collectively intensified negative interactions within healthcare settings and adversely affected patient care. Inadequate HIV-related knowledge and fear of occupational exposure perpetuated misconceptions about transmission, leading to overly cautious practices, emotional distancing, and compromised therapeutic relationships. Moral and cultural assumptions further contributed to patient labeling and social othering, undermining professional neutrality and equitable care. Breaches of confidentiality eroded trust and discouraged continued engagement with healthcare services, while unclear institutional guidelines allowed personal fears and beliefs to shape clinical decisions. Limited organizational support, including insufficient training and supervision, normalized stigmatizing practices and constrained efforts to deliver stigma-free, patient-centered HIV care.

Ethical clearance
This study was approved by Research Ethics Committee UNISBAR. Number: 00.002/EA/KEP-UNISBAR/1/2026

RESULTS

Using thematic analysis, four key themes were identified that capture the core impacts of stigma on healthcare practices and patient experiences within healthcare settings.

Theme 1: Fear-Based Negative Judgment and Patient Devaluation.
Participants described fear and anxiety when interacting with people living with HIV/AIDS, which often resulted in negative judgments and diminished professional commitment. Despite awareness of HIV transmission mechanisms, fear continued to influence care practices, leading to avoidance behaviors and emotional distancing from patients.

Theme 2: Restricted Access to Comprehensive Healthcare Services
Stigma was reflected in the limitation or withholding of healthcare services for HIV/AIDS patients. Some participants reported reluctance to provide full care, perceiving follow-up examinations as unnecessary due to beliefs about the incurability of HIV. Referral to specialized HIV clinics was often used as a means of distancing rather than ensuring continuity of care.

Theme 3: Patient Labeling and Social Othering
Participants acknowledged labeling patients based on assumptions or perceived risk, sometimes even prior to diagnostic confirmation. Such labeling positioned patients as "different" or "dangerous," reinforcing social othering and contributing to feelings of isolation, neglect, and inequitable treatment within healthcare environments.

Theme 4: Fear-Driven Overuse of Personal Protective Equipment
The excessive use of personal protective equipment (PPE) emerged as a visible manifestation of stigma. PPE overuse was primarily motivated by fear of transmission rather than clinical guidelines, inadvertently signaling distrust and reinforcing patients' experiences of being stigmatized.

DISCUSSION

This study, using a thematic analysis approach, identified multiple interrelated patterns of meaning that characterize how stigma is produced and enacted within healthcare settings in West Sumatra. The findings demonstrate that stigma experienced by people living with HIV/AIDS is not a single phenomenon but manifests through interconnected thematic processes, including fear-based negative judgment, patient devaluation, labeling practices, restricted access to healthcare services, and fear-driven overuse of personal protective equipment. Collectively, these themes reflect how HIV/AIDS continues to be constructed as morally charged, dangerous, and incurable, shaping discriminatory attitudes and clinical behaviors.

Across themes, stigma was consistently linked to fear of transmission, incomplete HIV-related knowledge, and culturally embedded moral assumptions. These underlying meanings were expressed through recurring practices—such as patient labeling, emotional distancing, service restriction, and excessive PPE use—that resulted in unequal treatment of patients perceived as high-risk. Such practices reinforced social exclusion within healthcare encounters and undermined patients' engagement with care and treatment adherence, echoing findings from previous studies, In conclusion, stigma in healthcare is driven by fear of HIV transmission, limited knowledge, and cultural moral assumptions, leading to discriminatory practices that hinder patient engagement and treatment adherence. Therefore, targeted interventions are needed, including evidence-based training for healthcare providers, stigma-reduction programs addressing implicit bias, and stronger institutional policies to ensure equitable and non-discriminatory care (9–11).

The theme of restricted access to healthcare services highlights how stigma operates not only at the interpersonal level but also structurally. Limitations in referrals, follow-up care, and rehabilitation reflect institutionalized inequalities that constrain equitable service delivery (12). Similarly, the theme of patient labeling and social othering reveals how stigmatizing categorizations produce emotional distress, reinforce isolation, and discourage healthcare-seeking behaviors, In conclusion, stigma operates both interpersonally and structurally, limiting access to healthcare services and reinforcing social exclusion through practices such as restricted referrals and patient labeling. These conditions contribute to emotional distress and reduced healthcare-seeking behavior among patients. Therefore, it is essential to strengthen institutional policies to ensure equitable access to services, improve coordination of referrals and follow-up care, and implement stigma-reduction interventions that address both systemic barriers and discriminatory attitudes among healthcare providers (13).

The fear-driven overuse of personal protective equipment emerged as a visible and symbolic expression of stigma, signaling distrust and reinforcing patients' sense of being perceived as dangerous. This pattern parallels observations from other public health crises, such as the COVID-19 pandemic, where heightened protective behaviors were often shaped by exaggerated risk perceptions rather than clinical evidence, In conclusion, the fear-driven overuse of personal protective equipment reflects stigma rooted in exaggerated risk perceptions, which undermines trust and reinforces patients' sense of marginalization. Therefore, it is necessary to strengthen evidence-based training on standard precautions, correct misconceptions about transmission risks, and promote balanced and non-stigmatizing protective practices to ensure both safety and respectful patient care (14).

Consistent with international literature, stigma within healthcare settings remains pervasive, with health workers sometimes exhibiting prejudicial attitudes, breaching confidentiality, or limiting care for people living with HIV/AIDS (15–17). These experiences contribute to delayed disclosure, avoidance of healthcare services, and diminished trust in providers, while stigma also extends beyond healthcare settings into workplaces and social environments (18–20).

Finally, the thematic analysis underscores the role of broader cultural narratives in sustaining stigma. Early epidemiological framings of HIV/AIDS as linked to socially taboo behaviors, combined with moral and religious interpretations, limited sexual health literacy, and norms emphasizing family honor, continue to shape silence, fear, and non-disclosure within Indonesian communities (21). These cultural meanings intersect with healthcare practices, reinforcing stigma across both social and institutional contexts.

CONCLUSION

The findings of this study demonstrate that stigma exerts a direct and pervasive impact on the quality of healthcare received by people living with HIV/AIDS. Stigma was expressed through fear-based negative judgment and patient devaluation, restricted access to healthcare services, patient labeling and social othering, and the fear-driven overuse of personal protective equipment. Collectively, these impacts disrupted therapeutic relationships, compromised equity and continuity of care, and diminished patient trust in healthcare providers. These findings have important implications for nursing practice, highlighting the need for strengthened HIV-related education, reflective and stigma-aware clinical training, and consistent adherence to evidence-based infection prevention guidelines. Institutional support through clear policies and sustained professional development is essential to support nurses in delivering equitable and stigma-free care. Future research should examine the effectiveness of stigma-reduction interventions in nursing practice and explore how organizational and educational reforms contribute to long-term improvements in care quality for people living with HIV/AIDS.

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