Knowledge of HIV / AIDS and Attitude towards People with HIV from Community Leaders in South Denpasar

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Abstract. Acquired Immune Deficiency Syndrome (AIDS) is a collection of symptoms caused by Human Immunodeficiency Virus (HIV). Bali is the 4th region with the largest number of HIV cases in Indonesia. Community leaders as a sample in this study considered to have a great influence on the community in the environment. The purpose of this research is to identify knowledge about HIV / AIDS and attitude of public figure to PLHIV patient especially in South Denpasar. This research is descriptive with cross sectional approach to 96 public figures in South Denpasar selected by using multi-stage random sampling technique. The result of community leaders who have good knowledge as many as 39 respondents (40.6%), quite as much as 57 respondents (59.4%) but there are no respondents with less knowledge category. In the category of attitude there are 50 respondents (52.1%) with good category, 39 respondents (40.6%) with enough category and 7 respondents (7.3%) with less category. This study is expected to be useful as a basis for further education to reduce transmission and increase HIV / AIDS prevention efforts and reduce the negative stigma and rejection of PLWHA and theoretically can be a reference in subsequent research.
Keyword : Knowledge, HIV/AIDS, Community Leaders.

1 Introduction

Health is a very basic part of human needs. One of the health problems that is a current disaster is HIV / AIDS. Acquired Immune Deficiency Syndrome (AIDS) is a collection of symptoms of a disease caused by a virus called Human Immune Deficiency Virus (HIV). This virus attacks the immune system of the human body, namely, the T-helper lymphocytes that have Cluster of Differentiation 4 (CD 4) receptor on the surface which plays a role in activating the body's cellular immunity, thus people affected by this virus will be susceptible to all types of infectious diseases [1].

HIV / AIDS is a disease that spreads very rapidly in various countries so that in a short time the prevalence is quite increasing. In Indonesia, HIV / AIDS has a significant transmission rate. HIV / AIDS in Indonesia was first discovered in Bali in 1987. Based on data from the Indonesian Ministry of Health for HIV / AIDS reported in March, 2016, the number is amounted to 32,711 HIV sufferers and 7,864 AIDS sufferers. Bali Province ranks 5th with the number of AIDS cases reaching 1747 cases. According to health data from the Province of Bali in 2013, Denpasar City ranked first with 326 AIDS cases. This virus tends to attack groups of adolescents or young people, namely 15-29 years, but does not rule out the possibility of infecting other groups. In Indonesia, every 25 minutes there is one new person infected with HIV. The highest transmission occurs through sexual intercourse and drug abuse by using unsterile needles [2].

HIV / AIDS is a disease that is very feared by the community because this disease is seen as a despicable disease, where patients who are infected are usually drug users or commercial sex workers. This fact illustrates that the negative stigma that develops in the community causes people with HIV / AIDS to not only be insulted but also humiliated and even shunned if the disease is known to others [3]. The public's understanding of HIV / AIDS in Indonesia is still very low, this was stated according to the AIDS Commission (KPA) in 2011. The lack of information on HIV / AIDS in the community is one factor in the lack of knowledge about HIV / AIDS, one of which is with regard to the transmission and prevention of the disease. There needs to be openness to the public that this disease can be prevented. Knowledge is very dominant in forming attitudes toward one's actions [4]. Therefore, an assessment of the knowledge of community leaders on HIV / AIDS as well as the risky attitudes and behaviors that lead to transmission of HIV / AIDS needs to be done among the community supported by the existence of accurate data sources regarding the high rates of HIV / AIDS cases in Indonesia, especially in Bali. Based on these reasons the researchers felt interested in conducting research on HIV / AIDS knowledge and attitudes towards people with HIV / AIDS from community leaders in South Denpasar.

2 Method

This study was conducted in four sub-districts in South Denpasar District in 2017 for two months (November-December). This research used a descriptive design with cross-sectional approach, namely measuring at one time or one period and observing the subject only once. The purpose of this study is to find out knowledge and attitudes about HIV / AIDS towards people with HIV / AIDS from community leaders in South Denpasar [4]. Based on the calculation from the sample size formula of cross sectional study, the sample size required in this study was 96 people who were selected using the Multi-stage random sampling system based on inclusion and exclusion criteria as follows:

Inclusion criteria:

1. Community leaders in South Denpasar.
2. Willing to be a respondent.

Exclusion criteria:

1. Community leaders in South Denpasar who could not be met when collecting data.
2. Elderly people who cannot write and read

Variables used in this study are the knowledge and attitudes of community leaders about HIV / AIDS. Characteristics of respondents are namely their respective gender, age, recent education and employment. The respondent's knowledge was assessed from the respondent's ability to answer the questionnaire correctly regarding HIV / AIDS including definition, etiology, symptoms, transmission, treatment, and prevention. The measurement scale is ordinal with a good level of knowledge if the correct answer is > 75%, the level of knowledge is sufficient if the correct answer is within 40-75% and the level of knowledge is lacking if the correct answer is <40%. Whereas the attitude of the community leaders towards HIV / AIDS and people with HIV / AIDS is seen from the reaction or viewpoint of respondents filling out questionnaires on matters related to HIV / AIDS, including agreeing or disagreeing with symptoms, transmission, treatment and prevention thereof. Respondents would be put in ‘good’ attitude category if the correct answer is > 75%, ‘sufficient’ attitude if the respondent's

correct answer is within 40-75% and a ‘bad’ attitude if the respondent's correct answer is <40%.

Data collection is done through questionnaires distributed to respondents, namely community leaders in South Denpasar District. Before the questionnaire was given to the respondent, the researcher first explained the purpose of the study and explained the procedure for filling out the questionnaire. Data was taken that day by researchers.

Data obtained in this study were analyzed descriptively. Before analyzing the data obtained from respondents, the data processing process is first carried out. The steps in data processing was done in several stages, namely the editing process, coding, scoring, tabulating, and analysis. For incomplete questionnaire, the data would not be used.

3 Results And Discussion

Respondents in this study were community leaders with a total of 96 people from four sub-districts in the South Denpasar District area. Characteristics of respondents obtained through interviews in the form of questionnaires are their age, sex, occupation and education which are presented in table 1

Table 1. Distribution of Respondents

No	Variable	Frequency	Percentage
1	Age		
	15-24	25	26.0
	25-44	35	36.6
	45-64	32	33.3
	>65	4	4.1
2	Sex		
	Male	78	81.2
	Female		18
3	Education Background		
	Junior High School	3	3.1
	Senior High School	50	52.1
	Bachelor Degree		43
4	Occupation		
	Unemployed	24	25.0
	Student	3	3.1
	University Student	15	15.6
	Civil Servant	26	27.1

Table 2. Respondent’s Distribution Based on Knowledge and Attitude

No	Variable	Frequency	Percentage
1	Knowledge		
	Good	39	40,6
	Sufficient	57	59,4
	Bad	0	0
2	Attitude		
	Good	50	52,1
	Sufficient	39	40,6

Bad	7	7.3

From 18 questions on the questionnaire for measuring knowledge, for the first to the eighteen questions more respondents answered correctly than those who answered incorrectly except for questions 10, 11, 12, 13 and 14. Questions number 10 to 14 each has 3 correct answers. From each of the questions above, it can be concluded that the most correctly answered question was the question number 3 with 82 people (85.4%) regarding their etiology. Then followed by question number 1 regarding the notion of HIV with 81 (84.4%) respondents answered correctly. For the questions in the category with the highest frequency of incorrect answer was the question number 11 concerning symptoms when someone has entered the AIDS phase with 71 respondents (74.0%). The results of the knowledge category based on table 2 show that the knowledge of community leaders regarding the definition, etiology, symptoms, methods of transmission of HIV / AIDS and PLWHA (People Living with HIV/AIDS) were mostly included in the 'sufficient' category (59.4%), while the rest were in the 'good' category (40.6%) and there were no respondents with less categories. Meanwhile for attitude category, for the first to the ten questions more respondents answered correctly than those who answered incorrectly except for the last question. From each question above, it can be concluded that the respondents who answered the most correctly were in question 2 with 88 people (91.7%). For the questions in the attitude category with the highest frequency of incorrect answer was question number 10 with 68 respondents (70.8%). Table 2 also shows that the attitudes of community leaders towards people living with HIV / AIDS are mostly in the 'good' category (52.1%), some are in the 'sufficient' category (40.6%) and the rest are in the less category (7.3%)

. The results of the study showed that respondents with highest frequency came from the age of 25-44 years with 35 people (36.6%). The age of 25-44 years (highest in number) is considered to be a productive age as a representative of community leaders in South Denpasar District. Based on gender, as seen in table 3, the majority of respondents were male with 78 respondents (81.2%). The last level of education of the respondents is shown in table 4, most of the respondents were educated in senior high school with 50 respondents (52.1%). In terms of employment, most of the respondents worked as private workers with 28 people (29.2%)

Knowledge of respondents is the ability of respondents to answer questionnaires regarding general understanding of HIV / AIDS. Based on table 7, it can be seen that the knowledge of the community leaders on HIV / AIDS is mostly included in the 'sufficient' category, namely 57 respondents (59.4%), some of them in the 'good' category with 39 people (40.6%) and with no respondents in the less category. The results of the study referring to table 2 obtained knowledge based on problem indicators. The indicator with the most 'good knowledge' is the third statement concerning statements regarding the etiology of HIV / AIDS. This question was answered correctly by as many as 82 people (85.4%). Then followed by the first question about the definition of HIV, as many as 81 people (84.4%) and the statement most answered incorrectly by respondents is the eleventh question with as many as 72 people (75.0%) for which there are 3 choices of correct answers. The results obtained were respondents 'with' good knowledge were 63.85% (the highest number), while respondents with sufficient level of knowledge and lack of knowledge had fewer numbers of 28.91% and 7.22%. This different level of knowledge is influenced by several factors including education, experience, age, socio-economic, cultural and media information [4].

People's attitude is a response of respondents' tendency to behave [5, 6]. Attitudes are determined or formed by 3 factors. Predisposing factors are knowledge, beliefs, values, and so forth that contained within the individual and society. Enabling factors include the physical

environment such as age, socioeconomic status, education, and human resources. The reinforcing factor includes the attitude of oneself and the attitude of others. For example: attitudes of parents, husbands, community leaders or health workers [7, 8]. The results showed that the attitudes of community leaders towards people with HIV / AIDS were mostly in the ‘good’ category with as many as 50 people (52.1%), some were included in the ‘sufficient’ category as many as 39 people (40.6%) and the rest were in the ‘bad’ category as many as 7 people (7.3%)

The existence of these ‘bad’ attitudes category can lead to negative stigma from the community [9, 10]. This is in line with the analysis from Riset Kesehatan Dasar (Basic Health Research of Indonesia) [11] which measures stigmatizing attitudes and states that most respondents showed an attitude of agreement regarding AIDS patients (62.7%) and the rest (37.3%) showed disagreeable attitudes about AIDS

The negative stigma arises because of the ignorance of the public about the correct and complete HIV information, especially on the mechanism of HIV transmission, groups of people at risk of contracting HIV and how to prevent it; including the use of condoms. Misunderstandings or lack of knowledge of people about HIV and AIDS often have an impact on people's fears of PLWHA (People Living with HIV/AIDS), which raises resistance to PLWHA [12, 13]. Providing complete information, both through counseling and socialization about HIV / AIDS to the community plays an important role in reducing the stigma and eliminating bad attitudes towards people living with HIV / AIDS [8].

4 Conclusions

Based on the results of the study, it can be concluded that the respondents’ knowledge of HIV/AIDS is included in the ‘sufficient’ category with a frequency of 57 respondents (59.4%) and the attitude of respondents towards people with HIV / AIDS is mostly in the ‘good’ category with a frequency of 50 respondents (52.1%). It is expected that community leaders should be more active in finding information on ways of transmission, risk factors and matters related to HIV / AIDS from available media so as to increase insights to minimize the occurrence of negative stigma towards PLWHA. In addition, health workers and health institutions are also expected to be able to improve health campaign to community leaders and to the wider community by providing more information

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