

DEVELOPING KARO CULTURE-BASED SPIRITUAL INTERVENTION MODEL TO REDUCE HIV/AIDS STIGMA

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ABSTRACT

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Introduction: People living with HIV/AIDS (PLWHA) experience various problems after being diagnosed with HIV, both physically and psychosocially. These problems cause PLWHA to close themselves so that they are not known to others because they feel stigmatised. This problem can cause PLWHA to continue stigmatising themselves and transmit HIV again to their partners or other people. This study aimed to develop a Karo culture-sensitive spiritual intervention model to prevent HIV stigma. Methods: Developing an intervention using the PATH (Problem – Analysis – Test – Help) method proposed by Buunk and Vugt (2008). Result: This model was developed based on cultural care theory and input from experts. Before the model development, the researcher had conducted preliminary studies both in qualitative and quantitative studies. The qualitative research established 14 themes, while the multivariate analysis found religiosity prevent HIV prevention dominantly. Conclusion: Developing a Karo culture-sensitive spiritual intervention model produces models, modules and pocketbooks in Karo culture-sensitive spiritual intervention to prevent HIV stigma.

KEYWORDS

Culturally Sensitive Spiritual Intervention Model, Religiosity, HIV Stigma

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INTRODUCTION

Human Immunodeficiency Virus (HIV) is a type of virus that infects white blood cells that causes a decrease in human immunity. Acquired Immune Deficiency Syndrome (AIDS) is a collection of symptoms that arise due to decreased immunity caused by infection with HIV (Infodatin HIV and AIDS, 2020).

14.640 new HIV cases were reported in Indonesia in October-December 2017, with the highest percentage of HIV risk factors being risky sexual behaviour with heterosexuals (22%), homosexuals (21%), and the use of unsterilised injection equipment for IDUs (2%). Meanwhile, the total number of new AIDS cases was 4,725 people (Ministry of Health, 2018). Researchers had conducted interviews and found the factors causing the most HIV was transmission through NAFZA and sexual injections in Karo District.

From January to mid-late September 2019, people living with HIV/AIDS (PLWHA) increased by 71 people in Karo Regency (Antara, 2018). Throughout 2016, Kabanjahe General Hospital reported that 102 people were positively infected. Meanwhile, in 2017, the number of people infected with HIV increased by 98 people. Then in 2018, it increased by 98 people. So, within five years, there were 1.016 people infected with HIV in Karo Regency. This condition continues to grow the prevalence of being infected with HIV every year as all regions in Karo Regency contribute to the incidence of HIV/AIDS.

The problems faced by PLWHA are not merely a matter of declining physical condition, but also the acceptance of negative labels that are socially accepted and various kinds of discriminatory treatment from the environment, including their families and surrounding communities (Makmur, 2017). Nostlinger (2015) stated that PLWHA faced physical disorders due to disease progression and social and emotional disturbances. Dinuriah (2015) added that people with chronic and life-threatening diseases such as HIV/AIDS experienced emotional mental problems, including anxiety, stress and suppressed depression. This condition shows that PLWHA will feel stressed by being diagnosed with HIV and then afraid of receiving stigma from the community. This condition will significantly affect the health of PLWHA.

Duval and Wicklund (1972) first proposed one of the theories of self-awareness. Solutions offered to solve the problems experienced by people infected with HIV/AIDS touch many aspects. They include; (1) increasing self-awareness; (2) preventing an increase in the number of HIV/AIDS; (3) public or public self-awareness not to isolate PLWHA; (4) self-awareness to take part in Voluntary Counseling and Testing (VCT) that the government has provided for people with a high risk of HIV/AIDS infection; and (5) self-aware to maintain the quality of life of PLWHA to live normally. Interventions carried out by previous research found that PLWHA giving positive spiritual meaning to their illness experience has eight times more chances to use adaptive coping strategies compared to those who negatively give spiritual meaning to their illness experience. These findings can provide evidence for nurses to facilitate and guide PLWHA in finding spiritual meaning from illness experiences and developing strategies to use positive coping to improve their positive attitudes and behaviours (Rohman et al., 2020).

The researchers increased self-awareness for HIV prevention behaviour by using a spiritually-based approach to Karo culture. This research uses the model of Transculture in Nursing. This model was developed by integrating the Transcultural nursing theory by Leininger and Mc Farland (2002). The specification of this model is culture, where every client's needs are treated spiritually based. Researchers developed an approach based on

the culture of the Karo, that is daliken si telu and tutur si waluh. This cultural approach points out the communication and attitudes that help each other, be optimistic, be tough and respect each other so that PLWHA can get good treatment and family support. The strategy chosen from transcultural nursing is preserving (maintaining) the culture, negotiating/changing the culture and restructuring or changing the culture or habits that are detrimental to the health of PLWHA. The fundamental assumption of this theory is the behaviour of Caring. This Transculture in Nursing can be practised through Karo culture by involving their own culture so that PLWHA remain optimistic and tough to solve their problems well.

RESEARCH METHOD

This study focused on developing a Karo culture-sensitive spiritual intervention model that PLWHA, cadres and nurses can use to change behaviour to reduce stigma against PLWHA. The development of the intervention used the Problem – Analysis – Test – Help (PATH) method proposed by Buunk and Vugt (2008). The steps of the PATH method in this study were as follows: 1) Phase Problem (problem): researchers identified, formulated, and defined the problem operationally. The research problem was focused on the internalised stigmatised behaviour of PLWHA, which was then made a model to solve it. 2) Analysis stage: the researcher used the data obtained in stage 1 and then analysed and explained them based on relevant theories, concepts, accurate and up-to-date. The results of the analysis compiled an initial model and were tested. The model referred to in this study was a model of Karo culture-sensitive spiritual intervention. 3) Test phase (model test): the researcher conducted model testing on a limited scale, then evaluated and revised the model and developed it. 4) Help stage was conducted towards the intervention program. The researcher developed a work program to implement the Karo culture-sensitive spiritual intervention model. Next, the researcher disseminated the Karo culture-sensitive spiritual intervention model. The flow of development of the Karo culture-sensitive spiritual intervention model is mapped in Figure 1.

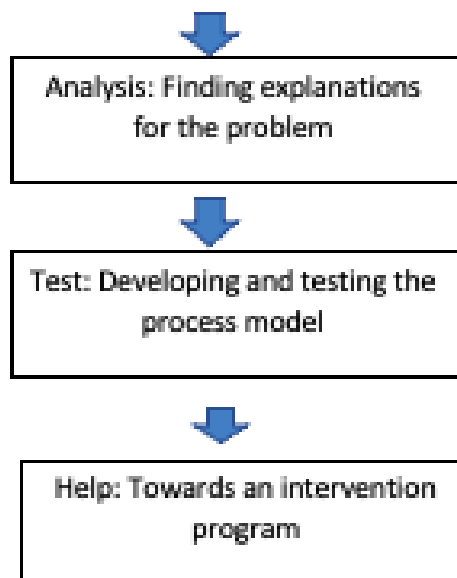


Figure 1: The PATH steps (Source of the PATH (Problem – Analysis – Test – Help) method proposed by Buunk and Vugt (2008).

Procedures and Methods of Data Analysis

The research procedure began with identifying the subject's problem and then theoretical analysis to create a model. The model was tested, and finally, a Karo culture-based spiritual intervention model was implemented to reduce HIV stigma. The data obtained was qualitative and analysed with the following stages: (1) data reduction aimed to simplify the data that had been collected. Data reduction was intended to summarise, choose the main things, focus on the essential things, look for themes and patterns and then discard the things that are not necessary or not related to research. The presentation of data was a set of structured information that could conclude. Conclusion or verification - Conclusion or verification was the final stage of qualitative data analysis. At this stage, the researcher expressed the conclusions drawn based on the data that had been reduced and presented previously. This stage aimed to find the meaning of the data collected by looking for relationships, similarities, or differences (Siyoto & Ali 2015).

RESULT AND DISCUSSION

The first step was to build a model or path *diagram according* to the conceptual framework created. The model contained the variables used in the study. Karo culture-sensitive spiritual intervention model used the PATH method. Before designing the model, the researcher conducted the first research stage using a qualitative research approach followed by a quantitative one. The technique used in the first research was qualitative with a phenomenological approach—qualitative data analysis using the Colaizzi method. The respondents were 34 people. The latter, quantitative study was conducted using a correlational analytic design with *cross-sectional*. 420 members of the GBKP congregation in Karo Regency participated as respondents through purposive samplings. At last, the culturally sensitive spiritual intervention model was carried out. The framework for the Karo culture-sensitive spiritual intervention model is shown in Figure 4.1 below.

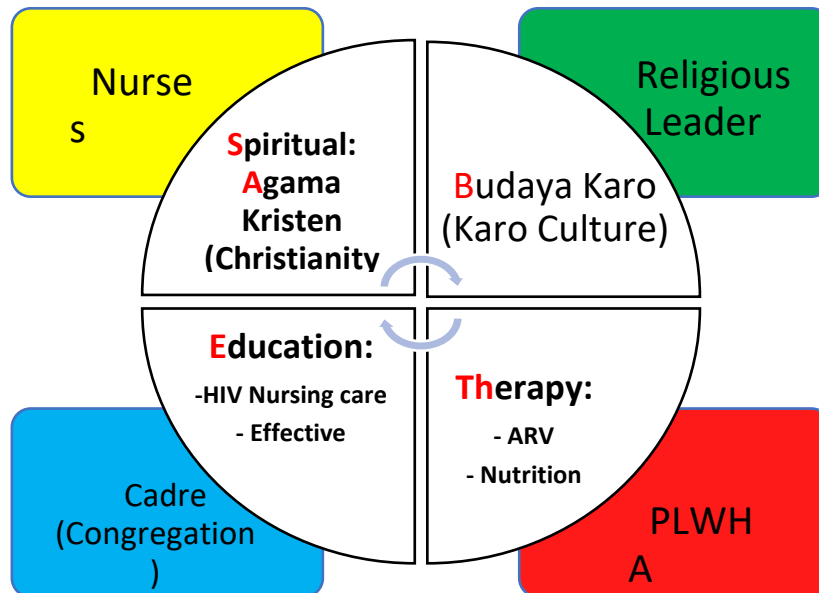


Figure 2 Framework: The Karo culture-sensitive spiritual intervention model (SABETH)

Nursing is a profession that is constantly evolving following the development of science and technology. In its implementation in the field, it is necessary to collaborate with religious leaders and cadres/congregations as companions of PLWHA to assist and provide higher quality nursing services. One of the efforts to train nurses, cadres, and PLWHA is through Spiritual: Religion & Culture, Education and Therapy (SABETH). SABETH module is needed. Through SABETH, the model can objectively help train participants optimally so that the Health of PLWHA can be achieved and thus reduce the PLWHA negative self-stigma.

Planning for implementing the Karo culture-sensitive model was carried out through joint training with community health centre nurses as a team aiming at caregivers or family members. These persons acted dominantly in caring for PLWHA and GBKP cadres (congregations) as companions with a minimum high school education background. The focus of developing this model was increasing the ability of PLWHA in reducing self-stigma through a Karo cultural approach. It mainly focused on lowering self-stigma by strengthening the attitude of the Karo people who are optimistic, tough, confident and assisted by family support to accept PLWHA with family ties to *Dalikan sitelu* and family communication with *tutur si waluh*. Before starting the training activities, identification of people living with HIV who had *internalised stigma*, families who stigmatised and discriminated against family members was carried out to ensure that the results of this study were right on target.

The family training activity began with a rewinding on cultural and health materials, followed by communication with PLWHA in Karo culture. The following material was about the concept of HIV and its stress control management in the context of Karo culture. Lastly, PLWHA and family support self-care in caring for PLWHA at home and in shelters was given. Each material was continued with demonstrations and demonstrations of stress control management skills and therapeutic communication during the training activities. Furthermore, cadres and families were taught how to fill out worksheets during treatment of PLWHA at homes and shelters.

A culturally sensitive intervention model was developed based on the qualitative and quantitative research results in phase 1. In developing the design of a Karo culture-sensitive spiritual intervention model, researchers conducted a literature search and review, including previous studies conducted by researchers. In addition, the researcher interviewed the PLWHA, religious leaders, nurses, congregation members who had experienced stigma against HIV-infected people with Karo cultural backgrounds. The interviews included the first stage of research results synthesis, plans for a Karo culture-sensitive spiritual intervention model, expert consultation on the Karo culture-sensitive spiritual intervention model, modules, manuals, workbooks, evaluation books, and implementation guidelines. Leininger's theory of *Culture Care and Caring* and nursing care for HIV-infected patients was used in preparing the Karo culture-sensitive spiritual intervention model,

Based on the 14 themes generated in phase I, the researchers grouped the themes included for the development of models and modules below:

Table 1. Theme of model development and module preparation

Themes for model development
1. Theme 4: Psychosocial problems
2. Theme 5. Social problems: society rejects
3. Themes 7: Spiritual

4. Theme 8: Management of taking ARV drugs

5. Theme 14. Being empathetic

Theme for the preparation of the module

6. Theme 1: Rejection of HIV/AIDS

7. Theme 2: Support system for PLWHA is available

8. Theme 3: Physical health problems in PLWHA

9. Theme 6. Economic problem: medical expenses and low cost of living

10. Theme 9. Stigma of church/community members

11. Theme 10. Discrimination in health services

12. Theme 11: Carrying out family health task

13. Theme 12: Family and church support

14. Theme 13: Nursing profession awareness

Table 1 shows the 14 themes identified from the qualitative phase I research; five were for model development and 9 for modelling as a series of models.

Meanwhile, the bivariate statistical test of the quantitative study found a relationship between behaviour and HIV prevention. These aspects include knowledge, stigma, PAS Nurses, religiosity and *self-awareness*, which can be seen in Table 1.2 as follows:

Table 2 The result of bivariate selection of independent and dependent variables

Independent variable	P Value	OR
Age	0,136	0,730
Education	0,985	1,048
Income	0,989	1,027
Employment	0,023	16,230
Knowledge	0,354	0,813
Personal Stigma	0,049	0,664
Disclosure Stigma	0,059	0,675
Negative Self Image Stigma	0,03	0,639
<i>Public Stigma</i>	0,311	0,803
Nurses PAS	0,007	1,744
Religiosity	0,0005	3,332
Self-Awareness	0,048	1,494

The bivariate analysis with correlation obtained p value for age (p = 0.136), education (p = 0.985), occupation (p = 0.023), income (p = 0.989), *personal stigma* (p = 0.049), *disclosure stigma* (p=0.059), *negative self-image stigma* (p=0.03), *public stigma* (p=0.311), PAS Nurse (P=0.007), Religious as (p=0.0005), and *self-awareness* (p=0.048). From these results, we could conclude that the variables of age, *personal stigma*, *negative self-image stigma*, Nurse PAS, religiosity and *self-awareness* have p value < 0.25; thus the six variables could continue to enter into multivariate modelling. Meanwhile, for frequency variables that had p value > 0.25, namely education (p=0.985), income (p=0.989), knowledge (p=0.354), and public stigma (p=0.311) could not proceed the multivariate category.

Furthermore, from the last multivariate model, it can be seen that there is no variable whose p-value is > 0.05. Thus, the variable exclusion process was completed, and the results from the multivariate analysis, religiosity, turned out to be significantly related to the behaviour of preventing HIV. The results of the multivariate analysis showed that age and religiosity were significantly associated with HIV prevention behaviour, with the first being the most dominant. Meanwhile, the personalised stigma and negative self-image stigma acted as controlling variables. The analysis results showed that the religiosity variable's Odds Ratio (OR) was 3.5 (5% CI: 2.324-5.329). This result indicated that members of the GBKP congregation with intense religiosity would have an odds (risk) of preventing HIV transmission behaviour by 3.5 times higher than those who do not.

After conducting qualitative and quantitative research in phase 1, Karo culture-sensitive intervention model was developed. The researcher also integrated several theories and concepts related to the model. The theories and concepts included the idea of religiosity, cultural, Karo culture, the concept/theory of interpersonal relations, and social support. Before testing the model, the researcher consulted the model and module with experts in nursing care with HIV infection, spiritual experts (religion and culture), Karo cultural anthropologists, and methodological experts to obtain input on the model and approval the application of the model.

In detail, the description of the theory and concepts used for model development can be seen in Table 3 below:

Table 3. Identification of the concepts used for the development of the Karo culture-sensitive intervention

Sources of developing and implementing the model	Concept	Model	Module
Phase 1	Qualitative Results Themes: 4, 5, 7, 8, 14 Themes:1, 2, 3, 6, 9, 10, 11, 13	Integrated with the principles of cultural intervention (theme 14.), religion (theme 7, quantitative results Religion relates to behavior preventing HIV.), education (theme 4), therapy (theme 8), the process of implementing the model (quantitative results:	Module 1: Karo culture-sensitive spiritual intervention module for PLWHA (Theme: 1,2,3,6) Module 2: Karo culture-sensitive spiritual intervention

	Quantitative Results	stigma related to HIV prevention behaviour	module for PLWHA cadres or companions of PLWHA (1, 2, 9)
	- Stigma related to preventing HIV behavior		
	- Religiosity related to HIV prevention behavior is dominant		Module 3: Karo culture-sensitive intervention module for nurses (10, 11,13)
The concept of religiosity (<i>Religiosity</i>)	Christian religious teachings from the Bible (Christian Scriptures)	Integrated with communication	A module that contains how to communicate with PLWHA with various problems through a Christian religious teaching approach.
The Karo	<i>Rakut sitelu culture concept and tutur siwaluh</i>	Model (integrated into communication) An integrated model in communication, steps for social support and the role of nurses)	A module containing how to communicate with PLWHA with various problems through the Karo cultural approach (<i>rakut sitelu</i> and <i>tutur siwaluh</i>) References for workbooks
Cultural nursing theory	Concepts and principles of cultural intervention: 1. Maintenance 2. Negotiation 3. Restructuring	Become part of the model in conducting culturally sensitive spiritual interventions Karo	Get to know Karo culture Referrals for opening jobs
Cultural change:	The concept of people-centred service (PLWHA),	The model is integrated with the concept of Karo culture, especially for	Culturally sensitive spiritual

- Peer mentoring model	communication and service according to plan. Assistance in implementing new things	the mindset of the Karo people, characteristics of the Karo community.	intervention module for PLWHA, cadres, and nurses
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The culturally sensitive spiritual intervention model involved stages of spiritual concepts as a means of interaction with PLWHA. This spiritual stage included Karo religion and culture. PLWHA were accompanied by nurses, religious leaders, cadres, or PLWHA assistants in its implementation. There were stages of the concept of mentoring in assisting PLWHA. These assistances included the preparation stage, the negotiation stage, the enabling or implementation stage, the closing stage (evaluation) and the supervision stage (Zachary (2005). Assistance techniques were disbursement of atmosphere, support, and counselling given to PLWHA (Ministry of Health, Republic of Indonesia, 2014).

Expert consultation or expert test was carried out before the reading test results. The expert test was consulted with experts in nursing on HIV, spiritual experts (religion and culture), and anthropologists. The researcher then planned a set of model books, a model book, three pocketbooks, one manual and one workbook. The online consultation (Zoom, via email, and Whatsapp) was held to get inputs and corrections that contributed to making model books, module books, manuals, and workbooks.

Karo culture-sensitive spiritual intervention model

The planning process for implementing the Karo culture-sensitive spiritual intervention model was:

1). Phase 1: preparation

The researcher prepared herself as a new person who entered the GBKP Moderamen KPA halfway house in this phase. Researchers did this preparation in collaboration with GBKP moderate KPA staff. Preparations which were done included:

- a. Before preparing for the implementation of the model, researchers first designed research permits starting from educational institutions to the Protestant Batak Karo Church (GBKP), GBKP Moderamen KPA (halfway house) and the Karo District Health Office.
- b. The preparation of models and modules was first carried out (duplicated) to interact with the shelter manager, Case Manager and GBKP moderate KPA Coordinator.
- c. The researcher first explained to the GBKP Moderament KPA manager, halfway house officers and assistants related to the implementation of the model that involved all facilitators (cadres) and PLWHA in practice.
- d. Together with the GBKP Moderamen and KPA managers, the researcher set routine activities. However, Researchers worked together to provide services to PLWHA under the auspices of the GBKP Service.

CONCLUSION

This research produces a model of Karo culture-sensitive spiritual intervention. Based on the study results using observations, interviews, and questionnaires distribution, it was found that there was a relationship between job stigma, nursing practice, religiosity, and self-awareness with behaviour to prevent HIV. In addition, the results of the

multivariate analysis showed two variables that were significantly related to HIV prevention behaviour, namely age and religiosity, with religiosity being dominant. The study also found a stigma against PLWHA. The study results showed a difference in the proportion of the incidence of HIV prevention behaviour between low and high personal stigma. Also, there was a difference in the incidence of HIV prevention behaviour between low and high negative image stigma in GBKP residents, Karo Regency. The effectiveness of a Karo culture-sensitive spiritual intervention model development will be tested next.

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