



## IDENTIFY BARRIERS THAT PREVENT ADOLESCENTS FROM ACCESSING ACCURATE INFORMATION ABOUT HIV/AIDS

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### ABSTRACT

The spread of misinformation about HIV/AIDS can cause misperceptions among the community. The community has a higher tendency to stigmatize people with HIV/AIDS (ODHA). Objective: To analyze the factors that are barriers to accessing accurate information about HIV/AIDS. Method: The research design uses cross-sectional with data from the 2017 Indonesian Demographic and Health Survey. Bivariate data analysis using chi-square and multivariate analysis with logistic regression. The sample used for this study was 8,838 respondents. The independent variables in this study were age, gender, education level, employment status, place of residence, wealth index, internet usage, and sources of information from the community. Results: The results of this study indicate that factors that are obstacles in accessing accurate information about HIV include age (OR = 0.948; 95% CI = 0.909-0.988), education level (OR = 3.986; 95% CI = 3.557-4.466), place of residence (OR = 0.374; 95% CI = 0.326-0.429), wealth index (OR = 1.518; 95% CI = 1.441-1.599) and internet use (OR = 1.419; 95% CI = 1.229-1.552) are more at risk than others. The conclusion of this study is that the inaccuracy of information received by the community about HIV/AIDS is still high, there are several factors that influence this condition. Conclusions: The most dominant factors related to the spread of inaccurate information are the variables of age, education level, place of residence, wealth index and internet usage. While the variables of gender and employment status do not have a significant relationship.

Keywords: accurate information; barriers; HIV; people with HIV/AIDS (ODHA)

### How to cite (in APA style)

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## INTRODUCTION

Human Immunodeficiency Virus (HIV) is a virus that damages the immune system and harms internal organs (Shutaywi et al., 2024). If not treated immediately, HIV can develop into Acquired Immunodeficiency Syndrome (AIDS). AIDS is the final stage of HIV infection when the body is no longer able to fight off viral infections (Afriana et al., 2023). Advanced HIV disease is a condition with a CD4 cell count below 200 cells/mm<sup>3</sup> or stage 3 or 4 according to the WHO classification for adults and adolescents. New HIV infections are more common in adolescent girls and are transmitted by older men. In addition, the main cause is children who are born and breastfed by mothers who do not know that they are infected with HIV, or are not treated immediately (Mendoza et al., 2024). The Joint United Nations Programme on HIV/AIDS (UNAIDS) estimates that by 2023, between 36.1 million and 44.6 million people are living with HIV worldwide. HIV infection remains a global health problem. The number of HIV-related deaths in 2023 is 630 thousand people. In Indonesia, the prevalence of HIV/AIDS is increasing as evidenced by approximately 329,581 people detected living with HIV (Kemenkes, 2022). Only 14.1% of the 22,864 respondents had accurate knowledge about HIV including stigma and discriminatory behavior that are still very strong in society (Benny et al., 2022).

Stigma is a major barrier to HIV prevention, care, treatment and support (Putri et al., 2023). In everyday life, people with HIV (PLWHA) are no longer able to carry out normal activities. This proves that the quality of life of people infected with HIV decreases and is coupled with inaccurate information that is widely spread in society so that it has an impact on social life which makes PLWHA anxious, down, stressed, tend to isolate themselves and avoid contact with the surrounding community (Al Fatih et al., 2021). The existence of prejudice and discrimination that leads to gaps in social life can make it difficult for people with HIV/AIDS (PLWHA) to open up and socialize. Decreased function in society will cause a further decline in the quality of life for people with HIV (Solehah et al., 2023). In previous studies, it can be concluded that people who receive accurate information about HIV/AIDS show a good attitude towards people with HIV/AIDS (PLWHA) (Dzah et al., 2019). Conversely, if people are less exposed to information, they have a higher tendency to stigmatize people with HIV/AIDS (PLWHA). This is one of the obstacles for PLWHA in seeking health facilities, information about HIV treatment or prevention, and educational opportunities (Hardiansyah et al., nd). In addition, lack of understanding and distrust of accurate information are also obstacles for PLWHA in accessing health services (Liu et al., 2020).

The spread of misinformation about HIV/AIDS can create a wrong perception among the public (Jaiswal et al., 2020). The public assumes that HIV is a cursed disease because of free association such as homosexuality, commercial sex workers (CSW). HIV/AIDS is also considered a life-threatening disease and HIV/AIDS can be transmitted through sneezing, coughing, mosquito/insect bites, food, air and water (Junita & Dewi, 2020). Public knowledge about HIV/AIDS affects attitudes towards people with HIV/AIDS. There is a close relationship between knowledge about HIV/AIDS and stigma towards people with HIV/AIDS. This shows that lack of knowledge about HIV/AIDS can increase stigma in society (Ledalero, 2024). Previous studies aimed to determine factors related to HIV knowledge among adolescents. The variables studied included residence, education, gender, religion, marital status, mobile phone ownership, access to media, having tested for HIV, health insurance, and ownership of television and radio (Dadi et al., 2020). Another study concluded that age, residence and citizenship have a close relationship with the level of community knowledge about HIV (Azri Adam Adnan et al., 2024). Other studies also mention the relationship between social media use, knowledge, and attitudes in PLWHA among school children (Nindrea et al., 2024). Therefore, it is important for adolescents to access accurate information about HIV/AIDS. Because the higher the knowledge of adolescents, the lower the stigma of HIV sufferers (Simorangkir et al., 2021).

The purpose of this study was to analyze the factors that hinder adolescents in accessing accurate information about HIV/AIDS. The difference between this study and previous studies lies in the location of the study. The journal was conducted in Ethiopia, while this study was conducted in Indonesia. The study seeks to evaluate the level of HIV knowledge and the factors influencing it among Ethiopian youths, utilizing data from the 2016 Ethiopia Demographic and Health Survey (Dadi et al., 2020).

## **METHOD**

This research uses an approach cross sectional to find out the factors that become obstacles in accessing accurate information about HIV/AIDS. This study used secondary data from the 2017 Indonesian Demographic and Health Survey (SDKI). The researcher received permission from the Inner City Foundation (ICF) International to use the survey data as part of the Health and Demographic Survey Program. Indonesia. Researchers combined the Indonesian Individual Recode Phase 7 (IDIR71FL) and Indonesian Male Recode Phase 7 (IDMR71FL) data to obtain the required male and female samples. This study used data from

men and women who had HIV/AIDS or had never heard of HIV/AIDS. Missing data were not considered in this study. The total sample of this study amount to 8,838 respondents. The independent variables in this study are age, gender, education level, employment status, place of residence, wealth index, internet usage, and sources of information from the community.

The age variable is categorized into two categories, namely >35 years and ≤35 years. Ages included in the category >35 years include adolescents and early adults who will be studied by researchers. Adolescents will tend to act like the knowledge they get, it is important to provide correct knowledge to adolescents (Aisyah & Fitria, 2019). The education level variable is grouped into two categories, namely low if it shows no education, primary and secondary. It is said to be high when shown higher. This grouping is based on the Draft Law on the National Education System (RUU Sisdiknas) article 7 paragraph 2 of 2022. The employment status variable is categorized into two, namely working and not working. The residence variable is grouped into two, namely urban and rural areas according to the Central Statistics Agency (BPS). The wealth index variable is categorized into two groups based on Principal Component Analysis (PCA) is said to be low if it shows the worst and poorer, high when showing middle, richer, and richest. Internet usage variables are grouped into two, namely using the internet and not using the internet at all. The research data were analyzed using IBM SPSS Statistics 27 software. Univariate analysis was used to describe the distribution of the population with bivariate analysis using the chi-square test and multivariate analysis using the logistic regression test. The adjusted odds ratio (AOR) has a 95% confidence interval (CI) and a significance of 5% (p value <0.05).

The sampling technique and population used for the 2017 Indonesian Demographic and Health Survey (IDHS) are usually two-stage probability samples drawn from an existing sampling frame, generally the latest census frame. The questionnaire used is the DHS model questionnaire. The DHS survey collects primary data with four types of questionnaires, namely, household questionnaires, individual women or men questionnaires, barker questionnaires and optional questionnaires. The quality of DHS data is guaranteed through several processes, such as questionnaire checking, coding open responses, and verifying the data entered.

## RESULT

Table 1.  
Respondent characteristics (n= 8,838)

Variables	f	%
Age (Mean±SD) (Range)		(1.54±0.499)(15-64)
< 35	4096	46,3
≥ 35	4742	53,7
Gender		
Male	788	9,4
Female	7612	90,6
Education Level		
Low	7556	85,5
High	1282	14,5
Employment Status		
Doesn't Work	2861	32,4
Work	5961	67,6
Place of Residence		
Urban	4418	50
Rural	4420	50
Wealth Index		
Low	3849	43,6
High	4989	56,4

Variables	f	%
Internet usage		
Do not use	5719	64,7
Use	3116	35,3
Source of information from the community		
Didn't hear	8503	96,2
hear	335	3,8
Information Exposure		
Not accurate	1914	21,7
Accurate	6924	78,3

Based on the results of Table 1, most respondents were aged  $\geq 35$  years (53.7%) and were female (90,6%) with low education levels (85.5%) and working status (67.6%). The wealth index that was most in the high category (56.4%) Most people did not use the internet (64.7%) did not hear information about HIV from the community (96.2%) and showed a good level of knowledge about HIV/AIDS (78.3%).

Table 2.  
Factors Related to Accurate Information (n= 8,838)

Variabel	Information about HIV/AIDS		p-value	OR (95%CI)
	Not accurate (%) (n=1,914)	Accurate(%) (n=6,924)		
Age				
< 35	37,5	48,7	0,001	0.636
$\geq 35$	62,4	51,2		(0.573-0. 705)
Gender				
Male	7,9	9,7	0,018	0.797
Female	92	90,2		(0.66-0.962)
Education Level				
Low	99,3	81,6	0,001	30.543
High	0,6	18,3		(17.991-51.852)
Employment Status				
Doesn't Work	31,3	32,7	0,001	1.853
Work	68,6	67,2		(1.67-2.057)
Place of Residence				
Urban	23,4	56,7	0,001	0.261
Rural	74,5	43,2		(0.233-0.292)
Wealth Index				
Low	69	36,4	0,001	3.854
High	30,9	63,5		(3.458-4.296)
Internet usage				
Do not use	93,6	56,7	0,001	11.316
Use	6,3	43,2		(9.356-13.685)
Source of information from the community				
Didn't hear	96,6	96	0,248	1.177
hear	3,3	3,9		(0.892-1.554)

The results of the analysis using *Chi Square* with a 95% confidence level, it was found that the age of respondents with inaccurate information was  $\geq 35$  years old with *p-value* 0.001, then the conclusion is that there is a relationship between age and exposure to accurate information about HIV. The next variable also shows that there is a relationship between gender and exposure to accurate information about HIV (*p-value* 0.018). Most of the low education levels know inaccurate information about HIV have a low level of HIV knowledge. *p-value* 0.001. The results of the analysis obtained an *odds ratio* (OR) value of 30,543. It can be concluded that low levels of education have a 30,543 times chance of hearing inaccurate information about HIV. Likewise, other variables such as employment status, place of residence, wealth index, internet use also have a significant relationship with exposure to inaccurate information about HIV/AIDS (*p-value* <0.05). Different from

respondents who did not hear HIV information from the community with a *p-value* of 0.248, which means there is no relationship between sources of HIV information from the community and exposure to accurate information about HIV/AIDS.

Table 3.  
Results of Multivariate Logistic Regression Model Analysis (n= 8,838)

Variables	B	P	OR	95%CI
Age	-0,054	0,012	0.948	0.909-0.988
Gender	-0,167	0,138	0.846	3.557-4.466
Level of education	1,383	0,001	3.986	3.557-4.466
Employment status	-0,002	0,866	0.998	0.979-1.018
Residence	-0,984	0,001	0.374	0.326-0.429
Wealth Index	0,417	0,001	1.518	1.441-1.599
Internet Usage	0,35	0,001	1.419	1.229-1.552
Sources of Information from the Community	0,059	0,721	1.061	0.766-1.469

Based on the analysis of table. 3 using *logistic regression test*, there are five variables that have a *p-value* <0.05 and three variables that have a *p value*> 0.05. The five variables are age, education level, residence, wealth index and internet usage. From the results of the multivariate analysis, the OR value of the age variable was 0.948 (95% CI = 0.909-0.988), which means that respondents aged  $\geq 35$  years are 0.9 times more at risk of knowing inaccurate information about HIV/AIDS compared to respondents aged <35 years. The next variable is the OR value of the Education level variable of 3.986 (95% CI = 3.557-4.466) which means that a low level of education is 3.9 times more at risk compared to a high level of education. The OR value of the residence variable is 0.374 (95% CI = 0.326-0.429) which means that living in rural areas is 0.3 times more at risk compared to living in urban areas. The OR value of the wealth index variable is 1.518 (95% CI = 1.441-1.599) which means that a low wealth index is 1.5 times more at risk compared to a high wealth index. The OR value of the internet usage variable is 1.419 (95% CI = 1.229-1.552) it can be concluded that people who do not use the internet are 1.4 times more at risk of hearing false information about HIV than people who use the internet.

## DISCUSSION

Analysis results Chi Square between age and exposure to inaccurate information found results *p-value* 0.001 or less than alpha 0.05. So it can be concluded that  $H_0$  rejected, which means there is a relationship between age and exposure to accurate information about HIV/AIDS. The results of this study are the same as previous studies showing a significant relationship between age and exposure to accurate information about HIV (*p* <0.014) (Haroen et al., 2024). Previous studies have shown that there is a relationship between age and HIV incidence. Based on the theory, age <40 years is at risk of being infected with HIV/AIDS 7.252 times greater than age > 40 years. (Rahmawati & Diniarti, 2023). The gender variable with exposure to accurate information about HIV/AIDS obtained result *p-value* 0.018 or less than alpha. So it can be concluded that  $H_0$  rejected, which means there is a significant relationship between gender and exposure to accurate information about HIV/AIDS. The results of this study are the same as previous studies, namely that there is a relationship between gender and exposure. accurate information about HIV (*p*<0.001) (Herlinda et al., 2023). Previous research found that men are 1.77 times more likely to contract HIV/AIDS than women (Rohmatullailah & Fikriyah, 2021).

Education level with exposure to accurate information about HIV results are obtained *p-value* 0.001, smaller than alpha which means  $H_0$  rejected and showed that there was a significant relationship between the level of education and exposure to accurate information about HIV/AIDS. Theoretically, the level of education has a significant influence on the

accuracy of information. The lower the level of education, the greater the likelihood of receiving misinformation about HIV. In addition, with higher education, you can make the right decisions in behaving and choosing the right health services for yourself and others (Kurniawati, 2022). The results of this study are the same as previous studies, namely that there is an influence of the level of education on exposure to accurate information about HIV with p-value 0.000 (Arisah et al., 2024). Previous studies have also found that self-efficacy is positively correlated with awareness of sexually transmitted disease prevention ( $P < 0.001$ ), indicating that students with higher self-efficacy are more likely to recognize sexually transmitted diseases and take preventive measures (Nindrea & Darma, 2025).

Analysis results Chi Square employment status with exposure to accurate information about HIV found Results p-value 0.001, less than alpha 0.05. The conclusion is  $H_0$  rejected and there is a significant relationship between employment status and exposure to accurate information about HIV/AIDS. The results of this study are the same as previous studies which showed a relationship between employment status and exposure to accurate information about HIV (Suantari, 2021). Based on the theory, high-income people are also more likely to spend their income on maintaining their health including HIV/AIDS-related services (Fadila et al., 2023). The variable of residence with exposure to accurate information found results p-value 0.001 is less than 0.05. So it shows  $H_0$  rejected and there is a relationship between residence and exposure to accurate information about HIV/AIDS. The results of this study are in line with the results of previous studies, namely that there is a relationship between the role of the environment and exposure to accurate information about HIV ( $p < 0.05$ ) (Handayani, 2018). The results of previous research indicate that place of residence is associated with app users who are more likely to be infected with HIV (Reeves et al., 2024).

The wealth index with exposure to accurate information about HIV obtained a p-value of 0.001 less than alpha. Which means it shows  $H_0$  rejected and there is a relationship between the wealth index and exposure to accurate information about HIV/AIDS. The results of this study are the same as previous studies which showed a significant relationship between the wealth index and exposure to accurate information about HIV as evidenced by the value p-value 0.001 (Suantari, 2021). whereas other studies obtained results ( $p > 0.05$ ) so that there was no relationship between the wealth index and the accuracy of information regarding HIV/AIDS (Hall et al., 2024). The variable of internet usage with accurate information exposure found a p-value of 0.001 less than alpha. It can be concluded that  $H_0$  rejected there is a relationship between internet use and exposure to accurate information about HIV/AIDS. The results of this study are the same as previous studies, namely there is a relationship between access to information and exposure to accurate information about HIV (p-value  $< 0.001$ ) (Fitria et al., 2023). The results of previous studies showed that there was a relationship between the level of application or internet use and information related to HIV ( $p < 0.05$ ) (Reeves et al., 2024).

Analysis results Chi Square sources of information from the community with exposure to accurate information about HIV found results p-value 0.248 which is greater than alpha. Which shows  $H_0$  accepted means there is no relationship between sources of information from the community and exposure to accurate information about HIV/AIDS. The results of this study are in line with previous studies which showed there was no relationship between sources of information from the community and exposure to accurate information about HIV as evidenced by the value p-value 0.76 (Nurmayani M et al., 2024). In another study, it can be concluded that people with many sources of information about HIV tend to know accurate information compared to people who only have one source of information ( $p < 0.01$ ) (Kurniadi et al., 2025).

## CONCLUSION

Barriers to accessing inaccurate information are caused by several factors, including age, gender, education level, employment status, place of residence, wealth index, and internet use. On the other hand, different sources of information from the community have less significant relationships. Advice to health workers is to always educate the community about HIV/AIDS so that they get accurate and clear information about HIV. This is to prevent misinformation from spreading to the community.

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