

The Correlates of Health Facility-related Stigma and Health-seeking Behaviors of People Living with HIV

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ABSTRACT

Objective. This study aims to assess the presence of stigma in health facilities and health-seeking behaviors of persons living with HIV (PLHIV).

Methods. This study utilized a cross-sectional design employing self-report questionnaires answered online. A total of 100 PLHIV participants were recruited using the respondent-driven sampling method.

Results. Results revealed that most participants are young adult men who have been diagnosed with HIV within the last five years. Overall, participants display moderate health-seeking behavior ($M = 2.94$, $SD = 0.54$), and moderate experience of health facility-related stigma ($M = 2.21$, $SD = 0.87$). Further, there is a negative correlation between age and health-seeking behavior ($r = -0.2796$, $p = 0.049$). The type of facility is significantly correlated with HIV stigma ($r = 0.4050$, $p = 0.036$).

Conclusion. A sustained linkage to care is essential for a PLHIV to remain engaged on his health and well-being. Necessary strategies should be implemented to improve the health-seeking behaviors of PLHIV. Public Rural Health Units are considered to be the most stigmatizing health facility. The presence of health facility-related stigma requires immediate action of the government to reinvigorate these catchment centers as providers of stigma-free and nondiscriminatory primary health care.

Keywords: Human Immunodeficiency Virus, HIV, Stigma, Health facility, Health-seeking behaviors, People living with HIV, PLHIV, Philippines

INTRODUCTION

High-resource countries have successfully controlled the incidence of new cases of HIV. However, the epidemic continues to be a serious public health issue in some parts of the world, in which 37.9 million people globally are infected with HIV, based on the 2019 report of the Joint United Nations Programme on HIV and AIDS (UNAIDS).¹ The report further details that this population comprises 36.2 million adults and 1.7 million children aged up to 15 years. Of that population, an estimated 79% of infected individuals are aware of their status, while the remaining 21% are unaware and in need of access to HIV testing services. The face of HIV has evolved from predominantly affecting female commercial sex workers to men who have sex with men (MSM), which has become the most prevalent case profile.¹

The state of HIV in the Philippines is in crisis, as it continues to be one of the fastest-growing numbers of cases in the world for almost a decade.² The latest UNAIDS figures



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show that 13,384 new HIV infections were recorded in 2018, mainly composed of MSM. The said record is 203% higher compared to the figures reported in 2010. Furthermore, the report added that approximately 77,000 Filipino people in the country live with HIV, of whom only 62,029 have been diagnosed and reported.³ These figure comparisons suggest an inadequate and ineffective health management response to the rising prevalence of cases in the country.

Various studies linked several factors to the rising incidence of HIV, including sexual conservatism, morality issues on condom use, geographical constraints, the increasing trend in transactional and casual sex, punitive policies against people who inject drugs (PWID), the lack of proper education on HIV, and fear of stigmatization.⁴⁻⁶

The Stigma of Persons Living with HIV (PLHIV)

The experience of stigma is true for all individuals with HIV, whether they are MSM, female commercial sex workers, or those of African descent.⁷ Scholars have agreed that the success of curbing the prevalence of HIV/AIDS relies on a focused effort to eliminate biases, stigma, and discrimination.⁸ Mounting evidence documents many detrimental effects of stigma, which serves as the main reason for late presentation to treatment, poor health-seeking behaviors, problems in medical compliance, poor adherence to treatment and rehabilitation, and delayed access to HIV care services.^{9,10}

Health facilities are considered a haven for HIV treatment and prevention, and health workers play a vital role in serving as guardians of health and well-being. Although stigma stems from various sources, it is ironic to note reports of its presence among health facilities.¹¹ Typical stigma drivers include health workers' negative attitudes, discriminatory behaviors, fears, lack of knowledge on HIV and HIV-associated stigma, and lack of clinical competency in managing HIV within the facility.⁹ Other contributing factors include institutionalized structures, protocols, and policies obligatory for care providers.^{12,13}

At present, few initiatives are being implemented across the globe to reduce and eliminate stigma in health facilities. Interventions developed to reduce misconceptions and improve attitudes in an integrated national initiative revealed significant reductions in stigmatizing behaviors.¹⁴ Moreover, promising improvements in stigma reduction were also observed for behavioral interventions involving the facility stakeholders.⁹

Health-Seeking Behaviors of Stigmatized PLHIV

To escape being stigmatized and discriminated against, PLHIV resort to several health-seeking behaviors apart from submitting themselves to a medical facility. Preference of informal networks is common among PLHIV when faced with psychosocial stressors. Studies revealed a marked decrease in the number of ideal health engagements among this group due to experiences of social discrimination.¹⁵

Other PLHIV resort to indigenous practices such as faith healing and the use of traditional, alternative, and complementary therapies in the management of their disease.¹⁶ Additionally, some PLHIV have lost interest in seeking medical aid due to past experiences of being refused care.¹⁷ Alternatively, some patients with HIV prefer high-tiered health facilities and travel farther distances in search of medical care.¹⁸ Enhancing health-related literacy through reading, the internet, and consultations with health providers are also helpful for some PLHIV to cope with their disease condition and manage their sense of self.¹⁹

The literature reports on how stigma impacts the health-seeking behavior of a person engaging in high-risk sexual behaviors and those diagnosed with HIV. For instance, Kutner et al.²⁰ observed that men who have sex with men do not disclose their sexual practices during medical consultations for fear of social devaluation. Moreover, Turan et al.²¹ discovered in their longitudinal study that HIV stigma leads to depression which compromises adherence to treatment. Although scholars have well documented and elucidated the effects of HIV stigma to a PLHIV health outcomes, in this paper, it is posited that the stigma in health facilities can be a potential barrier to HIV care because of its impacts on health-seeking behaviors.

Study Objectives

The purpose of this study is to describe and assess the health-seeking behaviors practiced by PLHIV after being diagnosed with HIV. It also aims to evaluate the prevalence of health facility-related stigma and determine whether correlation exists between these two variables (health-seeking behavior; health facility-related stigma).

METHODS

Research Design

This study utilized a cross-sectional design using self-report scales.

Participants and Setting

GPower software was used to determine correlations between the variables in the study and anticipate six predictor variables, and a minimum number of 97 samples was deemed necessary to achieve a probability level of .05, with an anticipated effect size of 0.15 and statistical power of 80%.²² The researchers estimated 110 participant samples and retrieved a 90% response rate with a final sample size of 100 PLHIVs.

PLHIV residing in the Philippines was the target population of this study. Because of the concealed nature of the participants, the researchers implemented a multi-level recruitment. This was accomplished by initially identifying five (5) HIV and AIDS support groups in the country. Representatives from the support groups were contacted and asked for possible collaboration in the study

as participants. After securing consent, a respondent-driven sampling method of recruitment was implemented. A SurveyMonkey link was forwarded to the consenting representatives who were made responsible for identifying and recruiting possible participants from their support groups. The representatives later cascaded the online link for the questionnaire to group members for answering.

The inclusion criteria for participant selection comprises the following: (1) of legal age; (2) clinically diagnosed as a PLHIV regardless of duration; (3) had experience seeking medical consultations in health facilities, and (4) consented to participate. Excluded in the study are PLHIV who (1) are in the advanced stage of disease (AIDS), or (2) have no internet access. Data collection was performed from June to December of 2019.

Instrumentation

There were two 5-point Likert scale instruments developed and utilized in the data collection for this study. Data points from in-depth interviews with PLHIV were used to devise the scales employed in this study. The first draft of the scales underwent subject matter expert (SME) evaluation for face and content validation. The validation was performed in two phases. For phase one, there were eight (8) SMEs who conducted structural assessments of the instrument. The experts eliminated and refined faulty items and suggested other items to be included in the scale. For phase two, the suggestions were integrated in the revision. The revised scale was assessed by another five (5) SMEs who were tasked with formally evaluating the content validity of the items and scale.

The English version of the instruments was utilized in this study. Both scales underwent rewording and rephrasing to enhance the thought and clarity of the items in the scale. The scale reliability was determined based on its internal consistency (Cronbach's alpha) reported in the present study. The scales are rated in terms of agreement where 1 is described as '*strongly disagree*'; 2 is '*disagree*'; 3 is '*neutral*'; 4 is '*agree*,' and 5 is '*strongly agree*'.

The first 5-point Likert scale instrument was the Health-seeking Behavior Scale, composed of 11 items. This was used to measure the health-seeking behaviors of PLHIV. The instrument revealed a scale content validity index (S-CVI) of .98. The scale displayed a good reliability score with a Cronbach's alpha of .82 and has a highest possible score of 55 points. Specifically, the scores are classified into three range descriptions: (a) good health-seeking behavior for scores between 41-55; (b) moderate health-seeking behavior for scores between 26-40; and (c) poor health-seeking behaviors for scores between 11-25.

The second 5-point Likert scale instrument was the HIV-related Stigma in the Health Facility (HIV-SHF) Scale, which was used to assess the participant's perceived stigma in health facilities. A total of 11 negatively worded items composed the scale of which a high score depicted

the presence of HIV stigma in the health facility. The validated scale had an S-CVI of .94 and a high internal consistency score based on its Cronbach's alpha value of .91. The highest possible score for this scale is 55 points, and scores are subsequently divided into three score descriptions: (a) high presence of HIV-related stigma for scores between 41-55; (b) moderate presence of HIV-related stigma for scores between 26-40; and (c) low presence of HIV-related stigma for scores between 11-25.

Finally, the questionnaire assessed the participant's profile. The participants were asked to disclose age, gender, civil status, educational attainment information. Participant's number of years living with HIV, HIV disclosure status, and appointments to health facilities were also assessed.

Data Analysis

The data were analyzed using descriptive statistics including frequency, percentage, and arithmetic mean. Analysis of variance (ANOVA) was also employed to determine if health-seeking behavior and stigma significantly differ across the categories of the participant's profile variables. Correlation analysis was performed to determine if the profile variables are related to health-seeking behavior and/or health facility-related stigma. Age, gender, civil status, and education were correlated with health-seeking behavior and stigma using Spearman rank coefficient and Chi square-based measures of association including Cramer's V and contingency coefficient. Data analysis was conducted using Stata v15.1, and the test of significance was performed at the 5% level.

Ethical Considerations

This study was technically and ethically reviewed by the St. Paul University Philippines Ethics Review Committee (2018-01-PhDNS-11) and was granted with approved and complied status. The multi-level recruitment process in the selection of participants assured that participant rights and confidentiality were well protected. An informed consent was secured before the data collection, in which the participant's willingness was indicated. Participants demonstrated in the agreement that they understood the intent of the study as well as the voluntary nature of participation by clicking the proceed button found in the introductory section of the survey link.

RESULTS

Descriptive Statistics of the Participants' Profile and Key Variables

A total of 100 PLHIV participated in this online study. The results show that most participants (93%) are young adult men between the ages of 20 and 29 years old (41%). 70% of the participants have been diagnosed with HIV within the last five years. The vast majority of them are unmarried (95%) and have attended high school (83%). 46%

Table 1. Profile of PLHIV, mean scores, standard deviations for Health-seeking Behaviors and HIV Stigma

| Characteristics | Categories | N | % | Health Seeking Behaviors | | | | HIV Stigma | | | |
|--|---------------------------------|----|----|--------------------------|------|-----------------|---------|------------|------|-----------------|---------|
| | | | | Mean | SD | Test Statistics | p value | Mean | SD | Test Statistics | p value |
| Age | 20-29 | 41 | 41 | 3.02 | 0.54 | 2.71* | 0.049 | 2.21 | 0.91 | 0.12 | 0.9470 |
| | 30-39 | 42 | 42 | 2.95 | 0.50 | | | 2.23 | 0.82 | | |
| | 40-49 | 13 | 13 | 2.82 | 0.56 | | | 2.10 | 0.77 | | |
| | 50 and above | 4 | 4 | 2.27 | 0.41 | | | 2.02 | 1.18 | | |
| No. of years living with HIV | Below 5 | 70 | 70 | 2.93 | 0.53 | 0.36 | 0.700 | 2.17 | 0.87 | 0.74 | 0.4800 |
| | 5-9 | 23 | 23 | 3.00 | 0.53 | | | 2.14 | 0.83 | | |
| | 10 and above | 7 | 7 | 2.80 | 0.69 | | | 2.61 | 0.89 | | |
| Gender | Female | 7 | 9 | 2.84 | 0.60 | 0.47 | 0.641 | 2.01 | 0.88 | 0.58 | 0.5620 |
| | Male | 93 | 93 | 2.94 | 0.53 | | | 2.21 | 0.86 | | |
| Civil status | Married | 5 | 5 | 3.05 | 0.33 | 0.50 | 0.619 | 1.96 | 0.77 | 0.62 | 0.5380 |
| | Unmarried | 95 | 95 | 2.93 | 2.93 | | | 2.21 | 0.86 | | |
| Educational attainment | Elementary | 8 | 8 | 2.64 | 0.62 | 1.35 | 0.263 | 2.10 | 1.01 | 0.16 | 0.8550 |
| | High School | 83 | 83 | 2.97 | 0.53 | | | 2.23 | 0.84 | | |
| | College | 9 | 9 | 2.93 | 0.51 | | | 2.09 | 0.95 | | |
| Employment | None | 20 | 20 | 2.79 | 0.68 | 0.65 | 0.631 | 2.36 | 0.96 | 1.04 | 0.3930 |
| | Student | 6 | 6 | 3.12 | 0.36 | | | 2.30 | 0.82 | | |
| | Self-employed | 21 | 21 | 2.92 | 0.31 | | | 2.10 | 0.77 | | |
| | Private | 46 | 46 | 2.98 | 0.59 | | | 2.08 | 0.86 | | |
| | Government | 7 | 7 | 2.96 | 0.33 | | | 2.68 | 0.75 | | |
| Disclosure status | Fully disclosed | 8 | 8 | 3.05 | 0.54 | 0.20 | 0.816 | 2.10 | 0.77 | 0.06 | 0.9455 |
| | Disclosed to few trusted people | 76 | 76 | 2.92 | 0.54 | | | 2.20 | 0.87 | | |
| | Not disclose to anyone | 16 | 16 | 2.96 | 0.53 | | | 2.23 | 0.89 | | |
| Type of health facility where discrimination and stigma were experienced* | Rural Health Unit | 37 | | 3.18 | 0.55 | 0.96 | 0.421 | 2.91 | 0.73 | 3.07* | 0.0360 |
| | Hospitals | 20 | | 2.93 | 0.35 | | | 2.52 | 0.73 | | |
| | Private polyclinic | 17 | | 2.97 | 0.53 | | | 2.26 | 0.85 | | |
| | Private treatment hub | 7 | | 3.16 | 0.59 | | | 1.79 | 0.88 | | |

* $p < 0.05$

of participants are working in private companies. Although the majority have disclosed their HIV status, most of them have only disclosed to people they trust (76%). 81% of participants experienced stigma in health facilities, primarily in Public Rural Health Units (RHUs; $n = 37$).

The results revealed that among the profile variables, only age has a significant impact on health-seeking behaviors. Younger PLHIV display better health-seeking behaviors as compared to older participants ($p = 0.049$).

Additionally, the results further conveyed that the experience of stigma varies significantly according to the type of health facility ($p = 0.036$). The findings show that stigma is more prevalent in RHUs than hospitals, private polyclinics, and private treatment hubs (Table 1).

Descriptive Means of the Items in the Key Variable Instruments

Table 2 presents the mean scores on the health-seeking behavior scale. Overall, the participants display moderate health-seeking behavior based on a mean score slightly above the midpoint ($M = 2.94$, $SD = 0.54$). Two items scored the highest among the items listed on the scale. One item is that most participants resorted to information-seeking ($M =$

3.97 , $SD = 1.12$) as their primary source of health-seeking behavior. They would 'read articles, books and magazines' on matters concerning their health and disease process. The second is the high mean score on the item 'have faith and surrender it all to the Lord' ($M = 3.79$, $SD = 1.50$), suggesting a healthy and adaptive behavior on spirituality, trust, having faith, and looking forward to recovery.

Table 3 displays the mean scores on the items in the HIV SAD-HF scale. The data show that participants experience moderate levels of stigma based on the mean score at the midpoint ($M = 2.21$, $SD = 0.87$). The item with the highest mean is 'Health workers who lack awareness of HIV care are those who are prone to discriminating against people with HIV' ($M = 3.18$, $SD = 1.40$), followed by the item "Health care workers gossip about gay people with HIV" ($M = 2.55$, $SD = 1.34$).

Correlation of Profile Variables to the Key Variables

Table 4 presents the correlation of the PLHIV profile, health-seeking behavior, and HIV stigma. Based on the results, age is the only profile variable that is significantly correlated with the health-seeking behavior of PLHIV ($r = -0.2796$, $p = 0.049$). The correlation between age and

health-seeking behavior is negative, indicating that older an PLHIV tends to have lower health-seeking behavior. As a PLHV gets older by one year, his health-seeking behavior score is expected to decrease by 0.02 points. This result is also observable in Table 1, where the age group 50 and above has the lowest health-seeking behavior mean.

The type of facility is significantly correlated with HIV stigma ($r = 0.4050$, $p = 0.036$). It is also shown in Table 1 that PLHIV are more prone to experiencing stigma in

RHUs than in private treatment hubs. These results further reveal that the health-seeking behaviors of PLHIV are not significantly correlated with the experience of HIV stigma.

DISCUSSION

The present study examined the health-seeking behaviors and HIV-related stigma associated with health facilities among PLHIV in the Philippines. The results

Table 2. Descriptive Statistics for the Health-Seeking Behavior Scale

| Heath seeking behavior | Mean | SD |
|---|-------------|-------------|
| 1. Keep it to myself | 3.05 | 1.37 |
| 2. Have faith and surrender it all to the Lord. | 3.79 | 1.50 |
| 3. Not do anything about it until it gets worse, and I cannot bear it anymore | 1.82 | 1.09 |
| 4. Try to self-medicate: | | |
| a. I buy medication in the pharmacy | 2.27 | 1.22 |
| b. I use herbal based products I can buy in the pharmacy | 1.83 | 1.03 |
| c. I use medication I can find at home for my ailment | 2.11 | 1.25 |
| 5. Search the internet to know what is best for my condition | 3.50 | 1.19 |
| 6. I read articles, books and magazines to get information about my disease | 3.97 | 1.12 |
| 7. Ask help from friends who had the same experience and do what they did to recover from it. | 3.32 | 1.24 |
| 8. Proceed to a health facility that is far from my residence | 3.37 | 1.40 |
| 9. Go to the nearest health facility to have myself checked. | 3.25 | 1.49 |
| Total Score | 2.94 | 0.54 |

Note: Scores ranged from 1 (strongly disagree) to 5 (strongly agree)

Table 3. Descriptive Statistics for the Health Facility-related Stigma Scale

| HIV Stigma and Discrimination in the Health Facility Scale | Mean | SD |
|---|-------------|-------------|
| The Health Facility & Protocols | | |
| 1. The health facility does not support privacy and confidentiality | 1.98 | 1.29 |
| 2. Protocols and procedures do not provide privacy and confidentiality | 2.02 | 1.25 |
| The Health Care Personnel | | |
| 1. The health care team are sources of discrimination and stigma | 1.83 | 0.97 |
| 2. Health workers are afraid to care for persons with HIV | 1.66 | 0.91 |
| 3. Health workers who lack awareness of HIV care are those who are prone to discriminate persons with HIV | 3.18 | 1.40 |
| 4. Health care workers gossip a gay person with HIV | 2.55 | 1.34 |
| 5. The disclosures to selected health workers only promote gossip, fear, and tension in the workplace. | 2.46 | 1.27 |
| 6. Health workers make jokes on patients with HIV | 2.08 | 1.10 |
| 7. Health workers use PPE excessively in caring for persons with HIV | 2.46 | 1.32 |
| 8. Health care workers does not observe confidentiality | 1.95 | 1.07 |
| 9. Health workers approach are judgmental towards HIV | 2.01 | 1.20 |
| Total Score | 2.21 | 0.87 |

Note: Scores ranged from 1 (strongly disagree) to 5 (strongly agree)

Table 4. Correlation of PLHIV Profile, their Health-Seeking Behavior and Health Facility-Related Stigma

| Variables | Health-Seeking Behavior | | HIV Stigma | |
|--|-------------------------|---------|-------------|---------|
| | Coefficient | p value | Coefficient | p value |
| Age | -0.2796* | 0.049 | 0.0432 | 0.671 |
| No. of years living with HIV | 0.0778 | 0.444 | 0.0933 | 0.360 |
| Gender | 0.0472 | 0.641 | 0.0589 | 0.562 |
| Civil status | 0.0502 | 0.619 | 0.0625 | 0.538 |
| Educational attainment | 0.0590 | 0.561 | 0.0018 | 0.986 |
| Employment | 0.1627 | 0.631 | 0.2055 | 0.393 |
| Disclosure status | 0.0646 | 0.816 | 0.0342 | 0.945 |
| Type of health facility where discrimination and stigma were experienced | 0.2399 | 0.421 | 0.4050* | 0.036 |
| HIV Stigma | 0.1546 | 0.126 | – | – |

* $p < 0.05$

suggest that the study participants experienced moderate stigmatization and were discriminated against in health facilities while exhibiting relatively good health-seeking behaviors. The findings also suggest that most PLHIV who report stigma have not disclosed their HIV status to anyone. This observation is similar to the results reported by Heggeness et al.,²³ which found high susceptibility to stigma and discrimination among PLHIV who have not fully disclosed their HIV status. These results explain why it is common for PLHIV to choose to keep matters to themselves and resort to isolation. The fear of being stigmatized because of HIV status is a strong emotional and social barrier to PLHIV. Other scholars have identified this condition as self-stigma, where someone would deliberately remove themselves from compromising situations out of distrust and fear of being identified, stigmatized, and discriminated against. In this case, the experienced self-stigma of a PLHIV would lead them to keep their HIV status private out of fear of being judged and losing their social circle.

Health-Seeking Behaviors of PLHIV

The result of moderate-to-good health-seeking behaviors of the participants indicate an appropriate behavioral response towards health despite HIV status. One crucial finding in this study is the difference in health-seeking behaviors between younger and older PLHIV. Literature suggests that older PLHIV, especially those who have been in treatment for some time, have a low self-perceived risk of complications compared to younger PLHIV.²⁴ The sense of health vulnerability of older PLHIV reduces with continued compliance to treatment regimens and may also be observed through a resurgence of risky sexual behaviors.²⁵ In contrast, younger counterparts are observed to be more health conscious based on the findings of this study. It is reported here that younger Filipino PLHIV have better health-seeking behavior compared to older PLHIV. This finding aligns with other studies in which younger PLHIV display a more positive and adaptive behavior towards their HIV diagnosis. For instance, Comulada et al.²⁴ reported that young PLHIV are more adept at searching online for information regarding sexual and reproductive health and well-being. Participants in the present study also displayed this behavior. Most resorted to information-seeking in books and the internet to learn and understand the expectations concerning HIV/AIDS. By gaining adequate information about their health condition, PLHIVs are empowered to decide and engage in healthy activities.²⁶ However, this finding contrasts with a multi-country study that reported how younger PLHIV tend to have a late presentation and low adherence to treatment.²⁷ Notwithstanding these conflicting reports, health practitioners need to practice vigilance in the care administered. Outside of medical treatment, HIV care involves the consideration of complexities and intersectionalities to fully understand and provide adequate care for a PLHIV. This is especially true when operating

within the generally conservative culture among Filipinos where HIV is considered a taboo and impermissible.

Stigma in Health Facilities

Study findings show that the type of facility in which stigma and discrimination were experienced is significantly related to the participants' stigma score. As indicated in Table 1, the mean stigma score is higher in RHUs, hospitals, and private polyclinics than in private treatment hubs. These data are supported by results reported by Robles and Canoy,²⁸ who presented that public health facilities appear to be displeasing and stigmatizing due to their unwelcoming, unsafe, and non-therapeutic spaces for PLHIV.

In the Philippines, RHUs are micro health facilities located in towns and municipalities providing primary health care for local communities. The operation of an RHU is spearheaded by healthcare professionals such as doctors, nurses, midwives, and other health attendants. The significant finding that stigma is correlated with the type of health facility is an indication that access to HIV health care in the Philippines may be difficult and stigmatizing. This contradicts health facility's primary purpose of providing accessibility and convenience for people with health care needs.

Likewise, the high mean scores for stigma in hospital facilities detailed this study are similar to data reported in previous studies pertaining to the incidence of stigmatizing factors present in medical care settings.^{9,29} Ironically, healthcare personnel who act as duty bearers and care providers may inadvertently display behaviors perceived by their patients as stigmatizing and discriminatory. Various literature has reported the presence of negative attitudes among health care providers towards HIV-related issues.^{30,31}

Scholars have advocated for the implementation of community treatment hubs as they have been shown to assist in the reduction of stigma.³² This is the first study to present a comparative analysis of stigma experience based on the type of health facility. Notably, the reports of low stigma in private treatment hubs are an indication that such facilities are enabling environments for PLHIV compared to other health units available. Private treatment hubs are less stigmatizing due to the homey ambiance, a more personalized approach taken towards patients' health care needs, and availability of psycho-emotional support.²⁸

Health-Seeking Behavior is Not Related to Health-Facility Stigma

Our results show that there is no correlation between health-facility stigma and health-seeking behaviors of PLHIV. These findings contrast with previous studies that suggest that HIV-related stigma is one of the critical drivers of poor health-seeking practices and reduced utilization of HIV care services.^{10,33} Perhaps that could be attributed to the moderate to low health-seeking behaviors observed in the participants in the study and not associated with health-

facility stigma. However, the low number of samples used in the present study may be a main contributing factor explaining the lack of association between the two study variables. It is advised that future studies utilize a larger sample size to determine when comparing these two variables.

Study Limitations

This study is not without limitations. Firstly, only those who have the capability to access and answer the online survey link were included in the study; hence generalizability of findings is limited. Additionally, answering thorough online survey forms and the sampling procedure implemented in this study may pose possible participant biases in acquiescence or provide socially desirable responses. It is suggested that future studies employ exhaustive participant sampling to ensure balanced representation. Similarly, other forms of data collection, such as printed questionnaires, may be used to enhance participant retrieval and increase sample size. A qualitative data gathering method may be utilized to triangulate the results of this study and provide a more complete picture of the health-facility-related stigma that quantitative means of gathering data may have failed to capture.

Implications for Public Health Practice

The presence of stigma in health facilities is a public health issue that requires responsive action. The control of HIV and AIDS should not exclusively be focused on treatment and addressing essential risks and transmission at the grassroots level.³⁴ There exists a need to revisit the policies and protocols in RHUs and to form strategies that make them more approachable, reassuring, culturally acceptable, and client friendly. It is believed that addressing stigma will increase HIV testing and contribute to reducing and controlling HIV incidence in the country. The Philippines is known as a country that is traditionally religious and conservative where deviations from societal norms are oftentimes detested and scorned. However, it cannot be contested that times and sexual practices have evolved, becoming more liberal likely due to the advent of social media and accessible networking. Healthcare workers should be well informed of these changes and potential challenges to address the surge of HIV cases. Moreover, there is a severe need for knowledge and training among healthcare workers on providing psycho-socio-emotional care and behavioral interventions. Studies suggest that when healthcare personnel are not equipped with proper HIV care and management training, they are prone to cause stigma and display discriminatory behaviors.³⁵ As a country of concern, the Philippines needs to take the initiative to curb the rising incidence of HIV. A vital step in this endeavor is to eliminate the stigmatization of HIV by care providers, guided by the fundamental principle that stigma exists when it is not openly and comfortably discussed. Government-

owned facilities may need to identify and utilize effective strategies practiced by private institutions and institute policies to provide stigma-free HIV care.

CONCLUSION

There is a moderate presence of stigma in health facilities perceived by PLHIV in the Philippines. Specifically, RHUs and private treatment hubs are considered as the most and the least stigmatizing health facilities, respectively. Although no relationship was found between stigma and health-seeking behaviors in the present study sample, there exists a need for consistent follow-ups and linkage to care for PLHIV because of the decreasing health-seeking behaviors observed as they age. Strengthening the implementation, promotion, and practice of the RA 11166, known as the Philippine HIV and AIDS Policy Act, is essential in establishing stigma-free, nondiscriminatory, and non-selective health care facilities.

Statement of Authorship

All authors contributed in the conceptualization of the work, acquisition and analysis of data, drafting and revising and approved the final version submitted.

Author Disclosure

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