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Proactive Health Seeking Behavior in HIV / AIDS on Local Culture of Mee Tribe in Paniai Central Mountain of Papua Indonesia

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A B S T R A C T

The epidemic of HIV AIDS in Papua has widespread throughout the population and this province is the highest prevalence of HIV / AIDS in Indonesia. This study was conducted using a mixed methods / qualitative and quantitative called Grounded Theory and Experimental. This research has generated a new theory of "Proactive Health Seeking Behavior," that developed based on the local situation in the Mee tribe in Papua's Central Highlands. This health behaviors study associated with social culture. The resulting propositions are 1) Health behavior change can be occurred quickly intervening through a proactive approach that bridges between health care providers (Provider) and beneficiary health care (Recipient); 2) Health behavior change can be happened quickly intervening if the desire and attitude of providers and recipients can be fused through socio-cultural approach and constant efforts; 3) Changes in proactive health seeking behavior are driven by leader attitudes, issues, facts, local wisdom, and health provider attitudes. While driven recipients come from knowledge, values and norms, mandatory check, care and support perceived society / stakeholders; 4) the stronger the impulse proactive factors from providers and recipients, the faster the change or acceleration of health development can occur. This quantitative study, before the intervention and after the intervention showed significant increases occurred on average per month was conducted examination of the coverage of HIV by 53-fold. Total coverage in the year 2013 amounted to 2001 people and 160 people reactive cases. The proportions of cases of reactive (positive) HIV / AIDS were 8%, indicating approximately 3 times higher than the data of HIV prevalence in Papua-based Integrated HIV and behavior survey in 2006.

Introduction

The increase in the spread and transmission of HIV / AIDS in the Papua Province 50 times higher compared to other provinces in

Indonesia (Kompas, 2007), it can be proved by the results of the HIV data analysis and Integrated Behavior Survey in 2006, showed

that the prevalence of HIV in Papua was 2.4%, in all age groups, this figure is higher than in all regions of Indonesia (Agus, 2006). Based on the topographic development of the disease which is highly variable, according to this survey, it reported the case in highlands is 2.9%, according to reports of the Department of Health Papua Province relate the data that HIV / AIDS is a province until the year 2012 amounted to 12,187 cases (Papua Health Profile, 2012).

Data until the end of January 2013 in Paniai Regency, totaling 2557 cases consisting of 1,191 HIV cases and 1,366 AIDS cases with cumulative mortality were recorded for 260 (10%), while the gain Antiretroviral (ARV) of 115 people, or 4.5 % of total cases of HIV / AIDS in the Paniai District. Data above mean 95.5%, yet accessible ARVs, poor people living with HIV who received services ARV in hospitals and health centers can be a great opportunity to reduce the quality of life of PLHIV (Paniai Health Dept., 2012).

Several factors that affect the high cases of HIV / AIDS and ARV is the lack of access to high risk factors of the case through the free sex were 82% and 18% other risk factors is not clear. As the material because of the occurrence of free sex *emaida* culture, as well as being *tegauwa* displacement values, indigenous cultural norms due to the influence of local autonomy as well as gold mining encourage the circulation of money which is high in the community (Leslie Butt, et al, 2010) and lack of access to antiretroviral drugs is due to geographical, transportation and communication, lack of financing and the ability of social factors other cultures (PO *Amibor gunrotifa* AB, 2012). Lack of support, lack of health services and the racist, lack of information, it restricts the right to access all the information that is the trigger stigma

mountains of Papua (Leslie Butt, Jack Morin, et al., 2010).

Material and Methods

Research Design

This research combined the data with other where one data provide support for the other data sets. Personally I believe that research methods must be adapted to the purpose of research and method combination (mixed methods) will be more powerful in explaining the research process as well reveal all the results rather than just a single research method. The main approach, and the quantitative approach: (pre and post intervention) as a method of supporting research.

Grounded theory methodology was first introduced by Glaser and Straus (1967) with their phenomenal book entitled "the discovery of grounded theory". Glaser (2002) in its development says all data sources can be used in the development of theories to explain the phenomenon that occurs somewhere. Data in the form of interviews, observations, documents or combinations of them, not just what its said, but also what is said or in what condition is being said. Phenomena are based on the data, which developed into the concept further into categories, properties and new theory. So a researcher is in the position as a "person who learns of the community instead of learning about the community (learning from the people, but no learning about the people) be empirically true qualitative is flexible, flexible, able to adjust as the process runs.

Grounded theory method in this study is a research effort to develop inductive strategy and confirm theories about HIV treatment seeking, as derived from empirical data.

Although a grounded approach study emphasizes the meaning of the experience for some individuals, but the purpose of grounded theory approach in this research is to generate or discover a theory or model that relates to a particular situation or in this study is referred to as care-seeking behavior of people with HIV and AIDS swampland. Situations where individuals with HIV and AIDS are related, act, or engage in one treatment process and take medication in response to the health care effort as an event. The essence of Grounded Theory approach is the development of a theory or model that is closely related to the context of the events in the study (Saryono, Dwi Anggraeni, Bloom, 2013).

Time and Field Research

The study lasted for approximately one year. Quantitative data achievement of the program is the data collected from the January to December 2013, while qualitative data actively collected from October 2013 to the completion of this research. Proactive approach to intervention and mass inspection starting August 1st, 2013, which was launched by head of Paniai Regency.

The study was conducted on two places, namely health care facilities (General Hospital, 18 health centers of the district of Paniai) and in the community. Site selection is based on the instructions given by the District Health Office Paniai, i.e the region of PLHIV supported by the service program, according to a report in 2008, that the Ministry of Health has implemented decentralization of ARV services in various hospitals and health centers are eligible for support services, through the selection and administration in the implementation of regional readiness support services for people living with HIV with antiretroviral drugs, the same year Paniai District General

Hospital as a reference center of ARV services.

The overall data OHDA registered for ARV support services listed in the Paniai District Hospital only 4.5% who received antiretroviral drugs, while 96.5% did not receive ARV services, with this condition, Paniai District Health Office and the researchers plan to approach it by leadership VCT units Paniai District Hospital, to check the name of the fund survived to reach PLWHA ARV services in the community setting appropriate research sites in total sampling. The selection of these locations we setup in such a way to avoid bias due to errors in the determination of the location and goal of our research is, as for the location of our study are: Paniai General Hospital, also 18 Health Center at Paniai Regency.

Data Collection

In this study we used three collection techniques data i.e. (1) in-depth interviews and focus group discussions; (2) observations; (3) documents, field notes.

a) This study use a qualitative research, the emphasis is more on the process than on the outcome, then we do in-depth interviews to: Head of P2PL, Kasie P2M and HIV Program handler and AIDS DHO Paniai, we question related: 1). Management; 2) Program unit 3) Resource availability and support policy makers as well as the level of community participation.

b) Hospital Chief, Chief of VCT unit at the General Hospital Paniai, we question related: 1) management 2) Program ARV support services for people living with HIV 3) Lost to follow-up issues ARV services in the Paniai hospitals.

c) Head Health Center, Chief of VCT units at the health center, we question related:

1) management 2) Program routine car service and support services for people living with HIV anti retroviral 3) Lost to follow-up issues ARV services at the Paniai health center.

d) Leaders and staff of NGOs engaged in HIV and AIDS programs, our question relates:

1) Management 2) Program ARV support services for PLWHA 3) lost to follow-up issues ARV services in the community of Paniai District.

e) Chief of Mee, Family and PLWHA separately, interview topics that we have designed is: 1) How the socio-cultural values and support in the implementation of the service choose if ill relatives live in house 2) How their views on support services at the hospital and patients who lived at home with his family. 3) How

customary social cultural values and how societies adapt to modern health care.

Result and Discussion

The results of this study are presented both of qualitative analysis and quantitative analysis as found during the research.

Selective Coding

During the manufacture of axial coding, it was found the categories that frequently arise and are considered essential to choose, then made a connection between the core categories and subcategories by means of freehand drawing (write down on a piece of poster board), as in the following image display:

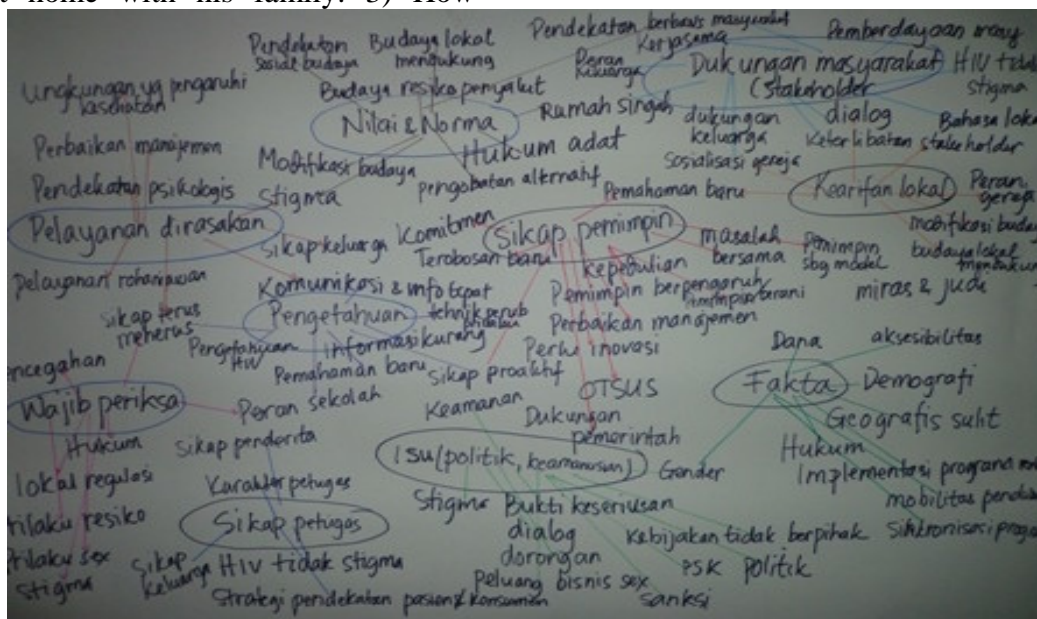


Figure.1 Freehand writing Testing Category and Subcategory

From free hand writing can be written back before the main categories and subcategories. There are 10 main categories (core categories) were selected, namely: issues (political, humanitarian), fact, leaders attitudes, local knowledge, officers attitudes, knowledge, values and norms, mandatory check,

Modeling

Based on the above findings and the data associated with the local context and Mee tribe in Paniai Regency, then formed a new model, named behavior model of seeking relief proactive health (Proactive Health Seeking Behavior Model).



Figure.2 Behavior Model of Seeking Relief Proactive Health

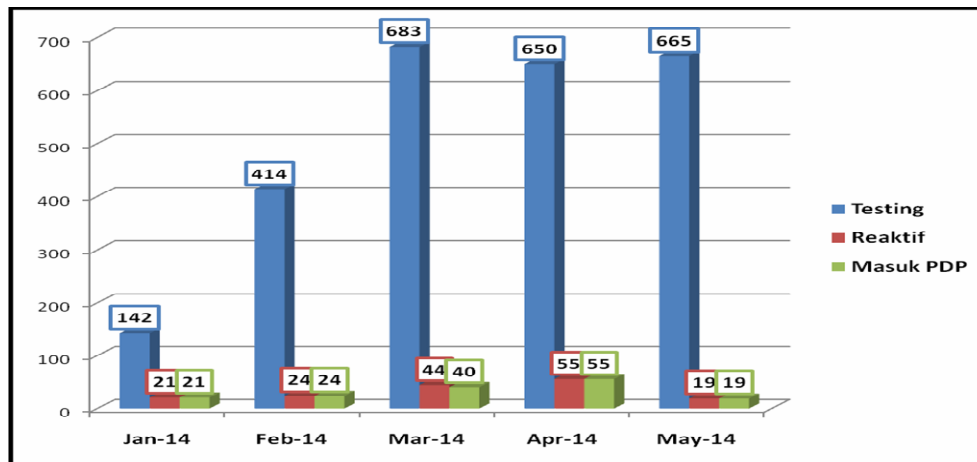


Figure.3 Coverage and HIV positive cases in Paniai 2014

Model behavior seeking relief proactive health has 10 variables: issue, facts, attitude leader, local knowledge (local wisdom), attitude of health personnel, knowledge society (knowledge), value & norm society, compulsory check (compulsory / regular examination), perceived service (service satisfaction) and

community support / stakeholder.

Quantitative Analysis

Quantitative data in the form of descriptive statistics used to support the qualitative data or models that have been formed. Proof that before the examination (intervention) and

after examination (intervention). From the results of the analysis of secondary data collection has proved a change and increase in numbers. Latest data coverage on the situation of HIV / AIDS in 2014 were collected from the Health Office, NAC Paniai and RSU Paniai.

Figure 3 shows that from January to May 2014 the coverage of the program after the intervention, the highest number of people who tested HIV were 683 in March people or average people do test for 5 months is 6 people per month. Then the highest reactive results (positive) were 55 people in April. On August 1st, 2013, the head of Paniai

Regent did Launching HIV for massive tests. From August to December 2013 and to May 2014, there was an increase to test.

Total coverage in the last 5 months were 1633 people and there were 102 cases that were reactive person. In December 2013, all the data yet complete because it only comes from the Paniai hospital. The average person is checked every month in the last 5 months by 323 people. So when compared to the average monthly pre and post intervention increased as much as 53-fold coverage. The similar figure in 2014 the data available until May 2014.

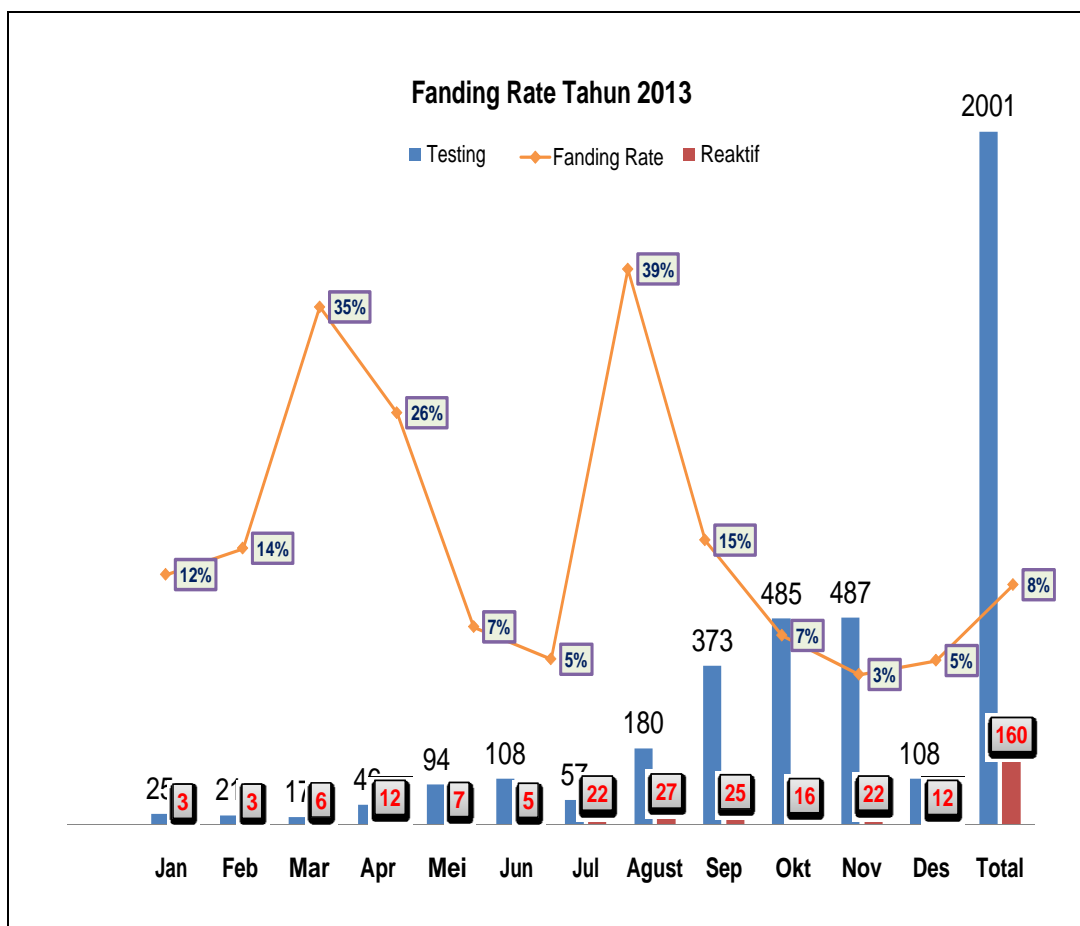


Figure.3 The proportion cases in Paniai District, 2013

Based on data from 2013, the total coverage within one year in 2001 and the

total reactive cases were 160 people, the proportion of cases of reactive (positive)

HIV / AIDS as much as 8%, indicating approximately 3 times higher than the data the HIV prevalence in the country Papua was 2.4% based on the Integrated HIV and Behavior Survey (STHP) 2006. It can be interpreted that 8 in 100 people in the productive age Paniai estimated risk of suffering from HIV / AIDS. In this study,

did not show age but it is important to look at the trend of transmission at a younger age. Data also do not show significant gender data to assess the accessibility of health services and also transmission of HIV among young women and mothers household.

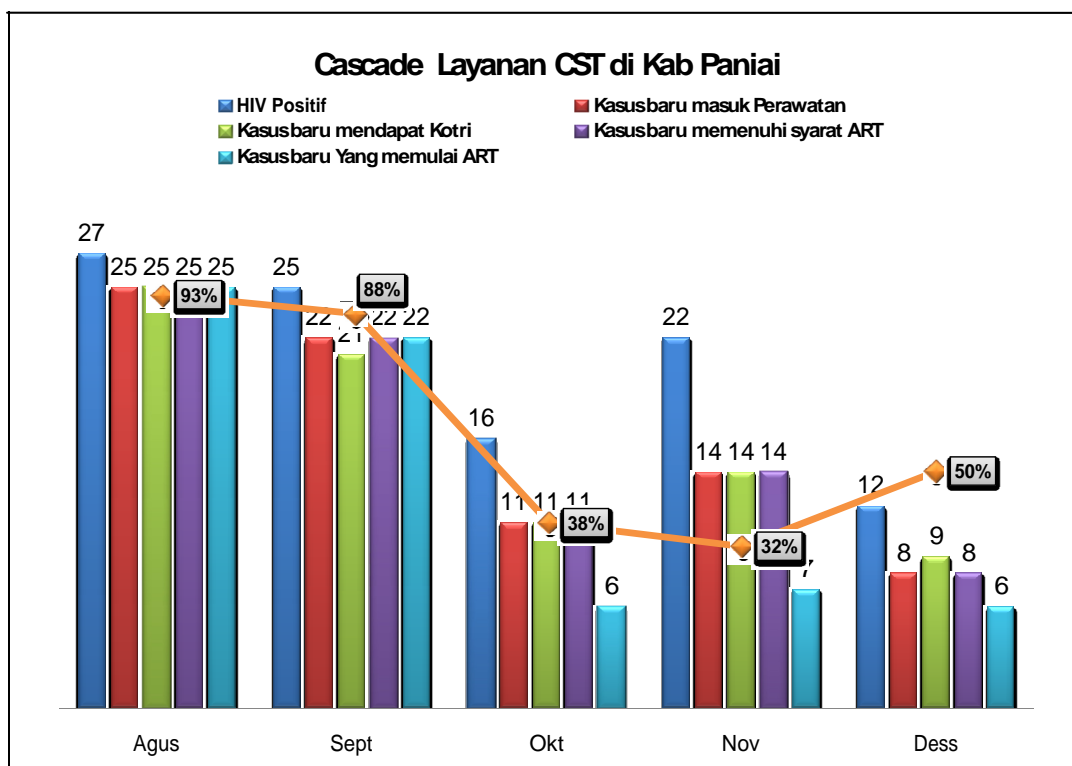


Figure.4 CST services in Paniai District 2013

Figure 4 illustrates the quality of HIV care program in Paniai hospital through CST (Care, Support and Treatment) is a follow up of the VCT program that is handling HIV patients coupled with providing support care and treatment. CST is a comprehensive treatment (thorough and continuous). Of 5 months, patients with HIV / AIDS amounted to 102 people, there were 80 people have qualified to receive ARVs but only 60 people who had given antiretroviral treatment (82.5%). There were 80 people receiving co-trimoxazole for prevention of opportunistic infections. From this data means that access to antiretroviral drugs has

been better than the previous years of data is only 4.5%, respectively.

Proposition

- a. Health Behaviour change can occur rapidly through a proactive approach that bridges between the Giver of Health Services (Provider) and the Health Services Recipients patients or public.
- b. Health Behaviour change can occur rapidly if the desire and attitude of giver and can be fused through a socio-cultural approach and constant effort.
- c. Changes in proactive health seeking

behavior is driven by the Care Giver because attitudes leader, issues, fact, local wisdom, and attitude officer. While the waiter receiver driven by knowledge, values and norms, mandatory check, care and support perceived society / stakeholders.

d. The stronger the push factors Proactive Health Care Giver and Receiver Proactive Health Services, the faster the change or accelerate health development can occur.

Theoretical Assumptions

Modeling at the top, it lead the application became effective in the study area requirements are: there is a good leader, had a caring heart and brave and backed by the resources and values and supporting norms. The situation safe area, no pressure and public confidence in the government or service providers is relatively sufficient.

This study shown that the results of the qualitative is "Proactive Health Seeking Behavior theory" in which supported by the quantitative results of significant changes between pre-intervention and post-intervention (after launching massive HIV testing by Paniai head regency on 1st August to December 2013. The findings of the study contribute significantly to the theory of health seeking behavior which, previously major theories of health behavior more focuses to the patient by the public such as: a) The Health Belief Model (HBM) of Sheeran and Abraham (1995) b) The Theory of Reasoned Action (Fisbein & Ajzen) and the Theory of Planned Behavior (Connors & Sparks, 1995); c) The Health Care utilization model (Andersen & Newman, 1973) and later modified by Kroeger 1983; d) The four As; e) Pathway models of Good (1987) and f) Ethnographic decision-making models (Garro, 1998 and Weller, 1997) as quoted in Muella Susanna Haussmann et al (2003).

This research have integrated the service recipient of patient and the donor community servant (providers) i.e., health officials or government. Both directions are mated together to work towards a change or acceleration. Provide maximum access and become universal access in services, especially in the examination, care and treatment of people living with HIV and provide support to them. Health behavior theoretical discuss many factors that affect health such as variables that we used to know is: the facts, the attitude of officers, community knowledge, values and norms that exist in the community and support community / stakeholders. However, the findings of modeling "Seeking Relief Proactive Health" found new variables that appear in the local context, especially in the Paniai Mee tribe namely: political issues / security, local knowledge, and attitudes required to check the leader.

This theory raises the power of socio-cultural approach to living in the community, which we know as the values and cultural norms that used as a local wisdom by the provider in the campaign and bring business service providers and service recipients, call it jargon: *Itano bokaine bokaine* means the fund *wadona* this is also going to die tomorrow also want to die, associated with this medical examination or test for HIV do not be afraid. Mee society considers it a matter of death experienced by all beings that mass HIV testing is not considered as problem. *Akiyaa Akikida Doutow* means your body guard himself. Long life on the earth is yours, the people should not be afraid to check up. Furthermore, and this is also in line with the new paradigm of health that we need to diligently check themselves and exercise and change our lifestyles healthier. It is a healthy choice (Health is a choice).

The phenomenon of a proactive approach gradually reduces the concept of illness of Papuan. Mee people feel sick when *a person cannot eat or cannot drink and cannot walk*. This concept of illness is considered that Papuans do not check their health regularly, come in severe sickness (delay of presentation). Data of HIV / AIDS in Papua shows most cases have advanced to AIDS and requires quite a lot of ARVs therapy. Proactive in this case can be interpreted that provide ARV treatment to HIV patients as soon as possible and provide adequate counseling and mentoring. There are several fundamental reasons for giving ARV regardless of CD4 levels or criteria based on WHO clinical stage however there are no studies yet looking at this issue, (WHO 1993).

Based on the experience of existing processes from HIV into the AIDS stage faster enough because people, especially tribal Mee daily meals very simple or still much less nutritious eating and only drinking water, and will be less intake if they are sick or do not work. The concept of illness caused delay of presentation is inherent in the Mee tribe opens opportunities not have sex with a partner so that transmission can occur. People do not consider he/she is sick if they still can walk or they can eat.

Conclusions

This research has produced new models of proactive health Behavior finding aid developed from the local context in Paniai tribe Mee Central highlands of Papua. The proposition of the model is as follows:

1. Health Behavior change can occur rapidly through a proactive approach that bridges between the giver of health services (Provider) and the health services recipients the patients or the public.

2. Health behavior change can occur rapidly if the desire and attitude of giver and can be fused through a socio-cultural approach and constant effort.

3. Changes in proactive health seeking behavior was driven by the employer services for attitude leader, issues, fact, local wisdom, and attitude officer. While the waiter receiver driven by knowledge, values and norms, mandatory check, care and support perceived society / stakeholders.

4. The stronger the impulse of pro active factors between health care provider and health care recipients, the faster the change or accelerate health development can be occurred.

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