

# Companion Strategy for Acceptance of HIV/AIDS Status in Women

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## ABSTRACT

**Background:** Women infected with HIV/AIDS had a double burden, including health, economic, mental, and social problems, and access to health services. Self-acceptance of HIV/AIDS status has always been a problem when women are diagnosed with HIV/AIDS, and companions are often needed to solve it. This study aimed to know the success of self-acceptance and companion strategies for women's acceptance of HIV/AIDS status.

**Method:** The research is mixed-method with a sequential exploratory. Informants are companion's HIV/AIDS in Bandar Lampung City. The qualitative phase of data collection with in-depth interviews with nine informants from 3 HIV/AIDS communities/networks was selected by purposive sampling. The quantitative phase used an online questionnaire to women living with HIV/AIDS who live in Bandar Lampung City and are a support group from 3 HIV/AIDS communities/networks, obtaining 27 people during two weeks of data collection. Qualitative analysis with content analysis and quantitative analysis with univariate analysis. This research was conducted for eight months (January – September 2021).

**Results:** The results of the study where the success of acceptance of HIV/AIDS status in women in the excellent category was 25 (92.6%) where the companion used an empowerment strategy through the stages of collaboration, case finding, self-introduction, exploring problems, and self-potential, implementation of accompaniment and monitoring and evaluation by utilizing the media whats app group and methods of personal approach and peer support groups. Suggestions, so that the length of time for acceptance of HIV/AIDS status is faster, the companion needs to get self-acceptance therapy training for women living with HIV/AIDS to empower women.

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## INTRODUCTION

HIV/AIDS cases in Indonesia are growing rapidly. Based on the Report on the Progress of HIV /IDS and Sexually Transmitted Infectious Diseases (PIMS) in the first quarter (January – March) 2021, 7,650 people with HIV/AIDS (PLHAs) were found with a maximum age group of 25 – 49 years (71.3%), male gender by 69% while female by 31%. The number of people living with HIV was found based on the three highest population groups, namely Male Sex Male (MSM) by 26.3%, pregnant women by 20.9%, and Tuberculosis (TB) patients by 11.5%. The number of people living with HIV with the highest third rank based on occupation is 21,249 employees, 18,848 housewives, and 16,963 entrepreneurs.<sup>1</sup>

The cumulative cases of people living with HIV in Lampung Province until March 2021 were 4,291. While the findings of cases in January - March 2021 amounted to 109 people. The results of the Evaluation and Activity Plan for the HIV & STI Program in Lampung Province in April 2021, where HIV was 4,519 cases, and the number of AIDS was 1,271 cases. Bandar Lampung is the most significant contributor to HIV/AIDS cases in Lampung Province. Until January – June 2021, HIV was found in 103 cases, of which 20 cases were female, and six of them were pregnant women with housewives and an entrepreneur.<sup>2,3</sup>

The number of findings of HIV/AIDS cases among women is smaller than that of men, with a ratio of

3:5. However, in reality, the condition of women living with HIV/AIDS is increasingly difficult because of the social construction of a society that places women in an unfavourable subordinate position to control their sexuality. Several cases show that when women are infected with HIV/AIDS, they carry a double burden. This further worsens the condition of women who are infected with HIV/AIDS even though their husbands infect them.

Some problems where women living with HIV/AIDS carry a double burden than men biologically; as many as 70.8% of pregnancies occur before HIV diagnosis.<sup>4</sup> Mentally, as much as 10% of HIV/AIDS women were categorized as having clinically relevant depression or anxiety.<sup>5</sup> Culturally, there is a role for HIV-positive men to have children living with HIV-negative women. It can potentially sacrifice women's reproductive and sexual autonomy and increase the risk of HIV transmission to women due to the absence of effective interventions.<sup>6</sup> Stigma, women who keep their HIV/AIDS status a secret will hinder adherence to taking medication and have difficulty accessing additional services.<sup>7</sup> As a result, it affects the level of poverty, unemployment, housing discomfort, and the need for access to services which are the dominant barriers for women to discontinue HIV cares.<sup>8</sup>

Acceptance of HIV/AIDS status is more difficult for women who do not behave at risk. Half of the women aged 29 years experienced depression before giving birth, and a third experienced depression. HIV diagnosis is the lowest point in a woman's sexual and emotional life experienced traumatically. An HIV diagnosis is usually associated with fear of death and social isolation.<sup>9</sup>

Assisting with other forms of support from people who care about HIV/AIDS can help overcome difficulties in life and relieve anxiety and psychological anxiety for women living with HIV/AIDS. The results of the study revealed that the empowerment process for people with HIV/AIDS could be carried out by assistants with the role of social workers, with the stages carried out when assisting, namely: 1) intake stage, 2) assessment stage, 3) implementation stage and 4) evaluation and termination stages.<sup>10</sup>

Facilitators can come from communities/networks that care about HIV/AIDS. In Bandar Lampung City, several HIV/AIDS communities/networks actively assist, including Ikatan Perempuan Positif Indonesia, Jaringan Odha Berdaya, and Saburai Support Group.

The results of an interview with one of the HIV/AIDS community/networks in Bandar Lampung City, where the problems that are often experienced by women living with HIV/AIDS are a long time to receive HIV status when first diagnosed, there is still stigma and discrimination in the family, and the community, as well

as irregularities, take medicine. The form of support from a companion for women living with HIV/AIDS has been provided, but it is not yet known how successful the acceptance of HIV/AIDS status is, and it is necessary to know the companion strategy for women's acceptance of HIV/AIDS status. This study aims to determine the success of acceptance of HIV/AIDS status and the companion strategy to acceptance of HIV/AIDS status.

## **METHOD**

This research was mixed-method with a sequential exploratory.<sup>11</sup> The study subjects were nine companions who assisted at least one -a month of women living with HIV/AIDS in Bandar Lampung City, Lampung Province, Indonesia. This research was conducted for eight months (January – September 2021). Data collection, qualitative phase through in-depth interviews with two key informants, namely the HIV/AIDS program holder from the Dinas Kesehatan Propinsi Lampung, obtained data related to the HIV/AIDS community/network actively providing assistance and the health condition of women living with HIV/AIDS. Based on information from key informants, 3 HIV/AIDS communities/networks were actively assisting in Bandar Lampung City. Nine accompanying informants consisted of two people from the Ikatan Perempuan Positif Indonesia, three from the Jaringan ODHA Berdaya, and four from the Saburai Support Group. Selected informants using purposive sampling, which has experience in assisting women living with HIV/AIDS for at least one month in the city of Bandar Lampung. The data collected is the acceptance of HIV/AIDS status and the companion strategy given to women living with HIV/AIDS. For data storage of informants, researchers used handhorne cameras, voice recorders, stationery, and field notes. In the quantitative phase, data collection used an online questionnaire where a questionnaire link was given to 3 coordinators of the HIV/AIDS community/network to be distributed to HIV-AIDS-infected women who live in Bandar Lampung City. A total of 27 people were obtained during two weeks of data collection. The data was collected in the form of emotion when diagnosed with HIV/AIDS, acceptance of the current status of HIV/AIDS, and companion strategies in assisting women living with HIV/AIDS.

Qualitative data were analyzed using content analysis, and quantitative data by univariate. The validity of the research results using triangulation of sources on one woman living with HIV/AIDS selected randomly based on the data from the questionnaire and in-depth interviews in a cafe with prior approval. The data obtained are the form of emotion when diagnosed with HIV/AIDS, acceptance of HIV/AIDS status, and companion strategies

in assisting women living with HIV/AIDS. Ethical learning from the Health Research Ethics Commission of Universitas Malahayati, Number: 1710/EC/KEP-UNMAL/IV/2021 dated 19 April 2021.

**RESULTS AND DISCUSSION**

**Table 1.** Characteristics of informants

Code	Age	Sex	Education level
Ak	43	Female	Undergraduate Studies
Hs	35	Female	Senior High School
El	37	Female	Undergraduate Studies
Fd	34	Male	Undergraduate Studies
Bj	23	Male	Senior High School
Js	29	Male	Senior High School
Nn	43	Female	Senior High School
Rk	32	Male	Senior High School
Er	37	Male	Senior High School

Source: Primary Data, In-depth Interview, 2021

**Table 2.** Characteristics of respondents

Characteristics	f	%
<b>Age (year)</b>		
20 – 24	1	3,7
25 – 29	5	18,5
30 – 34	7	25,9
35 – 39	10	37
40 – 44	3	11,1
45 – 49	0	0
50 – 54	1	3,7
<b>Education level</b>		
Junior High School	10	37
Senior High School	11	40,7
Diploma	3	11,1
Graduate	3	11,1
<b>Job</b>		
Housewife	16	59,3
Tailor	1	3,7
Social worker	1	3,7
Online driver	1	3,7
Street vendor	4	14,8
Hausemaid	1	3,7
Employee	3	11,1
<b>Length of time with HIV/AIDS</b>		
< 5 years	17	62,96
≥ 5 years	10	37,03

Source: Primary Data, Questionnaire, 2021

The number of informants involved was nine from three HIV/AIDS communities/networks. The respondents are women living with HIV/AIDS, as many as 27 people. Table 1 shows that most male companions are

5 (55.5%), minimum age – maximum 23 – 43 years, with a high school education level of 6 (66.6%).

Table 2 shows that most respondents aged 35 – 39 years 10 (37%), junior high school education level 10 (37%), with housewife work 16 (59.3%), and duration of infection with HIV/AIDS < 5 years 17 (62.96%).

Table 3 shows that the most emotions experienced by respondents when diagnosed with HIV/AIDS were anger 12 (28.6%), disappointment 7 (16.7%), and sadness 6 (14.3%).

**Table 3.** Respondents' emotions

Emotion	f	%
Annoyed	4	9,5
Disappointed	7	16,7
Shock	3	7,1
Sad	6	14,3
Resigned	2	4,8
Angry	12	28,6
Separated hope	5	11,9
No belief	1	2,4
Afraid	1	2,4
Distracted mind	1	2,4

Source: Primary Data, Questionnaire, 2021

This negative emotion is justified by one triangulation of sources who are 30 years old with the occupation of a housewife:

*"Awalnya terpuruk, kita tahu gitukan didiagnosa itu (HIV) pada saat di rumah sakit, takutnya gak sembuh ya... awalnya syok, kaget, kayaknya gak ada harapan lagi untuk hidup, bakalan meninggal neh."* Primary Data, In-depth Interview (S1, 30 years old, housewife)

*"Initially it was down, we knew that when we were diagnosed (HIV) we were in the hospital, we were afraid it would not heal... at first we were shocked, shocked, there seemed to be no hope of living anymore, we would die anyway."* Primary Data, In-depth Interview (S1, 30 years old, housewife)

Table 4 shows that the distribution frequency of acceptance of HIV/AIDS status in respondents with the components is responsible, opinionated, trusting, aware of limitations, and accepting of humanity. All components are mostly in the good category.

Distribution frequency of acceptance of HIV/AIDS status in respondents using five categories, namely strongly agree, agree, neither agree, disagree, and strongly disagree. Based on the histogram, the data is normally distributed. To assess the acceptance of

**Table 4.** Distribution frequency of acceptance of HIV/AIDS status in respondents

Component	Statements	Catagories (%)				
		Strongly Disagree	Disagree	Neither Agree	Agree	Strongly agree
Opinionated	1. Avoiding people who have a bad influence on my life	25,9	29,6	37	7,4	0
	2. Trying to manage my emotions when I'm angry	0	22,2	51,9	18,5	7,4
Trusting	3. Avoid comparing myself to others to decide if I am a worthy persons	14,8	33,3	40,7	11,1	0
	4. Feel I'm a worthy person even when others don't approve of it	7,4	22,2	51,9	18,5	0
Aware of limitations	5. I feel the same as other people, each of which has advantages and disadvantages	11,1	11,1	51,9	22,2	3,7
	6. Able to take advantage of the advantages that I have to achieve success	7,4	11,1	59,3	22,2	0
Accept humanity	7. Take criticism as an opportunity to improve my behavior	7,4	22,2	40,7	25,9	3,7
	8. Happy if my actions can be useful for others	7,4	25,9	44,4	22,2	0

Source: Primary Data, Questionnaire, 2021

HIV/AIDS status through a companion, the data are categorized into 2, namely well and unwell, with a cut of point of an average value of 3.2.

Table 5 shows that most respondents have acceptance HIV/AIDS status with a good category 25 (92.6%).

**Table 5.** Acceptance of HIV/AIDS status in respondents

Self Acceptance	f	%
Well	25	92,6
Unwell	2	7,4

Source: Primary Data, Questionnaire, 2021

About the strategy, all companions from the 3 HIV/AIDS communities/networks had almost the same information in providing a companion to acceptance of HIV/AIDS status. First, collaborating with service providers is a way to make it easier to companion. Two communities/networks collaborate with hospitals, while a community/networks collaborate with Puskesmas.

*"Kita MoU untuk mempermudah (kerjasama) dengan rumah sakit umum (RSAM), jadi kita tidak sembarangan masuk rumah sakit ... jadi kalo kita gak MoU itu gak enak,*

*jadi kita melakukan MoU, Alhamdulillah kita disambut baik dengan pihak rumah sakit ...."* Primary Data, Indepth Interview (Ak, 43 years old, companion)

*"We have an MoU to make it easier (cooperation) with public hospitals (RSAM), so we don't go to the hospital carelessly ... so if we don't have an MoU it's not good, so we do an MoU, Alhamdulillah we are well received by the hospital .... "* Primary Data, In-depth Interview (Ak, 43 years old, companion)

Second, most of the informants said that after being diagnosed with HIV/AIDS by a doctor, the companion would be contacted to assist, and case findings could also be found when the client was at the VCT clinic, inpatient and outpatient.

*"misal di VCT ada pasien HIV yang baru, habis itu diantar ke kita untuk di dampingi ... rata-rata seminggu itu pasti ada aja kasus baru ... kita bisa dapatkan klien dari rawat jalan di VCT atau kita dapat dari rawat inap, jadi ketahuannya karena dia sakit lalu langsung dirawat setelah itu baru dilakukan tes HIV, lalu ketika hasilnya positif akan kita damping juga ke ruangan, kalau misalnya pasiennya masih (terlihat baik) bisa kita ajak ngobrol, jika*

kondisi pasiennya jelek, kita ngobrol dengan keluarganya ...” Primary Data, In-depth Interview (El, 37 years old, companion)

*“For example, in VCT there are new HIV patients, after that they are brought to us to be accompanied ... on average a week there will be new cases ... we can get clients from outpatients at VCT or we get them from inpatients, so we find out because he was sick and then he was treated immediately after that an HIV test was done, then when the results were positive we would also accompany him to the room, if for example the patient still (looks good) we can talk to, if the patient's condition is bad, we chat with his family ...”* Primary Data, In-depth Interview (El, 37 years old, companion)

Third, all informants said they should introduce themselves as a companion, especially to women living with HIV/AIDS, their families, if possible, and health workers in health services.

*“setelah dari situ selain kita (melayani) di VCT juga ke ruangan, ke ruangan operasi, kita juga harus sosialisasi dengan bidan, dengan dokter kandungan, jadi kita lebih banyak kenal (tenaga kesehatan), jadi mereka hapal...”* Primary Data, In-depth Interview (Ak, 43 years old, companion)

*“After that, apart from us (serving) at the VCT, we also went to the operating room, we also had to socialize with the midwife, with obstetricians, so we knew more (health workers), so they memorized it...”* Primary Data, In-depth Interview (Ak, 43 years old, companion)

Fourth, most informants explored women living with HIV/AIDS problems and their potential. It is conducted as a form of attention, transfer of emotional problems, and self-development capital for women.

*“kasus kasus yang ada itu kebanyakan perempuan sudah hamil, jadi kita temukan dia positif. Dia bilang, mau bagaimana ini anak saya biar dia tidak ketularan? jadi kita beri edukasi tentang PPIA itu seperti apa, nanti kita telusurin sudah berapa bulan? viral load berapa? jadi kaauo misalkan viral loadnya tinggi, tidak bisa saecar oh no tidak bisa normal, tidak bisa menyusui ...”* Primary Data, Indepth Interview (Ak, 43 years old, companion)

*“The cases that exist are mostly women who are already pregnant, so we found him positive. She said, how can this be my child get infected? So we give education about what PPIA is like, how many months have we been tracking? how much viral load? so if you have a high viral load, you*

*can't go anywhere, oh no, you can't be normal, you can't breastfeed ...”* Primary Data, In-depth Interview (Ak, 43 years old, companion)

Fifth, most informants use social media such as what's app groups to communicate with their peer support groups. However, there are also informants holding face-to-face meetings at certain events. In addition, the informants carried out the counselling method, especially when discussing sensitive issues. The informants still maintained the existence of peer groups because it was quite effective in transferring information to women infected with HIV/AIDS.

*“Kalo aku lebih banyak tatap muka, kalau di rumah sakit lebih sering ketemu dengan aku tatap muka dan ngobrol jadikan menanyakan gimana keadaannya sekarang gimana setelah minum obat semalam? kalau misalnya dia belum pernah minum ARV kita arahkan untuk menunggu sampai hasil-hasilnya lab nya, yang sudah keluar (hasil lab) baru bisa untuk pengobatan, tapi kalau misalnya yang sudah pengobatan ARV pasti kita akan menanyakan bagaimana keadaannya setelah minum ARV”* Primary Data, Indepth Interview (Rk, 32 years old, companion)

*“If I'm more face-to-face, if I'm at the hospital more often I meet face-to-face and talk to ask how he's doing now, how about after taking the medicine last night? if for example, he has never taken ARV, we are directed to wait until the lab results are out, the ones that have come out (lab results) can only be used for treatment, but if for example those who have been on ARV treatment we will ask how he is after taking ARVs”* Primary Data, In-depth Interview (Rk, 32 years old, companion)

Sixth, all informants did not give a long time for a companion. As long as a woman living with HIV/AIDS is comfortable being accompanied, she will be in a peer support group.

*“Saat dia tidak mau, memang dia tidak mau, aku yakin dia sudah mampu. Misalkan, aku melihat kondisinya, pertama dia sehat, aku ngerasa dia sudah sehat, sudah mampu, fisik, jasmani dan rohaninya, sepertinya dia tidak perlu aku damping lagi”* Primary Data, Indepth Interview (Ak, 43 years old, companion)

*“When he doesn't want to, he doesn't want to, I'm sure he can do it. For example, I see his condition, first, he is healthy, I feel he is healthy, capable, physically, physically and spiritually, it seems that he doesn't need me to accompany him anymore”* Primary Data, In-depth Interview (Ak, 43 years old, companion)

The companion strategy for women's HIV/AIDS acceptance status is through a women's empowerment approach with the following stages: 1) Cooperation phase; 2) Case finding phase; 3) Introduction stage; 4) Stage of excavating problems and self-potentials; 5) Assistance implementation phase, and 6) Monitoring and evaluation phase. There was a success in receiving HIV/AIDS status in women by 92.6% in the good category through this stage.

The acceptance of HIV/AIDS status that occurs in many women is influenced by the presence of companions with many roles given through a women's empowerment approach, which is a strategy in mentoring. Empowerment is a process of helping disadvantaged groups and individuals to compete more effectively with other interests by helping them to learn and use lobbying, using the media, engaging in political action, understanding how to work the system, and so on.<sup>12</sup> This activity is carried out to improve one's situation and condition by involving the community to participate.

The companion was carried out through several stages in women's empowerment carried out by companion to accept HIV/AIDS status, as follows:

1. Cooperation stage. It is important to collaborate with health services such as hospitals or health centres. This collaboration is carried out to access the same health services as other general patients without stigma and discrimination.
2. Case finding stage. Collaboration between the HIV/AIDS community/network and health services makes it easier to find cases to provide health care support.
3. Introductory stage. Things that need to be introduced are a) Introducing yourself as a companion and offering to be accompanied; b) Introducing the existence of a VCT clinic for consultation related to health problems of people living with HIV and HIV/AIDS-related services in health services; c) Educate people living with HIV related to HIV/AIDS to increase knowledge and provide positive suggestions for mental strength; d) Introducing the existence of peer support groups as a forum for communication between PLHAs.
4. Stage of digging problems and self-potential. Identifying the problems and potentials of PLHAs can be done individually or in groups.
5. Assistance implementation phase. The implementation stage of mentoring is the stage where the role of the mentor is very influential in accepting women's HIV/AIDS status. This stage can be divided into two methods: a) Consultation method, which emphasizes intervention on PLHAs personally based on the sensitivity of the problem; b) Group method

(KDS), which emphasizes intervention on PLHAs in small, medium, or large groups.

6. Monitoring and evaluation stage. The monitoring and evaluation stage assesses whether the PLHAs being assisted are carrying out what is recommended by the companion, such as adherence to taking ARVs, administering the Covid-19 vaccine, improving mental health, and having a healthy lifestyle. At this stage, the facilitator also assesses the level of empowerment ( survival ) of PLHAs.

This study is different from the results of research by Phoenix et al (2014), which revealed six empowerment processes carried out online by peer support groups, are: exchanging information, sharing experiences, interacting with others, dealing with emotional support, finding recognition and understanding, and helping others. The outcomes were identified as increasing optimism, emotional well-being, social well-being, better information, better disease management, and confidence in relationships with doctors. But it also has potential downsides, such as: not being able to connect physically, inappropriate online behaviour, decreased real-life relationships, and information overload and misinformation.<sup>13</sup> It is also different from the research by Nufus, et al (2018) where facilitators with stages carry out the empowerment process for people with HIV/AIDS, are: 1) the intake stage where the facilitator facilitates VCT services to find out positive clients with HIV or not (as a facilitator, as an educator and as an enabler), 2) the assessment stage where the facilitator identifies problems and potential clients (as an enabler and as an expert), 3) the implementation stage where the facilitator helps people with HIV overcome problems on the social dimension (as an enabler, as an educator, as a representative, and as a facilitator), 4) evaluation and termination stage where the facilitator conducts data analysis to see the accuracy of PLHAs in utilizing treatment services and conducts briefings to PLHAs to see how far the results of the interventions that have been carried out (as a facilitator).<sup>10</sup>

The thing that distinguishes these two studies is the empowerment activities with specific targets, namely women living with HIV/AIDS. Where women living with HIV/AIDS experience a double burden, such as mental problems, economy, physical health, access to health services, pregnancy, future children, husband problems, and so on. So the approach taken by the companion is women's empowerment. Women's empowerment can be defined in several ways, including accepting women's perspectives or seeking them and improving women's status through education, awareness, literacy, and training.<sup>14</sup> Several principles define women's empowerment such as, to be empowered, they must come from a position of powerlessness. They must acquire

empowerment themselves rather than being given to them by outsiders. Other studies have found that the definition of empowerment requires people to have the ability to make important decisions in their lives while also being able to act on those decisions. Empowerment and powerlessness are relative to one another at a previous time; thus, empowerment is a process rather than a product. The benefits of implementing women's empowerment, according to Nursalam (2022) can increase knowledge from the good category by 39.9% to 60.2%. The selected cadres showed their awareness of the importance of inviting other HIV/AIDS sufferers to seek treatment at the puskesmas.<sup>15</sup>

In empowering women, it is necessary to pay attention to the selection of appropriate methods and media. The method used by the companion in this research is a personal and group approach. The method chosen depends on the field situation and conditions, such as the character of women, the sensitivity of the problem, stigma and discrimination, the severity of the disease, and the level of acceptance of HIV/AIDS status. While the media used are social platforms. Women's empowerment activities for acceptance of HIV/AIDS status must be carried out continuously so that people with HIV are more empowered, or their dependence will be reduced. It is a success in assisting.

According to Yusuf, et al (2016), individual counselling is a face-to-face relationship between the counsellor and the client, where the counsellor, as someone who has special competence, provides a learning situation to clients who are normal people to be helped in knowing themselves, situations that faced and the future so that clients can use their potential to achieve personal and social happiness and further clients will learn about how to solve problems and meet future needs.<sup>15</sup> The counselling method is used by counsellors when women living with HIV/AIDS come and talk about sensitive things that others do not want to know. In addition, the use of peer support groups can be done online and offline. Online by using what's app group while offline with a meeting at an agreed place. Of these two methods, the most frequently used is online discussion. Discussions that are often discussed are self-acceptance, sincerity, spirituality, adherence to medication, knowledge of HIV/AIDS transmission, clean and healthy living behaviour, and healthy food. However, only women living with HIV/AIDS who have androids can communicate with WAGs. According to Pustikayasa's research (2019), WhatsApp groups have the advantage that it can be used as a learning medium without being limited by space and time. By using WhatsApp groups, educators are expected not only to carry out learning based on the curriculum alone but also to provide encouragement to arouse, stimulate and increase students' learning

motivation so that the objectives of learning can be achieved properly.<sup>16</sup> The advantages of WAG as a stimulus in the acceptance of HIV/AIDS status in women living with HIV/AIDS. WAG is an effective medium for exchanging information, experiences, and complaints among women living with HIV/AIDS, but it becomes an obstacle for those who do not have an android. So the companion makes a home visit to see conditions or holds a meeting related to HIV/AIDS or entertainment activities that can bring women infected with HIV/AIDS to an event. According to Silubun and Abdillah (2022), the social support for a woman living with HIV/AIDS will first, there is emotional support from the closest person willing to listen and understand without prejudice and differentiation. Second, appreciation support that makes the subject feel valuable and feel safe. Third, instrumental support such as subsidizing drug costs. Fourth, information support related to HIV/AIDS. Fifth, peer group support is obtained from fellow people with HIV/AIDS.<sup>18</sup>

Furthermore, peer support occurs when people provide knowledge, experience, emotional, social, or practical help to each other.<sup>17</sup> The existence of peer support is beneficial in accepting HIV/AIDS status in women with the support of a companion of HIV/AIDS. The equality of being infected with HIV/AIDS, refusal to accept status, the problem of living burdens, and being in one community, namely peer groups, makes members mutually reinforce and support each other; this accelerates the acceptance of HIV/AIDS status in women. According to Aini et al. (2021), peer support increases the psychological adaptation of HIV/AIDS patients. The more optimal peer support, the more adaptive the psychological adaptation of the patient (p-value = 0.0005). So it can be concluded that peer support can increase the psychological adaptation of HIV/AIDS patients to be more adaptive.<sup>20</sup>

The companion strategy for women living with HIV/AIDS was in a good category (92.6%) by paying attention to the stages of mentoring, the media and methods used, and the time of mentoring that was carried out continuously. The long time for women to accept their HIV/AIDS status impacts their quality of life. It will impact the success of women's acceptance of HIV/AIDS status. The thing that becomes an obstacle is the double burden experienced by these women. Physical, mental, social, and economic problems, access to health services, pregnancy, children, husband, and place of residence become problems to accepting their HIV/AIDS status.

The term acceptance of status is taken from the term self-acceptance. According to Maslow (1943), self-acceptance is an essential concept in the development of humanistic psychology. Thus, humans must be seen as a whole and should not be divided. Self-acceptance occurs through self-actualization, which is the result of self-

discovery and development. Self-actualization is considered high in a person's hierarchy of needs. In an effort toward self-actualization, a person is required to understand himself.<sup>21</sup>

How well a person understands himself when he is diagnosed with a life-threatening disease impacts therapeutic actions, physical problems, and social and spiritual problems also occur in women infected with HIV/AIDS. The study results on all women diagnosed with HIV/AIDS showed negative emotions such as not believing they were infected with HIV/AIDS, shock, crying, fear, anger at their husbands, despair, and feeling they would die, stressed and hit. The results of this study were strengthened quantitatively where women diagnosed with HIV/AIDS showed emotions such as anger 12 (28.6%), disappointed 7 (16.7%), sad 5 (14.3%), desperate 5 (11.9%), annoyed 4 (9.5%), shock 3 (7.1%), resigned 2 (4.8%), distrusted 1 (2.4%), scared 1 (2.4%) and thought mixed 1 (2.4%).

The emotion that occurs in women living with HIV/AIDS in this study is almost to the results of research by Seffren, (2018) and Rodriguez (2018), where women living with HIV/AIDS hurt their quality of life, as many as 10% experience clinically relevant depression. Even half of HIV/AIDS women do not behave at risk of depression before giving birth, and a third experience depression after giving birth.<sup>5,9</sup> The result of the emotional process is self-acceptance, where self-acceptance is a catalyst for alleviating negative emotions and a stimulus that supports the quality of life of women infected with HIV/AIDS. Acceptance of HIV/AIDS status that has not been good is a natural response when a woman is diagnosed with HIV/AIDS by health workers or counsellors. Even with risky behaviour, not a single woman received a diagnosis of a chronic disease such as HIV/AIDS. However, it becomes unnatural if the acceptance of HIV/AIDS status that has not been good continues for a long time in the lives of women living with HIV/AIDS because it impacts the quality of life in the future. Efforts are needed to get women infected with HIV/AIDS out of the cycle of depression to accept the reality of living with HIV/AIDS immediately.

The nature of positive and negative actualization is influenced by the individual who will intervene in this case, PLHAs, and the person who will intervene in this case is the companion. The facilitator has a role in accepting HIV/AIDS status because the facilitator can meet the needs and assist in solving the problems of women infected with HIV/AIDS. So that there is good interaction between the facilitator and women infected with HIV/AIDS. It is important to have a positive companion in attitude and behaviour so that the acceptance of HIV/AIDS status can be adequately achieved.

The results showed acceptance of HIV/AIDS status in the good category by 92.6%, while the poor category was only 7.4% in many women infected with HIV/AIDS. In the results of this study, the most dominant factor was not tested, but the acceptance of HIV/AIDS status occurred as long as women infected with HIV/AIDS were in assistance from the HIV/AIDS community/network. According to Ifeanyichukwu Anthony Ogueji (2021), experiences and predictors of psychological distress in pregnant women living with HIV are depressive reports, loneliness, regrets, self-blame and guilt feelings, as the experiences of psychological distress, and respondents' socio-cultural contexts determined these experiences.<sup>22</sup>

According Amie Koch, et al (2022), the six themes related to resilience and coping: are self-acceptance, disclosure, self-compassion, social support, will to live, and service. Social support was a driving protective element and an essential component to building and sustaining resilience and coping. Women who experienced positive support often expressed a will to live and a desire to support other WLWH. Resilience and social support were characterized by patterns of reciprocity, in that they were mutually sustaining, stabilizing, and strengthening.<sup>23</sup>

The acceptance of HIV/AIDS status in women in the good category, indicated by positive actualization, such as being seen as surviving, being more independent, having no complaints, not feeling anxious, no longer feeling inferior to taking ARV to VCT clinics and looking to enjoy life more. Whilst the acceptance of the status of HIV/AIDS in women in the category is not good, indicated by negative actualization, such as not believing in the diagnosis of HIV/AIDS, physically and mentally depressed, much complaining, not being involved in activities organized by the facilitator.

Many variables influence self-acceptance. According to Bury (1988), self-acceptance occurs when a person is diagnosed with a chronic disease that significantly affects the way that person views his life, himself, and his future. It is related to the consequences of the disease and the significance of the disease, and the long-term meaning of one's life for the disease.<sup>24</sup>

Uncertainty about the length of HIV/AIDS status is influenced by the presence or absence of risky behaviour in women, the condition of children with HIV/AIDS, physical conditions, opportunistic infectious diseases, psychological conditions, pregnancy conditions, women's character and HIV/AIDS status of husbands/partners and the experience of companions in assisting women with HIV/AIDS. It also affects the speed of acceptance of status. In addition, the study results show that all facilitators have not been able to determine the standard



length of time for receiving HIV/AIDS status for women from being diagnosed to being assisted by the HIV/AIDS community/network. The time range stated is one day to 12 months.

According to Elisabet Kubler - Ross (2009), the uncertainty of the length of time that one woman receives HIV/AIDS status from one woman to another is influenced by one of the women themselves. Before reaching the stage of self-acceptance, individuals will go through several stages, including the stages of denial, anger, bargaining, depression, and acceptance.<sup>22</sup>

Almost to Stanton, Revenson, & Tennen (2007), psychological adjustment to chronic disease can be influenced by many factors, such as disease severity, functional impairment, level of self-management, disease prognosis, and even the level of symptoms experienced, and it should be noted that there are levels of high heterogeneity among individuals with the chronic disease along these dimensions as well as within adjustment.<sup>14</sup>

Acceptance of HIV/AIDS status is a psychological problem faced by almost all women. If this problem is resolved, it will positively impact physical, mental, social, and economic health. HIV/AIDS facilitators carry out the concept of empowerment to return women to everyday lives before being diagnosed with HIV/AIDS. There needs to be good cooperation between the facilitators as implementers of empowerment or facilitators and the participation of women infected with HIV/AIDS as targets in empowerment.

## CONCLUSION

The success of receiving HIV/AIDS status in women with a companion role is 92.6% in the good category. The strategy carried out by the facilitator for accepting HIV-AIDS status with an approach to empowering women went through several stages, namely: 1) Cooperation stage, 2) Case finding stage, 3) Introduction stage, 4) Problem exploration and self-potential stage, 5) Assistance implementation stage, 6) Monitoring and evaluation stage. The method used is counselling and peer support groups, while the media used is by utilizing social platforms, such as WhatsApp groups. So that the length of time for receiving HIV/AIDS status is faster, the companion needs to get self-acceptance therapy training for women infected with HIV/AIDS to empower women.

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