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Community Health Worker-Based Empowerment Against Stigmatization of People Living with HIV/AIDS: A Meta-Synthesis

Ernawati [1,4], Nursalam [2], Shrimarti Rukmini Devy [3]

Doctoral Nursing Student, Faculty of Nursing, Universitas Airlangga, Surabaya Indonesia.
[2]Corresponding Author, Faculty of Nursing, Universitas Airlangga, Surabaya Indonesia, Kampus C Mulyorejo, Surabaya, East Java 60115, Indonesia,
[3]Faculty of Public Health, Universitas Airlangga, Surabaya Indonesia,
[4]Faculty of Nursing and Health Sciences, Universitas Muhammadiyah Semarang, Indonesia,

Corresponding Author: nursalam@fkp.unair.ac.id

ABSTRACT

This study seeks to investigate the relationship between the impact of multidimensional and complex stigma problems on women's groups, especially those with low social status and the role of cadres through the empowerment model of community-based HIV/AIDS cadres. By using a systematic review study design, with an in-depth analysis of keywords of empowerment from respected sources and bibliometrics in the health field, the results of this study can be used as a framework for the development of science, especially community nursing. The results show that the role of cadres for HIV-positive people is needed because of the need for women's groups to get support from groups and the environment to express feelings of pressure, facilitate the safe disclosure of HIV status, build networks of friendship, socialize and provide emotional support so that they become empowered, respectful self and enhance emotional and physical life. The practical implication is a credible empirical explanation of the empowerment model of HIV/AIDS cadres on the stigma and quality of life of women with HIV/AIDS. The theoretical contribution of this study is the effort to develop application theory that can be directly applied in care to the community by integrating the health empowerment intervention theory and the community as partner model.

Keywords: CHW, PLWHA, cadre empowerment, stigma, quality of life, systematic review.

Correspondence:
Nursalam
Corresponding Author, Faculty of Nursing, Universitas Airlangga, Surabaya Indonesia, Kampus C Mulyorejo, Surabaya, East Java 60115, Indonesia.
Email: nursalam@fkp.unair.ac.id

INTRODUCTION

The complexity of the problem of stigma becomes an obstacle for people with HIV/AIDS (PLWHA) accessing health services. HIV stigma has a very detrimental effect on sufferers and society. Absorption of HIV testing services is lower and transmission rates are higher (Golub & Gamarel, 2013), high-risk groups avoid health services (Kemppainen, MacKain, Alexander, Reid, & Jackson, 2017; Sidibé, 2018; Steward, Koester, & Fuller, 2018) even more than half of women in Latin America and China convey this as a major obstacle (Doskoch, 2015). Most PLHIV (40-51%) in seven Asian countries including Indonesia are late getting HIV treatment (Koirala et al., 2017) and PLWHA often faces psychological challenges, fear of physical decline, and deteriorating quality of life (Han et al., 2018). Stigma is significantly correlated with psychological variables, social support, and quality of life (Rasoolinajad et al., 2018).

Quality of life of PLWHA is felt to be worse in women, younger age, living in rural environments, newly diagnosed with HIV positive, not taking ART, and experiencing many experiences related to stigma (Nyamathi et al., 2017). They experience psychosocial problems, demands for social and financial support (Lindayani, Chen, Wang, & Ko, 2018). Low social support is one predictor of poor quality of life (Nyamathi et al., 2017). Efforts to handle and reduce stigma determine the conditions of his quality of life (Chidrawi, Greeff, Temane, & Ellis, 2015). Data shows that 77.7% of HIV women in 27 countries experience community stigma, regardless of the condition of the severity of the illness. Stigmatization of

PLWHA in Indonesia is still widespread (Chew & Cheong, 2012; Waluyo, Culbert, Levy, & Norr, 2015).

Men and women living with HIV experience stigma. However, women are more susceptible to stigma (Darlington & Hutson, 2017). Women bear the 'triple joepardy' impact of HIV/AIDS, namely as people infected with HIV, as mothers of children and as caregivers for spouses, parents or orphans with AIDS. The risk is very high to live a painful and shameful life, even millions of people are stigmatized and rejected by their families, friends and partners (Paudel & Baral, 2015). Women face higher discrimination from society simply because they are women (Paudel & Baral, 2015). Gender inequality and poverty have increased women's vulnerability to HIV risk behavior and exposure. Demographic factors of women have a high prevalence of stigma, and even more so if the status of separation/divorce/widow (Paudel & Baral, 2015). In this context, this study seeks to investigate the relationship between the impact of multidimensional and complex stigma problems on women's groups, especially those with low social status and the role of cadres through the empowerment model of community-based HIV/AIDS cadres. The role of cadres for HIV-positive women is needed because of the need for women's groups to get support from groups and the environment to express feelings of distress, facilitate the safe disclosure of HIV status, build networks of friendship, socialize and provide emotional support so that they become empowered, respect themselves and improve emotional and physical life (Paudel & Baral, 2015). By using a systematic review study design, with in-depth

analysis of key words of empowerment from respected sources and bibliometrics in the health field, the results of this study can be used as a framework for the development of science, especially community nursing. The practical implication is a credible empirical explanation of the empowerment model of HIV/AIDS cadres on the stigma and quality of life of women with HIV/AIDS. The theoretical contribution of this study is the effort to develop application theory that can be directly applied in care to the community by integrating the health empowerment intervention theory and the community as partner model.

Literature Review

The Role of Nurses in Psychosocial Support in Patients

In the context of community empowerment, nurses build effective partnerships through community participation. If nurses do not develop a right relationship with the community, then the potential members of the community cannot be maximally empowered. Transformation occurs when the right relationship between one or more levels of the human and nurse system as an agent of moral change promotes concern without judgment (Anderson & McFarlane, 2010).

Nurses play an important role in the process of facilitating the right relationships to help the community, family, and individuals. Correct relationships are defined as all organizational patterns in systems that support, encourage, enable, or produce transcendence and self-actualization. Multidimensional support which includes, emotional support (attention, empathy, trust, caring, and listening); award support (affirmation, feedback, and social comparison); informative support (advice, direction, advice, and information); instrumental support (assistance in the form of goods, money, labor, time, transportation and the environment). Nurses' social support can facilitate abilities, overcome and improve active coping strategies to help individual cadres adjust to life changes (Li, Chen, Chang, Chou, & Chen, 2015).

The ability to participate consciously in change, characterizes the ongoing process between humans and their environment. There are four dimensions of power building (making empowerment/empowerment) that cannot be separated according to Barrett (1986), namely awareness, choice, freedom to act intentionally, involvement in creating change (Ann and Barrett, 2010).

Power as knowing participation in change is to realize what you choose to do, feel free to do it, and do it intentionally. The integral nature of the manifestation of 'power' is awareness and freedom to make choices to act consciously directing participation in choices and involvement creating changes that encourage health. People consciously participate in creating reality by actualizing some of their potentials than others, participating in creating change as a manifestation of their experience by being aware, making choices, feeling free to act according to their intentions and engaging themselves. Health workers are role models for the community to convey concepts and ideas related to health. His attitude and behavior as a figure of community members in treating PLWHA without stereotypes and discriminatory attitudes. Health workers are responsible for promoting positive attitudes towards people living with HIV. Intensive training is needed in order to hone sensitivity to the needs of care and treatment of quality PLWHA without discrimination (Paudel & Baral, 2015). Strengthening the empowerment program needs to be harmonized in 3 priority areas including coordination, integration, and program sustainability. Recognition of cadre training programs, incentives and training processes, proposed existence of organizational structures, involvement of community leaders in decision making (De Neve, Boudreaux, et al., 2017).

HIV/AIDS cadres

The term cadre (in English 'cadre') was previously known as community social worker. Social workers are defined internationally as 'social work professions that promote social change, problem solving in empowerment relationships and the freedom of people to improve welfare. Hare (2004) said that social workers intervene in the points where people interact with their environment. The basic principle of social work is to fight for human rights and social justice '(van Dop, Depauw, & Driessens, 2016).

WHO (2015) termed "Community Health Workers" (CHW) people who were selected, trained and worked in their communities to help overcome public health problems. Community health workers must be members of the community where they work, be elected by the community, be responsible to the community for their activities, be supported by the health system but do not have to be part of the organization, and have short training compared to professional staff. Views in various countries, CHW has many different terms. More than 36 terms including cadres or lay health workers now exist to provide services for people living with HIV/AIDS (PLWHA).

The directorate of community development at the Ministry of Health defines cadres as members of the local community chosen from and by the community, working voluntarily. A cadre is a group of people or organizations that have the same goals and functions. This HIV/AIDS cadre will later become a motivator and source of learning for the community to recognize and care in handling and managing HIV/AIDS cases. CHW are community members who receive basic training in disease prevention, care and care to carry out certain types of health services but they do not formally qualify as health care professionals (Mundeva, Snyder, Ngilangwa, & Kaida, 2018).

CHW is defined as a health worker performing functions related to the delivery of health services; have been trained in several ways of intervention; and do not have formal certificates or professional or paraprofessional degrees in tertiary education (Mwai et al., 2013). Community health workers (Community Health Workers/CHW) are the main support group for primary health care recruited from and for civil society (Mottiar & Lodge, 2018). Cadres come from various groups of people with different backgrounds. Based on the process and the background of its formation, cadres are categorized into two namely mechanical cadres and organic cadres. Mechanical cadres have a formal relationship, economic orientation and are impermanent, take into account the use value (utilitarian), more based on rationality (rational will), and contractually formed. Meanwhile, organic cadres have a relationship that is based on closeness, a desire to increase togetherness (collectivity) to give birth to solidarity, always uphold the shared values, there is a strong inner bond with community members, relationships are informal, and are formed based on spontaneous emotions and natural (natural will). Organic

cadres are more independent, for example in terms of funding carried out collectively on the basis of mutual care and help so that it has the potential for program sustainability (Winarso I, 2019).

Support group element for PLHA

Support group elements for PLHALiterature revealed that there are main support group elements for PLWHA, including people living cloce to them/PLC, local community leaders, community groups, health workers in the community, and peer support groups.

Close family members, partners, children, close friends, spiritual leaders and community members including people close to PLWHA (French, Greeff, Watson, & Doak, 2015). Acceptance of family members can influence attitude changes among relatives, in their environment and later in the community. PLWHA families must be supported and given sufficient information about caring for their relatives who are HIV positive, how to reduce stigma in the household and support their psychology (Angula & Ncama, 2016). Spiritual leaders (religious leaders/traditional healers). Spiritual leaders play a role in reducing HIV stigma (Kruger, Greeff, & Letšosa, 2018). They encourage PLWHA not to be discouraged, treat well (French et al., 2015), foster acceptance and empathy for PLWHA, awareness of their own ignorance, moreover awareness of the presence of God and the awareness that they can inspire the hopes of PLHIV (Kruger et al., 2018). As community members, those who understand vulnerability to HIV, are motivated to act, have practical knowledge and act using personal and social contextual resources.

Local community leaders refer to influential people such as community leaders able to influence other community members to change the attitudes and behavior of people towards PLHA (Angula & Ncama, 2016), mobilize the community about the stigma, causes and effects in life and increase epidemics (Angula & Ncama, 2016), and reduce the level of loss to follow-up (Mutagoma et al., 2018).

For community groups, support from community groups extracted threats to the identity and well-being of PLWHA due to being stigmatized by the social environment (Nhamo-Murire, Campbell, & Gregson, 2014). Communities and social workers advocate in non-governmental organizations to support strategies for reducing risk of sexual risk (Shaw, Saifi, Lim, Saifuddeen, & Kamarulzaman, 2017).

Furthermore, health care workers have an important role in reducing stigma as service providers such as providing counseling, treating sick PLHIV and their families (Angula & Ncama, 2016; Sari & Parut, 2018). Health workers must be given the necessary support in the form of training, skills development and resources to enable them to carry out their duties successfully (Angula & Ncama, 2016).

Finally, peer support groups are groups that have grown up from and by PLWHA that aim to improve the quality of life of PLWHA, are empowered and free from stigma and discrimination, provide a place for sharing information, mutual support and motivation. The existence of CHW is more on the function of mentoring and sharing experiences with fellow sick friends, they are accepted by PLWHA without fear and suspicion (Kartono, 2019). Having treatment friends decreases perceived stigma scores, peer adherence support interventions also have a positive effect on having treatment friends (Masquillier, Wouters, Mortelmans, & le Roux Booysen, 2015). WHO and The US President's Emergency Plan for AIDS relief (PEPFAR) promote peer support groups facilitated by PLHIV trained to deal with the specific needs of fellow PLWHA and their partners (Bateganya, Amanyeiwe, Roxo, & Dong, 2015) PLHIV are motivated and trained as agents of change through testimonials to convince members society to reduce or stop stigma (Angula & Ncama, 2016).

Method

This study was conducted with a systematic review method with certain keywords that included some literature relating to the empowerment of HIV/AIDS cadres, stigma reduction interventions and quality of life for HIV/AIDS sufferers. Search strategies using English-language studies that are relevant to the topics in the Scopus, ProQuest, CINAHL, MEDLINE, Science Direct, Pubmed and Google Scholar databases are limited from January 2013 to May 2019. Keywords used are Cadre, Community empowerment, Community Health Workers, Lay health workers, Social workers, Community participation, Interventions to reduce HIV/AIDS stigma, Women living with HIV/AIDS.

Result

(Angula & Ncama, 2016) examined PLWHA, their families and community members in rural Namibian communities and found that strategies to reduce HIV stigma were carried out through education, community involvement and contacts with groups of people infected and affected by HIV/AIDS. Quasi-experimental non-equivalent control groups before and after intervention design Influential people such as community leaders are able to change people's attitudes and behavior towards PLHIV. The findings show that there is a significant difference in stigma reduction between the intervention group and the control group. A combination of strategies will be more effective than a single approach.

(French et al., 2015) tested 18 people living with HIV (PLWH) (n=10 urban, n=8 rural) and 6 groups (n=60) people living close (PLC) consisting of:-Partners (n=3)-Children (n=11)-close family members (n=7)-close friends (n=8)-spiritual leader (n=16)-community members (n=15). Holistic multiple case study design is used to describe the implementation of meaningful interventions. The case study method is used to collect data during an intervention. The basic principle of the workshop was conducted by sharing information about HIV stigma and overcoming it and balancing the relationship between PLWH and PLC through increased interaction and contact and empowering participants to become leaders in reducing HIV stigma through practical knowledge and implementation programs in their communities. The findings show that all groups want to get out and work to change the community. Community intervention in stigma reduction and comprehensive health improvement succeeded in reducing PLWH stigma and changing the attitude of PLC. The involvement of groups of people who are not infected and PLWH as facilitators, they become a positive relationship model of PLWH and PLC.

In a study in Zimbabwe, Busza et al. (2018) investigated 19 Community Health Workers (CHW) with a longitudinal qualitative design (3 x during implementation) to analyze the role of nurses in expressing motivation, commitment, and strong job satisfaction. The results of the study show that interventions are acceptable and deserve to be delivered

and the level of satisfaction increases. Long-term satisfaction is connected with supervision and intensive assistance, providing work aids, standard manuals and refresher training, formal links between CHW and clinics. On the other hand, the level of concern is associated with poor remuneration, stopping providing support, program sustainability, intensive supervision and integration with difficult clinical services. Taking 14,222 respondents in (Mutagoma et al., 2018) analyzed the relationship of HIV-positive people with HIV treatment programs in health facilities through 5-day training for CHW and local leaders with a longitudinal prospective cohort survey design. The results noted that participant retention was very high after 12 months. (De Neve, Garrison-Desany, et al., 2017) also tested the harmonization of CHW programs and HIV services led by CHW in low-and middle-income settings through a literature review. Test results reveal that harmonization priorities include coordination among stakeholders, integration into the wider health system, guaranteeing the sustainability of the CHW program. Furthermore, (Geldsetzer, De Neve, Boudreaux, Bärnighausen, & Bossert, 2017) through a qualitative study on 54 CHW and 15 CHW cadre program managers rural health motivators, mothers-to-mothers (M2M) mentors, HIV expert clients, and a community outreach team stated 4 changes to improve CHW performance through financial compensation , availability of equipment and consumables, additional training and expansion of responsibilities to cover a variety of community health needs. In the context of motivation, CHW supervision also needs to involve opportunities for career advancement to improve CHW performance.

(Lindayani et al., 2018) examined 215 PLWHA in referral hospitals and AIDS NGOs in Indonesia with a focus on HIV-related problems, demands for palliative care at different stages of the disease, and quality of life (QoL) through cross-sectional studies. The results show that the spiritual and financial aspects of demand are higher in PLHIV with stage IV HIV with a mean age of 33.5 years (SD 0.47) and 66% of them are men. The most common symptoms demonstrated from this study were fatigue (67%), problems with sleep symptoms (54.9%). The study also revealed a negative relationship between QoL and psychosocial problems, and demands for social and financial support.

Furthermore, by taking the basis of community leaders and their interactions with PLWHA, (Kruger et al., 2018) through a qualitative description, obtained 3 main themes covering interactions with PLWHA, which are new experiences for spiritual leaders, raising awareness about the difficulties of living with HIV, disclosure and stigma, reducing HIV stigma. Through a qualitative study design, Lohiniva et al. 2016 took 30 skilled and uneducated men and women in Egypt and found that a strong stigma against PLWHA was related to fear of transmission and moral judgment. This is manifested by the reluctance to use health facilities, and like PLWHA women have more moral judgment on PLWHA than men. In a cultural context, there is a strong stigma that women are expected to distance themselves from behaviors deemed "socially inappropriate" such as illegal sex. (Prinsloo & Greeff, 2016) tested about 1440 community members without differences in HIV status in South Africa. Through a holistic single-case design and with 5-month interventions, the results succeeded in activating activators to initiate change, reducing stigma experiences for PLWHA, and discussing HIV stigma throughout the community using a combination of strategies including individual, interpersonal, social networking, and public levels.

In relation to the psychosocial aspects of PLWHA, (Ojikutu et al., 2016) stated that 45% of women living with HIV recognized the community's perceived HIV stigma (community belief that HIV infection among women was associated with sex work and multiple sexual partners), 42.9% recognized perceived community gender norms (norm beliefs traditional gender norms such as adherence to husband/sexual partner) 67% reveal HIV status to sex partners.

(Kawakatsu et al., 2015) found that CHW performance was measured by three indicators including the level of reporting, health knowledge and household coverage. Factors that significantly influence CHW performance are marital status, education level, household size, work experience, personal sanitation practices, the amount of supervision received and the interaction between the health knowledge of supervisors and the amount of supervision (Azza, Setyowati, & Fauziah, 2015). (Kane et al., 2016) state that the inhibiting factors that affect CHW's global performance are related to frustration by a lack of sense/lack of control over the work environment, and feelings of being unsupported, and not valued. (Pallas et al., 2013) identified 23 enabling factors and 15 barriers to improving and sustainability of CHW in low and middle income countries (LMICs)..

Furthermore, (Cooper, Clatworthy, Harding, Whetham, & Consortium, 2017) reviewed fulfilling the inclusion, health related quality of life (HRQoL) criteria covering at least 3 domains of quality of life, including physical function, social function/role and mental/emotional function. (Mottiar & Lodge, 2018) states that the motivation and commitment of volunteers/altruism, the provision of benefits supports mobilization, contracts and salaries 'service providers are related to the sustainability of voluntary programs of high dedication. (Mundeva et al., 2018) state that substantive and ethical challenges that impact on the provision of CHW services in the context of low and middle income include inadequate training, supervision and compensation.

(Mburu et al., 2013) examined the extent to which the success of interactions or collective resilience of PLWHA and open interactions between PLWHA and community members decreased the perceived stigma of finding that although HIV stigma in the community generally declined over time, the role of groups did not always have a positive impact on stigma, especially at the beginning of interaction out of fear and thinking when others see them with PLWHA labeled as having HIV. (Wu et al., 2015) states that perceived stigma and social support correlate with QoL of PLWHA. (Nyamathi et al., 2017) found a low social role and source of support obtained from the number of close friends or family, where 57% of PLWHA reported having no friends or family they could trust. (Han et al., 2018) found that CHW interventions had no effect on social support in 2 of 4 studies, and stigma in 3 of 4 studies. No CHW intervention has been successful in reducing depressive symptoms of PLWHA. (Mohajer & Singh, 2018) found 3 constructs that enable public health workers to change behavior in the community including the call to serve motivated altruistic values, mentoring and empowering communities. (Bhatta & Liabsuetrakul, 2016) found that the mean value of empowerment, social support and quality of life increased and the stigma score

decreased in the intervention group at 3- and 6 months and the effect of the intervention on social support, stigma and quality of life increased significantly. Effective empowerment interventions to improve the quality of life of PLHA (Azza, 2010; Ibrahim, Mardiah, & Priambodo, 2014). Through a systematic review, (Bateganya et al., 2015) reported that support groups were associated with decreased mortality and morbidity, increased retention in care, and improved quality of life.

(Paudel & Baral, 2015) through systematic literature found 5 themes about the role of groups in coping strategies for women living with HIV including disclosure as sensitive issues, stigma and discrimination related to HIV/AIDS and multidimensional effects on women's health and well-being, stigma internalized, women's experiences with HIV/AIDS is rejected, shunned, treated differently by doctors, family and close friends, and group support is the best intervention for stigma and discrimination.

The Role of Cadres as Support Groups for PLHA: Specific Implications

The cadre position in the community social work group is at the lowest level. The role of social worker practitioners in society as an important matter is central to the mission of social work. Distinctive features of the community to be realized are social justice, promoting and improving social and economic development (Lee, 2001). Cadres' motivation and commitment were initially volunteers/unpaid volunteers or altruism motivation (van Dop et al., 2016). Concern, power and hope are very important for individuals (social workers and clients) in building a community. In Indonesia, in accordance with Regulation of the Minister of Health No. 21 of 2013 concerning HIV and AIDS prevention, it is mentioned in article 51 paragraph (1) that the community participates in efforts to combat HIV and AIDS by promoting healthy behavior; increase family resilience; prevent stigma and discrimination against people infected with HIV and families; establish and develop AIDS care citizens; and encourage community members who have the potential to carry out risky HIV infections to go to voluntary counseling and testing services.

The role of these nurses needs to be broadly supported by communities that are said to be competent with regard to HIV marked by opportunities for dialogue about HIV/AIDS (Nhamo-Murire et al., 2014), ideally leading to sharing knowledge related to HIV; critical thinking about barriers to behavior change that improves health and discussion of local strategies that enable to overcome problems; a sense of local ownership and responsibility to contribute to the fight against HIV/AIDS, not just passively relying on government and NGOs; identify individual and group strengths for this challenge; social capital ties, establish a sense of solidarity and shared goals in relation to HIV/AIDS prevention; bridging social capital, building relationships with external support groups in the public, private and NGO sectors.

Theoretically, the specifications of the findings from several previous studies that convey the role and function of social workers or cadres in the HIV/AIDS program are that supporters of PLHA (counseling, opportunity-based care for dialogue about home, education, adherence support and support for getting a job) and support health services (Selection, referral to health service and supervision organizations) (Mwai et al., 2013). Community-based nurses also need to actively monitor the delivery of therapy directly; TB screening and nutrition, providing information about side effects and opportunistic infections, social support and friendship (Rich, Lipson, Libersky, & Parchman, 2012). In the context of HIV counseling and testing, it includes adherence counseling; referral for ART; TB screening; facilitate income generating opportunities; PMTCT referral for HIV positive mothers (Zachariah et al., 2006).

Home visits are needed to ensure the availability of ARVs, monitor medication adherence, condom distribution, education about HIV prevention (Kipp et al., 2012). Individual care which includes food preparation, household chores, drug administration, assessment of inventory requirements on the other hand is useful for increasing income income; behavior change communication; HIV education and counseling (Johnson et al., 2015). As an inherent part of the nature of community-based nurses, relationship with the community is one of the basic prerequisites. In this context, community-based nurses need to actively motivate people to be aware of the need for access to HIV testing and care; promotion to the community in the surrounding environment to access health services, conduct care referrals and strengthen PLHIV compliance strategies (Besada et al., 2018). It also includes conducting pre-treatment counseling "care readiness classes" for routine preparation of patients in daily treatment as well as for introducing the side effects of antiretroviral drugs, ensuring basic patient needs are met such as adequate eating, ensuring patients remain in medical care, providing health education in the clinic or door to door (van Dop et al., 2016).

This shows that community-based nurses play a role in providing interventions as counselors and supporters, educators or navigators (Han et al., 2018) and are important intermediaries between community members and the formal health service sector; offering a variety of HIV testing, counseling and referral services; increase public knowledge about HIV/AIDS and how it is transmitted; it also plays an important role in reducing HIV-related stigma (Mundeva et al., 2018).

In an effort to reduce the stigma of HIV/AIDS, the role of cadres as a support group specifically with PLWHA by providing opportunities to practice disclosure, empower women to respect themselves, facilitate coping/problem solving strategies, improve friendship networks so as to reduce isolation and shame, bring women to places and situations in togetherness, the most important psychological interventions for women living with HIV/AIDS, provide anticipatory guidance that has the potential to reduce fear (Paudel & Baral, 2015). Following training to be able to provide counseling, psychosocial support and peer support to their colleagues (Besada et al., 2018). The role of cadres as PLHA support groups also includes the protection of PLHIV rights and public access and social advocacy by providing patient counseling, referring them to social services and advocating for their broader rights (Cobbing, Chetty, Hanass-Hancock, & Myezwa, 2017). Specifically, (Prinsloo & Greeff, 2016) suggests a number of activities to reduce stigma such as HIV stigma workshops, stigma coping workshops, door-to-door education, support groups, community projects such as home visits to PLWHA, feeding projects in PLHIV clinics. (Kawakatsu et al., 2015) stated that the main interventions in maintaining CHW performance were high quality routine supervision and improvement in the quality of CHW education.

Conclusions

A systematic literature analysis of the stigma of PLWHA and the role of CHW reveals that the role of cadres for HIV-positive people is needed because of the need for women's groups to get support from groups and the environment to express feelings of distress, facilitate the safe disclosure of HIV status, build networks of friends, socialize and provide emotional support so that they become empowered, respect themselves and improve their emotional and physical life. This is based on the development of anti-stigma interventions in a value-based focused society by linking social norms, gender and ethical considerations.

The success of stigma reduction in PLWHA is related to the involvement of CHW and local leaders by strengthening capacity, motivation and intensive tracking mechanisms. Several remedial steps related to health problems, interventions, stakeholders, health systems and broad context. In the context of CHW, their performance is supported by psychosocial encouragement and resources to meet the expectations of the community, meet their non-health needs, fulfill the expectations that give tasks and provide health services. This dichotomy of needs between the community and health services can be resolved if policy makers and program designers accommodate community-based cadres. The integration of CHW into the health system impacts the quality of care, supports promotion and empowerment. Here, effective program design and management is needed including adequate training, supervision, motivation and funding. Acceptance of programs in the communities served, including support for programs from political leaders and other health service providers. Practically, this can be used in determining the criteria for selecting a new CHW which includes good educational status, availability of supporters for domestic work and good sanitation practices. which includes program design and management, community suitability, and integration with the wider environment.

Based on the results of studies on previous studies, there is still little research that evaluates the impact of HIV/AIDS cadre empowerment interventions to reduce perceived stigma and improve the quality of life of women with HIV/AIDS and there is no development of conceptual frameworks. The next study is expected to be able to model the empowerment of HIV/AIDS cadres from cadre factors (personal and social contextual), nurse support and community line of resistance for HIV/AIDS cadres. HIV/AIDS cadre elements can combine local leaders, spiritual leaders/young cadres of religious organizations and people close to the event.

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