

Layered Stigma Among Health Facility & Social Services Staff

Toward Most-at-Risk
Populations in Jamaica

April 2012



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Contents

Acknowledgments.....	iv
Acronyms.....	v
Executive Summary.....	1
Components One and Two: Health Facility and Social Services Workers.....	2
Component Three: Sex Workers Reports of S&D.....	4
Conclusions and Recommendations.....	5
Background.....	7
Introduction.....	8
Methods.....	10
Study Locations.....	10
Instruments.....	10
Sampling.....	11
Data Collection Methods.....	13
Data Entry and Analysis.....	14
Ethics and Consent.....	14
Study Limitations.....	14
Findings.....	17
Components One and Two: Health Facility and Social Services Workers.....	17
Participant Demographics.....	17
Organization Types.....	18
Participant’s Organizational Role.....	18
Training Exposure.....	19
S&D: Fear/Avoidance of Casual Contact with PLHIV, MSM, and SW.....	21
Shame, Blame, Judgment.....	27
Enacted Stigma.....	30
Other S&D Measures.....	32
Vignette Findings.....	32
Component Three: Sex Workers.....	38
Demographics.....	38
Stigma and Discrimination.....	39
Disclosure.....	40
Experience with Health Services within the Last Six Months.....	40
Experiences of SW in Ever Seeking Care.....	41
Use of HIV–Prevention Services and Medical Care.....	43
Discussion.....	46
Components One and Two: Health Facilities and Social Services Organizations.....	46
Component Three: Sex Workers.....	48
Conclusions and Recommendations.....	49
Conclusions.....	49
Recommendations.....	51
References.....	53
Annex 1: Health Facility Survey.....	56
Annex 2: Social Services Survey.....	69
Annex 3: Sex Worker Survey.....	82

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Acronyms

AIDS	Acquired Immune Deficiency Syndrome
CBO	Community-based organization
FHI 360	Family Health International 360
FSW	Female Sex Worker
HIV	Human Immunodeficiency Virus
JASL	Jamaica AIDS Support for Life
J-FLAG	Jamaica Forum for Lesbians, All Sexuals, and Gays
KAPB	Knowledge, attitudes, practices, and behavior
MARPs	Most-at-risk populations
MOH	Ministry of Health
MSM	Men who have sex with men
MSW	Male sex worker
NHP	Jamaica National HIV/STI Program
PLHIV	Person living with HIV
RDS	Respondent-driven sampling
SBCC	Social and behavior change communication
S&D	Stigma and discrimination
SPSS	Statistical Package for the Social Sciences
STI	Sexually transmitted infection
SW	Sex worker
UDC	Urban Development Corporation
UNAIDS	The Joint United Nations Program on HIV and AIDS
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing

Executive Summary

FHI 360's Communication for Change (C-Change) project, funded by USAID/PEPFAR, in Jamaica provides technical assistance in social and behavior change communication (SBCC) to improve the quality and scale of Jamaica's response to the HIV and AIDS epidemic. In keeping with its mandate of supporting civil society and government partners in developing evidence-based programming and in working to create supportive enabling environments for most-at-risk populations (MARPs), C-Change conducted a study in 2011 on stigma and discrimination (S&D) within health and social services settings toward persons living with HIV (PLHIV), men who have sex with men (MSM), and sex workers (SW).

S&D occurs when someone is devalued as a result of practices, behaviors, diseases or other characteristics with which they are associated (International Center for Research on Women 2012). MSM and SW are among the most heavily stigmatized groups due to their own unique identifications and the socio-cultural hostilities and fears associated with them. The resulting S&D creates an environment that is intimidating and that increases vulnerabilities for infection, abuse, and death among these groups as they relate to accessing crucial prevention and treatment information and services, quality of services received, and treatment, among others. S&D norms within health services often mirror and mutually reinforce wider social norms. Within health care settings, S&D is particularly of concern given its impact on the ability of those stigmatized to receive appropriate and quality prevention services, treatment, and care.

Along with examining the level of S&D in within health facilities and social services environments, the study sought to understand the association between staff training, or the lack thereof, and reported S&D. It also sought to explore the degree to which layered stigma existed. Layered stigma is HIV-related stigma combined with stigma toward marginalized groups—a scenario MSM and SW frequently experience as they are often assumed to be core transmitters of HIV infection. Prevalence data show that close to a third of the population of MSM and 4.2 percent of SW in Jamaica are HIV-infected (Jamaica National HIV/STI Program 2010), and S&D of MARPs is a major barrier to their access of health and social services that can help mitigate the growing HIV and AIDS epidemic. With these statistics in mind the overall aim of the study was to inform critical SBCC interventions for the health and social services sectors.

The study was conducted in Kingston, Montego Bay, and Ocho Rios. It included three components with separate samples: 165 health services staff in 23 public, private, or NGO-owned health facilities identified as either MARP-friendly or a general facility; 63 staff members of 12 social services organizations that provided support services to MARPs; and 450 male and female sex workers located in popular sites/locations (i.e., clubs, streets, massage parlors, the beach, hotels, guest houses, and bars). Modified survey instruments were pretested and used for each of the components with items adapted from previously tested instruments (Nyblade and MacQuarrie 2006; Kelly et al. 1987; Berger, Estwing, and Lashley 2001). The results of the study are summarized below.

Components One and Two: Health Facility and Social Services Workers

Training Exposure

- The majority of respondents were not trained in HIV or working with MARPs.
 - Across different types of training, with the exception of interpersonal communication training, health facilities had more untrained staff than social services organizations.
 - Within health facilities, untrained nonclinical staff outnumbered clinical staff across several training categories.
 - Across all types of health facilities (public, private, NGO), general health facilities reported more untrained staff than did MARP-friendly facilities (although sizable proportions of staff in MARP-friendly facilities were also untrained in HIV prevention, care, and treatment).
 - Regarding the type of health facility, public health facilities had more untrained staff than did private or NGO-owned facilities across all types of training.
 - Location-based differences were also reported in exposure to training. Higher proportions of staff were trained in interpersonal communication ($p \leq .001$) and working with MARPs ($p \leq .01$) in Montego Bay, followed by Ocho Rios, and Kingston.

Fear/Avoidance of Casual Contact with PLHIV, MSM, SW

Fear of HIV transmission and refusal of casual contact with PLHIV and MARPs is one key underlying stigma construct (Nyblade and MacQuarrie 2006).

- Regarding fear/avoidance of casual contact with PLHIV and MARPs, between 19 percent and 45 percent of health facility and social services workers reported fear or avoidance desires across measures, such as sharing a bathroom with a colleague or touching someone's sweat or saliva.
 - Greater levels of discomfort or fear were found with higher prevalence among health facility than social services staff.
- Between 3 percent and 50 percent of health facility staff expressed fear of HIV transmission or desire for avoidance of contact, depending on the type of clinical interaction and the population served.
 - More fear of HIV transmission was reported based on the complexity of the clinical interaction (i.e., dressing wound vs. suturing/operating).
 - Fear of clinical interactions was highest when serving PLHIV (44–50 percent, depending on the type of interaction); among MARPs, desire for avoidance of clinical interaction was highest when serving MSM (6–10 percent, depending on the type of interaction) followed by avoidance desires with SW (3–4 percent).
 - Overall, the desire to avoid interactions with MSM was greater than it was with SW.
- Training in HIV prevention was positively associated with respondents' lack of fear or desire to avoid casual contact with PLHIV, MSM, or SW.
 - While this relationship was found among both health facility and social services staff, the relationship was significantly higher among health services staff (ranging from $p \leq .05$ to $p \leq .001$, depending on the population served).
- Training in HIV prevention was also positively associated with clinical providers' lack of fear with more clinical contact measures.
- Regarding type of health facility, staff at MARP-friendly facilities was less likely to report HIV-transmission fears or avoidance desires than counterparts in general facilities on some measures and with some populations served.

- Regarding the type of health facility (public, private, and nongovernmental organization), NGO staff felt less need to avoid PLHIV, MSM, or SW, followed by staff in public, and lastly private health facilities.

Shame, Blame, and Judgment

Values or moral-driven judgments related to those stigmatized are another key stigma construct examined by this study.

- While most respondents believed PLHIV and MARPs were deserving of quality care, reported shame, blame, and judgment were high (ranging from 7–83 percent, depending on the category).
 - Respondents were most judgmental regarding the belief that homosexuality (63–83 percent) and sex work (75–61 percent) were immoral with significantly more clinical staff than social services staff reporting these judgments ($p \leq .001$).
 - Across most measures, greater levels of shame, blame, and judgment were shown toward MSM, followed by SW, and then PLHIV among both health services and social services staff, demonstrating effects of layered stigma.
 - Significant sex differences in responses were found in relation to SW. Females were more likely to feel that SW deserved the same level of care as other clients and to disagree that sex work was immoral than males ($p \leq .001$, $p \leq .05$, respectively).
- Of those health facility staff trained in HIV prevention, less shame, blame, and judgment were reported toward PLHIV and MARPs as compared to untrained staff. Among social services staff, a reverse trend was shown.
- On the belief that homosexuality was immoral, significantly fewer health staff in MARP-friendly vs. general facilities believed this was the case ($p < .05$).
- On the belief that homosexuality or sex work was immoral, health staff in NGOs vs. those in either public or private health facilities were significantly less likely to believe this ($p \leq .001$, $p \leq .05$, respectively).

Enacted Stigma

Enacted stigma was the third stigma construct examined with health facility and social services respondents. Enacted stigma includes unlawful discrimination as well as a wider set of stigmatizing actions (Nyblade and MacQuarrie 2006).

- Gossip about PLHIV, MSM, and SW was the most common form of enacted stigma reported among respondents (8–25 percent, depending on type of worker and type of client). A significant number of social services staff reported seeing organizational policies relevant to MARPs violated (13–33 percent, depending on population).
- Other forms of enacted stigma (received less care than other patients, assigned by senior provider to junior provider, HIV tested without consent, refused health care services) were less prevalent (1–9 percent, depending on the measure and population).
- Concerning health facility type, incidences of enacted stigma were reported more often by private health facility staff than those in public or NGO facilities.
- Health facility staff in Montego Bay and social services staff in Ocho Rios were less likely to report instances of enacted stigma toward MARPs than staff in other locations.

Vignette Findings (*Vignettes of eight characters were described and participants responded to 10 S&D-related statements for each character/vignette.*)

- Across both health facility and social services respondents, the highest stigma levels were found for the MSM HIV–positive character followed by the SW HIV–positive character and the non-MSM HIV–positive character, which again demonstrated layered stigma.
- Regarding the participant ratings for each character, the magnitude of stigma was highest for the statements related to the belief that the character was responsible for their own illness (72 percent for SW HIV positive and 55 percent for MSM HIV positive) and the belief that the character was a danger to others (46 percent for SW HIV positive and 38 percent for MSM HIV positive).
- Social services staff reported higher levels of S&D across all characters (MARP and non-MARP) than did health services staff.
- On four of the eight vignettes and some of the related statements, staff at MARP–friendly health facilities reported less S&D than staff at general facilities.
- Overall, an inverse relationship was found between respondent training and S&D reported via the vignettes with the trained staff reporting less S&D than untrained staff.
- Regarding two of the MARP characters, females were more likely to report less S&D than males based on certain stigma-related statements.

Component Three: Sex Workers Reports of S&D

Disclosure

Disclosure is the fourth underlying stigma construct examined in this study. Disclosure is often used as a proxy for the level of S&D that exists within a particular setting. This assumes that greater disclosure occurs in settings with decreased S&D (Nyblade and MacQuarrie 2006).

- Almost half of respondents had ever told a health care provider that they engaged in sex work; nearly half of those experienced some type of reaction from the provider.
- Over a third of those who had disclosed their sex work regretted doing so.
- MSW reported higher negative reactions from providers than did FSW.

S&D Experiences with Health Services

- Close to a quarter of respondents reported that they were gossiped about when seeking health services; one in 10 reported that they were given poorer quality health services and/or staff hurried to finish their exam because of their profession. Only 4 percent reported being denied services.
- Those who had disclosed their SW status were significantly more likely than those who had not to report being denied services ($p < .05$), experiencing poorer quality of services ($p < .05$), and feeling rushed by health staff during their exam ($p < .001$).
- Regarding the psycho-social experience of stigma in the health service environment, SW carefully selected who to tell about their lives as sex workers (76 percent), worried that people who knew their sex work status would tell others (61 percent), worried that people in the clinic would judge them when learning of their SW status (52 percent), and believed that telling someone at the clinic of their SW status was risky (50 percent). Surprisingly, about two-thirds reported that they never needed to hide their SW status from clinic staff.
- Across nearly all stigma measures, MSW reported experiencing higher S&D within the last six months and when seeking health care than FSW.

Use of HIV–Prevention and Medical Services (last six months)

- More than eight in 10 respondents had spoken to a peer educator and about two-thirds reported speaking to someone from the Ministry of Health's (MOH) programs about ways to prevent HIV. Few, one in 10, had spoken to someone at an NGO.
- About a third reported visiting a community-based organization in addition to a health center.
- About two out of five had attended HIV–prevention education sessions and about three-quarters had read HIV–prevention material, which most commonly came from MOH agencies. About nine in 10 had received condoms, which, again, came largely from the MOH.
- Three-quarters of respondents reported visiting a medical facility most commonly for a general physical, STI concern, and for HIV testing. Of those who visited clinics, about half reported disclosing their SW status.
- FSW were more likely to have had exposure to peer educators, and MSW were more likely to have visited community-based organizations to access HIV–prevention services. FSW were more likely to visit medical facilities than were MSW.

Conclusions and Recommendations

The study findings support past research indicating widespread stigma toward PLHIV, MSM, and SW in health services in general and specific to Jamaica. Fear of casual contact or desire to avoid contact with PLHIV and MARPs occurred in both clinical and nonclinical settings. Measures of shame, blame, and judgment, particularly as they related to views on immorality toward PLHIV and MARPs, appeared to be the norm. While with less frequency, enacted stigma also was reported. MARPs experienced layered stigma, which threatens their quality of care and services, thereby increasing their vulnerability.

Staff training was directly related to the degree to which client S&D was manifested in the health and social services sectors. Moreover, S&D in the health sector varied by type of facility as well as location, demonstrating the need for more MARP–friendly providers.

Based on these conclusions, the following recommendations are provided, which are discussed in more detail in the body of the report:

- Train all staff in the health sector, including nonclinical staff, in at least HIV prevention focused interpersonal communication with a focus on S&D toward MARPs. All health and social services sector staff should also receive increased training in psycho-social support for MARPs.
- Provide a minimum package of care including a standard medical protocol for MARPs in all health and social sector settings.
- Increase the number of MARP–friendly providers in Jamaica.
- Conduct further qualitative research to deepen understanding of some of the present findings.
- Address providers' fear of HIV transmission through dialogue, training, and monitoring of clinical procedures.

- Make health services strengthening a priority as the National Health Program moves away from vertical delivery of HIV/STI programs.
- Conduct needs assessment of MARP providers to address capacity and policy gaps.
- Strengthen the policy and legislative framework to sanction health care providers when confidentiality is breached and discriminatory practices occur.
- Conduct targeted and interactive communication campaigns addressing S&D toward PLHIV and MARPs in the broader community and specifically with health and social services providers.
- Treat the present survey as a baseline of S&D and monitor over time.

Background

FHI 360's Communication for Change (C-Change) project in Jamaica provides technical assistance in social and behavior change communication (SBCC) to improve the quality and scale of Jamaica's current response to the HIV and AIDS epidemic. The project works toward the overall goal of a national-led, sustainable, integrated, and coordinated HIV-prevention effort that enables national programs to plan, implement, and evaluate evidence-based, comprehensive programs for most-at-risk populations (MARPs), including men who have sex with men (MSM) and sex workers (SW). C-Change works closely with civil society and MOH implementers at community, regional, and national levels; policymakers, as influencers of the programming environment; and MARPs, as end-users of the programs that address them.

Through this strategic approach, C-Change aims to achieve: increased coordination between the MOH and civil society actors; increased scale and reach of programs through technical assistance; increased quality of implementation and documentation; increased sustainability of programs; and accelerated momentum of social mobilization and advocacy. In keeping with its mandate of supporting civil society and government partners in developing evidence-based programming and in working to create supportive enabling environments for MARPs, C-Change conducted a study in 2011 on stigma and discrimination (S&D) within health and social services settings toward these groups.

Introduction

Stigma and discrimination (S&D) occur when someone is devalued as a result of practices, behaviors, diseases, or other characteristics with which the person is associated (International Center for Research on Women 2012). Most-at-risk populations (MARPs), including MSM and SW are among heavily stigmatized groups due to hostilities and fears stemming from societal perceptions of gender roles; cultural, religious, and social taboos; and lack of knowledge, misconceptions, and stereotypes (Kidd, Clay, and Chiya 2007; Pact Inc. and International Center for Research on Women 2010). This in turn leads toward increased vulnerabilities among these marginalized populations with regard to infection, disease, abuse, and violence, often perpetuated by lack of access to information and services, level and quality of care, and treatment.

Both sex work and homosexual behaviors are illegal and heavily stigmatized in many countries, including Jamaica. This has resulted in MSM and SW experiencing discrimination and also verbal and physical abuse, imprisonment, and homicide. In the context of HIV and AIDS, SW and MSM often face additional stigmatization due to society's assumptions that they are core transmitters of HIV infection. Several studies have documented the HIV-related stigma experienced by these vulnerable populations in many regions of the world (Pyett and War 1997; Scambler and Paoli 2008; Okal, Luchters, Geibel, Chersich, Lango, and Temmerman 2009; Feng, Wu, and Dentels 2010; Muñoz, Adedimeji, and Alawode 2010; Argento, Reza-Paul, Lorway, Jain, Bhagya, Fathima, et al. 2011). Thus, SW and MSM experience what is referred to as compounded or layered stigma—HIV-related stigma combined with stigma toward marginalized groups—which often acts to further marginalize vulnerable groups.

While HIV and AIDS-related S&D have been witnessed within the general population, they also have been well documented among health care workers serving people living with HIV (PLHIV) or those suspected of having the disease (Hossain and Kippax 2011; Li, Liang, Wu, Lin, and Wen 2009; Kartavya, Gulab, Shkla, and Mathews 2010; Mugala, Mutale, Kalesha, and Sinyinza 2010; Andrianasolo, Radotoarivelo, Randriarimanana, Angijiro, and Randria 2011; Cianelli, Ferrer, Norr, McCreary, Irarrzábal, Bernales, and Minder 2011).

Several S&D domains have been identified in these settings based on its underlying roots—fear of casual transmission of HIV and its subsequent action of refusal of contact; values: shame, blame, and judgment; enacted stigma/discrimination; and disclosure (Nyblade and MacQuarrie 2006). Values are judgments related to the morality or perceived immorality of the stigmatized lives. Enacted stigma covers both discrimination that is unlawful as well as a wider set of stigmatizing actions (Nyblade and MacQuarrie 2006).

Due to both high HIV and AIDS prevalence and through association with the disease, MSM and SW have frequently been the target of stigma from health care workers (Lande, Mogale, Struthers, McIntyre, Mrcog, and Kegeles 2008; Araújo, Montagner, da Silva, Lopes, and de Freitas 2009; Chandra and Madison 2009; Fay, Baral, Trapence, Motimedi, Umar, Lipinge, et al. 2011; Rispel, Metcalf, Cloete, Moorman, and Reddy 2011).

HIV-related S&D exist in Jamaica and are pronounced toward MSM and SW. One study conducted with young Jamaicans sought to measure variations in “sympathy” toward various sub-populations, such as MSM and SW with HIV. This study found that young Jamaicans were least sympathetic toward MSM and SW came in a close second when compared with heterosexual men and non-SW women and children with HIV (Normal, Carry, and Jiménez 2006). Findings from a study conducted in 2003 by White and Carr demonstrated how HIV-related stigma against MSM was manifested in Jamaica, including in its laws; politics (i.e., homosexuality in smear campaigns against opposing political parties); the socio-cultural environment (homophobia supported by religious institutions and popular cultural icons, common street lingo, “don’t ask don’t tell” policy of disclosure to family and community); gender (males with HIV assumed to be homosexual and females assumed to be SW); class (poor MSM with HIV who use public services more visible and stigmatized than wealthy MSM); and color (association between color and class inherent in post-colonial society).

In the same study (White and Car 2005) there was limited evidence of HIV-related stigma toward MSM among health care workers in Jamaica. One nurse respondent was quoted as having said, *“If they know you get it straight, then they will tolerate it. But if they think they deal that way [are homosexual], then it is an additional thing.”* A doctor in this study was noted to have asked the researchers if homosexuality actually existed in Jamaica, because he had never *“come across any.”* Caribbean research overall provides some limited validation regarding stigma among health care workers. A survey conducted in the eastern Caribbean found that most HIV and AIDS discrimination among health care workers was directed toward MSM and injecting drug users (Abell, Rutledge, McCann, and Padmore 2007). Another qualitative study conducted with health service providers and PLHIV in Grenada and Trinidad and Tobago found that both PLHIV and providers identified passive neglect and active refusal by health facility staff to provide care to PLHIV and that provider scorn was especially prevalent when the patient was perceived to be gay or bisexual (Rutledge, Abell, Padmore, and McCann 2009).

Health care workers are often the professionals who most directly address HIV and AIDS-related prevention, testing, treatment, and care, and therefore, S&D in this sector has a direct impact on access, utilization, and quality of care for those in need of these services. When faced with a hostile health care environment, it becomes a challenge for MSM and SW to come forward and identify their sexuality and their sexual experiences, even when it means that their health, and perhaps their lives, are on the line. As a result, they do not receive the support that they need to reduce their risks and prevent the spread of HIV.

This is a strong concern in Jamaica where the estimated HIV prevalence among female sex workers (FSW) and MSM is much higher than that of the general population (4.2 percent, 31.8 percent, and 1.7 percent, respectively) (Jamaica National HIV/STI Program [NHP] 2010). Among the total HIV and AIDS disease burden, 71 percent of cases are reported to be heterosexual, 3 percent bisexual, 2 percent homosexual, and 24 percent sexual identification unknown (NHP 2010).

Methods

The purpose of this quantitative study was to understand the level of S&D that SW (both male and female) and MSM encounter when seeking health-related and social services in Jamaica to better inform SBCC programming for MARPs. The study looked at S&D through three components:

- Component one: health facility workers
- Component two: social services organization workers
- Component three: male and female sex workers

C-Change did not collect quantitative measures of stigma with MSM as there were four other agencies in Jamaica (MOH NHP, UNAIDS, Jamaica Red Cross, and the USAID-funded Health Policy Project) collecting or intending to collect stigma-related data with this population during the study's timeframe. In this study, PLHIV were not the primary interest group, but questions related to HIV-related S&D were administered in components one and two in order to differentiate it from S&D toward SW and MSM and to gain insight into layered HIV and AIDS stigma.

Study Locations

The study was conducted in three locations—Kingston, Montego Bay, and Ocho Rios. Kingston is the capital city of Jamaica and the most important commercial and industrial urban area on the island. Montego Bay is Jamaica's second largest city and is both a commercial area as well as the largest and most important tourism area on the island. Ocho Rios has the smallest population of the three urban centers and is also an important area for tourism.

Instruments

Modified survey instruments were used for each of the three study components. All instruments were pretested prior to their use.

Components One and Two: Health Facility and Social Services Organization Workers

For components one and two, questions recommended in Nyblade and MacQuarrie's 2006 publication on S&D measurement and quantification were used. The study focused primarily on three S&D constructs—fear of casual transmission and refusal of contact; values: shame, blame, and judgment; and enacted stigma/discrimination. In addition to these questions, instruments for components one and two also included a modified version of Kelly et al.'s (1987) prejudicial evaluation scale.

Component Three: Sex Workers

A modified version of the HIV stigma scale, developed by Berger, Estwing, and Lashley (2001), was used in component three.

Sampling

Component One: Health Facility Workers

A mapping of health providers was conducted for component one. Health facilities included in this component offered treatment for sexually transmitted infections (STIs), including highly active antiretroviral therapy, as well as general practitioner and some specialist services. Eligible providers could be public, private, or affiliated with an NGO. Health facilities were identified using a directory of HIV services entitled *HIV Workplace Programme Instructional Guide* (Bailey, Brown, and Stuart-Dixon 2010), via the MOH's regional health authority websites, and through liaisons from the Sex Worker Association of Jamaica, Jamaica AIDS Support for Life (JASL), Jamaica Forum for Lesbians, All Sexuals, and Gays (J-FLAG), and the Jamaica Red Cross's SW project. This resulted in a total sample frame of 48 health facility providers, of which, 10 were designated as MARP-friendly by agencies that worked with these populations and from anecdotal reporting from MARPs themselves.

The study aimed for a sample of 10 MARP-friendly and 15 general health providers for a total of 25 health providers. The 15 general providers were selected using a simple random sampling method, and the 10 MARP-friendly providers were purposively selected. It was not possible to select these providers randomly as the 10 identified accounted for the entire universe of MARP-friendly providers that fit the study criteria across the three locations.

At the health facility level, clinical administrators selected a stratified sample of facility staff in each of four categories to reach the targeted numbers listed in Table 1 below.

Table 1: Criteria for Health Facility Sample

1. Professional (3)	3. Administrative (2)
2. Semi-Professional (3)	4. General support staff (security guards, porters, orderlies, ward assistants, drivers, etc.) (2)

Component Two: Social Services Organization Workers

A similar mapping exercise was conducted for component two of the study with social services organizations serving MSM and SW. To be included as a social services organization, the entity must have provided social support services to MARPs. A total of 39 agencies made up the sampling frame; 12 were selected for assessment using simple random sampling methods or purposeful sampling, depending on the number of eligible agencies in a particular location.

Within social services organizations, agency directors selected a stratified sample of agency staff in each of four categories to reach the targeted numbers listed in Table 2.

Table 2: Criteria for Social Services Staff Sample

1. Professional (1)	3. Semi-Professional (2)
2. Administrative (1)	4. General support staff (volunteers and others) (1)

Component Three: Sex Workers

Under component three, a modified version of respondent-driven sampling (RDS) was used to recruit female and male SW into the study. RDS has been considered an effective way to gain access to a representative sample of a “hidden population” where confidentiality and anonymity are paramount and no reliable sampling frame or population size estimate exists (Johnston and Sabin 2010). RDS has been successfully used with MARPs.

Site Clusters: For the purposes of recruiting SW for the study, the following specific geographical sites, also known as common SW sites, were selected in the three study locations:

- **Kingston:** New Kingston, Constant Spring Road, Kingsway area, Ocean Boulevard, the Parade area (including the park in downtown Kingston), Mandela Park in Half Way Tree, and private enterprises such as go-go clubs, bars, and clubs frequented by SW nearby the corporate area.
- **Montego Bay:** The Hip Strip, Dump-Up Beach, private beaches such as Doctor’s Cave where MSW (“Beach Boys”) solicit female tourists, and private enterprises such as go-go clubs, bars, and clubs frequented by SW and MSW.
- **Ocho Rios:** Main Street, the cruise ship pier, the market area and taxi stands, the Urban Development Corporation Beach, private beaches where MSW solicit female tourists, and private enterprises such as go-go clubs, bars, and clubs frequented by FSW and MSW.

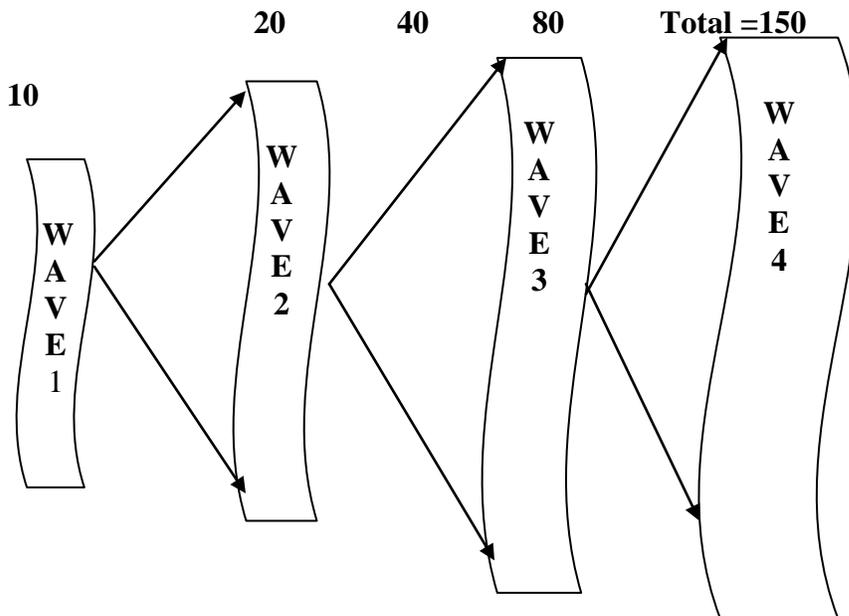
The modified RDS method used in this study relied on purposively selecting a number of initial SW (herein referred to as “seeds”) to recruit other SW from their personal network into the study. Initial seed selection also used the location-based criteria such that one seed was randomly selected from specified popular sites in each of the study locations, Kingston, Montego Bay, and Ocho Rios (Table 3).

Table 3: Seed Selection Criteria

INITIAL SEED SELECTION CRITERIA	
Female Sex Workers (n=7)	Male Sex Workers (n=3)
1. Club	1. Club/party
2. Brothel	2. Street/beach
3. Street (including market and taxis)	3. Hotel/tourist area
4. Beach/tourist area	
5. Massage parlor	
6. Hotel	
7. Cruise ship pier	

The initial seed was asked to recruit two more SW into the study, who in turn each identified two more SW through four waves to best achieve statistical equilibrium and until the total desired sample size per region was reached—100 FSW and 50 MSW per location (Figure 1) or 300 FSW and 150 MSW in total.

Figure 1: Schematic RDS Wave Distribution by Study Location



Data Collection Methods

Components One and Two: Health Facility and Social Services Organization Workers

Three interviewers were trained in the administration of the data collection tool, including interviewing techniques, gaining consent, and ensuring confidentiality. The interviewers facilitated the self-administered survey instrument under components one and two in small group settings or singularly where convenient.

Component Three: Sex Workers

Field coordinators (one for each study location) and 30 interviewers (10 per location) with prior knowledge and experience working with SW were selected and trained in RDS, administering the survey instrument, interviewing techniques, gaining consent, and ensuring confidentiality. Each interviewer was instructed to interview 15 persons via the personal network of each initial respondent (seed).

Recording of Network Information: Each region was assigned a prefixed code as follows:

- *K—Kingston*
- *OR—Ocho Rios*
- *MB—Montego Bay*

In each location the 10 interviewers were assigned a letter from A–J. Each seed was assigned the number one, and each SW recruited in that network thereafter was assigned a follow-up number in the sequence, up to the number 15 (see Table 4).

Table 4: Seed Numbering Example

K -A-1-2-3-4-5-6-7-8-9-10- 11-12-13-14-15	OR-B-1-2-3-4-5-6-7-8-9- 10-11-12-13-14-15	MB -C-1-2-3-4-5-6-7-8-9- 10-11-12-13-14-15
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Each SW, including the seed, was interviewed and given two redeemable coupons, coded accordingly, and asked to recruit an additional two SW into the study. Coupons were redeemed for successful recruitment of two additional persons with a J\$100.00 (approximately US\$1.13) Digicel call credit for each.

To ensure that persons were not interviewed twice due to the movement of the population, interviewers were trained to ask respondents if they had been interviewed previously before they proceeded with the interview.

Data Entry and Analysis

Data from questionnaires across all three study components were entered into SPSS (Statistical Package for the Social Sciences) 16.0 to produce statistical frequencies and cross tabulations using Pearson Chi-Square tests of significance.

Ethics and Consent

Ethical approval was granted by the Ministry of Health Jamaica, Ethics Committee and the Institutional Review Board in Washington, DC, for the study protocol. The purpose and risks of the research were read to all respondents before obtaining their consent. In the case of health sector and social support agencies (components one and two), staff written consent was obtained. Under component three, SW initialed their consent forms to maximize confidentiality. The consent process was also witnessed by a third party interviewer who signed that consent had been granted. All questionnaires were unlinked to consent forms to minimize the identification of individual responses. All participants in the study were 18 years of age and older.

Study Limitations

Component One: Health Facility Workers

- MARP–friendly designations used to categorize health providers were attained via secondary sources. Since the information was anecdotal in nature, this may have introduced bias.
- Public clinics were severely short staffed with very heavy case loads (the majority of Type V public clinics¹ only have one doctor). Therefore, access to medical doctors was limited due to the 30 minutes required for informed consent and questionnaire

¹ Type V clinics provide comprehensive health services including specialist services.

completion. While many doctors were interested and supportive of the study and willing to participate, they were unable to spend 30 minutes of clinic or hospital time to do so.

Component Two: Social Services Organization Workers

- A very limited number of organizations work with MARPs, especially outside of Kingston, which may have made their representativeness questionable.
- During the first week of November 2011, the United Kingdom threatened to apply sanctions for aid to countries that in effect criminalize homosexuality. This resulted in some public anger in Jamaica, and in turn, resistance among some providers to engage in the study. Three out of six participants from one social services agency demanded their surveys back because they said they did not want to contribute to what they termed, “efforts to decriminalize sex work or homosexuality.” These participants were advised that the study was not connected to the sanctions issue or any legal lobbying effort. Refusals to participate in the study and delays experienced in securing appointments with some organizations were mainly due to this issue.
- Through the use of unlinked questionnaires and case vignettes researchers attempted to reduce social desirability bias. However, men have the tendency to overstate their objections to MSM, which in Jamaica is considered the socially desirable male response (Boxhill 2011). This limitation also applied to component one.

Component Three: Sex Workers

- Views conflict on the effectiveness of RDS with regard to achieving representative samples of hidden populations (Johnston and Sabin 2010).
- Obtaining information on statistical equilibrium under component three for the respondent-driven sample of SW was not possible, as respondents were not queried regarding their network size.
- The views and experiences of SW may not necessarily relate directly to health services obtained from the study location in which the interview was conducted as SW are mobile populations that may work across the island as well as throughout the greater Caribbean region.

Findings

Components One and Two: Health Facility and Social Services Workers

Participant Demographics

Health Facility Staff: A total of 165 health facility workers were interviewed, representing 23 health facility settings in Kingston, Montego Bay, and Ocho Rios (see Table 4). Twenty-three percent (n=38) were male and 77 percent (n=127) were female. Participant ages ranged from 18 to 75 years old, with a mean age of 38.3 years.

Eighteen percent (17.7%; n=29) had not completed secondary education while 21.3 percent (n=35) had. Forty-four percent (43.9 percent, n=73) of health facility workers had completed university, attended a professional school higher than university, or had a nursing or medical degree (See Table 4).

Social Service Staff: A total of 63 social services workers were interviewed representing 12 social services organizations serving MARPs (including SW and MSM) in Kingston, Montego Bay, and Ocho Rios (see Table 4). Of those that responded, 31 percent (n=19) were male and 69 percent (n=42) were female. Participant ages ranged 19 to 63 years with a mean of 35.6 (standard deviation 10.2 and median age 34 years).

Of those interviewed, 13.1 percent (N=8) had not completed secondary education while 11.5 percent (n=7) had. Fifty-seven percent (n=35) of social services agency staff had completed university, attended a professional school higher than university, or had a nursing or medical degree (See Table 4).

Table 4: Demographic Characteristics of Health Facility and Social Services Workers

Variable	Health Facility Workers		Social Services Workers	
	%	(n)	%	(n)
Age (Years)				
Mean	38.3		35.6	
Median	37.0		34.0	
Mode	28.0		26.0	
Standard deviation	119.0		10.2	
Minimum	18.0		19.0	
Maximum	75.0		65.0	
Missing	3.0		3.0	
Gender				
Male	23.0	(38)	31.1	(19)
Female	77.0	(127)	68.9	(42)

Variable	Health Facility Workers		Social Services Workers	
	%	(n)	%	(n)
Highest Level of Education				
Less than secondary school	7.3	(12)	3.3	(2)
In secondary school	10.4	(17)	9.8	(6)
Completed secondary school	21.3	(35)	11.5	(7)
Attending university	14.6	(24)	11.5	(7)
Completed university	22.0	(36)	11.5	(7)
Professional school (> university)	2.4	(4)	11.5	(7)
Nursing degree	14.6	(24)	29.5	(18)
Medical degree	4.9	(8)	4.9	(3)
Other	1.8	(3)	6.6	(4)
Missing	0.6	(1)	3.2	(2)
Total	100.0	(165)	100.0	(63)

Organization Types

Health Facility Staff: Among the health facility staff sampled, the largest proportion of workers represented the public sector (71.5 percent, n=118)—these included health centers, hospitals, and clinics. Twenty-three percent (n=38) and 5.5 percent (n=9) of health facility workers represented the private sector and NGO health facilities, respectively (see Table 5). Of the 23 health facilities sampled, 39.1 percent (n=9) were designated as MARP-friendly, accounting for 28.5 percent (n=47) of workers interviewed.

Table 5: Sample of Health Facility Organizations and Respondents by Type

Variable	Facility %	Facility (n)	Workers %	Workers (n)
Sector				
Public	61.0	(14)	71.5	(118)
Private	26.0	(6)	23.0	(38)
NGO-owned	13.0	(3)	5.5	(9)
Total	100.0	(23)	100.0	(165)
Designation				
MARP-friendly	39.1	(9)	28.5	(47)
General	61.0	(14)	71.5	(118)
Total	100.0	(23)	100.0	(165)

Social Services Staff: All social services workers sampled represented NGOs or public agencies. A designation of MARP-friendly vs. general organization was not made for component two.

Participant's Organizational Role

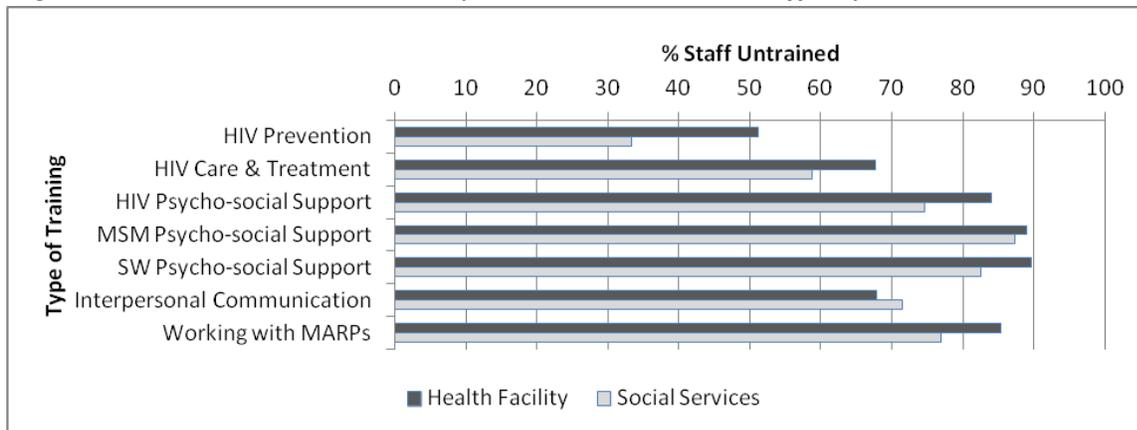
Health Facility Staff: Of respondents, the largest proportion of health facility staff interviewed identified as nonclinical staff (43.8 percent, n=70), followed by nurses (18.8 percent, n=30), health aids (20.0 percent, n=32), doctors (7.5 percent, n=12), clinical counselors (5.6 percent, n=9), or other (4.4 percent, n=6). Health facility workers specified their duration of employment as ranging from one month to 38 years and 10 months. The median time served was four years.

Social Services Staff: Of those that responded, the largest proportion of social services staff interviewed identified as administrative, finance, or support staff (27.1 percent, n=16), followed by program coordinators/officers (25.4 percent, n=15), peer educator/outreach workers (20.3 percent, n=12), senior management (10.2 percent, n=6), social workers (8.5 percent, n=5), and medical professionals (6.8 percent, n=4).

Training Exposure

The majority of the sampled staff in health facilities and social services organizations had not received HIV– or MARP–related training. For all types of training queried (HIV prevention, HIV care and treatment, HIV psycho-social support, MSM psycho-social support, SW psycho-social support, interpersonal communication, and working with MARPs), health facilities reported higher proportions of untrained staff (except in the area of interpersonal communication) (see Figure 2). The difference in the proportion of untrained/trained health facility and social services organization staff for HIV prevention was significant ($p \leq .05$). No significant differences were seen for the other types of training between these groups.

Figure 2: Untrained Health Facility and Social Services Staff Key Areas



Health Facility Staff: Approximately half (51.2 percent, n=84) of the health facility staff who responded had not received training on HIV prevention–related topics. A larger proportion of staff had not received training on HIV care and treatment (67.7 percent, n=111), psycho-social support for HIV patients (84.1 percent, n=138), MSM (89.0 percent, n=146), or issues related to SW (89.7 percent, n=148). Eight-five percent of health facility staff (85.4 percent, n=140) were untrained in working with MARPs.

Within health facilities, differences between clinical and nonclinical staff were found related to training. The difference in the proportion of untrained clinical staff in HIV prevention (40.8 percent, n=31) was significant ($p \leq .05$) as compared with nonclinical staff (59.8 percent, n=49) in the expected direction. Significant differences ($p \leq .001$) were also found between clinical and nonclinical staff not trained in HIV care and treatment (51.3 percent, n=39 vs. 81.7 percent, n=67). For training related to psycho-social support for HIV, differences ($p \leq .05$) between untrained clinical and nonclinical staff were found: 76.3 percent (n=58) vs. 90.2 percent (n=74).

Across all facility types, staff from MARP–friendly institutions reported higher proportions of training than those in general health facilities (see Table 6). A significant ($p \leq .01$) difference in the proportion of MARP–friendly staff (34.8 percent, $n=16$) without training in HIV prevention was found as compared with staff from general health facilities (57.6 percent, $n=68$). Fifty-seven percent (56.5 percent, $n=26$) of MARP–friendly staff were untrained in HIV care and treatment as compared with 72 percent ($n=85$) of staff from general organizations. Staff who had not received psycho-social support training at MARP–friendly organizations ranged from 76.1 percent (HIV) to 76.6 percent (SW) as compared with staff from general organizations at 87.3 percent to 94.9 percent, respectively. A large percentage of MARP–friendly organization staff (43.5 percent) were trained in working with MARPs as compared with only 3.4 percent of staff from general health facilities ($p \leq .001$).

Table 6: Untrained Health Facility Staff by MARP–Friendly Designation

Variable	MARP– Friendly Health Facility Staff		General Health Facility Staff	
	%	(n)	%	(n)
Training				
HIV prevention**	34.8	(16)	57.6	(68)
HIV care and treatment	56.5	(26)	72.0	(85)
Psycho-social support—HIV	76.1	(35)	87.3	(103)
Psycho-social support—MSM**	78.3	(36)	93.2	(110)
Psycho-social support—SW***	76.6	(36)	94.9	(112)
Interpersonal communication	63.8	(30)	69.5	(82)
Working with MARPs***	56.5	(26)	96.6	(114)

*The proportion of MARP–friendly staff vs. general health facility staff reporting is statistically significant at $p \leq .05$.

**The proportion of MARP–friendly staff vs. general health facility staff reporting is statistically significant at $p \leq .05$.

***The proportion of MARP–friendly staff vs. general health facility staff reporting is statistically significant at $p \leq .001$.

Differences in staff training levels were also found by type of health facility. Higher proportions of untrained staff were found in public health facilities as compared with private and NGO–owned when looking across all training measures (see Table 7). Significant training differences ($p \leq .05$, $p \leq .01$, $p \leq .001$) among the type of health facility were reported with the exception of interpersonal communication.

Table 7: Untrained Health Facility Staff by Organization Type

Variable	Public Health Facility		Private Health Facility		NGO Health Facility	
	%	(n)	%	(n)	%	(n)
HIV prevention**	47.0	(55)	71.1	(27)	22.2	(2)
HIV care and treatment*	66.7	(78)	78.9	(30)	33.3	(3)
Psycho-social support—HIV*	87.2	(102)	81.6	(31)	55.6	(5)
Psycho-social support—MSM**	91.5	(107)	89.5	(34)	55.6	(5)
Psycho-social support—SW***	93.2	(110)	92.1	(35)	33.3	(3)
Interpersonal communication	71.2	(84)	60.5	(23)	55.6	(5)
Working with MARPs***	87.2	(102)	94.7	(36)	22.2	(2)

*Statistically significant difference between type of health facility, $p \leq .05$
**Statistically significant difference between type of health facility, $p \leq .01$
***Statistically significant difference between type of health facility, $p \leq .001$

Significant differences related to training based on location were seen for interpersonal communication ($p \leq .001$) and working with MARPs ($p \leq .001$). Montego Bay health facility respondents reported the greatest amount of training (53.1 percent, $n=26$ and 33.3 percent, $n=16$, respectively vs. Ocho Rios: 28.6 percent, $n=14$ and 16.3 percent, $n=8$ and Kingston: 23.8 percent, $n=31$ and 10.9 percent, $n=14$).

Social Services Staff: Thirty-three percent (33.3 percent, $n=21$) of participants from social services organizations had not received HIV prevention training, and 58.7 percent ($n=37$) had not received training in HIV treatment and care. A greater proportion of social services staff were untrained in psycho-social support related to HIV (74.6 percent, $n=47$), MSM (87.3 percent, $n=55$), and sex work (82.5 percent, $n=52$). Just under a quarter of social services staff (23.0 percent) had been trained in working with MARPs. For all training categories specified, the greatest proportion of social services staff trained was found in Montego Bay.

S&D: Fear/Avoidance of Casual Contact with PLHIV, MSM, and SW

Fear of HIV Transmission

One construct of S&D explored in this study was fear of casual contact with PLHIV. For questions related to clinical activities, participants classified as nonclinical based on their profession and answers to clinical questions were excluded from analysis. Across both health and social services organizations serving MARPs, discomfort and fear related to HIV transmission related to contact with PLHIV were reported. Among nonclinical indicators (i.e., discomfort sharing bathroom, touching sweat/saliva), health facility staff reported greater levels of discomfort or fear than did social services organization staff.

Table 8: Health Facility and Social Services Organization Employees' Fear of HIV Transmission or Desire to Avoid Contact, by MARP Group

Variable	Health Facility Staff						Social Services Staff	
	Nonclinical		Clinical		Total		%	(n)
	%	(n)	%	(n)	%	(n)	%	(n)
Discomfort sharing bathroom with colleague								
PLHIV	33.3	(27)	29.7	(22)	31.6	(49)	21.0	(13)
MSM*	33.3	(27)	36.5	(27)	34.8	(54)	18.6	(11)
SW	-	-	-	-	-	-	21.7	(13)
Touching sweat/saliva								
PLHIV ^a	26.8	(15)	34.2	(25)	31.0	(40)	30.0	(15)
MSM ^b	41.4	(24)	47.2	(34)	44.6	(58)	32.7	(16)
SW ^b	25.5	(14)	41.7	(30)	34.6	(44)	22.6	(12)
Giving injection or IV								
PLHIV ^a	-	-	47.1	(32)	47.1	(32)	-	-
MSM ^b	-	-	6.3	(4)	6.3	(4)	-	-
SW ^b	-	-	3.1	(2)	3.1	(2)	-	-
Dressing wounds								
PLHIV ^a	-	-	44.3	(31)	44.3	(31)	-	-
MSM ^b	-	-	9.9	(7)	9.9	(7)	-	-
SW ^b	-	-	4.1	(3)	4.1	(3)	-	-
Suturing/operating on								
PLHIV ^a	-	-	50.0	(28)	50.0	(28)	-	-
MSM ^b	-	-	9.3	(5)	9.3	(5)	-	-
SW ^b	-	-	3.8	(2)	3.8	(2)	-	-
Physical contact with ^b								
MSM	-	-	-	-	-	-	13.6	(8)
FSW	-	-	-	-	-	-	8.5	(5)
MSW	-	-	-	-	-	-	16.9	(10)

^a Fear of HIV transmission with

^b Desire for avoidance of

* Statistically significant difference in the proportion of health facility and social services staff who responded at the $p \leq .05$ level

Of those who responded, approximately one-third of health facility (31.6 percent, n=49) and one-fifth of social services staff (21.0 percent, n=13) reported discomfort in sharing a bathroom with a colleague with HIV and AIDS (see Table 8). Fear of contracting HIV related to contact with an HIV-positive person's sweat or saliva was also reported. Thirty-one percent (n=40) of health facility and 30 percent (n=15) of social services workers reported this fear. Surprisingly, among health facility workers, no statistical difference was found in the proportion of clinical (34.2 percent, n=25) vs. nonclinical (26.8 percent, n=15) staff with fear for this indicator. Approximately 10 percent (n=13) of health facility and 6 percent (n=3) of social services staff responded that they did not know if they feared HIV transmission under this scenario.

Within health facilities, higher proportions of clinical staff reported HIV transmission fears from contact with PLHIV as the complexity of their clinical interactions increased. Of relevant responders, 44.3 percent (n=31) feared HIV transmission from dressing the wounds of PLHIV, 47.1 percent (n=32) feared HIV transmission from giving an injection or IV, and 50.0 percent (n=28) feared HIV transmission from suturing or conducting surgery on an HIV-positive individual.

Gender Differences: No significant differences were found in the proportion of males and females related to fear of HIV transmission.

Desire for Avoidance of MSM

Desire for avoidance of MSM and SW was examined related to the same scenarios presented above. A greater proportion of staff from health facilities (34.8 percent, n=54) than those from social services organizations (18.6 percent, n=11) reported discomfort in sharing a bathroom with a homosexual colleague (see Table 8) ($p \leq .05$). Minimal differences for this indicator were found for clinical (36.5 percent, n=27) and nonclinical (33.3 percent, n=27) health facility staff. The desire to avoid touching the sweat or saliva of an MSM was reported by nearly half (44.6 percent, n=58) of health facility staff and 32.7 percent (n=16) of social services participants (with no significant difference between the two groups).

Approximately 10 percent (9.9 percent, n=7) of clinical health facility staff expressed a desire to avoid dressing the wounds of an MSM. Nine percent (9.3 percent, n=5) wanted to avoid suturing or operating on MSM patients, and 6.3 percent (n=4) wanted to avoid giving an injection or IV. Among social services staff, 13.6 percent (n=8) reported a desire to avoid physical contact of a nonsexual nature with someone they suspected to be MSM.

Gender Differences: No significant differences were found in the proportion of males and females expressing avoidance desires related to MSM.

Desire for Avoidance of SW

Discomfort over sharing a bathroom with a colleague who was an SW was reported by 21.0 percent (n=13) of social services workers (see Table 8). Approximately one-third (34.6 percent, n=44) of health facility and 21.7 percent (n=13) of social services workers reported wanting to avoid the sweat or saliva of an SW. Very few clinical health facility participants reported a desire to avoid the other clinical scenarios presented (suturing/stitching, dressing wounds, giving IV/injection). Among social services staff, 8.5 percent (n=5) reported a desire to avoid physical contact of a nonsexual nature with someone they suspected was an FSW and 16.9 percent (n=10) with someone they thought was an MSW.

Gender Differences: No significant differences were found in the proportion of males and females expressing avoidance desires related to SW.

Comparison of Avoidance Desire Related to MSM and SW

Across most examined scenarios, the desire to avoid interactions with MSM was greater than it was with SW. These included respectively:

- Touching sweat/saliva: MSM (44.6 percent, n=58) health facility and (32.7 percent, n=16) social services workers vs. SW (34.6 percent, n=44) health facility and (22.6 percent, n=12) social services workers
- Giving an injection/IV drip: MSM (6.3 percent, n=4) vs. SW (3.1 percent, n=2) of health facility workers
- Dressing wounds: MSM (9.9 percent, n=7) vs. SW (4.1 percent, n=3) of health facility workers
- Suturing/operating on: MSM (9.3 percent, n=5) vs. SW (3.8 percent, n=2) of health facility workers

HIV transmission fear reported from clinical interactions related to PLHIV was much greater than the same staff's desire to avoid similar scenarios with MSM and SW. Fear of HIV transmission and avoidance desires for sweat/saliva and sharing a bathroom with a colleague, however, were similar across PLHIV, MSM, and SW groups.

Influence of Training on Fear or Avoidance Desire with MARPs

A significant association was found between health facility staff respondents who received HIV-prevention training and no reported HIV transmission fear and no desire for avoidance related to sweat/saliva (PLHIV, MSM, SW) as well as comfort in sharing a bathroom with a colleague (PLHIV, MSM) at $p \leq .05$, $p \leq .01$, and $p \leq .001$ levels (see Table 9). The same trend was observed (with the exception of sharing a bathroom) among social services respondents though these findings were not significant.

Table 9: Relationship between Exposure to HIV-Prevention Training and No Fear of HIV Transmission/No Desire for Avoidance of Nonmedical Interactions

	% Health Facility Staff Trained		% Health Facility Staff Untrained		P Value	% Social Services Staff Trained		% Social Services Staff Untrained		P Value
	%	(n)	%	(n)		%	(n)	%	(n)	
No fear of HIV transmission or desire to avoid sweat or saliva of person suspected to be:										
PLHIV ^a	76.4	(55)	51.0	(25)	.004**	72.7	(24)	57.1	(8)	.295
MSM ^b	66.2	(45)	37.3	(22)	.001***	70.0	(21)	46.2	(6)	.137
SW ^b	70.1	(47)	50.9	(27)	.032*	79.4	(27)	50.0	(5)	.066
Comfort sharing bathroom with colleague suspected to be:										
PLHIV	78.5	(62)	55.6	(45)	.002**	75.0	(15)	81.0	(34)	.590
MSM	80.0	(64)	47.5	(38)	.000***	87.8	(36)	66.7	(12)	.055
SW	-	-	-	-	-	82.9	(34)	68.4	(13)	.205

^aNo fear of HIV transmission with

^bNo desire for avoidance

Note: Analysis excludes those that responded they do not know or do not do this kind of work.

* Statistically significant difference between trained and untrained staff, $p \leq .05$ level

** Statistically significant difference between trained and untrained staff, $p \leq .01$ level

*** Statistically significant difference between trained and untrained staff, $p \leq .001$ level

Upon examination of the relationship between HIV–prevention training and more clinical contact measures, similar findings were seen. Findings were significant ($p \leq .05$) for differences in the proportion of trained clinical staff and untrained clinical staff who did not have fear of HIV transmission from giving an injection or IV (62.5 percent, $n=25$ vs. 32.0 percent, $n=8$) or dressing wounds (61.1 percent, $n=22$ vs. 34.6 percent, $n=9$) of someone with HIV (see Table 10).

Table 10: Relationship between Exposure to HIV–Prevention Training and No Fear of HIV Transmission/No Desire for Avoidance of Medical Procedures

	% Clinical Health Facility Staff Trained		% Clinical Health Facility Staff Untrained		P Value
	%	(n)	%	(n)	
Giving injection or IV drip					
PLHIV ^a	62.5	(25)	32.0	(8)	.017*
MSM ^b	97.4	(37)	88.5	(23)	.148
SW ^b	94.7	(36)	100.0	(25)	.244
Dressing wounds					
PLHIV ^a	61.1	(22)	34.6	(9)	.039*
MSM ^b	92.5	(37)	85.7	(24)	.365
SW ^b	94.9	(37)	96.8	(30)	.696
Suturing or conducting surgery					
PLHIV ^a	53.1	(17)	40.9	(9)	.377
MSM ^b	93.1	(27)	88.0	(22)	.519
SW ^b	96.4	(27)	95.7	(22)	.887

^aNo fear of HIV transmission with

^bNo desire for avoidance

NOTE: Analysis excludes those that indicated they did not know or did not do this kind of work.

* Statistically significant difference between trained and untrained staff, $p \leq .05$

Fear/Avoidance Findings by Health Facility Type

MARP–friendly facilities were less likely to report HIV–transmission fears or avoidance desires than their counterparts at general health facilities for some measures and groups. Specifically, those in MARP–friendly facilities were more likely not to report a desire to avoid touching the sweat/saliva of MSM (71.8 percent, $n=28$ vs. 44.9 percent, $n=40$) and SW (76.5 percent, $n=26$ vs. 56.3 percent, $n=49$) than those in general health facilities ($p \leq .01$ and $p \leq .05$, respectively). Greater levels of comfort in sharing a bathroom with an HIV–positive ($p \leq .01$) and MSM colleague ($p \leq .001$) were also found (see Table 11). A significant difference ($p \leq .01$) was also found in the proportion of clinical health facility staff from MARP–friendly vs. general health facilities reporting no fear of HIV transmission from PLHIV when giving injections or an IV (77.8 percent, $n=14$ vs. 40.4 percent, $n=19$); dressing wounds (81.3 percent, $n=13$ vs. 39.1 percent, $n=18$); and suturing/conducting surgery (84.6 percent, $n=11$ vs. 36.6 percent, $n=15$) (see Table 11). The same trend was seen with MSM and SW, but it was not significant.

Table 11: Relationship between Type of Health Facility (MARP–Friendly and General) and No Fear of HIV Transmission/No Desire for Avoidance of Medical Procedures

	MARP-Friendly Facility		General Facility		P Value
	%	(n)	%	(n)	
No desire to avoid sweat/saliva					
PLHIV ^a	75.6	(31)	61.7	(50)	.125
MSM ^b	71.8	(28)	44.9	(40)	.005**
SW ^b	76.5	(26)	56.3	(49)	.040*
Comfort sharing bathroom with colleague suspected to be:					
PLHIV	83.0	(39)	60.5	(69)	.006**
MSM	83.0	(39)	56.1	(64)	.001***
Giving injection or IV drip					
PLHIV ^a	77.8	(14)	40.4	(19)	.007**
MSM ^b	100.0	(18)	91.3	(42)	.196
SW ^b	100.0	(18)	95.6	(43)	.363
Dressing wounds					
PLHIV ^a	81.3	(13)	39.1	(18)	.004**
MSM ^b	100.0	(17)	86.3	(44)	.107
SW ^b	100.0	(16)	94.4	(51)	.335
Suturing or conducting surgery					
PLHIV ^a	84.6	(11)	36.6	(15)	.003**
MSM ^b	100.0	(13)	87.8	(36)	.186
SW ^b	100.0	(13)	94.7	(36)	.399

^aNo fear of HIV transmission with

^bNo desire for avoidance

NOTE: Analysis excludes those that indicated they did not know or did not do this kind of work.

* Statistically significant difference in the proportion of MARP–friendly and general health facility staff at the $p \leq .05$ level

** Statistically significant difference in the proportion of MARP–friendly and general health facility staff at the $p \leq .01$ level

*** Statistically significant difference in the proportion of MARP–friendly and general health facility staff at the $p \leq .001$ level

Differences in the proportion of staff from public, private, and NGO health facilities were also statistically significant ($p \leq .05$) for:

- Comfort sharing a bathroom with an HIV–infected colleague: 67.8 percent (n=78) public vs. 56.8 percent private (n=21) vs. 100.0 percent (n=9) NGO staff
- No desire for avoidance of touching the sweat/saliva of someone suspected to be an MSM: 54.0 percent (n=47) public vs. 40.6 percent (n=13) private vs. 88.9 percent (n=8) NGO
- No desire for avoidance of touching the sweat/saliva of someone suspected to be an SW: 64.0 percent (n=55) public vs. 46.4 percent (n=13) private vs. 100.0 percent (n=7) NGO.

Location

No significant differences were found with regards to fear/avoidance measures related to study location.

Shame, Blame, Judgment

HIV

Values or moral-driven judgments related to those who are stigmatized were another key stigma construct examined by this study. While most believed PLHIV and MARPs were deserving of quality care, blame and judgment were high. All clinical and most nonclinical (92.7 percent, n=76) health facility staff believed that PLHIV deserved the same level/quality of care as other clients (see Table 12). This finding was similar among social services staff; only 1.6 percent (n=1) believed PLHIV did not deserve the same quality of care.

Despite these findings, approximately 14 percent (13.5 percent, n=21) of health facility and 6.6 percent (n=4) of social services staff believed HIV and AIDS was a punishment for bad behavior. Approximately 10 percent (n=16) of health facility and (n=6) of social services respondents believed that people who have HIV and AIDS should be ashamed of themselves. The only significant difference found between clinical and nonclinical health facility staff related to HIV was agreement/disagreement that PLHIV deserved the same quality of care as others (p≤.05).

Gender Differences: No significant differences were found in the proportion of males and females on questions related to shame, blame, and judgment related to PLHIV.

Table 12: Measures of Shame, Blame, and Judgment with Health Facility and Social Services Organization Employees

Variable	Health Facility Staff						Social Services Staff	
	Nonclinical		Clinical		Total		%	(n)
	%	(n)	%	(n)	%	(n)	%	(n)
Disagreement that client deserves the same quality of care as other clients								
PLHIV ^{c*}	7.3	(6)	0.0	(0)	3.8	(6)	1.6	(1)
MSM ^{c*}	15.7	(13)	4.1	(3)	10.3	(16)	9.8	(6)
SW ^{c**}	9.6	(8)	0.0	(0)	5.0	(8)	3.4	(2)
HIV and AIDS is punishment for bad behavior	15.9	(13)	11.0	(8)	13.5	(21)	6.6	(4)
HIV and AIDS spreads due to immoral behavior	49.4	(41)	56.2	(41)	52.6	(82)	46.4	(26)
Homosexuality is immoral ^{f***}	82.7	(67)	83.6	(61)	83.1	(128)	62.7	(37)
Sex work is immoral ^{f*}	75.3	(61)	75.0	(54)	75.2	(115)	60.7	(34)

Variable	Health Facility Staff						Social Services Staff	
	Nonclinical		Clinical		Total		%	(n)
	%	(n)	%	(n)	%	(n)	%	(n)
People with HIV should be ashamed of themselves	12.2	(10)	8.1	(6)	10.3	(16)	10.0	(6)
MSM are the ones that spread HIV in our community	33.3	(27)	37.5	(27)	35.3	(54)	39.7	(23)
It is the women prostitutes who spread HIV	28.4	(23)	32.4	(24)	30.3	(47)	33.9	(20)

^{c*} Statistically significant differences between nonclinical vs. clinical staff, $p \leq .05$ level
^{c**} Statistically significant differences between nonclinical vs. clinical staff, $p \leq .01$ level
^{f*} Statistically significant differences between health facility vs. social services staff, $p \leq .05$
^{f***} Statistically significant differences between health facility vs. social services staff, $p \leq .001$

MSM

Approximately 10 percent of health facility and social services staff (10.3 percent, $n=16$ and 9.8 percent, $n=6$, respectively) disagreed that MSM deserved the same level/quality of care as other clients (see Table 12). Most health facility (83.1 percent, $n=128$) and social services (62.7 percent, $n=37$) staff believed that homosexuality was immoral with a significant difference between the two ($p \leq .001$). Thirty-five percent (35.3 percent, $n=54$) of health facility and 39.7 percent ($n=23$) of social services respondents believed that MSM were the ones that spread HIV in their community.

Gender Differences: No significant differences were found in the proportion of males and females on questions related to shame, blame, and judgment related to MSM.

Sex Workers

Five percent ($n=8$) of health facility and 3.4 percent ($n=2$) of social services respondents believed SW deserved less quality care than other respondents. The majority (75.2 percent, $n=115$) of health facility and (60.7 percent, $n=34$) social services respondents believed that sex work was immoral ($p \leq .05$). And 30.3 percent ($n=47$) of health facility and 33.9 percent ($n=20$) of social services workers believed it was the women prostitutes who spread HIV.

Gender Differences: The proportion of females from health facility and social services organizations who believed that SW deserve the same level of care as other clients was significantly higher ($p \leq .001$) (94.0 percent, $n=156$) than males (78.6 percent, $n=44$). Females were also significantly ($p \leq .05$) more likely to disagree that sex work is immoral (25.5 percent, $n=41$) than males (40.4 percent, $n=21$).

Comparison of Shame, Blame, Judgment Indicators across Groups

Across most measures, greater levels of shame, blame, and judgment were found toward MSM, followed by SW, than toward PLHIV among both health facility and social services staff.

Influence of Training on Shame, Blame, Judgment Indicators

Of those health facility staff trained in HIV prevention, fewer findings of shame, blame, and judgment toward PLHIV and MARPs were evident compared to untrained staff across all measures listed in Table 12. Differences in the proportion of trained vs. untrained health facility staff were statistically significant at the $p \leq .001$ level for those that agreed that MSM (97.4 percent, $n=76$ [trained] vs. 81.9 percent, $n=68$ [untrained]) deserved the same level of care as other clients and at the $p \leq .05$ level for those that agreed SW (98.8 percent, $n=79$ [trained] vs. 91.7 percent, $n=77$ [untrained]) deserved the same care (see Table 13). Also significant were findings related to the proportion of HIV prevention trained vs. untrained health facility staff who disagreed that HIV and AIDS spread due to immoral behavior ($p \leq .01$) and that homosexuality and sex work was immoral ($p \leq .05$ and $p \leq .01$, respectively).

A reverse trend between HIV–prevention training was seen among social services staff. Those who were untrained in HIV prevention generally reported less shame, blame, and judgment than those trained (see Table 13). An exception to this, however, was the belief that homosexuality and sex work were immoral. In these instances, those trained in HIV prevention were more likely to disagree.

Table 13: Relationship between Exposure to HIV–Prevention Training and Shame, Blame, and Judgment Indicators among Health Facility and Social Services Staff

	% Health Facility Staff Trained		% Health Facility Staff Untrained		P Value	% Social Services Staff Trained		% Social Services Staff Untrained		P Value
	%	(n)	%	(n)		%	(n)	%	(n)	
Agreement with: Client deserves same level/quality of care as other clients										
PLHIV	98.8	(79)	93.9	(77)	.102	97.6	(40)	100.0	(20)	.481
MSM	97.4	(76)	81.9	(68)	.001***	88.1	(37)	94.7	(18)	.420
SW	98.8	(79)	91.7	(77)	.035*	97.6	(40)	94.4	(17)	.542
Disagreement with:										
HIV and AIDS is punishment for bad behavior	89.7	(70)	84.1	(69)	.295	90.5	(38)	100.0	(19)	.164
People with HIV should be ashamed of themselves	91.1	(72)	89.0	(73)	.654	85.4	(35)	100.0	(19)	.079
MSM are the ones that spread HIV	68.8	(53)	61.3	(49)	.320	57.5	(23)	66.7	(12)	.509
Women prostitutes spread HIV	76.9	(60)	63.0	(51)	.055	65.9	(27)	66.7	(12)	.952

	% Health Facility Staff Trained		% Health Facility Staff Untrained		P Value	% Social Services Staff Trained		% Social Services Staff Untrained		P Value
	%	(n)	%	(n)		%	(n)	%	(n)	
HIV and AIDS spread due to immoral behavior	57.7	(45)	36.6	(30)	.007**	52.5	(21)	56.3	(9)	.799
Homosexuality is immoral	23.7	(18)	11.0	(9)	.034*	40.0	(16)	31.6	(6)	.532
Sex work is immoral	35.5	(27)	14.8	(12)	.003**	44.7	(17)	27.8	(5)	.225

* Statistically significant difference between trained and untrained staff, $p \leq .05$ level
** Statistically significant difference between trained and untrained staff, $p \leq .01$ level
*** Statistically significant difference between trained and untrained staff, $p \leq .001$ level

Findings on Shame, Blame, Judgment Measures Related to Health Facility Type

Significant differences were reported ($p \leq .01$) in the proportion of staff from MARP–friendly designated health facilities vs. general facilities regarding the belief that homosexuality was immoral (68.9 percent, $n=31$ [MARP–friendly] vs. 88.6 percent, $n=101$ [general facilities]). For the same indicator, staff in NGO facilities were significantly less likely ($p \leq .001$) to believe that homosexuality was immoral (11.1 percent, $n=1$) than those in public (86.7 percent, $n=98$) and private (89.2 percent, $n=33$) facilities. The same trend was also seen related to the belief that sex work was immoral ($p \leq .01$)—25.0 percent ($n=2$), 77.0 percent ($n=87$), and 78.4 percent ($n=29$), respectively. No other significant findings related to health facility type were found.

Location

No significant differences were found with regards to shame, blame, and judgment measures related to study location.

Enacted Stigma

Enacted stigma was the third stigma construct examined with health facility and social services respondents. Enacted stigma includes unlawful discrimination as well as a wider set of stigmatizing actions (Nyblade and MacQuarrie 2006). Among health facility staff, reports of enacted stigma within their facilities/organizations were highest for PLHIV, followed by MSM and SW (Table 14). Gossip was the most predominant form of enacted stigma, with 10.4 percent ($n=17$) of health facility staff having seen or heard this happen related to someone’s HIV status, 13.1 percent ($n=21$) to someone’s MSM status, and 8.0 percent ($n=13$) to someone’s SW status (see Table 14). The second most frequently reported enacted stigma event was seeing or hearing of HIV testing without someone’s consent—reported by 8.6 percent ($n=14$) of health facility staff for someone who was HIV positive or suspected of being HIV positive, 5 percent ($n=8$) for suspected MSM, and 3.1 percent ($n=5$) for suspected SW.

Table 14: Health Facility Staff that have Seen or Heard of Select S&D–Related Scenarios by Type of MARP

	PLHIV		MSM		SW	
	%	(n)	%	(n)	%	(n)
Received less care than other patients	6.8	(11)	4.4	(7)	1.2	(2)
Assigned by senior provider to junior provider	5.0	(8)	1.9	(3)	1.2	(2)
HIV tested without consent	8.6	(14)	5.0	(8)	3.1	(5)
Status (HIV, MSM, SW) gossiped about by health care provider	10.4	(17)	13.1	(21)	8.0	(13)
Refused health care services	5.5	(9)	1.9	(3)	1.8	(3)

Among social services staff, seeing or hearing jokes, gossip, or negative statements in reference to someone’s suspected status as HIV positive, MSM, or SW were reported. Over one-quarter of social services staff reported hearing or seeing these types of comments related to someone’s status as a sex worker (25.4 percent, n=15), 15.3 percent (n=9) around someone’s status as an MSM, and 11.9 percent (n=7) around someone’s status as HIV positive.

Over half (54.2 percent, n=32) of social services respondents said they had seen or heard of policies within their organization related to clients who were HIV positive. Fewer had seen or heard of these dealing explicitly with clients who identified as MSM or SW (18.6 percent, n=11 and 15.5 percent, n=9, respectively). Reports related to seeing/hearing co-workers disregard policies for these populations were small across all respondents—6.9 percent (n=4) for PLHIV, 6.8 percent (n=4) for MSM, and 5.2 percent (n=3) for SW. But of those that indicated having organizational policies, the proportion who had observed them violated were far greater—12.5 percent for PLHIV, 36.4 percent for MSM, and 33.3 percent for SW.

Findings on Enacted Stigma Measures Related to Health Facility Type

Significant differences ($p \leq .05$, $p \leq .01$) were found in the proportion of respondents from public, private, and NGO health facilities reporting seeing or hearing incidences of enacted stigma within their facility. Only private health facility staff reported seeing/hearing a senior health care provider assign a more junior provider to a client because they were suspected of being an SW (5.4 percent, n=3) ($p \leq .05$) or MSM (8.1 percent, n=3) ($p \leq .01$). Private health facility staff were also the only ones to report hearing/seeing an SW (8.1 percent, n=3) or MSM (7.9 percent, n=3) refused care because of suspicion over their status as MSM or SW ($p \leq .01$). Additionally, private health facility staff were more likely to report hearing of an HIV–positive client assigned from a senior to junior provider because of their status (13.9 percent, n=5 [private] vs. 11.1 percent, n=1 [NGO] vs. 1.7 percent, n=2 [public]) ($p \leq .01$). No other significant differences were found based on health facility type.

Location

Significant differences were found in the proportion of staff reporting hearing or seeing the following enacted stigma measures within their health facility/organization:

- Health facilities:
 - Staff in Montego Bay (100.0 percent, n=42) were more likely to have not seen or heard of someone gossiped about because they were suspected to be an SW than

staff in Ocho Rios (97.6 percent, n=37) and Kingston (84.8 percent, n=67) ($p \leq .01$).

- Staff in Montego Bay (100.0 percent, n=39) were more likely to have not seen or heard of someone gossiped about because they were suspected to be an MSM than staff in Ocho Rios (90.2 percent, n=37) and Kingston (78.7 percent, n=63) ($p \leq .01$).
- Social services organizations:
 - Staff in Ocho Rios (100.0 percent, n=6) were more likely to have not seen or heard of someone disregarding their organization's policies toward the treatment of those with HIV and AIDS than staff in Kingston (95.6 percent, n=43) and Montego Bay (71.4 percent, n=5) ($p \leq .05$).
 - Staff in Kingston (95.6 percent, n= 43) were more likely to have not seen or heard of organizational policies toward clients who are sex workers than staff in Montego Bay (57.1 percent, n=4) and Ocho Rios (33.3 percent, n=2) ($p \leq .001$).

Other S&D Measures

The majority of health facility staff (88.0 percent, n=139) reported that seeing two men kiss made them feel uncomfortable. Among social services organization staff, 20 percent (n=11) reported that there were certain types of MSM they felt more comfortable working with than others. Similarly, 16.1 percent (n=9) of social services staff indicated that there were certain types of SW they felt more comfortable with than others, and 44.7 percent (n=21) said that they would prefer not to know the details of the work their SW clients engaged in.

Vignette Findings

Eight scenarios were interspersed throughout the health facility and social services organization questionnaire. Each scenario described the fictional character's occupation, romantic partner, symptoms, and diagnosis. For each condition diagnosed in the vignette, a brief description of the illness was given with information as to whether it was communicable or not. The following analysis looked at a variety of S&D constructs by vignette character type—non-MSM and HIV positive, non-MSM and HIV negative, MSM and HIV positive, MSM and HIV negative, non-SW and HIV positive, non-SW and HIV negative, SW and HIV positive, and SW and HIV negative.

For each vignette respondents were read 10 identical statements and asked to indicate if they strongly agree, agree, strongly disagree, or disagree. Responses were tabulated using an eight-point scale across each of the 10 questions—with one representing the lowest stigma score and eight the highest.

The statements generating the highest collective stigma scores were as follows²:

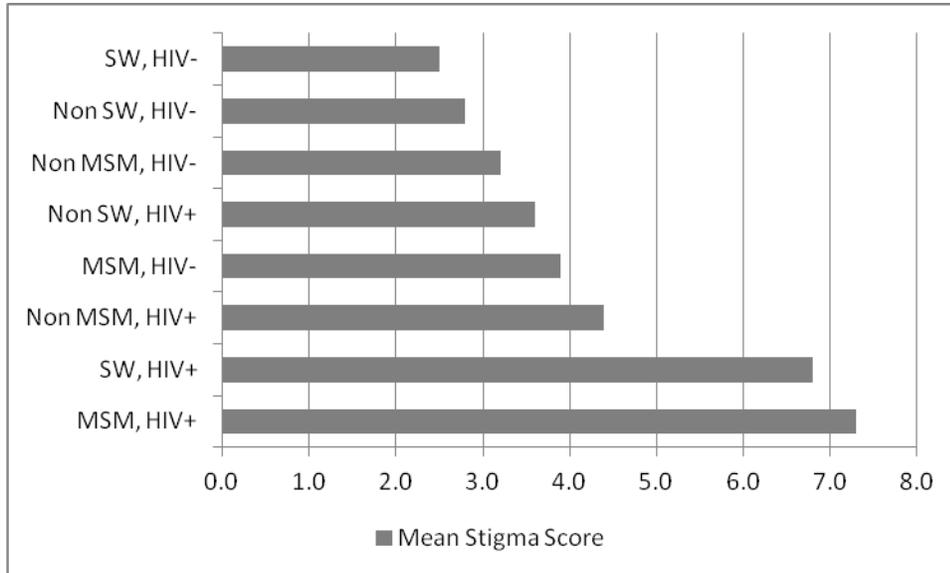
- [Character name] is responsible for his/her illness.
- You would allow your children to visit [character name] in his/her home.
- You would attend a party where [character name] was preparing food.

² Participants were asked to note their level of agreement or disagreement with each statement.

- [Character name] is dangerous to other people.
- [Character name] deserves sympathy.

Across both health facility and social services respondents, the highest stigma levels were found for the MSM and HIV positive character (see Figure 3) followed by the SW character who was HIV positive. Ranking third and fourth in terms of degree of stigma were the non-MSM HIV positive character and the MSM HIV negative character, respectively.

Figure 3: Mean Stigma Score by Character Type for Vignettes



Of particular note among the findings was the magnitude of stigma reported for certain questions, namely belief around responsibility for one’s illness and danger to others (see Table 15):

- Seventy two (72.1 percent, n=158) of respondents believed the SW and HIV–positive character was responsible for her illness, followed by 54.6 percent (n=118) who believed the MSM and HIV–positive character was responsible.
- Forty-six percent (n=97) of respondents believed the SW and HIV–positive character was dangerous to others, followed by 38.0 percent (n=82) who believed the MSM and HIV–positive character was dangerous.

Statistically significant differences were seen in the proportion of staff from health facilities and social services organizations reporting across the vignette S&D constructs. Social services staff indicated higher levels of S&D across all vignette constructs (MARP and non-MARP–friendly) than did health facilities staff. Staff from health facilities were significantly more likely than social services staff to believe that all depicted characters deserved the best care possible ($p \leq .05$, $p \leq .01$, or $p \leq .001$). They also were significantly less likely to believe that the world would be better off without the individuals portrayed and that the characters deserved to lose their jobs ($p \leq .05$, $p \leq .01$, or $p \leq .001$).

Health facility and social services staff's responses were most aligned on stigma measures such as attending a party where someone was serving food and allowing their children to visit someone's home.

Table 15: Stigma Domains in Health and Social Services Sector from Vignette Responses

	Non- MSM, HIV- (Robert)	MSM, HIV- (James)	Non- MSM, HIV+ (John)	MSM, HIV+ (Mark)	Non- SW, HIV- (Mary)	SW, HIV- (Katie)	Non- SW, HIV+ (Paula)	SW, HIV+ (Linda)
Agrees: Responsible for illness	***	***		*	**	***		***
Health facility	12.2	8.8	39.5	58.9	8.1	21.7	27.9	78.8
Social services	31.6	27.1	42.1	43.1	20.7	45.0	37.9	54.2
Total	17.4	13.7	40.2	54.6	11.5	28.1	30.7	72.1
Disagrees: Deserves sympathy	**	***	***	***	***		***	**
Health facility	15.1	11.9	9.9	11.9	8.1	9.4	8.2	17.3
Social services	31.0	36.7	33.9	37.3	36.8	18.3	34.5	34.5
Total	19.4	18.7	16.4	18.8	15.6	11.9	15.2	21.8
Agrees: Deserves what happened to him/her	***	***	**		***	*	***	
Health facility	3.2	1.9	6.4	12.6	1.9	5.0	3.2	9.4
Social services	19.3	19.3	19.0	20.7	17.2	13.3	18.6	17.9
Total	7.4	6.5	9.8	14.7	6.0	7.3	7.4	11.6
Agrees: Is dangerous to others	***	***			***	***		
Health facility	4.5	6.9	27.5	37.7	5.0	12.1	25.8	49.3
Social services	27.6	30.5	38.6	38.6	27.1	36.7	35.7	36.8
Total	10.8	13.3	30.4	38.0	11.0	18.9	28.4	46.0
Disagrees: Deserves best care possible	***	***	***	***	***	**	***	***
Health facility	7.1	6.2	5.6	7.6	6.1	4.4	4.4	8.8
Social services	26.3	28.3	27.6	31.7	30.5	15.0	31.7	27.1
Total	12.3	12.2	11.5	14.2	12.6	7.3	11.9	13.8
Agrees: World would be better off without	***	***	***	***	***	***	***	**
Health facility	3.8	5.2	3.1	6.3	2.5	1.9	2.6	7.0
Social services	20.3	22.4	15.8	24.1	25.4	13.3	17.2	20.0
Total	8.3	9.9	6.5	11.1	8.6	5.0	6.5	10.3
Agrees: Deserves to lose job	***	***	***	***	***	*	***	***
Health facility	5.0	5.7	2.5	8.4	6.8	3.2	3.1	8.2
Social services	24.1	27.1	24.1	35.6	28.8	11.7	25.9	28.8
Total	10.1	11.6	8.2	15.9	12.7	5.6	9.2	13.8
Disagrees: Willing to have conversation	***	***	**	**	***		***	***
Health facility	3.7	5.0	4.4	7.6	2.5	2.5	3.1	4.3
Social services	16.9	24.1	17.2	21.1	19.0	6.7	20.0	22.4

	Non- MSM, HIV- (Robert)	MSM, HIV- (James)	Non- MSM, HIV+ (John)	MSM, HIV+ (Mark)	Non- SW, HIV- (Mary)	SW, HIV- (Katie)	Non- SW, HIV+ (Paula)	SW, HIV+ (Linda)
Total	7.3	10.1	7.8	11.2	6.8	3.6	7.8	9.1
Disagrees: Would attend party where s/he is preparing food		*			***			
Health facility	8.1	15.7	29.5	41.7	7.0	28.8	28.5	34.0
Social services	16.7	28.8	32.8	33.3	24.1	33.3	25.9	25.4
Total	10.5	19.3	30.4	39.4	11.6	30.1	27.8	31.7
Disagrees: Would allow children to visit in her/his home		*			***	*		
Health facility	10.7	22.5	26.1	44.9	5.7	17.2	25.2	26.8
Social services	20.0	37.3	37.9	42.1	27.1	30.0	32.2	32.8
Total	13.2	26.5	29.3	44.2	11.5	20.7	27.2	28.4

*Statistically significant difference between health facility and social services staff reporting, $p \leq .05$
** Statistically significant difference between health facility and social services staff reporting, $p \leq .01$
*** Statistically significant difference between health facility and social services staff reporting, $p \leq .001$

Effect of Training on Vignette Responses

The relationship between vignette stigma responses and whether respondents had received HIV-prevention training was examined. Findings showed an overall positive relationship between taking part in training and reduced enacted stigma. Vignette stigma responses that were significant are summarized below.

- Non-MSM, HIV-negative character:
 - Disagreement that he was responsible for his illness: 88.6 percent (n=101) trained vs. 75.5 percent (n=74) untrained ($p \leq .05$).
- Non-MSM, HIV-positive character:
 - Agreement that respondent would attend a party where he was preparing food: 78.3 percent (n=90) trained vs. 59.2 percent (n=58) untrained ($p \leq .01$).
 - Disagreement that he deserves what has happened to him: 94.9 percent (n=112) trained vs. 84.4 percent (n=81) untrained ($p \leq .01$).

- MSM, HIV–positive character:
 - Agreement that respondent would attend a party where he was preparing food: 69.0 percent (n=80) trained vs. 50.0 percent (n=48) untrained (p≤.01).
- Non–SW, HIV–negative character:
 - Disagreement that she was responsible for her illness: 93.2 percent trained (n=110) vs. 82.8 percent (n=82) untrained (p≤.05).
 - Agreement that respondent would be willing to have a conversation with her: 96.6 percent (n=114) trained vs. 89.0 percent (n=89) untrained (p≤.05).
- SW, HIV–negative character:
 - Agreement that respondent would be willing to have a conversation with her: 99.2 percent (n=118) trained vs. 93.0 percent (n=93) untrained (p≤.05).
- SW, HIV–positive character:
 - Agreement that respondent would attend party where she was preparing food: 76.7 percent (n=89) trained vs. 58.4 percent (n=59) untrained (p≤.01).

Vignette Findings by Health Provider Type

Among health facility staff, significant differences were found related to the proportion of clinical vs. nonclinical staff who believed that the non–MSM, HIV–positive character deserved the best medical care possible (p≤.01) and who would attend a party where he was preparing food (p≤.05). Nonclinical staff (98.8 percent, n=80) were more likely than clinical staff (89.0 percent, n=65) to believe that this character deserved the best care. Conversely, it was clinical staff who were more likely (82.4 percent, n=56) to agree that they would be willing to attend a party where this same person was preparing food than nonclinical (64.6 percent, n=53).

Vignette Findings by Health Facility Type

Significant differences (p≤.05 and p≤.01) were found between MARP–friendly and general health facility staff responses related to four of the eight vignette characters—the non–SW, HIV–positive character, the non–SW, HIV–negative character, the non–MSM, HIV–positive character, and the MSM, HIV–positive character. These findings are presented below.

- Non–SW, HIV–positive character:
 - Disagreement that she was dangerous to others: 90.7 percent (n=39) MARP–friendly vs. 67.9 percent (n=76) general health facility staff (p≤.01).
 - Agreement that the respondent would attend a party where she was preparing food: 86.0 percent (n=37) MARP–friendly vs. 66.1 percent (n=76) general health facility staff (p≤.05).
 - Agreement that respondent would allow his/her children to visit her in her home: 88.4 percent, n=38 MARP–friendly vs. 69.8 percent (n=81) general health facility staff (p≤.05).
- Non–SW, HIV–negative character:
 - Disagreement that the world would be better off without her: 99.1 percent (n=116) general vs. 93.5 percent (n=43) MARP–friendly staff (p≤.05).

- Disagreement that she deserves to lose her job: 95.7 percent (n=111) general vs. 87.0 percent (n=40) MARP-friendly staff ($p \leq .05$).
- Non-MSM, HIV-positive character:
 - Agreement that the respondent would attend a party where he was preparing food: 88.6 percent (n=39) MARP-friendly vs. 63.4 percent (n=71) general health facility staff ($p \leq .01$).
 - Agreement that the respondent would allow his/her children to visit him in his home: 88.6 percent (n=39) MARP-friendly vs. 68.1 percent (n=77) general health facility staff ($p \leq .01$).
- MSM, HIV-positive character:
 - Disagreement that he was dangerous to others: 78.3 percent (n=36) MARP-friendly vs. 55.8 percent (n=63) general health facility staff ($p \leq .01$).
 - Agreement that he deserves the best medical care possible: 100.0 percent (n=44) MARP-friendly vs. 89.5 percent (n=102) general health facility staff ($p \leq .05$).
 - Agreement that the respondent would attend a party where he was preparing food: 73.3 percent (n=33) MARP-friendly vs. 52.3 percent (n=58) general health facility staff ($p \leq .05$).
 - Agreement that respondents would allow their children to visit him in his home: 72.7 percent (n=32) MARP-friendly vs. 48.2 percent (n=55) general health facility staff ($p \leq .01$).

Gender

A significant difference ($p \leq .05$) was found in male and female responses from both health facilities and social services organizations for the MSM, HIV-positive character and the SW, HIV-negative character. For the MSM, HIV-positive individual, females were more likely to disagree that the world would be better off without this individual (91.9 percent, n=148) than males (81.8 percent, n=45). For the HIV-negative, SW character, females were more willing to have a conversation with her—98.2 percent (n=160) females vs. 91.1 percent (n=51) males. Additionally, females were more likely to disagree that this character deserved what happened to her (95.1 percent, n=156 [females] vs. 85.5 percent, n=47 [males]) and deserved to lose her job (96.3 percent, n=155 vs. 88.9 percent, n=48) ($p \leq .05$).

Component Three: Sex Workers

Demographics

Interviewer-administered questionnaires were used to solicit information on SW's experiences and perceptions of stigma. Having received money in exchange for sex within the last three months constituted the inclusion criteria for this study. A total of 450 SW were interviewed in Kingston, Ocho Rios, and Montego Bay; 26 percent (n=117) were males, 72 percent (n=324) females, and 1.8 percent (n=8) male-to-female transgendered individuals (see Table 16). Participant ages ranged from 18 to 59 years, with the mean age 27.8 years.

Table 16: Sex Work Sample by Gender

Target Group	Parish			Total	% Sample Reached**
	Kingston	Ocho Rios	Montego Bay		
Male	35	45	37	117	83.3%
Male to female*	3	0	5	8	
Female	112	105	107	324	108%
Missing	0	0	1	1	
Total	150	150	150	450	

*For further analyses, male-to-female transgender were counted as male

** The original sample of 300 FSW was exceeded by 8% (n=24), however, the original sample of 150 MSW fell short by 16.7% (n=25)

The majority of SW participants were operating in clubs at the time of the survey (47.1 percent, n=210), followed by working on the street (33.6 percent, n=150), and in massage parlors (12.1 percent, n=54). MSW were most likely to be working on the street (43.1 percent, n=53) while FSW worked most commonly in clubs (56.5 percent, n=182) (see Table 17).

Table 17: SW Sites by Location

Site	MSW		FSW		Total	
	%	(n)	%	(n)	%	(n)
Clubs	22.8	28	56.5	182	47.1	(210)
Street	43.1	53	29.8	96	33.6	(150)
Massage parlor	25.2	31	7.1	23	12.1	(54)
Beach	8.1	10	1.2	4	3.1	(14)
Hotel	0.0	0	4.0	13	2.9	(13)
Guest house	0.0	0	0.9	3	0.7	(3)
Bar	0.8	1	0.3	1	0.4	(2)
Total	100.0	123	100.0	322	100.0	(445)

Of those who responded, almost all SW had received formal education and training (97.5 percent, n=429) (see Table 18). The mean years of schooling attained for respondents was 13 years. Gender differences in schooling were significant ($p \leq .05$). Sixty percent (59.5 percent,

n=66) of males and 42.5 percent (n=131) of females had attained education beyond secondary levels.

Of those responding, 93.3 percent (n=416) had never been married (see Table 18). Reported marriage was slightly higher among males (12.1 percent, n=15) than females (4.7 percent, n=15). The majority of respondents were not married or living with any sexual partner (66.5 percent, n=292), followed by not married but living with a sexual partner (27.8 percent, n=122). Fifty-six percent (n=70) of MSWs indicated that they had a main male partner who they saw regularly.

Table 18: Demographic Characteristics of Participants

Variable	FSW		MSW		Total	
	%	(n)	%	(n)	%	(n)
Age						
Mean		28.4		26.1		27.8
Min		18.0		18.0		18.0
Max		59.0		53.0		59.0
Education						
Ever attended						
Yes	97.2	(309)	98.4	(120)	97.5	(429)
No	2.8	(9)	1.6	(2)	2.5	(11)
Mean years of schooling		13.0		14.2		13.3
Highest level attained						
None	0.3	(1)	0.0	(0)	0.2	(1)
Primary	8.8	(27)	4.5	(5)	7.6	(32)
Secondary	48.4	(149)	36.0	(40)	45.1	(189)
Higher	42.5	(131)	59.5	(66)	47.0	(197)
Total	100.0	(308)	100.0	(111)	100.0	(419)
Marital status						
Ever been married						
Yes	4.7	(15)	12.1	(15)	6.7	(30)
No	95.3	(307)	87.9	(109)	93.3	(416)
Current status						
Married/living w/spouse	0.3	(1)	4.3	(5)	1.4	(6)
Married/living w/other sex partner	1.5	(5)	1.7	(2)	1.6	(7)
Married/not living w/any partner	2.2	(7)	4.3	(5)	2.7	(12)
Not married/living w/sex partner	27.6	(89)	28.4	(33)	27.8	(122)
Not married/not living w/any partner	27.8	(221)	61.2	(71)	66.5	(292)
Total	100.0	323	100.0	116	100.0	439

Stigma and Discrimination

The survey instrument contained three series of questions that sought to measure S&D experienced by sex workers. One series focused on disclosure of SW status, one on S&D

experienced within the last six months, and the third on experiences with stigma, specifically in a clinic setting and respondent perceptions of these experiences.

Disclosure

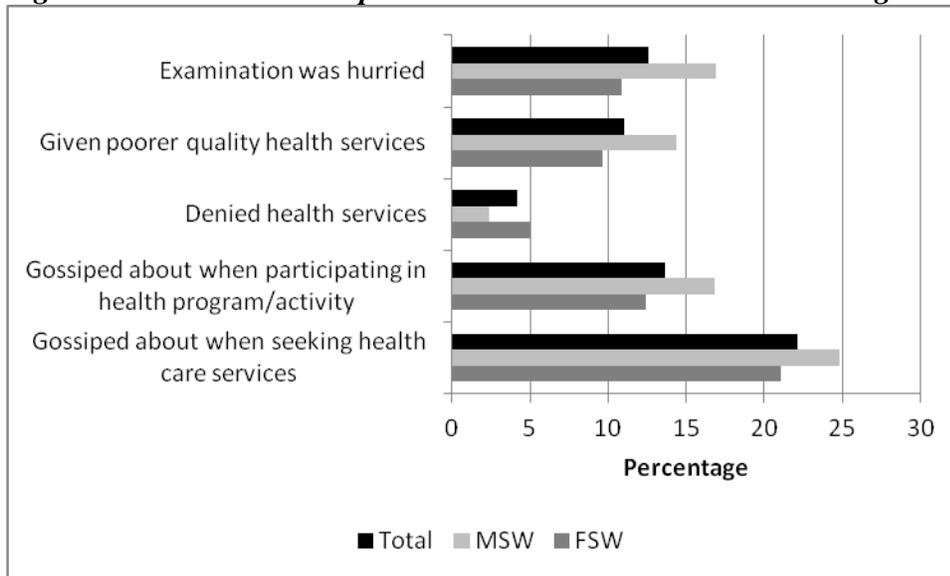
Disclosure is the fourth underlying stigma construct examined in this study. Disclosure is often used as a proxy for the level of S&D that exists within a particular setting. This assumes that greater disclosure occurs in settings with decreased S&D (Nyblade and MacQuarrie 2006). Almost half of the respondents (49.9 percent, n=223) had ever told a health care provider that they engaged in sex work. Similar proportions of males (48.8 percent, n=61) and females (50.3 percent, n=162) reported disclosure. The majority of those who had disclosed did so to a doctor (58.0 percent, n=105), followed by a nurse (38.6 percent, n=86), peer educator/influencer (14.8 percent, n=31), receptionist (7.2 percent, n=16), or others (6.7 percent, n=5). Nearly half (48.0 percent, n=107) indicated that the person they told had some type of reaction in response to their disclosure. These immediate reactions varied from looking surprised (18.4 percent, n=41) to being lectured or told it was bad (19.3 percent, n=43) to having the person refer them to someone else (1.8 percent, n=4). No respondents indicated that they were asked to leave the facility immediately after this disclosure, though 12.5 percent (n=17) reported on another question that they had been told not to return to the clinic. MSW were significantly more likely to be told not to return (26.2 percent, n=16 vs. 11.0 percent, n=17) ($p \leq .01$) for FSW. More than one-third of those who had disclosed regretted doing so (37.3 percent, n=47). MSW reported a slightly higher proportion of negative reactions than did FSW based on disclosing their status.

Experience with Health Services within the Last Six Months

As a proxy for determining recent (within the last six months) S&D against SW by health care workers and health-related program workers, participants were asked about their experiences when accessing health services. A proportion of respondents (22 percent, n=99) reported that they were gossiped about while seeking health care services because of how they earned their money (see Figure 4). Reported gossip when participating in health programs or activities was less, at 13.6 percent (n=61).

Four percent (4.2 percent, n=19) of SW reported having been denied health care services because of how they earned their money, and 11.0 percent (n=49) reported that they were given poorer quality health care services for the same reason. Some participants (12.6 percent, n=56) believed staff hurried to finish their exam because of their SW status.

Figure 4: Sex Workers' Experiences with Health Services and Programs (Last Six Months)



**Includes those who responded, 'I don't know.'*

Gender

Across nearly all stigma measures, MSW reported experiencing the highest proportion of S&D within the past six months. Gender differences were significant ($p \leq .05$) for those who answered definitely no or yes³ to being gossiped about while participating in a health-related program or activity—23.1 percent ($n=21$) of MSW reported gossip vs. 13.9 percent ($n=40$) of FSW. The proportion of males vs. females that believed staff had/had not hurried to finish their exam because of how they earned their money was also significant ($p \leq .05$)—20.2 percent, $n=21$ of MSW reported they were hurried as compared with 11.4 percent ($n=35$) of FSW.

Influence of Disclosure on Stigma within the Last Six Months

Significant differences² were found in the proportion of SW who had ever disclosed their status to a health care provider as compared with those who had not on several stigma items. Those who disclosed their SW status were significantly more likely to report:

- Being denied health care services compared with those who had not disclosed (6.8 percent, $n=15$ vs. 1.9 percent, $n=4$) ($p \leq .05$).
- Being given poorer quality health care services compared with those who had not disclosed (15.4 percent, $n=32$ vs. 7.7 percent, $n=16$) ($p \leq .05$).
- Feeling hurried through their examination so they would leave quickly compared to those who had not disclosed (21.3 percent, $n=43$ vs. 6.4 percent, $n=13$) ($p \leq .001$).

Experiences of SW in Ever Seeking Care

Male and female SW experiences at clinics and their feelings related to these experiences were measured using a Likert-type scale. Agree and strongly agree responses were aggregated. The findings reported in this section refer to all SW respondents regardless of disclosure status. The researchers assumed that respondents' SW status might have been known or suspected by clinic

³ Excludes those who responded "I don't know."

workers through means other than direct disclosure. Of all SW who responded, over half (50.4 percent, n=214) believed it was risky to tell someone in a clinic of their SW status, and 76.4 percent (n=331) said they were very careful to whom they disclosed their sex work (see Table 19). Despite this, 66.6 percent (n=295) reported that they never felt the need to hide the fact that they were an SW from clinic staff.

SW reported a variety of feelings related to their experiences at clinics, including worrying about how they might be treated. One-third of respondents (33.2 percent, n=64) reported feeling hurt by the response of clinic staff to learning that they were an SW (see Table 19). Some respondents believed that clinic staff treated them coldly or were distant because they knew they were an SW (22.8 percent, n=91). Forty-three percent (43.8 percent, n=195) of respondents worried that since they became an SW health care providers would discriminate against them. And over half (52.4 percent, n=223) of respondents worried clinic staff would judge them upon learning they were an SW or would tell others of their SW status (61.3 percent, n=272).

Some SW felt that they were unable to seek health or emotional support from health providers due to the fact they were SW. Sixteen percent (16.6 percent, n=71) believed they could not go anywhere for health, emotional, or social support because they were an SW (see Table 19). Nearly 10 percent (9.2 percent, n=37) had stopped going to the clinic because of staff reactions and 30 percent (30.3 percent, n=132) believed it was easier to avoid getting help than to worry about telling someone they were an SW.

Table 19: Stigma Environment Reported by SW

Variable	FSW		MSW		Total	
	%	(n)	%	(n)	%	(n)
Hurt by clinic reaction to learning s/he was an SW**	26.6	(37)	50.0	(27)	33.2	(64)
Some in clinic who knew of SW status were distant/cold***	18.3	(53)	34.5	(38)	22.8	(91)
Since becoming an SW, felt they couldn't go anywhere for health/emotional/social support***	10.9	(34)	31.6	(37)	16.6	(71)
Stopped going to clinic because of reactions due to being an SW***	4.8	(14)	20.9	(23)	9.2	(37)
Believed telling someone at clinic of SW status was risky***	41.1	(127)	75.0	(87)	50.4	(214)
Believed it was easier to avoid getting help than tell clinic they are an SW*	27.2	(86)	38.7	(46)	30.3	(132)
Respondent is very careful who s/he tells s/he is an SW**	73.1	(231)	85.5	(100)	76.4	(331)
Worries about health providers discriminating against her/him since becoming an SW***	35.9	(115)	64.0	(80)	43.8	(195)
Never feels the need to hide SW status from clinic staff*	63.8	(203)	73.6	(92)	66.6	(295)

Variable	FSW		MSW		Total	
	%	(n)	%	(n)	%	(n)
Worries people in clinic may judge when they learn respondent is SW***	44.1	(141)	73.6	(92)	52.4	(233)
Worries people in clinic who know respondent is SW will tell others***	53.9	(172)	80.0	(100)	61.3	(272)

*Statistically significant difference between FSW and MSW, $p \leq .05$ level

**Statistically significant difference between FSW and MSW, $p \leq .01$ level

*** Statistically significant difference between FSW and MSW, $p \leq .001$ level

Gender

Across all measures of SW–perceived stigma, significant differences at the $p \leq .05$, $p \leq .01$, or $p \leq .001$ levels were found; MSW reported higher levels than FSW of worry, avoidance, and feelings of isolation as it related to health, emotional, or social support (see Table 19).

Use of HIV–Prevention Services and Medical Care

Exposure to HIV–Prevention Programs

This study also examined recent access (within the past six months) to HIV–prevention services among SW. The majority of respondents had spoken in the last six months with a peer educator or influencer about ways to prevent HIV (82.1 percent, $n=363$ of those who responded).

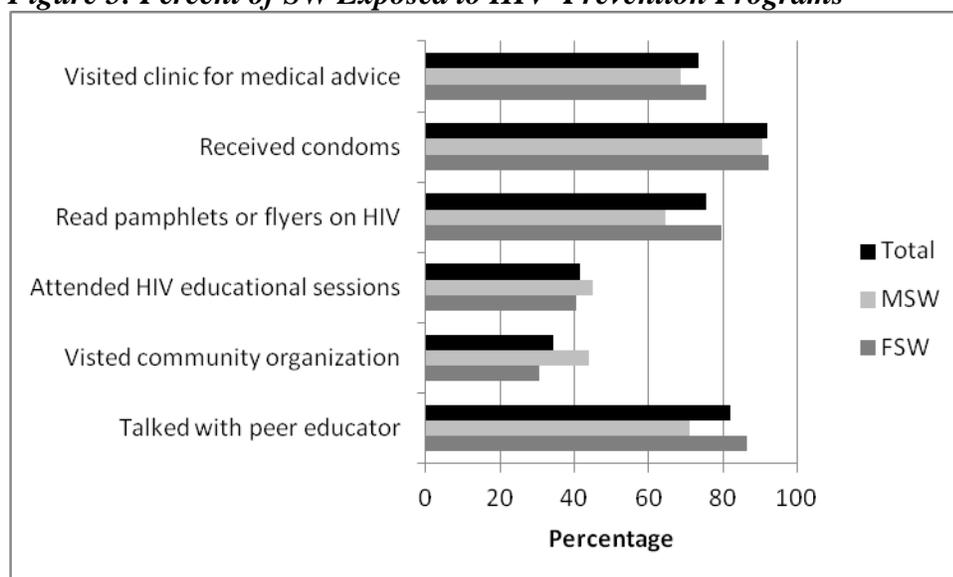
Significant differences were found between males and females who had done so (71.0 percent, $n=88$ [males] vs. 86.5 percent [females], $n=275$) ($p \leq .001$) with greater reach among FSW (see Figure 5). The majority of those who responded reported talking with someone from MOH clinics or program staff (67.5 percent, $n=284$) followed by NGOs, including JASL, Jamaica Red Cross, and Children First (10 percent, $n=42$).

Approximately a third (34.4 percent, $n=149$) of respondents reported that they had visited a CBO in the last six months. Among respondents, a significantly larger proportion of the males (43.9 percent, $n=54$) had visited a CBO than females (30.6 percent, $n=95$) ($p \leq .05$) (see Figure 5). Unfortunately, a significant number of MOH clinic facilities were inadvertently listed among the community-based organizations that the respondents were asked to name. The primary CBOs named were, again, Jamaica Red Cross, JASL, and Children First.

Attendance at HIV–prevention educational sessions for SW was reported by 41.7 percent ($n=183$) of respondents, comprising 45.1 percent ($n=55$) of males and 40.5 percent ($n=128$) of FSW. Additionally, 75.4 percent ($n=331$) of respondents had read HIV–prevention printed material in the last six months (see Figure 5). MOH agencies and personnel were the primary sources for distributed materials (90 percent). Only 7 percent ($n=35$) of respondents received printed educational material from JASL and 1.7 percent ($n=6$) from Children First.

The majority of SW who responded (92.4 percent, $n=400$) received condoms from HIV–prevention organizations within the last six months with little difference seen by gender. MOH facilities and personnel were the main sources of condoms. Only a few respondents reported receiving condoms from JASL, the Red Cross, or Children First.

Figure 5: Percent of SW Exposed to HIV-Prevention Programs



Medical Visits

Of the total SW interviewed who responded, 73.6 percent (n=321) reported visiting a medical facility within the past six months (see Figure 5). A slightly higher but not significant proportion of females than males reported facility visits. The primary reason for visits listed were for a general physical (42.4 percent, n=189), followed by STI concern (24.1 percent, n=108), and HIV testing (23.4 percent, n=105) (see Table 20).

Table 20: Reason for Health Facility Visit within the Past Six Months

Reason for Visit	FSW		MSW		Total	
	%	(n)	%	(n)	%	(n)
General physical	44.3	(143)	37.4	(46)	42.4	(189)
STI concern	23.1	(75)	26.4	(33)	24.1	(108)
HIV concern	6.5	(21)	6.4	(8)	6.5	(29)
HIV testing	26.5	(86)	15.2	(19)	23.4	(105)
Pregnancy concern	6.5	(21)	0.0	(0)	4.7	(21)
Other family planning/reproductive health services	3.1	(10)	0.0	(0)	2.2	(10)
Psychological services	0.3	(1)	1.6	(2)	0.7	(3)
Other concern	3.4	(11)	5.6	(7)	4.0	(18)

Disclosure at Visit within Last Six Months: Of those who responded, 45.0 percent (n=153) reported disclosing their status as an SW during their clinic visit within the last six months⁴; females (48.0 percent, n=122) reported this in higher proportion than males (36.0 percent, n=31). Of those who did not disclose, only 63 offered an explanation. The primary reasons provided for nondisclosure: feeling it was not necessary or that they were not asked (10.2 percent); believing

⁴ Forty-three (28.7 percent) participants reported disclosing their status as an SW at a health facility within the last six months who reported they had not ever disclosed their SW status on an earlier question; this makes the validity of these data and findings questionable.

the disclosure would not be kept confidential (5.8 percent); fearing discrimination (5.3 percent); or feeling uncomfortable or too shy to disclose (2.7 percent).

Discussion

Components One and Two: Health Facilities and Social Services Organizations

Among the most pressing findings from this study was the lack of training among health facility and social services staff and its link with reported S&D. The majority of health facility and social services staff interviewed had not received training specific to HIV or working with MARPs; the higher preponderance of untrained staff was found in health facilities vs. social services organizations. While clinical staff reported having more training than their nonclinical colleagues, they also reported similar levels of S&D, or in some cases, greater levels than their untrained colleagues. Overall, however, training was significantly linked to decreased S&D across a variety of constructs for health facilities⁵. The dearth of training across sectors in psycho-social support, interpersonal communication, and specific to working with at-risk populations speaks to a clear unmet need.

Training exposure also varied by type of health facility and by location. Higher proportions of staff reported being untrained in public facilities as compared to private or NGO facilities. Those facilities designated as “MARP-friendly” prior to sampling reported less instances of S&D in general than those designated as general facilities and had higher levels of training in HIV prevention, psycho-social support (for MSM and SW), and work with MARPs. It is important to note, however, that despite this designation and training, these facilities still had considerable levels of reported stigma requiring intervention.

S&D were examined across several constructs. The first—fear of casual contact with PLHIV and desire for avoidance of casual contact with MSM and SW—were one lens through which S&D were assessed via general questions and the vignettes. Fear of HIV transmission from PLHIV reported in this study was very high—approximately a third of staff across sectors feared contracting HIV from touching the sweat/saliva of someone with HIV or wanted to avoid the same contact with someone who was an MSM or an SW. What is most surprising about this finding is that relatively little difference was found between clinical and nonclinical health facility staff reporting this fear. The desire to avoid a bathroom with a colleague suspected to be PLHIV, MSM, or SW provoked similar responses.

Findings from the vignettes further illustrated widespread fear and avoidance desires as well as evidence of layered stigma. While approximately 10 percent of respondents expressed a desire to avoid attending a party where an HIV-negative person (not MSM or SW) was preparing food, the avoidance desire was magnified as the food preparer’s characteristics changed. When the food preparer was HIV positive (not MSM or SW), the avoidance desire increased dramatically to roughly 30 percent. This finding was not surprising given that one of the pervading stigmatizing attitude measures recorded in the current National KAPB report is “would not eat food prepared by PLHIV” (National KAPB 1996, 2004, 2008). The level of reported stigma

⁵ Note: No significant differences were seen related to training and stigma and discrimination with social service organizations. Training was positively correlated with lower stigma and discrimination scores for the most part related to fear of casual contact measures but was mixed or negatively correlated with shame, blame, and judgment measures.

increased even further when the food preparer in question was HIV positive as well as an MSM or SW (39.4 percent and 31.7 percent, respectively), demonstrating the compounding effect of HIV stigma plus stigma toward MARPs.

Among health facility staff, findings were concerning with regards to fear of conducting clinical procedures on PLHIV. Approximately half of clinical providers were afraid of getting HIV when suturing or operating on PLHIV and nearly half reported fear of dressing PLHIV's wounds or giving an IV or injection. Avoidance desires for the same procedures with MSM and SW were much lower. Despite these findings, clinical and nonclinical providers expressed similar desires to avoid going to a party where MARPs were preparing food as noted above as well as having their children visit MARP homes.

Health facility staff trained in HIV prevention was significantly less likely to report fear of HIV transmission or avoidance desires with PLHIV and MARPs, particularly as it related to sweat/saliva contact and sharing a bathroom. These findings were also supported by the vignettes where those trained were more likely to attend a party where an HIV-positive individual (non MSM, MSM, and SW) was preparing food.

For the second set of indicators examined—shame, blame, and judgment—the study found that most believed PLHIV and MARPs deserved the same quality of care as other clients. This was also supported by vignette findings. Despite this belief, respondents made overwhelming reports of negative judgment of PLHIV and MARPs related to the perceived immorality of HIV transmission, homosexuality, and sex work. Respondents reserved the greatest judgment for MSM, followed by SW, and PLHIV. More than eight out of 10 health facility staff and six out of 10 social services staff believed that homosexuality was immoral. Three-quarters of the health facility and six out of 10 social services staff felt the same way toward SW. Approximately half of respondents said that they believed HIV and AIDS was spread through immoral behavior.

One interesting finding was the link between training and reduced reports of shame, blame, and judgment. The training link was significant related to the belief that clients who were MSM or SW deserved the same quality of care as other clients as well as disagreement that homosexuality and SW were immoral. For social services staff, though not significant, the tie with training showed a reverse trend. Those untrained were for the most part less likely to report shame, blame, and judgment than individuals trained. Further examination is needed into the cause of this trend.

Reports of staff seeing or hearing of instances of enacted stigma within their workplace were far less than the other stigma measures examined. Gossip toward those suspected of being PLHIV, MSM, or SW was the most predominant report among health facility and social services staff, ranging from a tenth to a quarter reporting this behavior across the three populations and demonstrating evidence of layered stigma.

Component Three: Sex Workers

The findings from this study indicate that prior disclosure of SW status and gender had significant impacts on SW's perceptions of stigma in health care settings. Almost half of respondents had ever disclosed their SW status, namely to doctors or nurses. While reported reactions of providers were less overt, a link between disclosure and reported incidences and fear of S&D were seen. A similar link with gender was also found. MSW were more likely to report being victims of S&D than their female counterparts.

For those individuals who had disclosed, none were asked to leave a facility, however, on a separate question, more than one out of 10 respondents reported being asked not to return to the clinic based on their SW status. Looks of surprise or lecturing/being told sex work was bad were the primary reactions reported by SW upon disclosure of their work.

Reports of S&D within the last six months varied based on the type of stigma reported. Close to a quarter reported being gossiped about when seeking health care services because of how they earned their money and about one in 10 believed staff hurried through their exam. More than one in 10 respondents believed they were given lower quality care because they were an SW. Those who had disclosed their status as SW were more likely to report being denied health care services in the last six months, receiving poorer quality services, or being hurried than those who had not disclosed. MSW were significantly more likely to report being gossiped about or hurried than were FSW.

The impact of experienced S&D, or the fear of experiencing it, was great for SW respondents. Half of respondents believed that telling someone in a clinic of their SW status was risky. And, of those who had ever disclosed, nearly two in five regretted doing so. Respondents believed (and in significantly greater proportions among MSW) that they were treated differently because they were an SW—nearly a third said they were hurt by clinic staff's reactions and almost a quarter believed staff were cold or distant due to how they earned their money. Anticipation or worry about providers' reactions to respondents because of their SW status was also high. Approximately three out of five of those who responded expressed fear that clinic staff would tell others of their SW status, over half feared being judged, and two out of five feared discrimination. This had a great effect on health-seeking behavior—nearly a third of respondents believed it was easier to avoid getting help than telling health facility staff they were an SW, and nearly one out of 10 stopped going to the clinic altogether as a result of providers' reactions.

Despite reported experiences or fear of S&D, access and exposure to health and HIV-prevention services among respondents was high. Approximately four out of five respondents had spoken with a peer educator or influencer within the past six months (with just under half attending some type of HIV-related educational session), almost a third had visited a community/social services organization working in HIV prevention, and nearly all had received condoms from HIV-prevention organizations/agencies. Nearly three-quarters of respondents had also visited a health facility for services. These findings suggest that reach is not as much of an issue with SW as the quality of services provided that are free from S&D.

Conclusions and Recommendations

Conclusions

The pervasive norm of stigma and discrimination toward MARPs within Jamaica creates and reinforces a hostile environment where MSM and SW are unable to safely identify their sexuality and experiences. This stigmatization results in diminished life chances and support needed to reduce risks and prevent the spread of HIV (Nyblade and MacQuarrie 2006). MARPs are subjected to stigma and discrimination both as a result of their unique identifications and as a result of underlying associations by the community with HIV, which carries with it, its own stigma. This ‘layered stigma’—HIV-related stigma combined with stigma towards marginalized groups—compounds S&D’s devastating effects and most acutely in health care settings threatens the level and quality of care those stigmatized receive. The ability of individuals to take measures towards their own protection and well-being is deeply affected by the greater environment in which they live.

Findings of S&D within health care and social services settings toward PLHIV, MSM, and SW were great and both mirrored and mutually reinforced greater community norms. The study findings supported the literature, which indicated widespread stigmatizing attitudes, beliefs, and judgments towards PLHIV, MSM, and SW are present in health care settings in general as well as throughout Jamaica. Based on published literature, this appears to be the first study looking at S&D in the social services sector. Prevailing S&D was reported by participants from this sector as well.

This study found widespread fear of casual contact (e.g. fear of HIV transmission from sweat), one the underlying causes of stigma, as well as desires to avoid contact with MARPs in both clinical and nonclinical settings. Measures of shame, blame, and judgment (e.g. belief that HIV/AIDS spreads through immoral behavior), which are other key stigma constructs, were the norm across providers, particularly as they related to views on immorality toward PLHIV and MARPs. Although to a lesser degree than other forms of stigma, enacted stigma was also reported by both health care and social services providers as well as by SWs themselves. Layered stigma most strongly evident in the vignette responses directed toward MSM and SW.

Enacted stigma entails both unlawful discrimination in addition to a wider set of stigmatizing actions (Nyblade and MacQuarrie 2006). Fewer incidents of enacted stigma were reported across both sectors than levels of stigma reported under the other examined stigma constructs. This may possibly indicate that while stigmatizing attitudes and beliefs have a critical impact on accessing quality services in Jamaica, these attitudes may not translate into overt discrimination in the health and social services sector. Instead, what exists may be a perception and probable reality that PLHIV, SW, and MSM experience covert discrimination when they access services. This was also supported by findings under component three of this study with SW. Reduced access results as PLHIV and MARPs opt out of services. When services are accessed, they may be of lower quality due to the provider’s stigmatizing attitudes or because MARPs are fearful of disclosing their sexual orientation or their engagement in sex work, resulting in inappropriate care or interventions.

A critical finding of this study was that PLHIV were the clients most likely to be discriminated against, particularly based upon reports of fear of HIV transmission. A significant proportion of health facility and social services staff feared touching and conducting important clinical procedures on this population. This must urgently and comprehensively be addressed through training and other stigma-reduction initiatives. In turn, SW and MSM may secondarily be assumed to be HIV infected and therefore experience layered stigma arising from providers stereotyping these individuals as the ones who spread HIV in addition to stigma they face as a result of being MSM or SW alone. MSM experienced the highest measures of S&D based upon reported shame, blame, and judgment construct responses, followed by SW.

Recommendations

- Both clinical and nonclinical staff need training. The health care sector includes not only those that provide clinical services but those who provide social services or interact with PLHIV and MARPs in waiting areas or in another capacity within facilities and organizations. Therefore, all staff should be trained (at least) in HIV prevention and interpersonal communication with emphasis on S&D in the health care settings. This training needs to be ongoing to address staff turnover in the public, private, and NGO sectors and to address new and emerging issues related to HIV and S&D. Additionally; increased training of all health care and social services staff in psycho-social support for MARPs is needed.
- Based on the high prevalence of HIV among MARPs, findings that show less S&D in general among MARP-friendly providers, and limited numbers of such facilities, the amount of MARP-friendly providers needs to be increased. The aim is that all health providers, regardless of sector, work toward “MARP-friendly status.” In response to these improvements MARPs are actively encouraged and motivated to seek these services through health promotion campaigns.
- MARP-friendly provider criteria should be established so that each provider offers a minimum package of care, including standard medical protocol, to MARPs and is committed to similar philosophies and ongoing internal anti-S&D efforts.
- Further qualitative work should be undertaken to deepen the understanding of some of the findings in relation to MARP-friendly providers and social services organizations. The goal of the work is to prepare organizations for improvements in professionalism, attitudes, and capabilities to effectively reach and support MARPs based on a positive deviance approach.
- Fear of HIV transmission needs to be addressed through dialogue, training, and monitoring related to the conduct of clinical procedures on PLHIV in health care settings.
- As the National Health Program moves away from vertical delivery of HIV/STI programs, health services strengthening must be given priority. In cases where there are gaps and inadequacies, it is usually the vulnerable that are most adversely affected. Strengthening health systems can only be beneficial for MARPs that are often among those lower socio-economic groups with limited options for seeking private health care.
- A MARP provider needs assessment should be conducted to address capacity and gaps in knowledge, attitudes, and practices as it relates to MARP and PLHIV service provision. Including a review of organizational policies to address this significant deficit and standardize and improve working practices with MARPs should be considered.

- The supportive environment for social and behavior change must be addressed. Policies regarding homosexuality and SW must be addressed directly and comprehensively to facilitate nondiscriminatory attitudes and ultimately to increase access.
- Policies and the legislative framework must support the sanctioning of health care providers in cases where confidentiality is proven to be breached and when discrimination occurs to encourage compliance with ethical guidelines and standards of care and the protection of the rights of clients.
- Targeted and interactive communication campaigns addressing S&D toward PLHIV and MARPs broadly in communities and specifically within health and social services need to be developed in an ongoing effort to encourage dialogue and community solutions to this critical issue. Such campaigns can also reinforce in-service, interpersonal communication, and anti-S&D training.
- This survey should be considered as a baseline of S&D within the health and social services sectors, and efforts to reduce S&D should be measured against its findings in subsequent years. For more informal measurement, conduct regular “mystery client” assessments to gauge S&D of PLHIV and MARPs.

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Annex 1: Health Facility Survey

For Interviewer use only

Interviewer ID (Initials AHB, AEB, QP)	
Clinic ID	
Location ID	

Please read all instructions carefully and answer each question. There is no identifying information on the questionnaire, so your responses cannot be linked back to you. So please be sure to give as accurate and honest answers as possible.

Questions	Responses
1. How old were you on your last birthday? (Please write your age in numbers e.g., 25)	[__ __]
2. What sex are you? (Please circle one option)	1. Male 2. Female 3. Male to female transgender 4. Female to male transgender 5. Other
3. What is the highest level of education you have reached? (Circle highest level only)	1. Less than high school 2. In secondary school 3. Completed secondary school

Questions	Responses
	<ul style="list-style-type: none"> 4. Attending college or professional training school 5. Completed college or professional training school 6. Attending university 7. Completed university 8. Professional school beyond the university 9. Nursing degree 10. Medical degree 11. Other (please specify): _____
<p>4. What type of health care worker are you? (Please circle one option)</p>	<ul style="list-style-type: none"> 1. Health/medical aid 2. Counselor 3. Nurse 4. Doctor 5. Non-medical staff (Please state job title): _____ 6. Other (please specify): _____

Questions	Responses
5. How long have you worked at this clinic/practice? (Please write number of months or number of years and months)	Years: _____ Months: _____
6. While at your job, have you received any training on? (Please circle all the options that apply)	<ol style="list-style-type: none"> 1. HIV prevention (Please describe): _____ 2. HIV care and treatment (Please describe): _____ 3. Psycho-social support for people living with HIV 4. Psycho-social support for men who have sex with men (MSM) 5. Psycho-social support for sex workers (SW) 6. Psycho-social support for youth 7. Interpersonal communication/communicating effectively with clients/patients. (Please describe): _____ 8. Counseling (Please describe): _____ 9. Working with youth (Please describe): _____ 10. Working with most-at-risk populations (MARPs), such as sex workers or men who have sex with men (Please describe): _____

Robert's Story

Robert lives in Montego Bay and is a well-known real estate agent. Robert enjoys socializing with his friends and going out to eat with his girlfriend. For some time, Robert experienced fatigue and achiness. When it began to interfere with his ability to go to work, his girlfriend became concerned and encouraged him to go to a doctor. After many tests, he was diagnosed with Rheumatoid Arthritis.

Rheumatoid Arthritis is a disease that causes inflammation in the joints and cannot be transmitted person-to-person.
(Please tick the boxes that best describe how you feel for each statement.)

Statement	Strongly Disagree	Disagree	Agree	Strongly Agree
a) Robert is responsible for his illness.				
b) Robert deserves sympathy.				
c) Robert deserves what has happened to him.				
d) Robert is dangerous to other people.				
e) Robert deserves the best medical care possible.				
f) The world would be better off without Robert.				
g) Robert deserves to lose his job.				
h) If you met Robert, you would be willing to have a conversation with him.				
i) You would attend a party where Robert was preparing food.				
j) You would allow your children to visit Robert in his home.				

<p>In response to the following situations, please indicate if you have fear of HIV transmission, do not have fear of HIV transmission, or do not know if you have fear of HIV transmission.</p> <p>(Please tick the boxes that best describe how you feel for each question)</p>	Do have fear of HIV transmission	Do NOT have fear of HIV transmission	Don't know	I do not do this kind of work
7. Touching the sweat or saliva of a person with HIV or AIDS				
<p>In response to the following situations, please indicate if you would avoid, would NOT avoid, or do not know if you would avoid:</p>	Would avoid	Would NOT avoid	Don't know	I do not do this kind of work

8. Touching the sweat or saliva of a man you suspect has sex with other men.				
9. Touching the sweat or saliva of someone you suspect is a sex worker.				

In response to the following situations, please indicate if you have fear of HIV transmission, do not have fear of HIV transmission, or do not know if you have fear of HIV transmission:	Do have fear of HIV transmission	Do NOT have fear of HIV transmission	Don't know	I do not do this kind of work
10. Giving an injection or putting an IV drip into a person with HIV or AIDS				
11. Dressing the wounds of a person living with HIV or AIDS				
12. Conducting surgery on or suturing a person with HIV or AIDS				

Linda's Story

Linda has lived in Kingston all of her life. She is close with her family and works part-time at a local retailer. In order to help make ends meet, Linda also engages in sex work in the evenings with men she meets at local bars. A few months ago, Linda began having night sweats. She also realized that she had been feeling “under the weather” for some time. Her friends also became concerned and encouraged her to go to the doctor. After being tested, Linda found out that she was HIV positive. HIV is a virus that can lead to AIDS and can be transmitted person-to-person. **(Please tick the boxes that best describe how you feel for each statement.)**

Statement	Strongly Disagree	Disagree	Agree	Strongly Agree
a) Linda is responsible for her illness.				
b) Linda deserves sympathy.				
c) Linda deserves what has happened to her.				
d) Linda is dangerous to other people.				
e) Linda deserves the best medical care possible.				

Statement	Strongly Disagree	Disagree	Agree	Strongly Agree
f) The world would be better off without Linda.				
g) Linda deserves to lose her job.				
h) If you met Linda, you would be willing to have a conversation with her.				
i) You would attend a party where Linda was preparing food.				
j) You would allow your children to visit Linda in her home.				

In response to the following situations, please indicate if you would avoid, would NOT avoid, or do not know if you would avoid:	Would avoid	Would NOT avoid	Don't know	I do not do this kind of work
13. Giving an injection or putting an IV drip into someone you suspect is a sex worker				
14. Dressing the wounds of someone you suspect is a sex worker				
In response to the following situations, please indicate if you would avoid, would NOT avoid, or do not know if you would avoid:	Would avoid	Would NOT avoid	Don't know	I do not do this kind of work
15. Conducting surgery on or suturing someone you suspect is a sex worker				
16. Giving an injection or putting an IV drip into a man you suspect has sex with other men				
17. Dressing the wounds of a man you suspect has sex with other men				

18. Conducting surgery on or suturing a man you suspect has sex with other men				
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James's Story

James lives in Ocho Rios and works as an IT specialist. He is an avid runner and participates in races with his boyfriend Tom. On and off over the past few months James felt too tired to go running. He also noticed that he had swollen lymph nodes in his neck. Tom became worried and asked James to visit the doctor. His doctor performed many tests and eventually diagnosed James with leukemia. Leukemia is a type of cancer and cannot be transmitted person-to-person. **(Please tick the boxes that best describe how you feel for each statement.)**

Statement	Strongly Disagree	Disagree	Agree	Strongly Agree
a) James is responsible for his illness.				
b) James deserves sympathy.				
c) James deserves what has happened to him.				
d) James is dangerous to other people.				
e) James deserves the best medical care possible.				
f) The world would be better off without James.				
g) James deserves to lose his job.				
h) If you met James, you would be willing to have a conversation with him				
i) You would attend a party where James was preparing food.				
j) You would allow your children to visit James in his home.				

Do you strongly agree, agree, disagree, or strongly disagree with each statement: (Please tick box that best describes your feelings)	Strongly Agree	Agree	Disagree	Strongly Disagree
19. I am comfortable sharing a bathroom with a colleague who is HIV-infected.				
20. I am comfortable sharing a bathroom with a colleague who is a homosexual.				

Do you strongly agree, agree, disagree, or strongly disagree with each statement: (Please tick box that best describes your feelings)	Strongly Agree	Agree	Disagree	Strongly Disagree
21. Clients who have HIV and AIDS deserve to receive the same level and quality of care as other clients.				
22. Clients who are sex workers deserve to receive the same level and quality of care as other clients.				
23. Clients who are homosexual deserve to receive the same level and quality of care as other clients.				
24. HIV and AIDS is a punishment for bad behavior.				
25. People with HIV should be ashamed of themselves.				

Paula's Story

Paula is from Negril. She enjoys spending time with her family and friends and is a vice president at a local financial firm. Lately, Paula's colleagues at work began to notice that she seemed very tired while in the office, which was unlike her. Paula also discovered some swollen lymph nodes under her arm. Her co-worker encouraged her to go to the doctor. After undergoing some tests, Paula's doctor diagnosed her with HIV. HIV is a virus that can lead to AIDS and can be transmitted person-to-person.

(Please tick the boxes that best describe how you feel for each statement.)

Question	Strongly Disagree	Disagree	Agree	Strongly Agree
a) Paula is responsible for her illness.				
b) Paula deserves sympathy.				
c) Paula deserves what has happened to her.				
d) Paula is dangerous to other people.				
e) Paula deserves the best medical care possible.				
f) The world would be better off without Paula.				
g) Paula deserves to lose her job.				
h) If you met Paula, you would be willing to have a conversation with her.				

Question	Strongly Disagree	Disagree	Agree	Strongly Agree
i) You would attend a party where Paula was preparing food.				
j) You would allow your children to visit Paula in her home.				

Do you strongly agree, agree, disagree, or strongly disagree with each statement:	Strongly Agree	Agree	Disagree	Strongly Disagree
26. Men who have sex with other men are the ones that spread HIV in our community.				
27. It is the women prostitutes who spread HIV.				
28. HIV and AIDS spreads due to immoral behavior.				
29. Homosexuality is immoral.				
30. Sex work is immoral.				
31. Seeing two men kiss makes me feel uncomfortable.				

Mark's Story

Mark is a lawyer in Negril. He is 30 years old and is good at his job. Mark enjoys playing tennis with friends and with his boyfriend Bob. Earlier this year, Bob began to notice that Mark was losing weight. Because Mark had also been having ongoing diarrhea, he went to the doctor. The doctor performed several tests and then diagnosed him with HIV. HIV is a virus that can lead to AIDS and can be transmitted person-to-person.

(Please tick the boxes that best describe how you feel for each statement.)

Statement	Strongly Disagree	Disagree	Agree	Strongly Agree
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a) Mark is responsible for his illness.				
b) Mark deserves sympathy.				
c) Mark deserves what has happened to him.				
d) Mark is dangerous to other people.				
e) Mark deserves the best medical care possible.				
f) The world would be better off without Mark.				
g) Mark deserves to lose his job.				
h) If you met Mark, you would be willing to have a conversation with him.				
i) You would attend a party where Mark was preparing food.				
j) You would allow your children to visit Mark in his home.				

<p>In the past 12 months, have you seen or observed the following happen in this health facility because a client was known to have or was suspected of having HIV and AIDS?</p> <p>Please tick all boxes that apply.</p>	Seen	Heard	Neither
32. Receiving less care/attention than other patients.			
33. A senior health care provider assigned the client to a junior provider.			
34. Was tested for HIV without his/her consent.			
35. Had their HIV status gossiped about by a health care provider.			
36. Was refused health care services.			

Mary's Story

Mary is a nurse who lives in Ocho Rios. She enjoys her work and in her free time likes to go on long bike rides with her sister. Lately, work and bicycling seemed to tire Mary out more than usual. After talking with her sister about it, she decided to visit the doctor. After an exam and tests, the doctor diagnosed Mary with Lupus. Lupus is a disease of the immune system and cannot be transmitted person-to-person. **(Please tick the boxes that best describe how you feel for each statement.)**

Question	Strongly Disagree	Disagree	Agree	Strongly Agree
a) Mary is responsible for her illness.				
b) Mary deserves sympathy.				
c) Mary deserves what has happened to her.				
d) Mary is dangerous to other people.				
e) Mary deserves the best medical care possible.				
f) The world would be better off without Mary.				
g) Mary deserves to lose her job.				
h) If you met Mary, you would be willing to have a conversation with her.				
Question	Strongly Disagree	Disagree	Agree	Strongly Agree
i) You would attend a party where Mary was preparing food.				
j) You would allow your children to visit Mary in her home.				

In the past 12 months, have you seen or observed the following happen in this health facility because a client was known to be or was suspected of being a sex worker?	Seen	Heard	Neither
37. Receiving less care/attention than other patients.			
38. A senior health care provider assigned the client to a junior provider or any other provider.			
39. Was tested for HIV without his/her consent.			
40. Was being gossiped about by a health care provider.			
41. Was refused health care services.			

Katie's Story

Katie is from Montego Bay. She enjoys knitting and spending her free time with her brother and nieces and nephews. During the day, she works as a receptionist where she enjoys her job. At night in order to earn extra income, Katie engages in sex work with men she meets at local bars. In the past month, Katie began having ongoing diarrhea and started feeling more tired than usual. Her brother encouraged her to go to the doctor. After undergoing several tests, she found out that she has Irritable Bowel Syndrome. Irritable Bowel Syndrome is a disorder that affects the bowels (stomach) and cannot be transmitted person-to-person. **(Please tick the boxes that best describe how you feel for each statement.)**

Question	Strongly Disagree	Disagree	Agree	Strongly Agree
a) Katie is responsible for her illness.				
b) Katie deserves sympathy.				
c) Katie deserves what has happened to her.				
d) Katie is dangerous to other people.				
e) Katie deserves the best medical care possible.				
f) The world would be better off without Katie.				
g) Katie deserves to lose her job.				
h) If you met Katie, you would be willing to have a conversation with her.				
i) You would attend a party where Katie was preparing food.				
j) You would allow your children to visit Katie in her home.				

In the past 12 months, have you seen or observed the following happen in this health facility because a client was known to have or was suspected of being a man who has sex with other men:	Seen	Heard	Neither
42. Receiving less care/attention than other patients.			
43. A senior health care provider assigned the client to a junior provider or any other provider.			

In the past 12 months, have you seen or observed the following happen in this health facility because a client was known to have or was suspected of being a man who has sex with other men:	Seen	Heard	Neither
44. Was tested for HIV without his consent.			
45. Was being gossiped about by a health care provider.			
46. Was refused health care services.			

John's Story

John is an accountant in Kingston. He is 32 years old and enjoys his job. John is an avid football fan and loves going to games with his girlfriend and friends. A few months ago, John started feeling tired and became short of breath. He then recently developed a dry cough. John's girlfriend became concerned and encouraged him to go to the doctor. After several tests, John's doctor told him that he had HIV. HIV is a virus that can lead to AIDS and can be transmitted person-to-person.

(Please tick the boxes that best describe how you feel for each statement.)

Statement	Strongly Disagree	Disagree	Agree	Strongly Agree
a) John is responsible for his illness.				
b) John deserves sympathy.				
c) John deserves what has happened to him.				
d) John is dangerous to other people.				
e) John deserves the best medical care possible.				
f) The world would be better off without John.				
g) John deserves to lose his job.				
h) If you met John, you would be willing to have a conversation with him.				
i) You would attend a party where John was preparing food.				
j) You would allow your children to visit John his home.				

Thank you for your time in completing this survey.

Annex 2: Social Services Survey

For Interviewer use only

Interviewer ID (AHB, AEB, QP)	
Name of Org	
Location ID (KGN, OR, MB)	

Respondent Background (Circle appropriate number for response)

Questions	Responses
47. How old were you on your last birthday? (Please write your age in numbers e.g., 25)	[__ __]
48. What sex are you? (Please circle one option)	6. Male 7. Female 8. Male to female transgender 9. Female to male transgender 10. Other
3. What is the highest level of education you have reached? (Circle highest level only)	12. Less than high school 13. In secondary school 14. Completed secondary school 15. Attending college or professional training school 16. Completed college or professional training school 17. Attending university 18. Completed university 19. Professional school beyond the university 20. Nursing degree

Questions	Responses
	21. Medical degree 22. Other (please specify): _____
4. What is your role in this organization? (Please circle one option)	1. Senior management 2. Program coordinator/officer 3. Administration/finance 4. Medical professional (nurse, doctor) 5. Peer educator/outreach worker 6. Other (please specify): _____ _____
5. How long have you worked at this organization? (Please write number of months or number of years and months)	Years: _____ Months: _____
6. While at your job, have you received any training on: (Please circle all the options that apply)	11. HIV prevention (Please describe): _____ 12. HIV care and treatment (Please describe): _____ 13. Psycho-social support for people living with HIV 14. Psycho-social support for men who have sex with men (MSM) 15. Psycho-social support for sex workers (SW) 16. Psycho-social support for youth 17. Interpersonal communication/communicating effectively with clients/patients. (Please describe): _____ 18. Counseling:

Questions	Responses
	(Please describe) _____ 19. Working with youth: (Please describe): _____ 20. Working with most-at-risk populations (MARPs), such as sex workers or men who have sex with men (Please describe) _____ _____

Robert's Story

Robert lives in Montego Bay and is a well-known real estate agent. Robert enjoys socializing with his friends and going out to eat with his girlfriend. For some time, Robert experienced fatigue and achiness. When it began to interfere with his ability to go to work, his girlfriend became concerned and encouraged him to go to a doctor. After many tests, he was diagnosed with Rheumatoid Arthritis. Rheumatoid Arthritis is a disease that causes inflammation in the joints and cannot be transmitted person-to-person.

(Please tick the boxes that best describe how you feel for each statement.)

Statement	Strongly Disagree	Disagree	Agree	Strongly Agree
k) Robert is responsible for his illness.				
l) Robert deserves sympathy.				
m) Robert deserves what has happened to him.				
n) Robert is dangerous to other people.				
o) Robert deserves the best medical care possible.				
p) The world would be better off without Robert.				
q) Robert deserves to lose his job.				
r) If you met Robert, you would be willing to have a conversation with him.				

s) You would attend a party where Robert was preparing food.				
t) You would allow your children to visit Robert in his home.				

In response to the following situations, please indicate if you have fear of HIV transmission, do not have fear of HIV transmission, or do not know if you have fear of HIV transmission:	Do have fear of HIV transmission	Do NOT have fear of HIV transmission	Don't know	I do not do this kind of work
7. Touching the sweat or saliva of a person with HIV or AIDS.				
In response to the following situations, please indicate if you would avoid, would NOT avoid, or do not know if you would avoid:	Would avoid	Would NOT avoid	Don't know	I do not do this kind of work
8. Touching the sweat or saliva of a man you suspect has sex with other men.				
9. Touching the sweat or saliva of someone you suspect is a sex worker.				
10. Having physical contact of a nonsexual nature with a man you suspect has sex with other men.				
11. Having physical contact of a nonsexual nature with a woman you suspect is a sex worker.				
12. Having physical contact of a nonsexual nature with a man you suspect is a sex worker.				

Linda's Story

Linda has lived in Kingston all of her life. She is close with her family and works part-time at a local retailer. In order to help make ends meet, Linda also engages in sex work in the evenings with men she meets at local bars. A few months ago, Linda began having night sweats. She also realized that she had been feeling “under the weather” for some time. Her friends also became concerned and encouraged her to go to the doctor. After being tested, Linda found out that she was HIV positive. HIV is a virus that can lead to AIDS and can be transmitted person-to-person. **(Please tick the boxes that best describe how you feel for each statement.)**

Statement	Strongly Disagree	Disagree	Agree	Strongly Agree
k) Linda is responsible for her illness.				
l) Linda deserves sympathy.				
m) Linda deserves what has happened to her.				
n) Linda is dangerous to other people.				
o) Linda deserves the best medical care possible.				
p) The world would be better off without Linda.				
q) Linda deserves to lose her job.				
r) If you met Linda, you would be willing to have a conversation with her.				
s) You would attend a party where Linda was preparing food.				
t) You would allow your children to visit Linda in her home.				

	Strongly Agree	Agree	Disagree	Strongly Disagree
Do you strongly agree, agree, disagree, or strongly disagree with each statement:				
13. I am comfortable sharing a bathroom with a colleague who is HIV-infected.				
14. I am comfortable sharing a bathroom with a colleague who is a homosexual.				

	Strongly Agree	Agree	Disagree	Strongly Disagree
15. I am comfortable sharing a bathroom with a colleague who is a sex worker.				
16. Clients who have HIV and AIDS deserve to receive the same level and quality of care as other clients.				
17. Clients who are sex workers deserve to receive the same level and quality of care as other clients.				
18. Clients who are homosexual deserve to receive the same level and quality of care as other clients.				
19. HIV and AIDS is a punishment for bad behavior.				
20. People with HIV should be ashamed of themselves.				

James's Story

James lives in Ocho Rios and works as an IT specialist. He is an avid runner and participates in races with his boyfriend Tom. On and off over the past few months, James felt too tired to go running. He also noticed that he had swollen lymph nodes in his neck. Tom became worried and asked James to visit the doctor. His doctor performed many tests and eventually diagnosed James with leukemia. Leukemia is a type of cancer and cannot be transmitted person-to-person. **(Please tick the boxes that best describe how you feel for each statement.)**

Statement	Strongly Disagree	Disagree	Agree	Strongly Agree
k) James is responsible for his illness.				
l) James deserves sympathy.				
m) James deserves what has happened to him				
n) James is dangerous to other people.				
o) James deserves the best medical care possible.				
p) The world would be better off without James.				
q) James deserves to lose his job.				
r) If you met James, you would be willing to have a				

conversation with him.				
s) You would attend a party where James was preparing food.				
t) You would allow your children to visit James in his home.				

Do you strongly agree, agree, disagree, or strongly disagree with each statement: Please put "X" in the box that best describes your opinion.	Strongly Agree	Agree	Disagree	Strongly Disagree
21. Men who have sex with other men are the ones that spread HIV in our community.				
22. It is the women prostitutes who spread HIV.				
23. HIV and AIDS spreads due to immoral behavior.				
24. Homosexuality is immoral.				
25. Sex work is immoral.				
26. There are certain types of sex workers that I feel more comfortable working with than others (e.g., street-based workers or establishment-based workers, etc.)				
27. There are certain types of MSM that I feel more comfortable working with than others (e.g., tops or bottoms, etc.).				
28. MSM that prefer to give rather than receive (tops vs. bottoms) deserve to get HIV more than men that prefer to be bottoms.				
29. Sometimes I would rather not know about details of the work my sex worker clients are engaged in.				

Paula's Story

Paula is from Negril. She enjoys spending time with her family and friends and is a vice president at a local financial firm. Lately, Paula's colleagues at work began to notice that she seemed very tired while in the office, which was unlike her. Paula also discovered some swollen lymph nodes under her arm. Her co-worker encouraged her to go to the doctor. After undergoing some tests, Paula's

doctor diagnosed her with HIV. HIV is a virus that can lead to AIDS and can be transmitted person-to-person. **(Please tick the boxes that best describe how you feel for each statement.)**

Question	Strongly Disagree	Disagree	Agree	Strongly Agree
k) Paula is responsible for her illness.				
l) Paula deserves sympathy.				
m) Paula deserves what has happened to her.				
n) Paula is dangerous to other people.				
o) Paula deserves the best medical care possible.				
p) The world would be better off without Paula.				
q) Paula deserves to lose her job.				
r) If you met Paula, you would be willing to have a conversation with her.				
s) You would attend a party where Paula was preparing food.				
t) You would allow your children to visit Paula in her home.				

In the past 12 months, have you seen or observed the following happen in this organization toward people who have HIV and AIDS? (Please tick box)	Seen	Heard	Neither
29. A co-worker making negative or derogatory statements about someone because they have HIV and AIDS.			
30. A co-worker making jokes about someone's HIV status.			
31. Someone's HIV status gossiped about by a co-worker?			
32. Organizational policies about how to treat people with HIV and AIDS.			
33. A co-worker disregard the organization's policies toward the treatment of those with HIV and AIDS.			

Mark's Story

Mark is a lawyer in Negril. He is 30 years old and is good at his job. Mark enjoys playing tennis with friends and with his boyfriend Bob. Earlier this year, Bob began to notice that Mark was losing weight. Because Mark had also been having ongoing diarrhea, he went to the doctor. The doctor performed several tests and then diagnosed him with HIV. HIV is a virus that can lead to AIDS and can be transmitted person-to-person. **(Please tick the boxes that best describe how you feel for each statement.)**

Statement	Strongly Disagree	Disagree	Agree	Strongly Agree
k) Mark is responsible for his illness.				
l) Mark deserves sympathy.				
m) Mark deserves what has happened to him.				
n) Mark is dangerous to other people.				
o) Mark deserves the best medical care possible.				
p) The world would be better off without Mark.				
q) Mark deserves to lose his job.				
r) If you met Mark, you would be willing to have a conversation with him.				
s) You would attend a party where Mark was preparing food.				
t) You would allow your children to visit Mark in his home.				

Please tick the boxes that best describe your experience for each statement:

In the past 12 months, have you seen or observed the following happen in this organization because a client was known or suspected to be a sex worker? (Please tick box.)	Seen	Heard	Neither
34. A co-worker making negative or derogatory statements about someone because they are a sex worker.			

35. A co-worker making jokes about someone's status as a sex worker.			
36. Someone's status as an SW gossiped about by a co-worker.			
37. Organizational policies toward clients who are sex workers.			
38. A co-worker disregards the organization's policies toward clients who are sex workers.			
39. A co-worker having a sexual or romantic relationship with a sex worker project beneficiary.			

Mary's Story

Mary is a nurse who lives in Ocho Rios. She enjoys her work and in her free time likes to go on long bike rides with her sister. Lately, work and bicycling seemed to tire Mary out more than usual. After talking with her sister about it, she decided to visit the doctor. After an exam and tests, the doctor diagnosed Mary with Lupus. Lupus is a disease of the immune system and cannot be transmitted person-to-person. **(Please tick the boxes that best describe how you feel for each statement.)**

Question	Strongly Disagree	Disagree	Agree	Strongly Agree
k) Mary is responsible for her illness.				
l) Mary deserves sympathy.				
m) Mary deserves what has happened to her.				
n) Mary is dangerous to other people.				
o) Mary deserves the best medical care possible.				
p) The world would be better off without Mary.				
q) Mary deserves to lose her job.				
r) If you met Mary, you would be willing to have a conversation with her.				
s) You would attend a party where Mary was preparing food.				
t) You would allow your children to visit Mary in her home.				

In the past 12 months, have you seen or observed the following happen in this organization because a client was known to have or was suspected of being a man who has sex with other men (MSM): (Please tick the box that best describes your experience.)	Seen	Heard	Neither
40. A co-worker making negative or derogatory statements about someone because he is MSM.			
41. A co-worker making jokes about someone's status as an MSM.			
42. Someone's status as an MSM gossiped about by a co-worker?			
43. Organization's policies towards clients who are MSM.			
44. A co-worker disregard the organization's policies toward clients who are MSM.			
45. A co-worker having a sexual or romantic relationship with a MSM project beneficiary.			

Katie's Story

Katie is from Montego Bay. She enjoys knitting and spending her free time with her brother and nieces and nephews. During the day, she works as a receptionist where she enjoys her job. At night in order to earn extra income, Katie engages in sex work with men she meets at local bars. In the past month, Katie began having ongoing diarrhea and started feeling more tired than usual. Her brother encouraged her to go to the doctor. After undergoing several tests, she found out that she has Irritable Bowel Syndrome. Irritable Bowel Syndrome is a disorder that affects the bowels (stomach) and cannot be transmitted person-to-person. **(Please tick the boxes that best describe how you feel for each statement.)**

Question	Strongly Disagree	Disagree	Agree	Strongly Agree
k) Katie is responsible for her illness.				
l) Katie deserves sympathy.				
m) Katie deserves what has happened to her.				
n) Katie is dangerous to other people.				
o) Katie deserves the best medical care possible.				
p) The world would be better off without Katie.				
q) Katie deserves to lose her job.				
r) If you met Katie, you would be willing to have a conversation with her.				
s) You would attend a party where Katie was preparing food.				
t) You would allow your children to visit Katie in her home.				

For the following questions please tick in boxes yes, no, or don't know	Yes	No	Don't know
46. Do you believe that there are individuals within your organization that stigmatize against MSM and SW?			

47. If yes, why? (please fill in)	
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John's Story

John is an accountant in Kingston. He is 32 years old and enjoys his job. John is an avid football fan and loves going to games with his girlfriend and friends. A few months ago, John started feeling tired and became short of breath. He then recently developed a dry cough. John's girlfriend became concerned and encouraged him to go to the doctor. After several tests, John's doctor told him that he had HIV. HIV is a virus that can lead to AIDS and can be transmitted person-to-person. **(Please tick the boxes that best describe how you feel for each statement.)**

Statement	Strongly Disagree	Disagree	Agree	Strongly Agree
k) John is responsible for his illness.				
l) John deserves sympathy.				
m) John deserves what has happened to him.				
n) John is dangerous to other people.				
o) John deserves the best medical care possible.				
p) The world would be better off without John.				
q) John deserves to lose his job.				
r) If you met John, you would be willing to have a conversation with him.				
s) You would attend a party where John was preparing food.				
t) You would allow your children to visit John at his home.				

Annex 3: Sex Worker Survey

NETWORK ID:

(Please ensure all network information is filled in, otherwise questionnaire will be void.)

Interviewer ID:	
Date:	
Geographical Location:	
Type of Sex Work Site:	
Coupon Number:	

Please follow the questions in the sequence (1-47)

Data Collection Questions	Response
1. Age on last birthday (Write numbers clearly above line)	[_][_] years
2. Gender/sex (Read out and circle one option only as identified by the respondent)	1. Male: ____ 2. Female: ____ 3. Male to female transgender: ____ 4. Female to male transgender: ____ 66. Other: ____

<p>3. Have you ever attended school? (Circle one option only)</p> <p><i><u>If no skip to question 6.</u></i></p>	<p>0. No</p> <p>1. Yes</p>
<p>4. What is the highest level of school you completed: (Circle one option only)</p>	<p>0. NONE</p> <p>1. PRIMARY</p> <p>2. All AGE</p> <p>3. SECONDARY</p> <p>4. HIGH SCHOOL</p> <p>5. TERTIARY</p> <p>6. VOCATIONAL/SKILLS TRAINING</p> <p>88. NO RESPONSE</p>
<p>5. How many total years of education have you completed up to now? (Write numbers clearly in the boxes)</p>	<p># YEARS COMPLETED [_ _]</p> <p>88. NO RESPONSE</p>
<p>6. Which of the following applies to you?</p>	<p>0. UNEMPLOYED AND <i>NOT</i> LOOKING</p> <p>1. UNEMPLOYED AND LOOKING</p> <p>2. STUDENT AND <i>NOT</i> EMPLOYED</p>

<p>Are you employed:</p> <p>(Read out circle all options that apply)</p> <p>For “self employed” ask respondent for nature of self employment, e.g. , sex work, masseur, vending, etc. Unless self employed in more than one area, please write one word only to describe self employment.</p> <p>For “other” write the response clearly using no more than 2 words.</p>	<p>3. STUDENT AND EMPLOYED</p> <p>4. EMPLOYED PART TIME (LESS THAN 30 HRS)</p> <p>5. EMPLOYED FULL TIME (30 HRS OR MORE)</p> <p>6. SELF EMPLOYED</p> <p>Please describe type of self employment.</p> <p>-----</p> <p>6. Other_____</p> <p>88. NO RESPONSE</p>
<p>7. Have you <i>ever</i> been married? (Circle one option only)</p>	<p>0. No</p> <p>1. Yes</p> <p>88. No Response</p>
<p><u>ASK MALES AND FEMALES</u></p> <p>8. Are you <i>currently</i> married or living with a sexual partner? (Circle one option only)</p>	<p>1. Currently married, living with spouse</p> <p>2. Currently married, living with other sexual partner</p> <p>3. Currently married, not living with spouse or another sexual partner</p> <p>4. Not married, living with sexual partner</p>

	5. Not married, not living with sexual partner 88. NO RESPONSE		
<u>ASK MALES ONLY</u>			
9. Do you have a main (male) partner who you see regularly? (Circle one option only)	0. No 1. Yes 88. No Response		
10. Have you had sex in exchange for money in the last 3 months? (abort interview if answer is NO)	0. No 1. Yes		
In the last 6 months because of the way you earn your money have you? [fill in from list below] <i>Place a tick in one box only for questions 10-14</i>			
	Yes	Definitely No	Don't know
11. Been gossiped about while seeking health care services?			
12. Been gossiped about while participating in a health-related program or activity?			
13. Been denied health care services?			
14. Been given poorer quality health care services?			

15. Felt that the staff was hurrying to get your exam finished so you could leave quickly?			
16. Have you ever told any health care provider that you have engaged in sex work? (circle one option only) <i>If no skip to question 18.</i>	0. No 1. Yes		
17. What kind of health care worker have you told? (Circle all that apply)	1. Doctor 2. Nurse 3. Receptionist 4. Other (please specify: _____)		
17. How did they react? (Circle all that apply)	0. No reaction 1. Looked surprised but said nothing 2. Judged me and said it was a bad thing 3. Judged me and lectured me about it 4. Judged me and had someone else work with me 5. Judged me and asked me to leave the clinic 66. Other (please specify): _____		

<p>18. Have you ever been refused health services because you are a sex worker? (Circle one option only for no)</p> <p>(Circle one or two options for yes)</p>	<p>0) No</p> <p>1) Yes (at any time)</p> <p>2) Yes (within the last six months)</p>				
<p><i>Circle one option only for questions 19-27</i></p>	<p>Strongly Disagree</p>	<p>Disagree</p>	<p>Agree</p>	<p>Strongly Agree</p>	<p>N/A Q's 19, 20 & 24 <u>only</u> are N/A if the answer was no for Q 15. Please tick boxes</p>
<p>19. I have been hurt by how people in a clinic reacted to learning I am a sex worker.</p>	<p>1</p>	<p>2</p>	<p>3</p>	<p>4</p>	
<p>20. I regret having told someone in a clinic that I'm a sex worker.</p>	<p>1</p>	<p>2</p>	<p>3</p>	<p>4</p>	
<p><i>Circle one option only for questions 19-27</i></p>	<p>Strongly Disagree</p>	<p>Disagree</p>	<p>Agree</p>	<p>Strongly Agree</p>	
<p>21. Some people in a clinic who know that I'm a sex worker are distant or cold toward me.</p>	<p>1</p>	<p>2</p>	<p>3</p>	<p>4</p>	
<p>22. Since becoming a sex worker, I feel like I can't go</p>	<p>1</p>	<p>2</p>	<p>3</p>	<p>4</p>	

anywhere for health care or emotional or social support.					
23. I have stopped going to a clinic because of their reactions to my being a sex worker.	1	2	3	4	
24. I have been told not to return to a clinic after telling them that I'm a sex worker.	1	2	3	4	
25. Telling someone in a clinic that I'm a sex worker is risky	1	2	3	4	
26. It is easier to avoid getting help than worry about telling someone that I'm a sex worker.	1	2	3	4	
27. I am very careful with whom I tell that I'm a sex worker.	1	2	3	4	
Circle one option only for questions 28-31	Strongly Disagree	Disagree	Agree	Strongly Agree	
28. Since becoming a sex worker I worry about health care providers discriminating against me.	1	2	3	4	
29. I never feel the need to hide the fact that I'm a sex worker from the staff in a	1	2	3	4	

clinic.				
30. I worry that people in a clinic may judge me when they learn I'm a sex worker.	1	2	3	4
31. I worry that people in a clinic who know I'm a sex worker will tell others.	1	2	3	4

Exposure to HIV-Prevention Interventions and Programs

Questions	Response
<p>32. In the past 6 months have you talked with a peer educator/influencer/outreach worker about ways to prevent contracting or spreading HIV? (circle one option only)</p> <p><i>If no skip to question 34.</i></p>	<p>0. No 1. Yes 77. Don't know</p>
<p>33. If yes, what agency/organization were they from? (circle one option only)</p>	<p>Please write the name of the organization:</p> <p>.....</p> <p>77. Don't know 99. Refused to Answer</p>
<p>34. In the past 6 months have you visited any community organizations other than the health center that provide HIV prevention services? (circle one option only)</p> <p><i>If no skip to question 36.</i></p>	<p>0. No 1. Yes 77. Don't know</p>
<p>35. If yes, can you tell us the name of the organization?</p>	<p>Please write the name of the</p>

<p>(circle one option only)</p>	<p>organization:</p> <p>.....</p> <p>77. Don't know</p> <p>99. Refused to answer</p>
<p>36. In the past 6 months have you attended any educational sessions or events for sex workers to talk about HIV prevention? (circle one option only)</p>	<p>0. No</p> <p>1. Yes</p> <p>77. Don't know</p>

<p>37. In the past 6 months have you read any pamphlets or flyers that provide information on HIV prevention? (circle one option only)</p> <p><i>If no skip to question 39.</i></p>	<p>0. No</p> <p>1. Yes</p> <p>77. Don't know</p>
<p>38. If yes, who gave them to you? What agency or clinic? (circle one option only)</p>	<p>Please write the name of the organization:</p> <hr/> <hr/> <p>77. Don't know</p> <p>99. Refused to answer</p>
<p>39. In the past 6 months, have you received condoms from any organizations? (circle one option only)</p> <p><i>If no skip to question 41.</i></p>	<p>0. No</p> <p>1. Yes</p> <p>77. Don't know</p>

<p>40. If yes, who gave them to you? What agency or clinic? (circle one option only)</p>	<p>Please write the name of the organization:</p> <p>.....</p> <p>77. Don't know</p> <p>99. Refused to answer</p>
<p>41. In the past 6 months have you visited any medical health clinics or doctors seeking medical advice? (circle one option only)</p> <p><i>If no skip to question 46.</i></p>	<p>0. No</p> <p>1. Yes</p> <p>77. Don't know</p>
<p>42. If yes, what clinic or doctor did you visit?</p> <p>(Please circle all options, then write clearly the names on the dotted line. e.g., St Anns Bay)</p>	<p>Please list all that apply:</p> <p>1. Health center Name:.....</p> <p>2. Hospital Name:.....</p> <p>3. Doctor</p>

	<p>Name:.....</p> <p>4. Other.....</p> <p>77. Don't know</p> <p>99. Refused to answer</p>
<p>43. What was the purpose of that visit? (circle all that apply)</p> <p>For other please circle and then write clearly on the dotted lines.</p>	<p>1. General physical</p> <p>2. Concern about a possible STI</p> <p>3. Concern about HIV</p> <p>4. To get tested for HIV</p> <p>5. Concern about being pregnant</p> <p>66. Other (please specify):.....</p> <p>.....</p>

<p>44. When you went there, did you disclose that you are a sex worker? (circle one option only)</p>	<p>0. No</p> <p>1. Yes</p>
<p>45. If you did not, please tell me in your own words. (Please summarize why they said they did not disclose clearly.)</p>	
<p>46. Have you ever had a health care worker use the fact that you were a sex worker against you to obtain sexual favors? (circle one option only)</p>	<p>0. No</p> <p>1. Yes</p>
<p>47. Have you ever had an NGO worker use the fact that you were a sex worker against you to obtain sexual favors? (circle one option only)</p>	<p>0. No</p> <p>1. Yes</p>

THANK YOU FOR YOUR TIME.



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