



GETTING TO "STIGMA-FREE" HIV SERVICES IN ST. KITTS AND NEVIS

Survey Results

September 2013

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Getting to “Stigma-Free” Services in St. Kitts and Nevis: Survey Results

SEPTEMBER 2013

This publication was prepared by staff from the National AIDS Programme/Ministry of Health, University of the West Indies HIV/AIDS Response Programme and the Health Policy Project.

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EXECUTIVE SUMMARY

HIV-related stigma and discrimination (S&D) are widely recognised in the Caribbean region and globally as critical barriers to HIV prevention, care, and treatment, particularly for key populations who often experience additional stigmas beyond HIV. S&D keep people from seeking HIV testing, disclosing their HIV status, practicing prevention, accessing care, and adhering to treatment, while frequently causing human rights violations. Regionally, countries are addressing S&D through efforts led by the Pan Caribbean Partnership Against HIV and AIDS (PANCAP), with support from the USAID-funded Health Policy Project (HPP). Together these and other regional partners, have recently developed *The PANCAP Stigma Reduction Framework for HIV and AIDS: National Actions to Reduce HIV-Related Stigma & Discrimination and Improve Health Outcomes* (2012), to guide developing national strategies for action to address S&D. While S&D occur in all spheres of life, including the family, workplace, community, schools, places of worship, and healthcare facilities, experiences of S&D in healthcare facilities are particularly detrimental to the health and overall well-being of individuals and society.

Recognising the harmful role that S&D can play in the health setting in particular, the National AIDS Programme of the Ministry of Health (MOH) of St. Christopher (St. Kitts) and Nevis, in collaboration with HPP, the University of the West Indies (UWI), and other partners, is developing and testing a comprehensive S&D-reduction programme in health facilities that will bring lessons learned to share with the rest of the region. This programme includes strengthening individual and health system capacities to ensure stigma-free health services and measuring stigma as a way of informing programme design, policy at the health facility and national levels, ongoing learning, and support evaluation.

This report details the findings from a baseline survey report, five focus groups, and a participatory discussion and recommendations workshop based on its findings in St. Kitts and Nevis. The study and the survey instrument were adapted from global best practices for S&D-reduction programming in health facilities. The Office of the Chief Medical Officer and the Health Media Lab's Institutional Review Board of the St. Kitts and Nevis Ministry of Health (MOH) provided ethical approval for the study. The survey involved interviews conducted with a representative sample of all levels of health and auxiliary staff in health facilities. Survey questions addressed critical programming areas including: fears of HIV transmission through work-based exposure to people living with HIV (PLHIV), opinions about PLHIV and in particular pregnant women living with HIV, and the health facility environment. The survey data also measured levels of S&D, willingness to provide treatment to stigmatised populations, secondary stigma, and possible S&D towards health facility staff living with HIV.

The research employed a combination of self-administered and face-to-face interviews; the interviewers were identified by the National AIDS Programme of the St. Kitts and Nevis MOH. The analysis provides basic information needed to address stigma at the health facility level.

In total, 307 respondents including support administrative staff, medical personnel, cleaning/auxiliary staff, pharmacists, and related technicians formed the basis of this report. Frequencies for key results areas of all the questions asked—training, infection concerns, health facility environment, health facility policies, opinions about PLHIV and key populations, caring for pregnant women living with HIV—are presented by these broad job categories.

The programme includes two key elements: 1) strengthening the capacity of health facilities and health facility staff to provide S&D-free services and 2) collecting data to inform programme design, policy at the health facility and national levels, and ongoing learning, and to support evaluation. This report focuses on the initial stage of this second element, collection of baseline data from the health delivery system in St. Kitts and Nevis. These data provide a foundation on which to design evidence-informed S&D-reduction programming and evaluate change over time. In addition, the implementation of this survey

contributes to a global effort to develop a standardised tool and indicators for measuring S&D among health facility staff, providing a Caribbean perspective to the process that also includes sites in Dominica, China, Egypt, Kenya, and Puerto Rico.

USAID/HPP support for this work is part of an overall strategy to support S&D-reduction activities globally. The strategy includes 1) measuring stigma and discrimination in healthcare facilities; 2) training health personnel on stigma and discrimination and having them develop facility policies for reduction of S&D; and 3) working with key populations to enhance stigma reduction and stigma monitoring skills.

The report identifies key areas for action in the health system in order to reduce stigma. Although S&D varied among categories of workers, the differences were not consistently higher in any group. Respondents reported high levels of concern about HIV exposure. A significant percentage of respondents held stigmatising views about PLHIV and other high risk groups; roughly one in three respondents agreed that PLHIV did not care if they infect others, while just over one in three persons (34.9%) stated that PLHIV could have avoided HIV. The study revealed opportunities for encouraging empathy among healthcare workers and promoting a stigma-free environment—most respondents (61.2% across all categories) indicated that they could easily imagine being in the same situation as patients living with HIV in that facility.

Using the Health Facility Stigma Survey to Advance Change in St. Kitts and Nevis's Health Facilities

Participatory Workshop

After producing a range of tables and analysis, the National AIDS Programme of the Ministry of Health of St. Christopher (St. Kitts) and Nevis, HPP, and UWI organised a participatory workshop to share the findings and to discuss implications for the health system based on the survey results. The discussion and recommendations sections in this report reflect the participants' conclusions from that event.

Recommendations focus on a range of training suggestions including the development of creative, targeted strategies for bolstering S&D training for all categories of healthcare workers. Participants recommended integrating trainings and ongoing education as well as strengthening efforts to support universal precautions. In addition to sensitising workers on the importance of confidentiality, participants highlighted the need to develop written facility and national policies, including confidentiality and redress policies, as well as support for a patient bill of rights. Participants expressed a strong sense of motivation and duty to respond to the data and to reduce stigma in their facilities. They urged a call to action based on human rights and a professional obligation to provide equitable, high-quality services to all. The discussion and recommendations highlight the effectiveness of a participatory approach to data analysis to inform action.

As part of the next steps agreed upon during the meeting, the National AIDS Programme will roll out a training programme using an HPP tool, *Understanding and Challenging HIV & Key Population Stigma and Discrimination: Caribbean Facilitators' Guide*. The tool was already adapted and piloted with facilitators in St. Kitts and Nevis. It provides high-quality, piloted material for stigma-reduction training and has been used regionally to support stigma-reduction trainings, community dialogues, and policy development around HIV and key population S&D. As a follow-on to training of all health facility staff, the National AIDS Programme plans to develop facility-level policies for stigma-free HIV services.

ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
FGD	focus group discussion
HIV	human immunodeficiency virus
HPP	Health Policy Project
IV	intravenous
MOH	ministry of health
MSM	men who have sex with men
PANCAP	Pan Caribbean Partnership Against HIV & AIDS
PEPFAR	U.S. President's Emergency Fund for AIDS Relief
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
PWID	people who inject drugs
S&D	stigma and discrimination
SW	sex worker
TG	transgender
UNAIDS	United Nations Joint Programme on HIV/AIDS
USAID	U. S. Agency for International Development
UWI	University of the West Indies
UWIHARP	University of West Indies' HIV/AIDS Response Program

BACKGROUND

HIV-related stigma and discrimination (S&D) are widely recognised in the Caribbean region and globally as critical barriers to HIV prevention, care, and treatment, particularly for key populations who often experience additional stigmas beyond HIV. S&D violate human rights and keep people from seeking HIV testing, disclosing their HIV status, practicing prevention, accessing care, and adhering to treatment.

Recognising the importance of reducing S&D for an effective and efficient response to HIV, the Caribbean region is taking the lead in developing a way forward. The Pan Caribbean Partnership Against HIV and AIDS (PANCAP), with support from the USAID-funded Health Policy Project (HPP) and other regional partners, has developed *The PANCAP Stigma Reduction Framework for HIV and AIDS: National Actions to Reduce HIV-Related Stigma & Discrimination and Improve Health Outcomes* (2012), which provides guidance on developing national strategies for action to address S&D.

The PANCAP HIV framework highlights the importance of the health and development sector in building an understanding and evidence base for decision making and action to comprehensively respond to S&D. Responding to and learning about HIV-related stigma also strengthens broader understanding of stigma and health services. While S&D occur in all spheres of life, including the family, workplace, community, schools, places of worship, and healthcare facilities, experiences of S&D in healthcare facilities are particularly detrimental to the health and overall well-being of individuals and society. In response, the National AIDS Programme of the Ministry of Health of St. Christopher (St. Kitts) and Nevis, with assistance from HPP, the University of the West Indies (UWI), and other partners, is developing and testing a comprehensive S&D-reduction programme in health facilities that will bring lessons learned to share with the rest of the region.

The programme includes two key elements: 1) strengthening the capacity of health facilities and health facility staff to provide S&D-free services and 2) collecting data to inform programme design, policy at the health facility and national levels, and ongoing learning, and to support evaluation. This report focuses on the initial stage of this second element—collection of baseline data from the health delivery system in St. Kitts and Nevis. These data provide a foundation on which to design evidence-informed S&D-reduction programming and evaluate change over time. In addition, the implementation of this survey contributes to a global effort to develop a standardised tool and indicators for measuring S&D among health facility staff, providing a Caribbean perspective to the process that also includes sites in Dominica, China, Egypt, Kenya, and Puerto Rico.

HIV-related stigma is a powerful social process that devalues people or groups either living with or associated with HIV and AIDS. This stigma often stems from the pre-existing and intersecting stigmatisation of sex workers, people who inject drugs, transgender people, and men who have sex with men. Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status or membership of a specific group. Discrimination occurs when a distinction is made about a person that results in him or her being treated unfairly or unjustly on the basis of belonging to, or being perceived to belong to, a particular group.

TECHNICAL APPROACH: MEASUREMENT FOR STRENGTHENING STIGMA AND DISCRIMINATION–REDUCTION PROGRAMMING IN HEALTH FACILITIES

The study design and the survey instrument built on regional and global best practice experience for S&D-reduction programming in health facilities and measured key areas for programmatic intervention at both the individual and facility levels. Specifically, interviews were conducted with a representative sample of all levels of health facility staff (medical and nonmedical) in different types of health facilities. Information was collected in the following key areas for programmatic intervention: fears of HIV transmission through work-based exposure to people living with HIV (PLHIV), opinions about PLHIV and in particular pregnant women living with HIV, and the health facility environment. In addition, data were collected to assess levels of S&D, experiences with secondary¹ S&D, potential S&D towards health facility staff living with HIV, and willingness to provide treatment to stigmatised populations.

Fear of HIV Transmission

A known cause of S&D behaviour within health facilities is fear of becoming infected with HIV when providing care for PLHIV at all levels, ranging from forms of contact that pose no risk (e.g., touching clothing) to those that pose risk that can be mitigated through proper use of universal precautions. This fear of acquiring HIV may lead staff in health facilities to take unnecessary actions that can inadvertently, but visibly, mark patients as living with HIV to those around them, thereby breaking confidentiality. Data on specific types and degrees of fears health facility staff may hold around HIV transmission in the workplace provide information that allows S&D-reduction programming to directly address those fears, thereby reducing S&D behaviour.

Opinions about People Living with HIV

Negative opinions about the moral character or behaviours of PLHIV and key populations may underlie S&D in health facilities, manifesting in ways that are often inadvertent or not recognised as stigmatising behaviour (e.g., body language, tone of voice, language, gossip). Understanding common stigmatising opinions held by facility staff provides information on the prevalence of different attitudes, allowing S&D-reduction programming to tailor sensitisation and training accordingly.

Health Facility Environment

Best practice has shown that successful S&D-reduction programmes in health facilities include a focus on strengthening the health facility environment to ensure a safe and supported workspace for staff, thereby strengthening their ability to provide stigma-free services. Safe workspaces include both the physical environment (ensuring that staff members have the information, supplies and equipment necessary to practice universal precautions and prevent occupational transmission of HIV and other infectious diseases) and the health facility policy environment. To protect the safety and health of patients and staff, policies relating to the specific care of PLHIV or key populations must be developed and enforced. S&D in health facilities not only affects clients, but may also affect the willingness and comfort level of staff to be tested for HIV, work alongside staff living with HIV, and seek treatment for HIV.

¹Secondary stigma and discrimination is experienced by a person, because they are associated with PLHIV. In this case a healthcare worker could experience S&D, because they are known to be caring for patients living with HIV.

Observed Stigma and Discrimination

Surveys of S&D rarely ask respondents if they themselves have engaged in S&D behaviour, because direct questions pertaining to sensitive topics often elicit unreliable responses. As such, measures of S&D are often done through indirect questioning that asks respondents if they have observed various acts of S&D occurring in their facility during a given time frame (e.g., past 12 months). This approach may be prone to unreliable responses but is assumed to be less so than a direct question. It may also provide a conservative estimate (undercount) of S&D if there are forms of S&D occurring that are not easily observed by other staff in the facility.

Secondary Stigma

Health facility staff members who are known to provide care and services to PLHIV may experience S&D by association, both within and outside the facility. While this may be more of an issue in much higher HIV prevalence settings, we thought it important to explore in the context of St. Kitts and Nevis. If health facility staff are experiencing, or fear experiencing, secondary S&D, this may affect their own willingness to care for clients living with HIV, or the way they interact with PLHIV. It is important to provide support for staff to cope with and challenge that secondary S&D.

Willingness to Provide Treatment

Lastly, stigmas towards groups associated with HIV—for example men who have sex with men (MSM), sex workers (SWs), people who inject drugs (PWID), or immigrants—are also important to measure as they may deter those groups most in need of health services.

METHODOLOGY

A standard survey methodology was applied, and five focus groups were held with workers across the job categories. After the results were available, a participatory approach was used to discuss and interpret the study findings. A workshop was conducted with a diverse group of key stakeholders in the health sector in St. Kitts and Nevis, and these participants developed recommendations based on the survey findings.

Sample Selection and Implementation of Fieldwork

Survey: The sample was drawn from all adults working in a public health facility at the primary, secondary, or tertiary level, across all categories of workers (both technical and non-technical), as well as the private sector in St. Kitts and Nevis. A multistage sampling approach was adopted. In each of the healthcare facilities, the workers were stratified at the level of the broad occupation classification, technical and non-technical. The former included senior technical/professional staff (including specialists), other technical staff, and senior administrative staff. The latter included all other administrative staff and auxiliary staff.² Within each stratum, quota sampling was reapplied in the selection of respondents for the survey. This approach was based heavily on the proportions of the occupation categories that fall under each of these broad headings. This approach ensured that the key occupations were represented among those selected to respond to the survey.

Before starting fieldwork, a two-day briefing session was held for the field personnel, which focused on the identification and selection of respondents as stipulated by the sampling approach and classification of occupations. A detailed briefing on the questionnaire followed, accompanied by forms as well as confirmation of allocated quotas for the health facilities.

The survey was implemented through a combination of self-administered questionnaire and face-to-face interviews in cases where respondents were not comfortable or able to complete a self-administered questionnaire. Fieldwork interviewers at the survey stage were drawn from the National AIDS Programme of St. Kitts and Nevis.

Focus group discussions: Focus group participants were selected based on a quasi-random self-selecting method. After participants completed the survey, they were asked by research assistants whether they would like to volunteer to participate in a focus group discussion (FGD), which would take place shortly after the survey interview. Participants who were interested completed a single sign-up sheet to share background information such as name, age, gender, position in the facility, and whether their work included direct interaction with people living with or thought to be living with HIV. Participants were assured that both sets of information—the questionnaire and the contact sheet—would not be linked, allaying any fears of a breach of confidentiality.

The University of the West Indies’ HIV/AIDS Response Programme (UWI-HARP), with the support of the MOH, initially selected participants for five groups (three for St. Kitts and two for Nevis) using the categories Junior Administrative, Clerical and Auxiliary, Senior Administrative, and Professional/Technical staff. The group division would minimise the likelihood of staff members withholding their views and opinions in the presence of senior or technical personnel. The actual number of focus groups, however, turned out to be much lower, and groups were much smaller than anticipated,

² Technical staff will include: those classified as Professional (CMO, Principal Nursing Officer, health planners, doctors, PS, directors of services, lab techs, programme coordinators, etc.); those classified as Other Technical (nurses, nursing assistants, environmental & insect vector officers); and those classified as Senior Administrative Staff (Medical Records Technician, Accounts Officer, Executive Officer, Finance Officer, Manager Medical Stores). Non-Technical staff will include: Other Administrative Staff (Clerk, Telephone Operator, Orderly, and Medical Supply Officer); and Elementary Occupations (cleaners, laundry, seamstress, messengers).

especially in St. Kitts. The sessions with “groups” of three or two participants turned out to be more like in-depth interviews with some interaction between the participants. However, in a second round of FGDs, two additional mixed groups for St. Kitts could be organised which brought the total number of groups to five, as originally intended.

Inclusion criteria included FGD participants’ availability and background characteristics that would provide diversity in terms of age, gender, and position. Each FGD had at least some people with direct experience of working with PLHIV (or thought to be living with HIV). The sign-up sheets were kept in a separate envelope, secured by research personnel. A total of 101 respondents expressed interest in participating in the FGDs. However, many were unable to participate due to other commitments on the day. The MOH organised a location for the FGDs and, in consultation with UWIHARP, a day and time. The FGDs were scheduled to take place after the data collection for the survey. The survey was complete by the end of November, which left early December for the FGDs.

DATA CAPTURE

Survey: Completed questionnaires were scanned using Cardiff Teleform scanning software, now the standard used by statistical departments in a number of countries in the region. This approach has greatly enhanced the speed and efficiency of the data capture process. It also enhanced the accuracy of the data obtained by eliminating almost all manual data entry and subsequent coding errors, and ensuring a substantial amount of verification of the data captured from the scanned images on which the software operates.

Focus group discussions: None of the participants objected to the recording of the discussions. A note-taker took the role of recorder-observer to capture information that might not be audible (facial expressions and other body language). No real names were used and participants were asked not to use their names or those of the other group members when responding to the questions. The FGDs were led by a facilitator/moderator who was originally from Grenada and currently works with UWI, Mona Campus.

ANALYSIS PROCESS

Survey: Data captured from the questionnaires were exported from Teleform to Microsoft SQL Server where all additional data cleaning and aggregations were done. Survey data processing was done in Statistical Package for Social Scientists for Windows version 17. A comprehensive range of tables was generated from the analysis based on the reporting requirements and monitoring indicators identified during survey development.

The data were analysed to assess the presence and levels of the immediately actionable drivers of S&D (e.g., fear of casual transmission of HIV and attitudes towards PLHIV); observed S&D; experience of secondary S&D; and a facility environment supportive of S&D-free care. This level of analysis provided basic information to assess the situation and needs in the health facilities and what type of programming is most needed. A secondary analysis, focused on examining the individual questions, was carried out as part of a global process that is working to develop, test, and assess questions on S&D in health facilities in multiple sites across the globe to recommend a short set of questions and accompanying indicators for approval by the Joint United Nations Programme on HIV/AIDS (UNAIDS) that can be used for routine monitoring and evaluation globally.

Focus Groups: The recordings were transcribed by a professional of Caribbean origin who was familiar with Caribbean languages. Transcripts were coded using qualitative analysis software (Atlas.ti). Based on the survey questionnaire, a provisional “start list” of central concepts in understanding S&D (e.g., fear, lack of knowledge, myths, morals, peer pressure, organisational culture, institutional loyalties, forms of stigma, etc.) guided the discussion. However, open coding was the major method of creating codes developed throughout the analysis.

ETHICAL CLEARANCE AND CONSENT PROCESSES

Ethical approvals for the study were obtained from the St. Kitts and Nevis MOH, Office of the Chief Medical Officer, and the Health Media Lab’s Institutional Review Board.

Signed informed consent was collected from each respondent. The consent form explained

- Procedures
- Risks and Discomforts
- Benefits
- Alternatives
- Confidentiality
- Refusal or withdrawal without penalty (participation is voluntary)
- Cost of participation (respondent’s time)
- No payment for participation
- Legal rights

RESULTS

A total of 307 respondents formed the basis of the analysis that follows. As indicated in the methodology, these respondents covered a range of job classifications in the health sector. These job categories were further grouped under four major headings: Support administrative staff, Medical personnel, Cleaning/auxiliary staff, and Pharmacist including technicians. Seven respondents did not provide their job classification. They are listed separately in the tables as “job category not stated.”

Frequencies for the key results areas (training, infection concerns, health facility environment, health facility policies, opinions about PLHIV and key populations, caring for pregnant women living with HIV) for all the questions asked are presented by these broad job categories.

The specific sample sizes (number of respondents – n) are also included in the tables for each question. In cases where the numbers differ within the table, this was either because there was a non-applicable response category for that particular question or because of non-response. In several of the tables, response categories have been combined. For example, for a question that asked a respondent whether they strongly agreed, agreed, disagreed or strongly disagreed, the two agree categories were combined, as were the two disagree categories. The appendix provides the data for all response categories.

Table 1: Sample Breakdown by Health Facility

Facility Type	Count	Percentage
National referral hospital	164	53%
Health centre	61	20%
Private providers	58	19%
District hospital	41	13%
Clinic	22	7%
Other	21	7%
Pharmacy	7	2%
Not stated	4	1%

Table 1 provides a breakdown of staff by the facilities where they were employed at the time of the study. Other facilities' staff members were employed at the Environmental Health Office, Health Promotion Office, laboratories, nursing homes, and senior citizens' homes.

The breakdown illustrates the fact that practitioners work at multiple facilities during working hours.

Exposure to Training

Respondents in general were not found to be involved in any significant training initiatives over the last 12 months. Among the more popular areas of training highlighted were infection control and universal precautions and patients' informed consent, as identified by 26.1 per cent and 24.4 per cent of the respondents, respectively. Training programmes covering HIV prevention and S&D were identified by 16.3 per cent and 15.0 per cent of the respondents, respectively. Medical personnel were more inclined to attend training programmes affiliated with their field such as infection control and HIV treatment and care, while programmes in areas such as S&D, patients' informed consent, and HIV prevention were more likely to be attended by the nonmedical staff as shown in Table 2.1.

Table 2.1 Training Received in the Last 12 Months by Job Category (By Percentage)

Training Areas		Support Administrative Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Position Not Given	Total
Sample size (n)		42	199	26	33	7	307
HIV S&D	Yes	16.7	15.1	23.1	9.1	0	15.0
	No	71.4	75.4	65.4	81.8	85.7	74.9
	Not stated	11.9	9.5	11.5	9.1	14.3	10.1
Gender sensitivity	Yes	7.1	7.1	11.5	9.1	0	9.4
	No	81.1	77.4	76.9	78.8	85.7	78.2
	Not stated	11.9	12.6	11.5	12.1	14.3	12.4
HIV care and treatment	Yes	0	14.6	3.8	9.1	0	10.7
	No	85.7	74.9	76.9	78.8	85.7	78.2
	Not stated	11.9	12.6	11.5	12.1	14.3	12.4
Infection control and universal precaution	Yes	4.8	33.7	15.4	18.2	14.3	26.1
	No	81.0	55.8	65.4	69.7	71.4	61.9
	Not stated	14.3	10.6	19.2	12.1	14.3	12.1
Patients' informed consent, privacy, and confidentiality	Yes	11.9	28.6	30.8	9.1	28.6	24.4
	No	73.8	61.3	53.8	72.7	57.1	63.5
	Not stated	14.3	10.1	15.4	18.2	14.3	12.1
HIV counselling and testing	Yes	4.8	11.1	7.7	6.1	0	9.1
	No	83.3	76.9	73.1	78.8	85.7	77.9
	Not stated	11.9	12.1	19.2	15.2	14.3	13.0
Prevention of vertical transmission (mother to child)	Yes	2.4	11.1	7.7	0	0	8.1
	No	83.3	74.4	76.9	84.8	85.7	77.2
	Not stated	14.3	14.6	15.4	15.2	14.3	14.7

Training Areas		Support Administrative Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Position Not Given	Total
Prevention of HIV transmission between adults	Yes	9.5	18.1	26.9	9.1	0	16.3
	No	78.6	69.3	57.7	81.8	85.7	71.3
	Not stated	11.9	12.6	15.4	9.1	14.3	12.4
Youth-friendly health services	Yes	4.8	7.5	3.8	9.1	0	6.8
	No	81.0	77.4	76.9	78.8	85.7	78.2
	Not stated	14.3	15.1	19.2	12.1	14.3	15.0
Received other training	Yes	7.1	2.5	3.8	3.0	0	3.3
	No	61.9	60.8	46.2	48.5	57.1	58.3
	Not stated	31.0	36.7	50.0	48.5	42.9	38.4

Participants in the FGDs made the link between reduced worries about becoming infected with HIV and increased exposure to training. They argued that concerns would be greatly reduced “... depending on the person’s educational level about HIV and AIDS.” As was said about some staff, “[t]hey would come up with those concerns about touching and doing the temperature but once they’re educated, I don’t think that they would come up with such an answer—because they know.”

Participants generally agreed “... since the advent of universal precautions ... and the educating of persons within the workplace, [the concerns about getting HIV infected] have changed a lot.”

Infection Concerns

Respondents were asked to indicate their level of concern about becoming infected with HIV while engaged in procedures involving PLHIV. The degree of worry was found to be directly linked to the degree of interaction with the PLHIV that the procedure required. Therefore the more invasive procedures such as dressing wounds, inserting intravenous (IV) drips, suturing wounds, and drawing blood recorded higher levels of worry among respondents (ranging from 40.1% to 45.1%) than less invasive procedures such as taking the temperature of a patient living with HIV with 5.9 per cent stating worry and 6.4 per cent declining response. This pattern was also found to be consistently reported along the lines of the occupation classification as illustrated in Table 2.2.

Among the participants in the FGDs, there were no significant concerns except about needles and fluids, which related to invasive procedures. There was general agreement across the groups that worries were about “injuries and so on, but not the basic casual contact,” as one participant described. Auxiliary staff’s concerns were greater than those of other categories of staff, because they dispose of the waste/garbage. Increased protective measures when providing care or services to PLHIV were relatively common. One in three respondents (34.7%) cited the use of gloves during all aspects of patient care and service provision (9.4% did not respond), with most of these being medical personnel. Across the FGDs, participants referred to closely following the “universal (health) precautions” which gave them a sense of protection. Double gloves and masks seem to be used less frequently as a precautionary measure, with regular use being reported by 18.2 per cent and 16.5 per cent of respondents respectively. This trend was also reported along occupation classification as seen in Table 2.3. As the FGD participants noted, “We... put on our gloves, we wash our hands, we put on our masks. ... If it’s an infectious patient you put on the entire clothing.” Reference was also made to treating every patient as possibly infectious and doubling up on the use of protective gear: “... we try to treat all patients as if they are HIV positive so we take the necessary precautions ... we wear protective clothing, protective gear... double up and everything.” It was not always clear, however, whether the wearing of gowns and masks was reserved for the treatment of HIV-positive patients, although respondents from the professional/technical category stated that these were necessary for the treatment of any infectious patient—especially one who was coughing—and in the treatment of any wound (such as in a diabetic patient) in which blood or any other body fluid was likely to spew.

Despite education, some scepticism still existed about the ways in which HIV can be transmitted. According to one FGD participant, “Even though we know... the education is out there ... the ways of contracting HIV, like when you’re touching... you tell the other person that you cannot get HIV by touching, but even in yourself you’re still sceptical. You’re still reluctant to touch. And you’d know for a fact that you can’t catch it by touching but you still have that extra...”

Table 2.2 Areas of Concern About HIV Exposure by Job Category (By Percentage)

Areas of Concern		Support Administrative Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Position Not Given	Total
Took the temperature of a patient living with HIV	Sample size (n)	7	175	5	13	2	202
	Not worried	85.7	89.7	60	69.2	100	87.6
	Worried	0	4.6	20	23.1	0	5.9
	Not stated	14.3	5.7	20	7.7	0	6.4
Touched the clothing of a patient living with HIV	n	13	194	8	20	4	239
	Not worried	69.2	88.7	87.5	80	50.0	86.2
	Worried	15.4	4.6	0	15.0	25.0	6.3
	Not stated	15.4	6.7	12.5	5.0	25.0	7.5
Cleaned the operating room or exam area after a patient living with HIV was seen	n	5	158	9	10	4	186
	Not worried	40	70.9	66.7	60	25.0	68.3
	Worried	20	19.6	11.1	30	25.0	19.9
	Not stated	40	9.5	22.2	10	50.0	11.8
Did a physical exam on a patient living with HIV	n	3	167	4	12	2	188
	Not worried	33.3	82.6	75.0	58.3	100	80.3
	Worried	0	10.8	0	33.3	0	11.7
	Not stated	66.7	6.6	25.0	8.3	0	8.0
Gave an injection to a patient living with HIV	n	6	166	4	11	2	189
	Not worried	0	56.0	75.0	45.5	100	54.5
	Worried	50	37.3	0	45.5	0	37.0
	Not stated	50	6.6	25.0	9.1	0	8.5
Dressed the wounds of a patient living with HIV	n	6	173	4	12	2	197
	Not worried	0	53.8	75.0	33.3	50.0	51.3
	Worried	66.7	39.3	0	58.3	0	40.1
	Not stated	33.3	6.9	25.0	8.3	50.0	8.6

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Areas of Concern		Support Administrative Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Position Not Given	Total
Inserted a central line/IV drip in a patient living with HIV	n	3	141	4	12	2	162
	Not worried	0	52.5	75.0	41.7	50.0	51.2
	Worried	33.3	39.7	0	50.0	0	38.9
	Not stated	66.7	7.8	25.0	8.3	50.0	9.9
Drew blood from a patient living with HIV	n	3	145	4	21	2	175
	Not worried	0	47.6	75.0	38.1	50.0	46.3
	Worried	33.3	45.5	0	57.1	0	45.1
	Not stated	66.7	6.9	25.0	4.8	50.0	8.6
Sutured the wounds of a patient living with HIV	n	3	146	4	10	2	165
	Not worried	0	47.9	75.0	20.0	50.0	46.1
	Worried	33.3	43.8	0	70.0	0	43.6
	Not stated	66.7	8.2	25.0	10.0	50.0	10.3
	Total	100	100	100	100	100	100

Table 2.3 Precautionary Measures Adopted by Job Category

Measures Adopted		Support Administrative Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Position Not Given	Total
Avoid physical contact when providing care/services for a patient living with HIV	Sample size (n)	7	167	6	17	3	200
	Yes	28.6	3.0	0	0	33.3	4.0
	No	28.6	87.4	83.3	94.1	33.3	85.0
	Not stated	42.9	9.6	16.7	5.9	33.3	11.0
Wear gloves during all aspects of the patient's care when providing care/services for a patient living with HIV	n	6	173	4	16	3	202
	Yes	16.7	30.1	75.0	68.8	100	34.7
	No	33.3	61.8	0	25.0	0	55.9
	Not stated	50	8.1	25.0	6.3	0	9.4
Use masks during all aspects of the patient's care when providing care/services for a patient living with HIV	n	7	168	3	19	3	200
	Yes	0	16.7	66.7	10.5	33.3	16.5
	No	57.1	75.0	0	84.2	66.7	74.0
	Not stated	42.9	8.3	33.3	5.3	0	9.5
Wear double gloves when providing care/services for a patient living with HIV	Yes	14.3	20	0	5.6	25.0	18.2
	No	42.9	71.2	75.0	88.9	75.0	71.9
	Not stated	42.9	8.8	25.0	5.6	.0	9.9
Wear goggles during all aspects of the patient's care when providing care/services for a patient living with HIV	n	7	165	4	18	4	198
	Yes	0	7.9	0	5.6	25.0	7.6
	No	57.1	83.0	75.0	88.9	75.0	82.3
	Not stated	42.9	9.1	25.0	5.6	0	10.1
Use other measure when providing care/services for a patient living with HIV	n	5	163	5	19	3	195
	Yes	0	7.4	0	0	33.3	6.7
	No	20	80.4	60.0	94.7	66.7	79.5
	Not stated	80	12.3	40.0	5.3	0	13.8

Health Facility Environment

In spite of the strides made in forging a comprehensive response to HIV in both the health and non-health sectors, there remain instances of discrimination associated with the provision of care for PLHIV who present at healthcare facilities, as observed by respondents to this study. Staff members were asked to report on instances where they had observed discriminatory and positive behaviours from peers within their facility occurring in their facility in the past 12 months, such as the following:

- Unwilling to provide care
- Providing sub-standard levels of care
- Saying bad things
- Confronting or educating others about mistreatment
- Members disclosing HIV status without the client’s permission
- Using extra infection control precautions
- Providing extra support or care

Referring patients living with HIV to other health facilities

The responses were wide ranging with between 3.3 per cent and 36.2 per cent of staff members reporting these acts occurring in their health facilities in the past 12 months. Among medical personnel between 2.5 per cent and 45.2 per cent reported observing these acts. The lowest reported percentage was linked to instances where patients living with HIV were transferred to other facilities, with a mere 3.3 per cent of the staff reporting to have observed this. Among the highest reported percentage of acts observed was use of extra infection control measures (34.9%). On the positive side, 36.2 per cent of the respondents reported observing instances where extra care was provided to patients with or thought to be living with HIV and health facility staff confronting or educating someone who was verbally mistreating PLHIV (23.1%). While significantly higher percentages of auxiliary staff reported observing acts of discrimination, this job category had a small sample size, so some degree of caution is advised in drawing any broad conclusions from this group.

A remaining key feature of these data, however, is that between 10 and 12 per cent of the respondents declined to answer these questions. Details on the responses by job classification are captured in Table 2.4.

FGD participants emphasised that HIV-positive patients had to receive different care but clarified that this did not denote discrimination. HIV-positive patients were said to be “[Treated] differently, yes, because of their condition ... medically differently ...but not... not socially,” HIV-positive patients require a special diet, more support, and isolation from other patients in order to prevent co-infection, especially when the CD4 count was very low. Several participants echoed the view that: “... if a patient admits that he or she is positive then they will treat that patient like in a separate way... in terms of ... OK like the instruments that we use on that patient ... are separated.” Other participants suggested offering more care to HIV-positive patients: “The care would be different because ... we’d be giving them more ... you are giving them extra ...and more love.”

Observed or experienced instances of secondary stigma were not very high among the respondents, with 8.6 per cent of respondents reporting verbal defamation of those known to care for PLHIV—the highest reported rate of secondary stigma. A complete breakdown is found in Table 2.5.

Respondents were also asked about observed willingness of staff members to address personal health issues at the facility. Just over one half of respondents (51.8%) stated that workers at their facility would

be hesitant to undergo an HIV test at the facility due to peers' reactions if the test was positive. This percentage was consistently high, particularly among the job categories that were in contact with patients.

In terms of working alongside a PLHIV, 37.8 per cent of respondents felt that there would be some degree of hesitancy among staff to work alongside a fellow staff member living with HIV, no matter what their duties. Respondents reported that a healthcare worker would be most hesitant to receive HIV care and treatment at the facility (67.4%). This pattern was consistent across the various job categories grouping and particularly high among medical personnel, with 72.4 per cent expressing hesitancy (Table 2.6).

Table 2.4 Observed Practices in Health Facility by Job Category (By Percentage)

Observed Practices		Support Administrative Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Position Not Given	Total
Sample size (n)		42	199	26	33	7	307
Health facility staff unwilling to care for a patient living with HIV	Never observed	73.8	68.8	46.2	87.9	85.7	70
	Observed	7.1	22.6	42.3	3.0	14.3	19.9
	Not stated	19.0	8.5	11.5	9.1	0	10.1
Health facility staff providing poorer quality of care to a patient living with HIV than to other patients	Never observed	73.8	67.3	53.8	78.8	85.7	68.7
	Observed	4.8	24.6	30.8	12.1	0	20.5
	Not stated	21.4	8.0	15.4	9.1	14.3	10.7
Health facility staff talking badly about people living with or thought to be living with HIV	Never observed	71.4	71.4	57.7	75.8	85.7	65.5
	Observed	7.1	7.1	26.9	15.2	14.3	22.8
	Not stated	21.4	21.4	15.4	9.1	0	11.7
Health facility staff confronting or educating someone who was mistreating or speaking badly about PLHIV	Never observed	64.3	62.3	57.7	78.8	85.7	64.5
	Observed	14.3	27.6	26.9	9.1	0	23.1
	Not stated	21.4	10.1	15.4	12.1	14.3	12.4
Health facility staff disclosing a patient’s HIV status without the patient’s permission	Never observed	66.7	75.4	61.5	78.8	85.7	73.6
	Observed	9.5	15.6	19.2	9.1	14.3	14.3
	Not stated	23.8	9.0	19.2	12.1	0	12.1

Observed Practices		Support Administrative Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Position Not Given	Total
Health facility staff using extra infection control precautions when caring for a patient living with HIV	Never observed	69.0	47.2	42.3	69.7	71.4	52.8
	Observed	4.8	43.7	38.5	21.2	14.3	34.9
	Not stated	26.2	9.0	19.2	9.1	14.3	12.4
Health facility staff workers providing extra support or care for patients living with or thought to be living with HIV	Never observed	52.4	43.2	61.5	60.6	71.4	48.5
	Observed	14.3	45.2	19.2	27.3	14.3	36.2
	Not stated	33.3	11.6	19.2	12.1	14.3	15.3
Health facility staff workers sending or referring patients living with HIV to other health facilities	Never observed	73.8	88.4	65.4	90.9	85.7	84.7
	Observed	0	2.5	19.2	0	0	3.3
	Not stated	26.2	9.0	15.4	9.1	14.3	12.1

Table 2.5 Instances of Secondary Stigma Experienced by Job Category

Instances of Secondary Stigma		Support Administrative Staff	Medical Personnel	Cleaning/ Auxiliary staff	Pharmacist/ Technicians	Position Not Given	Total
Experienced people talking badly about you because you care for patients living with HIV	Sample size (n)	24	183	17	29	3	256
	Never observed	83.3	83.1	47.1	89.7	100	81.6
	Observed	0	7.1	41.2	6.9	0	8.6
	Not stated	16.7	9.8	11.8	3.4	0	9.8
Been avoided by friends because you care for patients living with HIV	n	23	183	16	29	3	254
	Never observed	82.6	88.5	68.8	96.6	100	87.8
	Observed	0	.5	18.8	0	0	1.6
	Not stated	17.4	10.9	12.5	3.4	0	10.6
Been avoided by colleagues because you care for patients living with HIV	n	22	182	16	29	3	252
	Never observed	81.8	90.1	68.8	96.6	100	88.9
	Observed	0	0	18.8	0	0	1.2
	Not stated	18.2	9.9	12.5	3.4	0	9.9
Been assumed to be HIV positive because you care for patients living with HIV	n	23	182	13	29	3	250
	Never observed	78.3	86.3	84.6	93.1	100	86.4
	Observed	0	3.8	0	3.4	0	3.2
	Not stated	21.7	9.9	15.4	3.4	0	10.4

Table 2.6 Hesitancy of Healthcare Workers in an HIV Environment by Job Category (By Percentage)

Areas Identified		Support Administrative Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Position Not Stated	Total
Sample size (n)		42	199	26	33	7	307
How hesitant are healthcare workers in this facility to take an HIV test due to fear of other people's reactions if the test is positive?	Not hesitant	38.1	33.7	15.4	39.4	0	32.6
	Hesitant	31.0	54.3	65.4	48.5	71.4	51.8
	Not stated	31.0	12.1	19.2	12.1	28.6	15.6
How hesitant are healthcare workers in this facility to work alongside a co-worker living with HIV regardless of their duties?	Not hesitant	35.7	41.2	15.4	60.6	0	39.4
	Hesitant	28.6	39.7	50.0	21.2	71.4	37.8
	Not stated	35.7	19.1	34.6	18.2	28.6	22.8
How hesitant do you think a healthcare worker living with HIV would be to seek healthcare in this facility?	Not hesitant	26.2	15.6	7.7	24.2	0	16.9
	Hesitant	40.5	72.4	73.1	60.6	100	67.4
	Not stated	33.3	12.1	19.2	15.2	0	15.6

Health Facility Policies

Just over 43 per cent of the staff members interviewed cited the presence of an anti-discrimination policy to protect patients living with HIV in their facility, with recall higher among administrative and medical staff and lower among auxiliary and related staff. It is worth noting that 39.1 per cent of the respondents were unaware of such a policy. Roughly one half (51%) of the staff interviewed made reference to the likelihood of ramifications for not following policies to protect patients living with HIV. The job categories likely to be in either direct (medical personnel) or indirect contact (administrative and auxiliary staff) with HIV-positive patients made reference to this outcome. Fewer of those who were not likely to come into contact with HIV-positive patients (pharmacists and technicians) were able to identify this possible outcome, as seen in Table 2.7 below.

A significant 65.8 per cent of the respondents indicated that they were exposed to some degree of training in protecting the confidentiality of patients’ HIV status. Medical (70.9%) and pharmacist/technical personnel (72.7%) were more likely to have been trained along these lines.

Roughly 38 per cent of the respondents indicated that post-exposure prophylactic medications were accessible at their facility, while 39.1 per cent said their facility was without such access (Table 2.7).

Based on the response from the interviews, health facilities were both fairly well-supplied and possessed the environment that was supportive of staff providing care safely to patients living with HIV. This is supported by 84.7 per cent of the respondents who felt that facilities were adequately equipped to reduce the risk of becoming infected and 80.8 per cent who identified the presence of standard procedures to reduce such risks. While 92.5 per cent of the respondents endorsed their responsibility to maintain the confidentiality of patients with HIV when responding to the statement, “No matter my views or feelings, it is my professional responsibility to maintain the confidentiality of patients living with HIV,” 80.8 per cent identified the fact that it was obvious to everyone which patients had HIV in their facility (Table 2.8).

One participant in a FGD related her own experience of being a patient in the hospital and kissing a co-patient upon the co-patient’s discharge. She said that she was “warned” by another member of the staff who asked “You kissed her?” to which she answered “Yes she was nice to me and so I kissed her on the cheek.” The participant said that the member of staff said to her “why you do that, you ain’t know that she had AIDS?”

In all FGDs across the job categories, respondents noted procedure manuals for the wards. One participant noted: “Yes we have procedure manuals... all of the units... and you have the one for HIV.” However, several other members of staff were not aware of the manuals. There was mention of the policies not always being enforced. A member of the professional/technical staff pointed out that “... People here are very relaxed. ... so, even if they know that this is wrong ... they find an excuse.”

Adhering to confidentiality was not without challenges. One category of staff mentioned that charts were not kept absolutely confidential, stating they “go around too much in circles.” This, they felt, caused persons outside of the work area to sometimes have access to confidential information. Another category of staff felt, however, that confidentiality was observed “cause all our dockets have ... [a] mark on them ‘confidential’ ... right across in bold letters.” Participants in two of the FGDs indicated that when HIV testing happens, no names are generally used on patients’ charts, substituted instead for codes written on the charts: “... when you do a request for an HIV test you will not write the patient’s name in the ... in the form. It has a ... certain code. That hides the patient’s identity.” Other participants, however, indicated that using codes to protect confidentiality is not as effective as it should be—those who see the

codes on a daily basis can eventually identify patients based on their code. Two FGDs discussed concerns about confidentiality as indicated by one participant:

“That is the problem we have with the same chart. I don’t know how ... how confidential they are. Leave it at that.”

“... If everybody there reading the chart what do you expect? OK. At the end of the day you don’t even know how the information got it.”

“... And you can’t always take it for granted that ‘oh this person can’t read so they ain’t going to’ When you think people don’t know, as long as you give them a chance they will find out.”

Confidentiality is also challenged when not all medication for a PLHIV is available from one single pharmacy. In one of the FGDs composed of one category of staff, participants noted that the patient in such a situation would have to fill the remainder of the prescription at a district pharmacy. Although no names would be used (“... the three pharmacies alone handle that ... no names, just coded”), one participant argued that in moving around to fill prescriptions more than one pharmacist becomes aware of a patient’s status: “... one of the concerns is that ... even though the medication is collected in one area, what happens with that prescription ... in one prescription you write everything ... but you wouldn’t get everything there ... then you have to go the district pharmacy for it ... and the pharmacist can see everything.” Another participant in the same group retorted: “Oh and then the pharmacist will realize [that the patient has HIV].”

The realities and dynamics of life in a small society were acknowledged as one of the challenges to confidentiality. It is easier in such societies to break confidentiality through informal communication or observing body language because residents live in such close proximity. This was recognised in several of the FGDs, across the job categories, with one participant saying “If someone comes in with HIV you’re not supposed to know, but because it’s a small society, a small community, it’s very easy for someone to say ‘the girl... so and so have HIV and she tested positive or he tested positive but don’t say nothing that’s just between me and you.’”

Table 2.7 Views on Policy and Work Environment in the Facility by Job Category (By Percentage)

Statements on Policy & Environment		Support Administrative Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Position Not Stated	Total
Sample size (n)		42	199	26	33	7	307
My health facility has policies to protect patients living with HIV from discrimination	Yes	45.2	47.7	26.9	30.3	28.6	43.3
	No	11.9	10.6	0	9.1	0	9.4
	Do not know	38.1	32.2	61.5	60.6	57.1	39.1
	Not stated	4.8	9.5	11.5	0	14.3	8.1
I will get in trouble at work if I do not follow the policies to protect patients living with HIV	Yes	52.4	53.8	53.8	36.4	28.6	51.1
	No	14.3	8.5	15.4	9.1	14.3	10.1
	Do not know	19.0	25.6	19.2	48.5	28.6	26.7
	Not stated	14.3	12.1	11.5	6.1	28.6	12.1
Since I have been working at my institution, I have been trained in protecting the confidentiality of patients' HIV status	Yes	59.5	70.9	30.8	72.7	57.1	65.8
	No	28.6	19.1	30.8	12.1	14.3	20.5
	Do not know	4.8	3.0	26.9	9.1	0	5.9
	Not stated	7.1	7.0	11.5	6.1	28.6	7.8
You have access to post-exposure prophylactic medications in your health facility	Yes	4.8	44.2	38.5	45.5	14.3	37.8
	No	57.1	37.2	19.2	33.3	85.7	39.1
	Do not know	31.0	11.6	26.9	21.2	0	16.3
	Not stated	7.1	7.0	15.4	0	0	6.8

Table 2.8 Levels of Agreement with Statements on Policy and Environment by Job Category

Statements on Policy & Environment		Support Administrative Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Not Stated	Total
Sample size (n)		42	199	26	33	7	307
There are adequate supplies (e.g., gloves) in my health facility that reduce my risk of becoming infected with HIV	Agree	64.3	88.9	76.9	93.9	71.4	84.7
	Disagree	16.7	6.5	3.8	6.1	0	7.5
	Not stated	19.0	4.5	19.2	0	28.6	7.8
There are standardised procedures/protocols in my health facility that reduce my risk of becoming infected with HIV	Agree	66.7	85.4	65.4	87.9	57.1	80.8
	Disagree	14.3	8.5	15.4	6.1	14.3	9.8
	Not stated	19.0	6.0	19.2	6.1	28.6	9.4
At my health facility, it is obvious to everyone which patients are living with HIV	Disagree	7.1	11.6	3.8	12.1	0	10.1
	Agree	71.4	83.4	73.1	87.9	57.1	80.8
	Not stated	21.4	5.0	23.1	0	42.9	9.1
No matter my views or feelings, it is my professional responsibility to maintain the confidentiality of patients living with HIV	Agree	90.5	94.5	76.9	100	71.4	92.5
	Disagree	0	2.0	3.8	0	0	1.6
	Not stated	9.5	3.5	19.2	0	28.6	5.9
I would never test a patient for HIV without the patient's informed consent	Agree	69.0	84.9	46.2	84.8	57.1	78.8
	Disagree	0	7.0	15.4	9.1	0	6.8
	Not stated	31.0	8.0	38.5	6.1	42.9	14.3

Opinions About People Living with HIV and Other Risk Groups

Respondents were asked to indicate their level of agreement with a number of statements and opinions about PLHIV. Just over one in three persons (34.9%) agreed that PLHIV could have avoided HIV infection, while far fewer saw HIV as a punishment (3.9%). Roughly one in three respondents (33.6%) agreed that PLHIV did not care if they infect others—a view supported largely by lower-skilled staff and less-so by medical and related support staff. Few respondents supported the view that HIV was a result of a sinful life (7.2%) or that PLHIV should feel some sense of shame for their acquired status (6.5%). More respondents were inclined to link HIV to multiple sexual partners (23.8%) and irresponsible behaviour (31%) as seen in Table 2.9. It is worth noting that half of those interviewed (50.2%) agreed that PLHIV should be allowed to have babies if they so wished. There was more widespread agreement in response to this opinion across all the job categories except those in the support and administrative staff.

Just under one half (48.9%) of the respondents indicated that they would be ashamed if they were to become infected with HIV, while even higher percentages were likely to express shame if one of their relatives were to be infected (68.1%). Medical and related staff members were more inclined to express shame than the lower level staff. (Table 2.10)

As it relates to the provision of health and related services to selected high-risk groups, in general, staff members were not in favour of withholding services from these groups. For example, for PWID and MSM, 14.2 per cent and 11.2 per cent of the respondents preferred to not provide service to these groups, while 10.5 per cent and 9.2 per cent were not prepared to provide service to SW and TG respectively. When it came to providing services to sexually active unmarried youth, 5.1 per cent noted they preferred not to provide services to this group. Those who preferred not to provide services to a particular group consistently identified lack of training working with specific populations as explanation. The perception that providing services exposed providers to higher risk of disease was among the key reasons given for all the groups with the exception of immigrants and women who have sex with women. The perceived immoral behaviour of this latter group, as well as MSM, PWID, SW and TG was also among the more popular reasons given for the reluctance in providing services to these groups.

In terms of general comments or opinions about PLHIV, there were calls across the FGDs for increased public education. Participants described reactions by the general society as mixed, ranging from expressed sorrow for PLHIV to derogatory comments imputing promiscuity

“It would always be derogatory.”

“Like ‘she had a lot of man,’ ‘all kinds of man.’”

“Not all the time ... trust me, not all the time.”

“The most nice things they would say is ... ‘Lord I sorry she get that ... I sorry she get that. But if you sorry within yourself you ain’t supposed to be talking about it ...’.”

“So to talk about it is to gossip, so it’s derogatory.”

“They ain’t gonna say anything good about anybody with AIDS.”

Table 2.9 Opinions Related to People Living with HIV by Job Category (by Percentage)

Opinions Related to People Living With HIV		Support Administrative Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Not Stated	Total
Sample size (n)		42	199	26	33	7	307
PLHIV could have avoided HIV if they had wanted to	Agree	35.7	33.2	34.6	42.4	42.9	34.9
	Disagree	45.2	60.8	38.5	54.5	28.6	55.4
	Not stated	19.0	6.0	26.9	3.0	28.6	9.8
HIV is punishment for bad behaviour	Agree	4.8	2.0	19.2	3.0	0	3.9
	Disagree	81.0	94.0	65.4	97.0	85.7	89.9
	Not stated	14.3	4.0	15.4	0	14.3	6.2
Most PLHIV do not care if they infect other people	Agree	31.0	33.2	65.4	21.2	0	33.6
	Disagree	47.6	59.8	19.2	75.8	85.7	57.0
	Not stated	21.4	7.0	15.4	3.0	14.3	9.4
PLHIV should feel ashamed of themselves	Agree	4.8	6.0	19.2	3.0	0	6.5
	Disagree	76.2	88.9	65.4	97.0	85.7	86.0
	Not stated	19.0	5.0	15.4	0	14.3	7.5
Most people living with HIV have had many sexual partners	Agree	21.4	21.6	57.7	12.1	28.6	23.8
	Disagree	59.5	73.9	26.9	87.9	57.1	69.1
	Not stated	19.0	4.5	15.4	0	14.3	7.2
People get infected with HIV because they engage in irresponsible behaviours	Agree	23.8	34.2	23.1	27.3	28.6	30.9
	Disagree	57.1	60.3	61.5	69.7	71.4	61.2
	Not stated	19.0	5.5	15.4	3.0	0	7.8
Becoming infected with HIV is the result of living a sinful life	Agree	4.8	8.0	15.4	0	0	7.2
	Disagree	81.0	87.4	69.2	100	85.7	86.3
	Not stated	14.3	4.5	15.4	0	14.3	6.5
PLHIV should be allowed to have babies if they wish	Agree	38.1	52.8	46.2	57.6	28.6	50.2
	Disagree	50.0	33.2	34.6	36.4	57.1	36.5
	Not stated	11.9	14.1	19.2	6.1	14.3	13.4

Table 2.10 Opinions About Becoming Infected with HIV by Job Category (By Percentage)

Opinions About Becoming Infected With HIV		Support Administrative Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Not Stated	Total
Sample size (n)		42	199	26	33	7	307
I would be ashamed if I were infected with HIV	No	40.5	40.7	57.7	33.3	71.4	42.0
	Yes	40.5	50.8	30.8	66.7	28.6	48.9
	Not stated	19.0	8.5	11.5	0	0	9.1
I would be ashamed if someone in my family were infected with HIV	No	23.8	23.6	46.2	15.2	42.9	25.1
	Yes	57.1	70.9	46.2	84.8	57.1	68.1
	Not stated	19.0	5.5	7.7	0	0	6.8
I can easily imagine myself in the same situation as patients living with HIV in this healthcare facility	Yes	61.9	64.3	50.0	57.6	28.6	61.2
	No	19.0	24.6	34.6	36.4	42.9	26.4
	Not stated	19.0	11.1	15.4	6.1	28.6	12.4

Table 2.11 Opinions Related to Providing Services to At Risk Populations by Job Category(By Percentage)

Opinions Related to Providing Services to at Risk Populations		Support Administrative Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Not Stated	Total
I would prefer not to provide services to: PWID	Sample size (n)	35	199	22	32	7	295
	Agree	11.4	12.6	45.5	6.3	14.3	14.2
	Disagree	74.3	80.4	45.5	93.8	57.1	78.0
	Not stated	14.3	7.0	9.1	0	28.6	7.8
I would prefer not to provide services to: MSM	n	36	199	21	32	7	295
	Agree	5.6	10.1	38.1	9.4	0	11.2
	Disagree	80.6	83.9	52.4	90.6	71.4	81.7
	Not stated	13.9	6.0	9.5	0	28.6	7.1
I would prefer not to provide services to: SW	n	36	199	21	32	7	295
	Agree	11.1	8.5	38.1	6.3	0	10.5
	Disagree	77.8	85.9	52.4	93.8	71.4	83.1
	Not stated	11.1	5.5	9.5	0	28.6	6.4
I would prefer not to provide services to: TG	n	36	199	21	31	7	294
	Agree	2.8	8.5	33.3	6.5	0	9.2
	Disagree	83.3	85.9	57.1	93.5	57.1	83.7
	Not stated	13.9	5.5	9.5	0	42.9	7.1
I would prefer not to provide services to: women who have sex with women	n	34	199	22	32	7	294
	Agree	5.9	5.5	36.4	6.3	0	7.8
	Disagree	85.3	89.4	54.5	93.8	71.4	86.4
	Not stated	8.8	5.0	9.1	0	28.6	5.8

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Opinions Related to Providing Services to at Risk Populations		Support Administrative Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Not Stated	Total
I would prefer not to provide services to: immigrants	n	34	199	22	31	7	293
	Agree	2.9	5.5	9.1	6.5	0	5.5
	Disagree	85.3	88.9	81.8	93.5	71.4	88.1
	Not stated	11.8	5.5	9.1	0	28.6	6.5
I would prefer not to provide services to: sexually active unmarried youth	n	34	199	21	32	7	293
	Agree	2.9	5.5	9.5	3.1	0	5.1
	Disagree	88.2	89.9	81.0	96.9	57.1	89.1
	Not stated	8.8	4.5	9.5	0	42.9	5.8
I would prefer not to provide services to: pregnant women living with HIV	n	34	199	21	31	7	292
	Agree	0	5.0	14.3	3.2	0	4.8
	Disagree	88.2	88.9	76.2	96.8	71.4	88.4
	Not stated	11.8	6.0	9.5	0	28.6	6.8

Antenatal Care, Prevention of Mother-to-Child Transmission, and Delivery

This section specifically addressed service providers who work with pregnant women in antenatal care, prevention of mother-to-child transmission (PMTCT), and delivery. On the issue of assisting a woman living with HIV in labour and delivery, 58.4 per cent of medical staff expressed some degree of worry, while just over half (50.6%) expressed worry about assisting with the delivery in the case where the woman's HIV status is unknown.

Respondents were next asked whether they had ever observed certain procedures by other providers at their health facility. With respect to performing an HIV test on a pregnant woman without her informed consent or disclosing an HIV-positive pregnant woman's status to others without her consent, instances of these acts were rarely observed, with just 2.3 per cent and 6.2 per cent of the respondents respectively citing such instances. In addition, 6.9 per cent and 6.2 per cent did not answer these questions. Just over one in four respondents (25.6%) cited the use of additional infection control measures during labour with pregnant women who were HIV positive. These data are captured in Table 2.13.

Respondents were then asked to indicate the extent to which they agreed with statements pertaining to pregnant women who were living with HIV. The majority of respondents (87.8%) did not believe that women with HIV were bad mothers. Additionally 75.4 per cent disagreed that with sterilising a woman living with HIV even if it is not her choice, while 15.4 per cent agreed and 9.2 per cent declined to answer. Other statements, however, had mixed responses. On the issue of disclosure, 53.4 per cent of the respondents supported disclosure to family, while 39.7 per cent disagreed. In the area of testing, 61.8 per cent of the respondents agreed that refusal to be tested was seen as an irresponsible act. Failure to adhere to the recommended infant feeding guidelines for PMTCT was also seen as an act of irresponsibility by 67.9 per cent of the respondents. While 58.8 per cent of the respondents agreed with the position that women living with HIV who already have children should not get pregnant, 32.1 per cent disagreed. A more detailed breakdown of these data can be found in Table 2.14.

Table 2.12 Worry Associated With Assisting With Delivery by Job Category (By Percentage)

Statement		Medical Personnel
Sample size (n)		89
The woman is living with HIV	Not worried	39.3
	Worried	58.4
	Not stated	2.2
The woman's HIV status is unknown	Not worried	46.1
	Worried	50.6
	Not stated	3.4

Table 2.13 Observations over Past 12 Months by Job Category (By Percentage)

Observations		Medical Personnel	Pharmacist/ Technicians	Not Stated	Total
Sample size (n)		102	12	3	117
Performing an HIV test on a pregnant woman without informed consent	Never observed	89.2	100	100	90.6
	Observed	2.0	0	0	1.7
	Not stated	8.8	0	0	7.7
Neglecting a woman living with HIV during labour and delivery because of her HIV status	Never observed	90.2	100	100	91.5
	Observed	1.0	0	0	0.9
	Not stated	8.8	0	0	7.7
Using additional infection control procedures with a pregnant woman living with HIV during labour and delivery because of her HIV Status	Never observed	58.8	91.7	100	63.2
	Observed	29.4	8.3	0	26.5
	Not stated	11.8	0	0	10.3
Disclosing a pregnant woman living with HIV's status to others without her consent	Never observed	88.2	92.3	66.7	88.1
	Observed	4.9	7.7	0	5.1
	Not stated	6.9	0	33.3	6.8
Making HIV treatment for a woman living with HIV conditional on use of family planning methods	Never observed	79.4	92.3	66.7	80.5
	Observed	6.9	7.7	0	6.8
	Not stated	13.7	0	33.3	12.7

Table 2.14 Levels of Agreement with Selected Statements By Job Category

Statements		Medical Personnel	Pharmacist/ Technicians	Not Stated	Total
Sample size (n)		102	14	3	119
If a pregnant woman is HIV positive, her family has a right to know	Agree	51.0	50.0	33.3	50.4
	Disagree	43.1	42.9	33.3	42.9
	Not stated	5.9	7.1	33.3	6.7
Pregnant women who refuse HIV testing are irresponsible	Agree	60.8	71.4	66.7	62.2
	Disagree	32.4	21.4	0	30.3
	Not stated	6.9	7.1	33.3	7.6
Women living with HIV are unable to be good mothers	Agree	2.9	7.1	0	3.4
	Disagree	92.2	85.7	66.7	90.8
	Not stated	4.9	7.1	33.3	5.9
Women living with HIV who do not follow infant feeding recommendations for preventing transmission of HIV to their infant are irresponsible	Agree	66.7	71.4	66.7	67.2
	Disagree	26.5	28.6	0	26.1
	Not stated	6.9	0	33.3	6.7
Women living with HIV should not get pregnant if they already have children	Agree	55.9	71.4	66.7	58.0
	Disagree	35.3	21.4	0	32.8
	Not stated	8.8	7.1	33.3	9.2

Getting to “Stigma-Free” Services in St. Kitts and Nevis: Survey Results

Statements		Medical Personnel	Pharmacist/ Technicians	Not Stated	Total
A pregnant woman living with HIV should undergo antiretroviral therapy, even if this is not her choice, for the health of the baby	Agree	73.5	84.6	66.7	74.6
	Disagree	19.6	7.7	0	17.8
	Not stated	6.9	7.7	33.3	7.6
It can be appropriate to sterilise a woman living with HIV, even if this is not her choice	Agree	12.7	15.4	0	12.7
	Disagree	78.4	76.9	66.7	78.0
	Not stated	8.8	7.7	33.3	9.3

LIMITATIONS

There are several limitations to this study that affected sample selection and data collection.

Sample Selection

Survey: One of the key limitations of implementing studies of this nature in small island states is directly linked to the issue of size and small numbers of personnel across facilities and departments. The environment is characterised by the relatively high turnover of staff as they migrate in search of better opportunities or move within and between jobs. The list of persons from which the sample must be drawn is constantly changing as people change jobs, which posed a challenge for sample selection. This affected the proposed quotas allocated by facilities—in some instances the number of personnel listed in facilities was not in alignment with the actual number at the facility across the various job categories.

Another key feature of the health sector in this context is the absence of any clear distinction between practitioners who work in the public and private sector, as a significant proportion of persons who practice in the public sector also have a private practice. This overlap resulted in double counting, as personnel were listed across both the private and public sectors.

Focus Groups: In spite of the expressed willingness to participate in the more in-depth discussion about the issues covered in the survey (questionnaire), participation in the FGDs was low, as shown by Table 3.1.

Table 3.1 Number of Participants By Job Category/Classification

Job Category/Classification	Nevis	St. Kitts
Junior administrative, clerical, and auxiliary	6 + 1 (who had to be interviewed separately because she came after the FGD had ended)	0
Other technical/senior administrative	3	0
Professional and technical	2	6
Mixed: one GP, three nurses and two community members	0	6
Mixed: two phlebotomists (lab), one technical staff (lab), one auxiliary and one nurse	0	5

The time and location of the discussions may have influenced low participation, because they were scheduled during the working hours of most of the participants and, in some instances, took place on the hospital compound, as in the case of Nevis. In two of the discussions, a few participants were interrupted by work demands and had to be excused. They did, however, return.

Scheduling the FGDs in December was problematic because the policy regarding vacation leave for government healthcare workers only allowed workers to take leave up to mid-December. In the case of St. Kitts, some critical individuals who had indicated their availability for the FGDs were on leave and others were overseas.

Data Collection

Some specific limitations arose during fieldwork that negatively affected the rate of completion as well as the final number of completed interviews. They include the following:

- Reluctance of medical staff to respond in large group settings and complete the questionnaire as a self-administered tool, for fear that their responses could be aligned with them; this was particularly evident among some of the administrative staff
- Significant number of “not stated” responses to certain questions
- Reluctance by staff to commit to taking time off to complete the questionnaire, due largely to the demands of facility at the point in time which ultimately affected the time taken for completion of fieldwork
- Getting higher-level medical staff to complete the questionnaires also proved difficult, resulting in a number of “call backs”
- Inaccurately completed surveys, resulting, in some cases, in the questionnaires having to be redone or left as incomplete

DISCUSSION AND RECOMMENDATIONS

Discussion

This study represents the first effort to systematically measure S&D in healthcare facilities in St. Kitts and Nevis, and provides an evidence base for a comprehensive approach to achieving stigma-free health services.

To facilitate a participatory analysis process and collective development of the recommendations based on the data, a workshop was conducted in April 2013 with key stakeholders from the health sector in St. Kitts and Nevis. During the one-day workshop, stakeholders worked in small groups of five to seven participants to review summary data tables and discuss their implications, as well as possible strategies to respond to the findings. They then presented their deliberations back to the larger group, including specific recommendations for action. The larger group then discussed and reached a consensus about these recommendations, which were documented by a note-taker. Written recommendations documented in the workshop were again vetted by email with workshop participants. The discussion and recommendations developed during the workshop provided the basis for developing the country-led strategy for planning to reduce stigma in health facilities.

Infection concerns: The discussion revolved around surprise that the levels of fear were as high as they were, considering all the information and training on HIV transmission that has occurred over the years. While the numbers were low for the first two items in this section, taking the temperature (5.9% worried, 6.4% didn't respond) and touching the clothing (6.3% worried and 7.5% did not respond) of a patient living with HIV, workshop participants noted that there should not be any worry at all among health facility staff about transmission through these modes, and particularly not among medical staff. The level of worry increasing with the invasiveness of the procedure was to be expected, but still raises concern, because worry can translate into visible actions that could stigmatise a patient or inadvertently disclose a patient's status. The group also discussed what they think may cause the disconnect between knowledge of HIV transmission and continued fear of infection among health facility staff, even when they know it is not possible for HIV to be transmitted that way. It was noted that a significant number of respondents chose not to answer these questions (ranging from 6.4–10.3% of respondents), and that this might reflect a group of people who know that they should not be worried, but actually are worried, and thus chose not to answer the question.

The levels of worry are reflected in the data on reported use of unwarranted precautionary measures when caring for a patient living with HIV. For example, 34.7 per cent of all respondents reported observing in the past 12 months staff wearing gloves during all aspects of a patient's care when providing services to a patient living with HIV, while 20 per cent of medical personnel reported observing the use of double gloves for providing care to a patient living with HIV. The issue of double gloves led to a discussion about the quality of gloves and whether this practice was the result of issues with the quality of the gloves (ripping), rather than a reflection of fear of HIV transmission. However, it was noted that if quality was the issue, then double gloves should be used to treat all patients, not just patients living with HIV.

Health facility environment: The discussion of these questions revolved around what was seen as a disconnect between the reported observed stigma levels (e.g., 19.9% reporting observing unwillingness to care for a patient living with HIV and 10.1% not answering) and the perception that most health facility staff (67.4%) would be hesitant to seek healthcare in their facility if they were living with HIV. Respondents may have been hesitant to report what they observed, as they knew it was not appropriate (a significant number of respondents chose not to answer these questions (ranging from 3–15% of respondents), but were more comfortable reflecting reality in their response to the question about

willingness to seek care. Another reason could be that the stigmatising actions they have observed, which are of a relatively significant level (e.g., 24.6% of medical personnel reporting they have observed health facility staff providing poorer quality care to a patient living with HIV compared to other patients), have a strong impact on perceptions of the levels of S&D. It may take only a few observations of stigmatising behaviour to create a strong perception that stigma is very common, and therefore has a much larger effect on the willingness of health facility staff to test and seek treatment than might be expected, given the actual levels of reported stigmatising behaviours. Others noted that if one were to look at the numbers on stigmatising attitudes, which are relatively high, it is understandable that health facility staff would hesitate to seek care. As one participant noted, “We know how we treat others, so I would expect to be treated the same [if I had HIV].”

Participants were surprised at the number of auxiliary staff who reported experiencing any level of secondary stigma (especially in contrast to medical personnel). They do not provide direct physical care to patients living with HIV, so the participants thought it was puzzling that they would report experiencing secondary stigma, since it is unlikely that people outside the facility would associate them with caring for patients living with HIV. The participants felt that these respondents may not have understood this question.

Health facility policies: The relatively high number of respondents (43.3%) who cited facility-level policies to protect patients living with HIV from discrimination was puzzling, given the absence of such specific policies at facility-level. Several explanations were put forward for this result, including that respondents could have been referring to an unwritten policy, mission statement (e.g., that all patients are treated equally), or code of ethics to which staff are expected to adhere. Others noted that a workplace policy was recently developed and perhaps respondents were referring to it when answering this question. There is also an HIV procedures manual, and while it focused on protocols, respondents may have been referring to it. It is perhaps understandable that 39.1 per cent of respondents answered, “don’t know” to this question, while 8.1 per cent declined to answer. The group felt that some of the numbers were unexpectedly high for the category of auxiliary staff/cleaners and wondered if they had understood the questions. Participants agreed that most respondents (92.5%) stated a professional responsibility to maintain the confidentiality of patients living with HIV, because they know it to be the expected or “right” answer.

The high level of agreement (80.8% agreement and 9.1% non-response) with the statement: “At my health facility, it is obvious to everyone which patients are living with HIV” was cause for discussion and consternation. Some found the question ambiguous and hard to answer, and wondered if respondents understood the question as there are no practices that would obviously mark a patient as living with HIV (e.g., isolation rooms). Others noted that there are many subtle ways in which patients can be visibly marked as having HIV (e.g., double gloves, certain types of body language, etc.), so it may be a collection of less obvious things that mark a patient as living with HIV.

Opinions and willingness to treat: Overall the workshop participants were not surprised by the data in this section. They commented that stigmatising attitudes could be rooted in lack of knowledge and low levels of education, as well as religious beliefs. They noted that for most items auxiliary/cleaning staff responded in the affirmative more than other categories of staff did and wondered if this was because other groups—in particular medical personnel—were giving what they perceived as the appropriate response based on their knowledge, as opposed to their genuine opinion. Questions about shame led to a discussion of whether respondents would interpret shame in the same way. It was noted that medical personnel in particular may fear or experience more shame because people expect them to “know better” and therefore not become infected with HIV. Therefore the expectation is that if they are living with HIV, stigma would be even more intense, because they are medically trained.

The group had mixed views about findings related to preference for treating key populations. Some felt it was an honest reflection of the situation, while others had expected more reluctance to treat those groups. Those who thought the numbers were too low felt that respondents may not have understood the questions or were not answering truthfully, but rather the way they thought they should answer. Others thought that the issue was with the wording of the question. Even though the question asked specifically about the respondent's own preference with regards to providing services to a specific group, respondents may have answered from the perspective of thinking they do not have a choice, therefore they answered they would prefer to provide treatment, even if they did not. Based on this feedback, a recommendation has been made to change the wording of the question to include the qualifier "if I had a choice" for any future use. As to opinions relating to pregnant women living with HIV, while many of the responses were low, some are still worrisome. For example, 15.4 per cent agreed with the statement "It can be appropriate to sterilise a woman living with HIV, even if this is not her choice," while another 9.2 per cent chose not to answer the question.

Recommendations

Participants offered a range of recommendations regarding training, particularly around S&D from a human rights and equality perspective. Specific recommendations addressed the rights of key populations to access health services and are framed in this context.

Bolster stigma and discrimination training and education for all categories of workers

- Develop more creative, targeted strategies

Participants recommended a new approach to education, emphasising the need to develop the trainings with attention to the use of more creative and effective strategies. They urged that all categories of healthcare workers be included and that messaging should be tailored to their duties. They also noted that the messages and content of the training should be specific to individual positions rather than delivering the same training to everyone.

Participants pointed out that while staff might have been trained or educated on HIV transmission, this education did not preclude double gloving or extraordinary precautions when performing even low- or no-risk tasks while caring for patients living with HIV. They called for a more in-depth understanding of transmission that would address infection fears and behaviours reflected in these extraordinary precautions.

The participants urged that trainings should include more dialogue and creative strategies that would target this sort of fear-based behaviour. They stressed the need to push participants to reflect on more deeply rooted attitudes and fear rather than just providing basic information using didactic methods.

- Integrate trainings into ongoing education and training programmes

Other strategic recommendations included methods for integrating the training and education into existing programmes. Participants called for integrating these approaches and the topic of S&D into pre-service orientation for all health and auxiliary workers, nursing school curricula, and other ongoing education for nurses and medical staff.

- Focus on gaps identified in the survey; universal precautions

In addition to improving strategies and developing more targeted approaches to training, participants highlighted topics in need of emphasis. For example, following the considerable discussion about double-gloving when providing care to a patient living with HIV (or presumed to be living with HIV), the participants concluded the need to stress the use of universal

precautions for all patients (i.e., avoiding double gloving with selected patients). Participants also flagged the inconsistent use of universal precautions when providing antenatal care for mothers and newborn care for babies assumed to be HIV positive.

In response to specific concerns raised during discussion about pregnant women and mothers living with HIV, participants urged that training and education strategies should address the attitudes, fear, and lack of knowledge in this area. They stressed that healthcare workers should understand fully the implications of differential treatment of different patients—inadvertent disclosure by the healthcare worker to other health and auxiliary staff and sending a stigmatising message to other patients or family members.

- Provide cadre-specific training for post-exposure prophylaxis

Participants emphasised that all healthcare workers should receive training on post-exposure prophylaxis, as they suggested that not all workers know the protocols, including when to use it and where and how to access it.

- Ensure that all healthcare workers understand and commit to a code of confidentiality

The participants expressed a strong concern about confidentiality and recommended it be included among the key topics in health and auxiliary worker education. It would be incorporated into orientations and ongoing sensitisation. They wanted to be sure that workers understood the ramifications of failing to maintain confidentiality.

Patient rights, confidentiality, and redress policies

In addition to sensitising workers to the importance of confidentiality, participants highlighted the need to develop written facility and national policies. They suggested that while workers generally understood the need for confidentiality, they are not bound by strong facility-level policies that are reinforced by a national policy for confidentiality and redress. As a result they urged the need to

- Develop strong national confidentiality and workplace policies specific to the health sector

They indicated that a code of ethics exists—a workplace policy was developed and an HIV policy and procedures manual describes expectations—but these policies do not have legal accountability, as they do not provide avenues for redress. The participants concluded the need to develop such policies with a particular focus on the redress aspects to help reinforce notions of confidentiality.

- Create a patient bill of rights

Participants called for supporting a patient bill of rights to reinforce the code of conduct. This would serve as a facility-level method to inform patients of standards and expectations including confidentiality. It would reinforce the idea among staff that they are accountable for upholding the principles of confidentiality, and patients would hold the same expectations.

ANNEX: RESPONDENT NUMBERS BY QUESTION

Table 4.1 Areas OF Concern About HIV Exposure (By Percentage)

	Not Worried	A Little Worried	Worried	Very Worried	Not Applicable	Not Stated
Took the temperature of a patient living with HIV	68.9	2.7	0.8	1.2	21.4	5.1
Touched the clothing of a patient living with HIV	80.8	3.1	1.2	1.6	6.3	7.1
Cleaned the operating room or exam area after a patient living with HIV was seen	49.4	11.3	1.9	1.2	27.6	8.6
Did a physical exam on a patient living with HIV	59.0	4.7	3.1	0.8	26.6	5.9
Gave an injection to a patient living with HIV	40.2	20.3	3.1	3.9	26.2	6.3
Dressed the wounds of a patient living with HIV	39.5	21.5	6.3	3.1	23.0	6.6
Inserted a central line/IV drip in a patient living with HIV	32.4	16.8	5.1	2.7	36.7	6.3
Drew blood from a patient living with HIV	31.6	19.9	6.3	4.7	31.6	5.9
Sutured the wounds of a patient living with HIV	29.7	15.2	6.6	6.3	35.5	6.6

Table 4.2 Precautionary Measures Adopted (By Percentage)

	Yes	No	Not Applicable	Not Stated
Avoid physical contact when providing care/services for a patient living with HIV	3.1	66.9	21.3	8.7
Wear gloves during all aspects of the patient's care when providing care/services for a patient living with HIV	27.3	44.1	21.1	7.4
Use masks during all aspects of the patient's care when providing care/services for a patient living with HIV	12.9	57.8	21.9	7.4
Wear double gloves when providing care/services for a patient living with HIV	14.5	57.0	20.7	7.8
Wear goggles during all aspects of the patient's care when providing care/services for a patient living with HIV	5.9	63.9	22.4	7.8
Use other measure when providing care/services for a patient living with HIV	5.1	60.8	23.5	10.6

Table 4.3 Observed Practices in Health Facility (By Percentage)

	Never	Once or Twice	Several Times	Most of the Time	Not Stated
Health facility staff unwilling to care for a patient living with HIV	70.0	12.4	5.5	2.0	10.1
Health facility staff providing poorer quality of care to a patient living with HIV than to other patients	68.7	16.9	3.3	0.3	10.7
Health facility staff talking badly about people living with or thought to be living with HIV	65.5	16.3	6.2	0.3	11.7
Health facility staff confronting or educating someone who was mistreating or speaking badly about PLHIV	64.5	15.3	5.9	2.0	12.4
Health facility staff disclosing a patient's HIV status without the patient's permission	73.6	9.4	4.2	0.7	12.1
Health facility staff using extra infection control precautions when caring for a patient living with HIV	52.8	15.6	10.1	9.1	12.4
Health facility staff workers providing extra support or care for patients living with or thought to be living with HIV	48.5	15.6	13.0	7.5	15.3
Health facility staff workers sending or referring patients living with HIV to other health facilities because the	84.7	2.0	0.7	0.7	12.1

Table 4.4 Instances of Secondary Stigma Experienced (By Percentage)

	Never	Once or Twice	Several Times	Most of the Time	Not Applicable	Not Stated
Experienced people talking badly about you because you care for patients living with HIV	68.1	4.2	2.0	1.0	16.6	8.1
Been avoided by friends and family because you care for patients living with HIV	72.6	0	1.0	0.3	17.3	8.8
Been avoided by colleagues because of your work caring for patients living with HIV	73.0	0.3	0.3	0.3	17.9	8.1
Been assumed to be HIV positive because you care for patients living with HIV	70.4	2.6	0	0	18.6	8.5

Table 4.5 Hesitancy of Healthcare Workers In An HIV Environment (By Percentage)

	Not Hesitant	A Little Hesitant	Somewhat Hesitant	Very Hesitant	Not Stated
How hesitant are healthcare workers in this facility to take an HIV test due to fear of other people’s reactions if the test is positive?	32.6	18.6	18.6	14.7	15.6
How hesitant are healthcare workers in this facility to work alongside a co-worker living with HIV regardless of their duties?	39.4	16.3	15.0	6.5	22.8
How hesitant do you think a healthcare worker living with HIV would be to seek healthcare in this facility?	16.9	11.7	17.6	38.1	15.6

Table 4.6 Views on Policy and Work Environment In The Facility (By Percentage)

	Yes	No	Do Not Know	Not Stated
My health facility has policies to protect patients living with HIV from discrimination	43.3	9.4	39.1	8.1
I will get in trouble at work if I do not follow the policies to protect patients living with HIV	51.1	10.1	26.7	12.1
Since I have been working at my institution, I have been trained in protecting the confidentiality of patients' HIV status	65.8	20.5	5.9	7.8
You have access to post-exposure, prophylactic medications in your health facility	37.8	39.1	16.3	6.8

Table 4.7 Levels of Agreement With Statements on Policy And Environment (By Percentage)

	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Stated
There are adequate supplies (e.g., gloves) in my health facility that reduce my risk of becoming infected with HIV	54.1	30.6	5.2	2.3	7.8
There are standardised procedures/protocols in my health facility that reduce my risk of becoming infected with HIV	46.3	34.5	7.8	2.0	9.4
At my health facility, it is obvious to everyone which patients are living with HIV	3.9	6.2	34.5	46.3	9.1
No matter my views or feelings, it is my professional responsibility to maintain the confidentiality of patients living with HIV	83.7	8.8	0.3	1.3	5.9
I would never test a patient for HIV without the patient's informed consent	67.1	11.7	5.2	1.6	14.3
PLHIV should be allowed to have babies if they wish	21.2	29.0	17.3	19.2	13.4

Table 4.8 Opinions Related to People Living With HIV (By Percentage)

	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Stated
PLHIV could have avoided HIV if they had wanted to	13.0	21.8	36.8	18.6	9.8
HIV is punishment for bad behaviour	1.6	2.3	31.3	58.6	6.2
Most PLHIV do not care if they infect other people	8.8	24.8	39.7	17.3	9.4
PLHIV should feel ashamed of themselves	3.3	3.3	33.6	52.4	7.5
Most PLHIV have had many sexual partners	10.1	13.7	37.8	31.3	7.2
People get infected with HIV because they engage in irresponsible behaviours	5.9	25.1	37.8	23.5	7.8
Getting HIV is the result of living a sinful life	2.6	4.6	35.5	50.8	6.5

Table 4.9 Opinions about Becoming Infected With HIV (By Percentage)

	Yes	No	Not Stated
I would be ashamed if I were infected with HIV	42.0	48.9	9.1
I would be ashamed if someone in my family were infected with HIV	25.1	68.1	6.8
I can easily imagine myself in the same situation as patients living with HIV in this healthcare facility	61.2	26.4	12.4

Table 4.10 Opinions Related To Providing Services to At Risk Populations (By Percentage)

	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Stated
I would prefer not to provide services to : PWID	7.8	6.4	46.4	31.5	7.8
I would prefer not to provide services to : MSM	5.8	5.4	47.8	33.9	7.1
I would prefer not to provide services to : SW	6.1	4.4	50.8	32.2	6.4
I would prefer not to provide services to : TG	5.4	3.7	50.7	33.0	7.1
I would prefer not to provide services to : women who have sex with women	4.4	3.4	50.3	36.1	5.8
I would prefer not to provide services to : immigrants	2.7	2.7	48.1	39.9	6.5
I would prefer not to provide services to : sexually active unmarried youth	2.0	3.1	49.8	39.2	5.8
I would prefer not to provide services to : pregnant women living with HIV	3.1	1.7	50.3	38.0	6.8

Table 4.11 Worry Associated With Assisting With Delivery (By Percentage)

	Not Worried	A Little Worried	Worried	Very Worried	Not Applicable	Not Stated
The woman is living with HIV	33.0	25.0	13.4	8.9	17.9	1.8
The woman's HIV status is unknown	38.4	20.5	9.8	10.7	17.9	2.7

Table 4.12 Observations over Past 12 Months (By Percentage)

	Never	Once or Twice	Several Times	Most of the Time	Not Stated
Performing an HIV test on a pregnant woman without informed consent	90.6	1.7	0.0	0.0	7.7
Neglecting a woman living with HIV during labour and delivery because of her HIV status	91.5	0.9	0.0	0.0	7.7
Using additional infection control procedures with a pregnant woman living with HIV during labour and delivery because of her HIV status	63.2	15.4	4.3	6.8	10.3
Disclosing a pregnant woman living with HIV's status to others without her consent	88.1	4.2	0.8	0	6.8
Making HIV treatment for a woman living with HIV conditional on use of family planning methods	80.5	3.4	1.7	1.7	12.7

Table 4.13 Levels of Agreement With Selected Statements (By Percentage)

	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Stated
If a pregnant woman is HIV positive, her family has a right to know	18.5	31.9	25.2	17.6	6.7
Pregnant women who refuse HIV testing are irresponsible	22.7	39.5	24.4	5.9	7.6
Women living with HIV are unable to be good mothers	3.4	0.0	42.0	48.7	5.9
Women living with HIV who do not follow infant feeding recommendations for preventing transmission of HIV to their infant are irresponsible	27.7	39.5	18.5	7.6	6.7
Women living with HIV should not get pregnant if they already have children	21.8	36.1	26.9	5.9	9.2
A pregnant woman living with HIV should undergo antiretroviral therapy, even if this is not her choice, for the health of the baby	37.3	37.3	11.0	6.8	7.6
It can be appropriate to sterilise a woman living with HIV, even if this is not her choice	6.8	5.9	46.6	31.4	9.3

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