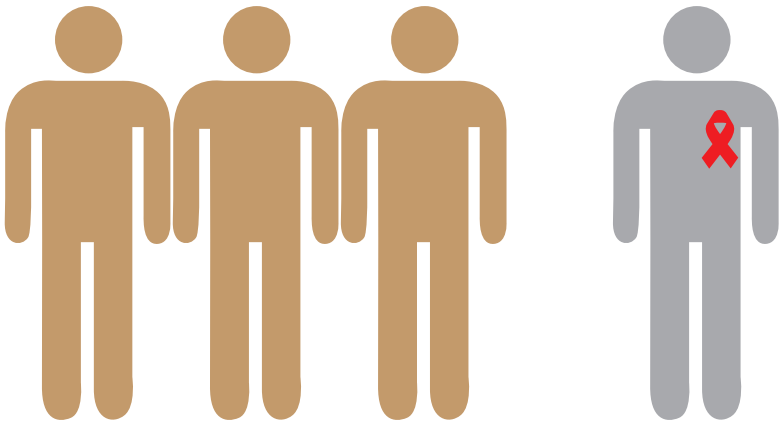
Stigma & Discrimination



Stigma & Discrimination

Base Line Survey

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Stigma & Discrimination among Health Care Provider on HIV/AIDS

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Base Line Survey

Stigma & Discrimination among Health Care Provider on HIV/AIDS: Baseline Survey

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List of Abbreviations

CSPRO	Census and Survey Processing System
DAC	Department of AIDS Control
FHI 360	Family Health International
GOI	Government of India
HCP	Health Care Provider
HIV/AIDS	Human Immunodeficiency Virus /Acquired Immune Deficiency Syndrome
IHBP	Improving Healthy Behaviors Program
MBBS	Bachelor of Medicine, Bachelor of Surgery
MD	Doctor of Medicine
MS	Master of Surgery
NACO	National AIDS Control Organisation
PEP	Post Exposure Prophylaxis
PLHIV	Person Living with HIV AIDS/Person Living with HIV
SRI-IMRB	Social and Rural Research Institute, IMRB International
SRSWOR	Simple Random Sampling without Replacement
TV	Television
UNAIDS	United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development

Executive Summary

Findings from the National AIDS Control Organization (NACO) reveal that the numbers of people infected with HIV in India are increasing in areas where HIV/AIDS-related services are inadequate (National AIDS Control Organisation, 2007). The data also indicate that about one-third of reported AIDS cases are among people younger than 30 years. It is estimated, however, that many more AIDS cases go unreported and AIDS-related deaths are not accounted for. Fear of stigma and discrimination and problems in claiming life insurance coverage have been identified as key reasons for cases not being reported (FHI 360, May 2014). This study aims to further recognize the underlying roots of stigma and discrimination associated with people living with HIV (PLHIV) in health care settings in India and factors that may facilitate promotion of more equitable attitudes and actions to support them.

The Study and Settings

The present study, promoting a more Equitable Attitude toward PLHIV among Health Care Providers in Selected States of India: Baseline, was conducted by the Improving Healthy Behaviors Program (IHBP) in India, in the states of Rajasthan, Madhya Pradesh, Karnataka, Manipur, West Bengal, and Goa, covering a total of 17 districts. A total of 1,260 health care providers (HCPs) were selected for the study. The study was executed by the Social and Rural research institute of IMRB International (SRI-IMRB).

Target Groups

The target group for the study was HCPs—medical and non-medical staff. These were divided into two broad categories:

- Primary Group (medical staff) (those who can diagnose and prescribe medicine): Bachelor of Medicine, Bachelor of Surgery (MBBS) doctors, full-time medical students, and those who have completed at least three years in a medical college and use Internet at least four hours per week

- Secondary Group (non-medical staff) (provide support to medical staff): nurses, paramedics, attendants, lab-technicians

Data Collection

Data were collected using structured questionnaires each for:

1. Doctors and medical students
2. Nurses and lab technicians
3. Ward staff (ward boy/girl and sweepers)

Interviews with HCPs were conducted in the health facilities where they worked during the month of July 2014. A total of 635 doctors, 266 medical students, and 358 non-medical staff were covered.

Measurement

The key indicators covered in the survey were: knowledge about transmission of HIV, care and management of PLHIV in health care settings, precautions used by HCPs for protection from casual HIV transmission, fear and concerns regarding treatment of PLHIV, awareness of policies for the protection of PLHIV, and attitudes toward PLHIV.

The study also covered information on the type of health facility respondents worked in, duration of their work within the facility, and their educational and media profile.

Research Findings

Knowledge about HIV Transmission

There were significant gaps in knowledge among health care providers about transmission of HIV in general, as well as within a hospital setting. HIV transmission knowledge increased with education level and was reported to be lowest among the ward staff.

Blood, genital fluids, and breast milk were identified as a medium of transmission by almost 8 out of 10 professionals. However, lower knowledge of HIV transmission was reported related to transmission through sputum, vomit, or splashes of bodily fluids on gloves and/or intact skin. More than half of all HCPs had incorrect knowledge of transmission through blood splashes to eyes or mouth. More than 75% of all HCPs believed sputum was a transmitter of HIV.

Apart from incorrect knowledge, misconceptions such as the possibility of HIV transmission through touch, sharing clothes or utensils, mosquito bites, and breath were prevalent among HCPs. Among the medical staff, 16% reported at least one of these transmission misconceptions.

Exposure to Occupational Training

Seventy percent of medical staff, 58% of nurses, and 45% of ward staff reported to have received training on universal precautions and HIV transmission in their current health facility. Only one-third of all HCPs, however, were exposed to this type of training within the last year. Less than half of HCPs were exposed to topics on legal and ethical issues related to HIV and counselling.

Fear of Work-Related Transmission

Medical staff and nurses reported the highest levels of fear of HIV transmission when dealing with large quantities of blood. Fear of transmission was higher among the medical staff who had never treated an HIV-positive person, among those who never received any in-service training related to HIV, or those who had not been exposed to HIV-related communication in the past year.

Apart from fear, almost half of all medical staff reported lack of medicine and antiretrovirals (ARV) as their major concern related to the treatment of an HIV positive patient.

Table 1: Precautions taken by Doctors and Medical Students to Protect Themselves from HIV Transmission

Precautions taken to Protect Self from HIV	% (base 901)
Using gloves	98
Using disposable syringes	94
Using aprons	87
Using masks	81
Using double gloves	77
By taking PEP	68
Using boots	67
Universal precautions	59
Using goggles	55
Vaccine	39
Not going near the patient	7
Not touching the patient	5

Many medical staff reported taking extra precautions such as double gloves (77%), PEP (68%), boots (67%), vaccines (39%), and complete avoidance of the patient (6%) while dealing with an HIV-positive patient.

Stigma and Discrimination in Health Facilities

Fear-based, enacted, and anticipated stigma manifests itself in many forms within health facilities.

Within health facilities, one form of stigma was visible as breach of right to confidentiality and information. Among the medical staff, 44% said that they do not always take patients' consent before disclosure of results and about a third reported to always withholding the results even from the patient (N=901). Discriminatory practices were also visible as 53% of medical staff reported that invasive procedures on patients from high-risk groups (sex workers, poor, etc.) were postponed until their serostatus was confirmed.

Attitudes toward PLHIV

Ward staff reported the most negative attitudes toward PLHIV among the various HCP types. Among the various forms in which stigma may manifest itself, anticipated stigma, or the shame within an individual through an association with someone who is HIV positive, generated the most negative attitudes from all cadres of health care providers.

Conclusion and Recommendations

Stigma and discriminatory practices were present within health facilities at various levels and behaviors, and evident through practices such as segregation of PLHIV from other patients, needless labelling of beds, excessive use of barrier precautions by HCPs, delay in treatment, breach of confidentiality, withholding HIV test results from patients, disclosure without consent, mandatory HIV-testing before invasive procedures, and providing insufficient or inadequate counseling. Gaps in knowledge, lack of training and policies, fear of contagion, value-laden assumptions, attitudes of shame and blame toward PLHIV, and self-identified inefficiencies of doctors to treat HIV-positive patients, all contributed to an environment of stigma and discrimination toward PLHIV within health facilities.

Need for an intervention targeting medical staff members addressing knowledge gaps, stigmatizing attitudes, and discriminatory practices within the health facilities has been identified by the study findings.

Chapter 1: Introduction and Background

1.1. HIV-related Stigma and Discrimination

HIV-related stigma is pervasive in the lives of PLHIV marking them as different and disgraced and denying them dignity, respect, and the right to participate fully in society. This may include their right to education,, occupation, and treatment and care, and freedom of choice. The degree of prevalence of such stigma varies but it exists in almost all national settings across Asia (UNAIDS, 2011).

In India, HIV is often perceived as a *disease of the marginalized* and is associated with low income, low education, and prostitution. PLHIV receive hostility and isolation from the society. HIV is often viewed as a *punishment for bad behavior* by people who indulge in (sexual) acts that are not acceptable to the Indian society (Ambati, et al., 1997 as cited in: FHI 360, 2014).

1.1.1. Forms of Stigma

Enacted Stigma: Enacted stigma refers to sanctions applied to people on the basis of their belonging or perceived belonging to a particular group.

Enacted HIV/AIDS-related stigma is, therefore, the discrimination and violation of human rights that PLHIV or people assumed to be infected with HIV may experience (Morris, 2003). This may be indicated through subtle discrimination such as maintaining distance, denial/delay of care, gossip, and attempts to humiliate PLHIV.

Anticipated Stigma: Anticipated stigma, also known as ”the stigma of self”, is when one is thought to be perceived as belonging to a certain group or in being associated with a group that is stigmatized by others (such as an HIV positive patient). It is an ***internalized stigma*** experienced as shame or fear of being discriminated against by others. This may include for example, negative responses from society, denial of participation in community activities and may be internalized by PLHIV in the form of shame and disgrace because of their HIV status.

1.2. Institutional Policies for Protection of PLHIV

The Indian government is making efforts to defend human rights as they relate to HIV status and to protect PLHIV from stigma and discrimination. A comprehensive HIV testing policy indicates that no individual should mandatorily be tested for HIV, either as a pre-condition for employment or for providing health care facilities during employment. Voluntary testing is to be followed by disclosure of results with counseling in an HIV testing center that has designated counseling facilities (FHI 360, May 2014). Clauses related to confidentiality of test results and patient consent to disclose results are also a part of Government of India (GOI) policies.

1.3. Stigmatizing and Discriminatory Practices as a Barrier to Public Action

The literature suggests that it is the fear of social disgrace that leads to people not testing for HIV or seeking treatment for the same (UNAIDS, 2011).

Stigmatizing and discriminatory practices are not innate and change form over time. The identification of its origin requires preemptive efforts so as to understand its manifestations by location and practice. The lack of such efforts hinders the development of interventions or social policies that can adequately address the issue of stigma and discrimination.

1.4. Rationale for the Study

NACO has undertaken steps to ensure quality health care and support in medical institutions for PLHIV. This includes training health care workers to improve case management and HIV counseling and testing practices (Mahendra, et al., 2006).

These measures, alone, are likely not enough to ensure high-quality care and management for PLHIV in clinical settings. Underlying stigma by providers may manifest itself into various forms of discriminatory practices.

Based on this, NACO requested IHBP to develop a communication campaign that would address stigma and discrimination among HCPs. IHBP developed a three-month campaign that primarily targeted doctors, with the intention of using them as a communication channel for further motivation and information with lower levels of providers within health facilities given their elevated and esteemed status among HCPs. Internet was a primary communication channel selected for this campaign, though mass and print media were also developed and executed prior to the web-based campaign

The present study was undertaken as a baseline to better understand the knowledge levels related to HIV, attitudes towards PLHIV, and manifestations of stigma and discrimination to PLHIV in health care facilities among health care providers.

Chapter 2: Study Objectives, Sample, and Methodology

2.1. About the Study

To promote a more equitable attitude toward PLHIV among HCPs in selected states of India, and to engage doctors directly on the issue of stigma and discrimination within health facilities, IHBP is working on an Internet based campaign "Heroes in White."

Heroes in White is an NACO and IHBP initiative to address stigma and discrimination faced by PLHIV at health care settings by providing a platform for likeminded doctors to talk about the issue and ways to address it. Formative research by IHBP revealed that doctors are the most influential authority in a health care setting and are important drivers of any action taken by the hospital staff, especially at the lower level of nurses, paramedics, and other staff. These insights helped to zero on the doctors as the primary target group of the campaign. Delving into the media habits of doctors, it was found that due to the paucity of time as a result of their demanding work schedule, TV viewership among doctors was low (qualitative data). However, it has been reported that between 85% and 90% of health care practitioners are Internet users, and between 70% and 80% of them search for disease conditions and drug related information (Usage of media among physicians, www.brandcare.net).

The insights discussed above and more that we came across led NACO and IHBP to conceptualize a campaign with Internet as the main medium, supported by TV and radio. The campaign website www.heroesinwhite.com was launched on Doctors' Day, July 1, 2014, at an event hosted by the Indian Medical Association (IMA) in the presence of the Union Health Minister of India, Dr. Harsh Vardhan. The campaign urged doctors to join the cause by promoting equal care of all patients regardless of age, sex, and disease. Thus, doctors are asked to define equal care on the campaign website and join the cause. Through the website doctors have access to various content consisting of blogs, articles, and interviews with doctors and much more, on the main campaign issue of stigma and discrimination as well as generic clinical content. Doctors who have joined the website by defining equal care could also contribute content for the website, for example, write blogs/articles. The campaign was promoted by strategic media buying on websites frequented by doctors, like news and health websites. Campaign was also promoted on social media platforms like LinkedIn and Facebook (www.facebook.com/heroesinwhite).

The campaign was run from the period of July 10–September 30, 2014, and was able to garner 22,000+ unique visitors on the website and 37,000 members on the Facebook page. The audience on website consisted of doctors as well as the general public.

It is hypothesized that after the campaign has been implemented and HCP have a chance to be exposed to campaign:

- The HCPs who were exposed to this campaign will have lower levels of stigmatizing attitudes toward PLHIV than those who were not exposed.
- Doctors who were exposed to the campaign will sensitize the non-medical staff for non-stigmatizing attitudes and discriminatory practices toward PLHIV.

2.2. Study Objectives

The objectives of the baseline study were:

- To understand the current levels of knowledge and attitudes around HIV-related stigma and discrimination among HCPs
- To understand practices related to the care and management of PLHIV in the health settings

2.3. Research Design and Methodology

The study is the baseline assessment for a pre-post cross sectional research design to be implemented after the campaign has been completed. The following section describes the different aspects of the study's research design as a part of this study. It discusses in detail the target respondents, geographical coverage, and the research process used for the purpose of the present study.

2.3.1. Target Population

Primary Group (Medical Staff): MBBS doctors and medical students (who have completed at least three years of full time education)

Secondary Group (Non-Medical Staff): Nurses, lab technicians, attendants

Inclusion Criteria – All those who gave consent to participate in the study and fulfilled the following conditions:

For doctors

- MBBS and practicing
- Used the Internet at least four hours per week

For medical students

- Full-time medical student and have had completed at least three years in a medical college (may be MBBS and pursuing MD/MS or PhD)
- Used the Internet at least four hours per week

For non-medical staff

- A regular clinical and/or non-clinical staff of the health post/sub health post/primary health care center.

Figure 2.1: States Selected for the Baseline Study

2.3.2. Geographic Coverage

As per the Census of India, India has been divided into six zones (Northern, Southern, Eastern, Western, Central, and North-East). There is a total of nine states in the Northern region, two in the Central region, six in the Eastern region, seven in the North Eastern region, four in the Western region, and seven in the Southern region.

Heroes in White was a pan-India campaign, and therefore for the study, geographic representation from all the zones in India was maintained. One state was randomly selected from each zone of India to conduct the baseline study.

Within each state, all the districts having at least one medical college were listed. Three districts were selected from this list using simple random sampling without replacement (SRSWOR). In case the state had fewer than three districts that have a medical college, all districts with a medical college were selected and the remaining districts were selected from the other districts in the state using SRSWOR. The following table details the states and districts selected for the study:

Table 2.1: Sampled States and Districts

State	Number of Districts Selected	Districts Selected		
		District 1	District 2	District 3
Rajasthan	3	Ajmer	Jaipur	Udaipur
West Bengal	3	Burdwan	Darjeeling	Kolkata
Manipur	3	Imphal East	Imphal West	Thoubal
Karnataka	3	Bengaluru	Mangalore	Mysore
Madhya Pradesh	3	Bhopal	Indore	Jabalpur
Goa	2*	North Goa	South Goa	-

*There are only 2 Districts in Goa as per census 2011

2.3.3. Sample Size Justification

The required sample size for this study was calculated using the formula below

$$n = \frac{deff \times \left[Z_{1-\alpha}\sqrt{2P(1-P)} + Z_{1-\beta}\sqrt{P_1(1-P_1)+P_2(1-P_2)}\right]^2}{(P_2-P_1)^2}$$

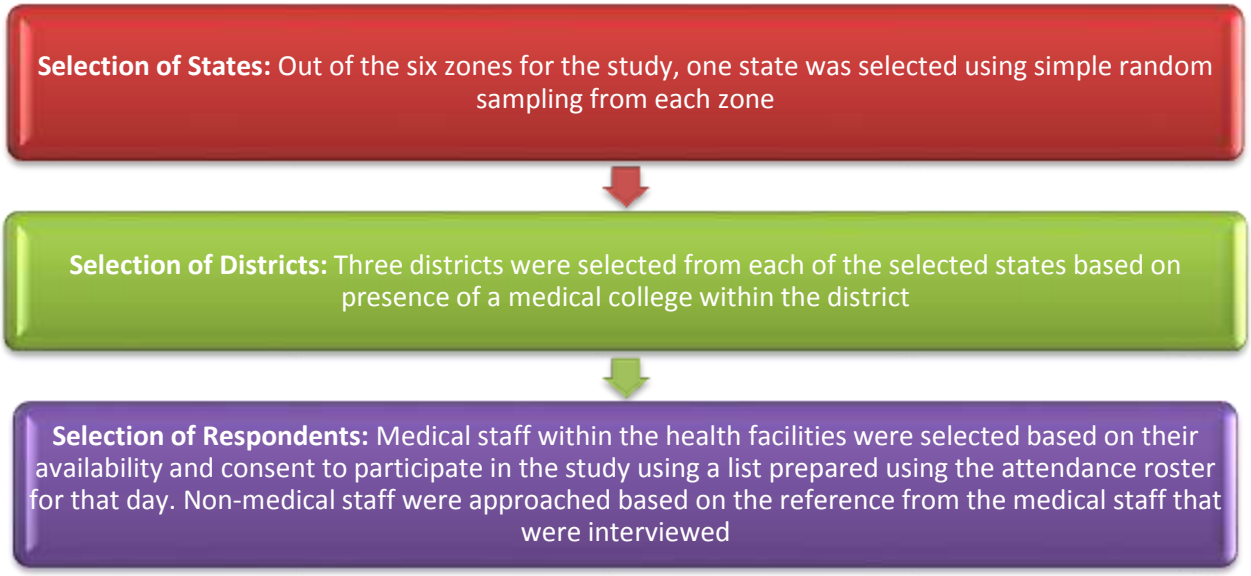
In this study,

P_1 is the hypothesized value of the indicator at the baseline (50% level of stigmatizing attitude toward PLHIV)
P_2 is the expected value of the indicator at the endline (40%)
P= $(P_1+P_2)/2$
Z_α is the standard normal deviate value for an α type I error (1.64)
$Z_{1-\beta}$ is the standard normal deviate value for a c type II error
Deff is the design effect in case of multi-stage cluster sample design (Deff=3.0)

In this instance, P1 is the value of different levels of P1 and P2-P1, setting the design effect to 3; α to 0.05, and β to 0.20. Using conservative estimates to assume that the campaign will bring about a 10% change to the current levels of HIV-related stigmatizing attitudes among the health care providers (assumed at 50%), the sample size was calculated as 1,243 health care providers across the selected districts in India.

2.3.4. Sampling Methodology

A multi-stage approach was adopted to reach the desired target respondents. A description of the approach for the study is mentioned below:



Step 1 – Selection of states: The sampling frame for this stage was the list of all the states within one zone of India. With an aim to select one state from each of the six zones, six such

lists were prepared. One state from each list was selected using simple random sampling. Thus, a total of six states were selected as follows:

1. **North Zone:** Rajasthan
2. **Central Zone:** Madhya Pradesh
3. **East Zone:** West Bengal
4. **North East Zone:** Manipur
5. **West Zone:** Goa
6. **South Zone:** Karnataka

Step 2 – Selection of districts: The sampling frame for this stage was the list of all districts within the selected state. The sampling frame was further divided into two strata, stratum A and stratum B. Stratum A had all the districts with the presence of at least one medical college in them (in order to cover medical students). Three districts were selected using SRSWOR from stratum A. In cases where there were only three districts in stratum A, all the three were selected. In case the number of districts in stratum A was fewer than three, all the districts in the stratum were selected and the remaining districts were selected using SRSWOR from stratum B in order to make the total selected districts as three per state..

Step 3 – Selection of Respondents: Because the target group for the study was medical and non-medical staff who were interviewed in their workplace (that is, a health facility), the health facilities within the selected districts were approached giving priority to the number of staff working in them, that is, hospitals with more staff were approached first. For the selection of medical staff, the list of all medical staff on duty that day was prepared using the roster. The staff was approached one by one and was interviewed based on their availability and consent to participate. If the staff person was busy and provided another time for interview on the same day, they were interviewed. No attempts were made to interview the medical staff if they were not available that day. The non-medical staff were recruited randomly after receiving a list from the medical staff that had the names of the non-medical staff members within their respective facility.

The investigators visited both, government and private facilities, maintaining an almost equal quota in order to select equal number of respondents from both type of facilities. Due to the lack of the universe, and hence, the sampling frame, all health facilities within the district were not covered. The process of visiting to the next health facility was stopped once the desired sample was achieved.

2.3.5. Sample Size Distribution

The following table gives details about the sample size planned versus what was achieved in the baseline study:

Table 2. 2: Sample Size Planned versus Achieved

State	Number of Districts	Sample Size Per State (Planned)				Sample per State (Achieved)			
		Doctors	Medical Students	Para Medics	TOTAL	Doctors	Medical Students	Para Medics	TOTAL
Rajasthan	3	105	45	60	**210**	104	46	61	**211**
West Bengal	3	105	45	60	**210**	106	44	60	**210**
Manipur	3	105	45	60	**210**	104	45	60	**209**
Karnataka	3	105	45	60	**210**	111	39	60	**210**
Madhya Pradesh	3	105	45	60	**210**	104	45	60	**209**
Goa	2	105	45	60	**210**	106	47	57	**210**
TOTAL	**17**	**630**	**270**	**360**	**1,260**	**635**	**266**	**358**	**1,259**

2.4. Data Collection and Data Processing

The data collection for the current study was done in the month of July 2014. All study operations like pre-testing of the questionnaire, field training (including research ethics), data collection, data entry, data analysis, and report writing were managed by the research agency. To collect the data in the field, all the enumerators and supervisors were trained extensively for two days in the presence of research teams from SRI-IMRB and also technical specialists from the IHBP team.

All of the participants in the study were given information about the study objectives and study design. Informed consent was also obtained from each participant if they agreed to participate in the study.

2.4.1. Survey Instrument

Considering the key objective as described above, a structured questionnaire with special provision to record open-ended responses wherever required was used. The questionnaire was translated into regional languages (Bengali, Hindi, Kannada, and Manipuri) and a bilingual version with English followed by the regional language was used for data collection.

2.4.2. Pre-Testing the Questionnaire

Prior to undertaking the main fieldwork, the translated versions of the questionnaire were pre-tested in real field settings. The pre-test was used to gather information on the following points:

- Flow of the questions
- Ease in understanding the questions by the respondents
- Ease in administering the questionnaire
- Comprehensiveness in terms of information coverage
- Testing of the language used

The pre-test was conducted at a different location from where the main survey's data collection took place. Post the pre-test, the findings from the various locations were collated and shared with IHBP and revisions were made to the questionnaire.

2.4.3. Training of Investigators

A two-day web-based training for all state-level trainers was conducted, following which trainings were conducted in each of the study's respective states with the field teams by the trainer in the presence of researchers from SRI and technical experts from IHBP. For every four investigators, there was one supervisor whose primary role was to supervise the performance of the investigators, and to ensure adherence to the research protocol like sampling, and ethics.

The following topics were covered during the training:

Overview about stigma and discrimination with regard to PLHIV: The teams were briefed about stigma faced by PLHIV and its effects on their lives. This was followed by a discussion on the various forms in which stigma manifests itself within health facilities.

Briefing on the objectives of the study: Post introduction, there was a session on the reasons for the study and understanding the key objectives.

Briefing on the sampling methodology: This was followed by a discussion on target group, sampled districts, and sample size.

Briefing on how to approach the respondent: The field teams were briefed on how to reach the ultimate respondents (all HCPs) to conduct successful interviews.

Team structure and roles: Both supervisors and investigators were informed of their respective roles. Supervisors were instructed to conduct accompaniments and scrutinize the questionnaires. The investigators were instructed about their role as an interviewer: managing their body language, mannerisms, tone, etc., to reflect neutral attitudes.

Informed Consent: A consent form stating the purpose of the study, eligibility criteria, process of respondent selection, confidentiality of responses, possible risks, and benefits were explained to the trainers. They were briefed on the importance of the form and process of administration.

Briefing on the questionnaires: A complete briefing was done for each section of the three questionnaires with discussion and questions answered.

2.4.4. Interview Procedure and Ethical considerations

All interviews were one-on-one and conducted at the respondent's place of work (health facility). Informed consent was obtained from the participant before the interviewer started the interview. Privacy and confidentiality of the discussion was maintained and all possible measures were taken to ensure that no other staff members were present during the interview so as to avoid anybody's influence (bias) on the respondent's answers. All interviews were conducted in vernacular language/English (as chosen by the respondent) and the information was coded simultaneously on the questionnaire itself.

2.4.5. Data Management

Various checks were in place to ensure the uniformity and accuracy of data management.

Data Scrutiny and Coding: Before data entry, each and every questionnaire was scrutinized. All coders and supervisors who were involved in scrutiny and coding received training from the system analyst. Open-ended questions were coded as verbatim and captured in English. All questionnaires were checked to ensure there was no identifying information for respondents recorded on the questionnaire.

Data Entry: All questionnaires were sent to the SRI Delhi research office where a random scrutiny was conducted by the researcher. The scrutinized questionnaires were dispatched to a centralized data entry operator in Delhi. The data structure was developed by the agency. The data entry operation was carried out using CSPRO software. Double data entry was done to ensure correctness. Program-based logical checks were used to clean the data and the inconsistencies were resolved on the basis of the responses recorded in the questionnaires.

Data Security and Confidentiality: All tools were separated into two sections; section A and B. Section A had details such as name of state and districts, name and type of health facility, designation, gender, education, and age of respondent. Section B had the main questionnaire. The two sections were linked by a unique code and were separately scrutinized and entered. They were merged at a later stage using the unique code, after the database was ready. All consent forms were checked for signatures and date, which were removed prior to data entry.

2.4.6. *Data Analysis*

Analysis techniques such as linear regression analysis and multivariate factor analysis were used in the study.

Regression Analysis: Regression analysis is a statistical technique for estimating the quantitative relationship between the response variable and one (or more) explanatory variable (Cooper & Schindler, 2008). For the present study, regression analysis was used to model the value of a dependent (or response) variable (HCPs attitudes towards PLHIV) based

on its relationship to one or more predictors (type of health facility, gender, exposure to training, exposure to HIV related communication, knowledge about HIV etc.).

Factor Analysis: According to Cooper and Schindler (Cooper & Schindler, 2008) factor analysis is a technique used for computations. These factors, also called latent variables, aim to measure otherwise non-quantifiable items. To explain the relationships among variables, they are combined into smaller factors (Zikmund, 2003). The scales usually start with many questions or statements, and then by using factor analysis are reduced to a smaller number. These reduced results are then used for other analysis such as linear regression analysis (Pallant, 2007). Factor analysis is a good way of identifying latent or underlying factors from an array of seemingly important variables. In this study, various statements that depict HCPs attitudes towards statements that depict stigma and discrimination towards PLHIV, were reduced using factor analysis to four labels that depicted a common theme in which all the statements under that label seemed to belong.

Chapter 3: Sample Characteristics

This chapter covers the profile of the respondents surveyed for the stigma and discrimination study. It provides details with reference to both medical and non-medical staff accommodating for the differentiation of government and private health facilities. This chapter also details the media habits of the respondents.

3.1. Sample Coverage

Nearly three-fourths of the sample covered was composed of medical staff—doctors and medical students. Figure 3.1 provides the distribution of sample by type of respondent.

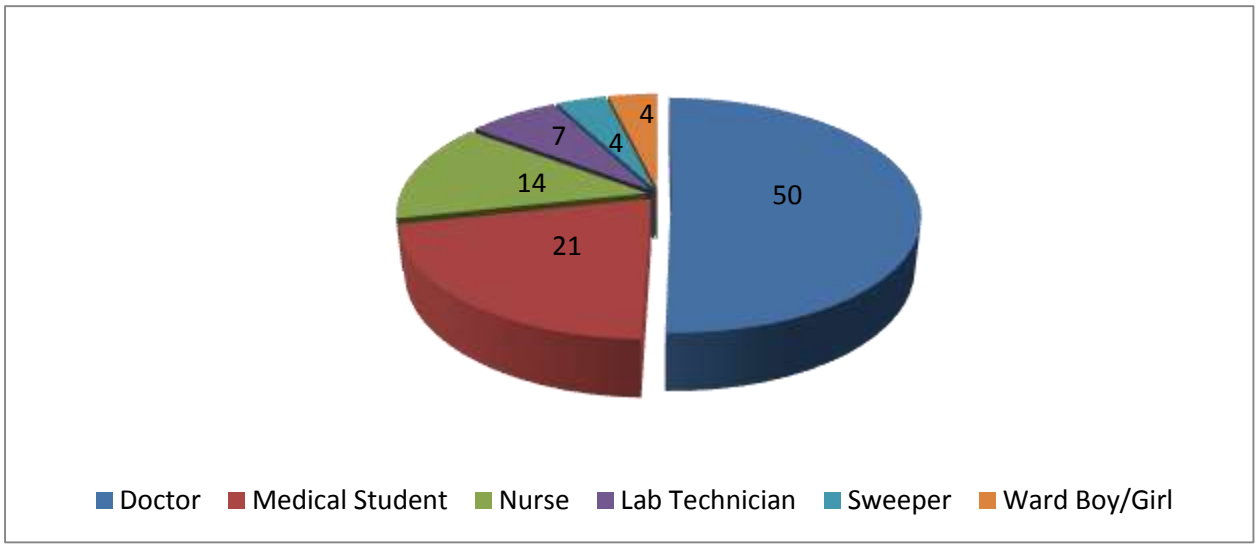


Figure 3.1: Sample Coverage (%)

3.2. Type of Health Facilities Covered

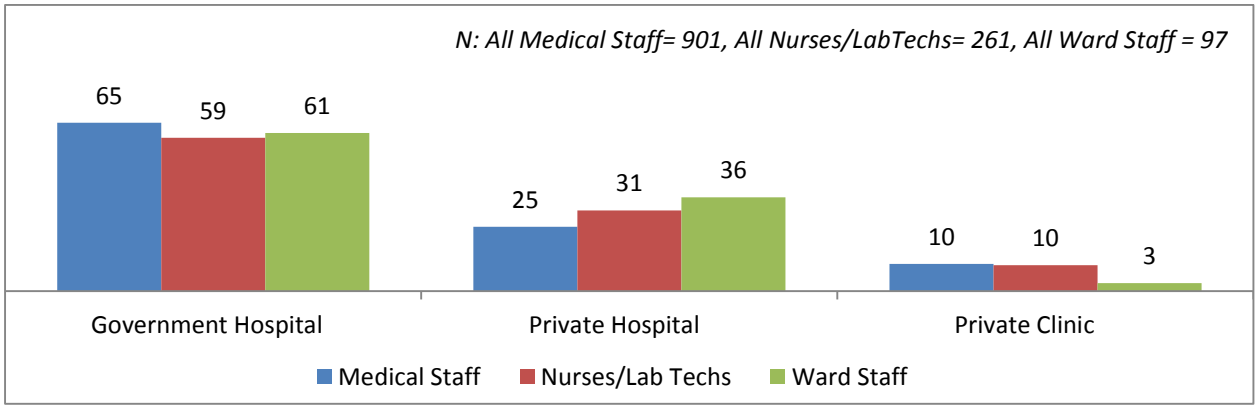


Figure 3.2: Type of Health Facilities Covered (%)

Majority of the interviews for the study were conducted in government health facilities. About 65% of the medical staff was working/studying in a government facility, about 25% in a private hospital, and 10% in a private clinic (N=901). More than three-fourths of medical students covered were affiliated with a government hospital (N=266). Among nurses, nearly 61% were working in a government hospital, 29% in a private hospital, and 10% in a private

clinic (N=173). Within the lab technicians that were interviewed, 56% were working in a government hospital, 34% in a private hospital, and 10% in a private clinic/lab (N=88). About 61% of interviews for ward staff were conducted in a government hospital, 36% in a private hospital and only 3% in a private clinic (N=97).

Location wise, more than 90% of medical staff from Manipur were affiliated with a government hospital (N=149). In Karnataka, however, the majority of medical staff (58%) belonged to a private clinic (N=150).

Within facilities, about 60% of interviews were conducted in various units from the outpatient department.

3.3. Demographic Profile of the Survey Respondents

The basic demographic profile in the present study corresponds to age group, gender, and marital status. A snapshot of the key demographic characteristics of the respondents interviewed in the study is shown in Table 3.1 below.

Table 3.1: Demographic Profile of the Respondents (%)

	Doctors	Medical Students	Nurses	Lab Technicians	Ward Staff
N	***635***	***266***	***173***	***88***	***97***
Age					
18-27 years	20	88	34	31	14
28-37 years	35	11	32	43	50
38-47 years	26	2	20	16	26
48-57 years	13	0	11	9	7
58-95 years	6	0	3	1	3
Gender					
Female	43	39	90	40	45
Male	57	61	10	60	55
Marital Status					
Married/cohabiting	75	5	71	60	77
Never married/single	25	95	27	40	21

The mean age for medical students was 24 years and for doctors was 38 years. The mean age for the paramedic staff was 33 years. Most of the nurses (90%) were female. About three-fourths of all respondents were either married or cohabiting.

3.4. Respondents' Work Duration in Current Facility

All respondents were health care providers and were interviewed within the health facility where they worked. The following graph (Figure 3.3) details the work duration of HCPs within their current facility.

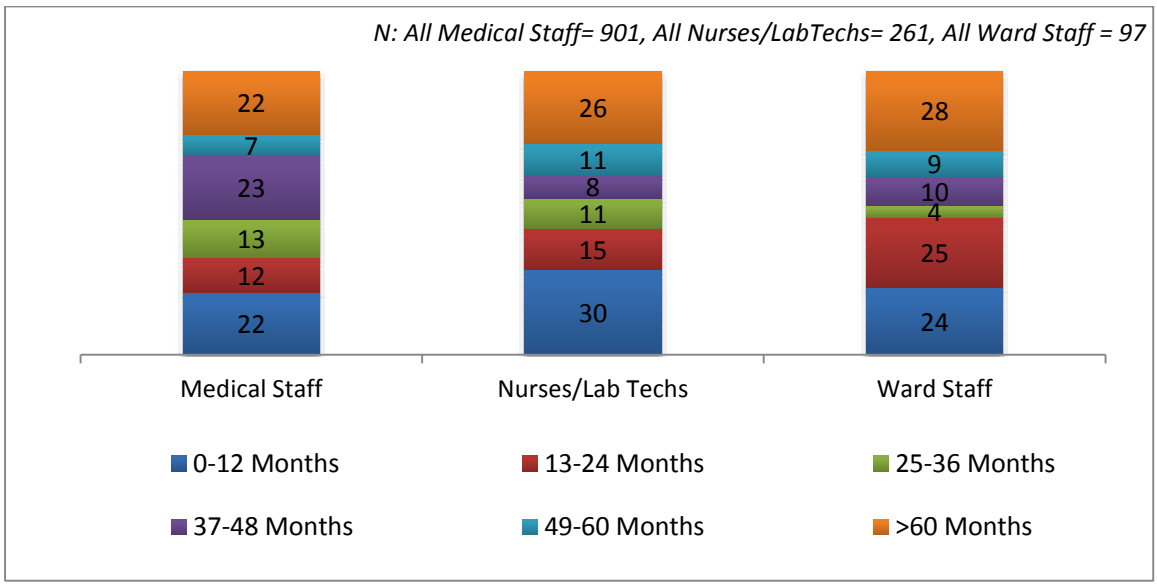


Figure 3.3: Respondents' Work Duration (%)

Among the medical staff, 22% had been working for less than 12 months in their current facility. The mean work duration for them in their current facility was 59 months, and the median was 37 months (N=901). Further analysis showed that the average work duration for medical staff in government hospitals (N=584) was 49 months, as compared with 69 months and 97 months, respectively, in private hospitals (N=223) and private clinics (N=94).

For the non-medical staff, on an average, the nurses interviewed had been working at their current facility for 57 months (N=261). Average work duration of ward staff was 58 months (N=97).

3.5. Educational Profile of the Respondents

The following sections highlight the educational profile of all the respondents covered in the study.

Nearly 37% of all medical staff covered in the study had completed their Bachelor of Medicine, Bachelor of Surgery (MBBS), 32% had completed Doctor of Medicine (MD), and 24% had Master of Surgery (MS) as their highest medical degree (N=901).

As many as 44% medical staff from private clinics had completed their MS (N=94). About 45% female medical staff were MBBS (N=374).

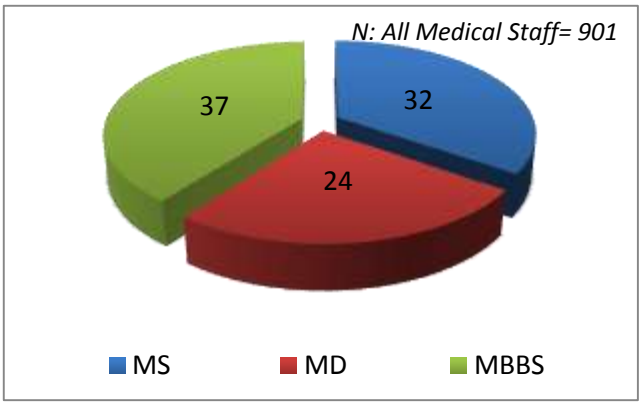


Figure 3.4: Highest Medical Degree – Medical Staff (%)

Figure 3.5 gives the educational qualifications of nurses and lab technicians. Among nurses, 44% were graduates, followed by 38% who had been educated up to senior secondary (N=173).

More than two-thirds of lab technicians were graduates (N=88).

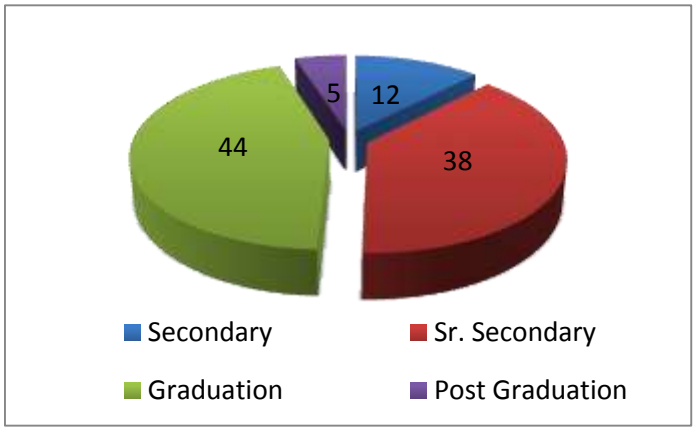


Figure 3.5: Highest Educational Degree – Nurses (%)

Among the ward staff (figure 3.6), a quarter (26%) had been educated up to middle level, followed by 24% who had completed Class 10 (N=97).

Ward staff from private facilities were slightly more educated than their counterparts from government hospitals, with as many as 20% educated up to Class 12 and another 20% who had achieved graduate and above (N=38).

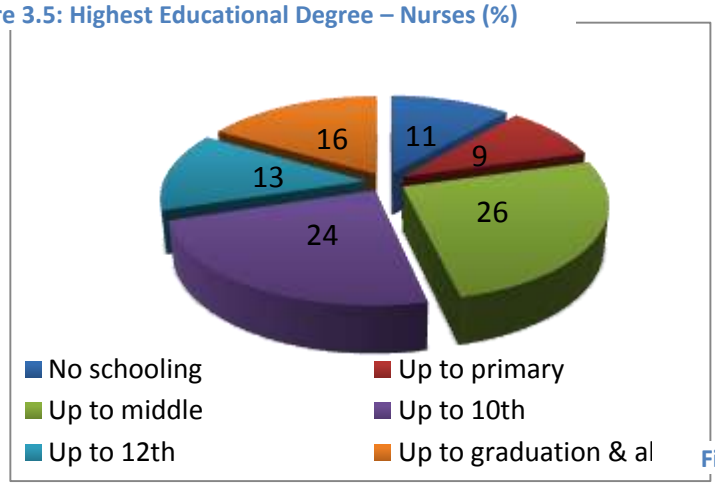


Figure 3.6: Highest Educational Degree – Ward Staff (%)

3.6. Respondents' Exposure to Media

The following table gives a snapshot of media activities of the respondents.

Table 3.2: Exposure to Media (%)

		Almost every day	At least once a week	Less than once a week	Not at all
Medical Staff (N=901)	Radio	31	22	21	27
	TV	85	11	3	1
	Newspaper	90	9	1	1
	Magazine	23	43	29	5
Nurses/ Lab Techs (N=261)	Radio	32	25	18	25
	TV	93	6	1	0
	Newspaper	82	11	4	2
	Magazine	10	33	38	19
Ward Staff (N=97)	Radio	39	13	15	32
	TV	95	3	1	1
	Newspaper	61	22	3	14
	Magazine	7	14	21	58

Among the medical staff (N=901), 90% read newspapers every day, and 85% watched TV every day. Radio listenership was restricted to less than three-fourths medical staff, with only 31% listening to a radio almost every day. Less than a quarter of the medical staff were daily readers of magazines, and 43% read them at least once a week.

All nurses/lab techs (N=261) were TV viewers and 93% watched it almost every day. Newspaper readership was also fairly common in this category, with 83% reading newspapers every day. Radio listenership and magazine readership was limited to less than a quarter of these respondents.

For the ward staff (N=97), TV was the most frequent media source with 95% watching TV every day. Newspaper readership was less common with about two-thirds reading them every day. Magazines were read by less than half of the ward staff and the readership was infrequent with only 7% reading magazines every day.

Use of other Media Sources – Internet and Mobile Phones

Exposure to Internet was nearly universal among the medical staff with about 90% accessing Internet almost every day (N=901). Nearly 64% of nurses (N=261) and 34% of ward staff (N=97) also had access to Internet.

Ownership of a mobile phone by medical staff was universal and more than 7 out of 10 used the internet over their phone, indicating the ownership of a smartphone (N=901).

Chapter 4: Knowledge and Awareness about HIV and Exposure to Related Training

This chapter covers the knowledge of different types of respondents about the transmission of HIV, their exposure to HIV-related training and communication, and their awareness about the legal rights of PLHIV.

4.1. Knowledge of Route of HIV Transmission

HCPs were asked about the route of transmission of HIV in general and within a health facility. Table 4.1 presents the percentage of HCPs who reported incorrect or no knowledge about a particular route of transmission of HIV. Incorrect knowledge is defined as either not identifying an actual transmission route or identifying an incorrect transmission route. No knowledge is given as the percentage of respondents saying "don't know" for a particular route.

Table 4.1: Incorrect or No Knowledge about HIV Transmission Routes (%)

	Medical Staff	Nurses/Lab Techs	Ward Staff
N	***901***	***261***	***97***
In general			
Having sex with PLHIV*	1	4	2
Being breathed on by PLHIV	1	7	13
By touching PLHIV	3	8	13
Transfusion with untested blood*	3	8	8
Sharing utensils with a PLHIV	4	6	13
Sharing needles*	5	6	7
Sharing clothes of a PLHIV	5	13	16
From infected mother-to-child*	6	7	11
Through mosquito bite	8	21	25
Through sputum of PLHIV	23	23	30
Inside a Hospital or Clinic			
By coming close to PLHIV	2	3	12
Serving food to PLHIV	2	3	15
Needle stick*	4	3	11
Blood splash on cut skin*	5	8	14
By handling dry linen without gloves	14	25	36
Handling blood with gloves	17	13	23
Contact with vomit	18	13	42
By handling blood without gloves*	20	24	26
Blood splash on intact skin	26	30	46
Blood splash to eyes or mouth	53	38	58

* Correct transmission routes

Sexual intercourse was almost universally reported by all HCPs as a route for transmission of HIV. When asked about the bodily fluids with high enough concentrations of HIV to transmit the virus, close to three-fourths of medical staff mentioned blood and genital fluids (N=901).

Significant knowledge gaps still were evident, however, regarding transmission of HIV through "other bodily fluids," especially sputum, which generated the least correct response across all categories of respondents.

Correct responses from ward staff increased with increase in education level. It is, however, noteworthy that almost a quarter of ward staff members believed that HIV could be transmitted even by handling blood with protection (gloves) (N=97). Many ward staff members believed HIV could be contracted through a blood splash on intact skin (46%), and by coming in contact with vomit (42%). These knowledge gap areas as associated with contact lay within ward staff's daily tasks and need to be addressed to achieve adequate care and management of PLHIV within health care facilities.

4.2. Exposure to Training

All health care providers were asked if they had ever been trained on different health service -related themes in their current health facility, and in the last year.

Most of the health care providers who had ever received any HIV-related training were trained on the basics such as universal precautions and HIV/AIDS. There were, however, significantly lower numbers of nurses and ward staff than medical staff who had ever been exposed to any training.

Table 4.3 provides the percentage of medical staff that had ever been exposed to training on different aspects within their current facility and in the last twelve months.

Table 4.2: Exposure to Training (Doctors and Medical Students) (%)

Training Exposure	*Ever in hospital/clinic*	*In last 12 months*
N	***901***	***901***
Universal Precautions	71	36
Basics of HIV/AIDS Transmission and Prevention	70	36
Basics of Hepatitis Transmission and Prevention	65	35
Clinical Management of HIV/AIDS	56	27
Procedures for HIV Testing and Confidentiality	54	25
Waste Management	53	29
Legal and Ethical Issues on HIV/AIDS	46	22
Counselling Techniques	46	25

About 16% of doctors (N=635) and 13% of medical students (N=266) interviewed never had received any training on any of the themes mentioned above.

Training on universal precautions within hospitals was received by 86% medical staff from private hospitals (N=223) as compared to 67% from government hospitals (N=584, p<0.001) and only 57% from private clinics (N=94, p<0.001). Exposure to training on counseling techniques was also better among medical staff from private hospitals (55%) as compared government hospitals (46%, p=0.022) and those from private clinics (22%, p<0.001). Exposure to training on all the themes mentioned above was the lowest among medical staff from private clinics.

Recentness of exposure to training declined with age for all type of trainings. Nearly 46% of medical staff members aged 18–27 years were trained on basics of HIV transmission and prevention in the last year, compared to 37% aged 28–37 years and 24% aged 38 and above, highlighting that more young(er) doctors were exposed to training recently.

Table 4.4 provides the percentage of non-medical staff that had ever been exposed to training on different aspects within their current facility and in the last twelve months.

Table 4. 3: Exposure to Training (Non-Medical Staff) (%)

Training Exposure	*Ever in hospital/clinic*		*In last 12 months*	
	Nurses/Lab Techs	*Ward Staff*	*Nurses/Lab Techs*	*Ward Staff*
N	***261***	***97***	***261***	***97***
Basics of HIV/AIDS Transmission and Prevention	58	44	28	25
Universal Precautions	57	45	30	23
Procedures for HIV Testing and Confidentiality	54	35	28	20
Waste Management	51	53	27	36
Clinical Management of HIV/AIDS	47	NA	21	NA
Counselling Techniques	40	NA	23	NA
Legal and Ethical Issues on HIV/AIDS	38	29	22	18

Among the themes mentioned above, health care providers reported the lowest training exposure on legal and ethical issues on HIV/AIDS and counselling techniques.

4.1.1. Effect of In-service HIV Training on Knowledge

The following table (Table 4.2) compares the percentage of incorrect or no knowledge among medical and non-medical staff who have ever received any in-service HIV training with those who have not.

Table 4.4: Incorrect or No Knowledge about HIV Transmission Routes (%) - In service HIV Training

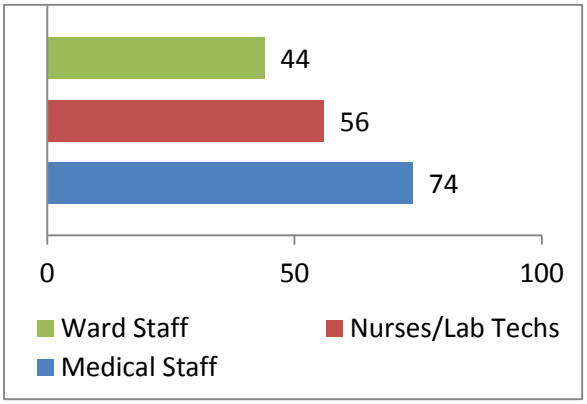
	Received HIV Training			Did not Receive HIV Training		
	Medical Staff	*Nurses/Lab Techs*	*Ward Staff*	*Medical Staff*	*Nurses/Lab Techs*	*Ward Staff*
N	***459***	***154***	***32***	***442***	***107***	***65***
In general						
Having sex with PLHIV	1	4	3	1	5	2
Being breathed on by PLHIV	1	5	13	2	11	14
By touching PLHIV	2	8	19	3	9	8
Transfusion with untested blood	2	6	3	5	11	11
Sharing utensils with a PLHIV	3	4	13	4	8	14
Sharing needles	5	7	6	5	5	8
Sharing clothes of a PLHIV	5	9	9	6	18	20
From infected mother-to-child	7	3	19	6	11	8
Through mosquito bite	7	16	25	8	28*	25
Through sputum of PLHIV	23	21	19	24	25	35*
Inside a Hospital or Clinic						
By coming close to PLHIV	3	5	9	2	4	14
Serving food to PLHIV	3	7	13	2	6	17
Needle stick	5	3	13	4	4	11
Blood splash on cut skin	6	11	13	4	4	15
By handling dry linen without gloves	13	29	34	16	25	37
Handling blood with gloves	17	19	22	17	11	23
Contact with vomit	17	21	28	20	22	49*
By handling blood without gloves	20	24	22	21	23	28
Blood splash on intact skin	31	32	38	22	29	51*
Blood splash to eyes or mouth	53	50	44	53	37*	65*

**:P≤0.05*

The findings revealed that exposure to in-service HIV training was not associated with significant differences in medical staff knowledge of correct HIV transmission routes. Among non-medical staff, however, some significant differences were observed. Nurses and lab technicians who had been trained in an HIV-related topic demonstrated better knowledge of HIV transmission routes. Peculiarly, a reverse trend was observed for knowledge of HIV transmission routes within a hospital setting. Those non-medical HCPs who had not received an in service HIV-related training demonstrated better knowledge than those who had regarding all transmission routes involving blood. Among the ward staff, HIV-related training was associated with increased knowledge that HIV is not transmitted through sputum, contact with clothes, and blood splashes on intact skin, mouth, or eyes.

4.3. Exposure to HIV-related Communication

Exposure to HIV-related communication in the last year was the highest among medical staff (74%), followed by nurses (56%), and the lowest among ward-staff (44%). Exposure was significantly higher among medical staff from private hospitals (84%; N=223; p<0.001). Within states, exposure was highest among medical staff from West Bengal (92%; N=150; p<0.001).



cal Staff= 901, Ward Staff = 97

Figure 4.1: Exposure to HIV Related Communication in the last year (%)

A higher number of lab assistants (69%; N=88) were exposed to communication compared to nurses (49%; N=173) (p=0.001). Contrary to medical staff, exposure to communication among ward staff was higher among those from government facilities (51%; N=59) compared to private facilities (34%; N=38).

The table below gives the medium of exposure to HIV-related communication in the last year:

Table 4.2: Medium for HIV Related Communication (%)

	Medical Staff	Nurses/Lab Techs	Ward Staff
N(All Exposed)	***667***	***145***	***43***
Television	83	83	95
Newspaper/Magazine	51	54	44
Internet	50	18	16
Poster/Billboard	33	30	44
Radio	29	40	56

Most of the respondents who were exposed to HIV-related communication were exposed through television. Nearly half of all respondents who saw/heard an HIV-related communication saw it in a newspaper or magazine. Posters and billboards were a source of communication for a third of medical staff and nurses, and about 44% ward staff. Exposure through a radio was low among the medical staff (29%; N=667)), but was reported by about 40% nurses/lab techs (N=145), and 56% of the ward staff (N=43), exposed to HIV related communication in the last year, as the medium of communication.

Internet was reported by half (N=667) of all medical staff to be one of the channels of HIV-related communication that they were exposed to in the last year. Higher numbers of medical staff from private hospitals (58%; N=186) were exposed through Internet, as compared with those from government hospitals (48%; N=401) (p=0.023). Center wise, in Rajasthan 83% of medical staff were exposed to communication through the Internet as compared with 47%

exposed through television (N=87). Exposure through the Internet was lowest in Manipur (36%; N=100), followed by West Bengal (38%; N=138).

Among the ward staff working in government hospitals who were exposed to communication, 93% heard it on a television and 63% on a radio.

4.4.1. Themes of Communication Related to HIV

Out of every 10 respondents who had heard any message related to HIV in the last year, nine recalled the topic was about transmission and prevention of HIV/AIDS.

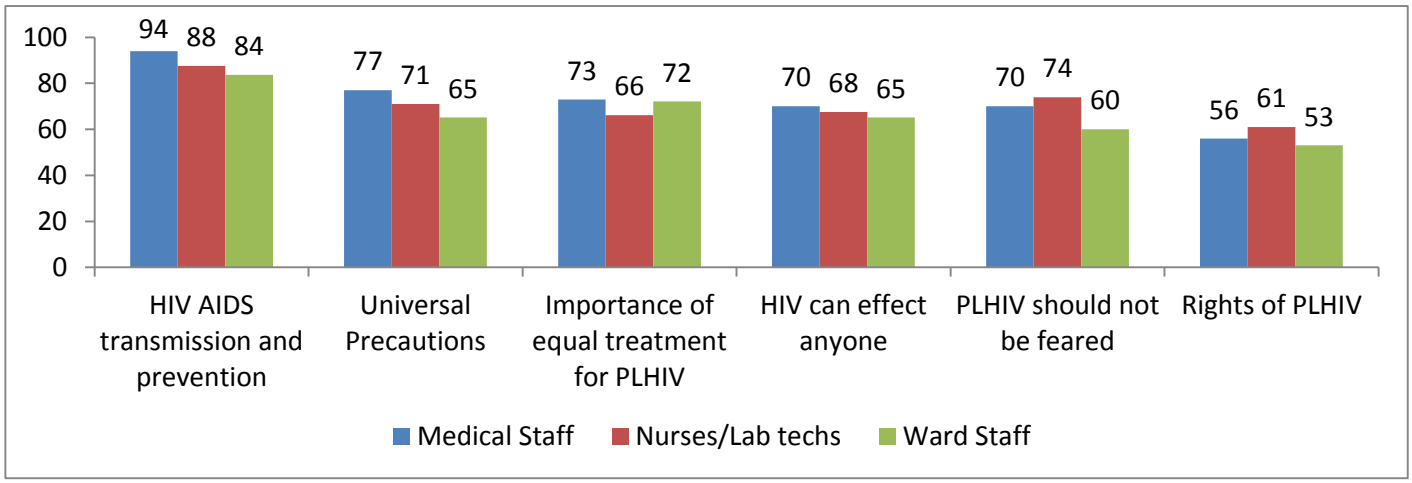


Figure 4. 3: Main Theme of Message Heard

4.4.2. Misconceptions[1] regarding transmission of HIV

Misconceptions regarding transmission of HIV were prevalent across all categories of respondents and were reported to be highest among the ward staff. However, it is necessary to analyze these misconceptions in the light of various disaggregation levels and explanatory factors in order to design an adequate intervention for the medical staff.

Further analysis showed that one out of every six medical staff member (16%) had at least one misconception regarding the spread of HIV (N=901). This was higher among women than men, with as many as 20% female medical staff having at least one misconception (N=374) (p=0.006). At least one misconception was reported by 18% of medical staff from government facilities (N=584) while about 13% medical staff from private facilities (N=317) reported these misconceptions (p=0.04).

A location-wise disaggregation showed that among the medical staff from Goa (N=153), misconceptions were significantly higher with 26% having at least one misconception (p=0.008). Misconceptions were lowest in medical staff from Manipur (6%; N=149; p<0.001). A cross tabulation analysis revealed that 20% of the medical staff who had not been exposed to any communication message related to HIV/AIDS in the last year had at least one

[1] Misconception: HIV is transmitted by coming close to PLHIV, by touching them, by being breathed on by them, by sharing clothes/utensils, or serving them food, or through a mosquito bite.

transmission misconception as compared with 15% of those who were exposed (p=0.041). Exposure to HIV communication and having no misconceptions were found to be significantly positively correlated. This correlation, however, does not imply causation.

4.4. Awareness about Treatments post Occupational Exposure to HIV

World Health Organization (WHO) defines post-exposure prophylaxis (PEP) as a short-term antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure, either occupationally or through sexual intercourse. Awareness of PEP was the highest among medical staff (80%) and the lowest among ward staff (43%). Among the medical staff who had access to PEP, 89% recalled it as ARV (N=702). The most common reason for seeking PEP was cited as needle stick injury from a patient known to be HIV positive by 88% of medical staff, followed by needle stick injury in general (48%), and any contact with blood (38%) (N=901).

Awareness of PEP was lower among ward staff with only 43% aware of it. Among those aware, 92% reported that they have access to PEP (N=42)

Chapter 5: Policies and Precautions within Health Facilities

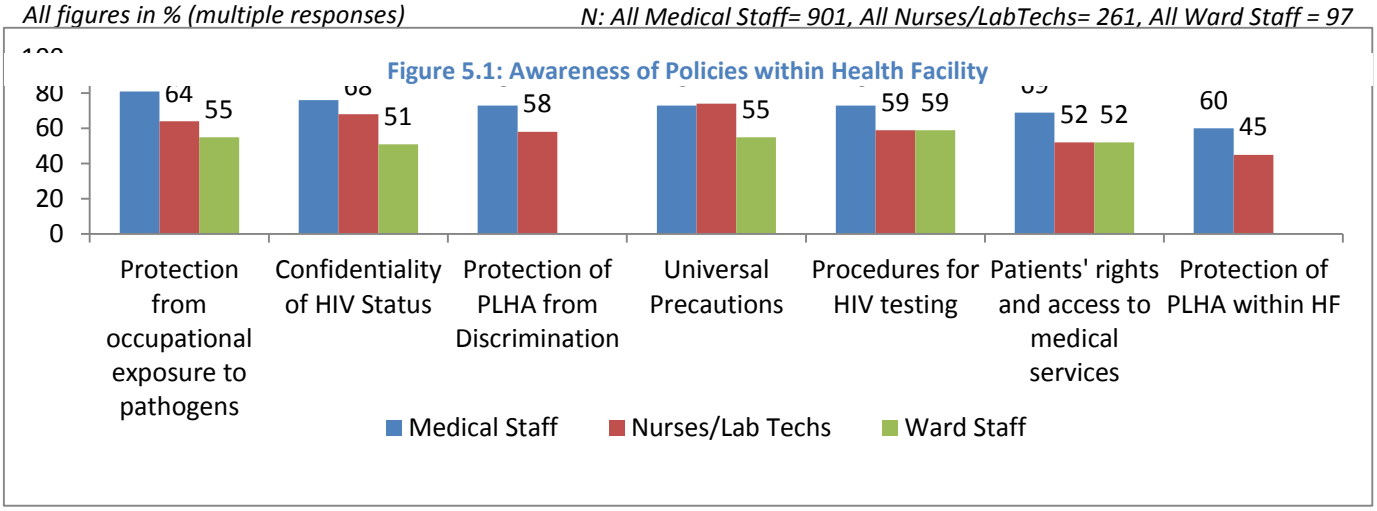
This chapter talks about awareness of policies relating to PLHIV and the knowledge and practices of taking precautions to prevent work-related transmission.

Researchers agree that one of the most common reasons for underlying stigma toward PLHIV is peril of contagion (Jones, et al., 1984), that is, risk of transmission from patient to HCP. It is therefore necessary to understand the practice of taking precautions to lower the risk of transmission while adhering to policies concerning equal rights of PLHIV within health facilities.

5.1. Awareness of Policies within Health Facilities

All respondents were asked if they were aware of various health care policies within their health facilities. Figure 5.1 gives the percentage of respondents aware of policies within their facilities.

All figures in % (multiple responses) *N: All Medical Staff= 901, All Nurses/LabTechs= 261, All Ward Staff = 97*



Awareness/recall of all policies mentioned above was the highest among medical staff and lowest among the ward staff. Policies related to the rights of PLHIV, such as confidentiality, protection in general, and related to discrimination were reported by a significantly higher number of professionals from government hospitals than from private hospitals. Three fourth of the medical staff from government hospitals (N=584) reported to have a policy on patients' rights and access to medical services, compared to 65% from private hospitals (N=223; p=0.014) and 49% from private clinics (N=94; p<0.001). Having policies on confidentiality was also reported by 80% of medical staff members from government hospitals, compared to 72% from private hospitals (p=0.020), and 61% from private clinics (p<0.001)

HIV-related testing policies were identified by medical staff as voluntary testing (94%), informed consent (88%), and results to be given to patient (83%).

5.2. Designated Counselling Centers within Health Facilities

Within government hospitals, 83% medical staff reported having a designated counseling center within the facility. This was significantly lower within private facilities with 60% of medical staff in private hospitals and only 16% in private clinics reporting so (p<0.001).

Among nurses, this knowledge was lower, with less than half of nurses citing the presence of such a center within their health facilities.

The presence of trained counselors in every department of the health facility was reported by less than 5% of all respondents.

5.3. Awareness of Universal Precautions

UP provide guidelines for HCPs on precautions to prevent occupational risks due to work-related exposure. About three-fourths of all respondents reported that their health facilities have a policy on universal precautions. Medical staff was asked to mention the components of the UP policy within their health facility (open-ended responses). Most professionals recalled universal precautions as "wearing gloves." The table below (Table 5.1) gives the components of the UP policy as identified by the medical staff.

Table 5.1: Components off UP Policy

Components of UP Policy	Medical Staff (%)
N (Medical Staff that agree to having a UP policy in their facility)	*Multiple (Open ended) Response – Top 8*
Wearing gloves	24
Being careful and safe around patients	13
Wearing other barrier precautions – masks, aprons, goggles	11
Information on safety from infection	10
Always following precautions	8
Wearing masks	6
Working with PLHA	4
Using disposable syringes	2
Don't know/can't say	22

5.3.1. Use of Barrier Precautions

The use of gloves as a precaution to prevent HIV transmission is almost universally reported across health facilities and different types of HCPs. The following table (Table 5.2) reports the use of gloves while conducting different tasks for general patients and HIV-positive patients.

Table 5. 2: Practice of Always Wearing Gloves among HCPs (%)

Always wearing gloves	With general patients	With HIV+ patients	Sig
N(Medical Staff)	*901*	*901*	
Dressing wounds	85	91	***
Drawing blood	74	90	***
Starting an IV	63	80	***
External examination	38	56	***
Base (Nurses/Lab Techs)	*261*	*261*	
Dressing wounds	61	72	***
Drawing blood	59	87	***
Sponging	51	62	**
Starting an IV	47	65	***
Giving injection	45	69	***
Giving medicine	36	40	ns

****:P≤0.001* ***:P≤0.01* **:P≤0.05* *ns: not significant*

HCPs reported taking higher precautions when dealing with HIV-positive patients and for tasks involving blood.

All respondents were asked if they always, sometimes or never wear gloves while performing usual tasks. The most common reason for not always wearing gloves was reported to be "gloves are not necessary" by about three-fourths of all the professionals (medical and non-medical staff) who do not always wear gloves.

Other barrier precautions ever taken by medical staff to protect themselves from HIV transmission were aprons (87%), masks (81%), boots (67%), and goggles (55%).

5.3.2. Precautions taken by Ward Staff

In general, more than 80% of ward staff reported that they always wear gloves while segregating waste; however, precautions taken were lowest for tasks such as delivering food (13%) and transporting patients (38%). When asked about the reason for not always wearing gloves, nearly two-thirds felt that gloves were not necessary for these tasks, and about one-fourth did not report any particular reason.

The table below shows the percentage of ward staff who report to always wear gloves while dealing with HIV patients and hepatitis patients

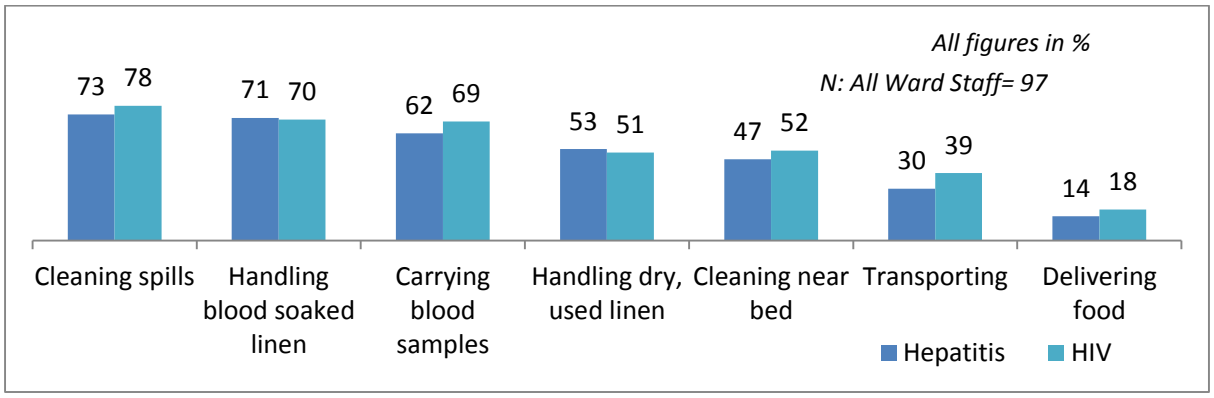


Figure 5.2: Ward Staff Reporting Always Wearing Gloves (%)

As compared with medical staff and nurses, no significant differences were observed while dealing with general patients and HIV-positive patients by the ward staff.

Chapter 6: Care and Management of PLHIV in Health Settings

This chapter covers the practices of care and management of PLHIV within health facilities with regard to various HIV-related policies.

6.1. Sources of Information about Presence of HIV+ Patients in the Ward

Respondents were asked about how they come to know if an HIV-positive patient was present in the ward. The table below gives the responses given by the medical and non-medical staff members about their source of information about the presence of an HIV-positive patient within the ward.

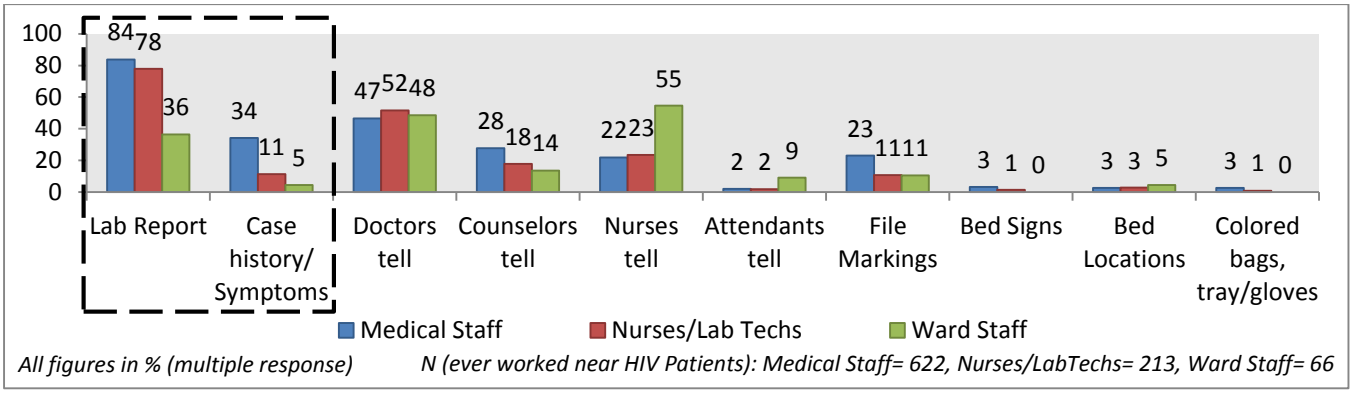


Figure 6.1: Indicators of HIV+ Patient in the Ward

More than 8 out of 10 medical staff, who had ever worked near an HIV-positive patient, reported that they usually came to know about an HIV-positive patient in a ward through lab reports (N=622). This was true of 78% of nurses who had ever worked near an HIV-positive patient (N=213). Most ward staff (55%) got the information about an HIV-positive patient's presence through a nurse (N=66).

An underlying stigma was revealed by about 28% of medical staff who reported that the counselors disclosed the presence of an HIV-positive patient in the ward to them. This was significantly higher among medical staff from government facilities (30%, N=404) as compared to those from private facilities (23%, N=218) (p=0.05). Within a government facility, 26% of medical staff relied on markings on files for confirming the presence of an HIV-positive patient in the ward as compared to 17% from private facilities (p=0.007). Doctors were a common source of information about the presence of an HIV-positive patient in the ward within private facilities as reported by 66% of nurses (N=80) and 52% of ward staff who had ever worked near an HIV-positive patient (N=24).

More than a quarter of female medical staff who had ever worked near an HIV-positive patient, reported that they came to know about an HIV-positive patients' presence in a ward through a nurse (N=269). Doctors were a source of this information for about two-thirds of medical students who had ever worked near an HIV-positive patient (N=157).

6.2. Segregation of HIV+ Patients from other Patients and Disclosure of HIV Status

Of all the respondents, as many as 26% of medical staff and 19% of nurses reported that HIV positive patients were separated from others within their health facilities because of their HIV status. This finding was also substantiated by 31% of members of the ward staff.

Protecting other patients, warning staff members to take precautions, and providing better care to patients were cited as main reasons for doing so.

Near two-thirds of all ward staff reported that they inform their colleagues—other ward staff and nurses—about the HIV status of a patient in the ward. One-third of the ward staff also reported that they passed this information on to other patients. Spontaneously, 69% of ward staff said that they disclosed HIV status of a patient to other patients so that other patients can take precautions (N=32). However, when prompted, nearly 66% of ward staff admitted to doing this so that the other patients could avoid the HIV-positive patient.

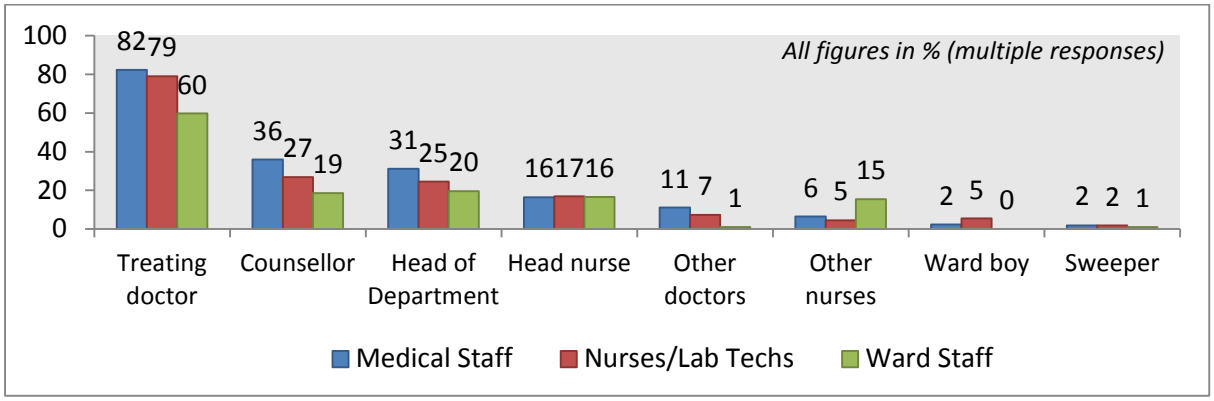
6.3. Testing before Invasive Procedures

Nearly 73% of medical staff were aware of having an equal access policy in their health facility (N=901). Among them, 94% identified one of its component as voluntary testing (N=662). From all medical staff that were interviewed, 30% said that in their health facility invasive procedure were always postponed until serostatus of the patient is confirmed. A value-based stigma was revealed by 53% of medical staff and 39% of nurses agreed that within their hospitals, invasive procedures were generally postponed for serostatus confirmation if the patient belonged to high-risk group (for example, sex worker, poor).

Further analysis revealed that postponement of surgeries in the case of high-risk groups was documented by almost 70% of medical staff in private clinics (N=55) where the presence of policies for patients' access to equal rights and policies for procedures of HIV testing were unreported.

Among the (73%) medical staff who reported that HIV tests were routinely conducted within their health facilities, the most common procedures before which these tests were conducted were delivery (91%), blood transfusion (91%), invasive surgery (88%), and dialysis (74%).

6.4. First Person to be Informed about HIV Test Results



N (all facilities where HIV+ ever admitted): Medical Staff= 810, Nurses/LabTechs= 220, Ward Staff = 66

Figure 6.2: First Staff Member to be Informed of Test Results

Respondents were asked about the first staff member to be informed about a patient's test results (Figure 6.4). Close to 80% of medical staff and nurses and 60% of ward staff said that the treating doctor was given the first information of the test results. Nearly 36% of medical staff said that within their facilities, counselors were (also) one of the first people to be informed of test results (N=810). No significant differences were observed by type of facilities.

Half of all medical staff said that upon finding the results, they always disclosed (would disclose) them to other staff members (N=901). Among the medical staff always or sometimes disclosing results, 80% informed other doctors (N=715).

One-third of all medical staff and nurses admitted to ALWAYS disclosing a patient's HIV status to ward boys. Spontaneously, they reported it was done so that ward boys could take precautions and provide better care to the patients. When prompted, as many as 40% of medical staff admitted telling ward boys so that they could avoid the patient and about 32% did without any reason (N=567). Prompted response for informing ward boys was given as "for providing better care" by 70% of nurses, and as "for avoiding patients" by 44% of nurses (N=167).

6.5. Patients' Rights to Informed Consent

The medical staff and nurses were asked about who was the first person (outside staff) they informed of HIV test results—the patient or their family. Approximately 43% of medical staff and 32% of nurses reported that the results are disclosed first to the patient, while nearly 22% of medical staff and 34% of nurses said that the family is informed. The rest said that the results were given to both, the patient

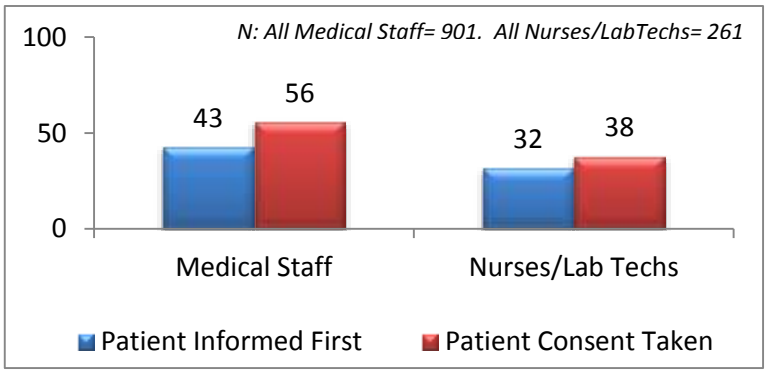


Figure 6. 3: Consent while Disclosure of HIV Status (%)

and family together. However, when asked if the patient's consent is always, sometimes, or never obtained before disclosing their HIV test results to their family, about 56% of all medical staff and 38% of nurses reported always taking a patient's consent before results are disclosed to others. As many as 26% medical staff and nurses said that the patient's consent was sometimes sought. However, 12% medical staff and 21% nurses clearly highlighted the stigma by saying that patients consent for disclosure of results was never taken in their facility.

Inconsistency of reporting among medical staff was highlighted when only 43% medical staff informed the patient first, which was significantly lower than the (56%) medical staff who ALWAYS took patient's consent ($p<0.001$). A possible reason for this discrepancy could be that even though HCPs are aware of ideal practice of always obtaining a patient's consent, they do not always act accordingly, signifying a gap between knowledge and practice.

Nearly 84% of all medical staff reported that the information about someone's HIV status was disclosed by the treating doctor.

About 29% of medical staff reported that the patient is never informed that (s)he is HIV positive. This was, however, more widely acknowledged by the non-medical staff, with 58% of nurses and 66% of ward staff saying that the patient is never given the results (Figure 6.3).

ard Staff = 97

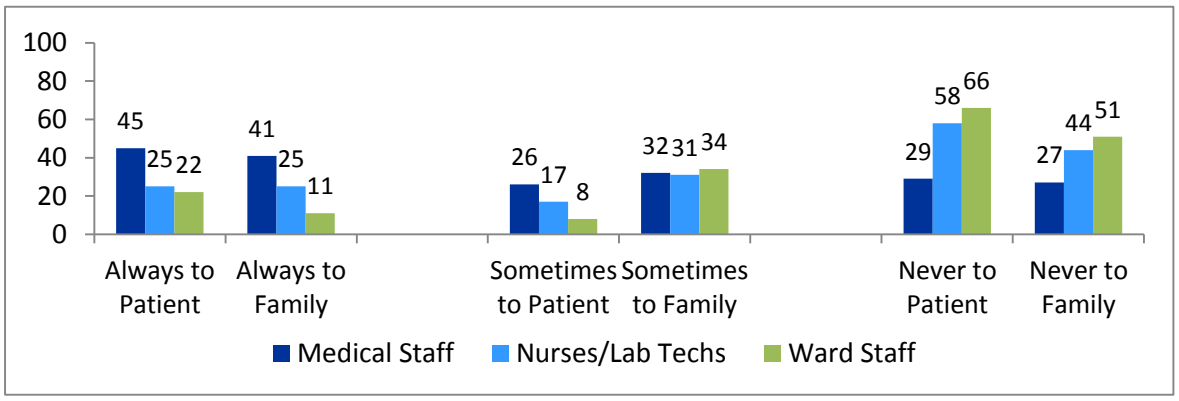


Figure 6. 4: Disclosure to HIV Test Results

6.6. HCPs Right to Refusal of Treatment of PLHIV

Responses to the statement "health care workers have a right to refuse to treat/care persons with HIV/AIDS" were captured using a five-point Likert scale with 5 being in strong agreement and 1 being in strong disagreement. About 16% of all medical staff interviewed agreed that "health care workers have a right to refuse to treat/care persons with HIV/AIDS" (top 2 boxes, N=901).

A linear regression analysis revealed that, controlling for other explanatory variables, agreement with this statement was lower among medical staff from a government hospital

as compared to those from private facilities. As compared to medical students, practicing doctors showed lower levels of agreement with this statement. With increased age of medical staff members, the tendency to agree with this statement declined. Misconceptions related to HIV transmission were found to be significantly associated with the tendency to agree with this statement. Medical staff members, who had no misconceptions about HIV transmission routes, showed lower agreement levels with this statement, than those who held even just one misconception.

Table 6.1: Results from Linear Regression Analysis for "health care workers have a right to refuse to treat/care persons with HIV/AIDS"

Explanatory Variables	*B*
Type of Facility	
Private+	
Government	-0.348***
Gender	
Male+	
Female	0.022 ns
Designation	
Medical student+	
Doctor	-0.233*
Exposure to TV	
Do not watch TV everyday+	
Watch TV everyday	0.164 ns
Exposure to Newspaper	
Do not read newspaper everyday+	
Read newspaper everyday	-0.175 ns
Misconceptions	
At least one misconception+	
No misconception	-0.254*
Others (Continuous Variables)	
Age	-0.011*
Work duration	0.001 ns

+: reference cat. ****:P≤0.001* **:P≤0.05* *ns: not Significant*

6.7. Fear of Transmission through Casual and Clinical Contact

The medical staff and nurses were asked if they had any fear of HIV transmission while treating a patient who was HIV positive. The following table presents the percentage of respondents who admitted having fear while performing routine clinical tasks on a PLHIV. Medical staff has been disaggregated by type of health facilities, gender, and work within the facility.

Table 6.2: Fear of Transmission through Casual and Clinical Contact (%)

	Doctor+	Medical Student	Medical Staff (Govt Hospital)+	Medical Staff (Pvt Hospital)	Medical Staff (Pvt Clinic)	Female Medical Staff+	Male Medical Staff	Nurses
N	***635***	***266***	***584***	***223***	***94***	***374***	***527***	***261***
Giving injection	35	45**	39	33	44	34	41*	43
Assisting delivery	41	48	45	35**	51	40	45	44
Dressing wounds	41	51**	44	41	48	42	45	45
Conducting surgery on or suturing	50	62***	54	50	57	51	55	NA
Putting a drip	28	42***	33	26*	44*	28	36*	36
Coming into contact with sweat	10	14	14	5***	4***	9	12	16
Coming into contact with saliva	18	22	21	18	9***	19	19	27
Drawing blood	44	52*	45	48	50	43	49	57
Caring	5	9*	5	7	13*	6	7	11

+comparison categories for two tailed z test ***:P≤0.001 **:P≤0.01 *:P≤0.05

Fear of getting infected through clinical contact was fairly high among medical students on all tasks as compared to doctors. Half of all medical students had fear in performing ANY tasks on PLHIV that involves even small amount of blood.

Compared to medical staff from government hospitals, those from private hospitals and clinics admitted to having lower fear on all tasks on PLHIV (except sweat contact). More than 40% of medical staff from government hospitals reported to have fear while performing tasks that involve blood.

Gender-wise disaggregation reveals that at an aggregate level, fewer numbers of female medical staff reported to have fear while preforming tasks such as giving injection and putting drip on an HIV-positive patient (Table 6.2).

Fear of getting infected through casual contact is fairly high among nurses, especially while handling large quantities of blood. Disaggregation reveals that fear while handling blood is reported by far fewer lab technicians than nurses.

6.8. Interaction with HIV+ Patients

Nearly 70% of the medical staff interviewed had worked near an HIV patient, however only 31% had treated one in the last three months (N=901).

Most of these (78%) had treated HIV-positive patients for a general illness. Fewer reported treating HIV-positive patients for invasive procedures such as surgery (33%) and delivery (24%) (N=286).

Nearly 43% of medical staff believed that they lacked adequate comfort level and access to training on management of HIV and opportunistic infections (N=901). This was significantly lower among those who had ever worked near an HIV-positive patient (37%, N=622) (p=0.018)

More than a third of all medical staff had referred HIV-positive patients to specialist doctors, mostly for specific tests. About a half of all medical staff were aware of the community-based sources for PLHIV, and 66% of them had even referred patients to these sources (N=449).

Interaction with an HIV-positive patient was seen to have significant effects on reporting of fear of transmission through clinical contact by medical staff. Table 6.3 provides the percentage of medical staff who reported to have fear of transmission during specific tasks.

Table 6. 3: Effect of Exposure to PLHIV on Fear

Have fear of transmission	Worked with HIV+ patient	Never worked with HIV+ patient	Sig
N (Medical Staff)	***622***	***279***	
Giving injection	33	49	***
Assisting delivery	38	54	***
Dressing wounds	38	56	***
Conducting surgery on or suturing	49	63	***
Putting a drip	25	49	***
Coming into contact with sweat	9	15	*
Coming into contact with saliva	17	24	*
Drawing blood	42	55	***
Caring	6	8	NS

****:P≤0.001* ***: P≤0.01* **:P≤0.05* *NS: Not significant*

Overall, the medical staff who reported to have ever worked near an HIV-positive patient in the past reported significantly lower fear of clinical contact while performing all tasks on PLHIV (except caring, in general).

6.9. Medical Staff's Concerns in Caring for HIV+ Patients

All medical staff were asked about their main concerns in caring for a patient who is HIV positive (multiple response). Table 6.4 provides their responses.

Table 6.4: Major Concerns in caring for PLHIV (%)

Major Concerns in caring for PLHIV (%)	
N	***901***
Lack of medicine	48
Lack of ARV	44
Lack of separate facility for PLHIV	40
Treatment costly	38
Differential treatment	36
Lack of treatment	33

A little less than half of the medical staff reported lack of medicines as their chief concern in treatment of PLHIV. Lack of ARV for doctors was reported by nearly 44% of medical staff. Lack of a separate facility for patients and high cost of treatment were cited by 4 out of 10 medical staff.

A cross tabulation analysis revealed that among government facilities, concerns over lack of medicines was reported by 45% medical staff as compared to 56% from private facilities (p=0.002). Cost of treatment was a lower concern in medical staff from government facilities (31%) than in private facilities (46%) (p<0.001).

6.10. Medical Staff's Attitude toward Work-related Exposure

A linear regression analysis was done to understand the effects of misconceptions of HIV transmission on four statements depicting medical staff's attitude toward fear of clinical exposure to HIV. Other explanatory variables used in the model were gender, age, designation, and health facility. The result of the linear regression analysis revealed that, holding constant the effects of other explanatory variables, medical staff with misconceptions had more negative attitudes toward caring for PLHIV and fear of clinical exposure to HIV than those with no misconceptions.

Statements[2]	***β (No Misconceptions)***
I am uncomfortable in providing health care services to patients who are HIV positive.	0.173*
I avoid touching the clothing/belongings of patients known/suspected to be HIV+ for the fear of contracting HIV.	0.459***
Most frequent ways of contracting HIV among health workers is through work-related exposure.	0.329***
Most HIV+ health care workers get infected at work.	0.330**

****:P≤0.001 **: P≤0.01 *:P≤0.05*

[2] Statements on a 5 point Likert scale: 1=Strongly Agree and 5= Strongly Disagree

The positive value of *β (No Misconceptions)* indicates higher level of disagreement with the statements from those who have no misconceptions as compared to those who have at least one misconception regarding transmission of HIV. Thus, a medical staff member having no misconceptions reported a score of 0.459 units higher (more disagreement) on the statement, *"I avoid touching the clothing/belongings of patients known/suspected to be HIV positive for the fear of contracting HIV,"* than his counterpart (of same age, gender, and type of facility) who had at least one misconception.

Chapter 7: Attitudes toward PLHIV

This chapter discusses the attitudes related to PLHIV held by medical and non-medical staff. This section also highlights anticipated stigma associated with PLHIV.

7.1. Attitude toward PLHIV – Factor Analysis

Table 7. 1: Attitude toward PLHIV

Statements	Top 2 Boxes (Agree + Somewhat Agree) (%)		
	Medical Staff	Nurses/Lab Techs	Ward Staff
Base	***901***	***261***	***97***
PLHIV have no reason to be ashamed.	83	82	77
In general, people living with HIV are ashamed of themselves because they have HIV.	78	82	87
I would be ashamed if someone in my family had HIV.	41	56	67
I would be ashamed if I were infected with HIV.	43	53	68
Prostitutes are to blame for spreading HIV in our community.	51	59	74
HIV/AIDS is a punishment for bad behavior.	35	44	77
People with HIV are promiscuous.	43	54	71
People who have HIV/AIDS should be given treatment and care, only if they stop participating in immoral or illicit activities.	39	56	57
If the young people in our community associate or interact with a person who has HIV/AIDS, they may be influenced to participate in immoral activities.	52	58	70
Most people who are HIV positive are poor and uneducated.	44	40	56
Sex workers are the only women who have to worry about getting HIV/AIDS.	36	46	63
PLHIV are not to be blamed for their infection.	82	84	71
People with HIV infection should be allowed to get married.	75	66	58
HIV-positive women should not be allowed to have babies.	51	57	55
Clothes and linen used by HIV patients should be disposed of or burned.	49	62	68
Patients with HIV/AIDS should be kept at a distance from other patients.	34	49	48
It is acceptable for a person who is HIV positive to continue to have protected sex with a steady partner.	71	64	65

The statements in black were reverse coded and after conducting a reliability analysis on all the attitudinal statements from the medical staff's data, factor analysis was conducted to establish common themes. Seventeen statements relating to attitudinal aspects of HIV were factor analyzed using maximum likelihood analysis with Varimax (orthogonal) rotation. The

loadings on the factors were restricted to 0.4, that is, all loading below 0.4 on any of the factors were dropped from analysis. The statements from the other two databases were recoded into factors that emerged from the medical staff data.

Table 7.2 presents the factors that were identified.

Table 7. 2: Factor Loadings

Statements	Loadings	Label
In general, people living with HIV are ashamed of themselves because they have HIV.	0.741	*Label 1: Internalized (anticipated) stigma*
I would be ashamed if someone in my family had HIV.	0.796	
I would be ashamed if I were infected with HIV.	0.827	
Prostitutes are to blame for spreading HIV in our community.	0.642	*Label 2: Shame and blame toward PLHIV*
HIV/AIDS is a punishment for bad behavior.	0.607	
People with HIV are promiscuous.	0.604	
People who have HIV/AIDS should be given treatment and care, only if they stop participating in immoral or illicit activities.	0.693	
If the young people in our community associate or interact with a person who has HIV/AIDS, they may be influenced to participate in immoral activities.	0.541	
Most people who are HIV positive are poor and uneducated.	0.466	
Sex workers are the only women who have to worry about getting HIV/AIDS.	0.578	
Clothes and linen used by HIV patients should be disposed of or burned.	0.778	*Label 3: Discrimination within health facilities*
Patients with HIV/AIDS should be kept at a distance from other patients.	0.754	
It is NOT acceptable for a person who is HIV positive to continue to have protected sex with a steady partner. [rec]	0.595	*Label 4: Negative attributes toward PLHIV*
PLHA are to be blamed for their infection. [rec]	0.801	
PLHA have a reason to be ashamed. [rec3]	0.718	

Mean score for each type of respondent was calculated on the five broad themes given above. The scores range from 1 to 3, **and higher scores represent higher levels of positive attitudes toward PLHIV.**

The mean scores for the three groups on each of the factor have been calculated as given in the table below.

[3] Recoded Statements

Table 7.3: Mean Score on Identified Labels

Label	Mean Score (Positive Attitude)		
	Medical Staff (N=901)	Nurses/Lab Techs (N=261)	Ward Staff (N=97)
Label 1	2.203	2.054	1.835
Label 2	2.408	2.252	2.025
Label 3	2.413	2.111	2.160
Label 4	2.240	2.194	2.079

Note: details of label in Table.7.2

On all labels, the mean scores are the highest for medical staff, indicating lower negative attitudes of medical staff as compared to non-medical staff.

Linear regression analysis was conducted with each of the four labels as response variables and demographics, type of facility, exposure to media and training, and misconceptions as explanatory variables. The results of the linear regression analysis are given in Table 7.4.

7.1.1. Internalized (Anticipated) Stigma

Fear of being HIV positive or being associated with someone who is HIV positive—defined as anticipated stigma—received the most negative responses across categories. Mean score for label 1 was lowest within medical staff (2.203, N=97) and non-medical staff (2.054 for nurses and 1.835 for ward staff), indicating the prevalence of a more negative attitude on this label as compared to other labels. A linear regression analysis (Table 7.4) was conducted using type of facility, gender of medical staff, designation, exposure to media, receipt of in-service HIV training, and having misconceptions as explaining variables to observe their effect on changes in mean score for this label as response variable. With other explanatory variables constant, type of facility was significantly associated and medical staff from government facilities had 0.112 units higher mean score on this label than those from private facilities (p=0.014). This means that medical staff from government facilities had lower levels of self-identified shame toward being HIV positive as compared to their counterparts in private facilities.

7.1.2. Shame and Blame toward PLHIV

Judgment about character of PLHIV, or associating HIV with someone who does not fit within society's moral circle was prevalent among ward staff. Mean score on label 2 was lower among ward staff (2.025, N=97) as compared to other medical staff (2.408, N=901) and nurses (2.252, N=261) implying that the ward staff associated HIV with immoral or illicit activities.

A linear regression analysis was done using mean scores for this label as response variable and the explanatory variables given in Table 7.4. Among the medical staff who did not have any misconception about transmission of HIV, the mean score was 0.166 higher than those

who had at least one misconception (p<0.001). The results also revealed that the mean score declined significantly with age of the medical staff (p=001) which means that the older medical staff associate HIV with morality more than their younger counterparts. However, even though the medical students are younger than doctors, their mean score on this label was significantly lower than doctors (after keeping constant other explanatory variables) by 0.155 units (p=0.001).

7.1.3. Discrimination toward PLHIV in Health Facilities

A regression analysis, holding constant the partial effects of age, gender, and type of health facility, showed that medical staff without transmission misconceptions disagreed more to the statements depicting discriminatory behaviors toward PLHIV such as burning of clothing and segregation from other patients (p=0.002). This practice was also less supported by medical staff from government hospitals (p=0.002). On this label, doctors have a mean score of 0.109 higher than medical students (p=0.044). This means that doctors were less supportive of the discriminatory practices toward PLHIV within health facilities than the medical students.

In-service HIV training had a positive effect on this label. Controling for other explanatory variables in the model (Table 7.4), those medical staff in receipt of HIV training had a mean score of 0.126 more than those who had not received training (p=0.002), that is, those exposed to training held less negative attitudes of discrimination toward PLHIV within health facilities compared to those who were never exposed.

7.1.4. Negative Attributes toward PLHIV

Analysis of explanatory variables for label 5 reveals that the mean score for this is expected to increase with increase in age of the medical staff (p=0.0390). That is, older medical staff members reported lower negative attributes toward PLHIV. Also, having no misconceptions related to transmission routes significantly was associated with increase in the mean score on this label for medical staff by 0.207, thus meaning medical staff without any misconceptions have a higher disagreement to statements of negative attributes associated with PLHIV (p<0.001).

Exposure to HIV-related training increased the mean score on this label by 0.085, for example, people who have received an in-service HIV training are less likely to hold attitudes of blame and shame toward PLHIV (p=0.039). Exposure to TV, however, follows a reverse trend. Medical staff who watch TV everyday report a mean score of 0.120 lower than those who do not (p=0.032).

Table 7. 4: Effect of Predictors on Medical Staff's Attitude

Explanatory Variables	L abel 1	Label 2	Label 3	Label 4
Type of Facility++				
Private+				
Government	0.118**	0.060 ns	0.121**	-0.057 ns
Gender++				
Male+				
Female	-0.023 ns	0.032 ns	0.018 ns	0.010 ns
Designation++				
Medical Student+				
Doctor	0.094 ns	0.155***	0.109*	0.103*
Exposure to TV++				
Do not watch TV everyday+				
Watch TV Everyday	0.007 ns	0.003 ns	-0.104 ns	-0.120*
Exposure to Newspaper++				
Do not read newspaper everyday+				
Read newspaper everyday	0.097 ns	0.001 ns	-0.111 ns	0.087 ns
Exposure to Training++				
Not received in-service HIV training+				
Received in-service HIV training	-0.020 ns	-0.012 ns	0.126**	-0.085*
Misconceptions++				
At least one misconception+				
No misconception	0.015 ns	0.164***	0.177**	0.207***
Others (Continuous Variables)++				
Age	-0.001 ns	-0.007***	-0.002 ns	-0.004*

*++: explanatory variable +: reference cat. ***:P≤0.001 **: p≤0.01 *:P≤0.05 ns: not Significant*

Note: details of label in Table.7.2

7.2. HCPs Understating of Stigma

The survey assessed how health care workers understand stigma through a series of numeric as well as open-ended responses. Nearly 70% of all medical and non-medical staff were familiar with the word "stigma." It was usually understood as the practice of maintaining distance, hatred, shame, discrimination, negative things, and so on. About a fourth of all those who were familiar with stigma directly associated it with HIV/AIDS.

The opinion of all HCPs was sought on four statements depicting anticipated stigma. Table 7.5 gives the percentage of HCPs agreeing to the statements depicting stigma.

Table 7. 5: Anticipated Stigma among HCPs

Statements	(% Agreement)		
	Medical Staff (N=901)	Nurses (N=261)	Ward Staff (N=97)
People talk badly to others about a person living with or thought to be living with HIV.	57	48	58
A person is hesitant to take an HIV test due to fear of people's reaction if the test result is positive for HIV.	50	46	41
A person living with or thought to be living with HIV lose respect or standing.	38	27	41
Children living with HIV should NOT be allowed to attend school with other children.	5	8	4

It is noteworthy that while medical staff themselves reported the most positive attitudes toward PLHIV on all four labels above, when it comes to their opinion of what others do, most of them admit to knowing of negative behavior/attitude of "others" toward PLHIV.

Acknowledgement of anticipated stigma and fear within people due to disclosure of their HIV status and resulting negative reactions was the highest among ward staff, followed by medical staff.

All health care providers were asked to exemplify circumstances or situations under which their agreement/disagreement holds as an open ended response. Many respondents, who agreed that people talk badly about PLHIV or PLHIV tend to lose respect, believed it was because the "society" feels HIV is a result of bad activities and PLHIV have a bad character. Some of them also agreed that the underlying fear of contraction of HIV is what causes people to form negative opinions about PLHIV.

As discussed in Chapter 4, Most of the respondents agreed that HIV does not spread by touching PLHIV or living with them. More than 95% of all HCPs agreed that children of HIV-positive parents should be allowed to attend school with other children, although, many believed this should only be after getting them tested and taking necessary precautions. In general, respondents were aware of every child's right to education and believed that their parents' HIV status should not be a reason for violation of these rights.

7.3. Discussion of Non-stigmatizing Attitudes among Medical Staff

Nearly 51% of all medical staff, 42% of nurses and 35% of ward staff reported discussing non-stigmatizing attitudes toward PLHIV with their colleagues.

Further analysis revealed that discussion was slightly higher among HCPs from hospitals that have policies in place for protection of PLHIV rights and safeguarding the protection of staff from occupational exposure.

The provider-to-provider communication channel was further strengthened by exposure to in-service training on HIV with as many as 58% of medical staff who had received any training on HIV acknowledging the practice of discussion about non-stigmatizing attitudes with junior staff ($p<0.001$). Further, receipt of in-service training was positively correlated with discussion of non-stigmatizing attitudes with other colleagues within the health facility. This correlation does not imply causality.

Conclusion and Recommendations

The baseline research findings clearly highlighted the need to address the issue of stigma and discrimination toward PLHIV in health care settings. Health care providers either knowingly or unknowingly indulged in acts that resulted in differential treatment of PLHIV, violated their rights, and compromised policies made for the protection of PLHIV.

It was also found that many health care providers lacked adequate knowledge and training on the basics of HIV transmission, clinical management of HIV/AIDS, counseling, and ethical and legal issues concerning PLHIV. This coupled with the lack of hospital policies protecting PLHIV and ensuring staff safety contributed to discriminatory practices. It was also revealed that misconceptions regarding transmission of HIV were prevalent among all HCPs. These misconceptions gave rise to fear, negative attitudes, and therefore, differential treatment of PLHIV within health facilities.

Peril of contagion gives rise to fear-based stigma that is observed among HCPs. Health care providers reported fear of infection through casual and clinical contact, and these fears made them take extra, and sometimes unnecessary, precautions such as double gloves, marking on files, special gowns and curtains, masks, boots, and avoiding touch, affecting their interactions with HIV-positive patients.

Similarly, HCPs also revealed high levels of anticipated and enacted stigma, as noted by the shame associated with having HIV and the blame drawn toward sex workers, and promiscuous and uneducated people for spreading HIV in the society and support of discriminatory practices. The value-laden opinions about the high-risk groups—sex workers, poor, and uneducated patients—and being unaware of policies on procedures to be followed for HIV testing, create an environment of inadvertent stigmatizing behaviors and may demonstrate the presence of compounded stigma.[4] These include: delay in care, unwarranted testing, and non-disclosure of test results, among others.

Although there was a general consensus that HIV-positive patients should be treated the same way as others, they should not be ashamed of their HIV status, and their children have a right to attend school with other children, the fear-based and value-based stigmatizing attitudes often override these sympathies and convert into discriminatory practices. Although these stigmatizing attitudes and discriminatory practices were not exclusively confined to a particular group of HCPs, they were most prevalent among the ward staff, even though they were not directly involved in providing medical care to PLHIV.

These findings were further substantiated by the HCPs who identified their concerns in treating an HIV-positive patient as lack of medicine, high cost of treatment, and inadequate access to training on policies and procedures to deal with PLHIV. This increased their level of

[4] Compounded stigma refers to the manifestation of one or more form of stigma—fear driven, value based, etc., in one type. For example, prostitutes are to be blamed for spreading HIV in society, is a statement depicting compounded (value-based) stigma.

apprehension in providing them with adequate treatment. It was, however, highlighted through research findings that the medical staff who had worked near HIV-positive patients ever in the past, reported much lower levels of fear of HIV transmission through a clinical contact with PLHIV.

Most health care providers were aware of the term stigma and understood its appearances in the life of PLHIV. There were discussions among colleagues for increasing attitudes that should lower stigma toward any patient with health facilities. This was specifically prevalent in hospitals where policies for protection of PLHIV rights, as well as policies for safety of staff, are in place. The doctors often engaged in discussions about non-stigmatizing attitudes toward PLHIV with their colleagues and junior staff, thereby opening a channel of communication from medical staff to the non-medical staff.

Thus, the study findings revealed that practices depicting stigma and discrimination within health care facilities are not limited to individual knowledge or attitudes but also prevail at the institutional level. Therefore, interventions aiming to promote more equitable attitudes and practices toward PLHIV among health care providers should not be limited to just addressing health care providers' knowledge gaps. The intervention should also aim to equip and support the health care providers through proper training on care and management of PLHIV, personal protection, and address moral judgment and other related attitudes.

Exposure to television was almost universal among HCPs and was the most common medium of receiving communication about HIV for all HCPs. The medical staff were frequent internet users and identified it as a medium of HIV related communication. The data also revealed the presence of a provider-to-provider communication channel which may be utilized to motivate exposed professionals to expose others directly on to the issue of stigma and discrimination. This may be through word-of-mouth or electronic media.

Apart from targeting individuals, a need for enforcement of policies within institutions to protect staff and decrease fear-based stigma and filling the gaps that arise due to lack of medicines for adequate treatment of PLHIV have also been identified through this research and should be addressed appropriately in order to achieve the program objectives.

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