

Getting to “Stigma-Free” Services in Antigua and Barbuda:

Survey Results

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EXECUTIVE SUMMARY

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

Recognising the particularly harmful role that S&D can play in health settings, the National AIDS Programme of the Ministry of Health (MOH) of Antigua and Barbuda collaborated with HPP, the University of the West Indies (UWI), and other partners in developing and testing a comprehensive S&D-reduction programme in health facilities that will share lessons learned with the rest of the region. This programme strengthens individual and health system capacities to ensure stigma-free health services and measures stigma to inform programme design, health facility and national-level policy, ongoing learning, and evaluation.

This report details the findings of a baseline survey report, as well as a participatory discussion and recommendations workshop based on the report's findings in Antigua and Barbuda. The study and the survey instrument were adapted from global best practices for S&D-reduction programming in health facilities. The survey involved interviews with a representative sample of health and auxiliary staff in all levels of health facilities. Survey questions addressed critical programming areas such as fear of HIV transmission through work-based exposure to people living with HIV (PLHIV), opinions about PLHIV (especially pregnant women living with HIV), and the health facility environment. Survey data also measured levels of S&D, willingness to provide treatment to stigmatised populations, secondary stigma, and possible S&D towards health facility staff living with HIV.

The research employed a combination of self-administered and face-to-face interviews; interviewers were identified by the Ministry of Health in Antigua and Barbuda. The analysis provides basic information needed to address stigma at the health facility level.

A total of 430 respondents—including administrative support staff, medical personnel, cleaning/auxiliary staff, pharmacists, and related technicians—formed the basis of this report. Frequencies for key results areas of all questions asked—training, infection concerns, health facility environment, health facility policies, opinions about PLHIV and key populations, caring for pregnant women living with HIV—are presented in these broad job categories.

The programme includes two key elements: 1) strengthening the capacity of health facilities and health facility staff to provide S&D-free services, and 2) collecting data to inform programme design, health facility and national-level policy, and ongoing learning, and to support evaluation. This report focuses on the initial stage of this second element: collection of baseline data from the health delivery system in Antigua and Barbuda. These data provide a foundation on which to design evidence-informed S&D-reduction programming and evaluate change over time. In addition, implementation of this survey contributes to a global effort to develop a standardised tool and indicators for measuring S&D among

health facility staff, providing a Caribbean perspective to a process that also includes sites in Dominica, St. Kitts and Nevis, Barbados, China, Egypt, Kenya, and Puerto Rico.

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

The report identifies key areas for action in the health system in order to reduce stigma.

ABBREVIATIONS

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

BACKGROUND

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

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

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

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

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

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

The study design and survey instrument built on regional and global best practice experience for S&D-reduction programming in health facilities, and measured key areas for programmatic intervention at both the individual and facility levels. Specifically, interviews were conducted with a representative sample of health facility staff (medical and nonmedical) at all levels, in different types of health facilities.

Information was collected in the following key areas for programmatic intervention: fears of HIV transmission through work-based exposure to people living with HIV (PLHIV), opinions about PLHIV (particularly pregnant women living with HIV), and the health facility environment. In addition, data were collected to assess levels of S&D, experiences with secondary S&D, potential S&D towards health facility staff living with HIV, and willingness to provide treatment to stigmatised populations.

Fear of HIV Transmission

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

Opinions About People Living with HIV

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

Health Facility Environment

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

Observed Stigma and Discrimination

Surveys of S&D rarely ask respondents if they themselves have engaged in S&D behaviour, because direct questions pertaining to sensitive topics often elicit unreliable responses. As such, measures of S&D

are often done through indirect questioning that asks respondents if they have observed various acts of S&D occurring in their facility during a given timeframe (e.g., past 12 months). This approach may be prone to unreliable responses but is assumed to be less so than a direct question. It may also provide a conservative estimate (undercount) of S&D if there are forms of S&D occurring that are not easily observed by other staff in the facility.

Secondary Stigma

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

Willingness to Provide Treatment

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

METHODOLOGY

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

Sample Selection and Implementation of Fieldwork

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

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

The survey was implemented through a combination of self-administered questionnaires and face-to-face interviews (in cases where respondents were not comfortable or able to complete a self-administered questionnaire). Fieldwork interviewers at the survey stage were drawn from the National AIDS Programme and the Ministry of Health of Antigua and Barbuda.

Data Capture

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

Analysis Process

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

The data were analysed to assess the presence and levels of the immediately actionable drivers of S&D (e.g., fear of casual transmission of HIV and attitudes towards PLHIV); observed S&D; experience of secondary S&D; and a facility environment supportive of S&D-free care. This level of analysis provided

basic information to assess the situation and needs in the health facilities and what type of programming is most needed.

Ethical Clearance and Consent Processes

Ethical approvals for the study were obtained from the Antigua and Barbuda MOH, Office of the Chief Medical Officer.

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

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

RESULTS

A total of 430 respondents formed the basis of the following analysis. As indicated in the methodology, these respondents covered a range of job classifications in the health sector. These job categories were further grouped under four major headings: support administrative staff, medical personnel, cleaning/auxiliary staff, and pharmacist (including technicians). Seven respondents did not provide their job classification, and are listed separately in the tables as “job category not stated.”

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

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

Table 1 provides a breakdown of staff by the facilities where they were employed at the time of the study.

Table 1: Sample Breakdown by Health Facility

Facility Type	Count	Percentage
Hospital	322	75%
Health centre/polyclinics	68	16%
Other facilities	49	9%

Exposure to Training

Respondents in general were not found to be involved in any significant training initiatives over the last 12 months, with no training area receiving more than 50 percent total participation. Among the more popular areas of training highlighted were patients’ informed consent, and infection control and universal precautions, as identified by 46.1 percent and 40.5 percent of respondents, respectively. Training programmes covering HIV S&D and key population S&D were identified by 38.4 percent and 19.7 percent of respondents, respectively. Medical personnel were more inclined to attend all training programmes, while programmes in areas such as patients’ informed consent and HIV prevention were more likely to be attended by the nonmedical staff, as shown in Table 2.1. Across the board, training in key population S&D received the least patronage.

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

Training Areas		Support Administrative Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Position Not Given	Total
Sample size (n)		83	214	96	12	22	427
HIV S&D	Yes	30.1	57.5	6.3	16.7	36.4	38.4
	No	69.9	42.5	93.8	83.3	63.6	61.6
	Not stated	0.0	0.0	0.0	0.0	0.0	0.0
Infection control and universal precaution	Yes	21.7	62.6	13.5	8.3	31.8	40.5
	No	78.3	37.4	86.5	91.7	68.2	59.5
	Not stated	0.0	0.0	0.0	0.0	0.0	0.0
Patients' informed consent, privacy, and confidentiality	Yes	32.5	67.3	12.5	41.7	40.9	46.1
	No	67.5	32.7	87.5	58.3	59.1	53.9
	Not stated	0.0	0.0	0.0	0.0	0.0	0.0
Key population stigma and discrimination	Yes	14.5	29.4	5.2	0.0	18.2	19.7
	No	85.5	70.6	94.8	100.0	81.8	80.3
	Not stated	0.0	0.0	0.0	0.0	0.0	0.0

Infection Concerns

Respondents were asked to indicate their level of concern about becoming infected with HIV while engaged in procedures involving PLHIV. The degree of concern was found to be directly linked to the degree of interaction with the PLHIV required by the procedure. Therefore, the more invasive procedures such as drawing blood from a patient, dressing wounds, and giving an injection recorded higher levels of concern among respondents (ranging from 51.9% to 44.6%) than less invasive procedures such as touching the clothing and taking the temperature of a patient living with HIV (with 18.0% stating worry and 11.5% declining response). This pattern was also found to be consistently reported along the lines of the occupation classification as illustrated in Table 2.2.

It is noteworthy that non-medical staff displayed higher levels of concern, regardless of the invasiveness of the procedure. For example, 40.4 and 28.1 percent of cleaning staff associated a higher level of concern of, respectively, contracting HIV from touching the clothing and taking the temperature of patients living with HIV. While it is significant that the pharmacists and technicians interviewed displayed the highest level of concern in different areas (drawing blood, 85.7%; dressing wounds, 75.0%; and giving injections, 66.7%), general conclusions should not be drawn, as these persons were the smallest in number (n=11).

When asked about the precautionary measures adopted when providing care to patients living with HIV, the measures reported were in tandem with the level of concern expressed. Three main precautionary measures were cited: wearing gloves during all aspects of patient care (49.4%), wearing double gloves when providing care to patients living with HIV (46.4%), and using any special precautionary infection control measures (43.8%).

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

Areas of Concern		Support Administrative Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Position Not Given	Total
Touched the clothing of a patient living with HIV	Sample size (n)	60	194	57	11	11	333
	Not worried	76.7	86.6	56.1	72.7	81.8	79.0
	Worried	15.0	11.9	40.4	27.3	18.2	18.0
	Not stated	8.3	1.5	3.5	0.0	0.0	3.0
Dressed the wounds of a patient living with HIV	n	34	183	38	8	9	272
	Not worried	20.6	50.8	34.2	12.5	44.4	43.4
	Worried	61.8	45.9	57.9	75.0	55.6	50.7
	Not stated	17.6	3.3	7.9	12.5	0.0	5.9
Drew blood from a patient living with HIV	n	32	166	30	7	6	241
	Not worried	18.8	48.2	23.3	14.3	33.3	39.8
	Worried	62.5	45.2	66.7	85.7	66.7	51.9
	Not stated	18.8	6.6	10.0	0.0	0.0	8.3
Took the temperature of a patient living with HIV	n	35	187	32	6	10	270
	Not worried	60.0	92.5	62.5	83.3	60.0	83.3
	Worried	22.9	4.8	28.1	16.7	40.0	11.5
	Not stated	17.1	2.7	9.4	0.0	0.0	5.2
Gave an injection to a patient living with HIV	n	32	168	30	6	6	242
	Not worried	31.3	51.8	23.3	33.3	66.7	45.5
	Worried	50.0	40.5	60.0	66.7	33.3	44.6
	Not stated	18.8	7.7	16.7	0.0	0.0	9.9

Table 2.3 Precautionary Measures Adopted by Job Category

Measures Adopted		Support Administrative Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Position Not Given	Total
Avoid physical contact when providing care/services for a patient living with HIV	Sample size (n)	38	194	36	9	8	285
	Yes	10.5	11.3	38.9	33.3	12.5	15.4
	No	71.1	83.0	38.9	55.6	75.0	74.7
	Not stated	18.4	5.7	22.2	11.1	12.5	9.8
Wear double gloves when providing care/services for a patient living with HIV	n	33	190	38	8	5	274
	Yes	33.3	44.2	65.8	50.0	60.0	46.4
	No	42.4	53.2	13.2	37.5	40.0	45.6
	Not stated	24.2	2.6	21.1	12.5	0.0	8.0
Wear gloves during all aspects of the patient's care when providing care/services for a patient living with HIV	n	28	193	35	8	7	271
	Yes	50.0	45.1	68.6	62.5	57.1	49.4
	No	25.0	50.8	14.3	37.5	42.9	42.8
	Not stated	25.0	4.1	17.1	0.0	0.0	7.7
Use any special infection control measures	n	26	191	28	7	6	258
	Yes	30.8	42.9	60.7	42.9	50.0	43.8
	No	34.6	52.4	14.3	42.9	50.0	46.1
	Not stated	34.6	4.7	25.0	14.3	0.0	10.1

Health Facility Environment

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

- Unwilling to provide care
- Providing substandard levels of care
- Saying bad things

The responses were wide-ranging, with between 7.5 percent and 47.8 percent of staff members reporting these acts in their health facilities in the past 12 months. Among medical personnel, 9.3–54.9 percent reported observing these acts. Overall, the least reported occurrences were linked to discriminatory acts more verbal in nature, such as talking badly about men who have sex with men (47.8%), patients living with HIV (45.5%), patients who are sex workers (37.2%), and patients who are transgender (30%).

Relating to unwillingness to care, observations ranged from 7.5–28.9 percent, with the majority of these acts aimed at persons living with HIV (28.9%), followed by men who have sex with men (16.6%). When dissected by job category, this same pattern of observed behavior maintains even among medical personnel.

As far as providing substandard care to patients, percentages ranged from a low of 9.5 percent to a high of 27.7 percent. Unfortunately, as previously observed, patients living with HIV (27.7%) were considered to receive the brunt of this discriminatory act, followed by men who have sex with men (17.4%), even under the care of medical personnel (34.6% and 22.8% for these patient categories, respectively). While significantly higher percentages of auxiliary staff and those working in the technical or pharmaceutical area reported observing acts of discrimination, this job category had a small sample size, so some degree of caution is advised in drawing any broad conclusions from this group.

A remaining key feature of these data, however, is that between 9.1–13.0 percent of respondents declined to answer these questions. Details on the responses by job classification are captured in Table 2.4.

Levels of observed (or fear of anticipated) secondary stigma were not very high among the respondents, with 16 percent reporting concern of being avoided by friends because of their interaction with patients living with HIV while performing job duties—the highest reported rate of anticipated secondary stigma. Ironically, despite being a group small in numbers ($n < 50$), those working in an administrative capacity were those showing the highest level of concern of being shunned by others as a result of interacting with persons living with HIV while on the job. A complete breakdown is found in Table 2.5.

Respondents were also asked about observed willingness of staff members to address personal health issues at the facility. A substantial 65 percent stated that workers at their facility would be hesitant to undergo an HIV test at the facility due to peers' reactions if the test was positive. This percentage was consistently high across all job categories.

In terms of working alongside a PLHIV, 60.8 percent of respondents felt that there would be some degree of hesitancy among staff to work alongside a fellow staff member living with HIV, no matter what their duties. Percentages also increased (76%) when respondents gave their viewpoint on the hesitancy of workers to seek healthcare at the same facility where they work should they become infected with HIV. This pattern was consistent across the various job categories and particularly high among medical personnel, with 78.8 percent sharing this viewpoint (Table 2.6).

Changing the focus to key populations, respondents were asked their opinion on healthcare workers' hesitancy to provide care to such groups. As observed in the earlier areas of investigation, respondents believed that this reluctance would be mostly focused towards persons living PLHIV (50.9%) and MSM (47.6). While medical personnel were least likely to associate such behavior with their coworkers, the overall percentages were still considerable, ranging from 30.7 percent to 46.6 percent. Table 2.6 provides further clarification.

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

Observed Practices		Support Administrative Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Position Not Given	Total
Sample size (n)		44	162	28	7	12	253
Healthcare workers unwilling to care for a patient living with HIV	Never observed	70.5	63.6	53.6	71.4	41.7	62.8
	Observed	11.4	34.6	28.6	28.6	16.7	28.9
	Not stated	18.2	1.9	17.9	0.0	41.7	8.3
Healthcare workers unwilling to care for a male patient who has sex with men	Never observed	81.8	74.7	64.3	100.0	50.0	74.3
	Observed	2.3	21.6	17.9	0.0	8.3	16.6
	Not stated	15.9	3.7	17.9	0.0	41.7	9.1
Healthcare workers unwilling to care for a patient who is a sex worker	Never observed	77.3	84.6	78.6	100.0	58.3	81.8
	Observed	4.5	12.3	3.6	0.0	41.7	9.1
	Not stated	18.2	3.1	17.9	0.0	0.0	9.1
Healthcare workers unwilling to care for a transgender patient	Never observed	75.0	81.5	78.6	100.0	58.3	79.4
	Observed	6.8	9.3	3.6	0.0	41.7	7.5
	Not stated	18.2	9.3	17.9	0.0	0.0	13.0
Healthcare workers providing poorer quality care to patients living with HIV than to other patients	Never observed	72.7	60.5	50.0	85.7	50.0	61.7
	Observed	11.4	34.6	28.6	0.0	8.3	27.7
	Not stated	15.9	4.9	21.4	14.3	41.7	10.7
Healthcare workers providing poorer quality care to a male patient who has sex with men	Never observed	75.0	73.5	67.9	100.0	58.3	73.1
	Observed	6.8	22.8	14.3	0.0	41.7	17.4
	Not stated	18.2	3.7	17.9	0.0	0.0	9.5
Healthcare workers providing poorer quality	Never observed	81.8	79.0	75.0	100.0	58.3	78.7
	Observed	0.0	14.8	7.1	0.0	0.0	10.3

Observed Practices		Support Administrative Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Position Not Given	Total
care to a patient who is a sex worker	Not stated	18.2	6.2	17.9	0.0	41.7	11.1
Healthcare workers providing poorer quality care to transgender patient	Never observed	72.7	80.2	75.0	100.0	50.0	77.5
	Observed	9.1	10.5	7.1	0.0	8.3	9.5
	Not stated	18.2	9.3	17.9	0.0	41.7	13.0
Healthcare workers talking badly about people living with HIV	Never observed	45.5	43.2	46.4	57.1	41.7	44.3
	Observed	34.1	53.1	32.1	42.9	16.7	45.5
	Not stated	20.5	3.7	21.4	0.0	41.7	10.3
Healthcare workers talking badly about a male patient who has sex with men	Never observed	45.5	38.3	57.1	42.9	25.0	41.1
	Observed	38.6	54.9	25.0	57.1	33.3	47.8
	Not stated	15.9	6.8	17.9	0.0	41.7	11.1
Healthcare workers talking badly about a patient who is a sex worker	Never observed	56.8	53.1	50.0	42.9	25.0	51.8
	Observed	27.3	40.7	32.1	42.9	33.3	37.2
	Not stated	15.9	6.2	17.9	14.3	41.7	11.1
Healthcare worker talking badly about a patient who is transgender	Never observed	59.1	56.8	60.7	42.9	41.7	56.5
	Observed	25.0	33.3	21.4	42.9	16.7	30.0
	Not stated	15.9	9.9	17.9	14.3	41.7	13.4

Table 2.5 Instances of Secondary Stigma Experienced by Job Category

Instances of Secondary Stigma		Support Administrative Staff	Medical Personnel	Cleaning/ Auxiliary staff	Pharmacist/ Technicians	Position Not Given	Total
Experienced people talking badly about you because you care for patients living with HIV	Sample size (n)	39	190	47	10	11	297
	Not worried	64.1	90.0	70.2	50.0	81.8	81.8
	Worried	23.1	7.4	14.9	50.0	18.2	12.5
	Not stated	12.8	2.6	14.9	0.0	0.0	5.7
Been avoided by friends because you care for patients living with HIV	n	41	182	45	10	10	288
	Not worried	63.4	82.4	64.4	80.0	80.0	76.7
	Worried	22.0	14.3	17.8	10.0	20.0	16.0
	Not stated	14.6	3.3	17.8	10.0	0.0	7.3
Been avoided by colleagues because you care for patients living with HIV	n	40	185	44	10	9	288
	Not worried	60.0	88.6	72.7	80.0	66.7	81.3
	Worried	25.0	7.6	13.6	10.0	22.2	11.5
	Not stated	15.0	3.8	13.6	10.0	11.1	7.3

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

Areas Identified		Support Administrative Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Position Not Stated	Total
Sample size (n)		58	175	60	11	11	315
How hesitant are healthcare workers in this facility to take an HIV test due to fear of other people's reactions if the test is positive?	Not hesitant	19.0	34.9	28.3	9.1	36.4	29.8
	Hesitant	69.0	62.9	65.0	81.8	63.6	65.1
	Not stated	12.1	2.3	6.7	9.1	0.0	5.1
How hesitant are healthcare workers in this facility to work alongside a coworker living with HIV, regardless of their duties?	n	55	153	58	11	9	286
	Not hesitant	29.1	34.0	36.2	9.1	33.3	32.5
	Hesitant	60.0	61.4	58.6	63.6	66.7	60.8
	Not stated	10.9	4.6	5.2	27.3	0.0	6.6
How hesitant do you think a healthcare worker living with HIV would be to seek healthcare in this facility?	n	64	184	66	12	13	339
	Not hesitant	15.6	18.5	21.2	8.3	15.4	18.0
	Hesitant	70.3	78.8	71.2	83.3	84.6	76.1
	Not stated	14.1	2.7	7.6	8.3	0.0	5.9
Areas Identified		Support Administrative Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Position Not Stated	Total
Sample size (n)		58	191	59	11	11	330
How hesitant are healthcare workers in this	Not hesitant	29.3	50.3	37.3	45.5	36.4	43.6
	Hesitant	56.9	46.6	55.9	54.5	63.6	50.9
	Not	13.8	3.1	6.8	0.0	0.0	5.5

Areas Identified		Support Administrative Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Position Not Stated	Total
facility to care for people living with HIV?	stated						
How hesitant are health care workers in this facility to care for men who have sex with men?	n	53	178	60	12	12	315
	Not hesitant	37.7	52.2	36.7	66.7	50.0	47.3
	Hesitant	50.9	46.1	56.7	16.7	41.7	47.6
	Not stated	11.3	1.7	6.7	16.7	8.3	5.1
How hesitant are health care workers in this facility to care for transgender persons?	n	50	167	55	12	10	294
	Not hesitant	42.0	61.1	36.4	66.7	50.0	53.1
	Hesitant	40.0	35.3	56.4	16.7	50.0	39.8
	Not stated	18.0	3.6	7.3	16.7	0.0	7.1
How hesitant are health care workers in this facility to care for sex worker	n	53	179	61	11	12	316
	Not hesitant	50.9	67.6	47.5	72.7	58.3	60.8
	Hesitant	34.0	30.7	45.9	18.2	33.3	33.9
	Not stated	15.1	1.7	6.6	9.1	8.3	5.4

Areas Identified		Support Administrative Staff	Medical Personnel	Cleaning/Auxiliary Staff	Pharmacist/Technicians	Position Not Stated	Total
s?							

Health Facility Policies

One-quarter (25.1%) of the staff members interviewed cited the presence of an anti-discrimination policy to protect patients living with HIV in their facility, with recall higher among administrative (28.9%) and medical staff (26.2%) and lower among auxiliary and related staff. It is worth noting that 44.7 percent of respondents were unaware of such a policy. Roughly half (50.8%) of the staff interviewed referenced the likelihood of ramifications for not following policies to protect patients living with HIV. However, unexpectedly, workers in a technical or pharmaceutical capacity (58.3%) and auxiliary staff (54.2%) made more reference to this outcome than medical personnel (51.4%). While variances among job classifications were not significant on this issue, it may be worth investigating further why a much higher level of caution is expressed by these workers. Consider Table 2.7 for a detailed breakdown.

Just over 34 percent of respondents indicated that post-exposure prophylactic medications were accessible at their facility, while 28.3 percent said their facility was without such access. Medical personnel (45.3%) were most aware of the availability of such medications, as opposed to non-medical staff (Table 2.7).

Based on the responses from interviews, health facilities were fairly well-supplied and possessed a supportive environment for staff providing care safely to patients living with HIV. This is supported by 53.6 percent of respondents who felt that facilities were adequately equipped to reduce the risk of becoming infected, and 60.9 percent who identified the presence of standard procedures to reduce such risks. Seven in ten workers (71.4 %) endorsed their responsibility to maintain the confidentiality of patients with HIV by responding affirmatively to the statement, “I would never test a patient for HIV without the patient’s informed consent.”

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

Statements on Policy and Environment		Support Administrative Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Position Not Stated	Total
Sample size (n)		83	214	96	12	22	427
I will get in trouble at work if I do not follow the policies to protect patients living with HIV.	Yes	50.6	51.4	54.2	58.3	27.3	50.8
	No	6.0	15.0	4.2	8.3	9.1	10.3
	Do not know	31.3	29.4	24.0	33.3	31.8	28.8
	Not stated	12.0	4.2	17.7	0.0	31.8	10.1
My health facility has policies to protect patients living with HIV from discrimination.	Yes	28.9	26.2	19.8	25.0	22.7	25.1
	No	18.1	24.3	16.7	33.3	22.7	21.5
	Do not know	42.2	46.7	47.9	33.3	27.3	44.7
	Not stated	10.8	2.8	15.6	8.3	27.3	8.7
There is access to post-exposure prophylactic medications in my health facility.	Yes	28.9	45.3	15.6	50.0	18.2	34.2
	No	27.7	29.4	27.1	25.0	27.3	28.3
	Do not know	33.7	21.5	40.6	25.0	27.3	28.6
	Not stated	9.6	3.7	16.7	0.0	27.3	8.9

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

Statements on Policy and Environment		Support Administrative Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Not Stated	Total
Sample size (n)		83	214	96	12	22	427
I would never test a patient for HIV without the patient's informed consent.	Agree	72.3	76.6	60.4	58.3	72.7	71.4
	Disagree	12.0	19.2	17.7	41.7	0.0	17.1
	Not stated	15.7	4.2	21.9	0.0	27.3	11.5
There are adequate supplies (e.g., gloves) in my health facility that reduce my risk of becoming infected with HIV.	Agree	60.2	55.1	42.7	83.3	45.5	53.6
	Disagree	25.3	39.7	33.3	16.7	22.7	34.0
	Not stated	14.5	5.1	24.0	0.0	31.8	12.4
At my health facility, there are standardized procedures/protocols that reduce my risk of becoming infected with HIV.	Disagree	62.7	70.1	40.6	75.0	45.5	60.9
	Agree	21.7	24.8	29.2	25.0	22.7	25.1
	Not stated	15.7	5.1	30.2	0.0	31.8	14.1

Opinions About People Living with HIV and Other Risk Groups

Respondents were asked to indicate their level of agreement with a number of statements and opinions about PLHIV. Roughly 62.8 percent agreed that most PLHIV do not care if they infect other persons, while far fewer (12.2%) believed that PLHIV should be ashamed of themselves.

Respondents were inclined to believe that persons contract HIV because they engage in irresponsible behaviours (50.4%) and consequently have many sexual partners (42.4%). This viewpoint was particularly accepted by those who operate in an auxiliary capacity and, surprisingly, those in a technical or pharmaceutical category of work—persons who are supposed to possess a more in-depth understanding of HIV transmission. On a positive note, only a minority (12.2%) were of the opinion that PLHIV should feel ashamed of themselves.

However, a clear majority (69.3%) opined that men decide that they want to be a man who has sex with other men. See Table 2.9.

Just under half (47.8%) of respondents indicated that they would be ashamed if they were to become infected with HIV, while even higher percentages were likely to express shame if one of their relatives were to be infected (66.5%). Medical and related staff members were more inclined to express shame than the lower-level staff (Table 2.10).

Related in general to the provision of health and other services to selected high-risk groups, staff members were not in favour of withholding services from these groups. For example, 26.7 percent and 16.6 percent of respondents preferred to not provide service to MSM and transgender patients, while just 13.8 percent were not prepared to provide service to sex workers. These values were reported as being the lowest among medical personnel and higher among auxiliary and technical staff (Table 2.11).

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

Opinions Related to People Living With HIV		Support Administrative Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Not Stated	Total
Sample size (n)		83	214	96	12	22	427
Most PLHIV do not care if they infect other people.	Agree	55.4	61.7	71.9	66.7	59.1	62.8
	Disagree	36.1	34.1	25.0	25.0	36.4	32.3
	Not stated	8.4	4.2	3.1	8.3	4.5	4.9
PLHIV should feel ashamed of themselves.	Agree	7.2	6.1	30.2	16.7	9.1	12.2
	Disagree	91.6	90.7	66.7	75.0	90.9	85.0
	Not stated	1.2	3.3	3.1	8.3	0.0	2.8
Most people living with HIV have had many sexual partners.	Agree	32.5	34.6	67.7	58.3	36.4	42.4
	Disagree	63.9	62.1	30.2	33.3	63.6	54.6
	Not stated	3.6	3.3	2.1	8.3	0.0	3.0
People get infected with HIV because they engage in irresponsible behaviours.	Agree	41.0	42.5	72.9	66.7	54.5	50.4
	Disagree	55.4	54.7	24.0	25.0	40.9	46.4
	Not stated	3.6	2.8	3.1	8.3	4.5	3.3
HIV is punishment for bad behaviour.	Agree	6.0	9.8	42.7	8.3	13.6	16.6
	Disagree	90.4	86.4	55.2	91.7	86.4	80.3
	Not stated	3.6	3.7	2.1	0.0	0.0	3.0
Most people living with HIV are homosexual.	Agree	13.3	11.7	32.3	8.3	9.1	16.4
	Disagree	81.9	83.6	62.5	83.3	86.4	78.7
	Not stated	4.8	4.7	5.2	8.3	4.5	4.9
Men decide or learn that they want to be a man who has sex with other men.	Agree	61.4	70.1	74.0	66.7	72.7	69.3
	Disagree	27.7	22.9	19.8	16.7	22.7	23.0
	Not stated	10.8	7.0	6.3	16.7	4.5	7.7

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

Opinions About Becoming Infected With HIV		Support Administrative Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Not Stated	Total
Sample size (n)		83	214	96	12	22	427
I would be ashamed if I were infected with HIV.	Yes	51.8	45.3	56.3	25.0	31.8	47.8
	No	42.2	48.1	36.5	75.0	63.6	45.9
	Not stated	6.0	6.5	7.3	0.0	4.5	6.3
I would be ashamed if someone in my family were infected with HIV.	No	30.1	22.4	47.9	25.0	9.1	29.0
	Yes	65.1	73.4	49.0	66.7	81.8	66.5
	Not stated	4.8	4.2	3.1	8.3	9.1	4.4

Table 2.11 Opinions Related to Providing Services to At-Risk Populations by Job Category

Opinions Related to Providing Services to at Risk Populations		Support Administrative Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Not Stated	Total
I would prefer not to provide services to men who have sex with men.	Sample size (n)	83	214	96	12	22	427
	Agree	22.9	20.6	39.6	58.3	27.3	26.7
	Disagree	68.7	74.8	50.0	41.7	54.5	66.0
	Not stated	8.4	4.7	10.4	0.0	18.2	7.3
I would prefer not to provide services to sex workers.	Agree	10.8	11.7	20.8	25.0	9.1	13.8
	Disagree	71.1	79.9	66.7	58.3	63.6	73.8
	Not stated	18.1	8.4	12.5	16.7	27.3	12.4
I would prefer not to provide services to transgender persons.	Agree	12.0	9.8	35.4	25.0	13.6	16.6
	Disagree	80.7	80.8	50.0	58.3	68.2	72.6
	Not stated	7.2	9.3	14.6	16.7	18.2	10.8

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

This section specifically addressed service providers who work with pregnant women in antenatal care, prevention of mother-to-child transmission, and delivery. On the issue of assisting a woman living with HIV in labour and delivery, most respondents chose to withhold their opinion (64%), with 26.2 percent of medical staff expressing some degree of worry and the minority (9.8%) having no trepidations with assisting with delivery.

Medical personnel were next asked whether they had ever observed certain procedures by other providers at their health facility. When considering these acts, respondents all agreed that they were infrequent, with just 1.4 percent citing instances of a woman living with HIV being neglected during labour and 5.6 percent having observed an HIV test administered to a pregnant woman without her consent. One reason behind these reported statistics could be the larger number of medical personnel using additional infection control measures with a pregnant woman living with HIV during labour (22.9%).

In the analysis, one must note the fact that roughly half of respondents chose not to answer all the sub-questions within this question (Q.34) of the survey. These data are captured in Table 2.13.

Respondents were then asked to indicate the extent to which they agreed with statements pertaining to pregnant women who were living with HIV. Roughly half of respondents (47.7%) agreed that pregnant women who refuse HIV testing are irresponsible, with 35.5 percent supporting the view that women living with HIV should not get pregnant if they already have children. A similar number (32.7%) also shared the opinion that if a pregnant woman is HIV-positive, her family has the right to know.

The area with the least support relates to sterilization—only 11.7 percent believed that it can be appropriate to sterilize a woman living with HIV, even if this is not her choice. Unfortunately, this area of the survey also experienced almost 50 percent of respondents declining to answer all questions. A more detailed breakdown of these data can be found in Table 2.14.

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

Statement		Medical Personnel
Sample size (n)		347
The woman is living with HIV	Not worried	9.8
	Worried	26.2
	Not stated	64.0

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

Observations		Medical Personnel
Sample size (n)		214
Performing an HIV test on a pregnant woman without informed consent	Never observed	47.2
	Observed	5.6
	Not stated	47.2
Neglecting a woman living with HIV during labour and delivery because of her HIV status	Never observed	50.0
	Observed	1.4
	Not stated	48.6
Using additional infection control procedures with a pregnant woman living with HIV during labour and delivery because of her HIV Status	Never observed	26.6
	Observed	22.9
	Not stated	50.5
Disclosing the status of a pregnant woman living with HIV to others without her consent	Never observed	42.1
	Observed	9.8
	Not stated	48.1
Making HIV treatment for a woman living with HIV conditional on use of family planning methods	Never observed	40.2
	Observed	8.4
	Not stated	51.4

Table 2.14 Levels of Agreement with Selected Statements By Job Category

Statements		Medical Personnel
Sample size (n)		214
If a pregnant woman is HIV-positive, her family has a right to know.	Agree	32.7
	Disagree	21.0
	Not stated	46.3
Pregnant women who refuse HIV testing are irresponsible.	Agree	47.7
	Disagree	6.5
	Not stated	45.8
Women living with HIV should not get pregnant if they already have children.	Agree	35.5
	Disagree	17.8
	Not stated	46.7
It can be appropriate to sterilise a woman living with HIV, even if this is not her choice.	Agree	11.7
	Disagree	42.5
	Not stated	45.8

LIMITATIONS

Several limitations to this study affected sample selection and data collection.

Sample Selection

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

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

DISCUSSION AND RECOMMENDATIONS

Discussion

This study sought to measure S&D in healthcare facilities in Antigua and Barbuda, and provides an evidence base for a comprehensive approach to achieving stigma-free health services.

To facilitate a participatory analysis process and collective development of the recommendations based on the data, a workshop was conducted on May 8, 2015 with key health sector stakeholders in Antigua and Barbuda. During the one-day workshop, stakeholders worked in small groups of five to seven participants to review summary data tables and discuss their implications, as well as possible strategies to respond to the findings. They then presented their deliberations back to the larger group, including specific recommendations for action. The larger group discussed and reached a consensus about these recommendations, which were documented by a note-taker. Written recommendations documented in the workshop were again vetted with the in-country project focal point and lead. The discussion and recommendations developed during the workshop provided the basis for developing the country-led strategy for planning to reduce stigma in health facilities.

Recommendations

Infection control

In the area of infection control, some degree of displeasure was expressed with the significant percentage of healthcare workers who expressed concern about less invasive procedures such as taking the temperature of a client, or engaging in such acts as double gloving while providing services to key populations. The key recommendations highlighted under this heading include

1. The need for training, building on initiatives such as the UWI CHART programme of training on Stigma and Discrimination for Health Care Providers. These training programmes should cover such topics as
 - a. HIV transmission basics
 - b. HIV care and management; this can be incorporated into existing programs already in place
 - c. Universal precautions for all staff on a rotation basis
2. Conducting annual refresher trainings for management (with pre- and post-test) to assess what was learned, followed by an annual internal survey questionnaire to see if an enabling environment is there.
3. Ensure that Mount St. Johns reinforces policies and standards related to universal precautions and infection control in management protocol by including these areas in in-service sessions, or in the existing Mount St. Johns or AIDS Secretariat.
4. Review the current system and existing training programmes to ensure that they can accommodate various cadres of healthcare workers.

Health facility environment

Participants felt that the general level of hesitancy displayed towards the provision of care should have been lower among professionals. On the basis of job category, it was also felt that the degree of hesitancy displayed by medical professionals—because of expected training and code of practice—was too high. Among the key recommendations suggested here are

1. The need for a programme of training with modules on gender for all categories of workers in the health system
2. Emphasis should be placed on a code of ethics to guide the actions of healthcare workers going forward
3. The process by which this is developed should involve a wider national discussion on values clarification that will feed into the development of the code

Health policy

Participants recognized that a significant number of healthcare workers were unaware of the presence of a health policy in their facility. The recommendations here are

1. A desk review of current policies and guidelines addressing S&D on HIV should be conducted. The findings of this review should be used to inform an updated set of policies based on regional and international standards.
2. Develop legislation to support the policies with accompanying sanctions for violation of the practices spelled out in the policies.
3. Create a level of awareness about this process throughout the health sector.
4. Educate healthcare workers regarding the use and availability of PeP for persons who may be exposed.

Opinions regarding PLHIV and key populations

In general, it was acknowledged that opinions related to PLHIV and other key populations were mixed, with more negative opinions coming from lower-level staff who may be less informed on the issues pertaining to HIV and AIDS.

The recommendations going forward suggest that

1. A programme of training must be initiated to include the non-clinical and lower-level categories of workers in the health system.
2. There is a need to embark on client satisfaction surveys to gauge feedback on the quality of care being delivered. This would be used to inform the programme of training and to track improvement in the quality of care provided over time.

Pregnant women

The high percentage of respondents who did not respond to this question reflected a general reluctance to highlight any negatives associated with the programme in the country. The key recommendations identified under this heading involved the following:

1. The need for legislation supporting S&D (programs, activities, practices ...) to protect staff and clientele. Rules and regulations exist but are not practiced, and legislation can work to facilitate the enforcement of rules and policies to better address anti-S&D strategies.
2. The establishment of a unit responsible for safeguarding welfare (ethics S&D, human rights) of staff and clientele of the Ministry of Health.
3. Programs, activities, and practices addressing matters concerning S&D should be a focus of institutions (stimulate/motivate)
 - a. Codes of ethics
 - b. Rules

4. Training among all categories of staff, applying appropriate components of S&D and related discipline:
 - a. Change in culture
 - b. Change in environment

ANNEX: RESPONDENT NUMBERS BY QUESTION

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

	Not Worried	A Little Worried	Worried	Very Worried	Not Stated
Touched the clothing of a patient living with HIV	79.0	12.9	2.4	2.7	3.0
Dressed the wounds of a patient living with HIV	43.4	25.4	12.5	12.9	5.9
Drew blood from a patient living with HIV	39.8	24.5	12.9	14.5	8.3
Took temperature of a patient living with HIV	83.3	7.8	1.9	1.9	5.2
Gave an injection to a patient living with HIV	45.5	24.0	9.5	11.2	9.9

Table 4.2 Precautionary Measures Adopted (By Percentage) Q10

Statements	Yes	No	Not Stated
Avoid physical contact when providing care/services for a patient living with HIV	17.1	82.9	0.0
Wear double gloves when providing care/services for a patient living with HIV	46.4	45.6	8.0
Wear gloves during all aspects of the patient's care when providing care/services for a patient living with HIV	49.4	42.8	7.7
Use other measures when providing care/services for a patient living with HIV	43.8	46.1	10.1

Table 4.3 Observed Practices in Health Facility (By Percentage) Q12

	Never	Once or Twice	Several Times	Most of the Time	Not Stated
Health facility staff unwilling to care for a patient living with HIV	62.8	15.8	8.7	4.3	8.3
Health facility staff unwilling to care for a male patient who has sex with men	74.3	9.9	4.3	2.4	9.1
Health facility staff unwilling to care for a male patient who is a sex worker	81.8	5.1	2.4	1.6	9.1
Health facility staff unwilling to care for a transgender patient	79.4	4.7	0.4	2.4	13.0
Health facility staff providing poorer-quality care to a patient living with HIV than to other patients	61.7	13.4	10.7	3.6	10.7
Health facility staff providing poorer-quality care to a male patient who has sex with men	73.1	12.3	3.2	2.0	9.5
Health facility staff providing poorer-quality care to a patient who is sex worker	78.7	6.7	2.0	1.6	11.1
Health facility staff providing poorer-quality care to a transgender patient	77.5	4.0	2.4	3.2	13.0
Healthcare workers talking badly about people living with HIV	44.3	29.2	11.9	4.3	10.3

	Never	Once or Twice	Several Times	Most of the Time	Not Stated
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Healthcare workers talking badly about a male patient who has sex with men	41.1	25.7	17.4	4.7	11.1
Healthcare workers talking badly about a patient who is a sex worker	51.8	24.1	9.1	4.0	11.1
Healthcare workers talking badly about a patient who is transgender	56.5	17.8	9.1	3.2	13.4

Table 4.4 Instances of Secondary Stigma Experienced (By Percentage) Q13

	Not Worried	A Little Worried	Worried	Very Worried	Not Stated
Experienced people talking badly about you because you care for patients living with HIV	81.8	6.1	3.7	2.7	5.7
Been avoided by friends and family because you care for patients living with HIV	76.7	7.3	5.2	3.5	7.3
Been avoided by colleagues because of your work caring for patients living with HIV	81.3	4.5	3.8	3.1	7.3

Table 4.5 Hesitancy of Healthcare Workers in an HIV Environment (By Percentage) q14–q20

	Not Hesitant	A Little Hesitant	Somewhat Hesitant	Very Hesitant	Not Stated
Hesitancy of healthcare workers to take HIV test in facility for fear of people's reaction if test is positive	29.8	22.2	22.9	20.0	5.1
Hesitancy of healthcare workers to work alongside coworker living with HIV	32.5	23.8	22.0	15.0	6.6
Hesitancy of healthcare worker living with HIV to seek healthcare in this facility	18.0	15.6	14.2	46.3	5.9
	Not Hesitant	A Little Hesitant	Somewhat Hesitant	Very Hesitant	Not Stated
Hesitancy of healthcare workers to care for people living with HIV	43.6	25.5	13.6	11.8	5.5

Hesitancy of coworkers to care for men who have sex with men	47.3	20.6	12.4	14.6	5.1
Hesitancy of coworkers to care for transgender persons	53.1	16.3	12.9	10.5	7.1
Hesitancy of coworkers to care for sex workers	60.8	17.4	10.1	6.3	5.4

Table 4.6 Views on Policy and Work Environment in the Facility (By Percentage) q22, q24, q25

	Yes	No	Do Not Know	Not Stated
Will get in trouble at work If I discriminate against patients with HIV	50.8	10.3	28.8	10.1
Health facility has written guidelines to protect patients living with HIV from discrimination	25.1	21.5	44.7	8.7
Have access to post-exposure prophylactic medications in your health facility	34.2	28.3	28.6	8.9

Table 4.7 Levels of Agreement with Statements on Policy and Environment (By Percentage) Q23a, Q23b, Q21, and Q27

	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Stated
Adequate supplies in health facility to reduce my risk of becoming infected with HIV	19.0	34.7	24.6	9.4	12.4
Standardized procedures/ protocols in my health facility that reduce my risk of becoming infected with HIV	20.6	40.3	16.9	8.2	14.1
Not allowed to test patient for HIV without his/her knowledge	47.3	24.1	11.9	5.2	11.5
Women living with HIV should be allowed to have babies	8.2	35.8	29.5	22.2	4.2

Table 4.8 Opinions Related to People Living with HIV (By Percentage) Q26

	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Stated
Most people living with HIV do not care if they infect other people	29.0	33.7	29.0	3.3	4.9
People living with HIV should feel ashamed of themselves	4.2	8.0	48.0	37.0	2.8
Most people living with HIV have had many sexual partners	17.1	25.3	37.0	17.6	3.0
People get infected with HIV because they engage in irresponsible behaviors	20.4	30.0	34.7	11.7	3.3
HIV is punishment for bad behavior	5.6	11.0	36.3	44.0	3.0
Most people living with HIV are homosexual	5.4	11.0	45.2	33.5	4.9
Men decide or learn that they want to be a man who has sex with other men	31.9	37.5	15.0	8.0	7.7

Table 4.9 Opinions About Becoming Infected with HIV (By Percentage) Q28, q29

	Yes	No	Not Stated
I would be ashamed if I were infected with HIV.	47.8	45.9	6.3
I would be ashamed if someone in my family were infected with HIV.	29.0	66.5	4.4

Table 4.10 Opinions Related To Providing Services to At-Risk Populations (by percentage) 30a, 31a, 32a

	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Stated
I would prefer not to provide services to MSM.	15.5	11.2	36.3	29.7	7.3
I would prefer not to provide services to sex workers.	7.5	6.3	42.9	30.9	12.4
I would prefer not to provide services to transgender people.	8.4	8.2	40.7	31.9	10.8

Table 4.11 Worry Associated with Assisting with Delivery (by percentage) q33

	Not Worried	A Little Worried	Worried	Very Worried	Not Stated
The woman is living with HIV.	9.8	10.7	8.4	7.2	64.0

Table 4.12 Observations over Past 12 Months (by percentage) q34

	Never	Once or Twice	Several Times	Most of the Time	Not Stated
Performing an HIV test on a pregnant woman without informed consent	36.8	2.6	0.7	0.9	59.0
Neglecting a woman living with HIV during labour and delivery because of her HIV status	39.3	0.2	0.2	0.5	59.7
Using additional infection control procedures with a pregnant woman living with HIV during labour and delivery because of her HIV status	23.4	4.7	3.7	7.3	60.9
Disclosing the status of a pregnant woman living with HIV to others without her consent	33.5	5.2	1.2	0.5	59.7
Making HIV treatment for a woman living with HIV conditional on use of family planning methods	32.1	1.4	1.9	2.6	62.1

Table 4.13 Levels of Agreement with Selected Statements (by percentage) q35

	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Stated
If a pregnant woman is HIV positive, her family has a right to know.	10.1	19.4	8.2	5.4	56.9
Pregnant women who refuse HIV testing are irresponsible.	20.4	17.8	3.7	1.6	56.4
Women living with HIV should not get pregnant if they already have children.	14.8	15.5	9.6	2.8	57.4
It can be appropriate to sterilise a woman living with HIV, even if this is not her choice.	5.2	6.6	17.1	13.8	57.4

