



# RAPID ASSESSMENT OF THE JAMAICA KEY POPULATIONS CHALLENGE FUND (KPCF) STIGMA-REDUCTION TRAINING



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# Rapid Assessment of the Jamaica Key Populations Challenge Fund (KPCF) Stigma-reduction Training

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## **ABBREVIATIONS**

CCM	client complaint mechanism
HIV	human immunodeficiency virus
HPP	Health Policy Project
HP+	Health Policy Plus
HTC	HIV testing and counseling
J-FLAG	Jamaican Forum of Lesbians, All-Sexuals and Gays
JN+	Jamaican Network of Seropositives
KP	key population
KPCF	Key Populations Challenge Fund
MOH	Ministry of Health
MSM	men who have sex with men
NFPB	National Family Planning Board
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
RHA	regional health authority
S&D	stigma and discrimination
TOT	training of trainers
USAID	United States Agency for International Development



# INTRODUCTION

## Background

The HIV epidemic in Jamaica disproportionately affects gay people, other men who have sex with men (MSM), transgender persons, female and male sex workers and their clients, and young people. For example, MSM in Jamaica are up to 20 times more likely to be living with HIV than people in the general population: an HIV prevalence rate of 33 percent (UNAIDS, 2014), compared to 1.6 percent among all adults ages 15–49 (UNAIDS, 2016). These populations are particularly vulnerable to stigma and discrimination (S&D) (White and Carr, 2005; Rogers et al., 2014; Figueroa et al., 2015).

Stigma and discrimination (S&D)—whether related to HIV, sexual orientation, or gender identity—is increasingly shown to hamper efforts to improve HIV testing, linkage to and retention in care, and (ultimately) viral suppression (Heunis et al., 2011; Katz et al., 2013; Musheke et al., 2013; Govindasamy et al., 2014; WHO, 2014; Parsons et al., 2015; UNAIDS, 2015). S&D in healthcare facilities—for example, experiencing, perceiving, or fearing refusal of care; sub-standard care; being made to wait longer than other patients; unnecessary referrals; judgmental attitudes; and involuntary disclosure (Mahendra et al., 2007; Nyblade et al., 2009; Ekstrand et al., 2012; Feyissa et al., 2012; Ekstrand et al., 2013; Nyblade et al., 2013; Pulerwitz et al., 2014)—is particularly detrimental. Two decades of stigma research and programming has demonstrated that it is feasible, particularly in health facilities, to measure and reduce stigma through interventions that address the social constructs that drive stigma (immediately actionable drivers) (Nyblade, 2006; Mahajan et al., 2008; Nyblade et al., 2013; Stangl et al., 2013). These include fear of transmission, awareness of stigma, attitudes, and healthcare facility environment (Nyblade et al., 2009; Li et al., 2013a; Li et al., 2013b; Li et al., 2014; Lohiniva et al., 2016).

In light of these challenges and innovations, the Key Populations Challenge Fund (KPCF) project aimed to improve the quality of and access to stigma-free HIV testing and counseling (HTC) services for key populations. The KPCF project was a joint interagency initiative between the Centers for Disease Control and Prevention, with ICF International acting as implementing partner focusing on HTC; and USAID, who partnered with the Health Policy Project (HPP) to implement the project’s stigma reduction component. Through this initiative, HPP delivered two-day stigma-reduction trainings between February and April 2015 to three health facilities in Jamaica: St. Jago Park Health Center in South East Region, Port Antonio Health Centre in North East Region, and Mandeville Health Center in Southern Region (see summary workshop agenda, page 2). The training curriculum was adapted from a longer training (Health Policy Project, 2013) designed for the Caribbean region (Health Policy Project, 2016). HPP organized a “training of trainers” (TOT) to equip a group of in-country facilitators to roll out the training and identify any necessary adaptations to the curriculum. The TOT engaged 11 individuals from government and civil society organizations, including Jamaica AIDS Support for Life, J-FLAG (formerly known as the Jamaican Forum of Lesbians, All-Sexuals and Gays), National Family Planning Bureau (NFPB), SANKOFA Arts & Facilitation, and Caribbean HIV/AIDS Regional Training. Each of the 11 participating individuals had previous experience providing training for their respective organizations or providing S&D-related trainings to their constituencies. Engaging these individuals allowed the study team to both learn from their experience and identify a core cadre of trainers to implement the project. Four of the trained facilitators were ultimately selected based on their availability and particular expertise in stigma reduction, gender identity, and/or sexual orientation. These facilitators delivered the revised training to both clinical and non-clinical healthcare facility staff (e.g., doctors and nurses, as well as medical

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records clerks, porters, etc.). The training employed a participatory methodology; facilitators guided healthcare facility staff through a series of interactive exercises and learning sessions designed to promote empathy and understanding of the causes, consequence, and forms of stigma faced by vulnerable populations, with a particular focus on MSM and transgender persons. In total, eight trainings were delivered and 169 healthcare facility staff members were trained (see Table 1, next page).

Summary of the KPCF Training Workshop Agenda	
Day 1	<b>Session 1</b> (Welcome and Warm-up; Introduction, Pre-Course Assessment, Hopes and Fears, Objectives; Naming Stigma and Discrimination Through Pictures, and Identifying Stigma in Personal Contexts)
	<b>Session 2</b> (Naming Stigma and Discrimination in the Health Facility, and the Effect of Stigma on the HIV Epidemic; Reflecting on Our Own Experience of Being Stigmatized)
	<b>Session 3</b> (The Blame Game; Breaking the Sex Ice: Anonymous Sex Survey; Interview Skills Practice: Talking About Sex; Discussions of Our Agreed Upon Norms and Practices for the Health Facility Setting)
<b>Homework: Key Population Questionnaire True/False</b>	
Day 2	<b>Session 4</b> (Warm-up; Homework Review; Our Multiple Social Identities; Understanding the Concepts of Gender and Sexual Diversity)
	<b>Session 5</b> (Understanding Different Identities; Exploring Beliefs and Attitudes)
	<b>Session 6</b> (Confidentiality; Understanding KP Panel Discussion; Review and Discussion of our Health Facility Environment Norms and Practices; Post-Course Assessment)

**Table 1: Snapshot of KPCF Trainings**

	Number of Trainings	Number of Persons Receiving Any Training	Number of Persons Completing the Training	% of Healthcare Facility Staff Receiving Any Training* <sup>l</sup>	% of Healthcare Facility Staff Trained Who Completed the Training <sup>l</sup>
Port Antonio Health Centre	3	50 (4 clinical <sup>^</sup> , 46 non-clinical)	40	67%	53%
St. Jago Park Health Centre	3	64 (22 clinical <sup>^</sup> , 42 non-clinical)	56	85%	75%
Mandeville Comprehensive Health Centre	2	55 (24 clinical <sup>^</sup> , 31 non-clinical)	46	92%	77%
<b>Total</b>	<b>8</b>	<b>169</b>	<b>142</b>	<b>80%</b>	<b>68%</b>

\*Training participants who were present for at least one day of training

<sup>l</sup>The denominator for each healthcare facility is the total number of staff at that facility, as provided by the facility administrator

<sup>^</sup>Clinical staff included doctors and nurses

The training was also designed to allow staff to create a code of conduct or practice that would ultimately be made into posters for display throughout their healthcare facilities. The code of conduct was intended to help staff come together—after gaining some common level of understanding of S&D—to develop a standard that enables a welcoming, professional, non-discriminatory healthcare facility environment. At the outset of the training, the facilitators explained this goal to participants, asking them to think about their expectations (from both themselves and their clients) to ensure a stigma-free environment. Following each activity or session, participants captured the key themes related to S&D faced when key populations attempt to access care, and considered how these barriers could be addressed. Staff were also encouraged to consider existing health facility policies that affect the quality and uptake of services for key populations. Each training cohort developed its own code of conduct. After all trainings were completed, project staff found that all final codes of conduct were similar and decided to combine them into one singular product. The code of conduct was then finalized, incorporated on posters containing a picture of healthcare facility staff in uniform, and delivered to facilities between January and April 2015 (see Figure 1, next page). These posters serve as a reminder to healthcare facility staff and inform clients of their own expectations.

## Purpose

In preparation for additional programmatic roll-out and evaluation of S&D-reduction activities beyond these three healthcare facilities under PEPFAR and USAID funding, Health Policy Plus (HP+) conducted a rapid retrospective qualitative assessment of the KPCF stigma-reduction intervention. This rapid review aimed to elicit insights into which elements of the intervention worked well, which did not, and how the approach and materials could be improved for future roll-out of S&D reduction activities in healthcare facilities. Findings from the rapid assessment are presented in this summary report.

## Methodology

Before embarking on this activity, the assessment team informed the senior medical officer of health in the Ministry of Health's (MOH) HIV/STI/TB unit of the assessment objectives and requested permission to conduct the assessment. Upon obtaining her approval, the study team held meetings with senior staff from all three relevant regional health authorities (RHAs) to inform them of the assessment and obtain their support. The three healthcare facility administrators, as well as all trainers and panelists, were contacted and invited to participate in the rapid assessment. The administrators were further asked to select five to seven training participants (approximately 10% of the total number of healthcare facility staff trained at each facility) to provide feedback in one-on-one semi-structured interviews as key informants. The NFPB and all three RHAs were also contacted due to their involvement in organizing the stigma-reduction trainings and finalizing the code of conduct. In an effort to elicit the client-side perspective, representatives from the Jamaican Network of Seropositives (JN+) were invited to participate. Representatives from J-FLAG were also contacted and invited to share their insights from rolling out and assessing a similar stigma-reduction training implemented under their "Mitigating Risks and Enabling Safe Public Health Spaces for LGBT Jamaicans" project. The Mitigating Risks project had a similar mandate to the KPCF project; both efforts were implemented as complements to one another in an effort to optimize resources and facilitate the spread of S&D reduction across the country.

Figure 1: Code of Conduct Poster



**Table 2: Key Informant Interviews**

Training participants	
Women	13
Men	5
Healthcare facility administrators	
Trainers	3
Panelists	
HPP/HP+ staff	2
MOH	1
NFPB	2
RHA	2
JN+	5
J-FLAG	2
<b>Total</b>	<b>40</b>

The assessment team then drafted interview guides designed to meet the following objectives:

- Gauge how the training was received
- Assess whether the training was perceived to have made a positive difference
- Explore the strengths and weaknesses of the training
- Discuss avenues for improving the training

The interview guides all followed a similar format, though separate guides were created for the panelists, trainers, healthcare facility staff, healthcare administrators, and each group of key stakeholders.

All interviews were conducted in a secluded location at the Palladium office, at the interviewee's office, or on the healthcare facility grounds. Prior to conducting interviews, the interviewer described the objectives of the rapid assessment and explained that participation was voluntary. If potential interviewees agreed, they took part in a one-on-one 20–40-minute interview. The interviewer took notes throughout interviews, recording the gender and title of each healthcare facility staff member but no other identifying information. No assessment participants received any compensation for their participation, but panelists received a travel reimbursement of JA\$1,500.

A total of 40 interviews were conducted as part of this rapid assessment (see Table 2, above). At the healthcare facilities, a total of 18 training attendees were interviewed—just over 10 percent of the total healthcare facility staff members trained. These 18 staff participants were comprised of both men and women, and included both clinical (doctors and nurses) and non-clinical staff (community health aids, orderlies, attendants, medical records clerks, contact investigators, etc.) (see Table 3, next page). Two individuals selected by the healthcare facility administrators as interviewees for the assessment had attended different stigma-reduction trainings, while one individual declined to be interviewed without providing a reason for the refusal. Any information captured from these partial interviews was excluded, and the interviews are not included among the 18 total interviews conducted under this assessment. Three of the four trainers and two of the four panelists were also available for interview. The following key

stakeholders were also interviewed: the senior medical officer of health of the MOH’s National HIV/STI Programme; the director of the Enabling Environment and Human Rights unit of the NFPB; the coordinator for the Greater Involvement of Persons Living with HIV and AIDS unit of the NFPB; two representatives from Southern and North East RHAs; the board president, a project manager, the Southern regional representative, and the North East and South East regional JN+ officers for the National HIV-related Discrimination Reporting and Redress System<sup>1</sup>; two health program coordinators from J-FLAG; and two HPP/HP+ project staff.

**Table 3: Healthcare Facility Staff Participant Characteristics (N=18)**

	North East (n=4)	South East (n=9)	Southern (n=5)
Clinical <sup>^</sup>	0	3	2
Non-clinical	4	6	3

<sup>^</sup>Clinical staff included doctors and nurses

This rapid assessment has several limitations. The exercise was a rapid, qualitative assessment yielding data from a limited number of healthcare facility staff and key stakeholders and should be interpreted as such. The assessment was conducted over a year after the training took place. Many healthcare facility staff, panelists, and trainers noted they were struggling to remember the specifics of the training and, while they remembered making specific suggestions or critiques, they could no longer recall those details. The South East Region RHA was unavailable and representatives from the other two RHAs stood in for the individuals involved with the training, so these interviewees were less familiar with the specifics of the training. While efforts were made to capture the client-side perspective through interviews of regional JN+ representatives and redress system officers, these efforts yielded limited insight, as these were not actual clients and had not personally received any feedback from key population (KP) clients accessing care from those specific healthcare facilities. Given the nature of this assessment, it was not possible to interview actual clients of specific facilities. Additionally, the researchers had to rely on facilities to select and approach staff interviewees, which may have created a response bias. While the study team was able to interview a breadth of gender and staff cadres, team members were unable to interview any of the 18 trainees who chose to leave the training early or refused to return for the second day. All interviewees from Port Antonio selected for interview in the assessment were those who had volunteered to be pictured in the code of conduct poster. Despite these limitations, the assessment generated several key insights into the training that will help strengthen future S&D-reduction approaches in health facilities.

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<sup>1</sup> The National HIV-related Discrimination Reporting and Redress System is managed by JN+ with funding from USAID and the MOH. Each RHA has a separate reporting system called the client complaint mechanism.

## RESULTS

Key themes emerging from the interviews and discussions included

- Insight into the value or appreciation of this stigma-reduction training
- An assessment of how the training was received and what healthcare facility staff gained from the training
- The training's strengths
- Recommendations for improving the training
- Opportunities for further investment in stigma-reduction

### The Value of Facility-level Stigma-reduction Training

Conversations with key stakeholders and healthcare facility staff confirmed that S&D-reduction training in facilities is largely seen as important and valuable. One facility administrator remarked

*"In training, persons were asked to confront the reality that there are people with different preferences from their own who are seeking care and if we don't provide a safe space for them it will be deleterious to their health and deleterious to our health because it is fueling the epidemic."*

Another administrator stated

*"I think it is [valuable], this is a group that needs to be cared for, we usually see them after something horrendous has happened, but [if they are encouraged to seek care and do come] then this training is important in terms of what we say and how we say it."*

Stakeholders recognized that key population-related S&D is a problem and a barrier to care. The MOH medical officer felt it important to build awareness of key population issues *"based on our societal norms, important for our healthcare providers to be cognizant of their subliminal views."*

Sensitizing healthcare facility staff—either through stigma-reduction training or other means of sensitization—was recognized as an avenue to address S&D and reduce a barrier to care.

### Training Reception

In general, both the training and the code of conduct posters seemed to be well-received by healthcare facility staff. All facility staff interviewed stated that they enjoyed the training as a whole. One non-clinical staff member said, *"Honestly, this was the best workshop I've ever attended."*

However, some staff and administrators admitted that not all staff members were pleased about attending the training, and that some felt uncomfortable talking about these topics. All facility staff members interviewed for this assessment stated that they liked the code of conduct posters, for the following reasons:

- The posters show unity across cadres of staff

- The code of conduct set expectations for facility staff on how to treat clients, and for clients on treating staff and other patients
- The posters provide clients with a mechanism to complain or report disclosure issues

Interviewees also generally felt that the training was put together well and felt that most of their colleagues benefited from and enjoyed the training.

The training was designed to facilitate healthcare facility staff in exploring S&D and in considering their own (and society's) biases toward the groups most affected by S&D. It was also meant to help facility staff in understanding what stigmatizing behavior looks like in the healthcare facility setting, and how it can be avoided. Staff members clearly gained an understanding of stigma directed at key populations, and the training helped many of them feel more comfortable interacting with these vulnerable groups.

After the training, the importance of treating everyone respectfully seemed to override biases for many interviewees. A clinical staff member stated, *"I don't accept their lifestyle, but I have to treat them the same as other patients."*

When asked about what they had learned, some staff members specifically described learning that certain phrases and names were stigmatizing. While none of the interviewees personally witnessed any changes in behaviors or attitudes, many articulated that the training helped them better understand S&D faced by key populations and made them feel more comfortable interacting with and providing care to these populations. As one clinical staff member described

*"It did help me because ... what I think it helped to do was show how hard it was for these individuals. It made me more compassionate ... I'm more aware of the tone of voice, my body language, questions I ask, how I ask them. [For example] Now when I speak about a partner I just say 'partner' instead of he or she."*

## Strengths

Several key aspects and sessions of the training were mentioned as particularly important to the success of the training, or described as especially meaningful to facility staff. The panel discussion was the most memorable component for facility staff by far. Staff members repeatedly described this session as very interesting and eye-opening.

- Non-clinical staff member: *"I was really struck by their stories, they were so sad."*
- Facility administrator: The panel discussion showed *"they [key populations] just want to be treated like normal people."*

The trainers agreed, insisting that this was by far the most important/powerful session. The panelists also agreed and noted that they enjoyed participating in the training. While one panelist admitted to being scared and nervous, they ultimately found the experience very rewarding:

*"I wanted to be a person who makes a difference, I want to be a part of this change."*

The "Interview Skills Practice: Talking About Sex" (role-play activity) and the "Understanding the Concepts of Gender and Sexual Diversity and Understanding the Continuum" activities were particularly impactful, educational, and memorable for healthcare facility staff. When asked what they had learned or gained from the training, facility staff could almost always recall these two activities. The material presented in the gender continuum was completely new to most of

the interviewed facility staff members. The role-play activity provided trainees with an opportunity to practice interacting with key populations, and allowed them to put themselves in the shoes of a MSM or transgender person trying to access healthcare. As one clinical staff member described, *“It really helped staff imagine what it’s like to be in their place.”*

Many healthcare facility staff members noted that they valued the interactive nature of the training. The participatory methodology was also appreciated by the trainers, some of whom wished that the training had been even more participant-driven, with more opportunities for staff to engage with and navigate the subject matter. A non-clinical staff member stated

*“I was expecting them to force the MSM on us ... [however, they were just trying to make staff aware of the issues] ... they made you want to learn, want to listen, didn’t force anything on you.”*

A clinical staff member felt that the training activities allowed trainees *“to put themselves in the position of the stigmatized,”* which she thought was important for teaching her colleagues *“how to appreciate people no matter the lifestyle they choose.”*

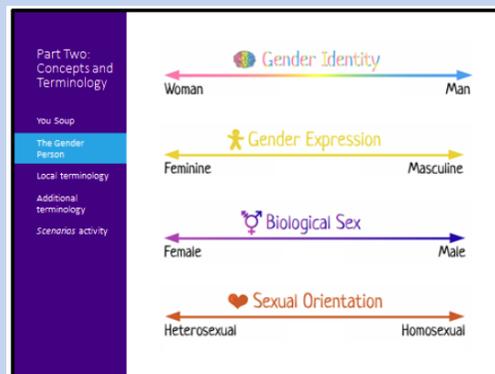
Another key strength of the training was that it engaged entire healthcare facility staff cadres, not just clinical providers. This was deemed important because non-clinical staff also interact with patients. For example, non-clinical staff thought it important that their departmental colleagues be trained, as *“we’re some of the first people clients talk to”* upon arriving at the healthcare facility. Facility staff also enjoyed interacting with colleagues whom they may not necessarily see or work with on a regular basis; such interactions allowed them to learn from varying perspectives. Another non-clinical staff member stated that he liked *“interacting with staff in a different setting, getting different perspectives.”* Project (HPP/HP+) staff members believed that training colleagues together allowed the facility staff to grow together as a whole. While the value of conducting training targeted at an entire facility was confirmed by the trainers, their experience with previous trainings also allowed them to speak to the value of bringing together staff from different facilities to elicit a diverse range of perspectives and experiences.

### “Interview Skills Practice: Talking About Sex” Activity

A role-play exercise to help participants practice talking more openly about sex with clients; participants are given scenarios that involve a member of a key population trying to navigate a discussion of HIV/STI prevention, testing, or treatment

### “Understanding the Concepts of Gender and Sexual Diversity and Understanding the Continuum” Activity

An exercise that focuses on building participants’ understanding of the different concepts around gender and sexuality through handouts that define gender and sex, addressing frequently asked questions about diversity, and a “concepts and definitions” matching game



## Challenges

The activity aimed to train 100 percent of healthcare facility staff members, and each facility was offered two or three trainings held on different days. However, only 53–77 percent of all staff members at each facility were able to attend both days of the training (see Table 1, page 3), due in part to scheduling issues. Facilities and staff are already overburdened, and each person attending the training is one less person present at the facility. Additionally, at least one staff member from each healthcare facility mentioned that they had not been made aware of the training until the day before or the day of, which not only discouraged attendance, but also further burdened the healthcare workers who remained on duty. One facility staff member who was unable to attend the second day of training because of scheduling challenges felt that prior awareness of the training by the department would have allowed them to attend the entire training. One project staff member, the trainers, and several facility staff members suggested increasing the number of trainings to facilitate attendance and ease the burden on the rest of the healthcare facility staff.

Overall attendance was further hampered by resistance to attend or return to the trainings. Between five and seven training attendees per healthcare facility did not return for the second day of training. Facility administrators admitted that some participants refused to attend or return to the training once they learned what it was about. Facility staff and trainers confirmed this, saying that some (but not many) participants had left the trainings after the first or second session. However, one administrator, and some project staff and trainers, believed that participants who stayed in the training through the first morning would likely stay through the entire training. One non-clinical staff member corroborated this sentiment

*“When I first got there, I wasn’t sure why I was there, but I was glad I stayed for the experience.”*

Trainers further stressed that healthcare facility administrators needed to better mobilize their staff to attend.

This activity also faced challenges in developing, finalizing, and displaying the code of conduct posters. While the posters themselves were well-received, JN+, J-FLAG, and representatives from the NFPB critiqued the training for not more strategically including KP perspectives when developing the codes of conduct. This was especially the case considering that the codes were finalized by healthcare facility staff immediately following the panel discussion, and panelists could easily have provided input. The second bullet of the original code of conduct submitted to the MOH for review read, “Provide services that are fair, equitable and respectful *regardless of sexual orientation or gender identity*.” However, due to concerns about the legality of this promise, the MOH and RHA officials decided that the code of conduct needed to be in keeping with the Jamaican Constitution<sup>2</sup> and “regardless of sexual orientation or gender identity” was removed. Furthermore, it took significant time to obtain RHA approval to hang the posters in healthcare facilities, possibly for fear of overlap or confusion with the patients’ rights charter (and other redress system or client complaint mechanism posters). St. Jago Park Health Centre had only received their posters two weeks prior to the rapid assessment, and they had not yet been hung (staff explained they would hang the posters after the waiting room was repainted). While the posters in Mandeville had been widely distributed to staff, it appeared that they had

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<sup>2</sup> See Chapter III Section 13 (3) I. “Sexual orientation would have to be removed and gender changed to sex (male or female).” Available at [http://www.japarliament.gov.jm/attachments/341\\_The%20Charter%20of%20Fundamental%20Rights%20and%20Freedoms%20%28Constitutional%20Amendment%29%20Act.%202011.pdf](http://www.japarliament.gov.jm/attachments/341_The%20Charter%20of%20Fundamental%20Rights%20and%20Freedoms%20%28Constitutional%20Amendment%29%20Act.%202011.pdf)

only been hung in offices or individual departments. As such, it was unclear whether or not posters would actually be seen by clients.

While the training seemed to successfully convey that all clients must be treated respectfully, regardless of sexual orientation or gender identify, some healthcare facility staff members continued to grapple with some of the S&D-related barriers the training brought to light. Issues around wearing appropriate clothing for facilities were brought up repeatedly, with many facility staff arguing that it was transgender patients' responsibility to dress appropriately when coming to the facility to receive care. Furthermore, in describing MSM and transgender persons, the discourse used by some facility staff reflected a belief that being MSM or transgender is a choice, learned behavior, or lifestyle—a view the training material repeatedly tries to negate. Panelists mentioned feeling that much of the panel discussion was rooted in addressing participant questions such as “Why did you *choose* this lifestyle?” This was brought up during interviews with the trainers, who hypothesized that this deficit may have been due to the structure of some of the panelists' stories (for example, “I was thrown out of my house and then I started having sex with men.”). The trainers were also concerned that training participants did not appreciate or understand the nuances involved in panelists' responses to participant questions, such as “If you could choose not to be MSM/transgender, would you?” The trainers believed that these interactions might have led facility staff to misunderstand the panelists' narratives and ultimately misinterpret the intended message.

## Recommendations for Improving the Training

Eliciting critiques and recommendations from healthcare facility staff proved difficult because over a year had passed since the training began. However, some facility staff, the two panelists, and the trainers were able to provide concrete recommendations. Additionally, some facility staff, the trainers, and representatives from J-FLAG were able to brainstorm a variety of ideas for new activities.

### ***Modify the agenda***

Two of the trainers felt that the training structure needed to be modified or rearranged, and recommended that the values clarification activity and MSM panelist discussion be moved to the end of the first day. These trainers argued that the values clarification activity allowed participants to confront their own biases, and that the panel discussion helped participants develop a sense of empathy toward these populations. Given the short timeframe, they wished to encourage or bring out this sense of openness as quickly as possible. However, the third trainer did not agree with this recommendation and several healthcare facility staff members commented that including the panel discussion at the end of the second day provided the perfect amount of time for participants to prepare for respectful interactions with MSM and members of gender minorities.

All three trainers agreed that the training was best conducted over two consecutive days (as opposed to one day one week, and one the next). They felt they had “lost a lot of ground if too much time passed between the first and second day of the training.” The trainers also wanted more time for training and suggested adding a dinner and activities that extended into the evening of the first day. Some facility staff wanted longer trainings too, although others felt that two days was just the right amount of time.

### ***Content recommendations***

The panel discussion was integral to the training, so it received the most attention during the rapid assessment interview. Nearly all interviewed healthcare facility staff members—even those

who admitted over the course of their interview that they didn't "condone the MSM or transgender lifestyle"—wanted more time with or more involvement from the panelists. Both panelists agreed and expressed interest in a greater presence during the trainings. One panelist had been involved in a similar activity with youth, for the entirety of the training. The panelist found that this had contributed to a better understanding of audience prejudices, but had also facilitated comfort and ease in the environment.

A more diverse panel (in terms of age, gender, background, and personality) was also requested. Panelists and trainers alike felt that this was particularly important. Panelists wanted to showcase the diversity of the MSM and transgender community, suggesting that (if possible in light of safety concerns) an optimal panel should include more feminine individuals, in addition to more stereotypically masculine individuals. They also desired a wider range of socioeconomic backgrounds and ages. Two trainers suggested exploring the possibility of holding a focus group discussion with potential panelists to allow more strategic selections. Several healthcare facility staff members expressed an interest in talking with more people from the key populations community at large, and suggested including lesbian women or women who identify as (or are transitioning into) men.

Also notably, both panelists expressed their concern for their safety when traveling to and from the trainings. This was considered particularly important for panelists who might be more feminine, and would definitely be a concern for transgender women. One panelist had recently completed her transition, and both agreed that it would be dangerous for her to travel across the country alone.

One critique was received from the trainers, a project staff member, and a couple of the facility staff members: that the training did not provide adequate space for participants to talk openly about their feelings on the topic or articulate what they found challenging to understand. For example, the training is not necessarily designed to provide participants an opportunity to say, out loud, "I don't agree with this," or to express why they find it difficult to interact with or provide care to MSM or transgender people. To address this possible deficiency, two of the trainers suggested adding a session or reserving time for some open-ended, unstructured conversation.

Some suggestions for the "beliefs about gender and sexual minorities (value clarification)," "naming stigma and discrimination through pictures," and "interview skills practice: talking about sex" activities emerged from this rapid assessment. During the value clarification activity, healthcare facility

#### **"Beliefs About Gender and Sexual Minorities" Activity**

A value clarification activity in which training participants are given a number of statements about gender and sexual minorities and must decide if they agree or disagree, generating a group discussion

#### **"Naming Stigma and Discrimination Through Pictures" Activity**

An activity that asks participants to look at pictures showing stigma or acts of discrimination and discuss what each picture means to them



staff members are given a number of statements about gender and sexual minorities and must decide if they agree or disagree. Two trainers felt that the values activity needed to be better tailored to Jamaican culture, as many participants reportedly found it difficult to identify with the values (but were unable to recall which specific values were the most troublesome). Two trainers also felt that this activity needed better pictures—or pictures better tailored to the Jamaican setting—as some scenes were unable to clearly depict certain issues. For example, for the picture of the nurse putting on gloves (see Figure 2), many training participants honed in on the action, arguing that the nurse was supposed to practice universal precaution; however, many completely missed her angry and disgusted facial expression. The trainers thought that pulling comics from local newspapers or magazines might better present engaging material for training participants. For the role-play activity, the trainers wished for one or more scenarios intended for staff who infrequently interacted with clients. One male records clerk and one female data entry clerk also critiqued this activity for its limited relevance to their specific positions. Two trainers felt that the scenarios were too scripted, and failed to “ask the touch questions” or fully allow participants to engage with the more challenging aspects of the subject matter.

**Figure 2: Picture with Nurse**



### ***Improve planning and mobilization of staff to attend trainings***

In consideration of overburdened healthcare facilities, scheduling challenges, and resistance to attend this type of training, four recommendations were made:

1. Trainings should be scheduled strategically and well in advance, through coordination with healthcare facility administration
2. Multiple sessions of each training should be offered to ease the burden on the rest of the facility
3. Facility staff should be made aware of the training and their required attendance well in advance to allow individual departments to make appropriate staffing arrangements
4. Facility administrators and/or other previously trained staff should more effectively mobilize and encourage staff to attend trainings in their entirety

### ***Revise the code of conduct development process***

As previously mentioned, the process of developing the code of conduct and delivering the finalized posters faced some critiques. The two national representatives from JN+, NFPB, and J-FLAG, and one RHA representative, recommended developing a code of conduct to include individuals from affected communities. Additionally, project staff, key stakeholders, and healthcare facility staff noted that the code of conduct could be understood as an abbreviated version of the patient charter, and that the posters advertise the RHA’s client complaint mechanisms. Possible overlap between the code of conduct and the patient charter, and the role of the redress system and client complaint mechanism (as possible accountability mechanisms for ensuring a stigma-free facility environment), were frequently brought up during interviews. For example, one RHA representative noted the similarity between the code of conduct and client charters, stating that she “*wished that the patients’ rights charter could be condensed into something similar.*” Logistically, many facility staff suggested that the posters needed to be larger and placed in more eye-catching locations.

### **Focus on sustainability of S&D reduction in healthcare facilities**

While not a direct goal of the assessment, the data confirmed a continued need for investment in stigma reduction at the healthcare facility level. Two facility administrators stated that there “*seems to be some warming of relationships, but it’s cordial, not necessarily friendly,*” and that “*a lot of staff are at the contemplation stage.*” This sentiment was echoed by one of the panelists: “*We are at a place of tolerance, but not yet acceptance.*” While drastic changes in attitudes toward key populations over the course of a two-day training were well beyond the scope of the intervention, many healthcare facility staff subtly revealed biases against these populations, demonstrating a need for continued engagement on S&D.

Nearly all interviewees in the rapid assessment were supportive of continued training for facility staff. Stakeholders were adamant that trainings or S&D-reduction activities for facility staff continue from a sustainability standpoint, arguing that investing in a “one-off” training is not a lucrative solution. While facility staff supported the idea of training for other staff who had not previously received the training, they were mixed on whether they personally needed further training. However, this sentiment was frequently expressed in combination with a defense of staff members’ individual and facility-level current treatment of key populations (perceived as exemplary). One clinic attendant felt that continuous training was necessary, as “*it takes time to really come to the concept ‘it’s my job, I have to treat people well, have to be confidential, to trust, not to stigmatize.’*” However, a clinical care provider who had attended several J-FLAG trainings, in addition to the HPP/HP+ training, expressed training fatigue, stating that “*some people are fed up with these trainings.*” Still, even this provider was supportive of continued training for colleagues who otherwise “would not get the exposure.”

Several healthcare facility staff members stated that their attendance at continued trainings would be more valuable if the trainings taught them something new or offered additional exercises and activities. Discussions with interviewees also explored ideas for planning and shaping refreshers or ongoing trainings. Some facility staff suggested offering the same training to untrained staff, incorporating training into the onboarding process for new staff, or offering shorter trainings that presented new material. Facility staff also recognized scheduling and human resource constraints and felt that trainings would need to be strategically scheduled. Some further suggested that HP+ explore the timing of quarterly meetings. Specific to Jamaica, some healthcare facilities reserve a day for meetings or trainings when there are five work weeks in a month; some interviewees suggested that this may be an optimal time for continued stigma-reduction efforts. Many healthcare providers specifically requested an adaptation focused on the clinical care needs of MSM and transgender people. Similarly, several interviewees felt that facility staff needed more specific guidelines for appropriate conversations and necessary questions for MSM and transgender clients. One facility administrator even suggested providing staff with example scripts.

Continuing this discussion, several key stakeholders offered ideas for a new “spin” on refresher trainings. These included a focus on leadership-building activities, psychosocial or counselling support, stress reduction, and building/creating advocates and advocacy while continuing to address S&D. The rapid assessment prompted a plethora of suggestions for new activities for inclusion in refreshers or expanded trainings.

- Add homework activity such as journaling or writing a story/poem (suggested by trainers)
- Add an activity wherein groups make presentations to healthcare facility management or staff (suggested by J-FLAG and trainers)
- Find ways to integrate the panelists into the training:

- For example, one facility staff member suggested modifying the role-play activity to allow panelists to play the stigmatized key population member in various scenarios with training participants—recognizing that this would pose a possible risk to the individual and would require skillful moderating
- Utilize previously trained facility staff to support trainers, and motivate staff to attend the training and be more engaged with the subject matter
- Conduct a training-of-trainers for healthcare facility staff to allow each facility to have an in-house staff member with some amount of expertise in key population-related S&D
- Conduct clinical training on specific healthcare needs of key populations (some training is currently being implemented by ITECH)

### ***Improve monitoring and evaluation of S&D reduction***

Stakeholders from the MOH, RHAs, and NFPB all expressed their need for an improved mechanism to measure and monitor S&D (and S&D reduction) in healthcare facilities. In fact, one RHA representative challenged HP+ “*to meet the challenges of S&D in a quantifiable or measurable way,*” describing the lack of measurement in this field as detrimental to continued efforts to address S&D. The MOH medical officer echoed this sentiment, stating that Jamaica had already invested considerable effort in addressing S&D. She wanted to see a more effective strategy: “*We’ve already invested a lot and should have more to show for it.*” She further mentioned that a key challenge to demonstrating change in levels of S&D was the lack of a high-quality monitoring system for S&D in Jamaica, adding that the redress system was not an adequate tool.

### **Other Opportunities to Invest in S&D Reduction at the Healthcare Facility Level**

Other issues that may influence access to stigma-free services came to light through the interviews and discussions. For example, many healthcare facility staff members mentioned that key population patients may be treated poorly, or may fear poor treatment by other patients, when they come to access care. Facility staff and administrators largely felt that S&D from other patients was just as much, if not more, of a concern than S&D from healthcare providers. While this sentiment from facility staff may be inherently biased, the RHA, NFPB, and J-FLAG representatives also recognized this challenge. To address S&D from other patients, several staff members suggested inviting general community members or community leaders to participate in the facility stigma-reduction trainings, thus making it a joint community and staff training. J-FLAG is also trying to address S&D from other patients by rolling out a “human rights awareness” training for patients awaiting treatment at healthcare facilities.

The rapid assessment also revealed some logistical and structural challenges to providing stigma-free services and enabling a stigma-free healthcare facility environment. Interviewees repeatedly mentioned that facilities are overburdened and currently serve too high a patient load. Inadequate space was a particular concern. Several facility staff and one administrator were concerned that overcrowding in waiting rooms and inadequate patient treatment rooms impeded privacy and compromised the confidentiality of medical records and nurse stations.

Each healthcare facility had a “modest dress code” institutional policy that was usually displayed on a sign by the entrance, where security would greet clients. It was clear from panelists’ stories and from discussions with facility staff and administrators that this policy is an issue of contention, especially for transgender persons. For example, one clinical staff member stated his

understanding that *“being gay is not a choice,”* but didn’t think “cross dressing” should be tolerated: *“Transgender people deserve the commotion they cause when they choose to come to the healthcare facility dressed like that.”* One RHA representative recognized that the dress code policy was particularly problematic, remembering that it had been used to turn away clients without the means to afford proper attire. She went on to state that she would not want this policy used as a basis for denying anyone care. Both panelists agreed and stated outright that they thought the dress code should be removed, as it would likely only be enforced with transgender patients. This policy needs further examination as part of the larger effort to reduce S&D-related barriers to care for key populations and review policies that influence the healthcare facility environment.

At the national level, discussions frequently touched on one key policy that institutionalized S&D: the “buggery law.” This law is an act that prohibits “acts of gross indecency” between men in public or private. The “buggery law” was brought up by J-FLAG as a key priority for addressing S&D targeted at MSM, but was also mentioned by representatives from the NFPB. These stakeholders believed that overturning the law will be necessary to further cement and defend the basis of this stigma-reduction training.

The discussions also revealed an underlying need for an improved/working accountability mechanism. One RHA representative remarked, *“We need systems of accountability, we need the standard that everyone has a right to get offered respectful treatment.”* This representative felt that facility staff must be *“held accountable for understanding what S&D is and [how it] stigmatizes [key populations].”* As such, facilities must *“have policies that have consequences and enforce those policies.”* Other representatives felt that the client complaint mechanism needed to be institutionalized as part of the larger effort to address S&D in healthcare facilities; they recommended that client complaint mechanisms be promoted through the training. However, discussions with these key stakeholders indicated that the redress system and client complaint mechanisms were not currently functioning in a manner conducive to recognizing and addressing reports of S&D. The NFPB representatives felt that client complaint mechanisms needed to be further operationalized and that those managing it must be made more aware of what reports of S&D look like. The MOH medical officer believed that the ministry would prioritize strengthening the redress system to address S&D, as it was currently inadequately robust or reliable to be used as a monitoring system. In fact, efforts were already underway to improve the Complaint Management System for both clients and employees of the MOH.

## CONCLUSIONS

This rapid assessment confirmed the value and importance of S&D-reduction activities in healthcare facilities, and an appreciation for this type of training as part of a larger effort to improve access to and quality of care for key populations. Furthermore, the assessment seemed to indicate that facility staff enjoyed the training and that it helped them feel more comfortable interacting with MSM and transgender persons. The assessment also yielded insights on the elements of KPCF intervention that worked well:

1. Training the entirety (i.e., all cadres) of healthcare facility staff was accepted and appreciated
2. The participatory nature (interactive methodology) was valued by both facility staff and trainers
3. The panelists' session was considered very powerful and the most memorable component
4. The “Interview Skills Practice: Talking About Sex,” and the “Understanding the Concepts of Gender and Sexual Diversity and Understanding the Continuum” activities were particularly educational

This assessment also helped identify some elements of the training that worked less well:

1. Scheduling challenges and resistance to engaging in training on this topic made it difficult to reach the goal of training 100 percent of staff
2. Developing and obtaining RHA/MOH approval for the code of conduct and ensuring that the code of conduct posters were appropriately displayed proved challenging
3. Some healthcare facilities were still working through an understanding of the “dress code” barrier to care, and how being MSM or transgender is not a learned behavior, choice, or lifestyle

Recommendations for improving the training approach and materials were also discussed:

1. Modify agenda
2. Revise content of exercises and activities in light of recommendations
3. Improve planning and mobilization of staff to attend training
4. Revise the code of conduct development process
5. Continue to provide ongoing stigma-reduction activities for healthcare facilities
6. Improve measurement and monitoring of S&D in healthcare facilities

The assessment also identified other opportunities for investment in S&D at the healthcare facility level, such as finding ways to address S&D from other patients. Physical space constraints and overburdened health workforce were also recognized as barriers to ensuring a stigma-free environment. Interviews and discussions also revealed institutional and national-level policies—including the “dress code” and “buggery law”—that may need further analysis as part of the effort to eliminate stigma within healthcare settings. Finally, the assessment also documented a need for an improved accountability mechanism or improvements to the existing redress system and client complaint mechanisms.

## REFERENCES

- Ekstrand, M.L., S. Bharat, J. Ramakrishna, and E. Heylen. 2012. "Blame, Symbolic Stigma and HIV Misconceptions Are Associated with Support for Coercive Measures in Urban India." *AIDS and Behavior* 16(3): 700–710.
- Ekstrand, M.L., J. Ramakrishna, S. Bharat, and E. Heylen. 2013. "Prevalence and Drivers of HIV Stigma Among Health Providers in Urban India: Implications for Interventions." *Journal of the International AIDS Society* 16(3Suppl 2).
- Feyissa, G.T., L. Abebe, E. Girma, and M. Woldie. 2012. "Stigma and Discrimination Against People Living with HIV by Healthcare Providers, Southwest Ethiopia." *BMC Public Health* 12(1): 522.
- Figuroa, J.P., C.J. Cooper, J.K. Edwards, L. Byfield, S. Eastman, et al. 2015. "Understanding the High Prevalence of HIV and Other Sexually Transmitted Infections Among Socio-economically Vulnerable Men Who Have Sex with Men in Jamaica." *PloS One* 10(2): e0117686.
- Govindasamy, D., J. Meghij, E.K. Negussi, R.C. Baggaley, N. Ford, et al. 2014. "Interventions to Improve or Facilitate Linkage to or Retention in pre-ART (HIV) Care and Initiation of ART in Low- and Middle-income Settings—A Systematic Review." *Journal of the International AIDS Society* 17(1).
- Health Policy Project. 2013. *Understanding and Challenging HIV and Key Population Stigma and Discrimination: Caribbean Facilitator's Guide*. Washington, DC. Futures Group, Health Policy Project.
- Health Policy Project. 2016. *Health Worker Quality of Care Training: Key Population Stigma Reduction*. Washington, DC. Health Policy Project.
- Heunis, J.C., E. Wouters, W.E. Norton, M.C. Engelbrecht, N.G. Kigozi, et al. 2011. "Patient- and Delivery-level Factors Related to Acceptance of HIV Counseling and Testing Services Among Tuberculosis Patients in South Africa: A Qualitative Study with Community Health Workers and Program Managers." *Implementation Science* 6(1): 27.
- Katz, I.T., A.E. Ryu, A.G. Onuegbu, C. Psaros, S.D. Weiser, et al. 2013. "Impact of HIV-related Stigma on Treatment Adherence: Systematic Review and Meta-synthesis." *Journal of the International AIDS Society* 16(3Suppl 2).
- Li, L., L.-J. Liang, Z. Wu, C. Lin, and J. Guan. 2014. "Assessing Outcomes of a Stigma-reduction Intervention with Venue-based Analysis." *Social Psychiatry and Psychiatric Epidemiology* 49(6): 991–999.
- Li, L., C. Lin, J. Guan, and Z. Wu. 2013a. "Implementing a Stigma Reduction Intervention in Healthcare Settings." *Journal of the International AIDS Society* 16(3Suppl 2).
- Li, L., Z. Wu, L.J. Liang, C. Lin, J. Guan, et al. 2013b. "Reducing HIV-related Stigma in Health Care Settings: A Randomized Controlled Trial in China." *American Journal of Public Health* 103(2): 286–292.

- Lohiniva, A.-L., M. Benkirane, T. Numair, A. Mahdy, H. Saleh, et al. 2016. "HIV Stigma Intervention in a Low-HIV Prevalence Setting: A Pilot Study in an Egyptian healthcare Facility." *AIDS Care*: 1–9.
- Mahajan, A.P., J.N. Sayles, V.A. Patel, R.H. Remien, D. Ortiz, et al. 2008. "Stigma in the HIV/AIDS Epidemic: A Review of the Literature and Recommendations for the Way Forward." *AIDS (London, England)* 22(Suppl 2): S67.
- Mahendra, V.S., L. Gilborn, S. Bharat, R. Mudoji, I. Gupta, et al. 2007. "Understanding and Measuring AIDS-related Settings: A Developing Country Perspective." *SAHARA J (Journal of Social Aspects of HIV/AIDS Research Alliance)* 4(2): 616–625.
- Musheke, M., H. Ntalasha, S. Gari, O. Mckenzie, V. Bond, et al. 2013. "A Systematic Review of Qualitative Findings on Factors Enabling and Deterring Uptake of HIV Testing in sub-Saharan Africa." *BMC Public Health* 13(1): 220.
- Nyblade, L., A. Jain, M. Benkirane, L. Li, A.L. Lohiniva, et al. 2013. "A Brief, Standardized Tool for Measuring HIV-related Stigma Among Health Facility Staff: Results of Field Testing in China, Dominica, Egypt, Kenya, Puerto Rico and St. Christopher & Nevis." *Journal of the International AIDS Society* 16(3 Suppl 2): 18718.
- Nyblade, L., A. Stangl, E. Weiss, and K. Ashburn. 2009. "Combating HIV Stigma in Health Care Settings: What Works?" *Journal of the International AIDS Society* 12(1): 15.
- Nyblade, L.C. 2006. "Measuring HIV Stigma: Existing Knowledge and Gaps." *Psychology, Health & Medicine* 11(3): 335–345.
- Parsons, J.A., V.A. Bond, and S.A. Nixon. 2015. "Are We Not Human?' Stories of Stigma, Disability and HIV from Lusaka, Zambia and Their Implications for Access to Health Services." *PloS One* 10(6).
- Pulerwitz, J., K.T.H. Oanh, D. Akinwolemiwa, K. Ashburn, and L. Nyblade. 2014. "Improving Hospital-based Quality of Care by Reducing HIV-related Stigma: Evaluation Results from Vietnam." *AIDS and Behavior* 19(2): 246–256.
- Rogers, S., K. Tureski, A. Cushnie, A. Brown, A. Bailey, et al. 2014. "Layered Stigma Among Health-care and Social Service Providers Toward Key Affected Populations in Jamaica and The Bahamas." *AIDS Care* 26(5): 538–546.
- Stangl, A.L., J.K. Lloyd, L.M. Brady, C.E. Holland, and S. Baral. 2013. "A Systematic Review of Interventions to Reduce HIV-related Stigma and Discrimination from 2002 to 2013: How Far Have We Come?" *Journal of the International AIDS Society* 16(3).
- UNAIDS. 2014. *Global AIDS Response Progress Reporting, 2009–2014*. Geneva, Switzerland: Joint United Nations Programmes on HIV/AIDS.
- UNAIDS. 2015. "15 by 15" – A global Target Achieved. Geneva, Switzerland: UNAIDS.
- UNAIDS. 2016. "Jamaica HIV and AIDS Estimates (2015)." Available at <http://www.unaids.org/en/regionscountries/countries/jamaica/>.
- White, R.C. and R. Carr. 2005. "Homosexuality and HIV/AIDS Stigma in Jamaica." *Culture, Health & Sexuality* 7(4): 347–359.

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Stigma-reduction Training

WHO. 2014. *Global Update on the Health Sector Response to HIV, 2014*. Geneva, Switzerland:  
WHO.



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