



HIV/AIDS STIGMA & DISCRIMINATION IN CARIBBEAN HEALTH CARE SETTINGS: TRIGGER SCENARIOS

Facilitator Guide

March 2007

Acknowledgements

The Caribbean HIV/AIDS Regional Training (CHART) Network is designed to strengthen the capacity of national health care personnel and systems to provide access to quality HIV and AIDS prevention, care, treatment and support services for all Caribbean people through the development of a robust and sustainable training network. One of CHART's goals is to strengthen the capacity of national health care personnel, including leaders and managers, to provide access to quality HIV/AIDS prevention, care, treatment and support services. The transfer of knowledge and technologies is helping to support the building of indigenous Caribbean capacity to sustain training competence at the local level.

International Training and Education Center on HIV (I-TECH) is a global AIDS training program that works to increase human and institutional capacity for care and treatment in countries hardest hit by the AIDS epidemic. I-TECH supports the ongoing development of health care worker training systems that are locally-determined, optimally resourced, highly responsive and self-sustaining.

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CHART Director of the Regional Coordinating Unit: Brendan Bain, MD, MPH

CHART Associated Reviewer: Althea Bailey, MPH

CHART National Training Coordinator, Jamaica: Terri Myrie, BS, MBA

CHART National Training Coordinator, Bahamas: Bernadette Hamilton-Saunders, PHN, MPH

I-TECH Health Communication Team Project Lead: Fiona Otway

I-TECH Facilitator Guide Authors: Anya Nartker, MPH and Sarah Wilhelm, MPH

I-TECH Quality Improvement Specialist: Stacey Lissit, MPH, MS

I-TECH Director of Communications and Instructional Materials: Tom Furtwangler, MA

I-TECH Caribbean Regional Director: Elaine Douglas, MS

I-TECH Caribbean Field Manager: June Alleyne Griffin, MA

Content Expert: Shane Neely-Smith, PhD, RN

Video Producer: Fiona Otway in collaboration with Visual Domain, Ltd.

Video Script Writer: Travis Weekes

Facilitator Guide Design: Anita Elder, Lolalu Design and Kim Tyburski, Skyhand Design

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Abbreviations and Acronyms

AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
ARV	Antiretroviral
ART	Antiretroviral therapy
CAREC	Caribbean Epidemiology Centre
CDC	United States Centers for Disease Control and Prevention
CHART	Caribbean HIV/AIDS Regional Training network
HAART	Highly active antiretroviral therapy
HCP	Health care provider
HCW	Health care worker
HIV	Human immunodeficiency virus
I-TECH	International Training and Education Center on HIV
L&D	Labour and delivery
MTCT	Mother-to-child transmission of HIV
NGO	Non-governmental organisation
OI	Opportunistic infection
PEP	Post-exposure prophylaxis
PLWHA	People living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission of HIV
PPE	Personal protective equipment
STD/I	Sexually transmitted disease/infection

UNAIDS	Joint United Nations Programme on HIV/AIDS
UP	Universal precautions
USAID	U.S. Agency for International Development
VCT	Voluntary Counselling and Testing
WHO	World Health Organization



PLEASE READ!

These trigger scenarios deal with sensitive issues. Therefore, it is important for the facilitator to be:

- Knowledgeable on HIV/AIDS and related topics
- Experienced in facilitating groups
- Well-informed on issues related to HIV/AIDS stigma and discrimination

Please take the time to read through this guide before presenting the trigger scenarios and facilitating a discussion.

Important Note to Facilitator:

Conducting training with these trigger scenarios requires preparation. Facilitators must be knowledgeable of HIV/AIDS prevention, transmission, care, treatment and other relevant facts. Facilitators must also be experienced in facilitating groups, ideally on sensitive topics. Finally, it is important for facilitators to have a thorough understanding of HIV/AIDS stigma and discrimination issues. Please refer to **Appendix A: Background – HIV/AIDS Stigma and Discrimination in Caribbean Health Settings** for a comprehensive summary of the causes, forms, and consequences of HIV/AIDS related stigma and discrimination in health care settings as well as effective ways to address them. Reviewing background information will help facilitators to ensure that they are fully prepared to facilitate discussions following the trigger scenarios.

These scenarios portray health care workers in situations in which HIV/AIDS stigma and discrimination commonly occur. Some participants may have personally witnessed or experienced similar situations. Some participants may have strong emotional responses to the videos based on their values, beliefs and experiences. The trigger scenarios intentionally portray controversial situations which may provoke a variety of reactions amongst viewers. Participants' reflections on their attitudes, experiences, and beliefs about sensitive topics like sex, religion, social status, substance abuse and death are an important component of the discussion sessions.

Skilled facilitation is required for the discussions to be effective and to help participants express feelings. The discussion themes that emerge may not always lead to a "right" or "wrong" answer. However, during the discussion it will be very important to make distinctions between fact and opinion. Facilitators must be prepared to facilitate the discussion with both flexibility and direction. It is

essential that facilitators create a safe, non-threatening space where participants can explore these feelings. Refer to **Appendix B: Tips and Tools for Facilitating** for guidance, suggestions and further information on facilitating these scenarios.

Finally, facilitators should be sensitive to the fact that HIV impacts all levels of society in much of the Caribbean. There may be participants who are themselves living with HIV, or who have family or friends living with HIV. An inclusive, respectful environment that is comfortable for all participants is a critical part of facilitating successful discussions on these trigger scenarios.

Section I

Overview of this Video Scenario-Based Training Package

SECTION I: OVERVIEW OF THIS VIDEO SCENARIO-BASED PACKAGE

INTRODUCTION

In the Caribbean region, stigma and discrimination related to HIV/AIDS are significant obstacles to providing quality care, treatment and prevention services. As the region scales up its response to HIV/AIDS, training health care workers to prevent, defuse and reduce stigma and discrimination is essential. Health care workers at all levels must understand the personal ramifications of the HIV/AIDS epidemic, as well as its impact on patients, co-workers and health care systems.

The International Training and Education Center on HIV (I-TECH), working on behalf of the Caribbean HIV/AIDS Regional Training network (CHART), has produced this series of thirteen short video segments on HIV/AIDS stigma and discrimination in health care settings in VHS and DVD format along with this accompanying Facilitator Guide.

The DVD or VHS accompanying this guide consists of thirteen short “trigger” scenarios, each approximately one to five minutes long. The scenarios portray professional actors in the roles of health care workers, patients and community members, highlighting different aspects of HIV/AIDS stigma and discrimination in health care settings. The videos present common scenarios in which stigma and discrimination occur and create opportunity for discussion, individual reflection and behavioural and/or institutional change.

The trigger scenarios can be effective tools for helping health care workers explore their own attitudes and beliefs, and analyse different techniques and strategies for addressing HIV/AIDS stigma and discrimination in the workplace. The trigger scenarios and facilitator guide are designed for group sessions and can be used in a variety of contexts. A short, controversial scenario is presented on the video; the facilitator then leads participants in a discussion of what they have seen and how it relates to their own experience in a local context.

The video segments can be used individually or together in any combination. Each video includes

- ♦ This video and curriculum package is targeted for use with all levels of health care workers
- ♦ After each scenario, the facilitator should lead a discussion with participants

The video scenarios can be used in a variety of contexts, including:

- ♦ As an add-on session to national or regional HIV/AIDS care trainings and conferences
- ♦ In health care facility in-service trainings
- ♦ As part of round table discussions
- ♦ In lunchtime “brown-bag” discussions
- ♦ HIV/AIDS courses

its own discussion guide for the facilitator so that it can stand alone as a training tool. The thirteen scenarios can be presented during a single training or separately over a period of time as dictated by the audience, training objectives, work setting and time constraints.

GOALS AND OBJECTIVES

The series of video segments and corresponding discussion guides address stigma and discrimination in Caribbean health care settings.

The questions included in the discussion guides are meant to provide a starting point for discussion about sensitive and challenging issues related to HIV/AIDS, stigma, and discrimination among health care workers.

Goals of the Training

The thirteen scenarios included in this training package may be used individually or together. Scenario-specific discussion themes are included in the discussion guide for each scenario. The goals of the training package as a whole are to:

- ✦ Increase awareness of patients' basic rights and human rights
- ✦ Highlight the role of institutional policy in preventing stigma and discrimination
- ✦ Provide opportunities to discuss basic HIV/AIDS transmission and prevention
- ✦ Dispel myths and misinformation about HIV/AIDS transmission
- ✦ Provide a forum to discuss values-based causes of stigma and discrimination
- ✦ Model behaviours that can reduce stigma and discrimination
- ✦ Give a human face to the stories of people living with HIV and AIDS (PLWHA)

Objectives of the Training

By the end of each trigger scenario discussion, participants should be able to:

1. Identify, analyse, and discuss causes of HIV/AIDS stigma and discrimination in their local settings
2. Articulate personal values and beliefs that relate to HIV/AIDS stigma and discrimination
3. Identify personal and/or institutional actions that can be taken to reduce or eliminate HIV/AIDS stigma and discrimination in health care settings

EQUIPMENT REQUIRED

Presentation of the trigger scenarios requires the following:

- VCR or DVD player or computer with DVD capacity
- TV or projector with speakers

HOW TO CHOOSE A SCENARIO OR SCENARIOS

This trigger scenario package was developed for use with all levels of healthcare workers in diverse settings throughout the Caribbean region. Facilitators may select scenarios that portray situations most likely to occur in their own setting or that raise issues or themes of particular relevance to them. They may choose to present only one scenario or may present a series of several scenarios touching on various themes. The scenarios may also be used in a dedicated session or in the context of a larger training or course, for example during a session on stigma and discrimination.

The table below can be used to guide selection of a scenario (or more than one scenario) appropriate for a given target audience and setting. Please refer to the key points section of each Discussion Guide for more details on the discussion topics and themes for the scenarios.

Note: Discussion sessions for scenarios 1 through 10 are approximately 30-45 minutes in length. Scenarios 11 through 13 are somewhat shorter, lasting about 20-30 minutes.

OVERVIEW OF TOPICS AND THEMES

Video	Title	Themes	Content/Scenario
1	<i>Ms. Dawson's meeting</i>	<ul style="list-style-type: none">• Value judgements• Basic HIV prevention and transmission• Non-verbal manifestations of stigma and discrimination• Confidentiality• Patient rights and equity of care• Confronting stigma and discrimination in the workplace• Institutional policy	A janitor has been avoiding cleaning a patient's room. When confronted by a supervisor, the janitor expresses her religious views about HIV and makes various value judgements about people with HIV. The supervisor must decide how to manage the janitor's stigma and discrimination.

Video	Title	Themes	Content/Scenario
2	<i>Who say that big man doh cry?</i>	<ul style="list-style-type: none"> + Patient rights + Basic HIV prevention and transmission + Value judgements + Confidentiality + Voluntary counselling and testing (VCT) for Health Care Workers (HCWs) + Confronting stigma and discrimination in the workplace + Institutional policy 	Five hospital workers gossip about a co-worker who tested positive for HIV. They share various opinions about the co-worker, including whether or not he should be allowed to continue working in the operating theatre.
3	<i>When push comes to shove</i>	<ul style="list-style-type: none"> + Value Judgements + Patient rights and equity of care + Confronting stigma and discrimination in the workplace + Institutional policy 	A nurse observes that a doctor in her facility appears to be prescribing treatment for HIV/AIDS patients without examining them. The nurse confronts the doctor about his stigma and discrimination.
4	<i>Taking chances...</i>	<ul style="list-style-type: none"> + Universal Precautions (UP) + Confronting stigma and discrimination in the workplace + Institutional policy 	Blood is escaping from the IV site of a patient with HIV. The nurse suddenly remembers that there is a shortage of gloves on her ward. She must decide what to do as the patient begins to panic.

Video	Title	Themes	Content/Scenario
5	<i>Better a positive spirit</i>	<ul style="list-style-type: none"> + Basic HIV prevention and transmission + Post-Exposure Prophylaxis (PEP) and Universal Precautions (UP) + Institutional policy 	A man with HIV is being seen for tests to monitor his treatment. A phlebotomist is called in to draw blood. The phlebotomist is fearful of his new job working with HIV/AIDS patients. Voices echo in the phlebotomist's head, calling out warnings about getting stuck with a needle, wearing two pairs of gloves, etc.
6	<i>You Know how long me a wait?</i>	<ul style="list-style-type: none"> + Patient rights and equity of care + Basic HIV prevention and transmission + Value judgements + Confidentiality + Confronting stigma and discrimination in the workplace + Institutional policy 	A patient has been waiting several hours to be seen for an appointment. She notices that others in the waiting room who arrived later are being called for their appointments sooner. The patient confronts the receptionist. The receptionist comments to a co-worker that the patient is an exotic dancer, "sleeps around," and is probably HIV-positive as a result.
7	<i>Test? What test?</i>	<ul style="list-style-type: none"> + Patient rights and equity of care + Confidentiality + Voluntary counselling and testing (VCT) + Informed consent + Institutional policy 	A patient brings a form from his doctor to a technician in a blood lab. The patient is surprised to learn from the lab technician that his doctor ordered an HIV test. It becomes clear that the doctor did not arrange pre-test counselling or obtain informed consent from the patient.

Video	Title	Themes	Content/Scenario
8	<i>Assumptions</i>	<ul style="list-style-type: none"> ✦ Patient rights ✦ Value judgements ✦ Confidentiality ✦ Non-verbal manifestations of stigma and discrimination ✦ Institutional policy 	A woman living with HIV is hospitalised with a complication unrelated to her HIV status. Family members are in her room visiting when the doctor arrives and starts asking questions about the patient's HIV medications. The patient had not yet disclosed her HIV status to her family.
9	<i>HIV is a reality, sister!</i>	<ul style="list-style-type: none"> ✦ Patient rights ✦ Basic HIV prevention and transmission ✦ Value judgements ✦ Confidentiality ✦ Confronting stigma and discrimination in the workplace ✦ Institutional policy 	An inquisitive patient in a waiting room notices another patient's HIV-positive lab results sitting on the receptionist's desk. A discussion between the inquisitive patient and the receptionist follows.
10	<i>I chyah dance</i>	<ul style="list-style-type: none"> ✦ Patient rights ✦ Confidentiality ✦ Modelling positive behaviour for co-workers ✦ Institutional policy 	A health care worker in an HIV clinic believes he has recognised a former schoolmate walking down the hall. The health care worker tries to pressure an administrative assistant into giving him the name of the patient.

Video	Title	Themes	Content/Scenario
11	<i>Peter goes for an HIV test</i>	<ul style="list-style-type: none"> + Confidentiality + Patient rights + Institutional policy 	A man sits in the waiting area of an HIV clinic with two other patients. While he is waiting for an HIV test, a janitor, sweeping the floor nearby recognises him. The janitor calls out the young man's name, greets him, and asks him what brings him to the clinic.
12	<i>Shift change on the labour and delivery ward</i>	<ul style="list-style-type: none"> + Confidentiality + Patient rights + Institutional policy 	During a labour and delivery ward shift change, the incoming nurse mentions that an admitted patient is her brother's girlfriend. The nurse leaving her shift states that this patient will need to take a dose of nevirapine. The incoming nurse was not aware of the HIV status of her brother's girlfriend.
13	<i>David sees his nurse on the street</i>	<ul style="list-style-type: none"> + Confidentiality + Patient rights + Institutional policy 	A nurse is walking with her friend on the street. She runs into one of her patients, who is also with a friend. The nurse greets her patient by name, remarking on how good he looks. After the nurse and her friend walk away, they discuss the patient's ARV treatment. Meanwhile, the patient struggles to explain the meaning of this encounter to his friend.

NOTE: The same actors appear in many of the scenarios playing different characters. If presenting more than one scenario during a single session, the facilitator may want to mention to participants that they can expect to see the same actors playing different characters throughout the scenarios to avoid confusion.

COMPONENTS OF THIS FACILITATOR GUIDE

This Facilitator Guide contains three main sections:

- ✦ *Section I: Overview of this Video Scenario-Based Training Package*
This section provides an overview of themes and topics covered, goals and objectives of the training, and components of the video trigger scenarios and Facilitator Guide.
- ✦ *Section II: Facilitator Instructions*
This section provides general instructions on how to facilitate discussions around the trigger scenarios.
- ✦ *Section III: Discussion Guides & Scripts*
This section contains an overview, facilitator instructions, a summary table of the discussion questions, discussion points, and key points for each trigger scenario.

Each discussion guide also contains activities related to the scenario and the scenario script.

Thirteen appendices providing supplemental information related to the trigger scenario training package are included at the end of the Facilitator Guide. These appendices are referenced throughout the Guide.

- ✦ Appendix A: Background on HIV/AIDS Stigma and Discrimination in Caribbean Health Care Settings
- ✦ Appendix B: How to Facilitate Trigger Scenarios
- ✦ Appendix C: Characteristics of Effective Facilitators/Trainers
- ✦ Appendix D: Training Ice Breaker Activities
- ✦ Appendix E: Epidemiology of HIV and AIDS in the Caribbean
- ✦ Appendix F: Facts about HIV/AIDS and Transmission
- ✦ Appendix G: HIV Risk Continuum
- ✦ Appendix H: CAREC Guidelines on PEP
- ✦ Appendix I: Universal Precautions, including Injection Safety
- ✦ Appendix J: Patient Rights and Confidentiality
- ✦ Appendix K: UNAIDS/WHO Policy Statement on HIV Testing
- ✦ Appendix L: Confidentiality Agreement
- ✦ Appendix M: Evaluation Form

Section II

Facilitator Instructions

Section II: Facilitator Instructions

Note to Facilitator

This section provides an overview of general steps to follow in presenting the scenarios. The facilitator should also follow the detailed instructions provided for each individual scenario in *Section III: Discussion Guides*.

The term **Facilitator Guide** refers to this entire booklet, and the term **Discussion Guide** refers to the individual guides for each trigger scenario.

INTRODUCTION

The facilitator's role is to present the video and facilitate a discussion of the scenarios in order to bring out various issues and topics related to stigma and discrimination. It is not necessary that the facilitator have experience in teaching with trigger scenarios, although skill in facilitating discussions will prove helpful.

STEPS IN USING THE TRIGGER SCENARIOS

1. Preparation: Read and Review Materials

Using video-based scenarios is new for many facilitators. Group discussion will be more productive if you are fully prepared and knowledgeable about the steps involved in facilitating the exercise. It is strongly recommended that you view scenarios at least twice before using them in a training session. You should also read through this Facilitator Guide in preparation for conducting the activity.

Detailed instructions for introducing, presenting and discussing each scenario are included in the Discussion Guide that accompanies the trigger scenario (See *Section III: Discussion Guides*). Key points are highlighted in the answers following the discussion questions. These can be used by the facilitator to engage the participants in discussion.

Refer to all of **Appendix B** and **Appendix C** in this Facilitator Guide for a comprehensive review of the knowledge and skills needed for facilitating these trigger scenario discussion sessions.

In addition to viewing the scenarios and reviewing the Appendices, you may want to prepare for the discussion by:

Each Discussion Guide contains:

- + Scenario Overview
- + Facilitator Instructions
- + Discussion questions, possible responses and key points
- + Activity
- + Scenario Script

- ✦ Familiarising yourself with the dialogue in the scripts by **reading through the script for each trigger scenario**. This will enable you to easily refer to the exact language used in the scenario and quote the characters if necessary.
- ✦ Making sure you are **comfortable using the DVD or VHS equipment**. You may want to replay the sections of the scenario during the training to review or reflect on a particular moment or line.
- ✦ Adapting the materials, if necessary. Take time to adapt these materials to your audience. One way to adapt the information in this guide is to develop additional questions which address issues and challenges your participants may face in their daily work with patients.

2. Introduce the Session

It is very important to establish ground rules and assure confidentiality for the discussion. This can help participants feel comfortable and safe sharing their attitudes, beliefs and experiences. See **Appendix B** and **Appendix C** for assistance in creating an optimal training environment.

- ✦ Begin with a **general introduction of stigma and discrimination** and the importance of the activity. (See **Appendix A** for a comprehensive overview of stigma and discrimination in the Caribbean region.)
- ✦ Discuss **confidentiality** and obtain agreement from participants regarding the confidential nature of the discussion. Refer to **Appendix L** for a sample confidentiality agreement.
 - ✦ Facilitators should consider asking participants to sign a confidentiality agreement before beginning discussion. In signing this document, participants and facilitators agree not to disclose any specific information or details shared during the training session. The purpose of the confidentiality agreement is to help participants to feel safe and comfortable speaking openly about their experiences and opinions during the discussion.
- ✦ Establish group norms/**ground rules**. (See **Appendix B** for examples.)
- ✦ Depending on the context of the training, facilitators may wish to conduct an **ice breaker** activity or have participants introduce themselves before starting the discussion (e.g. if participants have not already done so for another portion of the training/conference, or do not already know one another). See **Appendix D** for sample ice breaker activities.
- ✦ Before playing each trigger scenario, briefly **explain** to participants that they are about to see a scenario related to HIV/AIDS stigma and discrimination in a healthcare setting.
- ✦ Inform participants that the **same actors** appear in many of the scenarios playing different characters. Participants can expect to see the same actors in different roles throughout the various scenarios. This is especially important if presenting more than one scenario during a single session.

3. Play / watch the video

4. Facilitate the Discussion

At the end of each trigger scenario, the DVD will automatically stop. If using a VHS, the facilitator will need to stop the scenario after the screen fades to black and reads “End of Scenario.”

- ✦ Refer to the Discussion Guide for each scenario for detailed instructions and tips on facilitating the discussion.
- ✦ Use the questions provided to lead a discussion of the scenario. Use probing questions to stimulate discussion and draw out important topics.
- ✦ The facilitator should both share and elicit information and opinions. Possible participant responses, teaching points and references are included in bullet points following questions in the discussion guides. The possible answers are not necessarily considered the “right” answers, but can be used to ask probing questions or enhance the discussion. Please note that not all questions are followed by possible responses, which allows for direct and context applicable responses from the participants.
- ✦ After the discussion, you may choose to conduct the activity provided at the end of each Discussion Guide.

5. Adapt materials again, if necessary

Based on the discussion session, you may wish to further adapt these materials to your audience. For example, you may want to incorporate additional questions or adapt activities to apply to your particular context or setting.

6. Distribute evaluation forms

The facilitator may choose to solicit feedback from participants on the training session through a written evaluation form. Data obtained from these forms can help the trainer to assess the effectiveness of the session in triggering reflection, insights, and intention to act amongst the participants, and to obtain suggestions for improving the materials. After the final scenario and discussion are completed, distribute the evaluation form found in **Appendix M**. Explain the importance of the evaluation to participants to ensure they complete the form and provide useful feedback.

Section III

Trigger Scenario Discussion Guides



SCENARIO ONE: MS. DAWSON'S MEETING

SCENARIO OVERVIEW



Scenario Description (*do not read aloud to participants*): A janitor has been avoiding cleaning a patient's room. When confronted by a supervisor, the janitor expresses her religious views about HIV and makes various value judgments about people with HIV. The supervisor must decide how to manage the janitor's stigma and discrimination.

Discussion Themes:

- + Value judgements
- + Basic HIV prevention and transmission
- + Non-verbal manifestations of stigma and discrimination
- + Confidentiality
- + Patient rights and equity of care
- + Confronting stigma and discrimination in the workplace
- + Institutional policy

Session Time: Allow at least 30-45 minutes for a complete discussion of this video scenario (video is about 4 minutes long). Depending on the context of the discussion (e.g. part of larger training or stand alone), the discussion could be expanded/adapted with an additional activity.

Resources Needed:

- + VCR or DVD player or computer with DVD capacity
- + TV or projector with speakers



IF THIS IS THE FIRST SCENARIO TO BE PRESENTED TO THE GROUP:

1. Begin with a brief introduction to the issue of stigma and discrimination (5 minutes).
 - ✦ Stigma is an unfavourable attitude or belief directed toward an individual or a group, while discrimination is an unfavourable act or behaviour towards an individual or group.
 - ✦ Both stigma and discrimination occur even in healthcare settings and are significant obstacles to providing quality care, treatment, and prevention services.
 - ✦ As the Caribbean region scales up its response to HIV/AIDS, it is vitally important that all health care workers contribute to establishing an environment in which all patients are treated with kindness and compassion.
 - ✦ Additional background information on stigma and discrimination is available in **Appendix A**.
2. Discuss the importance of confidentiality, and obtain agreement from participants regarding the confidential nature of the discussion (refer to **Appendix L** for a sample confidentiality agreement).
3. Establish ground rules for the group discussion (see **Appendix B** for more information). The ground rules will depend in part on the size and composition of the group. Key ground rules include:
 - ✦ Do not interrupt or speak over another person
 - ✦ Cell phones off or on vibrate
 - ✦ Criticise the idea, not the person
 - ✦ Respect the views of others, not necessarily agreeing with them
 - ✦ Participate at your comfort level



FACILITATOR INSTRUCTIONS

1. Introduce the scenario to participants by reading the following:

- ✦ “The video scenario you are about to see shows a nurse and a janitor from the house-keeping staff having a discussion about a patient. After the video, we will have a discussion.”

2. Play the video. At the end of the trigger scenario video, the DVD will automatically stop. If you are using a VHS, you will need to manually stop or pause the video tape.

3. Initiate discussion with participants using the discussion questions and the possible answers below as a tool to guide the discussion. Use probing questions to stimulate discussion and draw out important topics. See **Appendix B** for more information on facilitation skills.

- ✦ Point out that there are not necessarily “right” or “wrong” answers to many of these questions. It is not necessary for the group to reach consensus on every question.
- ✦ Be sure to distinguish between facts and opinions during the discussion. Gently correct any misinformation or myths.

It is not necessary to ask the questions in the discussion guide in the order presented here.

- ✦ In many cases the discussion will move spontaneously from one topic to another.
- ✦ Use the summary table of Discussion Guide Questions to locate where specific questions appear in this guide.
- ✦ If participants have already discussed a particular question, it is not necessary to ask it again.



NOTE: Quotes in the boxes are from Caribbean Health Care Workers in response to the discussion questions.



DISCUSSION GUIDE QUESTIONS

The table below is a summary of the discussion questions included in this discussion guide. The discussion will likely move from one topic to another rather than follow the order of questions. Use this table to identify topics of discussion that arise and quickly locate where the responses appear in the Discussion Guide below.

DISCUSSION QUESTIONS
1. What happened in this scenario? What did you think?
2. What were Ms. Dawson's (the janitor's) views about HIV/AIDS, how the disease is transmitted, and people with the disease?
3. How do you think the patient whose room hadn't been cleaned felt? How do you think Ms. Dawson's (the janitor's) views about HIV affect the patients in the hospital?
4. How do you think the Nursing Supervisor handled the situation? <ul style="list-style-type: none"> • What were the strengths and weaknesses of her approach? • What could she have done differently?
5. Do you think Ms. Dawson will behave differently after her conversation with the Nursing Supervisor? Why or why not?
6. What would you tell Ms. Dawson about HIV and HIV transmission in order to reduce her fear of catching HIV from a patient?
7. Ask for volunteers to role play how they could provide this information to Ms. Dawson in a more respectful manner. After the role play, discuss the strengths of the approach used and make suggestions for strengthening the approach.
8. What are the confidentiality issues that came up in this scenario?
9. Have you seen anything similar to this happen in a health facility? What happened and how was it addressed?
10. What could you do in your facility to prevent this type of thing from happening?
11. Are there any policies in place in your setting that address this type of scenario? <ul style="list-style-type: none"> • If yes: a) what are they? b) are they monitored, enforced effectively? What could be done to ensure they are enforced? • If no, what types of policies would be relevant to this type of situation?

1. What happened in this scenario? What did you think?

- ✦ The Nursing Supervisor asks the janitor, Ms. Dawson, why she has not cleaned Mr. Thomas' (a patient) room.
- ✦ Ms. Dawson has heard that Mr. Thomas has HIV. The Nursing Supervisor does not address this breach in confidentiality.
- ✦ Ms. Dawson fears she may catch HIV by going into Mr. Thomas' room.
- ✦ Ms. Dawson believes that Mr. Thomas caught HIV because he is a homosexual and a sinner.
- ✦ Ms. Dawson believes that she cannot catch HIV because she is a married woman with religious values.
- ✦ The Nursing Supervisor attempts to educate Ms. Dawson, but uses a harsh tone.

2. What were Ms. Dawson's (the janitor's) views about HIV/AIDS, how the disease is transmitted, and people with the disease?

- ✦ She believes HIV is a homosexual disease and she displayed homophobia.
- ✦ She fears catching HIV.
- ✦ She believes married people cannot get HIV.
- ✦ She thinks that she can't get HIV if she is "a God-fearing" person.
- ✦ She believes people with HIV are being punished for their lifestyle. She believes they have sinned.
- ✦ She attaches a value judgement to the mode of transmission by which she assumes Mr. Thomas became infected.
- ✦ She fears that she will contract HIV by being physically close to or cleaning the room of a person with HIV.

"as long as you are having unsafe sex, you are at risk. I could be living right and still get HIV."

3. How do you think the patient whose room hadn't been cleaned felt? How do you think Ms. Dawson's (the janitor's) views about HIV affect the patients in the hospital?

- ✦ The patient might have felt neglected, abandoned, and discriminated against. This might result in lowered self-esteem and internalised stigma (e.g. loss of hope, feelings of worthlessness and inferiority).
- ✦ Other patients in the hospital may notice differential cleaning services amongst patients, which may contribute to their own stigmatising attitudes towards PLWHA.
- ✦ If patients become aware of discrimination in this facility, they may not seek testing, care, treatment or other support services they need.

- 4. How do you think the Nursing Supervisor handled the situation?**
- ✦ **What were the strengths and weaknesses of her approach?**
 - ✦ **What could she have done differently?**

Strengths

- ✦ The Nursing Supervisor stood up for the issue of patients' rights by confronting Ms. Dawson (the janitor) about her discriminatory behaviour.
- ✦ She stressed patient rights and equity of care as a professional duty.
- ✦ She spoke to the janitor in private to avoid embarrassing her.
- ✦ To further address these issues amongst the entire housekeeping staff, the Nursing Supervisor scheduled a follow-up meeting. This approach may help to prevent further problems in the future.

Weaknesses

- ✦ The Nursing Supervisor wasn't really able to put Ms. Dawson at ease – Ms. Dawson was put on the defensive from the beginning.
- ✦ The nurse spoke to Ms. Dawson in a very harsh manner. It appeared that she was talking down to the janitor. At the end, it was unclear whether actual communication or learning had taken place.

Suggestions

- ✦ The Nursing Supervisor could have been more respectful of the janitor by trying to understand her views.
- ✦ She could have corrected misconceptions and provided facts in a more gentle, respectful manner.
- ✦ The Nursing Supervisor could probably benefit from training in interpersonal communication.
- ✦ The Nursing Supervisor should have taken the opportunity to address issues of confidentiality during the course of the conversation with the janitor.
- ✦ The Nursing Supervisor might say, "Ms. Dawson, you know our hospital has a very clear policy on patient confidentiality. You should never discuss a patient's status with anyone, including staff inside the hospital or with anyone outside the hospital."
- ✦ The nurse could have referred to UP and PEP, and educated the janitor about gloves and gowns and how they provide protection.
- ✦ The nurse should have indicated that it is inappropriate to use the word "batiman" (derogatory term for a gay person) in the work place.
- ✦ The follow-up meeting or any subsequent trainings should go beyond simply providing information and facts to the housekeeping staff. Training should also sensitise the staff to needs, concerns and rights of PLWHA.

5. Do you think Ms. Dawson will behave differently after her conversation with the Nursing Supervisor? Why or why not?

- ✦ The janitor appeared to be submitting to the Nursing Supervisor's authority, but did not appear to have accepted the information.
- ✦ She might comply in the short-term to avoid losing her job, but it is likely she will remain with her discriminatory behaviour if she hasn't changed her beliefs.

6. What would you tell Ms. Dawson about HIV and HIV transmission in order to reduce her fear of catching HIV from a patient?

What Ms. Dawson needs to know:

- ✦ Basic facts about HIV. Refer to **Appendix F** for basic facts on HIV/AIDS.
- ✦ Everybody is at risk of contracting HIV, even if they are married and even if they are religious.
- ✦ Heterosexual transmission is the most common mode of transmission in the Caribbean; it is not a homosexual (gay) disease. Refer to **Appendix E** for the epidemiology of HIV in the Caribbean.
- ✦ The three main modes of transmission:
 - **Sexual contact:** vaginal, anal, oral
 - **Blood contact:** injections/needle sharing (through IV drugs, drug paraphernalia or injury from contaminated sharps), cutting tools (needles, razor blades, other instruments that can pierce the skin), transfusions, contact with broken skin (exposure to blood through cuts/lesions)
 - **Mother-to-child transmission:** pregnancy, delivery, breast feeding
- ✦ Ms. Dawson should be aware of **Universal Precautions (UP)** and post-exposure prophylaxis (PEP).
- ✦ Unprotected sexual intercourse and unsafe sexual practices carry a MUCH higher risk of HIV transmission than accidental exposure to blood and body fluids in the healthcare setting.
- ✦ Refer to **Appendix G** for detailed information on the risks associated with various behaviours and exposures.

"I know people who behave like this. Some think you can get it by drinking from the same cup."

7. Ask for volunteers to role-play how they could provide this information to Ms. Dawson in a more respectful manner. After the role-play, discuss the strengths of the approach used and make suggestions for strengthening the approach.

8. What are the confidentiality issues that came up in this scenario?

- ✦ There has been a breach of confidentiality in the hospital, as the janitor makes reference to Mr. Thomas, the patient, having HIV.
- ✦ The Nursing Supervisor implicitly confirmed that the patient was HIV-positive.
- ✦ Gossip, spreading rumours and violating Mr. Thomas' confidentiality with respect to his HIV status are forms of stigma and discrimination.

9. Have you seen anything similar to this happen in a health facility? What happened and how was it addressed?

10. How could you prevent this type of thing from happening in your facility?

- ✦ Ensure that all levels of staff have basic training on HIV including transmission.
- ✦ Conduct regular training and refresher training on UP and PEP.
- ✦ Engage the support of religious leaders in the community and ask them to speak to hospital staff.
- ✦ Establish a person, committee, or protocol for addressing this type of situation in which staff members are not observing policy (if a non-discrimination policy exists).

11. Are there any policies in place in your setting that address this type of scenario?

- ✦ If yes, discuss what they are, their effectiveness, and how monitoring and enforcement of these policies could be improved.
- ✦ If no, discuss what types of policies could be established that would be relevant to this situation.
- ✦ Health care facilities can adopt non-discrimination patient rights policies by which all health care workers must abide.
 - Health care workers can advocate for such policies in their own workplaces.
 - See **Appendix J** for a sample of a national patients' rights document.
- ✦ Training should be provided to staff at ALL levels on how to respect patients' rights. All new staff orientations should include this information. If such a policy existed in this scenario, the Nursing Supervisor could refer to it in her discussion with Ms. Dawson.
- ✦ UP and PEP are the best way to prevent transmission in a health care setting and can decrease HCWs' fears about HIV transmission.

“There are higher up issues...Why did this happen, what in the system allowed this to happen?”

- Refer to **Appendix H** for more information on UP and **Appendix I** for CAREC's PEP policy.
- UP and PEP policies should ensure availability of essential supplies (e.g. gloves, PEP) for maintaining optimum infection control practices at all times, not only for HCWs to protect themselves but also to protect patients.

SUMMARY

1. Summarise the discussion using the key points provided below which detail important take-home information from this scenario.
2. Ask the group to share action steps or anything that they will do differently when they return to their site as a result of this discussion.
3. Emphasise commitment to confidentiality and sensitivity to the information shared by members of the group.
4. Thank all for the discussion and their participation.
5. If this is the final scenario to be presented to the group, distribute the evaluation form found in **Appendix M**. The information obtained from this form can be used to assess the effectiveness of the training in triggering insight, reflection, and intent to act amongst participants, and to obtain suggestions for improving the materials.

KEY POINTS

- ❖ Supervisors have a responsibility to confront employees who are practicing stigma and discrimination. The interaction must be respectful and thoughtful in order to promote behaviour change rather than defensiveness in the employee.
- ❖ People become infected with HIV because of what they or their partner(s) do, not because of who they are. Everybody is at risk of HIV, not just certain groups.
- ❖ There are three main modes of transmission of HIV: sexual contact, blood contact and MTCT; each mode of transmission carries varying levels of risk.
- ❖ Staff at all levels need basic HIV training. This will help them to better serve patients and to understand their own risk for HIV infection at work and in their lives.
- ❖ There are many ways in which confidentiality can potentially be breached.
- ❖ Training, supervision, and supplies related to the prevention of infections (UP and PEP) must be in place and available to all levels of staff to ensure a safe workplace and decrease HCWs' fears related to HIV transmission.

TRIGGER SCENARIO I: ACTIVITY

Plan the Training

If time allows, facilitators should consider ending the session on this scenario with this activity.

This activity builds on the Nursing Supervisor's final statement, which calls for a meeting with all housekeeping staff the following day. This activity will allow participants to consider the training needs of the housekeeping staff at their own facility. It will also help them to think about how the ideas discussed in this session might play out in their own workplace.



Time: 20-40 minutes (see instructions)

Materials Necessary: Paper (optional)

Pens/pencils (optional)

INSTRUCTIONS:

- ✦ Divide participants into small groups (no more than 4 participants per group). Present the following task:
 - Think about the Nursing Supervisor and her upcoming meeting with the housekeeping staff. Reflect on the topics and issues she may want to address.
- ✦ If time is limited, ask each group to:
 - Identify at least 5 key points the Nursing Supervisor should cover at the meeting and record them on a flipchart.
- ✦ If there is ample time, ask each group to:
 - Brainstorm the training needs (related to issues covered in this session) of the housekeeping staff at their health care facility.
 - Make an outline on a piece of paper of a one-day training to be conducted with the housekeeping staff.
 - Ask groups to discuss challenges of various components of the training and how they might best address them.
 - After the groups have completed their outline, reconvene the large group. Have each small group briefly present their outline to the large group and discuss any issues that come up.



SCENARIO I: SCRIPT

MS. DAWSON'S MEETING

A Nursing Supervisor is sitting at desk in her office. The door is open. Outside the door, a janitor is mopping.

1. **Nursing Supervisor:** One word with you Ms. Dawson.
2. **Janitor:** *Me a lil' busy right now, ma'am.*
3. **Nursing Supervisor:** *We're all busy Ms. Dawson. This is important. Step in please. (Janitor enters and closes the door.) Have a seat. (Sifting through papers on her desk.) My roster says... Yes here it is... That you're the one assigned to clean room five.*
4. **Janitor:** *De room wid Mr. Thomas?*
5. **Nursing Supervisor:** *You're quite correct about his name. When was the last time you cleaned Mr.Thomas' room?*
6. **Janitor:** *Pardon me, ma'am?*
7. **Nursing Supervisor:** *You didn't hear the question? (Janitor doesn't respond.) Mr. Thomas complains that no one has been in to clean his room.*
8. **Janitor:** *Dey say him 'ave AIDS ma'am.*
9. **Nursing Supervisor:** *So?*
10. **Janitor:** *Is devil disease dat, ma'am. Me no want fe catch it.*
11. **Nursing Supervisor:** *Devil disease... You think you can catch AIDS by cleaning a room?*
12. **Janitor:** *Me no want fe go close to dat man ma'am. Him is a dirty man. If him wasn't so nasty him wouldn't catch AIDS. I believe in de teachings of me church ma'am and we believe say is a punishment him a get for his nasty behaviour!*
13. **Nursing Supervisor:** *And who is punishing him, Ms. Dawson?*
14. **Janitor:** *De Lord Jehovah of course ma'am. Who else?*
15. **Nursing Supervisor:** *And why would the good Lord do that, Ms. Dawson?*
16. **Janitor:** *Because him is a batiman! Me no surprise him catch de disease. One man lying down wid*

anudder is an abomination unto the Lord ma'am. Me no want fe go anywhere near him or him room.

17. **Nursing Supervisor:** *What? This doesn't sound good at all, Ms. Dawson. AIDS is not a gay disease. Don't you know that any one of us can get AIDS? You don't have to be gay! What about the babies who are being born with HIV; are they too being punished?*
18. **Janitor:** *Dem a pay fe dem mudder sin, ma'am.*
19. **Nursing Supervisor:** *Suppose it were you who had become infected with HIV. Suppose it were you lying down on the hospital bed and the janitor refused to clean your room? How would you feel?*
20. **Janitor:** *Me is a married woman, ma'am.*
21. **Nursing Supervisor:** *Yes, even married people have AIDS.*
22. **Janitor:** *Me and me husband are God-fearing people ma'am. If we did sin, den we mus face de wrath of de Lord.*
23. **Nursing Supervisor:** *With all due respect to you and your religion Ms. Dawson... Mr. Thomas is a human being like all of us and he deserves to be treated with dignity and respect. Even more so, he is sick and he is our patient. And we must be sensitive to his needs. And remember, it is our duty to provide care to all of our patients. Do you understand what I am saying, Ms. Dawson?*
24. **Janitor:** *Yes ma'am.*
25. **Nursing Supervisor:** *Ok. Good! I am calling a meeting tomorrow morning at 10.00 am sharp in the lunchroom, with all housekeeping staff, so that we may have more discussion on the matter. Okay?*
26. **Janitor:** *Yes ma'am.*



SCENARIO TWO: WHO SAY THAT BIG MAN DOH CRY?



SCENARIO OVERVIEW

Scenario Overview (*do not read aloud to participants*): Five hospital workers gossip about a co-worker who tested positive for HIV. They share various opinions about the co-worker, including whether or not he should be allowed to continue working in the operating theatre.

Discussion Themes:

- + Patient rights
- + Basic HIV prevention and transmission
- + Value judgements
- + Confidentiality
- + Voluntary counselling and testing (VCT) for Health Care Workers (HCWs)
- + Confronting stigma and discrimination in the workplace
- + Institutional Policy

Session Time: Allow at least 30-45 minutes for a complete discussion of this video scenario (video is about 3 and 1/2 minutes long). Depending on the context of the discussion (e.g. part of larger training or stand alone), the discussion can be expanded/adapted with additional questions and discussion.

Resources Needed:

- + VCR or DVD player or computer with DVD capacity
- + TV or projector with speakers



IF THIS IS THE FIRST SCENARIO TO BE PRESENTED TO THE GROUP:

1. Begin with a brief introduction to the issue of stigma and discrimination (5 minutes).
 - ✦ Stigma is an unfavourable attitude or belief directed toward an individual or a group, while discrimination is an unfavourable act or behaviour towards an individual or group.
 - ✦ Both stigma and discrimination occur even in healthcare settings and are significant obstacles to providing quality care, treatment, and prevention services.
 - ✦ As the Caribbean region scales up its response to HIV/AIDS, it is vitally important that all health care workers contribute to establishing an environment in which all patients are treated with kindness and compassion.
 - ✦ Additional background information on stigma and discrimination is available in **Appendix A**.
2. Discuss the importance of confidentiality, and obtain agreement from participants regarding the confidential nature of the discussion (refer to **Appendix L** for a sample confidentiality agreement).
3. Establish ground rules for the group discussion (see **Appendix B** for more information). The ground rules will depend in part on the size and composition of the group. Key ground rules include:
 - ✦ Do not interrupt or speak over another person
 - ✦ Cell phones off or on vibrate
 - ✦ Criticise the idea, not the person
 - ✦ Respect the views of others, not necessarily agreeing with them
 - ✦ Participate at your comfort level



FACILITATOR INSTRUCTIONS

1. **Introduce** the scenario to participants by reading the following:

- ✦ “The video scenario you are about to see shows a nurse and a janitor from the house-keeping staff having a discussion about a patient. After the video, we will have a discussion.”

2. **Play** the video. At the end of the trigger scenario video, the DVD will automatically stop. If you are using a VHS, you will need to manually stop or pause the video tape.

3. **Initiate discussion** with participants using the discussion questions and the possible answers below as a tool to guide the discussion. Use probing questions to stimulate discussion and draw out important topics. See **Appendix B** for more information on facilitation skills.

- ✦ Point out that there are not necessarily “right” or “wrong” answers to many of these questions. It is not necessary for the group to reach consensus on every question.
- ✦ Be sure to distinguish between facts and opinions during the discussion. Gently correct any misinformation or myths.

It is not necessary to ask the questions in the discussion guide in the order presented here.

- ✦ In many cases the discussion will move spontaneously from one topic to another.
- ✦ Use the summary table of Discussion Guide Questions to locate where specific questions appear in this guide.
- ✦ If participants have already discussed a particular question, it is not necessary to ask it again.



NOTE: Quotes in the boxes are from Caribbean Health Care Workers in response to the discussion questions.

DISCUSSION GUIDE QUESTIONS



The table below is a summary of the discussion questions included in this discussion guide. The discussion will likely move from one topic to another rather than follow the order of questions. Use this table to identify topics of discussion that arise and quickly locate where the responses appear in the Discussion Guide below.

DISCUSSION QUESTIONS

1. What happened in this scenario? What did you think?
2. What were the hospital workers' views about HIV/AIDS, how it is transmitted, and people who are HIV-positive?
3. Why do you think Allan remained quiet during the scenario?
4. If you had been sitting at the table in this scenario, what could you have said? Ask participants to give examples of positive responses in this type of situation.
5. Have you seen anything similar to this happen in a health facility? What happened and how was it addressed?
6. What could you do in your facility to prevent this type of breach in confidentiality from happening? How do you stand up to co-workers who are gossiping?
7. Should Michael be allowed to work in the theatre if he is HIV-positive? If you have an HIV-positive person on your staff, would you let them work in the theatre?
8. In your setting, where do HCWs go for VCT? What are some of the issues related to testing that are unique to health care workers?
9. Are there any policies in place in your setting that address this type of scenario?
 - If yes: a) what are they? b) are they monitored, enforced effectively? What could be done to ensure they are enforced?
 - If no, what types of policies would be relevant to this type of situation?

1. What happened in this scenario? What did you think?

- ✦ A group of hospital workers breached confidentiality by gossiping about a co-worker's (Michael) HIV status in the lunch room.
- ✦ Michael's right to keep his HIV status confidential has been violated.
- ✦ It is not clear from the scenario whether Stephanie actually witnessed Michael discussing his HIV status and job reassignment, or whether her story is based only on rumours.
- ✦ It appears that confidentiality was breached by other staff in the hospital since the theatre sister knew Michael's HIV status.
- ✦ According to Stephanie, Michael's supervisor informed him that he is no longer permitted to work in the theatre because he is HIV-positive.
- ✦ The characters discussed their ideas about how HIV can and cannot be transmitted.
- ✦ Several of the characters' remarks presumed that Michael became infected through casual/promiscuous sexual activity.
- ✦ Allan remained quiet while his co-workers gossiped.

"With the level of staff that had this information [about Michael's HIV status] I'm concerned about what would happen. I'm really empathising with this man. My fear is that this information will spread to patients."

2. What were the hospital workers views about HIV/AIDS, how it is transmitted, and people who are HIV-positive?

- ✦ Stephanie, one hospital worker, believed that she could catch HIV from hugging Michael.
- ✦ Marva and Ronnie, two other hospital workers, were concerned that Michael could pass the virus on to a patient while working in the theatre.
 - Facilitator's Note: Peripheral contact with blood (e.g. touching blood left on instrument) or other nonsexual body fluids carries an extremely low risk of HIV transmission. Refer to **Appendix G** for detailed information on the risks associated with various behaviours and exposures.
- ✦ The health care workers' remarks assumed that Michael became infected through promiscuous sexual activity and that he therefore deserved to be infected.
- ✦ The HCWs attached a value judgement to the behaviours they *assumed* Michael must have engaged in and the kind of life he leads.
- ✦ The hospital workers are perpetuating stigmatising attitudes in the workplace by gossiping and violating Michael's confidentiality with respect to his HIV status.

3. Why do you think Allan remained quiet during the scenario?

- + Allan may feel empathetic towards Michael.
- + He may be uncomfortable with or angry about the breach of confidentiality that is happening, but unable to stand up to his co-workers.
 - He may worry about what his co-workers might say about him behind his back.
- + He may be HIV-positive (or worried that he might be) and worry about the implications of his own status on his work and social interactions.
- + He may have been new at the job and just couldn't believe the discussion he was hearing.
- + He could be in shock – how could his co-workers know all this?
- + He may know or have heard some other aspect to Michael's story, but may not feel comfortable adding to the gossip.

4. If you had been sitting at the table in this scenario, what could you have said? Ask participants to give examples of positive responses in this type of situation.

- + "I don't think we should be talking about Michael this way. His HIV status is his business, and he has a right to keep it private."
- + "I'm sorry, but we shouldn't be talking about this. Can we change the subject?"
- + "How many of you know your status?"
- + "What if it were you in his shoes? Is this how you would want to be treated?"
- + "Stop. This is none of our business."
- + "Respecting confidentiality of our co-workers is no different from that of our patients. We have a professional responsibility to respect the confidentiality of both."

"Could ask, 'How many of you know your status?' That will shut them up quickly!"

5. Have you seen anything similar to this happen in a health facility? What happened and how was it addressed?

6. What could you do in your facility to prevent this type of breach in confidentiality from happening? How do you stand up to co-workers who are gossiping?

- + Training should be provided to all levels of staff on confidentiality and VCT policies. All new staff should be oriented to these policies.
- + Institute better confidentiality protocols for HIV-positive staff.

- ✦ Enforce staff only seeing files or becoming aware of other co-workers' HIV status on a need-to-know basis.
- ✦ Protocols regarding confidentiality and VCT policies and their enforcement can be addressed through formal (institutional level) and informal (one-on-one or peer level) channels.
- ✦ At a staff meeting, remind all staff that it is inappropriate to discuss other staff members' HIV status, assumed or known, unless it is part of a professional, confidential discussion (e.g. counselling on post-exposure prophylaxis following an exposure).
- ✦ Establish a person, committee, or protocol for addressing this type of situation in which staff members are not observing policy (if a non-discrimination policy exists).

7. Should Michael be allowed to work in the theatre if he is HIV-positive? If you have an HIV-positive person on your staff, would you let them work in the theatre?

- ✦ Many health care workers do not know their HIV status, so it is possible there could be others working in the theatre who are HIV-positive but unaware of their status.
- ✦ Consider the impact of banning all HIV positive staff from working in the theatre.
 - Other HCWs may not step forward to be tested.
 - If they do know their status, they may be afraid to disclose because of the gossip, rumours, breach of confidentiality, and loss of role status (like what happened to Michael).
- ✦ A decision regarding whether or not Michael should continue working in the theatre following testing positive for HIV should be based on clearly articulated and well-followed institutional policies to prevent further stigma and discrimination.
- ✦ Michael should have the opportunity to advocate for his own rights within the workplace both as an employee and as a PLWHA.
- ✦ Health care workers who know they are HIV-positive should not be involved in “**exposure-prone procedures**”, or any activities or procedures that present a recognised risk of percutaneous injury to the HCW. When a percutaneous injury occurs, the HCW's blood is likely to contact the patient's body cavity, subcutaneous tissues, or mucous membranes increasing risk of infection. Characteristics of exposure-prone procedures include:
 - Digital palpation of a needle tip in a body cavity
 - Simultaneous presence of the HCW's fingers and a needle or other sharp

“This is an issue of proper technique – if the person uses proper technique [in the theatre], there should be no problem [with his HIV status].”

instrument or object in a poorly visualised or highly confined anatomic site (CDC, 1991).

- Medical/dental/surgical organisations and institutions should identify which procedures are “exposure-prone” at the health care facilities where they are performed (CDC, 1991).

8. In your setting, where do HCWs go for VCT? What are some of the issues related to testing that are unique to health care workers

Facilitator’s Note: The situation of health care workers is unique because they may receive counselling and testing from co-workers; this may create concerns about confidentiality. Discuss this possibility with participants and their experiences with counselling and testing of health care workers.

9. Are there any policies in place in your setting that address this type of scenario?

- ◆ If yes: a) what are they? b) are they monitored, enforced effectively? c) What could be done to ensure they are enforced?
- ◆ If no, what types of policies would be relevant to this type of situation?

No Policies

- ◆ Policies should clearly address VCT for staff and protocols for when staff test positive.
- ◆ Health care facilities can adopt policies on VCT and confidentiality; health care workers at all levels should be educated on these policies. See **Appendix J** for sample patients’ rights documents that address confidentiality.
- ◆ HCWs can advocate for institutional policies around informed consent and confidentiality.

Better Enforcement:

- ◆ All clinic staff should be made aware of the clinic’s policies related to testing, informed consent, and confidentiality.
- ◆ Clinic staff can be required to sign statements indicating that they have read the policies and agree to abide by them.
- ◆ Training should be provided to all staff on confidentiality and VCT policies. All new staff should be oriented to these policies.
 - Staff training should address strategies for how HCWs can address breaches in confidentiality among their peers and supervisors/employees.

SUMMARY

1. Summarise the discussion using the key points provided below which detail important take-home information from this scenario.
2. Ask the group to share action steps or anything that they will do differently when they return to their site as a result of this discussion.
3. Emphasise commitment to confidentiality and sensitivity to the information shared by members of the group.
4. Thank all for the discussion and their participation.
5. If this is the final scenario to be presented to the group, distribute the evaluation form found in **Appendix M**. The information obtained from this form can be used to assess the effectiveness of the training in triggering insight, reflection, and intent to act amongst participants, and to obtain suggestions for improving the materials.

KEY POINTS

- ❖ All health care workers, whether or not they counsel patients, should have a thorough understanding of how HIV is and is not transmitted.
- ❖ Health care policy on HIV-positive health care workers should be based on clearly articulated and well-followed institutional policies to prevent stigma and discrimination.
- ❖ Health care workers have a professional obligation to uphold patient AND staff confidentiality at ALL times.
- ❖ Gossip, rumours, and violating the confidentiality of a co-worker are forms of stigma and discrimination and the consequences for the individual can be severe.
- ❖ Breaches of confidentiality by health care workers should be investigated and those responsible should be disciplined according to a clear policy.
- ❖ Institutional policies on HIV-positive staff can help to protect the confidentiality of staff and ensure that decisions regarding roles at work can be made as fairly as possible, with accurate assessment of risks involved to patients.

TRIGGER SCENARIO 2: ACTIVITY

Role Play

If time allows, facilitators should consider ending the session on this scenario with a role play activity.

This activity will allow participants to “re-write” the scenario they have just seen and discussed, incorporating their ideas about how the situation might have been handled differently by the characters involved. It will also help them to think about how the ideas discussed in this session might play out in their own work and lives.



Time: 15-30 minutes

Materials Necessary: Copies of *Scenario 2: Script* for each participant
Paper (optional)
Pens/pencils (optional)

Scenario 2

INSTRUCTIONS:

- ✦ Divide participants into groups of five.
- ✦ Each group should determine who will play each character in the scenario.
- ✦ Ask participants to refer to *Scenario 2: Script*, and use this script as a starting point for the role play.
 - Instruct the groups to consider how the characters could have behaved differently in this situation in order to prevent or divert the gossip, stigma, and discrimination in the conversation.
 - Participants should pay particular attention to:
 - ❑ Allan’s character – what might be leading him to remain silent, and how he might intervene in the situation?
 - ❑ How could the characters have responded to some of the rumours and value judgments expressed by other characters?
 - ❑ How could an institutional policy on HIV-positive staff influence the course of the scenario?
- ✦ Each group should enact the scenario, with the changes they have discussed.
- ✦ After the groups have completed the role plays, reconvene the large group.

- ✦ Discuss the strategies and approaches that were used. Lead a discussion using the following questions:
 - Ask the participants how successful they felt they were in responding to the rumours and value judgements of others. What did they do well? What would they change?
- ✦ If there is ample time, ask one group to volunteer to perform the role play in front of the large group. Ask the larger group to reflect on how the scene played out:
 - Ask the group to start with what they thought certain characters did well, then make suggestions for things they might have done differently.



SCENARIO 2: SCRIPT

WHO SAY THAT BIG MAN DOH CRY?

Groups of health care workers (Stephanie, Dixon, Ronnie, Marva and Allan) are sitting at a table in the lunchroom.

1. **Stephanie:** *Oy! All you eh hear de latest yet?!*
2. **Dixon:** *Well I suppose you go tell we.*
3. **Ronnie:** *Stephanie always have some story.*
4. **Marva:** *Stephanie why you never work for de Guardian?*
5. **Dixon:** *All you shut up, let de girl give we de news!*
6. **Stephanie:** *Oy, dah eh no joke you know. Dey send Michael home yesterday.*
7. **Ronnie:** *Michael who?*
8. **Marva:** *Michael Ling?*
9. **Stephanie:** *Michael working in theatre.*
10. **Dixon:** *They send him home?*
11. **Stephanie:** *Just for a couple of days. But they say when he return, he reporting straight to the X-Ray Department, to call names.*
12. **Ronnie:** *X-Ray department! Strange...*
13. **Stephanie:** *Yeah, to call names and do paper work. Hear de rest of the story. Michael had his annual medical check-up and when de results come back, de ting show dat de man have de virus.*
14. **Marva:** *HIV?*
15. **Stephanie:** *Positive!*
16. **Ronnie:** *Oh no!*
17. **Marva:** *Serve him right! Not cocksman he playing.*
18. **Dixon:** *After dey send de man on so many courses to assist in theatre, dey take him just so and*

transfer him to X-Ray?!

19. **Marva:** *Dey right I tell you! Let him stay in X-Ray to call names and do paperwork. No physical contact with the patients! Any man who chayn keep his hose in one corner must learn. Allan what you have to say about that?*

Allan shrugs his shoulders without saying anything.

20. **Ronnie:** *Wait, wait, wait... When dat happen boy?*

As Stephanie narrates, the shot dissolves to indicate flashback. We see Michael and the Theatre Sister performing the actions she describes. Their voices are not heard but we see their gesturing and moving lips.

21. **Stephanie:** *Yesterday self, I telling you. (flashback) De man went to work as usual, go in de locker room, change his clothes, go in theatre, wash his hands put on his gloves. When the Theatre Sister call him aside and tell him dat he can no longer work in de theatre.*

22. **Marva:** *She right.*

23. **Stephanie:** *Yea, Michael put up a fight. But de Sister tell him de orders coming straight from de Chief. Yea, she tell him take two days, go home, let dem work tings out. And when he come back, he must report straight to de X-Ray Department.*

24. **Marva:** *Serve him right. Dats what he was looking for, dats what he get! Michael like too much woman.*

25. **Ronnie:** *I feel sorry for he, you know. But I can understand why deh don't want him in surgery. Dah is blood and instruments going from one hand to the other.*

26. **Marva:** *You know wha Ah mean? Next ting Michael pass on de virus to de patients.*

27. **Ronnie:** *To de doctors too. He lucky he get to keep his job, boy. De way I see it, once you catch dat AIDS thing, you eh suppose to be around people, period! Far less work in a hospital.*

28. **Dixon:** *Every man can make a mistake. Michael was too damn stupid, dah is why he get ketch.*

29. **Marva:** *I woulda excuse de man if he had catch de virus a different way, but any man who was running woman and you catch AIDS... Dey shoulda throw you outta society. Allan, wha you have to say about that? You agree?*

Allan rests his head on his hand, without saying anything.

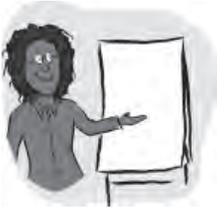


30. Stephanie: *Michael take it real hard. I wanted to give him some comfort, but there no way I was going to touch him! Next ting I get ketch! All you shoulda be dere yesterday when Michael left de hospital. Who say big man doh cry?*

Allan leans over, places his arms on the table, and buries his face.



SCENARIO THREE: WHEN PUSH COMES TO SHOVE



SCENARIO OVERVIEW

Scenario Overview (*do not read aloud to participants*): A nurse observes that a doctor in her facility appears to be prescribing treatment for HIV/AIDS patients without examining them. The nurse confronts the doctor about his stigma and discrimination.

Discussion Themes:

- + Value Judgements
- + Patient rights and equity of care
- + Confronting stigma and discrimination in the workplace
- + Institutional policy

Session Time: Allow at least 30-45 minutes for a complete discussion of this video scenario (video is 4 minutes long). Depending on the context of the discussion (e.g. part of larger training or stand alone), the discussion can be expanded/adapted with additional questions and discussion.

Resources Needed:

- + VCR or DVD player or computer with DVD capacity
- + TV or projector with speakers



IF THIS IS THE FIRST SCENARIO TO BE PRESENTED TO THE GROUP:

- 1.** Begin with a brief introduction to the issue of stigma and discrimination (5 minutes).
 - ✦ Stigma is an unfavourable attitude or belief directed toward an individual or a group, while discrimination is an unfavourable act or behaviour towards an individual or group.
 - ✦ Both stigma and discrimination occur even in healthcare settings and are significant obstacles to providing quality care, treatment, and prevention services.
 - ✦ As the Caribbean region scales up its response to HIV/AIDS, it is vitally important that all health care workers contribute to establishing an environment in which all patients are treated with kindness and compassion.
 - ✦ Additional background information on stigma and discrimination is available in **Appendix A**.
- 2.** Discuss the importance of confidentiality, and obtain agreement from participants regarding the confidential nature of the discussion (refer to **Appendix L** for a sample confidentiality agreement).
- 3.** Establish ground rules for the group discussion (see **Appendix B** for more information). The ground rules will depend in part on the size and composition of the group. Key ground rules include:
 - ✦ Do not interrupt or speak over another person
 - ✦ Cell phones off or on vibrate
 - ✦ Criticise the idea, not the person
 - ✦ Respect the views of others, not necessarily agreeing with them
 - ✦ Participate at your comfort level



FACILITATOR INSTRUCTIONS

1. **Introduce** the scenario to participants by reading the following:
 - ✦ “The video scenario you are about to see shows a nurse talking with a doctor about a patient. After the video, we will have a discussion.”
2. **Play** the video. At the end of the trigger scenario video, the DVD will automatically stop. If you are using a VHS, you will need to manually stop or pause the video tape.
3. **Initiate discussion** with participants using the discussion questions and the possible answers below as a tool to guide the discussion. Use probing questions to stimulate discussion and draw out important topics. See **Appendix B** for more information on facilitation skills.
 - ✦ Point out that there are not necessarily “right” or “wrong” answers to many of these questions. It is not necessary for the group to reach consensus on every question.
 - ✦ Be sure to distinguish between facts and opinions during the discussion. Gently correct any misinformation or myths.

It is not necessary to ask the questions in the discussion guide in the order presented here.

- ✦ In many cases the discussion will move spontaneously from one topic to another.
- ✦ Use the summary table of Discussion Guide Questions to locate where specific questions appear in this guide.
- ✦ If participants have already discussed a particular question, it is not necessary to ask it again.



NOTE: Quotes in the boxes are from Caribbean Health Care Workers in response to the discussion questions.

DISCUSSION GUIDE QUESTIONS



The table below is a summary of the discussion questions included in this discussion guide. The discussion will likely move from one topic to another rather than follow the order of questions. Use this table to identify topics of discussion that arise and quickly locate where the responses appear in the Discussion Guide below.

DISCUSSION QUESTIONS

1. What happened in this scenario? What did you think?
2. What were Dr. Charles' views about HIV/AIDS and people with the disease? Did it surprise you that a physician could hold these views?
3. How do you think Dr. Charles' views and approach to providing care affected the patients on the ward?
4. How do you think Nurse Smith handled the situation?
 - What were the strengths and weaknesses of her approach?
 - What could she have done differently?
5. What do you think the nurse was thinking at the end of the scenario when she was shaking her head in response to Dr. Charles' comment, "Whom do we leave out?"
6. In your setting, would a nurse be able to provide this type of feedback to a doctor? If no, what strategies could a nurse use to address the issue highlighted here (the doctor's failure to examine HIV-positive patients before prescribing treatment)?
7. Have you seen anything similar to this happen in a health facility? What happened and how was it addressed?
8. What could you do in your facility to prevent this type of thing from happening?
9. Are there any policies in place in your setting that address this type of scenario?
 - If yes: a) what are they? b) are they monitored, enforced effectively? What could be done to ensure they are enforced?
 - If no, what types of policies would be relevant to this type of situation?

1. What happened in this scenario? What did you think?

- ✦ Nurse Smith confronted Dr. Charles about his differential treatment of patients with HIV/AIDS.
- ✦ Dr. Charles became defensive and irritated about the issues raised by Nurse Smith and berated her for questioning his work.
- ✦ The doctor justified providing substandard care to HIV/AIDS patients stating that “they’re going to die anyway.”
- ✦ Nurse Smith stood up to the doctor and called for patient equity.

2. What were Dr. Charles’ views about HIV/AIDS and people with the disease? Did it surprise you that a physician could hold these views?

- ✦ Dr. Charles made assumptions about how his patients lived their lives based on their HIV status.
- ✦ Dr. Charles considered people with HIV “careless”, and felt that they “deserved it.”
- ✦ Dr. Charles had judgmental attitudes – PLWHA have been “running around.”
- ✦ He attached a **value judgement** to the mode of transmission by which he assumed his patients became infected.
- ✦ He justified providing HIV/AIDS patients with substandard care by stating they “do not value their own lives”.
- ✦ He believed that HIV/AIDS patients are going to “die soon anyway”, and argued that the hospitals’ limited resources were better focused on patients with curable illnesses.

“Even educated persons can have misconceptions. Personal, religious beliefs can affect people’s views.”

“This reminds us that before you became a doctor or a nurse you were a person, had views, opinions. You don’t lose those just because you’ve gained knowledge in a particular area.”

3. How do you think Dr. Charles’ views and approach to providing care affected the patients on the ward?

- ✦ Patients might believe they’re worthless and have no reason to live. They might believe they won’t be there much longer.
- ✦ Patients might feel neglected, discriminated against. This can potentially lower their self-esteem and lead to internalised stigma (e.g. loss of hope, feelings of worthlessness and inferiority). The doctor’s role as an authority figure could heighten these feelings.
- ✦ Patients might feel abandoned, hopeless.

- ✦ Patients may lose confidence in the health care system.
- ✦ If patients become aware of discrimination in health care settings, they may not seek testing, care, treatment or other support services they need.
- ✦ Other patients in the ward may see the differential care that PLWHA are receiving, which may contribute to their own stigmatising attitudes towards PLWHA.
 - If examination before prescribing treatment is the standard of care, then ALL patients in Dr. Charles' ward should receive this level of care.

4. How do you think Nurse Smith handled the situation?

- ✦ What were the strengths of her approach?
- ✦ What could she have done differently?

Strengths

- ✦ Nurse Smith stood up for her patients' rights by confronting Dr. Charles about the discriminatory care she observed.
- ✦ She spoke to Dr. Charles in a calm, respectful, yet assertive manner, showing leadership and advocacy for her patients.
- ✦ She was persistent without being disrespectful.
- ✦ She spoke to the doctor away from the patients.
- ✦ She was direct and firm.

Weaknesses

- ✦ The timing wasn't good. Dr. Charles appeared to be in a rush.
- ✦ A more private setting (e.g. in an office) may have made him less defensive.

Suggestions

- ✦ She could have scheduled a meeting with Dr. Charles to discuss this issue so that he wasn't rushed or pressed for time.
- ✦ She could have asked Dr. Charles, "How would you want to be treated (or want a family member to be treated) if you/they were infected with the virus?"
- ✦ She may want to consider speaking with the Dr. Charles' supervisor about his behaviour.
- ✦ If the facility had policies on patient rights and equity in care, she could have referred to those.

5. What was the nurse thinking at the end of the scenario when she was shaking her head in response to Dr. Charles' comment, "Whom do we leave out?"

- ✦ She might have been thinking that she needs to take the issue to a higher level – discuss with a supervisor, for example.
- ✦ Disappointed and angry that she may have been unsuccessful in convincing Dr. Charles that all patients deserve to receive equitable, high quality care.
- ✦ Sad or frustrated that discrimination occurs at her workplace.
- ✦ Powerless to further challenge the doctor's behaviour, given her role as a nurse.
- ✦ Disgust that the doctor expects her to engage in discriminatory acts/behaviours.
- ✦ Concern that she or other nurses are expected to follow his orders, which may put patients at risk.
- ✦ Wondering what she can do next to address this problem.
- ✦ Loss of respect for the doctor.

6. In your setting, would a nurse be able to provide this type of feedback to a doctor? If no, what strategies could a nurse use to address the issue highlighted here (the doctor's failure to examine HIV-positive patients before prescribing treatment)?

Facilitator's Note: Encourage participants to discuss how different cadres of HCWs can discuss challenging issues like stigma and discrimination with each other.

7. Have you seen anything similar to this happen in a health facility? What happened and how was it addressed?

8. What could you do in your facility to prevent this type of thing from happening?

- ✦ Have a team making rounds.
- ✦ Strengthen the multi-disciplinary team approach. Hold regular meetings to discuss patient care.
- ✦ Establish a regulatory system for enforcement of existing policies.
- ✦ Establish a person, committee, or protocol for addressing this type of situation in which staff members are not observing policies regarding equity of care (if a non-discrimination policy exists).
- ✦ Training should be provided to all levels of staff on patient rights and equity of care. All new staff should be oriented to these policies.
- ✦ Hold clinical review sessions at which staff meet and discuss patient care.
- ✦ Establish ways that doctors and nurses can meet together to discuss a collaborative team approach to care.
- ✦ Nurses can record their observations related to patient care in the chart notes.
- ✦ Establish a disciplinary committee, and channels of reporting.

9. Are there any policies in place in your setting that address this type of scenario?

- ♦ If yes: a) what are they? b) are they monitored, enforced effectively? c) What could be done to ensure they are enforced?
- ♦ If no, what types of policies would be relevant to this type of situation?

No Policies

- ♦ HCWs can advocate for institutional policies around patient rights and equity of care.
- ♦ Policies should clearly address patient rights and equity of care and have channels in place for enforcement.
- ♦ In many health care settings doctors don't have any accountability – this is a problem, and policies should be established to address this.
- ♦ Health care facilities can adopt these policies and educate health care workers at all levels. See **Appendix J** for sample patients' rights documents.

“Stigma and discrimination start at the top and work their way down.”

Better Enforcement:

- ♦ All staff should be made aware of the clinic's policies related to patient rights and equity of care. Training should be provided to staff on these policies.
- ♦ Training should include information on the proper channels to go through when HCWs observe discriminatory behaviour amongst their co-workers, particularly when the behaviour occurs in supervisors or other HCW that is in a position of authority.
- ♦ Interview patients to gather feedback on HCWs' behaviour and to monitor enforcement of policy.

SUMMARY

1. Summarise the discussion using the key points provided below which detail important take-home information from this scenario.
2. Ask the group to share action steps or anything that they will do differently when they return to their site as a result of this discussion.
3. Emphasise commitment to confidentiality and sensitivity to the information shared by members of the group.
4. Thank all for the discussion and their participation.
5. If this is the final scenario to be presented to the group, distribute the evaluation form found in **Appendix M**. The information obtained from this form can be used to assess the effectiveness of the training in triggering insight, reflection, and intent to act amongst participants, and to obtain suggestions for improving the materials.

KEY POINTS

- ❖ Discriminatory treatment of patients can occur at all levels of the health care system, even amongst physicians.
- ❖ HCWs have a responsibility to address discrimination by co-workers and supervisors using whatever channel is appropriate.
- ❖ Health care facilities should establish policies and processes that support co-workers in standing up for patient rights.
- ❖ Health care workers have a professional obligation to provide all patients with equal, high quality care.
- ❖ Staff at ALL levels need training on patient rights and equity of care. Training should include procedures by which staff can confront and address stigmatising and discriminatory behaviours in the workplace.
- ❖ If patients become aware of discrimination in health care settings, they may not seek testing, care, treatment or other support services they need.

TRIGGER SCENARIO 3: ACTIVITY

Role Playing

If time allows, facilitators should consider ending the session on this scenario with a role play activity.

This activity will allow participants to incorporate their ideas about the themes discussed in this session might play out in their own work and lives. This role play will also help HCWs step into the life of an HIV-positive patient and better understand how stigma and discrimination affect PLWHA.



Time: 15-30 minutes

INSTRUCTIONS:

- ✦ Divide participants into pairs.
- ✦ One participant will play the role of Dr. Charles and the other participant will play the role of an HIV-positive patient. Each pair should determine who will play each character.
 - Ask participants to imagine that the patient notices the differential treatment he or she is receiving from Dr. Charles and wishes to discuss it with him.
 - The person playing the role of the patient should confront Dr. Charles about his or her feelings and thoughts on the situation.
 - Ask participants to act out:
 - What the patient would convey to the doctor to address the stigmatising behaviour.
 - What the patient would communicate about how Dr. Charles' behaviour affects his or her life.
 - How Dr. Charles can respond in a sensitive, professional manner that does not continue his previous stigmatising actions.
- ✦ Each group should briefly discuss main points of discussion for the role play and then conduct the role play at least once within their pair.
- ✦ After the groups have completed the role plays, reconvene the large group and discuss the issues that came up. Lead a discussion using the following questions:
 - Ask the participants playing the patient role how they felt and if they felt they were successful in confronting Dr. Charles. What did they do well? What would they change?
- ✦ If there is ample time, ask one or two pairs to volunteer to perform the role play in front of

the large group. Ask the larger group to reflect on how the scene played out:

- Ask them to start with what they thought the two characters did well, then make suggestions for things she might have done differently.





SCENARIO 3: SCRIPT WHEN PUSH COMES TO SHOVE

A doctor is making final notes on a patient's chart. A nurse nearby is observing him.

1. **Nurse:** *Sorry for interrupting you so abruptly Doctor, but I wanted to have a word with you. May I please?*
2. **Doctor:** *Yes, but hurry. I am on my way to the office.*
3. **Nurse:** *Thank you, Doctor. Let's talk.*
4. **Doctor:** *Yes, what is it Nurse? What is your concern this time?*
5. **Nurse:** *Ok, let me get right to the point, Doctor. I have realized that you have been prescribing treatment for certain patients without first conducting an examination on them.*
6. **Doctor:** *Is this what you stopped me for? Why do you question my work?*
7. **Nurse:** *I am just making an observation, Sir.*
8. **Doctor:** *Who are you to question my work?*
9. **Nurse:** *There is no need to be so angry and defensive, Doctor.*
10. **Doctor:** *You should learn to stick to directives. As the Doctor I make the judgements and prescribe the treatments. I know what I am supposed to do. You should be concentrating on what you are supposed to do; not on what I am doing!*
11. **Nurse:** *This has nothing to do with you or me, Doctor Charles. For instance, the patients in beds six and eight are suffering with AIDS and I have never seen you conduct any examination on them. Yet I am supposed to treat them based on your orders. Don't you think I have the right to raise the issue with you?*
12. **Doctor:** *First of all, you should not tell me how to do my job. Second, why should we waste time on these people when they are going to die soon anyways?*
13. **Nurse:** *Die soon...?*

14. **Doctor:** *Yes! What do you expect? They lived their lives from one woman to the next, they live as if there is no tomorrow. They did all these crazy things in their young days, messing-up their lives catching things like HIV and AIDS. What do expect? You want us to perform miracles? Waste valuable time on those people when there are others who need our time and attention? Others who have illnesses that are curable?*
15. **Nurse:** *Don't you think are a little insensitive, Sir?*
16. **Doctor:** *Not insensitive. Realistic.*
17. **Nurse:** *All our patients are human beings and deserve to be treated the same.*
18. **Doctor:** *We are grossly understaffed, as you know. What are we supposed to do? We have to set priorities.*
19. **Nurse:** *Are you suggesting that I engage in discrimination?*
20. **Doctor:** *I'm asking that you exercise discretion. Listen Nurse Smith, I understand your dedication. I know that you care about your patients. But you must understand that we have too many patients here for the resources that we have available. And that includes the number of nurses and doctors.*
21. **Nurse:** *I understand that Sir, but all our patients are depending on us.*
22. **Doctor:** *Nurse Smith, you need to relax, take it easy. They all depend on us. But when push comes to shove, whom do we leave out?*



SCENARIO FOUR: TAKING CHANCES...

SCENARIO OVERVIEW



Scenario Overview (*do not read aloud to participants*): Blood is escaping from the IV site of a patient with HIV. The nurse suddenly remembers that there is a shortage of gloves on her ward. She must decide what to do as the patient begins to panic.

Discussion Themes:

- + Universal Precautions (UP)
- + Confronting stigma and discrimination in the workplace
- + Institutional policy

Session Time: Allow at least 30-45 minutes for a complete discussion of this video scenario (video is 3 minutes long). Depending on the context of the discussion (e.g. part of larger training or stand alone), the discussion could be expanded/adapted with an additional activity.

Resources Needed:

- + VCR or DVD player or computer with DVD capacity
- + TV or projector with speakers



IF THIS IS THE FIRST SCENARIO TO BE PRESENTED TO THE GROUP:

- 1.** Begin with a brief introduction to the issue of stigma and discrimination (5 minutes).
 - ✦ Stigma is an unfavourable attitude or belief directed toward an individual or a group, while discrimination is an unfavourable act or behaviour towards an individual or group.
 - ✦ Both stigma and discrimination occur even in healthcare settings and are significant obstacles to providing quality care, treatment, and prevention services.
 - ✦ As the Caribbean region scales up its response to HIV/AIDS, it is vitally important that all health care workers contribute to establishing an environment in which all patients are treated with kindness and compassion.
 - ✦ Additional background information on stigma and discrimination is available in **Appendix A**.
- 2.** Discuss the importance of confidentiality, and obtain agreement from participants regarding the confidential nature of the discussion (refer to **Appendix L** for a sample confidentiality agreement).
- 3.** Establish ground rules for the group discussion (see **Appendix B** for more information). The ground rules will depend in part on the size and composition of the group. Key ground rules include:
 - ✦ Do not interrupt or speak over another person
 - ✦ Cell phones off or on vibrate
 - ✦ Criticise the idea, not the person
 - ✦ Respect the views of others, not necessarily agreeing with them
 - ✦ Participate at your comfort level

FACILITATOR INSTRUCTIONS



1. **Introduce** the scenario to participants by reading the following:
 - ✦ “The video scenario you are about to see shows a nurse interacting with a patient with HIV. After the video, we will have a discussion.”
2. **Play** the video. At the end of the trigger scenario video, the DVD will automatically stop. If you are using a VHS, you will need to manually stop or pause the video tape.

3. **Initiate discussion** with participants using the discussion questions and the possible answers below as a tool to guide the discussion. Use probing questions to stimulate discussion and draw out important topics. See **Appendix B** for more information on facilitation skills.
 - ✦ Point out that there are not necessarily “right” or “wrong” answers to many of these questions. It is not necessary for the group to reach consensus on every question.
 - ✦ Be sure to distinguish between facts and opinions during the discussion. Gently correct any misinformation or myths.

It is not necessary to ask the questions in the discussion guide in the order presented here.

- ✦ In many cases the discussion will move spontaneously from one topic to another.
- ✦ Use the summary table of Discussion Guide Questions to locate where specific questions appear in this guide.
- ✦ If participants have already discussed a particular question, it is not necessary to ask it again.



NOTE: Quotes in the boxes are from Caribbean Health Care Workers in response to the discussion questions.



DISCUSSION GUIDE QUESTIONS

The table below is a summary of the discussion questions included in this discussion guide. The discussion will likely move from one topic to another rather than follow the order of questions. Use this table to identify topics of discussion that arise and quickly locate where the responses appear in the Discussion Guide below.

DISCUSSION QUESTIONS
1. What happened in this scenario? What did you think?
2. How did Nigel, the patient, respond to the nurse's desire to use gloves when adjusting his IV? What feelings or experiences might underlie Nigel's response?
3. What do you think happened at the end of the scene? Do you think the nurse went ahead and adjusted the IV without gloves?
4. If the nurse went ahead and adjusted the IV without gloves, how do you think the patient's HIV status affected the nurse's decision to do so?
5. Do you think the nurse dealt effectively with the situation? <ul style="list-style-type: none">• What could she have done differently?• How could the nurse have protected her own safety without offending the patient?
6. If you were this nurse's co-worker observing this interaction, what might you say to her?
7. What is the definition of Universal Precautions (UP)? Can you review some key points about why HCWs use UP?
8. In what situations should HCWs wear gloves? What are some good glove practices?
9. What would you do in the absence of gloves to protect yourself and the patient from blood-borne pathogens?
10. What could be done to help support HCWs adhere to Universal Precautions (UP)?
11. What can you do in your facility to ensure that there are no shortages of gloves?

1. What happened in this scenario? What did you think?

- The nurse and patient seemed to have a good relationship – she demonstrated empathy, compassion, and caring. At the beginning of the scene she appeared to have a good rapport with the patient.
- When the nurse noticed that the patient’s IV line was leaking, she realized she had no gloves and informed the patient she needed to get them from another ward.
- The patient became very anxious and upset. The nurse tried to reassure him, but her tone was a bit harsh.
- The patient suggested that the nurse’s desire to find gloves was an indication of discrimination because of his HIV status.
- The nurse faced the dilemma of protecting herself in a situation in which Universal Precautions (UP) are required without having the patient perceive that stigma/discrimination was occurring.

2. How did Nigel, the patient, respond to the nurse’s desire to use gloves when adjusting his IV? What feelings or experiences might underlie Nigel’s response?

Nigel’s Response

- Nigel appeared surprised that the nurse insisted on using gloves to adjust his IV. He seemed to feel that their personal relationship should have made using the gloves unnecessary.
- Nigel seemed to believe that the nurse was insisting on using gloves because of his HIV status.
- Nigel seemed upset, hurt, and as if he felt singled out because of his HIV status.
- He also appeared to get a bit panicky about the blood leaking from his IV.

Nigel’s Feelings and Experiences

- Nigel may have experienced stigma and discrimination in health care settings prior to this interaction.
- Other nurses might have done similar procedures on him without wearing gloves. He was likely unaware that HCWs are supposed to use gloves with everybody.
- Nigel may also be feeling depressed and/or hopeless about his health and life, resulting from internalised stigma and/or poor health.
- Nigel appears to have the impression that once he gets to know someone (e.g. a friend) then protective measures are unnecessary.

3. What do you think happened at the end of the scene? Do you think the nurse went ahead and adjusted the IV without gloves?

- While the video doesn't show what actually happened, it strongly suggests that the nurse went ahead and adjusted Nigel's IV without gloves, thereby putting herself at risk and failing to observe the policy on UP.

4. If the nurse went ahead and adjusted the IV without gloves, how do you think the patient's HIV status affected the nurse's decision to do so?

- Nigel's panicked comments about his and the nurse's friendship and his statement that his status was influencing her desire to wear gloves may have pressured the nurse to proceed without gloves to demonstrate that she was not discriminating against him because of his HIV status.

5. Do you think the nurse dealt effectively with the situation?

- **What could she have done differently?**
- **How could the nurse have protected her own safety without offending the patient**
- The nurse explained to Nigel that she was required to use gloves with all patients, regardless of their HIV status. However, her tone was a bit harsh when she provided this explanation, and the patient did not seem to be accepting her explanation.

Suggestions:

- The nurse could have checked her equipment before she came into the room to ensure that she had everything she needed.
- The nurse could gently explain in more detail to the patient that wearing gloves when there is possible contact with blood or other body fluids is part of the Universal Precautions (UP) policy at health care facilities and that she must follow these with every patient regardless of whether or not the patient has an infection (not just HIV).
- Many patients get anxious when blood is leaking. Her response to his anxiety was to get anxious herself. Had she remained calm she might have been more effective at easing his anxiety, and calming him down while she went for the gloves.
- She could have excused herself, saying she'd be right back without being specific about what she needed and how far she had to go to get it.

- ✦ She could have explained that wearing gloves not only protects the HCW, but also the patients.
- ✦ She could have called a co-worker to help with the situation – either to fetch gloves, or to apply pressure above the IV site to stop the bleeding while she retrieved gloves.
- ✦ She could have the patient apply pressure above the IV site if no other help is available.
- ✦ She could have turned the IV off.

Facilitator’s Note: The nurse may need support, training and education on how to handle dilemmas like this in the future. She needs to be reassured that her behaviour was not discriminatory.

6. If you were this nurse’s co-worker observing this interaction, what might you say to her?

- ✦ As a co-worker of this nurse, you might try to provide support to help her protect herself and resolve this dilemma. A co-worker might say:
 - “It looks like you were trying not to offend Nigel, but it is not discriminatory to use gloves or UP!”
 - “You know, our policy on UP says that we are to use gloves with all patients. Any patient could be HIV-positive or have another communicable disease and we might not know it.”
 - A co-worker could also assist the nurse by locating gloves while the nurse stays by Nigel’s bedside to calm and reassure him.

7. What is the definition of Universal Precautions (UP)? Can you review some key points about why HCWs use UP?

- ✦ UP are infection control measures that reduce risk of transmission of bloodborne pathogens through exposure to blood or body fluids among patients and health care workers. Refer to Appendix H for more information on UP.
- ✦ Under UP all persons should be considered infected with HIV or other blood borne pathogens regardless of their known or supposed status. (WHO, 2006)
- ✦ Exposure to blood or body fluids is a potential source of HIV and Hepatitis B and C infection. Although they account for the minority of HIV infections, health care procedures are a preventable source of HIV infection.
- ✦ Gloves are an important part of UP. While they cannot prevent a needle injury, less blood is transferred across membranes by a needle that passes through gloves. (Cardo; Buvo, 2001)
- ✦ HCW protection is an essential part of strategies to prevent stigma and discrimination against HIV infected patients by HCWs. When HCWs can protect themselves, they can provide better patient care.

8. In what situations should HCWs wear gloves? What are some good glove practices?

- ✦ HCWs should wear gloves every time they expect to come in contact with a patient's body fluids (blood, urine, saliva, semen, vaginal secretions), tissue or medical waste. Gloves protect both patients and HCWs by providing a barrier against infectious micro-organisms.
- ✦ HCWs should wash their hands after removing gloves and before moving on to another task. Gloves should be disposed of in the appropriate container.
- ✦ There are three kinds of gloves: surgical gloves, single-use gloves, and utility or heavy-duty household gloves. (EngenderHealth, 2004)
 - If possible, use disposable surgical gloves since reusable surgical gloves are difficult to process.
 - Single use gloves, should be thrown out after one use with one patient.
 - Utility gloves should be washed before you take the gloves off your hands.
 - Never use gloves while writing or operating monitors.
 - Always wash your hands after using any type of gloves.
 - Never reuse disposable gloves.

9. What would you do in the absence of gloves to protect yourself and the patient from bloodborne pathogens?

- ✦ The nurse should not draw blood, adjust an IV line or come in contact with blood on a patient without wearing gloves, regardless of whether she has open cuts or sores.
- ✦ In the instance that there are no gloves available and a procedure is necessary the nurse should consider the following factors:
 - Use proper hand washing technique.
 - Use available plastic barriers, for example, cling wrap or a plastic bag.
 - Use non-touch techniques, for example, forceps or clamps which can act as hands.
 - Have the patient assist as much as possible with your instructions.

10. What could be done to help support HCWs adhere to Universal Precautions (UP)?

- ✦ Make adequate supplies as accessible as possible.
- ✦ Ensure staff understanding of UP through regular training and education. Pre-service trainings with HCWs at all levels should address UP.
 - Training should be provided to ALL levels of staff. All new staff orientations

should include this information.

- The nurse should be fully trained in UP and should practice UP with all patients.

11. What can you do in your facility to ensure that there are no shortages of gloves?

- ✦ Improve inventory control and management systems
- ✦ Ensure that gloves are sufficiently stocked by developing an ordering schedule.
- ✦ Health care facilities should also:
 - Prevent wastage and stealing of personal protective equipment (PPE).
 - Have emergency supplies stocked away.
 - Have back up supplies available.

“(HCWs can help prevent glove shortages by) checking inventory, inventory management, and focus(ing) on the correct use of gloves so that none are wasted.”

SUMMARY

1. Summarise the discussion using the key points provided below which detail important take-home information from this scenario.
2. Ask the group to share action steps or anything that they will do differently when they return to their site as a result of this discussion.
3. Emphasise commitment to confidentiality and sensitivity to the information shared by members of the group.
4. Thank all for the discussion and their participation.
5. If this is the final scenario to be presented to the group, distribute the evaluation form found in **Appendix M**. The information obtained from this form can be used to assess the effectiveness of the training in triggering insight, reflection, and intent to act amongst participants, and to obtain suggestions for improving the materials.

KEY POINTS

- ❖ UP are infection control measures that reduce risk of transmission of bloodborne pathogens through exposure to blood or body fluids among patients and health care workers.
- ❖ UP should be used with all patients, regardless of known or presumed status. Consistent use of UP with all patients can help to reduce perception of stigma and discrimination by patients with HIV.
- ❖ Gloves are an important part of UP as they provide a barrier between the HCW and the patient. While they cannot prevent a needle injury, less blood is transferred across membranes by a needle that passes through gloves.
- ❖ Making adequate supplies available (including personal protective equipment - PPE), ensuring that staff understand UP, and minimising unnecessary procedures are three ways to help HCWs adhere to UP.

TRIGGER SCENARIO 4: ACTIVITY

Role Playing

If time allows, facilitators should consider ending the session on this scenario with a role play activity.

This activity will allow participants to “re-write” the scenario they have just seen and discussed, incorporating their ideas about how the situation might have been handled differently by the characters involved. It will also help them to think about how the ideas discussed in this session might play out in their own work and lives.



Time: 15-20 minutes (see below)

Materials: Paper (optional)
Pens/pencils (optional)

INSTRUCTIONS:

- ✦ Divide participants into pairs.
- ✦ One participant will play the role of a HCW and the other will play the role of a patient.
- ✦ The participant playing the role of the HCW should attempt to explain concepts of UP to a patient. The patient should consider the following in the role play:
 - What kinds of information could the HCW convey to the patient to explain the importance of UP?
 - How could the HCW explain UP in a way that is clearly understood and gives the patient confidence that using UP is not discriminatory?
- ✦ Each group should briefly discuss main points of discussion for the role play and then conduct the role play at least once within their pair. Each participant should have an opportunity to play the part of the HCW and patient.
- ✦ After the groups have completed the role plays, lead a discussion using the following questions:
 - Ask the participant who played the HCW how he/she thought it went. What did he/she feel she did well? What would he/she change next time?
 - Ask the participant who played the patient how he/she felt. What suggestions do they have for the HCW?

- ✦ If there is ample time, ask one or two pairs to volunteer to perform the role play in front of the large group. Ask the larger group to reflect on how the scene played out:
 - Ask them to start with what the HCW did well, and then make suggestions for things she might have done differently.

SCENARIO 4: SCRIPT TAKING CHANCES



Nigel, an HIV patient, sits up in bed. His nurse has just entered the room.

1. **Nurse:** *Well its good to see that we are up and smiling. (Drawing the curtains)*
2. **Nigel:** *It's bright outside.*
3. **Nurse:** *The rains have cleared, for a while at least.*
4. **Nigel:** *Nurse?*
5. **Nurse:** *What can I do for you?*
6. **Nigel:** *Whatever happened to the guy who was on this bed?*
7. **Nurse:** *He was discharged.*
8. **Nigel:** *But he could hardly walk. He looked like he was badly beaten up.*
9. **Nurse:** *The doctors thought that he was out of danger; and we need the beds of course. There is always some emergency.*
10. **Nigel:** *Do you know what happened to him?*
11. **Nurse:** *I have no idea.*
12. **Nigel:** *Life is strange. I was beginning to feel like I knew him.*
13. **Nurse:** *You miss him?*
14. **Nigel:** *He was steady company. I felt sorry for him. You must be used to seeing people come and go.*
15. **Nurse:** *The nature of my profession. Patients come, we treat them and the time comes when they must leave.*
16. **Nigel:** *All the world's a stage
And all the men and women merely players.
They have their entrances and exits...*
17. **Nurse:** *The other way round.*

18. **Nigel:** *What?*
19. **Nurse:** *They have their exits and entrances. Shakespeare. "As You Like It." There is always an open door Nigel, there is always hope.*
20. **Nigel:** *It doesn't matter anyway.*
21. **Nurse:** *Anyway? Oh, Mr. Patient your IV site looks wet with blood. It looks like it is leaking.*
22. **Nigel:** *Not again.*
23. **Nurse:** *Let me get some gloves first and then we will see what the problem is.*
24. **Nigel:** *Take care of me nurse, while I'm still around.*
25. **Nurse:** *I just remember...*
26. **Nigel:** *Remember what?*
27. **Nurse:** *We have no gloves! I need to go to another ward to get a pair.*
28. **Nigel:** *How come?*
29. **Nurse:** *The hospital is low on gloves, some shipment problem.*
30. **Nigel:** *You need gloves?*
31. **Nurse:** *Of course I need them. What are you talking about?*
32. **Nigel:** *You really need them, for me? I thought you were different.*
33. **Nurse:** *Not just for you. I need them for all of my patients!*
34. **Nigel:** *Yes, the IV is leaking. Oh my God, stop delaying! If I was not HIV-positive, you would not be worrying about gloves.*
35. **Nurse:** *Stop panicking! I must use gloves when dealing with blood, okay? Okay. Hold still, hold still, hold still...*



SCENARIO FIVE: *BETTER A POSITIVE SPIRIT*



SCENARIO OVERVIEW

Scenario Overview (*do not read aloud to participants*): A man with HIV is being seen for tests to monitor his treatment. A phlebotomist is called in to draw blood. The phlebotomist is fearful of his new job working with HIV/AIDS patients. Voices echo in the phlebotomist's head, calling out warnings about getting stuck with a needle, wearing two pairs of gloves, etc.

Discussion Themes:

- + Basic HIV prevention and transmission
- + Post-Exposure Prophylaxis (PEP) and Universal Precautions (UP)
- + Institutional policy

Session Time: Allow at least 30-45 minutes for a complete discussion of this video scenario (video is about 3 minutes long). Depending on the context of the discussion (e.g. part of larger training or stand alone), the discussion could be expanded/adapted with additional questions and discussion.

Resources Needed:

- + VCR or DVD player or computer with DVD capacity
- + TV or projector with speakers



IF THIS IS THE FIRST SCENARIO TO BE PRESENTED TO THE GROUP:

- 1.** Begin with a brief introduction to the issue of stigma and discrimination (5 minutes).
 - ✦ Stigma is an unfavourable attitude or belief directed toward an individual or a group, while discrimination is an unfavourable act or behaviour towards an individual or group.
 - ✦ Both stigma and discrimination occur even in healthcare settings and are significant obstacles to providing quality care, treatment, and prevention services.
 - ✦ As the Caribbean region scales up its response to HIV/AIDS, it is vitally important that all health care workers contribute to establishing an environment in which all patients are treated with kindness and compassion.
 - ✦ Additional background information on stigma and discrimination is available in **Appendix A**.
- 2.** Discuss the importance of confidentiality, and obtain agreement from participants regarding the confidential nature of the discussion (refer to **Appendix L** for a sample confidentiality agreement).
- 3.** Establish ground rules for the group discussion (see **Appendix B** for more information). The ground rules will depend in part on the size and composition of the group. Key ground rules include:
 - ✦ Do not interrupt or speak over another person
 - ✦ Cell phones off or on vibrate
 - ✦ Criticise the idea, not the person
 - ✦ Respect the views of others, not necessarily agreeing with them
 - ✦ Participate at your comfort level

FACILITATOR INSTRUCTIONS



1. **Introduce** the scenario to participants by reading the following:

- ✦ “The video scenario you are about to see shows a man who is new to his job as a phlebotomist . After the video, we will have a discussion.”

2. **Play the video.** At the end of the trigger scenario video, the DVD will automatically stop. If you are using a VHS, you will need to manually stop or pause the video tape.

3. **Initiate discussion** with participants using the discussion questions and the possible answers below as a tool to guide the discussion. Use probing questions to stimulate discussion and draw out important topics. See **Appendix B** for more information on facilitation skills.

- ✦ Point out that there are not necessarily “right” or “wrong” answers to many of these questions. It is not necessary for the group to reach consensus on every question.
- ✦ Be sure to distinguish between facts and opinions during the discussion. Gently correct any misinformation or myths.

It is not necessary to ask the questions in the discussion guide in the order presented here.

- ✦ In many cases the discussion will move spontaneously from one topic to another.
- ✦ Use the summary table of Discussion Guide Questions to locate where specific questions appear in this guide.
- ✦ If participants have already discussed a particular question, it is not necessary to ask it again.



NOTE: Quotes in the boxes are from Caribbean Health Care Workers in response to the discussion questions.



DISCUSSION GUIDE QUESTIONS

The table below is a summary of the discussion questions included in this discussion guide. The discussion will likely move from one topic to another rather than follow the order of questions. Use this table to identify topics of discussion that arise and quickly locate where the responses appear in the Discussion Guide below.

DISCUSSION QUESTIONS
1. What happened in this scenario? What did you think?
2. What were some of the phlebotomist's fears about his job working with HIV-infected patients?
3. Assume that the phlebotomist in the scenario had completed phlebotomy training. Is it possible that a trained phlebotomist might still have fears? Are these fears legitimate?
4. What might be the consequences of the phlebotomist's fears?
5. Have you seen anything similar to this happen in a health facility? What happened and how was it addressed?
6. Have you ever encountered family members, a partner or a friend who had beliefs similar to those of the phlebotomist's mother? How did you handle it? What did you say to reassure or educate them? What was the result?
7. Ask for volunteers to role play what they might say to the phlebotomist to reassure him and reduce his fears. After the role-play, discuss the strengths of their approach and make suggestions for other strategies for helping the phlebotomist to get over his fears.
8. Have you (or a co-worker) ever been afraid to give care to an HIV/AIDS patient? If yes, what were some of the reasons? How did you deal with these fears?
9. What would you do in the absence of gloves to protect yourself and the patient from blood-borne pathogens?

1. What happened in this scenario? What do you think?

- ✦ The scenario shows the first day of work of a phlebotomist at an HIV/AIDS clinic.
- ✦ The phlebotomist's mother had expressed worry and fear to him that he would become infected with HIV, and that it was a risky job he was doing.
- ✦ The phlebotomist feels panic as he enters the room to draw blood from an HIV-positive patient.

2. What were some of the phlebotomist's fears about his job working with HIV-infected patients?

- ✦ The phlebotomist was afraid that an accident could occur – he's concerned with his safety.
- ✦ The phlebotomist feared experiencing a needle stick and becoming infected with HIV.
- ✦ The worry and anxiety of his mother instilled fear in him – the phlebotomist might feel discouraged, apprehensive and doubtful after his conversations with his mother.
- ✦ The phlebotomist was doubtful.

3. Assume that the phlebotomist in the scenario had completed phlebotomy training. Is it possible that a trained phlebotomist might still have fears? Are these fears legitimate?

- ✦ Concerns about job safety and taking precautions while working in an HIV/AIDS clinic are normal.
- ✦ One of the ways in which you can become infected with HIV is from a needle stick and that's his job. His fears are legitimate. But if he follows the precautions he's been taught, this should reduce his fear and he shouldn't have to worry so much.
- ✦ His fear was not irrational, but it was increased by his mother's fears. His mother's lack of knowledge about safety procedures and protocols probably enhanced her fears.

4. What might be the consequences of the phlebotomist's fears?

- ✦ The phlebotomist's fear of being stuck might make him so nervous that he actually does stick himself.
- ✦ The phlebotomist may verbally or non-verbally convey his discomfort to Albert, the patient, while drawing blood. Treating Albert differently because of his HIV status (known or assumed) is discrimination.
- ✦ The phlebotomist's treatment of Albert could make Albert uncomfortable and prevent him from seeking or receiving the care and services he needs.
- ✦ The phlebotomist may not be effective in or able to perform his job due to his fears.

5. **Have you seen anything similar to this happen in a health facility? What happened and how was it addressed?**
6. **Have you ever encountered family members, a partner or a friend who had beliefs similar to those of the phlebotomist’s mother? How did you handle it? What did you say to reassure or educate them? What was the result?**
7. **Ask for volunteers to role play what they might say to the phlebotomist to reassure him and reduce his fears. After the role play, discuss the strengths of the approach and make suggestions for other strategies for helping the phlebotomist to get over his fears.**
 - ✦ Make him aware of the policy on what to do if he gets a needle stick in regard to post-exposure prophylaxis (PEP); provide specific, step-by-step instructions. Knowing that there are ways to prevent HIV infection following exposure can help to alleviate his fears.
 - Refer to for CAREC’s PEP policy.
 - ✦ The phlebotomist should be aware of personal protective equipment (PPE).
 - ✦ Reassure the phlebotomist that with time and experience he’ll become more confident and relaxed.
 - ✦ Training and education on Universal Precautions (UP), and practicing UP with all patients, regardless of their known or presumed HIV status, may reduce his fears.
 - For more information on UP, refer to **Appendix H**.
 - ✦ Remind the phlebotomist that any patient he draws blood from might be infected with HIV, regardless of whether the health care facility specialises in HIV/AIDS care. He likely has already drawn blood from an HIV-positive patient without knowing it.

“People are afraid of the unknown – they need information and education, training”.

Other Strategies

- ✦ New phlebotomists could be paired with a more experienced co-worker during their first few days to supervise them and reassure them that they are carrying out procedures correctly.
- ✦ Assurances or support from his co-workers and supervisors may be necessary to become more confident in his job and less anxious about an accident.
- ✦ The phlebotomist could be encouraged to educate his mother to alleviate her fears — this might result in a reduction in his own fear.

8. Have you (or a co-worker) ever been afraid to provide care to an HIV/AIDS patient? If yes, what were some of the reasons? How did you deal with these fears?

SUMMARY

1. Summarise the discussion using the key points provided below which detail important take-home information from this scenario.
2. Ask the group to share action steps or anything that they will do differently when they return to their site as a result of this discussion.
3. Emphasise commitment to confidentiality and sensitivity to the information shared by members of the group.
4. Thank all for the discussion and their participation.
5. If this is the final scenario to be presented to the group, distribute the evaluation form found in **Appendix M**. The information obtained from this form can be used to assess the effectiveness of the training in triggering insight, reflection, and intent to act amongst participants, and to obtain suggestions for improving the materials.

KEY POINTS

- ❖ In order for HCWs to best serve their patients, they need to recognise and deal with their own fears first.
- ❖ Fear can often be imposed on us or heightened by others. Fear related to HIV/AIDS can result in verbal and non-verbal expressions of stigma and discrimination.
- ❖ Health care workers have a professional duty to ensure that their personal thoughts, feelings, and attitudes do not affect the quality of their work and interactions with patients, either verbally or nonverbally.
- ❖ Awareness of the existence of PEP and the procedures surrounding what to do in case of an accidental needle stick can help to reassure healthcare workers.

TRIGGER SCENARIO 5: ACTIVITY

Role Play

If time allows, facilitators should consider ending the session on this scenario with a role play activity.

This activity will allow participants to continue the scenario they have just seen and discussed, incorporating their ideas about how the situation might have been handled differently by the characters involved. It will also help them to think about how the ideas discussed in this session might play out in their own work and lives.



Time: 20 minutes

Materials: *Scenario 5: Script* (optional)
Paper (optional)
Pens/pencils (optional)

INSTRUCTIONS:

- ✦ Ask for 2 volunteers to present a role play. Brief them on their roles as follows: one participant will play the part of a HCW working with HIV-positive patients. The other participant will play a concerned relative or friend.
- ✦ Give the participants a few minutes to think about the following issues and how they will address them in the role play:
 - The relative or friend's stated concerns about the HCW's job.
 - Information to reassure or educate the concerned relative or friend.
 - Effective methods to convey information and correct misconceptions that reduce stigma amongst their relatives or family members.
- ✦ Have the pair present the role play in front of the other participants.
- ✦ Conduct a discussion with the participants that performed the role play and with the entire group:
 - Ask the HCW how successful she felt she was in alleviating the relative's fears. What did she or he do well? What would she and he change?
 - Ask the relative how she or he felt- "did the HCW reduce your fears or concerns? What else could she or he have said?"
 - Open up the discussion to the group: What did the HCW do well? What suggestions do you have for him or her?
 - If time permits, ask for another pair to present the scenario.



SCENARIO 5: SCRIPT

TRIGGER SCENARIO FIVE: *BETTER A POSITIVE SPIRIT*

A Phlebotomist is walking through the halls of a hospital, on his way to see a patient, Albert.

1. **Phlebotomist:** *Risky business, risky business.* (His voice echoes in his head while he walks through the corridors of the hospital.)

Meanwhile, in a different section of the hospital, a Nurse examines a patient.

2. **Nurse:** *What's yuh name sir?*
3. **Albert:** *Albert, ma'am.*
4. **Nurse:** *I see you been coming to here for quite a while.*
5. **Albert:** *Quite a while, ma'am. Dem keep me since de test. Dem say dey wan do more tests.*
6. **Nurse:** *You're H...*
7. **Albert:** *HIV positive. Positive ma'am. I still positive you know.*

Doctor enters.

8. **Doctor:** *Good morning Nurse Nicholas.*
9. **Nurse:** *Good morning Doctor.*
10. **Doctor:** *How are you doing today Albert?*
11. **Albert:** *Same way, Doctor. Praying for a cure.*
12. **Doctor:** *Don't worry Albert.*

Cut to Phlebotomist walking down the hallway, still muttering to himself. Voices echo in his head.

13. **Phlebotomist:** *Risky business, risky business.*
14. **Mother:** *What if you get stuck with those needles my son? What if those needles prick my boy, my only son, Lord?*

Scene dissolves into a flashback of Phlebotomist and his mother at home sitting on a sofa.

15. **Mother:** *Yuh get a job at that clinic?*
16. **Phlebotomist:** *Yes ma.*
17. **Mother:** *Dis is risky business. De AIDS clinic?*

18. **Phlebotomist:** *Yes ma, dah is what I tell you.*
19. **Mother:** *Doing what?*
20. **Phlebotomist:** *Drawing blood.*
21. **Mother:** *And you takin it?*
22. **Phlebotomist:** *I need a job ma. Wha yuh expect me to do?*
23. **Mother:** *May the Lord help you my son. May his good light shine upon you. Take care with those needles my son, you hear me?*
24. **Phlebotomist:** *Yes ma.*
25. **Mother:** *Dis is risky business. (Her voice echoes as the flashback fades away.) What if those needles prick him? But he need a job, Lord. Dis is risky business. De AIDS clinic?*

Cut to Phlebotomist in hospital hallway, approaching patient's room.

26. **Phlebotomist:** (Echoing in flashback.) *Yes ma, dah is what I tell you.*
27. **Mother:** (Echoing in flashback.) *Doing what?*
28. **Phlebotomist:** (Echoing in flashback.) *Drawing blood.*

Cut to Doctor and Albert.

29. **Doctor:** *There may not be a cure but there is relatively good treatment that can keep you healthy. Just remember that. Now I'm going to ask Nurse Nicholas here to have some blood drawn so we can do some further tests, to see how well you're responding to the drugs. Now, I have to continue my rounds. Keep the positive spirit, Albert! (Phlebotomist begins to open door, but hesitates.) Here comes the Phlebotomist now. Over to you sir.*

Doctor leaves. Phlebotomist opens doorway and is seemingly frozen in panic. Various voices echo.

30. **Echoing Voice:** *Suppose you catch AIDS from dem patient...*
31. **Echoing Voice:** *Look how bad Rodney looks with AIDS...*
32. **Echoing Voice:** *You better wear two pairs of gloves just in case...*
33. **Echoing Voice:** *If you get stuck with the needle you must immediately...*
34. **Echoing Voice:** *You not going to take that job are you?*



SCENARIO SIX: YOU KNOW HOW LONG ME A WAIT...



SCENARIO OVERVIEW

Scenario Overview (*do not read aloud to participants*): A patient has been waiting several hours to be seen for an appointment. She notices that others in the waiting room who arrived later are being called for their appointments sooner.

The patient confronts the receptionist. The receptionist comments to a co-worker that the patient is an exotic dancer, “sleeps around,” and is probably HIV-positive as a result.

Discussion Themes:

- + Patient rights and equity of care
- + Basic HIV prevention and transmission
- + Value judgements
- + Confidentiality
- + Confronting stigma and discrimination in the workplace
- + Institutional policy

Session Time: Allow at least 30-45 minutes for a complete discussion of this video scenario (video is about 3 minutes long). Depending on the context of the discussion (e.g. part of larger training or stand alone), the discussion could be expanded/adapted with additional questions and discussion.

Resources Needed:

- + VCR or DVD player or computer with DVD capacity
- + TV or projector with speakers



IF THIS IS THE FIRST SCENARIO TO BE PRESENTED TO THE GROUP:

- 1.** Begin with a brief introduction to the issue of stigma and discrimination (5 minutes).
 - ✦ Stigma is an unfavourable attitude or belief directed toward an individual or a group, while discrimination is an unfavourable act or behaviour towards an individual or group.
 - ✦ Both stigma and discrimination occur even in healthcare settings and are significant obstacles to providing quality care, treatment, and prevention services.
 - ✦ As the Caribbean region scales up its response to HIV/AIDS, it is vitally important that all health care workers contribute to establishing an environment in which all patients are treated with kindness and compassion.
 - ✦ Additional background information on stigma and discrimination is available in **Appendix A**.

- 2.** Discuss the importance of confidentiality, and obtain agreement from participants regarding the confidential nature of the discussion (refer to **Appendix L** for a sample confidentiality agreement).

- 3.** Establish ground rules for the group discussion (see **Appendix B** for more information). The ground rules will depend in part on the size and composition of the group. Key ground rules include:
 - ✦ Do not interrupt or speak over another person
 - ✦ Cell phones off or on vibrate
 - ✦ Criticise the idea, not the person
 - ✦ Respect the views of others, not necessarily agreeing with them
 - ✦ Participate at your comfort level

FACILITATOR INSTRUCTIONS



1. **Introduce** the scenario to participants by reading the following:

- ✦ “The video scenario you are about to see shows a patient in the waiting room of a clinic. After the video, we will have a discussion.”

2. **Play** the video. At the end of the trigger scenario video, the DVD will automatically stop. If you are using a VHS, you will need to manually stop or pause the video tape.

3. with participants using the discussion questions and the possible answers below as a tool to guide the discussion. Use probing questions to stimulate discussion and draw out important topics. See **Appendix B** for more information on facilitation skills.

- ✦ Point out that there are not necessarily “right” or “wrong” answers to many of these questions. It is not necessary for the group to reach consensus on every question.
- ✦ Be sure to distinguish between facts and opinions during the discussion. Gently correct any misinformation or myths.

It is not necessary to ask the questions in the discussion guide in the order presented here.

- ✦ In many cases the discussion will move spontaneously from one topic to another.
- ✦ Use the summary table of Discussion Guide Questions to locate where specific questions appear in this guide.
- ✦ If participants have already discussed a particular question, it is not necessary to ask it again.



NOTE: Quotes in the boxes are from Caribbean Health Care Workers in response to the discussion questions.



DISCUSSION GUIDE QUESTIONS

The table below is a summary of the discussion questions included in this discussion guide. The discussion will likely move from one topic to another rather than follow the order of questions. Use this table to identify topics of discussion that arise and quickly locate where the responses appear in the Discussion Guide below.

DISCUSSION QUESTIONS
1. What happened in this scenario? What did you think?
2. What attitudes and beliefs about HIV/AIDS and PLWHA were expressed by the receptionist? How did she express these?
3. How do you think the receptionists' attitudes and actions affected Carol and other patients at the clinic?
4. What issues related to confidentiality and patient rights are raised in this scenario?
5. In this scenario, the janitor witnessed the stigma and discrimination displayed by the receptionist. What could the janitor have said or done in this situation?
6. What would you have done if you had witnessed the stigma and discrimination displayed by the receptionist?
7. What are some of the cultural beliefs and practices that underlie and encourage stigma and discrimination? How can you address these with a co-worker or supervisee?
8. What could you do in your facility to prevent this type of thing from happening?
9. Does your facility have policies that relate to this situation? <ul style="list-style-type: none">• If no, discuss what types of policies could help to prevent the situation that occurred in this scenario.• If yes, discuss how the policies could be better monitored and enforced.

1. What happened in this scenario? What did you think?

- ✦ The scenario showed a dancer, Carol, coming in for an HIV test. The receptionist assumed that she was HIV-positive and displayed a judgemental attitude towards the client.
- ✦ The receptionist looked down on the client, Carol, because of Carol's profession. The receptionist displayed stigma and discrimination both through her non-verbal behaviour and her failure to call Carol for her appointment.
- ✦ The patient ended up walking out prior to her VCT appointment because of the poor treatment she received from the receptionist.

2. What attitudes and beliefs about HIV/AIDS and PLWHA were expressed by the receptionist? How did she express these?

Attitudes and Beliefs

- ✦ The receptionist stigmatised and discriminated against Carol because of her profession.
- ✦ The receptionist assumed that Carol was infected with HIV because of her profession. She appeared to equate being a dancer with being promiscuous, and assumed that Carol became infected because of this casual/promiscuous sexual activity.
- ✦ The receptionist appears to think that only "certain types of people" get HIV.
- ✦ The receptionist appears to think that all dancers must be infected with HIV.
- ✦ The receptionist appeared to believe that people with a certain lifestyle are HIV positive, or that you can look at a person and know their status.
- ✦ Note: We don't know Carol's HIV status as she has come to the clinic that day for testing. The receptionist assumes Carol is HIV-positive based on her profession and/or appearance.

How did she express these attitudes and beliefs?

- ✦ The receptionist expressed her feelings towards Carol by not calling her for her appointment in a timely manner.
- ✦ The receptionist's body language and facial expressions also expressed her dislike and disapproval of Carol, and contributed towards her overall discriminatory actions.
- ✦ The receptionist was judgemental; she attached a value judgement to the behaviours she assumes Carol must have engaged in.
- ✦ The receptionist asked the janitor to disinfect a spot on the desk that Carol touched, suggesting that she believes Carol to be "dirty" in some way. She also breached confidentiality

"The receptionist was judgemental – her attitude was that Carol deserved to be positive (even though her status was unknown) because she was sleeping around."

"[The receptionist] assumed she was promiscuous based on the way a person looks, and the fact that she came for an HIV test."

by telling the janitor Carol's profession – this is another form of stigma and discrimination.

3. How do you think the receptionist's attitudes and actions affected Carol and other patients at the clinic?

- + Carol is obviously aware of the fact that she is being made to wait longer than other patients, and she realises that this is discrimination.
- + As the scenario ends, Carol leaves the clinic as a result of the discrimination she has experienced there.
- + Carol may end up not getting tested at all, jeopardising her employment opportunity and potentially putting her health at risk.
- + Carol might tell her friends about the poor treatment she received, which may discourage them from being tested as well.
- + Other patients at the clinic may be aware of the differential treatment Carol received. This may contribute to or reinforce their own stigmatising attitudes towards certain groups of patients. Or, the other patients may feel reluctant to be tested for HIV themselves after seeing Carol be treated this way based on her presumed HIV status.

“Carol probably felt depressed, neglected, impatient. She wasn't treated fairly. Her rights were violated.”

4. What issues related to confidentiality and patient rights are raised in this scenario?

- + Carol's right to confidential health care services has been violated. The receptionist violated her confidentiality by:
 - Suggesting to the janitor that Carol is HIV-positive.
 - Revealing her profession and place of employment to the janitor.
 - Calling patients by their first and last names – in Carol's case, this will further violate her confidentiality by attaching the receptionist's comments about her HIV status and profession to her full name.
- + The receptionist denied the patient the opportunity to get tested.
- + The receptionist demonstrated disregard for the patient's time by making her wait for several hours.
- + Gossip, spreading rumours, and violating a patient's confidentiality with respect to her HIV status and associating it with her profession and place of employment are forms of stigma and discrimination.
- + Carol also states that she is seeking an HIV test because it is required as a condition of employment at a hotel where she hopes to get a job.
 - HIV testing should be sought voluntarily and the results disclosed by choice.

5. In this scenario, the janitor witnessed the stigma and discrimination displayed by the receptionist. What could the janitor have said or done in this situation?

- + “Why are you treating her like that? You’re not being fair, you’re discriminating.”
- + “I don’t think it’s fair that you’re keeping her this long. It’s her turn”:
- + “I don’t think we should be talking about a patient this way. How she makes her money is her business, and she has a right to keep it private.”
- + “Your responsibility is to serve the patients.”
- + “Why do you think she’s HIV-positive just because she works there? I know there are lots of people who are HIV-positive with jobs just like you and me.”
- + “What if it were you, coming to the clinic? How would you feel, would you want people to talk about your status, where you work, etc. etc.?”
- + The janitor could inform a superior of what was happening and let the superior address it.
- + The janitor could have said that the receptionist was obligated to care for everyone and that she would report it.

6. What would *you* have done if you had witnessed the stigma and discrimination displayed by the receptionist?

7. What are some of the cultural beliefs and practices that underlie and encourage stigma and discrimination? How can you address these with a co-worker or supervisee?

8. What could you do in your facility to prevent this type of thing from happening?

- + Hold regular in-service meetings to address issues such as these before they happen. Emphasise that all health care workers have a professional responsibility to treat all patients fairly and to respect confidentiality.
- + The receptionist should be provided clear guidelines about how long patients have to wait.
- + If a HCW breaches confidentiality or is discriminatory they should be disciplined and/or dismissed.

9. Does your facility have policies that relate to this situation?

- + If no, discuss what types of policies could help to prevent the situation that occurred in this scenario.

- ✦ **If yes, discuss how the policies could be better monitored and enforced.**

No policies

- ✦ Health care facilities can adopt confidentiality, non-discrimination, and patient rights policies that all health care workers must abide by.
 - Health care workers can advocate for such policies in their own workplaces.
 - See **Appendix J** for an example of a national patients’ rights document.

Better Enforcement of Policy

- ✦ Health care workers can be asked to sign a statement indicating that they have read and agree to abide by non-discrimination, confidentiality, and patient rights policies.
- ✦ Training and sensitization should be provided to ALL levels of staff on respecting patient confidentiality and rights. All new staff orientations should include this information.
- ✦ Training should be provided to staff on basic HIV transmission.
- ✦ In-service workshops can be held to address underlying cultural attitudes and beliefs that lead to stigma and discrimination.
- ✦ If a policy had existed in this scenario, the janitor could have referred to it when responding to the receptionist’s comments about Carol.
 - The janitor might say, “You know our clinic’s patient rights policy says we are to treat all patients the same regardless of the type of work they do. That means you shouldn’t make this patient wait any longer than the others.”
- ✦ Making reference to institutional or national policies would help the janitor to confront the receptionist’s actions without making her feel personally attacked by a co-worker.
- ✦ Some clinics also post a “Patient’s Bill of Rights” in clinic waiting rooms. This helps to ensure that both clinic staff and the patients themselves are aware of their rights, and may serve as a reminder to staff to make sure that they do not treat patients in a way that may be violating their rights.
- ✦ Refer to **Appendix J** for an example of a patient rights document.

“The janitor seemed like she had knowledge – she wanted to see justice served. She couldn’t have said much more, though, because of her role/position.”

“The janitor was not in agreement with the receptionist... The janitor should have said more.”

“Health facilities should have a statement that says ‘In this clinic we don’t discriminate.’ Also a sheet with rules and regulations. Health care workers who come to work there must sign, agree to these principles.”



SUMMARY

1. Summarise the discussion using the key points provided below which detail important take-home information from this scenario.
2. Ask the group to share action steps or anything that they will do differently when they return to their site as a result of this discussion.
3. Emphasise commitment to confidentiality and sensitivity to the information shared by members of the group.
4. Thank all for the discussion and their participation.
5. If this is the final scenario to be presented to the group, distribute the evaluation form found in **Appendix M**. The information obtained from this form can be used to assess the effectiveness of the training in triggering insight, reflection, and intent to act amongst participants, and to obtain suggestions for improving the materials.

KEY POINTS

- ❖ Stigma and discrimination can result in patients not receiving the health care they need or desire.
- ❖ Non-verbal communication can be as powerful as verbal communication in stigmatising and discriminating against people.
- ❖ All patients have the right to receive equitable, high quality health care.
- ❖ All health care workers, whether or not they counsel patients, should have a thorough understanding of how HIV is and is not transmitted.
- ❖ People become infected with HIV because of what they or their partner(s) do, not because of what job they have. Health care workers should not make assumptions about patients.
- ❖ Health care workers have a professional obligation to remain objective and non-judgmental with patients, and to avoid letting their personal beliefs and attitudes prevent them from providing compassionate and high quality care to all patients.
- ❖ Gossip, rumours, and violating the confidentiality of a patient are forms of stigma and discrimination.
- ❖ Institutional policies on confidentiality, patient rights and equity of care can help health workers to confront and address stigmatising and discriminatory behaviours amongst their co-workers.
- ❖ Stigma and discrimination prevents people from accessing HIV/AIDS testing, care, support, treatment and prevention services.

SCENARIO 6: ACTIVITY

Develop a Patient Bill of Rights

If time allows, facilitators should consider ending the session on this scenario with this activity.

This activity will allow participants to incorporate their ideas about how patient's rights are addressed in health care facilities. It will also help them to think about how the ideas discussed in this session might play out in their own work and lives.



Time: 25 minutes

Materials: Flip chart paper (optional)

Pens/pencils (optional)

INSTRUCTIONS:

- + Divide participants into four small groups.
- + Each group will develop a patient bill of rights to be posted in the clinic of the recently viewed scenario.
 - Ask participants to consider:
 - 5-10 important concepts that should be communicated in this sign.
 - Design the sign on a piece of flip chart paper.
 - After the groups have completed the sign, reconvene the large group and ask volunteers to share their signs and comment on each group's signs.



SCENARIO 6: SCRIPT

YOU KNOW HOW LONG ME A WAIT...

A cleaner is mopping one corner of the room in a general clinic waiting room. A receptionist sits at a desk. Patients are seated on benches. A patient, Sarah, enters from outside.

1. **Carol:** *Sarah Andrew!*
2. **Sarah:** *Carol! Me gal! It's a long time me nuh see yuh. Whey yuh hiding?*
3. **Carol:** *Hear who a talk? Last time me remember me nah see yuh, me say to meself, a man mussa steal yuh away to England or New York.*
4. **Sarah:** *Just give me one minute. Let me check by de receptionist.*

Sarah fidgets with the cigarette. Sarah returns and sits next to her.

6. **Sarah:** *De receptionist not too nice yuh know.*
7. **Carol:** *Issues, issues!*
8. **Sarah:** *Yuh looking sexy, gal. Me hear yuh been island hopping. Barbados, St. Lucia, even Trinidad...*
9. **Carol:** *Is pure survival me chile.*
10. **Sarah:** *So wha yuh ah do here. You waiting long?*
11. **Carol:** *Me dere since nine o'clock and me appointment was nine terty.*
12. **Sarah:** *Carol, it's 12 noon.*
13. **Receptionist:** *(She calls.) David Joseph.*

A patient in the waiting room gets up for his appointment.

14. **Carol:** *Hey! What happen?! This man just reach here. It shoulda been me turn! Me dere long before he!*
15. **Sarah:** *Let him go, let him go Carol. Is talk we ah talk, is talk we ah talk.*
16. **Carol:** *What yuh come for?*
17. **Sarah:** *To see the doctor for a test.*

18. **Carol:** *Yuh in de same boat??*
19. **Sarah:** *Yeah. No! Wait, what you mean?*
20. **Carol:** *HIV?*
21. **Sarah:** *Na! Me come for a full check up, gal. Pressure, sugar and dem ting. You come for HIV test?*
22. **Carol:** *Ah so me say.*
23. **Sarah:** *How come?*
24. **Carol:** *What you mean how come? Dem sen me fuh it.*
25. **Sarah:** *Dem who Carol?*
26. **Carol:** *Lord have mercy! If somebody did tell me dat you can still ask so much question, me woulda defend you! Girl you nosy, yes! Well me ah go tell yuh... Me apply fuh a job at de hotel. Dem tell me dey wan me take HIV test. Because me ah dancer yuh know, dem sen me fuh test. Dem tink dancers no professional? Believe me Gal, me never did want come here.*
27. **Sarah:** *No?*
28. **Carol:** *No sah! Me woulda take one o' dem test on de street, but me know de big shot at de hotel woulda ask fe proper documentation. Gal, I gata see the doctor first for him fuh sen me fuh da tes.*
29. **Sarah:** *So Carol, yuh still a do dis?*
30. **Carol:** *Still a do what?*
31. **Sarah:** *De dance ting.*
32. **Carol:** *Me no ashame a it. Me entertain people, make plenty man feel happy and dem appreciate me fuh it. Yuh hear wha me a say? Is true some people in society wan turn up dem nose and discriminate, but dat no change the price of coffee.*

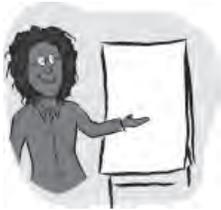
Janitor approaches the receptionist.

33. **Janitor:** *How come you nah send in Miss Feisty yet? Is a long time she a did sit dere.*
34. **Receptionist:** *She too knock about, dat's why! Run she body all over de place like ah ole car. She maybe done catch de virus already, sleeping with other people man!*

35. **Janitor:** *How you know?*
36. **Receptionist:** *Can't you see? It's written all over her! Besides, she too bold. If you read this holly paper here... Occupation: Dancer! Place of Work: Spotlight. Look, get some disinfectant and wipe dat part of me desk dere whey she ah lean 'pon. Leh me call she frien.*
37. **Receptionist:** *Sarah Andrew.*
38. **Carol:** *No. Dis chyan be right! Excuse me Miss, but sumting wrong. You know how long me a wait and yuh let everyone just step pon me!*
39. **Receptionist:** *Would you sit down and please wait your turn?*
40. **Carol:** *You done pass me turn already.*
41. **Receptionist:** *I am in charge here not you!*
42. **Carol:** *Wha yuh ah talk bout? Me no want fuh run your office. Me just want fuh keep me appointment.*
43. **Receptionist:** *If you want fuh keep your appointment, you will sit and wait your turn!*
44. **Sarah:** *Is trouble she want with you, Carol. Doh fall in de trap.*
45. **Carol:** *You see wha me a just tell you bout discrimination? Wasting so much a me precious time. Me a leave dis place. Chyan budder wit dis. (She picks up her bag walks out.)*
46. **Receptionist:** *Good riddance.*



SCENARIO SEVEN: *TEST? WHAT TEST?*



SCENARIO OVERVIEW

Scenario Overview (*do not read aloud to participants*): A patient brings a form from his doctor to a technician in a blood lab. The patient is surprised to learn from the lab technician that his doctor ordered an HIV test. It becomes clear that the doctor did not arrange pre-test counselling or obtain informed consent from the patient.

Discussion Themes:

- + Patient rights and equity of care
- + Confidentiality
- + Voluntary counselling and testing (VCT)
- + Informed consent
- + Institutional policy

Session Time: Allow at least 30-45 minutes for a complete discussion of this video scenario (video is almost 2 minutes long). Depending on the context of the discussion (e.g. part of larger training or stand alone), the discussion can be expanded/adapted with additional questions and discussion.

Resources Needed:

- + VCR or DVD player or computer with DVD capacity
- + TV or projector with speakers



IF THIS IS THE FIRST SCENARIO TO BE PRESENTED TO THE GROUP:

- 1.** Begin with a brief introduction to the issue of stigma and discrimination (5 minutes).
 - ✦ Stigma is an unfavourable attitude or belief directed toward an individual or a group, while discrimination is an unfavourable act or behaviour towards an individual or group.
 - ✦ Both stigma and discrimination occur even in healthcare settings and are significant obstacles to providing quality care, treatment, and prevention services.
 - ✦ As the Caribbean region scales up its response to HIV/AIDS, it is vitally important that all health care workers contribute to establishing an environment in which all patients are treated with kindness and compassion.
 - ✦ Additional background information on stigma and discrimination is available in **Appendix A**.

- 2.** Discuss the importance of confidentiality, and obtain agreement from participants regarding the confidential nature of the discussion (refer to **Appendix L** for a sample confidentiality agreement).

- 3.** Establish ground rules for the group discussion (see **Appendix B** for more information). The ground rules will depend in part on the size and composition of the group. Key ground rules include:
 - ✦ Do not interrupt or speak over another person
 - ✦ Cell phones off or on vibrate
 - ✦ Criticise the idea, not the person
 - ✦ Respect the views of others, not necessarily agreeing with them
 - ✦ Participate at your comfort level

FACILITATOR INSTRUCTIONS



1. **Introduce** the scenario to participants by reading the following:

- ✦ “The video scenario you are about to see shows a patient interacting with a lab technician. After the video, we will have a discussion.”

2. **Play** the video. At the end of the trigger scenario video, the DVD will automatically stop. If you are using a VHS, you will need to manually stop or pause the video tape.

3. **Initiate discussion** with participants using the discussion questions and the possible answers below as a tool to guide the discussion. Use probing questions to stimulate discussion and draw out important topics.

- ✦ Point out that there are not necessarily “right” or “wrong” answers to many of these questions. It is not necessary for the group to reach consensus on every question.
- ✦ Be sure to distinguish between facts and opinions during the discussion. Gently correct any misinformation or myths.

It is not necessary to ask the questions in the discussion guide in the order presented here.

- ✦ In many cases the discussion will move spontaneously from one topic to another.
- ✦ Use the summary table of Discussion Guide Questions to locate where specific questions appear in this guide.
- ✦ If participants have already discussed a particular question, it is not necessary to ask it again.



NOTE: Quotes in the boxes are from Caribbean Health Care Workers in response to the discussion questions.



DISCUSSION GUIDE QUESTIONS

The table below is a summary of the discussion questions included in this discussion guide. The discussion will likely move from one topic to another rather than follow the order of questions. Use this table to identify topics of discussion that arise and quickly locate where the responses appear in the Discussion Guide below.

DISCUSSION QUESTIONS
1. What happened in this scenario? What did you think?
2. How do you think John, the patient, is feeling at the end of the scenario? How do you think the scenario affected John and other patients who may have witnessed the scenario?
3. How did the lab techs in this scenario handle the situation?
4. What could the lab techs have done differently when they discovered that the patient had not given informed consent for an HIV test nor received proper counselling?
5. Why do you think the doctor might have ordered an HIV test for John without first obtaining informed consent and conducting pre-test counselling?
6. What is meant by “informed consent”?
7. Is it ever justified to test a patient without first obtaining informed consent? If so, under what circumstance?
8. What could you do in your facility to prevent: a) the breach in confidentiality; and b) the testing without informed consent that occurred in this scenario?
9. Does your facility have policies that relate to this situation? + If no, discuss what types of policies could help to prevent the situations that occurred in this scenario. + If yes, discuss how the policies could be better monitored and enforced.

1. What happened in this scenario? What did you think?

- ✦ The HIV test for John, the patient, was ordered without his knowledge or consent.
- ✦ The doctor didn't inform the patient of the test.
- ✦ The patient panicked at the thought of getting the test.
- ✦ The lab techs' shouting was a breach of confidentiality. They discussed the type of tests John's doctor had ordered for him in a loud, non-discreet manner.
- ✦ The technicians should have been more professional.
- ✦ There was a lack of sensitivity to the patient.
- ✦ The rights of the client to informed consent, confidentiality were violated.

2. How do you think John, the patient, is feeling at the end of the scenario? How do you think the scenario affected John and other patients who may have witnessed the scenario?

- ✦ John appeared angry at the end of the scenario. He possibly felt betrayed by his doctor and by the lab technicians.
- ✦ John seemed to be very afraid and anxious - he might not want to know his HIV status because of fear of stigma and discrimination.
- ✦ John might have felt embarrassed about the HIV test.
- ✦ John might have lost faith in the health care system. He might just leave and not go back to see the doctor.
- ✦ This possible breach of confidentiality may result in John feeling stigmatised and discriminated against.
- ✦ John may feel reluctant to be tested for HIV now and in the future.
- ✦ The door to the room was open – it is not clear whether other staff and/or patients were within earshot. Other patients or staff who overheard this scenario, or hear about it from John, may feel reluctant to be tested for HIV for fear that this might happen to them.

3. How did the lab techs in this scenario handle the situation?

- ✦ The lab tech embarrassed the client by calling out to the other lab tech about how to fill in the form for HIV. This made the client feel uncomfortable and embarrassed. It also violated his right to confidentiality.
- ✦ The lab techs violated John's right to confidentiality by discussing his HIV test loudly in a public place.
 - The lab techs discussed the type of tests John's doctor had ordered for him in a loud, non-discreet manner, which may have been overheard by staff and/or patients because the door to the room was open.

- ✦ When it became clear that the patient had not provided informed consent, the lab techs were not reassuring to the patient. They seemed to be accusing him.

4. What could the lab techs have done differently when they discovered that the patient had not given informed consent for an HIV test nor received proper counselling?

- ✦ If they realise that a patient has not given informed consent, the lab techs should deal with the issue in a way that maintains the patient's confidentiality. The lab techs could discuss the issue and how to proceed with each other privately, e.g. away from the lab counter, in a discreet manner.
- ✦ The lab techs could have tried to calm the patient's fears and reassured him that taking the test doesn't mean he has HIV. This discussion should take place in a confidential setting.
- ✦ The lab techs could have apologised, explained to John that he should have been informed about the test and counselled, and offered to follow-up with the doctor.
- ✦ If the health care facility where the lab techs work has a policy on informed consent, they could refer to this policy for guidance on how to proceed.
 - For example, the lab policy might be that all orders for HIV tests must include documentation of informed consent. If informed consent documentation is missing, the lab tech could simply note this on the patient's lab order and ask the patient to return the lab order to the doctor.
 - Making reference to this policy would help the lab techs to appropriately address John's need for informed consent prior to his HIV test and to protect his confidentiality
- ✦ If their facility does not have a policy or if they are still unsure how to proceed, they might:
 - Discuss the issues and how to proceed in a confidential setting.
 - Seek input from their supervisor and/or John's doctor.

5. Why do you think the doctor might have ordered an HIV test for John without first obtaining informed consent and conducting pre-test counselling?

We don't know exactly why this doctor ordered the test without first obtaining informed consent. Following are some possibilities:

- ✦ The doctor might not have been comfortable counselling patients. He might have been afraid of having to

"I've realised that some doctors do request HIV tests without consent. The lab has a policy for informed consent – if we don't receive the proper documentation, we'll send the request right back."

deal with the patient's reaction.

- ✦ The doctor might have been in a hurry and didn't want to take the time to counsel the patient.
- ✦ Health care workers in the Caribbean report a variety of reasons leading them to test patients for HIV without obtaining informed consent, including:
 - The patient is seriously ill.
 - The health care provider is planning to perform an invasive procedure on the patient, and fears exposure to HIV.
 - The patient is perceived to be a member of a "high risk" population, e.g. gay men or commercial sex workers (Massiah, 2004).

6. What is meant by "informed consent"?

- ✦ Informed consent refers to a process involving counselling about the possible positive and negative outcomes that might result from knowing one's HIV status, and making a personal choice to be tested for HIV based on this information.
 - Establishing informed consent requires that the patient demonstrate mental capacity to understand the information discussed, and freely agree without coercion to have the HIV test performed.
 - Consent may be established verbally or by signing an informed consent form, depending on the health care facility's policy.

7. Is it ever justified to test a patient without first obtaining informed consent? If so, under what circumstances?

- ✦ WHO/UNAIDS promotes the '3 C's' approach as guiding principles for the conduct of HIV testing:
 - Confidential
 - Be accompanied by counselling
 - Only be conducted with informed consent, meaning that it is both informed and voluntary
- ✦ According to WHO/UNAIDS' policy statement on HIV testing, "HIV testing without consent may be justified in the rare circumstances in which a patient is unconscious, his or her parent or guardian is absent, and knowledge of HIV status is necessary for purposes of optimal treatment." (UNAIDS/WHO, 2004)
 - Only in very extreme circumstances should a patient be tested for HIV without informed consent.
 - The decision to test without informed consent should be based solely on the patient's individual situation, not on the health care providers' beliefs or wishes.
- ✦ In this scenario, the above criteria did not apply. So the lab techs should not test this pa-

tient for HIV without his informed consent.

8. What could you do in your facility to prevent:

a) the breach in confidentiality; and

b) the testing without informed consent that occurred in this scenario?

Confidentiality

- Refer to tests by a code or number so that the conditions associated with tests are not discussed by name.
- Blood for HIV testing could be drawn by the physician or nurse, so that the patient is not sent to the lab at all.
- Health care workers should never shout to each other about a patient. If you hear somebody shouting a question to you, you should not shout back, but should go to the person and talk to them privately.
- HCWs can model positive behaviour in their own workplaces by always maintaining confidentiality.
- Training should be provided to all levels of staff on confidentiality policies. All new staff should be oriented to these policies.

Lack of informed consent

- Staff should be sensitised to the fact that this situation could occur, and should discuss strategies for how they would handle such a situation.
- The lab test form could include a check box indicating that the patient has been counselled and has consented to the test. The lab techs could be responsible for ensuring that this box is checked before proceeding with the HIV test.
- If informed consent policies exist, all staff should be made aware of the policies. Breaches of policy should be reported.
- Training should be provided to all staff on informed consent policies. All new staff should be oriented to these policies.

9. Does your facility have policies that relate to this situation?

- ✦ If no, discuss what types of policies could help to prevent the situations that occurred in this scenario.
- ✦ If yes, discuss how the policies could be better monitored and enforced.

No Policies

- ✦ Policies should guide who draws blood, how technicians are educated.
- ✦ Health care facilities can adopt policies on informed consent and confidentiality; health care workers at all levels should be educated on these policies, regardless of whether they counsel patients or not. See **Appendix J** for sample patients' rights documents.
- ✦ HCWs can advocate for institutional policies around informed consent and confidentiality. See the UNAIDS/WHO policy statement on HIV testing for information about informed consent for HIV testing, available from:
http://www.who.int/rpc/research_ethics/hivtestingpolicy_en_pdf.pdf

Better Enforcement of Policies

- ✦ All clinic staff should be made aware of the clinic's policies related to testing, informed consent, and confidentiality.
- ✦ Clinic staff can be required to sign statements indicating that they have read the policies and agree to abide by them.
- ✦ Training should be provided to ALL levels of staff on institutional policies. All new staff orientations should include this information.
- ✦ Breaches in policy should be reported.

SUMMARY

1. Summarise the discussion using the key points provided below which detail important take-home information from this scenario.
2. Ask the group to share action steps or anything that they will do differently when they return to their site as a result of this discussion.
3. Emphasise commitment to confidentiality and sensitivity to the information shared by members of the group.
4. Thank all for the discussion and their participation.
5. If this is the final scenario to be presented to the group, distribute the evaluation form found in **Appendix M**. The information obtained from this form can be used to assess the effectiveness of the training in triggering insight, reflection, and intent to act amongst participants, and to obtain suggestions for improving the materials.

KEY POINTS

- ❖ The indiscreet and unprofessional behaviour of laboratory technicians had a negative impact on a patient, and might have compromised his health seeking behaviour in both the present and future.
- ❖ All patients have a right to make a voluntary and informed choice about whether to be tested for HIV.
- ❖ Violating a patient's right to confidentiality by discussing his or her health and health care decisions publicly is a form of stigma and discrimination. Any worker in a health care facility can impact a patient's experience at the clinic, either positively or negatively.
- ❖ Health care workers must be constantly aware of the possibility of breaching confidentiality, even unintentionally.
- ❖ All levels of health care workers should receive training on confidentiality, informed consent, and other patient rights issues.
- ❖ Institutional policies on patient rights, informed consent, and confidentiality can help health workers to confront and address potentially stigmatising and discriminatory behaviours in their health care facilities.

TRIGGER SCENARIO 7: ACTIVITY 1

HIV Testing Activity

If time allows, facilitators should consider ending the session on this scenario with this activity on HIV testing.

This activity will allow participants to draw on the themes presented in the scenario they have just seen and discussed, relate them to a WHO/UNAIDS policy statement on HIV testing, and consider how the issues are addressed in their own health care facilities.



Time: 20 minutes

Materials: Sufficient copies of WHO/UNAIDS' Policy Statement on HIV Testing available from:

http://www.who.int/rpc/research_ethics/hivtestingpolicy_en_pdf.pdf

Paper (optional)

Pens/pencils (optional)

INSTRUCTIONS:

- ✦ Prior to presenting this scenario, make sufficient copies of WHO/UNAIDS' Policy Statement on HIV Testing for the group (available from: http://www.who.int/rpc/research_ethics/hivtestingpolicy_en_pdf.pdf).
 - *Note: If literacy is limited for some participants, the facilitator could present the main points covered in the WHO/UNAIDS policy statement prior to the activity, rather than distribute it to participants.*
- ✦ Ask participants to divide into groups of 3 or 4.
 - If participants are from more than one health facility, ask them to join a group with participants from facilities other than their own.
- ✦ Distribute the WHO/UNAIDS' policy statement. Ask the groups to look over this policy, and think about relevant policies, if they exist, and practices around informed consent and HIV testing at their own facilities.
- ✦ Allow the groups to spend about 10-15 minutes discussing these issues:
 - What do you think about the forms of HIV testing and the guiding principles discussed in the WHO/UNAIDS document?

- Are there policies around these issues in place at your health facilities? How are they similar or different from the policies discussed in the WHO/UNAIDS document?
 - Do you think the policies and practises related to testing and informed consent could be improved at your facilities? If so, how?
- ♦ After the small groups have discussed, reconvene the large group and discuss the issues that came up and answers to the questions.



SCENARIO 7: SCRIPT

TEST? WHAT TEST?

A patient is seated in a blood lab, waiting to be seen.

1. **Patient:** (Handing a form to the lab tech.) *Dats from de doctor, sir.*
2. **Tech 1:** *Okay, so we'll just draw some blood and get some of your tests going...* (Shouting across the hallway to Tech 2.) *Hey Steven, how do you fill out those forms?*
3. **Tech 2:** *What forms?*
4. **Tech 1:** *HIV forms?*
5. **Patient:** *HIV?*
6. **Tech 1:** *That's what it says here, HIV.*
7. **Patient:** *Nah! Nah... Nah... Nah! No way!*
8. **Tech 1:** *Hey take it easy, relax man.*
9. **Patient:** *Doh tell me relax man. I did not come here for any HIV test, man!*
10. **Tech:** *Didn't the doctor discuss this with you?*
11. **Patient:** *No! I did not discuss any HIV test with the doctor!*
12. **Tech1:** *Are you sure about this?*
13. **Tech 2:** (Joining them.) *You told the doctor you were sick right?*
14. **Patient:** *Yes.*
15. **Tech 2:** *What did you tell him was wrong with you?*
16. **Patient:** *I had the flu. Dats why I come to see the doctor.*
17. **Tech 1:** *Did the doctor examine you?*
18. **Patient:** *Yeah, he examine me. He check under my arm, around my neck.*
19. **Tech 2:** *So what test the doctor tell you that you must take?*

20. **Patient:** *He only tell me that I have to take some test to see why I was feeling so sick.*

21. **Tech 1:** *Well, one of the tests the doctor he ordered is for HIV.*

22. **Patient:** *I look like I have HIV to you? I going back to see the doctor man.*



SCENARIO EIGHT: ASSUMPTIONS



SCENARIO OVERVIEW

Scenario Overview (*do not read aloud to participants*): A woman living with HIV is hospitalised with a complication unrelated to her HIV status. Family members are in her room visiting when the doctor arrives and starts asking questions about the patient's HIV medications. The patient had not yet disclosed her HIV status to her family.

Discussion Themes:

- + Patient rights
- + Value judgements
- + Confidentiality
- + Non-verbal manifestations of stigma and discrimination
- + Institutional policy

Session Time: Allow at least 30-45 minutes for a complete discussion of this video scenario (video is 4 minutes long). Depending on the context of the discussion (e.g. part of larger training or stand alone), the discussion can be expanded/adapted with additional questions and discussion.

Resources Needed:

- + VCR or DVD player or computer with DVD capacity
- + TV or projector with speakers



IF THIS IS THE FIRST SCENARIO TO BE PRESENTED TO THE GROUP:

1. Begin with a brief introduction to the issue of stigma and discrimination (5 minutes).
 - ✦ Stigma is an unfavourable attitude or belief directed toward an individual or a group, while discrimination is an unfavourable act or behaviour towards an individual or group.
 - ✦ Both stigma and discrimination occur even in healthcare settings and are significant obstacles to providing quality care, treatment, and prevention services.
 - ✦ As the Caribbean region scales up its response to HIV/AIDS, it is vitally important that all health care workers contribute to establishing an environment in which all patients are treated with kindness and compassion.
 - ✦ Additional background information on stigma and discrimination is available in **Appendix A**.
2. Discuss the importance of confidentiality, and obtain agreement from participants regarding the confidential nature of the discussion (refer to **Appendix L** for a sample confidentiality agreement).
3. Establish ground rules for the group discussion (see **Appendix B** for more information). The ground rules will depend in part on the size and composition of the group. Key ground rules include:
 - ✦ Do not interrupt or speak over another person
 - ✦ Cell phones off or on vibrate
 - ✦ Criticise the idea, not the person
 - ✦ Respect the views of others, not necessarily agreeing with them
 - ✦ Participate at your comfort level



FACILITATOR INSTRUCTIONS

1. **Introduce** the scenario to participants by reading the following:
 - ✦ “The video scenario you are about to see shows a patient being examined by a doctor while family members are visiting. After the video, we will have a discussion.”
2. **Play** the video. At the end of the trigger scenario video, the DVD will automatically stop. If you are using a VHS, you will need to manually stop or pause the video tape.
3. **Initiate discussion** with participants using the discussion questions and the possible answers below as a tool to guide the discussion. Use probing questions to stimulate discussion and draw out important topics. See **Appendix B** for more information on facilitation skills.
 - ✦ Point out that there are not necessarily “right” or “wrong” answers to many of these questions. It is not necessary for the group to reach consensus on every question.
 - ✦ Be sure to distinguish between facts and opinions during the discussion. Gently correct any misinformation or myths.

It is not necessary to ask the questions in the discussion guide in the order presented here.

- ✦ In many cases the discussion will move spontaneously from one topic to another.
- ✦ Use the summary table of Discussion Guide Questions to locate where specific questions appear in this guide.
- ✦ If participants have already discussed a particular question, it is not necessary to ask it again.



NOTE: Quotes in the boxes are from Caribbean Health Care Workers in response to the discussion questions.



DISCUSSION GUIDE QUESTIONS

The table below is a summary of the discussion questions included in this discussion guide. The discussion will likely move from one topic to another rather than follow the order of questions. Use this table to identify topics of discussion that arise and quickly locate where the responses appear in the Discussion Guide below.

DISCUSSION QUESTIONS
1. What happened in this scenario? What did you think?
2. What assumptions did the doctor make?
3. How do you think the patient felt?
4. What might be the effects of this inadvertent disclosure for the patient? For the patient's family?
5. What are the patient rights issues in this scenario?
6. What should the doctor have done to protect the patient's confidentiality?
7. If you had been a nurse in this scenario assisting the doctor with care of this patient, what could you have said later, in private, to the doctor about his behaviour?
8. What could the doctor do to address the situation after it occurred?
9. What could you do in your facility to prevent this type of thing from happening?
10. Does your facility have policies that relate to this situation? <ul style="list-style-type: none">• If no, discuss what types of policies could help to prevent this situation from occurring.• If yes, discuss how the policies could be better monitored and enforced.



1. What happened in this scenario? What did you think?

- ✦ An HIV-positive patient was in the hospital for kidney stones.
- ✦ The doctor inadvertently disclosed the patient's HIV-positive status in front of the patient's family.

2. What assumptions did the doctor make?

- ✦ By initiating a conversation with the patient about her HIV medications, the doctor assumed that the patient had disclosed her status to her family.
- ✦ The doctor incorrectly assumed that because the people in the room were family and that the patient had already begun ARV treatment, that she had disclosed her status to them.
- ✦ The doctor disregarded the patient's confidentiality and had no regard for the patient's HIV status.

"The doctor was totally out of line. He should have asked the family to leave. He assumed they knew."

"You shouldn't discuss a diagnosis in front of a patient's family – that's basic medical ethics."

3. How do you think the patient felt?

- ✦ The patient probably felt embarrassed and upset.
- ✦ The patient may be fearful of the consequences and effects of this information. She may fear rejection, violence, isolation and abandonment from her family, friends and partner.
- ✦ The patient may become angry or depressed about the doctor's thoughtless actions (whether intended or not), which could have a negative impact on her treatment outcome. She may not want to return to the hospital for care and services if she does not feel she is treated with respect and that her rights are valued.

"HCWs should learn to treat people the way you want to be treated."

"She wanted to disappear!"

"The patient felt like the whole world came down on her."

4. What might be the effects of this inadvertent disclosure for the patient? For the patient's family?

Patient

- ✦ The disclosure might result in broken relationships between the patient and her family.
- ✦ The patient's family may stigmatize or discriminate against her by abandoning or rejecting her or by not supporting her in her care.
- ✦ She might lose her family, her accommodations, and her children.

- ♦ She might be isolated and rejected by her family.
- ♦ The patient appeared to have difficulty adhering to the ARV medications; this accidental disclosure, and the resulting feelings and actions may result in a negative impact on her adherence to ARVs.

Family

- ♦ The family members appeared confused, then shocked.
- ♦ They might react (either now or later) to the news in negative ways:
 - They could further violate the patient's confidentiality by telling other friends and family about her positive HIV status, potentially leading to stigma and discrimination against her in her community or family.
 - The family may fear being discriminated against by being associated with the patient.
- ♦ Stigma can cause psychosocial problems, such as anxiety, depression, guilt, shame and loss of hope. It can also cause problems for a person adhering to ARV treatment.

“You could see the stigma and discrimination on the sister-in-law’s face immediately.”

5. What are the patient rights issues in this scenario?

- ♦ The doctor violated the patient's rights to privacy, confidentiality, and disclosure.
- ♦ Violating a patient's confidentiality with respect to her HIV status is a form of stigma and discrimination.
- ♦ A HCW should never assume that a patient has disclosed to his or her family, partner, friends or anyone.
- ♦ Even if a HCW feels that it is the “right time” for family members to know about a patient's status, the decision to disclose status should be the patient's. A HCW may discuss (privately) with the patient, the benefits and disadvantages of disclosing status, but may not take it upon himself or herself to tell the family, partner or friends of the patient without their consent.
- ♦ Even just discussing the patient's medications, without mentioning the “HIV virus” is a violation of confidentiality. When the doctor had mentioned the patient's medication, Viracept, the family may have been confused and could have asked, “What's that for?” The patient would then have to decide in that moment whether or not to disclose to her family.
- ♦ Many times the doctor only wants to address the HIV. He should have dealt with the patient's primary complaint which was kidney stones.

“HCWs need to offer a personal touch so that their patients feel loved, cared for and respected.”

6. What should the doctor have done to protect the patient's confidentiality?

- ♦ Before discussing treatment, the doctor should have asked the family to step outside for a

moment and then asked the patient privately if she had disclosed her status to her family members. The doctor then could have asked the patient if she wanted information about her HIV care to be shared with her family.

- ♦ The doctor could have returned at a later time to discuss the patient's HIV care and medications.

“HCWs should make sure they're aware of what they're going to do before they do it.”

7. If you had been a nurse in this scenario assisting the doctor with care of this patient, what could you have said later, in private, to the doctor about his behaviour?

- ♦ The nurse could begin by asking the doctor whether the patient had previously disclosed her HIV status to her family. This will start a dialogue without making the doctor feel that the nurse is questioning his provision of care.
 - “Dr. X, do you know if [patient] has disclosed her HIV status to her family? I noticed you mentioned her status when they were in the room...”
- ♦ If it becomes apparent that the doctor does not know if the patient has disclosed her status, the nurse could have suggested that the patient's confidentiality may have been violated by discussing the patient's HIV status in front of her family.
- ♦ In doing this the nurse may help to prevent further violation of the patient's and other patients' confidentiality. The nurse might say:
 - “You know, it's up to the patient whether or not to disclose her status. We are supposed to keep all patients' information confidential.”
 - “I think she may have felt upset when you were discussing her ARVs in front of her family.”

8. What could the doctor do to address the situation after it occurred?

- ♦ The doctor could apologise to the patient (in private) about the breach in confidentiality and tell the patient that he recognises that what he did was wrong.
- ♦ He could offer to support the patient by talking with the family members about HIV. The doctor could also discuss the benefits and disadvantages of disclosing the patient's status to other family members or community members.
- ♦ The doctor could speak to the family members and ask them to maintain confidentiality. He could educate them about the fact that HIV is a treatable disease, and that she will need their care and support.
- ♦ The doctor could tell the patient's family members that not being able to disclose HIV status may make it difficult for the patient to take her ARV medication and he could give them

advice on how to support the patient with disclosure.

- ♦ The doctor can reassure the patient that she will be treated with respect and compassion during her stay. He can also tell her he will never make the mistake of breaching her confidentiality again.
- ♦ The doctor must try to regain the patient's confidence and trust after being honest about what happened.

9. What could you do in your facility to prevent this type of thing from happening?

- ♦ There should be no discussion of patients' conditions in front of relatives, partners or friends.
- ♦ If the nurse sees the doctor coming, she could ask the patient's family to step out of the room while the doctor conducts the examination.
- ♦ There should be a protocol that patients' conditions are not to be discussed with visitors.
- ♦ Training should be provided to ALL levels of staff of on how to respect patient confidentiality and raise their awareness of the fact that they should not ever assume disclosure. All new staff orientations should include this information.
- ♦ If a co-worker had observed the situation, he or she could make reference to institutional or national policies; this would help them to confront the doctor's actions without making him feel personally attacked.

10. Does your facility have policies that relate to this situation? If no, discuss what types of policies could help to prevent this situation from occurring. If yes, discuss how the policies could be better monitored and enforced.

No Policies

- ♦ Health care facilities can adopt policies that separate visiting time from exam time.
- ♦ Health care facilities can adopt patient rights policies which include confidentiality components that all health workers must abide by.
- ♦ Health care facilities can adopt policies related to disclosure.

Monitor/Enforce Existing Policies

- ♦ Some health care institutions post a "Patient's Bill of Rights" in hospital rooms. This helps to ensure that both staff and the patients themselves are aware of their rights, and may serve as a reminder to staff to make sure that they do not treat patients in a way that

may be violating their rights.

- Refer to See **Appendix J** for a sample of a national patients' rights document.
- ◆ HCWs should make it the standard to practice confidentiality in every patient situation. That way, they are not likely to accidentally breach confidentiality.

SUMMARY

1. Summarise the discussion using the key points provided below which detail important take-home information from this scenario.
2. Ask the group to share action steps or anything that they will do differently when they return to their site as a result of this discussion.
3. Emphasise commitment to confidentiality and sensitivity to the information shared by members of the group.
4. Thank all for the discussion and their participation.
5. If this is the final scenario to be presented to the group, distribute the evaluation form found in **Appendix M**. The information obtained from this form can be used to assess the effectiveness of the training in triggering insight, reflection, and intent to act amongst participants, and to obtain suggestions for improving the materials.

KEY POINTS

- ❖ HCWs must never make assumptions about patient disclosure to friends or relatives.
- ❖ Carelessness in discussing personal information can result in harm to the patient and the patient's family.
- ❖ Ensuring confidentiality is essential so that people aren't discouraged from accessing HIV/AIDS testing, care, support, treatment, and prevention services.
- ❖ Health care workers have a professional obligation to uphold patient confidentiality at all times. They must be aware of situations in which they could inadvertently breach confidentiality.
- ❖ Institutional policies on patient rights and equity of care can help health workers to confront and address inappropriate behaviours amongst their colleagues

TRIGGER SCENARIO 8: ACTIVITY

Role Play

If time allows, facilitators should consider ending the session on this scenario with this activity.

This activity will allow participants to continue the scenario they have just seen and discussed, incorporating their ideas about how the situation might have been handled differently by the characters involved. It will also help them to think about how the ideas discussed in this session might play out in their own lives. In addition, the role play activity will allow participants to practice acting as positive role models in their own workplace.



Time: 15-30 minutes (see below)

Materials: *Scenario 8: Script*

INSTRUCTIONS:

- ✦ Divide participants into pairs.
- ✦ One participant will play the role of the doctor in the scenario and the other participant will play the role of an additional character — a nurse. Each pair should determine who will play each character.
 - Ask participants to imagine that the nurse was assisting the doctor with the care of the patient in the scenario they just viewed. Imagine that the nurse has just witnessed the doctor's behaviour and the impact: the breach in confidentiality, the resulting confusion of the relatives, and the anxiety of the patient.
- ✦ Ask participants to refer to *Scenario 8: Script*, and use this script as a starting point for the role play.
 - The person playing the role of the nurse should confront the doctor about his behaviour in a professional manner. Ask participants to act out:
 - ✦ What the nurse could say to the doctor to confront the thoughtless behaviour he or she just witnessed.
 - ✦ What the nurse might suggest the doctor do to address the breach in confidentiality with the patient and her family.
 - ✦ How the nurse can best discuss the importance of patient's rights and confidentiality in their health care facility.

- ✦ Each pair should briefly determine main points of discussion for the role play and then conduct the role play at least once within their pair.
- ✦ After the pairs have completed the role plays, lead a discussion using the following questions:
 - Ask the participant who played the nurse how he/she thought it went. What did he/she feel she did well? What would he/she change next time?
 - Ask the participant who played the doctor how he/she felt. What suggestions do they have for the nurse?
- ✦ If there is ample time, ask one or two pairs to volunteer to perform the role play in front of the large group. Ask the larger group to reflect on how the scene played out:
 - Ask them to start with what the HCW did well, then make suggestions for things she might have done differently.
 - Open the discussion to the group — ask them to start with what the HCW did well, then make suggestions for things she might have done differently.

SCENARIO 8: SCRIPT

ASSUMPTIONS

A patient is lying in bed as two relatives look down at her.

1. **1st Relative:** *How you feeling?*
2. **Patient:** *My side...*
3. **2nd Relative:** *It hurts?*
4. **Patient:** (Nods her head.)
5. **1st Relative:** *Is what dem giving you for it?*
6. **2nd Relative:** *Doh make she talk so much. Is kidney problem she have. Dey giving she medication and mek she drink plenty water.*
7. **1st Relative:** *Okay, rest me luv, rest. (They move a little away from the bed.) Since when she have dis kidney problem?*
8. **2nd Relative:** *Sudden, sudden. It's true she's been sickly, sickly. But me never hear nothing about this kidney problem. Last week she did ketch de flu, but dis kidney business...*
9. **1st Relative:** *De doctor reach. (Doctor enters the room.) Good morning doctor.*
10. **Doctor:** *Good morning.*
11. **2nd Relative:** *Morning Doctor.*
12. **Doctor:** *You are family?*
13. **2nd Relative:** *I am her sister.*
14. **1st Relative:** *And I'm she sister in law.*
15. **Doctor:** *Good. (Leaning over patient.) How are you feeling?*
16. **Patient:** *I feel weak Doctor, and my side is still hurting.*
17. **Doctor:** *Yes, the kidney stones. We will treat it to get you ready for surgery.*
18. **Patient:** *Yes, Doctor.*

19. **Doctor:** *I'm more concerned, though, with your more serious condition. (The relatives exchange concerned glances as Doctor reviews the patient's chart.) Okay, I see you have been taking Viracept.*
20. **Patient:** (Nods her head.)
21. **Doctor:** *When was the last time you took it?*
22. **Patient:** *Every day, but I didn't take it yesterday.*
23. **Doctor:** *Why not?*
24. **Patient:** *Just get tired of taking them pills.*
25. **Doctor:** *No. You have to take it every day. It keeps you stronger if you take it on schedule and it prevents the HIV virus from spreading in your body. Do you understand that?*
26. **Patient:** *Yes, Doctor. (Answers feebly while glancing nervously at her relatives.)*
27. **Doctor:** *Now I am going to ask the nurse to administer your ARVs. She has to do that everyday together with the medication for your kidney, so that we can get you ready for surgery. Alright? Good.*

Doctor leaves. The relatives, appearing shocked, move closer to the bed.



SCENARIO 9: DISCUSSION GUIDE *HIV IS A REALITY, SISTER!*



SCENARIO OVERVIEW

Scenario Overview (*do not read aloud to participants*): An inquisitive patient in a waiting room notices another patient's HIV positive lab results sitting on the receptionist's desk. A discussion between the inquisitive patient and the receptionist follows.

Discussion Themes:

- + Patient rights
- + Basic HIV prevention and transmission
- + Value judgements
- + Confidentiality
- + Confronting stigma and discrimination in the workplace
- + Institutional policy

Session Time: Allow at least 30-45 minutes for a complete discussion of this video scenario (video is about 4 minutes long). Depending on the context of the discussion (e.g. part of larger training or stand alone), the discussion could be expanded/adapted with an additional activity.

Resources Needed:

- + VCR or DVD player or computer with DVD capacity
- + TV or projector with speakers



IF THIS IS THE FIRST SCENARIO TO BE PRESENTED TO THE GROUP:

1. Begin with a brief introduction to the issue of stigma and discrimination (5 minutes).
 - ✦ Stigma is an unfavourable attitude or belief directed toward an individual or a group, while discrimination is an unfavourable act or behaviour towards an individual or group.
 - ✦ Both stigma and discrimination occur even in healthcare settings and are significant obstacles to providing quality care, treatment, and prevention services.
 - ✦ As the Caribbean region scales up its response to HIV/AIDS, it is vitally important that all health care workers contribute to establishing an environment in which all patients are treated with kindness and compassion.
 - ✦ Additional background information on stigma and discrimination is available in **Appendix A**.
2. Discuss the importance of confidentiality, and obtain agreement from participants regarding the confidential nature of the discussion (refer to **Appendix L** for a sample confidentiality agreement).
3. Establish ground rules for the group discussion (see **Appendix B** for more information). The ground rules will depend in part on the size and composition of the group. Key ground rules include:
 - ✦ Do not interrupt or speak over another person
 - ✦ Cell phones off or on vibrate
 - ✦ Criticise the idea, not the person
 - ✦ Respect the views of others, not necessarily agreeing with them
 - ✦ Participate at your comfort level



FACILITATOR INSTRUCTIONS

1. Introduce the scenario to participants by reading the following:

- ✦ “The video scenario you are about to see shows a clinic waiting room, a receptionist and some patients. After the video, we will have a discussion.”

2. Play the video. At the end of the trigger scenario video, the DVD will automatically stop. If you are using a VHS, you will need to manually stop or pause the video tape.

3. Initiate discussion with participants using the discussion questions and the possible answers below as a tool to guide the discussion. Use probing questions to stimulate discussion and draw out important topics. See **Appendix B** for more information on facilitation skills.

- ✦ Point out that there are not necessarily “right” or “wrong” answers to many of these questions. It is not necessary for the group to reach consensus on every question.
- ✦ Be sure to distinguish between facts and opinions during the discussion. Gently correct any misinformation or myths.

It is not necessary to ask the questions in the discussion guide in the order presented here.

- ✦ In many cases the discussion will move spontaneously from one topic to another.
- ✦ Use the summary table of Discussion Guide Questions to locate where specific questions appear in this guide.
- ✦ If participants have already discussed a particular question, it is not necessary to ask it again.



NOTE: Quotes in the boxes are from Caribbean Health Care Workers in response to the discussion questions.



DISCUSSION GUIDE QUESTIONS

The table below is a summary of the discussion questions included in this discussion guide. The discussion will likely move from one topic to another rather than follow the order of questions. Use this table to identify topics of discussion that arise and quickly locate where the responses appear in the Discussion Guide below.

DISCUSSION QUESTIONS	
1.	What happened in this scenario? What did you think?
2.	What are the issues around confidentiality raised in this scenario?
3.	What could Paula, the receptionist, have done differently to better protect the HIV-positive patient's confidentiality?
4.	What were Heather's, (the inquisitive patient), views about HIV/AIDS and PLWHA?
5.	How did Paula respond to Heather's concerns? <ul style="list-style-type: none"> • What were the strengths and weaknesses of her approach? • What could Paula have done differently? Ask for volunteers to role play a more effective response to Heather's concerns.
6.	Have you seen anything similar to this happen in a health facility? What happened and how was it addressed?
7.	What could you do in your facility to prevent this type of thing from happening?
8.	Are there any policies in place in your setting that address this type of scenario? <ul style="list-style-type: none"> • If yes: a) what are they? b) are they monitored, enforced effectively? c) what could be done to ensure they are enforced? • If no, what types of policies would be relevant to this type of situation?

1. What happened in this scenario? What did you think?

- ✦ There was a breach in patient confidentiality. One patient (Heather) saw another patient's (Joe's) file on the receptionist's desk.
- ✦ The patient, Heather, then had a conversation with the receptionist, Paula, in which Heather revealed misconceptions about HIV transmission, as well as value judgements about people with HIV.
- ✦ The receptionist's response to Heather may not have been effective in educating her about HIV transmission and could possibly have breached confidentiality.

2. What are the issues around confidentiality raised in this scenario?

- ✦ Joe's right to keep his HIV status confidential was violated by the receptionist, Paula, who placed his lab results where they were visible to Heather. The receptionist, Paula, was careless in leaving the patient's lab results face up on her desk.
- ✦ Paula's response to Heather's inquiry about Joe's HIV status was not direct, but still indicated, "yes", that he was positive. Paula indirectly discussed a patient's HIV status with another patient.
- ✦ The conversation between Paula and Heather took place in a corridor and could have been overheard by other patients or staff.

3. What could Paula, the receptionist, have done differently to better protect the HIV-positive patient's confidentiality?

- ✦ Paula could have taken care to do only one task at a time.
- ✦ She should allow only one patient at the window at a time.
- ✦ She could have turned Joe's file face down so that no one would inadvertently see it.
- ✦ When Heather asked whether Joe had HIV, Paula should have clearly replied that she could not discuss another patient's status with her.

4. What were Heather's, the inquisitive patient, views about HIV/AIDS and PLWHA?

- ✦ Heather believed that a person could get HIV through casual contact.
- ✦ Heather was afraid that she could catch HIV from a handshake.
- ✦ She believes "nice people" don't get HIV.
- ✦ She seemed to think that she can tell from a person's outward appearance if they have HIV. She appeared shocked that the people that she had been conversing with might be HIV positive.
- ✦ She saw HIV as a death sentence.

5. How did Paula respond to Heather's concerns?

- ✦ What were the strengths and weaknesses of her approach?
- ✦ What could Paula have done differently? Ask for volunteers to role play a more effective response to Heather's concerns.

Strengths

- ✦ Paula pointed out that Heather has shaken hands with a number of other HIV positive patients at the clinic.
- ✦ Paula's response used Heather's actual experience interacting with other HIV-positive patients to help her understand that HIV cannot be transmitted through casual contact.
- ✦ Paula tried to deflect Heather's questions, but Heather was persistent.
- ✦ Paula challenged Heather's view that Joe is somehow a different person now that he is HIV-positive.

Weaknesses

- ✦ Paula suggested that HIV is transmitted through "carelessness or accidents".
- ✦ Paula gave Heather vague information on HIV transmission. This may have left Heather confused.
- ✦ Paula did not clearly correct Heather's misconception that you can catch HIV from a handshake.
- ✦ Paula was "reactive" to Heather's comments rather than proactive (e.g. she asked her if she was naïve or playing a fool). This may have gotten in the way of educating her.
- ✦ It did not seem that Heather was educated as a result of the encounter. She still appeared sceptical and concerned at the end of the scenario.

"I know people who behave like this. Some think you can get it by drinking from the same cup."

Suggestions

- ✦ Heather's questions and concerns provided an opportunity for Paula to provide education and correct Heather's misconceptions and judgmental attitudes. Paula should be very specific in discussing how HIV is and is not transmitted. She should explain the three main modes of transmission:
 - **Sexual contact:** vaginal, anal, oral (kissing is not a risk factor for transmission unless open sores/gingivitis)
 - **Blood contact:** injections/needle sharing (through IV drugs, drug paraphernalia or injury from contaminated sharps), cutting tools (needles, razor blades, other instruments that can pierce the skin), transfusions, contact with broken skin (exposure to blood through cuts/lesions)
 - **Mother-to-Child transmission:** pregnancy, delivery, breast feeding

- + Paula could explain:
 - “The most common way that people get infected with HIV is through unprotected sex (without using a condom) with a partner who is HIV-positive.
 - It is not possible to catch HIV by shaking hands with somebody, hugging them or by breathing in the same air.
 - “Here at the clinic, we only use disposable needles and syringes, so there is no way you could become infected with HIV.”
- + Paula should stress that people get HIV because of what they or their partner(s) do, not because of whom they are (e.g. a nice person).

6. Have you seen anything similar to this happen in a health facility? What happened and how was it addressed?

7. What could you do in your facility to prevent this type of thing from happening?

- + Use numbers instead of names to call patients.
- + ALL HIV test results should be sealed and marked confidential (negative as well as positive).
- + Use codes for diagnoses so even if a patient sees another patient’s file they won’t know what it means.
- + Staff should automatically and routinely turn patient files down so that they can’t be seen inadvertently.
- + Ensure that all clinic staff are aware of and trained on methods and systems for maintaining patient confidentiality.
- + Ensure that all levels of HCWs have training on how to effectively educate patients about HIV transmission.

8. Are there any policies in place in your setting that address this type of scenario?

- + If yes: a) what are they? b) are they monitored, enforced effectively? c) what could be done to ensure they are enforced?
- + If no, what types of policies would be relevant to this type of situation?

No Policies

- + Policies and training should ensure methods and systems are in place to maximise patient confidentiality and preserve patient rights.
 - Codes could be used to indicate a patient’s HIV test results or status in all clinic records.
 - Patients can be assigned a personal ID number that can be used instead of a name in

records and when calling the patient to be seen for appointments.

- ✦ Training should be provided to ALL levels of staff on how to respect patient confidentiality regardless of whether they counsel patients or not.
 - See **Appendix J** for an example of a national patients' rights document.
- ✦ All new staff orientations should include information on confidentiality policies.
- ✦ Health care facilities can adopt policies on patient confidentiality and educate HCWs at all levels regardless of whether or not they counsel patients.

Better Enforcement

- ✦ Health care workers can advocate for improved policies and systems to protect confidentiality in their own workplaces.
- ✦ Some clinics also post a "Patient's Bill of Rights" in clinic waiting rooms. This helps to remind both clinic staff and the patients to respect confidentiality.
- ✦ Health facilities can consider adopting coding systems, so that patients' personal information is not immediately interpretable to persons other than clinic staff.

SUMMARY

1. Summarise the discussion using the key points provided below which detail important take-home information from this scenario.
2. Ask the group to share action steps or anything that they will do differently when they return to their site as a result of this discussion.
3. Emphasise commitment to confidentiality and sensitivity to the information shared by members of the group.
4. Thank all for the discussion and their participation.
5. If this is the final scenario to be presented to the group, distribute the evaluation form found in **Appendix M**. The information obtained from this form can be used to assess the effectiveness of the training in triggering insight, reflection, and intent to act amongst participants, and to obtain suggestions for improving the materials.

KEY POINTS

- ❖ Health care workers must be vigilant in their care of patient files and should never leave a file open or unattended.
- ❖ Health care workers should be aware of the possibility of breaching confidentiality - even unintentionally - in their responses to patient questions.
- ❖ All health care workers, whether or not they counsel patients, should have a thorough understanding of how HIV is and is not transmitted and have the ability to convey this information to patients when appropriate. HCWs should take advantage of opportunities to educate and correct misinformation about HIV.
- ❖ Health care facilities can adopt confidentiality policies that use numbers instead of patient names and use codes for diagnosis. All HIV test results, both positive and negative, should be sealed and marked confidential.
- ❖ People become infected with HIV because of what they or their partner(s) do, not because of who they are.
- ❖ All levels of health care workers should receive training on confidentiality.

TRIGGER SCENARIO 9: ACTIVITY 1

Role Play

If time allows, facilitators should consider ending the session on this scenario with a role play activity.

This activity will allow participants to “re-write” the scenario they have just seen and discussed, incorporating their ideas about how the situation might have been handled differently by the characters involved. It will also help them to think about how the ideas discussed in this session might play out in their own work and lives. In addition, this activity can help participants develop skills to act as positive role models in their workplace.



Time: 15 minutes

Materials: *Scenario 9: Script*

Scenario 9

INSTRUCTIONS:

- ✦ Divide participants into pairs.
- ✦ Imagine that the scene continues after the camera has “turned off” and that Paula has asked a nurse to explain to Heather how HIV is and is not transmitted and discuss her value judgements about people with HIV.
- ✦ Each pair should determine who will play each character (Heather or the nurse) in the new scenario.
- ✦ Ask participants to refer to *Scenario 9: Script*, and use this script as a starting point for the role play. Allow the groups a few minutes to discuss how they will address the following in their role plays:
 - Explaining how HIV is and is not transmitted
 - Heather’s value judgements about people with HIV
- ✦ Each group should enact the scenario with the new dialogue they have discussed.
- ✦ After the groups have completed the role plays, reconvene the large group.
- ✦ Discuss the strategies and approaches that were used. Be sure to include in the discussion the following:
 - Ask the participants how successful they felt they were in responding to the value judgements of others. What did they do well? What would they change?

- ✦ If there is sufficient time, ask one group to volunteer to perform the role play in front of the large group. Ask participants to reflect on how the scene played out:
 - Ask participants what they thought certain characters did well and what they would change.





SCENARIO 9: SCRIPT

HIV IS A REALITY, SISTER!

A receptionist (Paula) is sitting at the desk. In the waiting room, a number of patients sit on a bench. Paula looks through a patient's docket. She picks up the patient's lab results and is about to staple them into the patient's file when she is interrupted by another patient, Heather, who approaches the reception desk.

1. **Heather:** *Leh me interrupt you a second Paula, where you toilet.*
2. **Paula:** (Paula looks around and holding up her hand to signal that Heather should wait. Paula calls a patient:;) *Joe Alexander*

Heather waits, fidgeting. There is the sound of a telephone ringing. Paula swivels her chair away from the counter to answer the phone, leaving the lab results exposed on the desk. Heather looks down at the folder on the receptionist's desk and is surprised when she sees HIV-positive lab results next to Joe Alexander's name.

3. **Paula:** (On the phone) *Yes , yes, yes, we are open through lunch. One o' clock is fine Mrs. Bascombe. I won't be there but Miss Cools, the other receptionist, will be there to assist you. Bye.*
4. **Joe:** (Joe and Heather are now both at the receptionist's desk.) *Yes ma'am.*
5. **Paula:** *Wait just a minute Sir. Yes Heather, you always find a way to give me work. This is not the first time you come here but you don't know where de toilet is. Look, just go down the corridor and check the first door to the right you will see a sign marked ladies. Not toilet but ladies.*

6. **Heather:** *Whatever.* (Heather walks down the corridor.)

7. **Paula:** *Will you follow me please Mr. Alexander?*

Paula escorts Joe down a corridor to the Doctor's office. In the background, Heather enters the washroom. Joe enters the Doctor's office. Just as Paula is about to return to her desk, Heather emerges from the washroom and stops Paula in the corridor .

8. **Heather:** *Him have AIDS?*

9. **Paula:** *Oh girl you never change. Who says it's any of your business?*

10. **Heather:** *But me see him all de time, we say hi to one another. Him even shake me hand!*

11. **Paula:** *Heather you still so naïve or you just playing the fool?*

12. **Heather:** *It so bad? Him was a very nice man.*
13. **Paula:** *Why the past tense? Who say him no nice no more. HIV is a reality sister, wake up. Don't be shocked!*
14. **Heather:** *No... no... no..Miss! It's not that me shocked uh, me just terri...fied!*
15. **Paula:** *Of what?*
16. **Heather:** *What you mean of what? All that HIV. No way I shaking hands with this man again.*
17. **Paula:** *Yea. Well during that time you been coming for your check ups here you probably say hi or shake hands to more than one, no... more than ten people who are HIV-positive so don't be so shocked.*
18. **Heather:** *You mean...?*
19. **Paula:** *So what you think this is? This place here? You think all we do here is conduct pregnancy tests, check your hypertension or treat the common cold? Trust me sweetheart, this place although a general clinic is fast becoming a check up point for people who are HIV-positive.*
20. **Heather:** *So why dem never tell me that?*
21. **Paula:** *So what you going do now? Run before your check up? Relax sweetheart, people only ketch HIV through accidents or carelessness and we try not to be careless here, so pray for no accident.*



SCENARIO 10: DISCUSSION GUIDE *I CHYAH DANCE*



SCENARIO OVERVIEW

Scenario Overview (*do not read aloud to participants*): A health care worker in an HIV clinic believes he has recognised a former schoolmate walking down the hall. The health care worker tries to pressure an administrative assistant into giving him the name of the patient.

Discussion Themes:

- + Patient rights
- + Confidentiality
- + Modelling positive behaviour for co-workers
- + Institutional policy

Session Time: Allow at least 30-45 minutes for a complete discussion of this video scenario (video is about 3 minutes long). Depending on the context of the discussion (e.g. part of larger training or stand alone), the discussion could be expanded/adapted with an additional activity.

Resources Needed:

- + VCR or DVD player or computer with DVD capacity
- + TV or projector with speakers



IF THIS IS THE FIRST SCENARIO TO BE PRESENTED TO THE GROUP:

- 1.** Begin with a brief introduction to the issue of stigma and discrimination (5 minutes).
 - ✦ Stigma is an unfavourable attitude or belief directed toward an individual or a group, while discrimination is an unfavourable act or behaviour towards an individual or group.
 - ✦ Both stigma and discrimination occur even in healthcare settings and are significant obstacles to providing quality care, treatment, and prevention services.
 - ✦ As the Caribbean region scales up its response to HIV/AIDS, it is vitally important that all health care workers contribute to establishing an environment in which all patients are treated with kindness and compassion.
 - ✦ Additional background information on stigma and discrimination is available in **Appendix A**.
- 2.** Discuss the importance of confidentiality, and obtain agreement from participants regarding the confidential nature of the discussion (refer to **Appendix L** for a sample confidentiality agreement).
- 3.** Establish ground rules for the group discussion (see **Appendix B** for more information). The ground rules will depend in part on the size and composition of the group. Key ground rules include:
 - ✦ Do not interrupt or speak over another person
 - ✦ Cell phones off or on vibrate
 - ✦ Criticise the idea, not the person
 - ✦ Respect the views of others, not necessarily agreeing with them
 - ✦ Participate at your comfort level





FACILITATOR INSTRUCTIONS

1. **Introduce** the scenario to participants by reading the following:
 - ✦ “The video scenario you are about to see shows an administrative assistant talking with a co-worker. The scene takes place in an HIV ward of a hospital. After the video we will have a discussion.”
2. **Play** the video. At the end of the trigger scenario video, the DVD will automatically stop. If you are using a VHS, you will need to manually stop or pause the video tape.
3. **Initiate discussion** with participants using the discussion questions and the possible answers below as a tool to guide the discussion. Use probing questions to stimulate discussion and draw out important topics. See **Appendix B** for more information on facilitation skills.
 - ✦ Point out that there are not necessarily “right” or “wrong” answers to many of these questions. It is not necessary for the group to reach consensus on every question.
 - ✦ Be sure to distinguish between facts and opinions during the discussion. Gently correct any misinformation or myths.

It is not necessary to ask the questions in the discussion guide in the order presented here.

- ✦ In many cases the discussion will move spontaneously from one topic to another.
- ✦ Use the summary table of Discussion Guide Questions to locate where specific questions appear in this guide.
- ✦ If participants have already discussed a particular question, it is not necessary to ask it again.



NOTE: Quotes in the boxes are from Caribbean Health Care Workers in response to the discussion questions.



DISCUSSION GUIDE QUESTIONS

The table below is a summary of the discussion questions included in this discussion guide. The discussion will likely move from one topic to another rather than follow the order of questions. Use this table to identify topics of discussion that arise and quickly locate where the responses appear in the Discussion Guide below.

DISCUSSION QUESTIONS
1. What happened in this scenario? What did you think?
2. How did Sheila handle Tyrone's questions about the patient? <ul style="list-style-type: none">• What were the strengths of her approach?• Is there anything you would change?
3. What thoughts do you have about Tyrone's behaviour?
4. What could have happened if Sheila had given Tyrone the name of the patient?
5. Have you ever had an experience similar to Sheila's in which a friend, relative, co-worker, etc. has pressured you to break confidentiality? <ul style="list-style-type: none">• How did you handle it?• What did you do well?• What would you change?
6. In this scenario, the unit in which Shelia worked saw only HIV/AIDS patients. What are some of the advantages and disadvantages of separate units, wards, clinics, or buildings for patients with HIV/AIDS?



1. What happened in this scenario? What did you think?

- Two co-workers in an HIV ward of a hospital are socialising. One sees a person that he thinks he knows, and tries to pressure the other to tell him the name of the person
- The administrative assistant provides a generally positive demonstration of how to maintain patient confidentiality, though she does confirm that the individual is “a patient.”

2. How did Sheila handle Tyrone’s questions about the patient?

- What were the strengths of her approach?
- Is there anything that you would change?
- Sheila used humour and jokes with Tyrone to maintain the patient’s confidentiality.
- She handled his questions very well. She told him point blank that she couldn’t tell him the name – she said it was none of his business.
- She used light humour yet was firm and professional.

Strengths:

- Sheila served as a good role model for maintaining patients’ rights and confidentiality.
- Even when Tyrone attempted to pressure Sheila (“Why you chyah tell me? We’re friends.” And “I work here too, you forget?”), she did not give in.
 - It is possible that Tyrone brought her the fruit basket as a bribe; nevertheless, Sheila did not provide the patient’s name.
 - Despite the personal relationship that she had with Tyrone, Sheila did not tell Tyrone the patient’s name.
 - Sheila did this in a manner that was professional, yet maintained a positive, upbeat attitude and used humour to deflect the situation.

“She never compromised the patient information, even with the fruit basket. She couldn’t be bribed.”

“She didn’t get side-tracked by the gift and sweet-talking.”

What she could have done differently:

- Sheila should not have confirmed to Tyrone that the man was a patient. This is technically a breach of the patient’s confidentiality.
- When Tyrone asks what the patient is doing there, Sheila could have asked Tyrone to empathise with the patient, “If you were a patient would you want me to disclose information about you?”
- Sheila could have made specific reference to institutional policies about confidentiality to deflect Tyrone’s questioning.

“She could have said, ‘If you recognize the guy, you should know his name.’”

3. What thoughts do you have about Tyrone's behaviour?

- ✦ Tyrone is a HCW at the hospital as well, but he may not have a clear understanding of confidentiality and patient's rights, evidenced by when he states, "I work here too, you forget?"
- ✦ Tyrone implies that he has a right to know the patient's status, which he does not.
- ✦ Tyrone was not behaving professionally. He should not have been asking the questions that he was asking.
- ✦ Pre-service training may be different for various levels of HCWs. Tyrone may need additional training, education and information to understand the importance of maintaining confidentiality and respecting patient rights.

"He shouldn't have been asking those things."

4. What could have happened if Sheila had given Tyrone the name of the patient?

- ✦ Sheila would have violated the patient's rights by breaking confidentiality of the patient.
- ✦ Sheila could lose her job for violating institutional policy.
- ✦ The information could have gotten back to the client that his confidentiality was breached. The patient might have felt disrespected and discouraged from accessing HIV/AIDS testing, support, treatment, or prevention services. If the patient was using ARV treatment, his adherence might be affected.
- ✦ Tyrone may have told his friends or other HCWs the status of the man, further violating his rights and confidentiality.

5. Have you ever had an experience similar to Sheila's in which a friend, relative, co-worker, etc. has pressured you to break confidentiality?

- ✦ How did you handle it?
- ✦ What did you do well?
- ✦ What would you do differently?

6. In this scenario, the unit in which Shelia worked saw only HIV/AIDS patients. What are some of the advantages and disadvantages of separate units, clinics, wards, or buildings for patients with HIV/AIDS?

Advantages

- Specialised staff with training in HIV/AIDS can be placed in such units and can thus provide better care.
- Staff acquire experience quickly in how to treat patients with HIV and become more skilled and able to provide better care.
- Facilitates a multi-disciplinary team approach.
- Patients in the separate clinic or ward may feel less stigma and discrimination directed toward them since dedicated staff with knowledge of their (the patients') HIV status agree to work in the unit.

Disadvantages

- Segregating persons with HIV in health care settings may lead to misunderstandings or reinforce myths about how HIV is transmitted.
- Segregating patients for unnecessary reasons may cause patients to feel demoralised, make them feel unwanted or hopeless.
- Segregation may decrease patient confidentiality. As in this scenario, Sheila confirmed to Tyrone that the man walking down the hall was a patient. If we are to assume that he was a patient of the unit that Sheila worked in, we could assume that the patient was HIV-positive.
- Separating HIV patients may be misleading for HCWs if they believe they don't have to use UPs in other wards because they are not at risk of HIV exposure. Segregated wards may create a false sense of security.
- Patients may be discouraged from seeking care for fear of being identified as HIV positive.

SUMMARY

1. Summarise the discussion using the key points provided below which detail important take-home information from this scenario.
2. Ask the group to share action steps or anything that they will do differently when they return to their site as a result of this discussion.
3. Emphasise commitment to confidentiality and sensitivity to the information shared by members of the group.
4. Thank all for the discussion and their participation.
5. If this is the final scenario to be presented to the group, distribute the evaluation form found in **Appendix M**. The information obtained from this form can be used to assess the effectiveness of the training in triggering insight, reflection, and intent to act amongst participants, and to obtain suggestions for improving the materials.

KEY POINTS

- ❖ HCWs often face challenging situations in regard to maintaining patient confidentiality. The scenario demonstrates a health care worker maintaining confidentiality even in the context of a personal relationship.
- ❖ It can be challenging to maintain confidentiality when a co-worker is persistent.
- ❖ HCWs can use various techniques to uphold confidentiality, including humour or reference to policy.
- ❖ HCWs must be aware of the many ways confidentiality can be breached, even unintentionally; for example, simply confirming that somebody is a patient can be a breach of confidentiality.

TRIGGER SCENARIO 10: ACTIVITY

Role Play

If time allows, facilitators should consider ending the session with this role play activity.

This activity will allow participants to continue the scenario they have just seen and discussed, incorporating their ideas about how the situation might have been handled differently by the characters involved. It will also help them to think about how the ideas discussed in this session might play out in their own work and lives. In addition, this activity can help participants develop skills to act as positive role models in their workplace.



Time: 15 minutes

Materials: *Scenario 10: Script*

INSTRUCTIONS:

- ✦ Divide participants into pairs.
- ✦ Ask participants to refer to *Scenario 10: Script*, and use this script as a starting point for the role play.
- ✦ Ask participants to act out a role play between two HCWs.
 - One HCW is attempting to pressure the other to tell him/her the name of a patient, or other confidential information such as the patient's HIV status.
 - The other HCW should practise positive role modelling by maintaining the patient's confidentiality.
 - Have the pairs switch roles and conduct the role play again.
- ✦ Ask participants to pay careful attention to the techniques they use to protect patient rights and confidentiality.
- ✦ After the groups have completed the role plays, reconvene the large group.
- ✦ If there is sufficient time, ask one group to volunteer to perform the role play in front of the large group. Ask participants to reflect on how the scene played out:
 - Ask the participant who played the first HCW how he/she thought it went. What did he/she feel she did well? What would he/she change next time?
 - Ask the participant who played the other HCW how he/she felt. What suggestions do they have for the other HCW?

- Open the discussion to the group – ask them to start with what the HCW did well, then make suggestions for things she might have done differently.





SCENARIO 10: SCRIPT

I CHYAH DANCE

A health care worker, Tyrone, approaches an administrative assistant, Sheila, who is replacing some files in a filing cabinet.

1. **Sheila:** *Hey, you make me jump! How come you so late today?*
2. **Tyrone:** *I had a bank appointment. But I talked to the boss, so doh worry.*
3. **Sheila:** *Good for you. But I know one of these days, you'll get in some serious trouble.*
4. **Tyrone:** *Look baby, I brought you something nice, man. (Tyrone presents Sheila with a fruit basket.)*
5. **Sheila:** *Hey, dats cool man. Thanks.*
6. **Tyrone:** *No problem. You know I always check for you, man. And it's my pleasure, baby.*
7. **Sheila:** *So wah you want in return?*
8. **Tyrone:** *But you know what I'm looking for, man...*
9. **Sheila:** *I have no idea.*
10. **Tyrone:** *Come on Sheila, you want me spell it out for you, baby? Listen, come to a dance with me this weekend and I'll let you know.*
11. **Sheila:** *Me? I chyah dance.*
12. **Tyrone:** *Everybody can dance, baby!*
13. **Sheila:** *Except me.*
14. **Tyrone:** *Well you doh wan hear the secret then.*
15. **Sheila:** *I know it already.*
16. **Tyrone:** *Well, leh me whisper it inna your ear.*
17. **Sheila:** *Listen man, you need to go back to your department. Don't forget how they feel about this HIV clinic. If the supervisor happens to pass and catch us fooling around on the job, you know she will not be too pleased.*

18. **Tyrone:** *Okay, okay. But we'll talk later, right? You're tough girl you know, but that's how I like dem! (A man passes briefly by the open door.) Wait! Who's that fella walking down there?*
19. **Sheila:** *What you mean?*
20. **Tyrone:** *What he doing here?*
21. **Sheila:** *What you mean what he doing here? Obviously he's a patient!*
22. **Tyrone:** *I know, I know, but I think I went to school with that man you know... He was such a braggart. What's his name again? Come on, help me now... You should know, Sheila!*
23. **Sheila:** *Yes, I should know.*
24. **Tyrone:** *So, what's his name Sheila?*
25. **Sheila:** *I chyah tell you that. And you know that.*
26. **Tyrone:** *Come Sheila, help me, we're friends right?*
27. **Sheila:** *Dat eh mean nothing. And it's none of your business.*
28. **Tyrone:** *I work here too you know. You forget or what?*
29. **Sheila:** *So?*
30. **Tyrone:** *Girl you tough, yes?*
31. **Sheila:** *Is not so you like dem?*
32. **Tyrone:** *Okay. I've had enough rejection for one day. I gone, baby! (He leaves.)*
33. **Sheila:** *Wait, Tyrone! (He turns around.) What time on Friday?*

Fade to black



SCENARIO 11: PETER GOES IN FOR AN HIV TEST



SCENARIO OVERVIEW

Scenario Overview (*do not read aloud to participants*): A man sits in the waiting area of an HIV clinic with two other patients. While he is waiting for an HIV test, a janitor, sweeping the floor nearby recognises him. The janitor calls out the man's name, greets him, and asks him what brings him to the clinic.

Discussion Themes:

- + Confidentiality
- + Patient rights
- + Institutional policy

Session Time: Allow at least 20-30 minutes for a complete discussion of this video scenario (video is about 1 minute long). Depending on the context of the discussion (e.g. part of larger training or stand alone), the discussion could be expanded/adapted with additional questions and discussion.

Resources Needed:

- + VCR or DVD player or computer with DVD capacity
- + TV or projector with speakers



IF THIS IS THE FIRST SCENARIO TO BE PRESENTED TO THE GROUP:

1. Begin with a brief introduction to the issue of stigma and discrimination (5 minutes).
 - ✦ Stigma is an unfavourable attitude or belief directed toward an individual or a group, while discrimination is an unfavourable act or behaviour towards an individual or group.
 - ✦ Both stigma and discrimination occur even in healthcare settings and are significant obstacles to providing quality care, treatment, and prevention services.
 - ✦ As the Caribbean region scales up its response to HIV/AIDS, it is vitally important that all health care workers contribute to establishing an environment in which all patients are treated with kindness and compassion.
 - ✦ Additional background information on stigma and discrimination is available in **Appendix A**.
2. Discuss the importance of confidentiality, and obtain agreement from participants regarding the confidential nature of the discussion (refer to **Appendix L** for a sample confidentiality agreement).
3. Establish ground rules for the group discussion (see **Appendix B** for more information). The ground rules will depend in part on the size and composition of the group. Key ground rules include:
 - ✦ Do not interrupt or speak over another person
 - ✦ Cell phones off or on vibrate
 - ✦ Criticise the idea, not the person
 - ✦ Respect the views of others, not necessarily agreeing with them
 - ✦ Participate at your comfort level



FACILITATOR INSTRUCTIONS

1. Introduce the scenario to participants by reading the following:

- ✦ “The video scenario you are about to see shows a patient waiting for an HIV test in a health care facility waiting room. After the video, we will have a discussion.”

2. Play the video. At the end of the trigger scenario video, the DVD will automatically stop. If you are using a VHS, you will need to manually stop or pause the video tape.

3. Initiate discussion with participants using the discussion questions and the possible answers below as a tool to guide the discussion. Use probing questions to stimulate discussion and draw out important topics. See **Appendix B** for more information on facilitation skills.

- ✦ Point out that there are not necessarily “right” or “wrong” answers to many of these questions. It is not necessary for the group to reach consensus on every question.
- ✦ Be sure to distinguish between facts and opinions during the discussion. Gently correct any misinformation or myths.

It is not necessary to ask the questions in the discussion guide in the order presented here.

- ✦ In many cases the discussion will move spontaneously from one topic to another.
- ✦ Use the summary table of Discussion Guide Questions to locate where specific questions appear in this guide.
- ✦ If participants have already discussed a particular question, it is not necessary to ask it again.



NOTE: Quotes in the boxes are from Caribbean Health Care Workers in response to the discussion questions.



DISCUSSION GUIDE QUESTIONS

The table below is a summary of the discussion questions included in this discussion guide. The discussion will likely move from one topic to another rather than follow the order of questions. Use this table to identify topics of discussion that arise and quickly locate where the responses appear in the Discussion Guide below.

DISCUSSION QUESTIONS
1. What happened in this scenario? What did you think?
2. How do you think Peter, the patient, felt during the exchange with his friend? What could be causing him to feel that way?
3. How could John, the janitor, have handled the situation differently?
4. How might this encounter impact Peter's future care-seeking behaviour?
5. What could you do in your facility to prevent this scenario from happening?



1. What happened in this scenario? What did you think?

- ✦ Peter, a patient, was sitting in the waiting area of an HIV clinic with two other patients, when a janitor at the clinic breached his confidentiality.
- ✦ The janitor, who was sweeping nearby, called Peter's name, greeted him and asked him why he had come to the clinic.

2. How do you think Peter, the patient, felt during the exchange with his friend John, the janitor?

- ✦ Peter may have felt embarrassed, ashamed, or cornered by the exchange with the janitor in the waiting room.
- ✦ Peter might not have wanted to see his friend because he has not disclosed his HIV status, or because he does not want his friend to know that he is being tested for HIV.
- ✦ He may fear that the janitor will tell others (e.g., girlfriend/boyfriend/family/others) that he was at the health care facility.
- ✦ When John greeted him loudly and used Peter's name, Peter may have felt like his confidentiality was breached in front of other patients in the waiting room.
- ✦ Peter may be surprised to encounter someone he knows at the facility, and feel caught off guard.

3. How could John, the janitor, have handled the situation differently?

- ✦ John should not have used Peter's name.
- ✦ John should not have asked his friend "so, what brings you here?" It is inappropriate for a HCW to ask a patient why they've come to a health care facility outside of a confidential setting.
 - While John may have intended only to greet his friend and show care and concern, asking "What brings you in here?" in a health care setting may put the patient in an uncomfortable position, and thus cause reluctance to seek care.
- ✦ If John felt obligated to say something to Peter, he could have:
 - Greeted him differently. For example, John could have said, "Hi. How are you?" without saying Peter's name or asking why he had come to the clinic, and then moved on with his sweeping.
 - If John and Peter are close friends, John could greet him briefly as above and then later, if appropriate, he could apologise and say that it is the hospital's policy that HCWs not talk to patients in order to respect their privacy and not violate their confidentiality. If Peter wishes to say anything more, John can be supportive of his friend.

4. How might this encounter impact Peter's future care-seeking behaviour?

- ✦ Peter may worry that he will run into John again in the future and that John may ask him again why he is there. This fear may prevent Peter from further seeking care, treatment, or other services.
- ✦ The other patients in the waiting room that witnessed the encounter may feel uncomfortable and be reluctant to return for care, treatment or other services.

5. What could you do in your facility to prevent this from happening?

- ✦ Train health facility staff about the importance of respecting the confidentiality of patients they see in the facility by not asking them questions about why they are there.
- ✦ Sensitise HCWs to the ways in which they can inadvertently violate confidentiality.
- ✦ Train HCWs on the proper way to address people that they know when in the healthcare setting.
- ✦ Provide training to ALL levels of staff on how to respect patient confidentiality. All new staff orientations should include this information.
- ✦ Health care facilities can adopt patient rights and confidentiality policies by which all health care workers must abide.
- ✦ Some facilities post a "Patient's Bill of Rights" in waiting rooms. This helps to ensure that both staff and the patients themselves are aware of their rights, and may serve as a reminder to staff to make sure that they do not treat patients in a way that may be violating their rights.
- ✦ Include information on HIV, such as posters, signs and brochures, in all waiting areas, not just in VCT waiting areas.
- ✦ Refer to **Appendix J** for an example of a national patients' rights document.

SUMMARY

1. Summarise the discussion using the key points provided below which detail important take-home information from this scenario.
2. Ask the group to share action steps or anything that they will do differently when they return to their site as a result of this discussion.
3. Emphasise commitment to confidentiality and sensitivity to the information shared by members of the group.
4. Thank all for the discussion and their participation.
5. If this is the final scenario to be presented to the group, distribute the evaluation form found in **Appendix M**. The information obtained from this form can be used to assess the effectiveness of the training in triggering insight, reflection, and intent to act amongst participants, and to obtain suggestions for improving the materials.

KEY POINTS

- ❖ Health care workers may unintentionally violate confidentiality if not sensitised to this possibility and the situations in which it might occur.
- ❖ Training on how to ensure the confidentiality of friends, relatives, and acquaintances should be provided to all levels of staff.
- ❖ Health care workers have a professional obligation to uphold patient confidentiality at all times.
- ❖ Health care facilities can adopt patient rights and confidentiality policies by which all health care workers must abide.
- ❖ Ensuring that confidentiality is always protected will facilitate accessing HIV counselling, testing, and treatment services.
- ❖ Preventing and reducing stigma is vital so that people are not discouraged from using or helping others on ARV treatment.

TRIGGER SCENARIO II: ACTIVITY

Design a Patient-Friendly Waiting Room

This activity will allow participants to practise incorporating their ideas about how a situation such as the one in the video might be handled in their own workplace. It will also help them to think about how the ideas discussed in this session might play out in their own lives.



Time: 15 minutes

Materials: Flip Chart Paper
Markers

INSTRUCTIONS:

- ✦ Divide participants into groups of four.
- ✦ Ask participants to brainstorm characteristics of a patient-friendly waiting room.
- ✦ Participants should consider:
 - Waiting room aesthetics
 - Appropriate health education and health promotion messages, including posters on the walls, reading material available, and/or other methods of providing information
 - Qualities and characteristics of staff that are in or passing through the waiting room, and how they interact with patients
- ✦ Encourage groups to be creative with their markers and paper. Groups can use the paper to draw on or write on.
- ✦ After groups have completed the exercise, reconvene the large group and ask volunteers to discuss their ideas and display their paper.





SCENARIO II: SCRIPT
PETER GOES IN FOR AN HIV TEST

1. **John:** *Hey Peter, how's it going?*
2. **Peter:** *Oh, hi John. I'm good. Hey, I thought you worked up in Labour and Delivery?*
3. **John:** *Yeah, they're moving us around. They fired a couple of the staff so we all have to cover a bit until they hire some more people. So, what brings you here?*
4. **Peter:** *Me? Oh, um ...*



SCENARIO 12: DISCUSSION GUIDE SHIFT CHANGE ON THE LABOUR AND DELIVERY WARD



SCENARIO OVERVIEW

Scenario Overview (*do not read aloud to participants*): During a labour and delivery ward shift change, the incoming nurse mentions that an admitted patient is her brother's girlfriend. The nurse who is leaving her shift states that this patient will need to take a dose of nevirapine. The incoming nurse was not aware of her brother's girlfriend's HIV status.

Discussion Themes:

- ✦ Confidentiality
- ✦ Patient rights
- ✦ Institutional policy

Session Time: Allow at least 20-30 minutes for a complete discussion of this video scenario (video is about 1 minute long). Depending on the context of the discussion (e.g. part of larger training or stand alone), the discussion could be expanded/adapted with additional questions and discussion.

Resources Needed:

- ✦ VCR or DVD player or computer with DVD capacity
- ✦ TV or projector with speakers





IF THIS IS THE FIRST SCENARIO TO BE PRESENTED TO THE GROUP:

1. Begin with a brief introduction to the issue of stigma and discrimination (5 minutes).
 - ✦ Stigma is an unfavourable attitude or belief directed toward an individual or a group, while discrimination is an unfavourable act or behaviour towards an individual or group.
 - ✦ Both stigma and discrimination occur even in healthcare settings and are significant obstacles to providing quality care, treatment, and prevention services.
 - ✦ As the Caribbean region scales up its response to HIV/AIDS, it is vitally important that all health care workers contribute to establishing an environment in which all patients are treated with kindness and compassion.
 - ✦ Additional background information on stigma and discrimination is available in **Appendix A**.
2. Discuss the importance of confidentiality, and obtain agreement from participants regarding the confidential nature of the discussion (refer to **Appendix L** for a sample confidentiality agreement).
3. Establish ground rules for the group discussion (see **Appendix B** for more information). The ground rules will depend in part on the size and composition of the group. Key ground rules include:
 - ✦ Do not interrupt or speak over another person
 - ✦ Cell phones off or on vibrate
 - ✦ Criticise the idea, not the person
 - ✦ Respect the views of others, not necessarily agreeing with them
 - ✦ Participate at your comfort level



FACILITATOR INSTRUCTIONS

1. Introduce the scenario to participants by reading the following:

- ✦ “The video scenario you are about to see shows two nurses having a discussion as they change shifts in a labour and delivery ward. After the video, we will have a discussion.”

2. Play the video. At the end of the trigger scenario video, the DVD will automatically stop. If you are using a VHS, you will need to manually stop or pause the video tape.

3. Initiate discussion with participants using the discussion questions and the possible answers below as a tool to guide the discussion. Use probing questions to stimulate discussion and draw out important topics. See **Appendix B** for more information on facilitation skills.

- ✦ Point out that there are not necessarily “right” or “wrong” answers to many of these questions. It is not necessary for the group to reach consensus on every question.
- ✦ Be sure to distinguish between facts and opinions during the discussion. Gently correct any misinformation or myths.

It is not necessary to ask the questions in the discussion guide in the order presented here.

- ✦ In many cases the discussion will move spontaneously from one topic to another.
- ✦ Use the summary table of Discussion Guide Questions to locate where specific questions appear in this guide.
- ✦ If participants have already discussed a particular question, it is not necessary to ask it again.



NOTE: Quotes in the boxes are from Caribbean Health Care Workers in response to the discussion questions.



DISCUSSION GUIDE QUESTIONS

The table below is a summary of the discussion questions included in this discussion guide. The discussion will likely move from one topic to another rather than follow the order of questions. Use this table to identify topics of discussion that arise and quickly locate where the responses appear in the Discussion Guide below.

DISCUSSION QUESTIONS
1. What happened in this scenario? What did you think?
2. Did you feel that confidentiality was violated in this encounter? Why or why not?
3. What were the ethical issues that Claire, the incoming nurse, faced? • Should she tell her brother what she knows?
4. How should Claire proceed with caring for Bernadette, the patient, to protect her confidentiality?
5. What effect might this encounter have on the patient's future care-seeking behaviour?
6. Have you ever encountered a similar situation? How did you handle it? What was the outcome?
7. What kinds of institutional policies could provide support in this situation?

1. What happened in this scenario? What did you think?

- ✦ During a shift change on the labour/maternity ward, a nurse, Claire, discovered that her brother's girlfriend (Bernadette) was a patient on the ward and that Bernadette is HIV positive.

2. Do you feel that confidentiality was violated in this encounter? Why or why not?

- ✦ As the patient's nurse, Claire needed to know that her patient required nevirapine. She also needs to maintain confidentiality of the information she now has, despite the fact that the patient is a family member.

3. What were the ethical issues that Claire, the incoming nurse, faced?

- ✦ Should she tell her brother what she knows?
 - Although the patient is the girlfriend of Claire's brother, the nurse still has a professional duty to keep the patient's HIV status confidential. Claire cannot violate the patient's confidentiality by telling her brother her HIV status.
- ✦ Claire has an obligation to treat all patients the same with regard to confidentiality.
- ✦ Claire may feel conflicted that the patient is the girlfriend of her brother and will need to consider how she will handle this dilemma.

4. How should Claire proceed with caring for Bernadette, the patient, to protect her confidentiality?

- ✦ If possible, Claire could suggest that a different nurse treat the patient.
- ✦ If this is not possible, Claire could explain to Bernadette her rights as a patient and assure the patient that she is entitled to confidentiality and respect, and that Claire intends to honour her rights as a patient.
- ✦ Claire should discuss disclosure with this patient as she would with any other. If her brother's girlfriend has not yet told Claire's brother, Claire could discuss the advantages and disadvantages of such disclosure. If this type of conversation is uncomfortable for the patient or Claire, Claire should find a counsellor to discuss disclosure with the patient.

5. What effect might this encounter have on the patient's future care-seeking behaviour?

- ✦ As the patient's nurse, Claire needed to know that her patient required nevirapine. However, if the patient feels worried or fearful that her confidentiality or rights will not be

respected because her boyfriend's sister (the nurse, Claire) knows her HIV status, this may have a negative impact on the patient's adherence to ARVs or may prevent her from using this hospital again for fear of seeing Claire.

- Claire can help to alleviate this fear by assuring the patient that she will respect her right to confidentiality.

6. Have you ever encountered a similar situation? How did you handle it? What was the outcome?

7. What kinds of institutional policies could provide support in this situation?

- Health care facilities should have policies on situations such as these, especially in smaller communities where HCW and patients are more likely to encounter each other within the health care facility. It is important for facilities to have policies in place so that confidentiality issues are dealt with in a consistent manner.
- HCWs at all levels should be trained on how to maintain patient confidentiality and be prepared for how they will deal with a relative. All new staff orientations should include this information.

SUMMARY

1. Summarise the discussion using the key points provided below which detail important take-home information from this scenario.
2. Ask the group to share action steps or anything that they will do differently when they return to their site as a result of this discussion.
3. Emphasise commitment to confidentiality and sensitivity to the information shared by members of the group.
4. Thank all for the discussion and their participation.
5. If this is the final scenario to be presented to the group, distribute the evaluation form found in **Appendix M**. The information obtained from this form can be used to assess the effectiveness of the training in triggering insight, reflection, and intent to act amongst participants, and to obtain suggestions for improving the materials.

KEY POINTS

- ❖ Health care workers have a professional obligation to uphold patient confidentiality at all times, including when treating patients with whom they have a personal connection.
- ❖ Health care facilities can adopt patient rights and confidentiality policies by which all health care workers must abide.



SCENARIO 12: ACTIVITY

Role Play

If time allows, facilitators should consider ending the session on this scenario with an activity.

This activity will allow participants to put themselves in the place of Bernadette and Claire in order to imagine how they would react in a similar situation. This will help participants think about how the ideas discussed in this session might play out in their own lives.



Time: 15 minutes

Materials: Paper (optional)

Pens/pencils (optional)

INSTRUCTIONS:

- ✦ Divide participants into pairs.
- ✦ One participant will play the role of Claire (the incoming nurse), the other the role of Bernadette Dolbey (the patient).
- ✦ Ask participants to consider the following:
 - As Claire, how you would protect the patient's confidentiality.
 - As the patient, Bernadette, how you might respond to seeing that Claire is your nurse.
 - As Claire, how you might address your concern for your brother's health without compromising the patient's confidentiality.
- ✦ After the pairs have completed the role plays, lead a discussion using the following questions:
 - Ask the participant who played Claire how he/she thought it went. What did he/she feel she did well? What would he/she change next time?
 - Ask the participant who played Bernadette how he/she felt. What suggestions do they have for Claire?
- ✦ If there is ample time, ask one or two pairs to volunteer to perform the role play in front of the large group. Ask the larger group to reflect on how the scene played out:
 - Ask them to start with what the pair did well, then make suggestions for things they might have done differently.



SCENARIO 12: SCRIPT

SHIFT CHANGE ON THE LABOUR AND DELIVERY WARD

The scenario opens with the interior of the labour and delivery area of a hospital. Two nurses, Monica and Claire, are talking at a nurses' station. Monica is just getting off her shift, and Claire will be taking over.

1. **Claire:** *Hey, ready to go?*
2. **Monica:** *Hi, yeah.*
3. **Claire:** *Oh, by the way, I heard Bernadette Dolbey is in here, my Mom told me. Did you know that she's my brother Gerald's girlfriend?*
4. **Monica:** *No I didn't know that. She's in Room 4, she just came in. She has a while to go, though. She's in there with her mom.*
5. **Claire:** *It's so sad Gerald won't be here to see the baby born. He's a waiter in Miami and it's hard for him to get time off during their busy season.*
6. **Monica:** *Well here's her file. It's coded, so you'll want to make sure she gets her nevirapine in about two hours. But you might want to check on her and decide for yourself.*
7. **Claire:** *Nevirapine? She needs nevirapine? ...*



SCENARIO 13: DAVID SEES HIS NURSE ON THE STREET



SCENARIO OVERVIEW

Scenario Overview (*do not read aloud to participants*): A nurse is walking with her friend on the street. She runs into one of her patients, who is also with a friend. The nurse greets her patient by name, remarking on how good he looks. After the nurse and her friend walk away, they discuss the patient's ARV treatment. Meanwhile, the patient struggles to explain the meaning of this encounter to his friend.

Discussion Themes:

- + Confidentiality
- + Patient rights
- + Institutional policy

Session Time: Allow at least 20-30 minutes for a complete discussion of this video scenario (video is about 1 minute long). Depending on the context of the discussion (e.g. part of larger training or stand alone), the discussion could be expanded/adapted with additional questions and discussion.

Resources Needed:

- + VCR or DVD player or computer with DVD capacity
- + TV or projector with speakers



IF THIS IS THE FIRST SCENARIO TO BE PRESENTED TO THE GROUP:

- 1.** Begin with a brief introduction to the issue of stigma and discrimination (5 minutes).
 - ✦ Stigma is an unfavourable attitude or belief directed toward an individual or a group, while discrimination is an unfavourable act or behaviour towards an individual or group.
 - ✦ Both stigma and discrimination occur even in healthcare settings and are significant obstacles to providing quality care, treatment, and prevention services.
 - ✦ As the Caribbean region scales up its response to HIV/AIDS, it is vitally important that all health care workers contribute to establishing an environment in which all patients are treated with kindness and compassion.
 - ✦ Additional background information on stigma and discrimination is available in **Appendix A**.
- 2.** Discuss the importance of confidentiality, and obtain agreement from participants regarding the confidential nature of the discussion (refer to **Appendix L** for a sample confidentiality agreement).
- 3.** Establish ground rules for the group discussion (see **Appendix B** for more information). The ground rules will depend in part on the size and composition of the group. Key ground rules include:
 - ✦ Do not interrupt or speak over another person
 - ✦ Cell phones off or on vibrate
 - ✦ Criticise the idea, not the person
 - ✦ Respect the views of others, not necessarily agreeing with them
 - ✦ Participate at your comfort level





FACILITATOR INSTRUCTIONS

1. **Introduce** the scenario to participants by reading the following:
 - ✦ “The video scenario you are about to see shows an interaction on the street between a nurse and a patient. After the video, we will have a discussion.”
2. **Play** the video. At the end of the trigger scenario video, the DVD will automatically stop. If you are using a VHS, you will need to manually stop or pause the video tape.
3. **Initiate discussion** with participants using the discussion questions and the possible answers below as a tool to guide the discussion. Use probing questions to stimulate discussion and draw out important topics. See **Appendix B** for more information on facilitation skills.
 - ✦ Point out that there are not necessarily “right” or “wrong” answers to many of these questions. It is not necessary for the group to reach consensus on every question.
 - ✦ Be sure to distinguish between facts and opinions during the discussion. Gently correct any misinformation or myths.

It is not necessary to ask the questions in the discussion guide in the order presented here.

- ✦ In many cases the discussion will move spontaneously from one topic to another.
- ✦ Use the summary table of Discussion Guide Questions to locate where specific questions appear in this guide.
- ✦ If participants have already discussed a particular question, it is not necessary to ask it again.



NOTE: Quotes in the boxes are from Caribbean Health Care Workers in response to the discussion questions.



DISCUSSION GUIDE QUESTIONS

The table below is a summary of the discussion questions included in this discussion guide. The discussion will likely move from one topic to another rather than follow the order of questions. Use this table to identify topics of discussion that arise and quickly locate where the responses appear in the Discussion Guide below.

DISCUSSION QUESTIONS
1. What happened in this scenario? What did you think?
2. How do you think this encounter on the street with the nurse made David feel?
3. What are some of the issues around confidentiality that were raised in the scenario? Was patient confidentiality breached in the conversation you saw? How?
4. What could the nurse have done differently upon seeing David on the street?
5. The nurse's friend does not know David. Does this matter when considering patient confidentiality? Is it okay to talk about a patient's treatment with friends and family if they have never met the patient?
6. What kind of impact might this encounter have on David's care-seeking behaviour?
7. What kind of confidentiality policy, if any, does your health care facility have for patient confidentiality outside the clinic?

1. What happened in the scenario? What did you think?

- ✦ A nurse was walking with her friend on the street. She breached confidentiality when she ran into one of her patients, who was also with a friend.
- ✦ The nurse remarked on how good the patient looked.
- ✦ The patient struggled to explain the meaning of this encounter to his friend.

2. How do you think this encounter on the street with the nurse made David feel?

- ✦ It appears that David felt uncomfortable with the encounter.
- ✦ The nurse's comments would make David's friend and the nurse's friend wonder how they know each other and why she is commenting on his physique and talking about seeing him next month.
- ✦ David may worry that his friend will make assumptions about him based on the encounter, even start gossip or rumours.
- ✦ This encounter indirectly puts David in a position where he may have to disclose his HIV status to his friend, or come up with a lie.

3. What are some of the issues around confidentiality that were raised in the scenario? Was patient confidentiality breached in the conversation you saw? How?

The nurse has breached confidentiality by:

- ✦ Acknowledging David by name.
- ✦ Indicating that they will be meeting again by saying, "See you next month" in front of their friends.
- ✦ Commenting on his physical appearance by saying "You look good" in front of their friends.
- ✦ Telling her friend that David was on HIV medications.

4. What could the nurse have done differently upon seeing David on the street?

- ✦ The nurse should not explicitly acknowledge David unless he acknowledges her first.
 - If the nurse feels the need to acknowledge patients as a courtesy, she should do so discreetly (nodding or smiling), and allow the patient to take the lead.
- ✦ Even if David does acknowledge her, she should proceed cautiously and let him take the lead on what information is disclosed.

- ✦ When HCWs see patients on the street, usually the patient will provide guidance for how to handle the situation. HCWs should be sensitive to the patient's verbal and nonverbal clues.
- ✦ Even in a caring environment with good people, confidentiality can be breached.

5. The nurse's friend does not know David. Does this matter when considering patient confidentiality? Is it okay to talk about a patient's treatment with friends and family if they have never met the patient?

- ✦ In the context of this scenario the nurse should not have said anything to her friend.
- ✦ It is only okay to discuss a patient with a co-worker when it is an unidentifiable case and completely out of any context that involves an encounter with a patient.
 - For example, it is okay to describe patient outcomes to friends and family in general terms: *"I had a patient who got on the new HIV drugs and is doing so much better, you'd hardly believe it."* But it is not okay to identify that patient.
- ✦ It is NOT okay, as portrayed here, to disclose medically private information about patients, such as their HIV status, to friends and acquaintances.

6. What kind of impact might this encounter have on David's care-seeking behaviour?

- ✦ If David's friend suspects he is HIV positive and begins to spread rumours and gossip about this and the encounter, David may begin to have feelings of internalised stigma (e.g. feelings of hopelessness or isolation). This could negatively affect his care-seeking behaviour, ARV treatment adherence, and other health outcomes.
- ✦ Stigma can extend to friends and care takers of people with HIV. David's friend may not want to affiliate himself with David if he suspects David is HIV positive.
- ✦ David may feel discouraged or angry about the breach in confidentiality and not want to seek further care at the health facility where the nurse works.
 - A breach of confidentiality is a form of stigma and discrimination.
- ✦ Preventing and confronting stigma is vital so that people are not discouraged from accessing, or helping others on, ARV treatment.

7. What kind of confidentiality policy, if any, does your health care facility have for patient confidentiality outside the clinic?

- ✦ Health care facilities should have policies around training to be provided to ALL levels of staff on how to respect patient confidentiality inside the clinic and outside the clinic. All new staff orientations should include this information.

- Staff should be instructed to let patients know that if they see them outside of the health care setting, they will not acknowledge the patient in order to protect their confidentiality.

SUMMARY

1. Summarise the discussion using the key points provided below which detail important take-home information from this scenario.
2. Ask the group to share action steps or anything that they will do differently when they return to their site as a result of this discussion.
3. Emphasise commitment to confidentiality and sensitivity to the information shared by members of the group.
4. Thank all for the discussion and their participation.
5. If this is the final scenario to be presented to the group, distribute the evaluation form found in **Appendix M**. The information obtained from this form can be used to assess the effectiveness of the training in triggering insight, reflection, and intent to act amongst participants, and to obtain suggestions for improving the materials.

KEY POINTS

- ❖ Health care workers have a professional obligation to uphold patient confidentiality at all times, both inside and outside the clinic.
- ❖ Health care workers should not acknowledge patients outside of the health care setting unless the patient has explicitly given permission to do so.
- ❖ When health care workers see patients outside of a health facility, they should let the patient take the lead in acknowledging and interacting with each other.
- ❖ Training should be provided to all levels of staff on how to respect patient confidentiality.
- ❖ Breaches of confidentiality can negatively impact a patient's care seeking behaviour.

SCENARIO 13: ACTIVITY

Role Play

If time allows, facilitators should consider ending the session on this scenario with a role play activity.

This activity will allow participants to continue the scenario they have just seen and discussed, incorporating their ideas about how the situation might have been handled differently by the characters involved. It will also help them to think about how the ideas discussed in this session might play out in their own work and lives. In addition, the role play activity will allow participants to practice acting as positive role models in their own workplace.



Time: 15 minutes

Materials: Paper (optional)

Pens/pencils (optional)

INSTRUCTIONS:

- ✦ Divide participants into pairs.
- ✦ One participant will play the role of nurse in the scenario. The other participant will play the role of a co-worker. Each group should determine who will play which character.
 - Ask participants to imagine that the additional character, the co-worker witnessed the recently viewed scenario on the street and is concerned about the breach of confidentiality that occurred. The co-worker intends to confront the nurse about her behaviour in a professional manner.
- ✦ Ask participants to act out:
 - What the co-worker would say to the nurse to address the breach in confidentiality she just witnessed.
 - What advice the co-worker might give to the nurse about maintaining patient confidentiality outside their facility.
 - How the co-worker can best discuss the importance of patient's rights and confidentiality in their health facility.
- ✦ Each pair should develop a short script with lines for the characters.
- ✦ After the pairs have completed the scripts, they should practice a few times within their pair.
- ✦ After the pairs have completed the role plays, lead a discussion using the following questions:

Scenario 13

- Ask the participant who played the nurse how he/she thought it went. What did he/she feel she did well? What would he/she change next time?
 - Ask the participant who played the co-worker how he/she felt. What suggestions do they have for the nurse?
- ✦ If there is ample time, ask one or two pairs to volunteer to perform the role play in front of the large group. Ask the larger group to reflect on how the scene played out:
- Ask them to start with what the pair did well, then make suggestions for things they might have done differently.



SCENARIO 13: SCRIPT

DAVID SEES HIS NURSE ON THE STREET

The scenario opens with two friends, David and Isaac, walking down a street in town, laughing and talking. Around the corner, Nurse Marshall is walking along the sidewalk with her friend. She is wearing casual street clothes. The two groups come face to face at the corner, and David and Nurse Marshall acknowledge each other.

1. **Nurse Marshall:** *Hi David!*
2. **David:** (shyly and awkwardly) *Hi.*
3. **Nurse Marshall:** *Nice to see you. You're looking great.*
4. **David:** *Thank you, thank you* (awkwardly).
5. **Nurse Marshall:** *Alright, I'll see you next month. Bye.*
6. **David:** *Ok, alright. Bye, bye.*

The two groups continue on their way.

7. **Isaac:** *David, who was that?* (Nudging David in the ribs with his elbow)
8. **David:** *That was nobody.* (awkwardly)
9. **Isaac:** *What do you mean about next month?*
10. **David:** *Don't worry about that, don't worry about that. Let's get something to eat.*
11. **Isaac:** *Alright, alright, alright.*

The scene turns again to Nurse Marshall and her friend, who are still walking away.

12. **Nurse Marshall:** *Do you remember that I was telling you how powerful these new HIV medications can be? Just a few months ago, he was really ill. His immune system was down and he was looking quite sick. But look at him now!*

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Ogden J, Nyblade L. Common at Its Core: HIV-Related Stigma Across Contexts. Washington, DC: International Center for Research on Women; 2005. Available from: http://www.icrw.org/docs/2005_report_stigma_synthesis.pdf.

O'Neil C, Samiel S. A Health Promotion Approach to Reducing Stigma and Discrimination: A Framework for Action. Caribbean Epidemiology Centre (CAREC) PAHO/WHO; 2004. Available from: <http://www.carec.org/pdf/sdframework.pdf>.

Pinsky LE, Wipf JE. A picture is worth a thousand words: practical use of videotape in teaching. *J Gen Intern Med*. 2000 Nov; 15 (11):805-10.

Piot P, Coll Seck AM. International response to the HIV/AIDS epidemic: planning for success. *Bull World Health Organ*. 2001; 79(12):1106-12.

UNAIDS. 2006 report on the global AIDS epidemic. May 2006. Available from: http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp.

UNAIDS/WHO. UNAIDS/WHO Policy Statement on HIV Testing. June 2004. Available from: http://www.who.int/rpc/research_ethics/hivtestingpolicy_en_pdf.pdf.

WHO. Universal Precautions, including injection safety. 2006. Available from: <http://www.who.int/hiv/topics/precautions/universal/en/print.html>.

Appendices A-M

Appendix A:

BACKGROUND ON HIV/AIDS STIGMA AND DISCRIMINATION IN CARIBBEAN HEALTH CARE SETTINGS

HIV/AIDS stigma and discrimination in health care settings can take many forms. It may be expressed or communicated in the content of communication with or about the patient, in non-verbal communication with the patient or co-workers, or through discriminatory actions or behaviours. It is important for facilitators to have a thorough understanding of HIV/AIDS stigma and discrimination so that they are able to effectively address the issues presented in these trigger scenarios. This section provides background information on the causes, forms, and effects of HIV/AIDS related stigma and discrimination in the Caribbean context.

What are HIV/AIDS-related stigma and discrimination?

UNAIDS provides the following definitions of HIV/AIDS-related stigma and discrimination:

HIV/AIDS-related stigma can be described as a “process of devaluation” of people either living with or associated with HIV and AIDS. This stigma often stems from the underlying stigmatisation of sex and intravenous drug use—two of the primary routes of HIV infection. Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status. Discrimination occurs when a distinction is made against a person that results in being treated unfairly and unjustly on the basis of belonging, or being perceived to belong, to a particular group.¹

HIV/AIDS is only the latest in a long history of conditions and diseases that have been stigmatised in many different cultures around the world. Discussions of HIV-related stigma and discrimination go hand in hand – stigma is the attitude, and discrimination is the resulting behaviour.

Forms of Stigma

Expressions and forms of stigma, and the discriminatory behaviours that can result, can be categorised into four main areas²:

- **Physical**, including isolation and violence
- **Social**, including social isolation, voyeurism, and loss of identity/social role
- **Language/Verbal**, including gossip, taunting, expressions of blame and shame, and labelling

1 Ogden J, Nyblade L. Common at Its Core: HIV-Related Stigma Across Contexts. Washington, DC: International Center for Research on Women; 2005. Available from: http://www.icrw.org/docs/2005_report_stigma_synthesis.pdf.

2 Ogden J, Nyblade L. Common at Its Core: HIV-Related Stigma Across Contexts. Washington, DC: International Center for Research on Women; 2005. Available from: http://www.icrw.org/docs/2005_report_stigma_synthesis.pdf.

and use of derogatory words to describe people living with HIV/AIDS

- ✦ **Institutional**, including loss of livelihood/future, loss of housing, differential treatment in schools, health care settings, and other public spaces, and media and public health messages and campaigns

The trigger scenarios will focus on expressions of stigma and discrimination involving health care workers in a health care setting. Examples of health workers' stigmatising attitudes, behaviours, and actions that have been documented in Caribbean health care settings include³:

- ✦ Blaming those who are infected with HIV
- ✦ Poor treatment of patients that belong to stigmatised populations (e.g. drug users or commercial sex workers) or patients believed to be infected
- ✦ Breaching client confidentiality by sharing test results with relatives and/or other staff, thus making the client's status public
- ✦ Discriminating against or refusing to cooperate with co-workers known to be infected with HIV
- ✦ Demanding routine, mandatory HIV testing, or insisting on testing as a condition for providing services
- ✦ Testing for HIV without obtaining informed consent
- ✦ Segregating or isolating HIV and AIDS patients in special beds or wards when there is no clinical need to do so
- ✦ Discharging HIV-positive patients immediately or soon after test results become available, regardless of overall health status
- ✦ Withholding treatment from, or otherwise providing substandard care to, HIV and AIDS patients by treating them less aggressively than other seriously ill patients who are not HIV-positive

It is important to remember that health workers may simultaneously stigmatise and feel warmth and caring towards patients living with HIV/AIDS. Research conducted in Barbados, Trinidad & Tobago, and Grenada found that health workers reported compassion and positive feelings towards PLWHA, while also expressing lingering beliefs in transmission myths and feelings of condemnation towards or a wish to control PLWHA.⁴

Many of these examples are demonstrated in the trigger scenarios included with this discussion guide.

Causes of Stigma and Discrimination in Health Care Settings

There are numerous individual, institutional, and systemic causes of stigma and discrimination in health facilities. These include⁵:

³ EngenderHealth. Reducing Stigma and Discrimination Related to HIV and AIDS: Training for Health Care Workers. New York, NY: EngenderHealth; 2004. Available from: http://www.engenderhealth.org/res/offc/hiv/stigma/pdf/stigma_trainer.pdf.

- ✦ Lack of knowledge amongst staff about the modes and risk of transmission. While health workers may be more knowledgeable about transmission than the general population, they may still harbour fears about transmission that lead them to question what they know.
- ✦ Judgemental attitudes and assumptions about the sexual lives of people living with HIV. In the Caribbean, relatively small island populations and deep religious, social, and cultural taboos may influence health workers' judgemental attitudes.⁶
- ✦ Health workers' fear becoming infected during the course of their work, sometimes due to lack of assurance that they will be protected from the virus with access to post-exposure prophylaxis (PEP).
- ✦ "Structural violence", including racism, sexism, political violence, poverty and inequality, shapes the distribution and outcome of HIV/AIDS. At a societal level, structural violence influences who has access to various types of HIV related care.⁷

It is important to note that health workers' fears are not unfounded, and are based on real risks due to lack of access to supplies and training in infection prevention and standard precautions. Discussions around stigma and discrimination in the workplace must always acknowledge the realities of these fears, and the role of institutional policies in helping to address them.

Effects and Consequences of Stigma and Discrimination

Stigma and discrimination can have profound effects on individuals living with HIV/AIDS, their families, and communities. Stigma and discrimination also affects HIV/AIDS prevention and treatment efforts. The effects of stigma can vary considerably among different cultures, communities, and larger societies. Individuals also experience stigma differently, and thus it affects their lives differently. Consequences of stigma for people living with HIV/AIDS (PLWHA) may include:

- ✦ Loss of livelihood
- ✦ Loss of marriage and childbearing as life options
- ✦ Poor care within the health sector
- ✦ Withdrawal of caregiving within the home

A Haitian man describes experiencing many effects of stigma, and the positive impact that starting ART had on these effects:

"I was a walking skeleton before I began therapy. I was afraid to go out of my house and no one would buy things from my shop. But now I am fine again. My wife has returned to me and now my children are not ashamed to be seen with me. I can work again."

Castro A, Farmer P. Understanding and addressing AIDS-related stigma: from anthropological theory to clinical practice in Haiti. *Am J Public Health*. 2005 Jan; 95(1):53-59.

4 Abell N, Rutledge E, McCann TJ, Padmore J. Examining HIV/AIDS provider stigma: assessing regional

5 EngenderHealth. Reducing Stigma and Discrimination Related to HIV and AIDS: Training for Health Care Workers. New York, NY: EngenderHealth; 2004. Available from: http://www.engenderhealth.org/res/offc/hiv/stigma/pdf/stigma_trainer.pdf.

6 O'Neil C, Samiel S. A Health Promotion Approach to Reducing Stigma and Discrimination: A Framework for Action. Caribbean Epidemiology Centre (CAREC) PAHO/WHO; 2004. Available from: <http://www.carec.org/pdf/sdframework.pdf>.

7 Castro A, Farmer P. Understanding and addressing AIDS-related stigma: from anthropological theory to clinical practice in Haiti. *Am J Public Health*. 2005 Jan; 95(1):53-59.

- ✦ Domestic violence
- ✦ Rejection by family and community, potentially leading to homelessness
- ✦ Internalised stigma, including loss of hope, feelings of worthlessness and inferiority, and feeling like one has no future

Families of PLWHA can also experience various manifestations of the same types of effects of stigma, particularly loss of livelihood and reputation.

The relationship between stigma and discrimination and HIV/AIDS prevention and treatment services is complex, and can result in both positive and negative effects for patients. On the one hand, stigma and discrimination have long been seen as a major barrier to addressing the HIV/AIDS epidemic, particularly in resource-limited settings. Stigma and discrimination has been shown to have a negative effect on uptake of voluntary counselling and testing services (VCT), use of condoms and other prevention activities, and disclosure of HIV status. On the other hand, more recent research, including studies in the Dominican Republic and Haiti, indicates that scale-up of ART and other HIV/AIDS related care and treatment can have a positive impact on stigma and discrimination by providing hope and restoring health. Health care workers have a critical role to play in helping shape the relationship between stigma, discrimination, and HIV/AIDS care. By providing direct care to those affected by HIV/AIDS and the stigma and/or discrimination that often comes with infection, they can help to restore health and hope to PLWHA, empowering them to overcome the stigma and discrimination they may face.

Effective Ways to Address Stigma and Discrimination

While there is not a lot of evidence on how best to address HIV/AIDS related stigma and discrimination, there are some strategies that have been shown to be effective in reducing stigma and discrimination.¹¹

Evidence suggests that effective interventions targeting HIV/AIDS related stigma should address:

- ✦ Both individual and structural change
- ✦ Knowledge and fear about HIV and AIDS
- ✦ Values, norms, and moral judgements
- ✦ Involvement of PLWHA at all levels of HIV/AIDS related care and services

Because stigma is rooted in specific socioeconomic and cultural contexts, certain intervention methods have been shown to be more effective than others in reducing stigma and discrimination.

8 Piot P, Coll Seck AM. International response to the HIV/AIDS epidemic: planning for success. *Bull World Health Organ.* 2001;79(12):1106-12.

9 Ogden J, Nyblade L. *Common at Its Core: HIV-Related Stigma Across Contexts.* Washington, DC: International Center for Research on Women; 2005. Available from: http://www.icrw.org/docs/2005_report_stigma_synthesis.pdf.

This Facilitator Guide and accompanying trigger scenarios were developed with these methods in mind.

- Create opportunities for community dialogue to achieve collective problem identification, decision making and community-based implementation of solutions to locally relevant issues.
- Provide factual information in an interactive format, moderated by a knowledgeable and trusted facilitator. Such a facilitator can respond to all individual concerns and unambiguously dispel any myths about transmission
- Regular monitoring and evaluation of participants' understanding of messages, so that misconceptions can be dealt with quickly
- Use of positive images of PLWHA. Fear-based messages will only serve to perpetuate fear of HIV/AIDS and PLWHA; whereas positive messages reinforce that PLWHA can be productive, engaged members of the community and society

Use of Trigger Scenarios in Addressing Stigma and Discrimination

How do participants learn through trigger scenarios?

These scenarios portray visual images of common situations encountered in health care settings related to HIV/AIDS stigma and discrimination. Trigger scenarios are a powerful tool that can be used to focus discussion, improve learning and raise awareness about stigma and discrimination related to HIV and AIDS.

The facilitator engages participants in a discussion about the behaviour and actions of the characters in the scenario, while also highlighting important learning issues and possible solutions to decreasing stigma and discrimination. By watching these videos of realistic situations, viewers are able to project themselves into scenarios that may occur in their facility. Participants can learn to recognise stigmatising and discriminatory behaviour and engage in discussion about strategies to decrease stigma and discrimination in health care settings.¹³

Viewing video footage of realistic situations is an ideal opportunity for participants to reflect on their own behaviour and enhance their own self-directed learning and awareness.

Kagan NI, Kegan H. Interpersonal process recall. In: Dowrick PW, ed. Practical Guide to Using Video in the Behavioral Sciences. New York: John Wiley and Sons; 1991:221–30.

Are trigger scenarios effective in decreasing stigma and discrimination?

It may not be possible to eliminate stigma and discrimination completely, but they can be reduced through a variety of intervention strategies.¹⁴

10 Castro A, Farmer P. Understanding and addressing AIDS-related stigma: from anthropological theory to clinical practice in Haiti. Am J Public Health. 2005 Jan; 95(1):53-59.

11 Brown L, Trujillo L, Macintyre K. Interventions to reduce HIV/AIDS stigma: what have we learned? New York, NY: Population Council; 2001. Available from: www.popcouncil.org/pdfs/horizons/litrvwstgdisc.pdf.

A first step in addressing stigma and discrimination is to recognise its causes and manifestations. The characters in the trigger scenarios demonstrate how stigma and discrimination appear in attitudes, language, behaviour and actions. These videos aim to create awareness and recognition of the existence of stigma. Discussion can promote further understanding about the harmful effects of stigma and discrimination among health care workers, their patients and their communities.¹⁶

It is through discussion and reflection, that participants improve their awareness of stigma and discrimination in the workplace. Raising awareness can help stop people from inadvertently stigmatising and discriminating, and can motivate people to do something about it. Facilitators should emphasise that everyone can play a role in reducing stigma through their language, attitudes and behaviours.

Many forms of stigma are related to the fear of transmission through casual contact or other unlikely routes. Some of the trigger scenarios give facilitators the opportunity to address fears about HIV transmission. Facilitators can give clear information and facts about how HIV is and is not transmitted and the risk associated with various modes of transmission. When health care workers truly understand and believe the facts about transmission, they will be less likely to stigmatise PLWHA through avoidance and isolation.¹⁷

Interventions to reduce stigma and discrimination must also address taboo subjects such as values and beliefs around sexual behaviours, religion, drug use, and fears of death, as well as the context of social inequality and the interaction between gender and poverty. The discussions in this Facilitator's Guide are intended to create a safe, non-threatening place where participants can explore the link between stigma and discrimination and their own values and beliefs. Discussion is focused on the behaviours of fictional characters portrayed by actors, making it easier for participants to

The facilitator should acknowledge that anyone can have stigmatising thoughts or attitudes. Discussion participants should challenge themselves to analyse their own experiences of stigma and discrimination, including their roles as stigmatiser or stigmatised, as discriminator or discriminated (either directly or through association with people with HIV).

Providing information in an interactive discussion through a knowledgeable and trusted facilitator will encourage discussion, questions and dialogue. This format also allows the facilitator to address participants' concerns and dispel myths and misinformation.

12 Biggs SJ. Trigger tapes and training. In: Dowrick PW, ed. Practical Guide to Using Video in the Behavioral Sciences. New York: John Wiley and Sons; 1991:203–20

13 Pinsky LE, Wipf JE. A picture is worth a thousand words: practical use of videotape in teaching. J Gen Intern Med. 2000 Nov;15(11):805-10.

14 Brown L, Trujillo L, Macintyre K. Interventions to reduce HIV/AIDS stigma: what have we learned? New York, NY: Population Council; 2001. Available from: www.popcouncil.org/pdfs/horizons/litrvwstigidisc.pdf

15 Nyblade L, Pande R, Mathur S, MacQuarrie K, Kidd R, Banteyerga H, et al. Disentangling HIV and AIDS Stigma in Ethiopia, Tanzania and Zambia. International Center for Research on Women (ICRW); 2003. Available at: <http://www.icrw.org/docs/stigma-report093003.pdf>

discuss the issues in each scenario freely and objectively, without feeling personally “put on the spot” or otherwise implicated. This reflection can encourage participants to adopt non-stigmatising principles.

16 Ogden J, Nyblade L. Common at Its Core: HIV-Related Stigma Across Contexts. Washington, DC: International Center for Research on Women; 2005. Available from: http://www.icrw.org/docs/2005_report_stigma_synthesis.pdf.

17 Nyblade L, Pande R, Mathur S, MacQuarrie K, Kidd R, Banteyerga H, et al. Disentangling HIV and AIDS Stigma in Ethiopia, Tanzania and Zambia. International Center for Research on Women (ICRW); 2003. Available at: <http://www.icrw.org/docs/stigma-report093003.pdf>

18 Nyblade L, Pande R, Mathur S, MacQuarrie K, Kidd R, Banteyerga H, et al. Disentangling HIV and AIDS Stigma in Ethiopia, Tanzania and Zambia. International Center for Research on Women (ICRW); 2003. Available at: <http://www.icrw.org/docs/stigma-report093003.pdf>

Appendix B:

HOW TO FACILITATE TRIGGER SCENARIOS

The trigger scenarios that accompany this Facilitator Guide address topics that are sensitive and can be difficult to discuss. The training session is intended to establish an environment in which stigma and discrimination can be openly discussed among health care workers. By understanding how to facilitate discussions on sensitive topics, you can effectively encourage participants to explore their views on stigma and discrimination related to HIV and AIDS in their workplace. Through listening to the views and perspectives of others, we can begin to raise awareness and successfully address issues of stigma and discrimination in our own settings.

Even the experienced facilitator can benefit from new tools and techniques to enrich the participant learning experience. The following pages provide helpful information about facilitating the trigger scenarios.

Overview of a Trigger Scenario Training Session

A training session begins with the facilitator describing the main theme of the trigger scenario to be viewed. Students may jot down points of interest for discussion. The scenario is then played. Occasionally the facilitator may wish to replay the entire scenario or parts of the scenario to emphasise important issues or if participants feel it would be helpful.

The Facilitator/Trainer Role when using trigger scenarios includes¹⁹:

- ✦ Establishing the setting and basic so that the trigger scenario is clear to all participants.
- ✦ Leading a discussion focused on key themes, topics, and lessons brought out in the trigger scenario.
- ✦ Enabling all participants to express their views and participate in the discussion.
- ✦ Legitimising different views and approaches.
- ✦ Encouraging participants to critically assess the actions portrayed in the scenarios.

HOW TO FACILITATE EFFECTIVELY

Basic Facilitation Strategies

- ✦ Ask open-ended questions. For example, ask, “What did you learn from the nurse’s language?”

¹⁹ Adapted from “Twenty Years of Experience Using Trigger Films as a Teaching Tool,” by Rosalie Bernd Gideon Alroy, both of the Department of Medical Education at B. Rappaport Faculty of Medicine, Technion-Israel Institute of Technology in Haifa, Israel. Published in *Academic Medicine*, 2001; 76: 656-658. Ber R, Alroy G. Twenty years of experience using trigger films as a teaching tool. *Acad Med*. 2001 Jun;76(6):656-8.

instead of “Did you learn how to avoid stigmatising language?”

- ✦ Try to draw out lessons and insights from participants, rather than lecturing them or “telling them the answers.”
- ✦ Listen carefully to the communication and any feelings that may accompany the communication.
- ✦ Rephrase participants’ communications accurately and without judgement.
- ✦ Respect every participant’s feelings, perspectives, and contributions.
- ✦ Adhere to time schedule.
- ✦ Focus on developing skills and not only on knowledge.
- ✦ Encourage participants to think about actions they can take in their own setting to address issues raised in the videos.
- ✦ Make the learning process active.

Be well prepared

- ✦ You may want to consider co-facilitating with another person so that the facilitation team reflects different positions of authority, e.g. a doctor and an administrative staff member or a lab technician and a nurse. This is an especially important consideration if you feel some discomfort around leading the session. Staff members with counselling skills are more likely to be confident facilitating discussions related to feelings, attitudes and values. Criteria for selecting a co-facilitator should include experience with the topic, ability to serve in an objective role that is accepted by the group, and experience in facilitating group discussions.
- ✦ Before the first training session, review the facilitator instructions to familiarise yourself with the materials, topic and skills necessary to facilitate. This also can assist you in planning the format of the discussion: e.g. will it be a large group, a small group, a group of staff that know each other well or not at all?
- ✦ Arrange the physical environment so that the participants can talk with each other rather than just face the facilitator or TV. A half circle or U-shape works well.
- ✦ Being aware of your own feelings and fears about the topic will help you feel more confident during the session. Participants will be more likely to trust you if you can be honest about your feelings on the topic; in this way you are leading by example.
- ✦ Plan discussions of the trigger scenarios. Discussions may include the following topics²⁰:
 - The details of the situation depicted.
 - The communication style and content of the characters’ dialogue and actions.
 - Ethics, etiquette, and professional behaviour.
 - Alternative approaches to what was portrayed in the video; envisioning what might have happened differently.
 - Personal points of view — the participants’ personal views of the interaction of the overall scenario or particular aspects of it.

Prepare participants for the session

- ✦ Let staff and other appropriate persons know ahead of time about the training session.
- ✦ Prepare the participants for the sensitive nature of the trigger scenarios. Because they all deal with serious topics on HIV and AIDS in health care settings, participants may have strong emotional responses to the scenes. Let them know that no feeling is wrong, but that some participants may find it difficult to accept certain feelings.
 - For example, you can say, “Today we are going to discuss issues of stigma and discrimination relating to HIV and AIDS in the workplace. These trigger scenarios portray health care workers in situations that you or someone you know may have experienced. The scenarios may evoke strong feelings or emotions because of their personal nature. Talking about this might be difficult for some of us. It will be important to watch out for one another’s feelings today.”
- ✦ Do not avoid discussion around sensitive issues related to sexuality, religion and substance use. It is important to talk about them in order to raise awareness of stigma and discrimination related to HIV and AIDS.
- ✦ Acknowledge that a certain amount of conflict may occur and can help in the learning process.
- ✦ Set an appropriate tone by demonstrating your comfort with the topics and help others to feel comfortable so they will share their views more openly and honestly. For example, you can say,
 - “We are here to have a frank and open discussion about stigma and discrimination related to HIV and AIDS in health care settings. We are here to learn from each other and to raise awareness about how we think and feel about stigma and discrimination in health care settings. I hope that you will say what is on your mind and understand the challenges we may all face in sharing some of our experiences with each other. There may be disagreements on certain issues but that is OK. Our aim is to create a safe and respectful atmosphere so that everyone feels comfortable in expressing themselves.”

Plan how to discuss sensitive topics like religion, sexuality and substance use ahead of time.

Establish ground rules

When facilitating on sensitive topics it is important to build trust amongst participants. One way to do this is to establish ground rules (also sometimes called group norms) that all group members agree to follow. This can help participants feel comfortable about sharing their ideas and feelings. Ideally, participants would generate the ground rules themselves (the facilitator may ask them what they need in order to feel they are in a safe environment). If time for the session is tight, the facilitator may want to prepare the ground rules in advance and ask the group if they are in agree-

20 Source: Adapted from “Twenty Years of Experience Using Trigger Films as a Teaching Tool,” by Rosalie Bernd Gideon Alroy, both of the Department of Medical Education at B. Rappaport Faculty of Medicine, Technion-Israel Institute of Technology in Haifa, Israel. Published in *Academic Medicine*, 2001; 76: 656-658. Ber R, Alroy G. Twenty years of experience using trigger films as a teaching tool. *Acad Med*. 2001 Jun;76(6):656-8.

ment with the proposed rules. The ground rules should be posted on a sheet of paper where everyone can see them and refer to them as needed.

Some common ground rules that you may want to use:

- ✦ Listen actively
- ✦ Participate at your comfort level, it is okay to pass or not to speak
- ✦ Honour confidentiality about what is discussed in the session
- ✦ Stay focused on the discussion and avoid side conversations
- ✦ Respect others when they are talking, don't interrupt
- ✦ Refrain from generalizing and using "we," use "I" statements such as "I feel" or "I've observed." Speak from your own experience.
- ✦ Refrain from personal attacks. **Criticise the idea, not the person!**
- ✦ Goal is not necessarily to agree, but to explore and hear about different perspectives
- ✦ Be conscious of your body language and about using disrespectful language
- ✦ Ask questions of each other
- ✦ Don't make assumptions about what others mean

Establishing ground rules (or group norms) sets the foundation on which group communication will occur.

Build an atmosphere of trust amongst participants

- ✦ **Assure that confidentiality will be maintained.** Establish a group rule on the first day that everyone's confidentiality will be protected so that people can talk freely without fear that their comments will be shared outside the session. It can be helpful for everyone to sign a confidentiality agreement. (See **Appendix L** for a sample.)
- ✦ **Provide constructive and supportive feedback.** Let participants know when they've contributed something useful and interesting to the group. For example, you can say, "That's a good example of the concept we are discussing."
- ✦ **Model a positive attitude.** Although participants may get frustrated during the discussion, maintain a positive attitude. If there are difficult moments during the session, address them with honesty and with a constructive comment. For example, "This topic brings up difficult feelings, but if we explore our own feelings we can better address stigma and discrimination."

One of the most important tasks of a good facilitator is to build an atmosphere of trust. An accepting and non-threatening atmosphere will encourage the expression of ideas, beliefs and attitudes by all participants. This will also allow for exploration of fears and taboos.

Remain objective

As the facilitator expressing your opinion may discourage participants from expressing opinions that are different from yours.

Your role as facilitator is to create a space where all can participate comfortably. This does not mean that you have no opinions, but you need to play an objective role. Facilitators must recognize their own attitudes and stereotypes and have an open mind for understanding the limits of these. If partici-

pants ask you about your experiences or if you have discriminated in the past, be honest and acknowledge that you are working against stigma and discrimination. This will establish respect in the group.

Encourage participation from all members of the group

- ✦ Reflection on stigma and discrimination should be seen as a learning opportunity where all participants' contributions are appreciated and respected.
- ✦ When there are power dynamics or hierarchy amongst group participants, it is important to ensure that each participant has an equal voice.
- ✦ If one or two individuals are dominating the discussion, try to gently discourage this with comments such as "We'd like to hear what everyone in the group thinks about this issue. Can you give some others a chance?" Or "Let's remember that we're not here to argue and convince others of our point of view, but to hear everyone's views on the subject."
- ✦ People have the right to speak or choose not to speak.

When there are power dynamics or hierarchy among group participants, it is important to ensure that each participant has an equal voice.

Communicate appropriately

It is important to address language used by participants that may be offensive or inappropriate in the workplace. The trigger scenarios portray realistic situations and realistic language. Participants should be encouraged to talk openly about the impact of the language used by the actors in the scenarios while maintaining a respectful atmosphere during the discussion. For example, when derogatory language is used in a scenario to illustrate discriminatory behaviour, participants should discuss and quote the language in a way that does not make other participants uncomfortable.

Manage group dynamics

- ✦ Facilitators should be aware of group dynamics, such as tension within the group, one participant dominating the discussion or issues of hierarchy that may be affecting the discussion.
- ✦ Arguments can be avoided if the discussion is viewed as a learning opportunity and everyone's contributions are respected.
- ✦ When you recognise tension in the group respond quickly. One strategy is simply to acknowledge what is happening: "It seems that there is some tension around this issue. Why do you think that is the case?"
- ✦ Use the agreed upon ground rules.
- ✦ Clarify misinformation.
- ✦ Don't allow disrespect or insults. Negative behaviour should be addressed quickly so participants don't think it is condoned by the facilitator.

Troubleshooting during a discussion

- ✦ Responding to difficult statements made by participants
 - Acknowledge the contribution, “Thank you for sharing your opinion with us.”
 - Ask participant for clarification “Can you tell us more about why you feel that way?”
 - Ask the group of participants if anyone has a (differing) opinion; if not, offer one.
 - Offer facts that support different viewpoints, if there are any.
- ✦ No one responds to questions
 - Suggest an answer and ask for agreement or disagreement.
 - Consider breaking into smaller groups or pairs, people may feel more comfortable sharing in smaller groups. This may be particularly important when power dynamics are at play.
- ✦ One person is dominating
 - Make it clear you want input from everyone.
 - Acknowledge this person’s contribution and offer to talk with them further after the session.
 - Ask the group for contributions, “Let’s hear from those who haven’t spoken”. Or alternately, “I’d like to hear what the rest of the group has to say.”
- ✦ Someone keeps changing the subject or going off track:
 - Refocus their attention, “That is very interesting, but how do you feel about...?”
 - Offer to address their comments during a break or after the session.
 - Write additional topics identified by participants on a piece of paper as a reminder of topics to be covered if there is time remaining at the end of the session.
- ✦ Participants have noticed something in the scenario that you had not planned to discuss:
 - Be flexible and allow for discussion if it appears to pertain to the key points and there is participant interest.
 - If it is unrelated, re-focus the discussion and use a technique for preventing the group from going off track (as in the above example).
- ✦ People keep interrupting:
 - Remind participants of ground rules.
 - Practice “stacking”. The facilitator identifies people who would like to speak and places them in order.
- ✦ Hostile or belligerent group:
 - Stay calm.
 - Try to incorporate negative comments in a positive way. For example: “That’s an interesting/unique way to look at this situation. I appreciate your contributing that different point of view.”
 - Refer to ground rules.
 - Acknowledge the person’s feelings, opinions or values, while legitimatising different views and opinions.
 - If a person is belittling another group member, immediately step in. It may be necessary to announce to the group to take a break.

- ✦ A break allows the opportunity to speak with the member separately. For example: “I realise that this is a very heated topic, let’s take a break and come back to this topic in five minutes.”
- ✦ Consider setting some boundaries with the person regarding their behaviour. For example: “If it is not possible for you to refrain from doing X, we may have to figure out an alternative way for you to complete the training.”
- ✦ People keep addressing questions to you:
 - Clarify facts if you know them, admit it if you don’t.
 - Redirect questions to the group.
- ✦ Someone insults another:
 - Reiterate that participants should criticise ideas not people.
 - Separate and identify value statements from facts. Remind the group there are no right or wrong answers when it comes to values that everyone has right to their opinion.
- ✦ Inappropriate humour:
 - Do not tolerate it.
 - You could say, “I realize you may not have intended it, but this is a sensitive topic, and that kind of humour makes a lot of people very uncomfortable.”
- ✦ Conflict occurs:
 - Remind people they are there not to judge others or persuade others of their views but to further mutual understanding.
 - Conflict is a healthy part of group dynamics.
 - Summarise the conflict and ask others for ideas on how to proceed.
 - Acknowledge disagreement and agree to move on.
- ✦ Something is inappropriately stated (offensive or misinformation):
 - Legitimise dissenting opinions/ideas.
 - Don’t allow misinformation to persist.
 - Ask for other opinions, “Are there other views on this?”

Summarise the discussion/provide closure

- ✦ Summarise the major points of the discussion.
- ✦ Comment on how the session went.
- ✦ If appropriate, help group decide on what next steps should be, if any. Decide if people want to continue the discussion at another time.
- ✦ Emphasise commitment to confidentiality and sensitivity to the information shared by members of the group.
- ✦ Offer to be available to discuss related issues at another time.
- ✦ Thank all for the discussion and their participation.

Sources:

Ber R, Alroy G. Twenty years of experience using trigger films as a teaching tool. Acad Med. 2001 Jun;76(6):656-8.

Kidd R, Clay S. Understanding and challenging HIV stigma: toolkit for action. Washington, DC: CHANGE Project; 2003. Available from: <http://www.changeproject.org/technical/hivaids/stigma.htm>.

Stanford University. Residential Education. Facilitating Group Discussions. <http://www.stanford.edu/dept/resed/Staff/StaffResources/ResourceManual/training/facilguide.html>.

Appendix C:

CHARACTERISTICS OF EFFECTIVE FACILITATORS/TRAINERS

Effective facilitators/trainers:

Know their subject matter	They have researched their topic and are well informed; learners perceive them as credible.
Take the time to get to know their audience	They demonstrate respect for, and listen to, the learners. They call learners by name, if possible.
Are non-judgemental	They validate everyone's experiences and their right to their own perspective.
Respect differences of opinion and life choices Demonstrate cultural sensitivity	They know that key learning can take place when people express different viewpoints and bring their own perspectives into the adult learning classroom. They are aware that their cultural background shapes their personal views and beliefs, just as the perspectives of learners are shaped by their own culture and life experiences.
Are self-aware	They recognise their own biases and act in a professional manner when their "hot buttons" are pushed.
Are inclusive	They encourage all learners to share their experiences and contribute to the group-learning process in their unique ways.
Are lively, enthusiastic and original Use a variety of vocal qualities	They use humour, contrasts, metaphors and suspense. They keep their listeners interested and challenge their thinking. They vary their pitch, speaking rate, and volume. They avoid speaking in monotones.
Use "body language" effectively	Their body posture, gestures, and facial expressions are natural and meaningful, reinforcing their subject matter.
Make their remarks clear and easy to remember	They present one idea at a time and show relationships between ideas. They summarise when necessary.
Illustrate their points	They use examples, charts, and visual and audio aids to illustrate subject matter.

Understand group dynamics and are comfortable managing groups	They are comfortable with conflict resolution and know how to facilitate an inclusive course or workshop, where everyone's participation is encouraged.
Are flexible	They read and interpret learners' responses — verbal and non-verbal — and adapt training plans to meet their needs. They are "in charge" without being overly controlling.
Are open to new ideas and perspectives	They are aware that they do not know all the answers. They recognise that as well as offering their audience new knowledge or perspectives; they can also learn from course participants.
Are compassionate	They understand that the topics addressed during training may have an emotional impact on learners. They are empathetic and understanding about learners' emotional reactions.
Are receptive to feedback	They encourage co-trainers and learners to give them feedback, both informally and through formal evaluation. When they receive negative feedback about their performance, they critically analyse this feedback instead of becoming defensive.
Continuously work to improve their teaching and training	Even the most experienced trainers can improve their training skills. Effective trainers seek out opportunities to learn new skills and use negative feedback as an opportunity to improve.

This handout was created with the help of material from JHPIEGO's *Training Works!* 2003 (<http://www.reproline.jhu.edu/english/6read/6training/Tngworks/>), and K. Lawson's *The Trainer's Handbook*, 1998, Jossey-Bass/Pfeiffer.

Appendix D:

TRAINING ICE BREAKER ACTIVITIES

Depending on the context in which the training is conducted, facilitators may want to use an ice breaker activity. Ice breakers are a useful tool to put participants at ease and get them talking. They can also set the tone for the rest of the session. Sometimes participants may not look forward to coming to trainings, especially if they are balancing many work responsibilities. Facilitators should put thought into what kinds of ice breaker activities would work best for their participants given the context of the training.

- ✦ It is best if icebreakers are simple, not too personal and are not embarrassing.
- ✦ Check to make sure the group understands the directions in order to avoid any discomfort.
- ✦ Explain what the group will gain by performing the activity.
- ✦ Let participants know they can opt out of the activity if they are not comfortable.
- ✦ Time the exercise to keep the group on track with the time allotted for the session.

EXAMPLE ICE BREAKER ACTIVITIES

Challenges and Objectives

Divide the group into small teams. Instruct teams to identify their challenges in the topic and their objectives for the training. Post work on flip charts. Have them introduce their team and share their work with the rest of the class.

I'm Unique

Ask each person to share one thing that makes him/her unique.

Developing Yourself

Have each person introduce himself and share one action they have recently taken to improve or further educate themselves on the topic of patient care. This can be done as a group or in small teams.

Acceptance Speech

Have participants introduce themselves and thank someone whom has contributed to their professional development, and whom they admire. They should thank the person as if they are receiving an Academy Award. You may need to limit speeches to 30 seconds.

First Job

Have participants introduce themselves, sharing their name and something they learned on their first paying job.

Experience Tally

Ask each participant how long they've been with their clinic or hospital, or on their current job. Total the number of years. Point out that the class will have X number of years of experience on which to draw.

Good or New

Ask each person to share something good or new they have experienced in the last 24 hours.

Three Truths and a Lie (better for groups of less than 10 participants)

Give each individual a 3x5 card and instruct them to write 4 statements about themselves: one of the statements should be false while 3 should be true. Explain that the goal is to fool people about which is the lie. Allow 5 minutes to write statements; then have each person read the 4 statements and have the group guess the lie. Award a prize to the individual who makes the most correct guesses.

Guess Who

Prior to the session have each participant complete and return to you a survey with 5-7 questions about him or herself. For example:

- a. Favourite type of food
- b. Last movie you saw
- c. Last book you read
- d. Where you would love to visit
- e. Favourite activity

During the session, read the clues and have the rest of the class guess which person is being described.

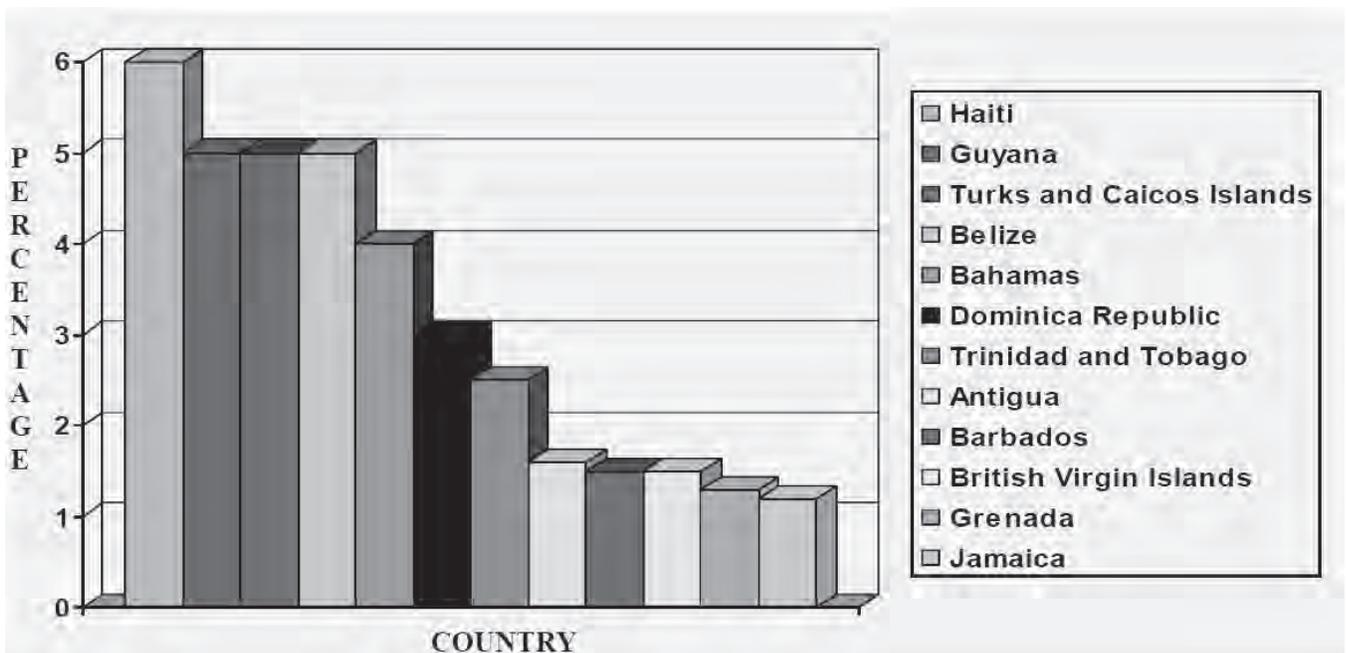
Source: *Results Through Training*, www.RTTWorks.com

Appendix E:

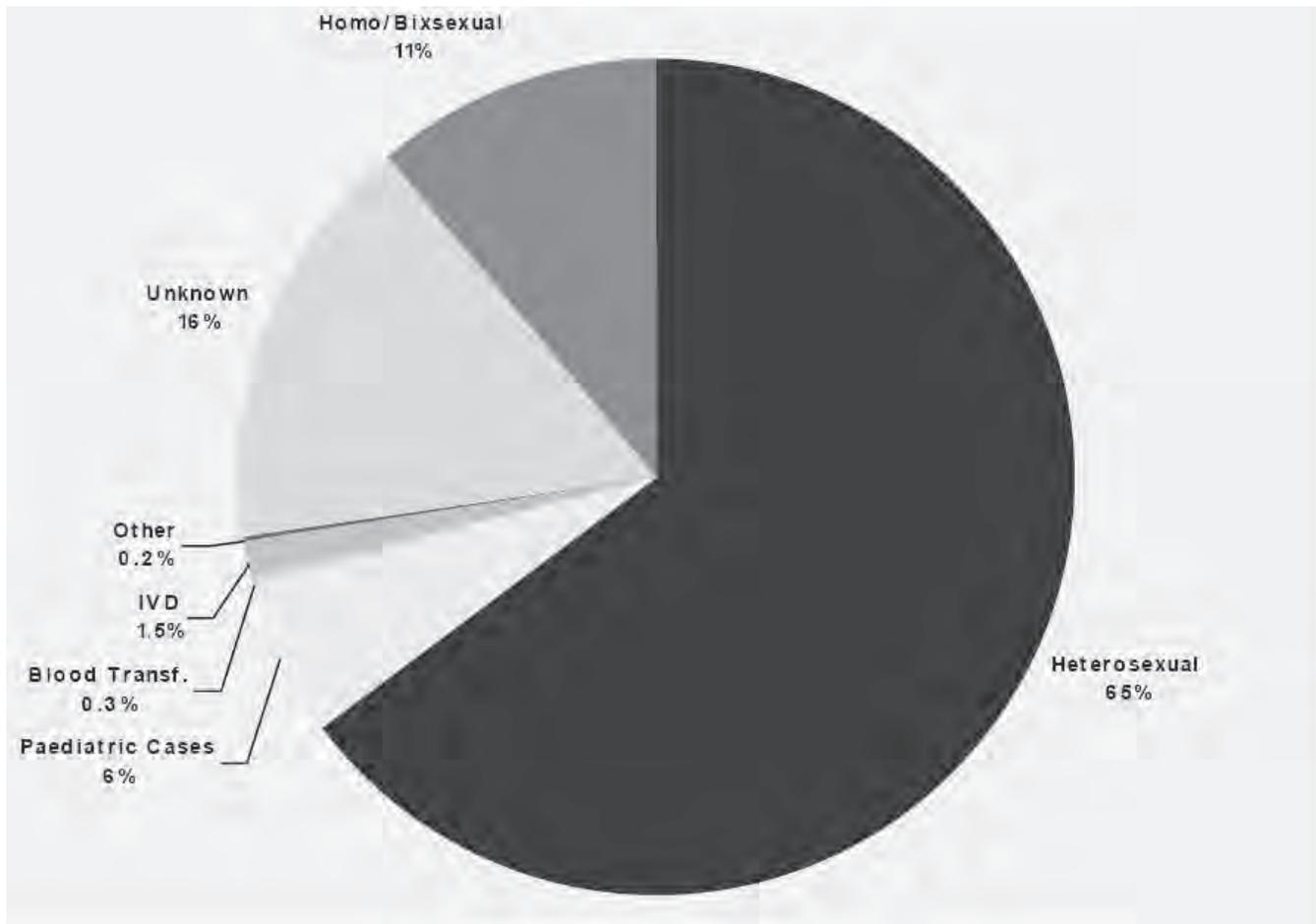
EPIDEMIOLOGY OF HIV/AIDS IN CARIBBEAN

The HIV/AIDS epidemic in the Caribbean is second in magnitude only to sub-Saharan Africa. As the epidemic spreads throughout the region, it is becoming more generalised, with unprotected heterosexual intercourse as the main mode of transmission. The scope and size of the epidemic varies considerably from country to country, as do countries' responses to HIV/AIDS. Nonetheless, HIV/AIDS has a considerable impact on the region overall, and AIDS is now the leading cause of death among adults in the region. 2005 data show:

- ✦ Approximately 300,000 people are living with HIV in the Caribbean
- ✦ About 30,000 people became infected with HIV
- ✦ 12% of reported HIV infections are attributed to unprotected sex between men
- ✦ Only about one in four of those in need of ART were receiving it



Caribbean Countries with Adult HIV Prevalence >1%, 2001 (CAREC, 2003)



Category of Transmission in Reported AIDS Cases in CAREC Member Countries:
1982-2001 (CAREC, 2003)*

*CAREC Member Countries (2006): Anguilla | Antigua & Barbuda | Aruba | Bahamas | Barbados | Belize | Bermuda | British Virgin Islands | Cayman Islands | Dominica | Grenada | Guyana | Jamaica | Montserrat | Netherlands Antilles | St. Kitts & Nevis | St. Lucia | St. Vincent & the Grenadines | Suriname | Turks & Caicos

Sources:

- UNAIDS. 2006 report on the global AIDS epidemic. May 2006. Available from: http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp.
- Camara B, Lee R, Gatwood J, Wagner H, Casal-Gamelsy, Boisson E. The Caribbean HIV/AIDS epidemic epidemiological status – success stories: a summary. CAREC Surveillance Report. October 2003; 23(suppl 1). Available from: http://www.carec.org/documents/csr_supplement.pdf

Graphs reproduced courtesy of CAREC

Appendix F:

FACTS ABOUT HIV/AIDS & TRANSMISSION

This appendix provides facilitators with an outline of basic information related to HIV/AIDS and HIV transmission that may be needed during discussions. Facilitators should feel comfortable providing accurate explanations and addressing any questions or misconceptions that participants may have related to the topics below. If you are unsure about any of the issues, you may want to seek additional information prior to presenting these trigger scenarios. It may also be helpful to know where to refer people for more information.

HIV TRANSMISSION MODES

- ✦ Unprotected sex
- ✦ Mother to child during pregnancy, birth, or breastfeeding
- ✦ Contact with infected blood or body fluids.
- ✦ Different modes of transmission have different degrees of risk (see Appendix G), HIV Transmission Risk

HOW HIV IS NOT TRANSMITTED

- ✦ Physical contact (shaking hands, kissing, etc.)
- ✦ Sharing dishes, etc.
- ✦ Washing or carrying dead bodies
- ✦ Mosquitoes

WHAT IT MEANS TO BE

HIV-POSITIVE

- ✦ The difference between HIV and AIDS; signs & symptoms; lab data
- ✦ HIV—infected with virus but have no signs and symptoms; different HIV subtypes
- ✦ AIDS — infected with virus + signs & symptoms; easy to get opportunistic infections

TESTING

- ✦ What test results mean—positive result, negative result, indeterminate result
- ✦ Antibodies vs. virus
- ✦ Window period
- ✦ Different types of tests
- ✦ Counselling process
- ✦ Discordant couples — if one is positive, sexual partner may be positive or negative

RISK OF MTCT COFACTORS

- ✦ Reinfection (role of partner); weakens placenta

PROGRESSION OF HIV/AIDS

- ✦ Different rates of progression
- ✦ CD4, CD8, antibodies, viral load
- ✦ Immune system

VIRAL LOAD

- ✦ Amount of viral copies detected in your blood
- ✦ Risk of HIV transmission goes up with increase in viral load
- ✦ At start the viral load goes up then decreases with the increase of antibodies, then goes up again as the antibodies decrease

ANTI-RETROVIRAL THERAPY

- When to start?
- Side effects
- Costs
- How ARVs work in body (not a cure)
- Triple therapy
- Drug resistance
- Alternative therapies (e.g. herbs)
- Minerals and vitamins

Adapted from: Kidd R, Clay S. Understanding and challenging HIV stigma: toolkit for action. CHANGE Project; September 2003. Available from: <http://www.changeproject.org/technical/hivaids/stigma.htm>

QQR (FORMULA FOR UNDERSTANDING HIV TRANSMISSION)

Quality

HIV cannot survive outside the body. HIV can only survive for a few seconds outside the body—and exposure to air or water kills HIV.

Quantity

There are different quantities of HIV in different fluids. There is very little HIV in saliva, sweat, tears, and urine so it is difficult to transmit HIV through these fluids. There are high proportions of HIV in semen, blood, vaginal and cervical fluids so it is easy to transmit HIV through these fluids. Breast milk has a smaller proportion of HIV.

Route of Transmission

HIV has to get inside your body. Our body is a closed system. Even if the body gets punctured, blood flows out, not flowing in from the outside. Example: if you have a plastic bag of water and you hit it with a sharp knife, water flows out and not in.

Appendix G:

HIV RISK CONTINUUM

HIV Risk Continuum

Practice	Risk	Notes
Abstinence	No risk	There is no risk for HIV transmission as long as no body fluids are exchanged.
Masturbation	No risk	There is no risk for HIV transmission as long as no body fluids are exchanged.
Unprotected sex with a monogamous, uninfected partner	No risk	Having unprotected sex in a monogamous relationship carries no risk as long as both partners are uninfected. However, it is often difficult to know if a partner is truly monogamous and uninfected.
Shaking hands with an HIV-positive person	No risk	There is no risk for HIV transmission as long as no body fluids are exchanged.
Sitting on a public toilet seat	No risk	There is no risk for HIV transmission as long as no body fluids are exchanged.
Getting bitten by a mosquito	No risk	Studies have found that mosquitoes do not transmit HIV between people.
Massage	No risk	There is no risk for HIV transmission as long as no body fluids are exchanged.
Hugging an HIV-positive person	No risk	There is no risk for HIV transmission as long as no body fluids are exchanged.
Helping someone with a nose-bleed	No risk	There is no risk for HIV transmission as long as no body fluids are exchanged.
Taking a blood pressure without gloves	No risk	There is no risk for HIV transmission as long as no body fluids are exchanged.
Taking a temperature without gloves	No risk	There is no risk for HIV transmission as long as no body fluids are exchanged.

Practice	Risk	Notes
Performing an abdominal exam without gloves	No risk	There is no risk for HIV transmission as long as no body fluids are exchanged.
Performing an antenatal abdominal exam without gloves	No risk	There is no risk for HIV transmission as long as no body fluids are exchanged.
Getting a client's blood on your hands	No risk	If the skin on your hands is intact, then there is no risk for transmission.
Cleaning up a blood spill wearing latex gloves	No risk	The gloves offer protection from the possible exchange of body fluids.
Performing a caesarean section delivery with gloves	Low risk/ No risk	In the absence of sharps injury, the risk of HIV transmission is very low.
Sexual stimulation of another's genitals using hands	Low risk/ No risk	Risk is very low if there are no cuts or broken skin on hands, especially if there is no contact with secretions, semen, or menstrual blood.
Oral sex on a man (fellatio) with a condom	Low risk/ No risk	Risk is very low if the condom is used correctly. However, some STIs (e.g., herpes) can be transmitted through contact with skin not covered by the condom.
Vaginal sex with a condom	Low risk	As long as the condom is used correctly, the risk of transmission is low. Some sexually transmitted infections (e.g., herpes) can still be transmitted through contact with skin not covered by the condom.
Vaginal sex with multiple partners; condom use with every time	Low risk	Multiple partners increase risk, however correct and consistent condom use lowers risk. A new condom must be used with every partner and for every sex act.
Cleaning up a blood spill without wearing latex gloves	Low risk	Risk is higher if hands have cuts or rashes.
Getting blood from a client splashed in your eye	Low risk	The risk of transmission is approximately 1 in 1,000.

Practice	Risk	Notes
Getting blood from a client splashed in your mouth	Low risk	The risk of transmission is approximately 1 in 1,000.
Performing a delivery without wearing latex gloves	Low risk	The risk of transmission is low as long as the skin of the hands is intact.
Performing a pelvic exam during labour without wearing gloves	Low risk	The risk of transmission is low as long as the skin is intact. However, meticulous handwashing is required to minimize infection transmission.
Getting a client's blood on your hand that has a recent cut on it	Low risk	Depending on the size and depth of the cut, the amount of blood, and the amount of virus in the blood. Few or no documented cases of this mode of transmission.
Getting a client's blood on your hand which has a rash	Low risk	Depending on the severity of the rash, the amount of blood, and the amount of virus in the blood. Few or no documented cases of this mode of transmission.
Getting a client's blood on your hand with a torn cuticle	Low risk	Depending on the size and depth of the tear, the amount of blood, and the amount of virus in the blood. Few or no documented cases of this mode of transmission.
Recapping a used needle	Low risk	Although the risk of injury is high, the actual risk of infection is low (approximately 1 in 300).
Sticking yourself with a used needle in the lab	Low risk/ possibly medium risk	The approximate risk of transmission is 1 in 300. Risk may vary depending on depth of injury and source patient's stage of illness.
Anal sex with a condom	Low risk/ possibly medium risk	Risk of condom breakage is greater than for vaginal sex. Some STIs (e.g., herpes) can be transmitted though contact with skin not covered by the condom.

Practice	Risk	Notes
Oral sex on a man (fellatio) without a condom	Low risk/ possibly medium risk	HIV can be transmitted through oral sex, though the risk is very low unless there are cuts or sores in the mouth. The risk of transmission is lower if no semen enters the mouth.
Oral sex on a woman (cunnilingus)	Low risk/ possibly medium risk	HIV can be transmitted through oral sex, though the risk is very low unless there are cuts or sores in the mouth.
Unprotected vaginal sex with withdrawal prior to ejaculation	High risk	HIV can be present in pre-ejaculate, and therefore, risk of transmission is high, however withdrawal may reduce risk of HIV transmission somewhat. Unlikely to reduce risk of other sexually transmitted infections.
Vaginal sex without a condom	High risk	One of the highest risk activities. Receptive partner is at greater risk.
Anal sex without a condom	High risk	One of the highest risk activities. Receptive partner is at greater risk.
Re-using sharp instruments to cut skin (e.g., instruments used for scarification, FGM, tattoos)	High risk	If these instruments have been used on others and are not properly processed, HIV and hepatitis could be transmitted.
Re-using injection needles or syringes between clients	High risk	Injection needles must be disposed of in a puncture-resistant container (disposable) or processed for reuse to prevent transmission of blood borne organisms from one client to another. To process correctly, use high-level disinfection or sterilization.
Breastfeeding from an HIV-positive mother	High risk	Although the risk is relatively high, if no other good source of nutrition is available, it is still recommended that an HIV-positive woman breastfeed.
Labour and delivery, risk to child when mother is HIV-positive	High risk	Risk can be significantly reduced with certain antiretroviral drug regimens and safe obstetric practices.

Practice	Risk	Notes
Sharing needles, syringes, drugs or other paraphernalia	High risk	HIV and hepatitis can readily be transmitted from an infected person through sharing of infection needles and syringes.
Traditional circumcision	Unknown risk	If the razor blade or cutting instrument is re-used and not properly sterilised, risk could be high.
Going to the dentist	Unknown risk	Depends on the dentist's infection prevention practices.
Having unprotected sex with your spouse	Unknown risk	It may be difficult to know whether your spouse engages in activities that put you at risk.
Receiving a blood transfusion	Unknown risk	In many countries, the blood supply is adequately screened for HIV.
Donating blood	Unknown risk	In the presence of correct infection prevention practices, there is no risk.

Source: ©2004 EngenderHealth. Used with permission.

Appendix H:

CAREC GUIDELINES ON PEP

CARIBBEAN EPIDEMIOLOGY CENTRE (CAREC)/PAHO/WHO



CARIBBEAN GUIDELINES RELATED TO HIV POST EXPOSURE PROPHYLAXIS

Introduction

It is generally acknowledged that existing data regarding HIV Post Exposure Prophylaxis (PEP) is based on cohort, retrospective observational studies among people exposed to HIV professionally or otherwise, and not on case-control studies. Thus, recommendations formulated from these studies are not from rigorous statistical analyses. Their conclusions, however, are very convincing. Taking into account the HIV prevalence in the region, it is important to promote and put in place PEP guidelines and programmes as an essential public health measure in every health institution in every Caribbean country.

Action to be Taken After Exposure

Immediately encourage site bleeding while washing the wound and skin sites exposed to blood or body fluids. Wash with soap and water or other antiseptics.

NOTE: Post Exposure Prophylaxis works best within the first 3 to 24 hours after the accident occurred. It can also be started up to 72 hours after the accident, but is not effective after that.

LEVELS OF RISK	ACTION
<u>Low</u> Exposure to body fluids or secretions from a potential source of HIV infection without any muco-cutaneous penetration	Counselling, and follow-up for 4 weeks (no antiretroviral treatment)
<u>Medium</u> Exposure to moderate quantity of body fluids or secretions from a potential source of HIV infection with superficial muco-cutaneous penetration (e.g. needle stick injuries).	Administer AZT 300 mg x bid + 3TC 150 mg x bid daily for 4 weeks
<u>High</u> Exposure to large body fluids or secretions from a potential source of HIV infection with deep muco-cutaneous penetration	Administer AZT 300 mg x bid + 3TC 150 mg x bid + Nelfinavir 1250 mg x bid- daily for 4 weeks OR AZT 300 mg x bid + 3TC 150 mg x bid + Indinavir 800 mg x tid- daily for 4 weeks OR AZT 300 mg x bid + 3TC 150 mg x bid + Efavirenz 600 mg at bedtime- daily for 4 weeks

scenarios for moderate and high risk levels:

Scenario 1: After prescribing the ARV treatment for moderate and high risk cases, undertake voluntary counselling and testing for both the exposed individual and the potential source of HIV infection to establish the baseline serological status for both individuals.

Scenario 2: Where the two individuals are HIV negative, stop the treatment and re-evaluate for HIV anti-bodies the situation in 3 and 6 months, with ongoing counselling and psychological support.

Scenario 3: Where the source is HIV positive and the exposed individual is HIV negative, continue the treatment and do a follow-up check for HIV anti-bodies in 1 month, 3 months and 6 months, with ongoing counselling and psychological support.

Scenario 4: Where the exposed individual and/or the potential source of HIV infection refuse to be tested, continue the post exposure prophylaxis treatment for the exposed individual based on the level of the risk. Stop the treatment at the end of four weeks, with ongoing counselling and psychological support.

Scenario 5: Where the source and the exposed individuals are HIV positive, stop the post exposure prophylaxis treatment and refer them to an HIV/AIDS treatment centre where they can be evaluated and managed adequately, based on the CAREC regional norms for ARV treatment, using the basic criteria for inclusion.

Important Laboratory Markers to be Monitored:

1. Haemoglobin
2. Kidney and Liver Functions
3. White Blood Cell Count: Total and Differentials

Appendix I:

UNIVERSAL PRECAUTIONS, INCLUDING INJECTION SAFETY



What it is

Universal Precautions are simple infection control measures that reduce the risk of transmission of blood borne pathogens through exposure to blood or body fluids among patients and health care workers. Under the “universal precaution” principle, blood and body fluids from all persons should be considered as infected with HIV, regardless of the known or supposed status of the person. Improving the safety of injections is an important component of Universal Precautions.

Why it is Important

- ✦ Any percutaneous or permucosal exposure to blood or body fluids represent a potential source of HIV infection. These include skin-piercing procedures with contaminated objects and exposures of broken skin, open wounds, cuts and mucosal membranes (mouth or eyes) to the blood or body fluid of an infected person.
- ✦ Although they account for a minority of HIV infections, health care procedures represent a highly preventable source of HIV infection. Among health care associated sources of infection, unsafe injections are of particular concern, accounting for an estimated 3.9% to 7.0% of new infections worldwide. In addition, unsafe practices in haemodialysis and plasmapheresis centres have been associated with HIV transmission.
- ✦ Health care worker protection is an essential component of any strategy to prevent discrimination against HIV infected patients by health care workers.
- ✦ If health care workers feel they can protect themselves from HIV infection, they can provide better care.

How it is Done

1. *Ensure Universal Precautions*

- ✦ Use of new, single-use disposable injection equipment for all injections is highly recommended. Sterilizable injection should only be considered if single use equipment is not available and if the sterility can be documented with Time, Steam and Temperature indicators.
- ✦ Discard contaminated sharps immediately and without recapping in puncture and liquid proof containers that are closed, sealed and destroyed before completely full.

- ✦ Document the quality of the sterilization for all medical equipment used for percutaneous procedures.
- ✦ Wash hands with soap and water before and after procedures; use of protective barriers such as gloves, gowns aprons, masks, goggles for direct contact with blood and other body fluids.
- ✦ Disinfect instruments and other contaminated equipment.
- ✦ Handle properly soiled linen. (Soiled linen should be handled as little as possible. Gloves and leak proof bags should be used if necessary. Cleaning should occur outside patient areas, using detergent and hot water.)

2. *Ensure Adherence to Universal Precautions*

- ✦ **Staff understanding of Universal Precautions:**

Health care workers should be educated about occupational risks and should understand the need to use Universal Precautions with all patients, at all times, regardless of diagnosis. Regular in-service training should be provided for all medical and non-medical personnel in health care settings. In addition, pre-service training for all health care workers should address Universal Precautions.

- ✦ **Reduce unnecessary procedures:**

Reduce the supply of unnecessary procedures: Health care workers need to be trained to avoid unnecessary blood transfusions (e.g., using volume replacement solutions), injections (e.g., prescribing oral equivalents), suturing (e.g. episiotomies) and other invasive procedures. Standard treatment guidelines should include the use of oral medications whenever possible. Injectable medications should be removed from the national Essential Drug List where there is an appropriate oral alternative.

- ✦ **Reduce the demand for unnecessary procedures:**

Create consumer demand for new, disposable, single-use injection equipment as well as increased demand for oral medications.

- ✦ **Make adequate supplies available:**

Adequate supplies should be made available to comply with basic infection control standards, even in resource constrained settings. Provision of single use, disposable injection equipment matching deliveries of injectable substances, disinfectants and “sharps” containers should be the norm in all health care settings. Attention should also be paid to protective equipment and water supplies. (While running water may not be universally available, access to sufficient water supplies should be ensured.)

♦ **Adopt locally appropriate policies and guidelines:**

Use of sterilisable injection equipment should be discouraged, as evidence shows that the adequacy of the sterilization is difficult to ensure. National health care waste management plans should be developed. The proper use of supplies, staff education and supervision needs should be outlined clearly in institutional policies and guidelines. Regular supervision in health care settings can help to deter or reduce risk of occupational hazards in the workplace. If injury or contamination results in exposure to HIV infected material, post exposure counselling, treatment, follow-up and care should be provided.

Human Resources, Infrastructure and Supplies Needed

Institutional guidelines for Universal Precautions should be in place. The necessary supplies (e.g., oral medications, needles and syringes, sharps containers, disinfectant, antiretrovirals) must be made available. Health care waste management may require the construction of adapted waste treatment options (e.g., incinerators and alternatives to incineration).

An infection control specialist is beneficial to ensuring that Universal Precautions are followed in all institutions. Universal Precautions should be a part of all health care worker training, which should be provided on a regular basis in health care worker in-service education. Specific efforts should be made to train health care workers in reducing unnecessary invasive procedures. In addition, professional associations, including the national nursing association and the national medical association, should be engaged in health care worker protection and support the “First do no harm principle” principle.

Cost Information

The cost of the equipment needed to make injections sterile (i.e., new, single-use disposable syringes and sharps boxes) should be covered by those who supply injectable substances. The average international retail price for disposable syringes ranges from 4 US cents (2 ml) to 8 US cents (5 ml). A typical five litre safety box costs US\$ 1 and holds 100 syringes and needles. In practice, in the case of essential drugs, these costs should not lead to an increase of the drug expenditure of more than 5% and can be compensated by an elimination of unnecessary injectable medications from the national list of essential medicines.

Source: WHO. *Universal Precautions, including injection safety*. 2006. Available from: <http://www.who.int/hiv/topics/precautions/universal/en/print.html>.

Appendix J:

PATIENT RIGHTS AND CONFIDENTIALITY

The following is a sample national patients' rights policy from South Africa, available at <http://www.doh.gov.za/docs/legislation/patientsright/chartere.html>.

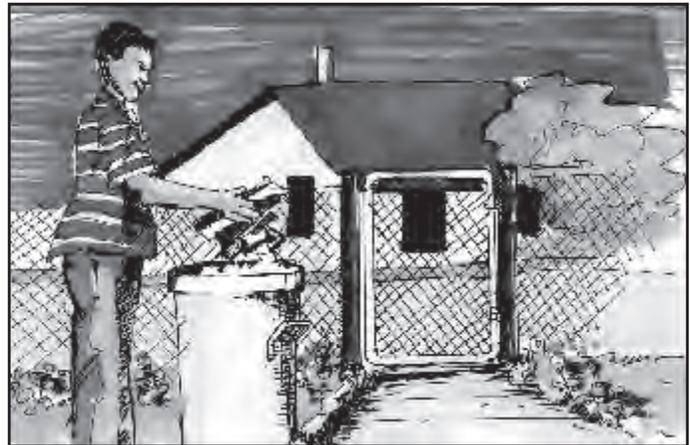
The Patients' Rights Charter

For many decades the vast majority of the South African population has experienced either a denial or violation of fundamental human rights, including rights to health care services. To ensure the realisation of the right of access to health care services as guaranteed in the Constitution of the Republic of South Africa (Act No 108 of 1996), the Department of Health is committed to upholding, promoting and protecting this right and therefore proclaims this **PATIENTS' RIGHTS CHARTER** as a common standard for achieving the realisation of this right.

This Charter is subject to the provisions of any law operating within the Republic of South Africa and to the financial means of the country.

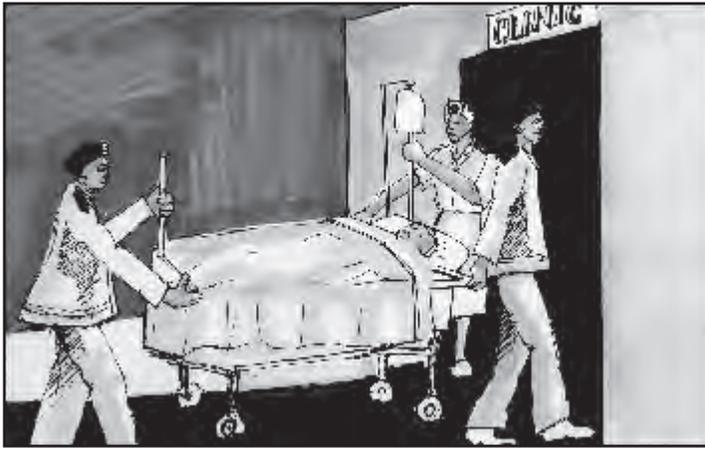
A HEALTHY AND SAFE ENVIRONMENT

Everyone has the right to a healthy and safe environment that will ensure their physical and mental health or well-being, including adequate water supply, sanitation and waste disposal as well as protection from all forms of environmental danger, such as pollution, ecological degradation or infection.



PARTICIPATION IN DECISION-MAKING

Every citizen has the right to participate in the development of health policies and everyone has the right to participate in decision-making on matters affecting one's health.



ACCESS TO HEALTHCARE

Everyone has the right of access to health care services that include:

- i. receiving timely emergency care at any health care facility that is open regardless of one's ability to pay;
- ii. treatment and rehabilitation that must be made known to the patient to enable the patient to understand such treatment or rehabilitation and the consequences thereof;
- iii. provision for special needs in the case of newborn infants, children, pregnant women, the aged, disabled persons, patients in pain, person living with HIV or AIDS patients;
- iv. counselling without discrimination, coercion or violence on matters such as reproductive health, cancer or HIV/AIDS;
- v. palliative care that is affordable and effective in cases of incurable or terminal illness;
- vi. a positive disposition displayed by health care providers that demonstrate courtesy, human dignity, patience, empathy and tolerance; and
- vii. health information that includes the availability of health services and how best to use such services and such information shall be in the language understood by the patient.

KNOWLEDGE OF ONE'S HEALTH INSURANCE/MEDICAL AID SCHEME

A member of a health insurance or medical aid scheme is entitled to information about that insurance or medical aid scheme and to challenge, where necessary, the decisions of such health insurance or medical aid scheme relating to the member.



CHOICE OF HEALTH SERVICES

Everyone has the right to choose a particular health care provider for services or a particular health facility for treatment provided that such choice shall not be contrary to the ethical standards applicable to such health care providers or facilities, and the choice of facilities in line with prescribed service delivery guide lines.



BE TREATED BY A NAMED HEALTH CARE PROVIDER

Everyone has the right to know the person that is providing health care and therefore must be attended to by clearly identified health care providers.

CONFIDENTIALITY AND PRIVACY

Information concerning one's health, including information concerning treatment may only be disclosed with informed consent, except when required in terms of any law or an order of the court.



INFORMED CONSENT

Everyone has the right to be given full and accurate information about the nature of one's illnesses, diagnostic procedures, the proposed treatment and the costs involved, for one to make a decision that affects anyone of these elements.



BE REFERRED FOR A SECOND OPINION

A person may refuse treatment and such refusal shall be verbal or in writing provided that such refusal does not endanger the health of others.

CONTINUITY OF CARE

No one shall be abandoned by a health care professional worker or a health facility which initially took responsibility for one's health.



COMPLAIN ABOUT HEALTH SERVICES

Everyone has the right to complain about health care services and to have such complaints investigated and to receive a full response on such investigation.

Responsibilities of the PATIENT

Every patient or client has the following responsibilities:

- ✦ To advise the health care providers on his or her wishes with regard to his or her death.
- ✦ To comply with the prescribed treatment or rehabilitation procedures.
- ✦ To enquire about the related costs of treatment and/or rehabilitation and to arrange for payment.
- ✦ To take care of health records in his or her possession.
- ✦ To take care of his or her health.
- ✦ To care for and protect the environment.
- ✦ To respect the rights of other patients and health providers.
- ✦ To utilise the health care system properly and not abuse it.
- ✦ To know his or her local health services and what they offer.
- ✦ To provide health care providers with the relevant and accurate information for diagnostic, treatment, rehabilitation or counselling purposes.

Appendix K:

UNAIDS/WHO POLICY STATEMENT ON HIV TESTING



The Context

As access to antiretroviral treatment is scaled up in low and middle income countries, there is a critical opportunity to simultaneously expand access to HIV prevention, which continues to be the mainstay of the response to the HIV epidemic. Without effective HIV prevention, there will be an ever increasing number of people who will require HIV treatment. Among the interventions which play a pivotal role both in treatment and in prevention, HIV testing and counselling stands out as paramount.

The current reach of HIV testing services remains poor: in low and middle income countries only 10 per cent of those who need voluntary counselling and testing, because they may have been exposed to HIV infection, have access to it. Even in settings in which voluntary counselling and testing is routinely offered, such as programmes for prevention of mother-to-child transmission, the number of people who avail themselves of these services remains low in many countries. The reality is that stigma and discrimination continue to stop people from having an HIV test.

To address this, the cornerstones of HIV testing scale-up must include improved protection from stigma and discrimination as well as assured access to integrated prevention, treatment and care services. The conditions under which people undergo HIV testing must be anchored in a human rights approach which protects their human rights and pays due respect to ethical principles. (cf Appendix 1). Young people require special attention to their needs through the provision of confidential youth friendly health services. Public health strategies and human rights promotion are mutually reinforcing.

The conditions of the '3 Cs', advocated since the HIV test became available in 1985, continue to be underpinning principles for the conduct of HIV testing of individuals. Such testing of individuals must be:

- + **confidential**
- + be accompanied by **counselling**
- + only be conducted with informed **consent**, meaning that it is both informed and voluntary.

In many low and middle income countries, the primary model for HIV testing has been the provision of **client-initiated** voluntary counselling and testing services. Increasingly, **provider-initiated** approaches in clinical settings are being promoted, i.e. health care providers routinely initiating an offer of HIV testing in a context in which the provision of, or referral to, effective prevention and treatment services is assured. To reach people in need of treatment, tens of millions of tests will have to be conducted among those who may have been exposed to HIV.

UNAIDS/WHO recommend that the following four types of HIV testing be clearly distinguished:

1) Voluntary counselling and testing

Client-initiated HIV testing to learn HIV status provided through voluntary counselling and testing, remains critical to the effectiveness of HIV prevention. UNAIDS/WHO promote the effective promotion of knowledge of HIV status among any population that may have been exposed to HIV through any mode of transmission. Pre-testing counselling may be provided either on an individual basis or in group settings with individual follow-up. UNAIDS/WHO encourage the use of rapid tests so that results are provided in a timely fashion and can be followed up immediately with a first posttest counselling session for both HIV-negative and HIV-positive individuals.

2) Diagnostic HIV testing is indicated whenever a person shows **signs or symptoms** that are consistent with HIV-related disease or AIDS to aid clinical diagnosis and management. This includes HIV testing for all **tuberculosis** patients as part of their routine management.

3) A routine offer of HIV testing by health care providers should be made to all patients being:

- + assessed in a **sexually transmitted infection** clinic or elsewhere for a sexually transmitted infection — to facilitate tailored counselling based on knowledge of HIV status
- + seen in the context of pregnancy — to facilitate an offer of **antiretroviral prevention of mother-to-child transmission**
- + seen in clinical and community based health service settings where **HIV is prevalent and antiretroviral treatment is available** (injecting drug use treatment services, hospital emergencies, internal medicine hospital wards, consultations etc.) but who are **asymptomatic**.

Explicit mechanisms are necessary in provider-initiated HIV testing to promote **referral to post-test counselling services** emphasising prevention, for all those being tested, and to **medical and psychosocial support**, for those testing positive. The basic conditions of confidentiality, consent and counselling apply but the standard pre-test counselling used in VCT services is adapted to simply ensure informed consent, without a full education and counselling session. The minimum

amount of information that patients require in order to be able to provide **informed consent** is the following:

- the clinical benefit and the prevention benefits of testing
- the right to refuse
- the follow-up services that will be offered and in the event of a positive test result, the importance of anticipating the need to inform anyone at ongoing risk who would otherwise not suspect they were being exposed to HIV infection

For provider-initiated testing, whether for purposes of diagnosis, offer of antiretroviral prevention of mother-to-child transmission or encouragement to learn HIV status, patients retain the right to refuse testing, i.e. to 'opt out' of a systematic offer of testing.²¹

4) Mandatory HIV screening

UNAIDS/WHO support mandatory screening for HIV and other blood borne viruses of all blood that is destined for transfusion or for manufacture of blood products. Mandatory screening of donors is required prior to all procedures involving transfer of bodily fluids or body parts, such as artificial insemination, corneal grafts and organ transplant.

UNAIDS/WHO do not support mandatory testing of individuals on public health grounds. Voluntary testing is more likely to result in behaviour change to avoid transmitting HIV to other individuals. Recognising that many countries require HIV testing for immigration purposes on a mandatory basis and that some countries conduct mandatory testing for pre-recruitment and periodic medical assessment of military personnel for the purposes of establishing fitness, UNAIDS/WHO recommend that such testing be conducted only when accompanied by counselling for both HIV-positive and HIV-negative individuals and referral to medical and psychosocial services for those who receive a positive test result.

²¹ HIV testing without consent may be justified in the rare circumstance in which a patient is unconscious, his or her parent or guardian is absent, and knowledge of HIV status is necessary for purposes of optimal treatment.

Appendix L:

ENSURING A RIGHTS BASED APPROACH

The global scaling up of the response to AIDS, particularly in relation to HIV testing as a prerequisite to expanded access to treatment, must be grounded in sound public health practice and also respect, protection, and fulfillment of human rights norms and standards.

The voluntariness of testing must remain at the heart of all HIV policies and programmes, both to comply with human rights principles and to ensure sustained public health benefits.

The following key factors, which are mutually reinforcing, should be addressed simultaneously:

1. Ensuring an ethical process for conducting the testing, including defining the purpose of the test and benefits to the individuals being tested; and assurances of linkages between the site where the test is conducted and relevant treatment, care and other services, in an environment that guarantees confidentiality of all medical information;
2. Addressing the implications of a positive test result, including non-discrimination and access to sustainable treatment and care for people who test positive
3. Reducing HIV/AIDS-related stigma and discrimination at all levels, notably within health care settings;
4. Ensuring a supportive legal and policy framework within which the response is scaled up, including safeguarding the human rights of people seeking services;
5. Ensuring that the healthcare infrastructure is adequate to address the above issues and that there are sufficient trained staff in the face of increased demand for testing, treatment, and related services.

UNAIDS Global Reference Group on HIV/AIDS and Human Rights

Appendix L:

CONFIDENTIALITY AGREEMENT

The purpose of the confidentiality agreement is to help participants to feel safe and comfortable speaking openly about their experiences and opinions during the discussion. Note that the confidentiality agreement asks you not to discuss any potentially identifiable information outside of the session — you can and should continue to discuss the issues raised in the session with your co-workers and communities.

Confidentiality Agreement

As an attendee of the “HIV/AIDS Stigma and Discrimination Trigger Scenarios” discussion, I understand that I may have access to confidential information about participants, including their HIV status or other medical conditions. By signing this statement:

- ♦ I agree not to divulge, publish, or otherwise make known the identities of participants in these training sessions.
- ♦ I agree not to divulge, publish or otherwise make known any potentially identifiable information shared by participants in the training sessions, either about themselves or others.

Signature _____ Date _____

Printed Name _____

Appendix M:

EVALUATION FORM

Participant Evaluation: Stigma and Discrimination Trigger Scenarios

Information collected from this form will enable us to assess the effectiveness and impact of these materials, and strengthen and improve materials such as these in the future. It is not necessary to put your name on this form.

Please check the scenario(s) you viewed in today's training or session:

- | | |
|--|--|
| <input type="checkbox"/> Scenario 1: Ms. Dawson's meeting | <input type="checkbox"/> Scenario 8: Assumptions |
| <input type="checkbox"/> Scenario 2: Who say that big man doh cry? | <input type="checkbox"/> Scenario 9: HIV is a reality, sister! |
| <input type="checkbox"/> Scenario 3: When push comes to shove | <input type="checkbox"/> Scenario 10: I chyah dance |
| <input type="checkbox"/> Scenario 4: Taking chances | <input type="checkbox"/> Scenario 11: What brings you here? |
| <input type="checkbox"/> Scenario 5: Better a positive spirit | <input type="checkbox"/> Scenario 12: Oh, by the way... |
| <input type="checkbox"/> Scenario 6: You know how long me a wait | <input type="checkbox"/> Scenario 13: Look at him now! |
| <input type="checkbox"/> Scenario 7: Test? What test? | |

What is your job title (i.e. nurse, lab technician, janitor, etc)? _____

* * * * *

Please reflect on the trigger scenario(s) and discussion(s) and respond to the questions below.

1. Please list 3 things that you learned from today's video and discussion:

2. What was the most powerful or surprising moment during today's session?

3. Did the session change your thinking about any aspect of HIV/AIDS testing, care or treatment?

4. What will you do differently when you return to your work place as a result of today's video and discussion?

5. Do you have any suggestions for how these materials could be improved?

6. Other Comments:

HIV/AIDS stigma and discrimination pose unique challenges for health care workers in the Caribbean. In this training package, 13 short video scenarios (each between 30 sec. and 5 min. long) are presented to “trigger” discussion about common situations in Caribbean health care settings where HIV/AIDS stigma and discrimination may occur and can be prevented. The trigger scenarios portray dramatized voices of health care workers, patients, and community members as they confront the personal ramifications of the HIV/AIDS epidemic and its impact on health care systems.

The video scenarios and discussion guides provide opportunities to:

- **IDENTIFY, ANALYZE, AND DISCUSS CAUSES** of HIV/AIDS stigma and discrimination in local settings
- **DISCUSS BASIC FACTS** related to HIV/AIDS transmission and prevention
- **INCREASE AWARENESS** of patients’ rights and human rights
- **REFLECT UPON PERSONAL VALUES AND BELIEFS** related to stigma and discrimination
- **REVEAL THE HUMAN FACE** behind stories of PLWHA in the Caribbean
- **MODEL BEHAVIOURS** that can reduce stigma and discrimination
- **IDENTIFY PERSONAL AND INSTITUTIONAL ACTIONS** that can be taken to reduce or eliminate HIV/AIDS stigma and discrimination in local settings

The 13 video scenarios can be used individually or together in any combination. A companion Facilitator Guide provides instructions for effective use of each trigger scenario, including suggested discussion questions and activities. Please note that these videos should only be used in a training setting with an experienced facilitator.

*Total Program Length: 13 scenarios, each under 5 minutes
Color, English*



This project is produced by the International Training and Education Center on HIV (I-TECH) for the Caribbean HIV/AIDS Regional Training (CHART) network. I-TECH supports the ongoing development of health care worker training systems that are locally-determined, optimally resourced, highly responsive, and self-sustaining in countries and regions hardest hit by the AIDS epidemic. For more information about I-TECH, visit www.go2itech.org. CHART is designed to serve the Caribbean region through training centres that utilise cost-effective mechanisms, institutions and concepts for the ongoing training and development of healthcare workers. For more information about CHART, visit www.chartcaribbean.org.

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