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# ATTITUDES AND BEHAVIORS REPORT

## GUYANA SAFER INJECTION PROJECT

MARCH 2005

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GUYANA  
MINISTRY OF HEALTH



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Nadya S. Nikiforova of FHI (Arlington, USA) oversaw assessment design, developed research instruments, trained and managed local focus group facilitators, conducted many focus groups and in-depth interviews on the ground, analyzed data, and wrote the final report. Paul W. Nary of FHI (Arlington, USA) provided essential guidance during the research design phase, day-to-day advice during the implementation of this assessment, and critically important recommendations for the development and editing of the final report.

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Finally, our gratitude and appreciation go to all the research participants who generously took time to share their thoughts and feelings with us. Their openness and candor gave substance to this report by providing deep insights into their lives. We appreciate their participation that made this effort possible.

# ATTITUDES AND BEHAVIORS REPORT

## GUYANA SAFER INJECTION PROJECT

NADYA S. NIKIFOROVA  
PAUL W. NARY

This report contains the findings of focus group discussions and in-depth interviews conducted by Family Health International and Initiatives Inc. to assess practices and attitudes toward the use of injections and disposal of sharps in Guyana. The report was prepared under the auspices of the Technical Assistance and Support Contract (TASC2 Global Health), implemented by Initiatives Inc. under Task Order No. GHS-I-02-03-00040-00 with the U.S. Agency for International Development.

Initiatives Inc.  
376 Boylston Street, Suite 4C  
Boston MA 02116 USA  
TEL (617) 262-0293  
FAX (617) 262-2514  
[www.initiativesinc.com](http://www.initiativesinc.com)

Family Health International  
2101 Wilson Blvd, Suite 700  
Arlington VA 22201 USA  
TEL (703) 516-9779  
FAX (703) 516-9781  
[www.fhi.org](http://www.fhi.org)

### **DISCLAIMER**

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## **LIST OF ABBREVIATIONS**

AIDS .....	Acquired Immuno-Deficiency Syndrome
FHI .....	Family Health International
GSIP .....	Guyana Safe Injection Project
GPHC.....	Georgetown Public Hospital Corporation
MOH .....	Ministry of Health
NGO .....	Non-Governmental Organization
PEP .....	Post-Exposure Prophylaxis
PEPFAR .....	President’s Emergency Plan for AIDS Relief
SIGN.....	Safe Injection Global Network
SIP .....	Safe Injection Plan
USAID .....	United States Agency for International Development
WHO .....	World Health Organization

## EXECUTIVE SUMMARY

This report presents the process and key findings of the qualitative assessment that took place under the auspices of the Guyana Safe Injection Project (GSIP) between November 22nd and December 15th, 2004. The report also recommends behavior change communication (BCC) interventions that may be integrated into the pilot project. GSIP is managed and implemented by Initiatives, Inc., and Family Health International (FHI) is a subcontractor responsible for the behavior change communication component of the project.

## PROJECT BACKGROUND

Guyana Safe Injection Project (GSIP), supported by the President's Emergency Plan for AIDS Relief, is designed to prevent the medical transmission of HIV by reducing unsafe and inappropriate injections in Guyana. A country of 750,000, Guyana has a reported HIV/AIDS rate of 2.5%, the second highest in the region. In 2000 AIDS became the 2nd largest cause of mortality, leading the statistics for potential years of life lost by a substantial margin. Unsafe and unnecessary injections exacerbate the problem by increasing the risk of HIV transmission by needle stick exposures for health care workers and the general public. The World Health Organization (WHO) estimates the number of injections per person in the Caribbean region to be 1.7 and the proportion of reuse 1.2%.

It is envisaged that GSIP will draw from the tools and resources developed under the Safe Injection

Global Network (SIGN) and follow the three-step strategy it supports: 1) providing communication for behavior change by targeting health care workers, policy makers, waste handlers and community members to promote safe injection practices; 2) ensuring availability of equipment and supplies to eliminate unsafe injections due to lack or inappropriate use of equipment; and 3) managing waste safely and appropriately to limit disease transmission.

The first phase of the GSIP will be to design and implement a pilot project in selected sites. The pilot project will test different strategies to improve injection safety by addressing the following:

- 1) training and capacity building of healthcare prescribers, health providers and facility managers in safe injection practices;
- 2) improving equipment, supplies and commodity management to ensure availability of safe injection equipment;
- 3) behavior change communication and advocacy interventions to reduce the number of unnecessary and inappropriate injections;
- 4) developing and strengthening sharps waste management.

The results of the pilot project will consequently be used to develop the National Injection Safety Plan through a consultative process with all the essential stakeholders. The findings of this formative assessment, therefore, will be used to inform the design and implementation of the pilot

project as well as the national strategy.

## METHODOLOGY

To provide a solid, evidence-based foundation for behavior change communication interventions, FHI has conducted a qualitative formative assessment on the following key audiences:

- prescribers – medical doctors who make decisions about treatment, including injections (14 respondents);
- providers – medical workers, such as nurses, Medex, and dentists who administer injections (49 respondents);
- waste handlers, such as hospital porters and maids, who work with medical waste (53 respondents);
- waste carriers who handle waste once it leaves a medical facility (15 respondents); and
- patients who receive injections (85 respondents).

The respondents were from the five pilot intervention sites in Georgetown (Region IV), Skeldon and New Amsterdam (Region VI), Bartica (Region VII) and Linden (Region X). All in all, the assessment included 221 respondents assessed via 23 focus group discussions (FGD) and 31 in-depth interviews (IDI) (please see chart below for details.) Every focus group consisted of 5 to 11 participants, and most respondents in the provider, prescriber and waste handler category were recruited from the facilities selected for the pilot sites.

	<b>Region IV</b>	<b>Region VI</b>	<b>Region VII</b>	<b>Region X</b>	<b>Total</b>
<b>Prescribers</b>	1 FGD 2 IDIs	4 IDIs		3 IDIs	1 FGD 9 IDIs 14 respondents
<b>Providers</b>	3 FGD 1 mixed FGD	1 FGD	1 IDI	1 FGD	6 FGD 1 IDI 49 respondents
<b>Waste handlers</b>	2 FGD	2 FGD	1 FGD	1 FGD	6 FGD 53 respondents
<b>Waste carriers</b>	1 FGD	1 FGD	4 IDIs	1 IDI	2 FGD 5 IDIs 15 respondents
<b>Patients</b>	3 IDIs 4 mixed FGD	3 FGD	1 FGD	8 IDIs	8 FGD 11 IDIs 85 respondents
<b>TOTALS*</b>					<b>23 FGD</b> <b>31 IDIs</b> <b>221 respondents</b>

\*An additional five interviews with policymakers are not reflected in the matrix, but are included in the totals.

Several policy makers in occupational safety, healthcare policy and waste management areas were also interviewed. Please see Appendix I for a detailed breakdown of research program by regions, pilot sites and respondents, including their affiliation with pilot site facilities.

## KEY FINDINGS

### PROVIDERS

- Nurses and Medex stated that they see themselves as important professionals and vital figures in their communities. They said that a big part of their job satisfaction came from feeling appreciated and respected.
- Most nurses and Medex said they cared deeply about their jobs, and seeing their patients improve and return to health was a major motivation of their professional lives.

- Many providers reported personal experiences with needlestick injuries and a strong fear of HIV infection.
- While providers said that their choice of patient's treatment was dictated only by medical necessity, they stated that injections were a faster and stronger way of delivering medication, especially for pain relief. They also said that their patients felt the same way and strongly preferred injections to tablets, although some were uncomfortable with receiving shots.
- Respondents said that good relationships and communication with patients were paramount, and that they were capable of finding a right approach to establish effective connections with patients.

- Disposal of sharps was an issue. Many respondents were interviewed, including nurses in the only hospital with the most consistent approach to segregation, said they were dissatisfied with one or more aspects of the disposal procedures and felt that they were not protected well enough from risk.

### PRESCRIBERS

- Prescribers said that they considered themselves important figures in their communities who do valuable work. They stated that their work takes place under heavy constraints, and most of their job satisfaction came from helping their patients improve their health.
- The majority of medical doctors interviewed said that patients across Guyana, particularly older people, had

a strong preference for injections compared to other forms of treatment, and were prepared to go out of their way to make sure they get one, even if they had to go to a private doctor and pay more.

- The doctors said they were happy to answer more questions and provide more explanations to their patients.
- Prescribers reported that their choice of treatment is dictated only by what is medically necessary. With a few exceptions, they did not say that injections are a preferred choice of treatment, and reported that their choice of treatment was driven by what they thought was right, not by what patients preferred.
- Disposal procedures were guided by individual circumstances in each facility, and prescribers said they were not widely aware of what happens to used sharps once they left the facility.

#### **WASTE HANDLERS<sup>1</sup>**

- Medical waste handlers said their jobs were important for effective operation of their hospitals and health centers. However, many of them said they were not given proper respect by their coworkers, such as doctors or nurses, because of their “lowly” status and association with trash.

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<sup>1</sup> Workers employed by hospitals or health centers responsible for removal and treatment of medical waste and/or preparation of waste for subsequent pickup by waste carriers.

- Waste handlers said that doctors and nurses routinely disregard the rules for safe disposal of sharps and create additional risks for porters and maids by discarding needles in a careless manner. They said they did not feel that they can communicate their dissatisfaction to these workers without repercussions due to their perceived low status.
- Procedures and available equipment for disposal of sharps varied across different hospitals and health centers. Regardless of specific details, most respondents said that the equipment they use is not as safe as it should be. Reports of needles found around the facilities were common.
- Most waste handlers said they were aware that their job places them at risk of HIV infection. Many of them said they did not feel safe on the job, and most underscored the need to use protective gear, although they were not entirely satisfied with the protection that their gear provided.
- Reports of needlestick injuries were common across all regions and medical facilities. Many respondents said they were aware of the steps they need to follow after getting stuck. Many also said they needed more training on handling the risks they face on a daily basis.

#### **WASTE CARRIERS<sup>2</sup>**

- Waste carriers said their jobs were important for the well-being of their communities, but many said they felt disrespected and disregarded by the community because of their “lowly” status and association with garbage.
- Waste carriers said the medical staff routinely disregarded the rules for safe disposal of sharps and created additional risks for sanitation workers by exposing them to sharps and needles. While respondents said they could easily communicate their frustration to their supervisors, it would not make much difference in the behavior of medical staff at the facilities that generated the waste.
- Procedures followed by different municipalities for disposal of sharps varied; the common thread was dissatisfaction of sanitation workers with the way the medical waste was segregated and packaged for pick-up. Reports of needles and sharps found in medical waste were common.
- Respondents did not report a high number of incidents of needles found on the streets or elsewhere in the community. However, needles were often seen at dump sites, which they attributed to scavengers and

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<sup>2</sup> Workers employed by municipal agencies or town authorities responsible for removal of waste from residential and commercial properties at their localities, including, but not limited to, hospitals and health centers.

drug users who opened the bags to look for items they could use.

- Most sanitation workers were aware that contact with needles and sharps places them at risk of HIV infection. Many said they do not feel safe on the job, and most underscored the need for more protection and training on dealing with the risks they faced.
- Reports of needlestick injuries were common in all regions. Many respondents were aware that a needlestick injury requires immediate medical attention and must be brought to their supervisor’s attention.
- Members of the waste management community said they were dissatisfied with medical waste disposal, and wanted to limit or eliminate their contact with sharps and needles.

**PATIENTS**

- The patients interviewed uniformly said that injections deliver faster and stronger relief, in addition to being easier and more convenient because there was no need to remember to take tablets for many days. Many of them said they had painful experiences with injections, and many expressed fear of shots, but that did not alter their perception that injections brought better relief than oral medication.
- Clients stated that they could discuss their condition with the doctors and ask questions if necessary, but they did not express a strong desire to insist on alternative treatments if they didn’t like what the doctor prescribed. In fact, many of them said that interfering with a doctor’s prescription was inappropriate.

- Clients’ responses made it clear that they were aware of the risks of handling dirty/used needles, with a special emphasis on HIV/AIDS, and said that disposal of these sharps in their localities needs to be improved. However, this was not a point of great concern to the clients.

**RECOMMENDATIONS**

Based on the findings of this assessment, FHI believes that BCC interventions should place a special emphasis on providers and prescribers who make decisions about treatment on a daily basis – decisions that clients, based on their reported opinions, are largely happy to leave to them. Under these circumstances, interventions tailored to the needs of healthcare workers will be likely to deliver practical, tangible results to meet GSIP objectives. In addition, suggested BCC interventions may include:

**Shorter Term (May Be Site-Specific)**

Providers	<ol style="list-style-type: none"> <li>1. Development of training modules to improve communication skills. These training modules will be focused on doctor/nurse and nurse/patient contexts, and contain exercises and role plays tailored to providers’ needs. The modules for this training will be developed based on FHI’s in-house experience and expertise in training healthcare providers and adaptation of tested SIGN toolkit interventions. These training modules will need to be adapted to the needs and realities of Guyana’s health workers through ongoing collaboration with stakeholders to ensure buy-in and acceptance of this training.</li> <li>2. Training sessions based on the modules described above.</li> <li>3. Job aids on safe and appropriate injection practices, post-exposure prophylaxis and safe sharps disposal. These aids can take the form of wall charts, cue cards and posters to be displayed in medical facilities, and should be adapted to the needs of specific facilities and stakeholders in Guyana.</li> </ol>
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Prescribers	<p>1. Development of training modules to improve communication skills. These training modules will be focused on doctor/nurse and doctor/patient contexts, and contain exercises and role plays tailored to prescribers' needs. The modules for this training will be developed based on FHI's in-house experience and expertise in training healthcare providers and adaptation of tested SIGN toolkit interventions. These training modules will need to be adapted to the needs and realities of Guyana's health workers through ongoing collaboration with stakeholders to ensure buy-in and acceptance of this training;</p> <p>2. Training sessions based on the modules described above.</p> <p>3. Job aids on safe and appropriate injection practices, post-exposure prophylaxis and safe sharps disposal. These aids can take the form of wall charts, cue cards and posters to be displayed in medical facilities, and should be adapted to the needs of specific facilities and stakeholders in Guyana.</p>
Patients	<p>1. Materials on safe and appropriate injection use. These can include posters, brochures and pictures to be displayed at medical facilities or distributed through community outreach carried out by local non-government organizations.</p> <p>2. Articles in print media and broadcast programming (such as radio scripts, TV talk shows and news items) promoting safe injection and proper disposal practices.</p>
Waste handlers	<p>1. Development of training modules to improve communication skills. These training modules will be focused on nurse/waste handler context, and contain exercises and role plays tailored to waste handlers' needs. The modules for this training will be developed based on FHI's in-house experience and expertise in training healthcare providers and adaptation of tested SIGN toolkit interventions. These training modules will need to be adapted to the needs and realities of Guyana's health workers through ongoing collaboration with stakeholders to ensure buy-in and acceptance of this training.</p> <p>2. Training sessions based on the modules described above.</p> <p>3. Job aids on safe disposal and work safety (including post-exposure prophylaxis). These can include posters, wall charts, stickers, etc. to be used at various job locations.</p>
Waste carriers	<p>1. Job aids on safe disposal and work safety (including post-exposure prophylaxis). These can include posters, wall charts, stickers, etc. to be used at various job locations.</p>

**Longer-Term  
(May Be Site-Specific Or  
Nationwide)**

- Advocacy activities targeting Guyana's Ministry of Health to promote adoption and dissemination of new guidance on safe and appropriate injections, disposal of sharps and post-exposure prophylaxis;
- Advocacy activities targeting professional medical, nursing and dental associations to promote safe and appropriate injections, disposal of sharps and post-exposure prophylaxis;

- Articles in professional publications (if these exist) for doctors or the use of existing publications promoting fewer prescriptions of injections and the importance of safe disposal practices;
- Articles in professional publications (if these exist) for nurses or the use of existing publications promoting safe disposal practices and reduction of needlestick injuries;
- FHI will explore potential areas of collaboration with NGOs and FBOs to include entertainment, theatre and

drama as channels for conveying messages about injection safety;

- Personal testimonies of doctors who decided to prescribe fewer injections and nurses who follow safer disposal practices to reduce the number of needlestick injuries;
- Peer education on the use of safety gear among waste handlers and waste carriers.

Please note that the suggestions above are meant to be a starting point for further discussions aimed at selecting the appropriate plan of interventions. Final recommendations will be based on

the results of site visits scheduled in February/March and consultations with essential stakeholders and local GSIP team and key project consultants, as well as budgetary limitations. These decisions will be guided by the specific needs of each pilot site and other programming elements as appropriate. As always, it will be critically important that the team works closely with the stakeholders to ensure buy-in and acceptance of the interventions.

## I. PROJECT BACKGROUND

Guyana Safe Injection Project (GSIP), supported by the President's Emergency Plan for AIDS Relief funds, is designed to prevent the medical transmission of HIV by reducing unsafe and inappropriate injections in Guyana. A country of 750,000, Guyana has a reported HIV/AIDS rate of 2.5%, the second highest in the Caribbean region. In 2000 AIDS became the 2nd largest cause of mortality, leading the statistics for potential years of life lost by a substantial margin.

Unsafe and unnecessary injections exacerbate the problem by increasing the risk of HIV infection through needlestick injuries for health care workers and the general public. WHO estimates the number of injections per person in the Caribbean region to be 1.7 and the proportion of reuse 1.2%.

Guyana Safe Injection Project will draw from the tools and resources developed under the Safe Injection Global Network (SIGN) and follow the three-step strategy it supports:

- 1) Providing communication for behavior change by targeting health care workers, policy makers, waste handlers and community members to promote safe injection practices.
- 2) Ensuring availability of equipment and supplies to eliminate unsafe injections due to lack or inappropriate use of equipment.
- 3) Managing waste safely and appropriately to limit disease transmission due to sharps.

The project team will build on existing efforts, working collaboratively with the offices overseeing the national response, such as the Presidential Commission on HIV/AIDS, the National AIDS

Programme Secretariat, the National AIDS Committee and the Expanded UN HIV/AIDS Theme Group, as well as donor supported projects relevant to safe injection objectives. Advisory councils under these offices will assist the development of an appropriate National Safe Injection Group. Policies and procedures developed under the immunization program, the Georgetown Hospital Occupational, Safety and Health Department and MOH policies will be reviewed for their adaptability potential. The project implementation will include the following major phases:

- 1) Assess current injection practices within the public sector (and private sector, if possible) from both a client and provider perspective.
- 2) Draft a national plan that includes the safe and appropriate use of injections with recommendations for a pilot project to improve injection safety in selected areas.
- 3) Design and field test a project to enhance injection safety in selected areas including improving provider skills, procurement and management of equipment, managers' awareness and skills and advocacy to reduce demand.
- 4) Develop and implement an advocacy strategy for wider

public understanding and support to the development of the national injection safety plan.

- 5) Finalize the National Plan for Injection Safety.

The formative assessment described in this report was conducted to inform development and implementation of the behavior change communication strategy for the pilot sites (Stage 3 above) as well as development of the national safe injection strategy.

## II. ASSESSMENT GOALS AND METHODOLOGY

### GOALS OF ASSESSMENT

Planning for behavior change must necessarily begin with understanding the present behavior of the target audiences and the reasons why this behavior is being practiced. To address this need, the assessment targeted the perceptions, feelings, and motivations surrounding the use of injections and disposal of used needles held by medical personnel, patients and handlers of medical waste. In addition, the professional concerns, hopes and/or aspirations of target audiences were also explored.

### SCOPE OF ASSESSMENT: TARGET AUDIENCES

This assessment targeted the following key audiences:

- 1) *Prescribers*. This target audience includes the medical professionals who make a decision on the use of injections for patients - primarily medical doctors who work at the variety of healthcare facilities, such as hospitals, clinics and individual doctor's offices.
- 2) *Providers*. This group includes medical professionals who physically administer injections to patients, such as nurses, dentists, and Medex.
- 3) *Medical waste handlers*. This group includes auxiliary medical workers who typically work at a hospital or other medical facilities and are responsible for collecting and

disposing of medical waste, including sharps and used needles.

- 4) *Waste carriers*. This target audience covers those who serve as a link between disposal of medical wastes at hospitals and other medical facilities and municipal dumpsites. The members of this group typically work for the government services or private companies that deliver hospital and other waste to the municipal dumping sites and implement its further disposal.
- 5) *Patients*. This key group includes a diverse mix of community members who receive injections at hospitals and other medical facilities. These are the members of the "general public" who routinely use medical services and facilities.

### SCOPE OF ASSESSMENT: AREAS OF INVESTIGATION

#### PRESCRIBERS

- Feelings and beliefs about injections and choice of treatment
- Perceptions of patients' feelings about injections
- Awareness of risks associated with injections, including disposal and needlesticks
- Environmental factors that encourage or restrict prescription of injections
- Disposal practices
- Sources of information

- Professional hopes and dreams
- Communication with patients

#### PROVIDERS

- Feelings and beliefs about injections and choice of treatment
- Perceptions of patients' feelings about injections
- Awareness of risks associated with injections, including disposal and needlestick injuries
- Awareness of risks associated with injections, including disposal of needles and needlestick injuries
- Disposal practices
- Professional hopes and dreams
- Communication with patients
- Sources of information

#### PATIENTS

- Perceptions and beliefs about injections and their efficacy
- Awareness of risks associated with injections and dirty needles
- Feelings and beliefs about disposal of used needles
- Awareness of risks of handling dirty needles in the environment
- Sources of information on health-related subjects

- Hopes and dreams
- Communication with providers and prescribers

## WASTE HANDLERS

- Awareness of risks of handling used needles, including needlesticks
- Disposal practices
- Perceptions and experiences of occupational risks and personal safety on the job
- Hopes and dreams
- Communication with medical personnel

## WASTE CARRIERS

- Awareness of risks of handling used needles, including needlesticks
- Experiences with used needles found in the environment
- Disposal practices for medical waste
- Perceptions and experiences of occupational risks and safety on the job
- Hopes and dreams

## SEGMENTATION

Decisions made by medical professionals and members of the general public surrounding the use of injections are determined by a variety of factors associated with each individual's background and environment. A doctor working at a large city hospital may not have

the same views on the use of injections and disposal of needles as a nurse working at a small rural clinic. Likewise, a young male patient who lives in a major city may approach injections differently from an older woman who lives in a remote rural area. We did not necessarily expect to find significant differences between subgroups, but we felt that it was important to include as many subgroups as possible to ensure that results were comprehensive.

The target audiences were therefore segmented as follows:

- *prescribers* were segmented into urban/rural subgroups. We originally planned for the additional segmentation of public vs. private physicians, but early into the assessment it became clear that this distinction was immaterial because most public physicians had private practices and thus belong to both groups;
- *providers* were segmented into nurses/Medex/dentists in the rural and urban categories;
- *waste handlers* were segmented into subgroups of those based at hospitals and those based at health centers. Conveniently, this distinction closely matched the rural/urban divide, so further segmentation was unnecessary;
- *waste carriers* were divided into rural/urban subgroups;
- finally, *patients* were divided into male/female, urban/rural and under 25/over 25. The under 25/over 25 age

segmentation was chosen because it is likely that there will be significant differences in the ways that older and younger people perceive health risks and process health-related information, as well as their values and goals. People over 25 are also more likely to have had children, which becomes a factor in their attitudes toward health risks and personal motivations.

## METHODOLOGY

This assessment relied on the qualitative methods of focus group discussions and in-depth interviews. These methods are most useful when the proposed research aims to explore deeper feelings, perceptions and reasons that guide human behavior that do not lend themselves well to quantitative inquiries. Focus group discussions and in-depth interviews allow for probing and exploration of the underlying motivations and ambitions, and provide rich insights that will be useful during development of messages and communication strategies.

Because of time and logistical limitations, the recommended numbers of focus group discussions and in-depth interviews was minimal while at the same time adequate to assure validity of results. In addition, the team had to make last-minute adjustments based on the circumstances in the field. Although the recommended numbers are two focus groups and 10 to 15 interviews per variable (such as urban/rural, male/female, etc.), some regions simply did not have the necessary numbers of participants (for instance, only three waste carriers or one prescriber per site), so the team

did what was possible under the circumstances to ensure the maximum coverage. The team also had to allow for flexibility when the necessary numbers of participants for a focus group were not available and in-depth interviews had to be conducted instead.

The chart below provides a brief breakdown of focus groups and in-depth interviews conducted during the assessment. Please also see Appendix I for a detailed breakdown of focus groups and interviews across subgroups and regions.

## PROCESS

The assessment began with two days of team discussions, planning, and overview of research plans and training of the team (including role playing of FGDs/IDIs.) Facilitator guides (adapted from the focus group guides in the SIGN Toolkit) were reviewed and discussed at that time, and adjustments made based on the input of the team members. (See Appendix 2 for complete focus group facilitator guides for each key audience.)

Each interview and focus group discussion took between 1 and 2 hours. All, with a few exceptions where participants objected, were tape-recorded and consequently transcribed. Participant information

sheets (age, location, gender) and consent forms were collected and are available from FHI upon request (see Appendix 3 for a copy of the consent form). Transcripts of all focus groups and interviews are also available upon request.

The FHI consultant and the staff of Initiatives, Inc. (Guyana) and Guyanese consultants served as facilitators and note-takers during focus group discussions and interviews. Every focus group discussion was conducted by a team of two: a facilitator who led the discussion and a note-taker who was responsible for taping the remarks and making notes. In-depth interviews were conducted and notes taken by the same person.

	<b>Region IV</b>	<b>Region VI</b>	<b>Region VII</b>	<b>Region X</b>	<b>Total</b>
<b>Prescribers</b>	1 FGD 2 IDIs	4 IDIs		3 IDIs	1 FGD 9 IDIs 14 respondents
<b>Providers</b>	3 FGD 1 mixed FGD <sup>^</sup>	1 FGD	1 IDI	1 FGD	6 FGD 1 IDI 49 respondents
<b>Waste handlers</b>	2 FGD	2 FGD	1 FGD	1 FGD	6 FGD 53 respondents
<b>Waste carriers</b>	1 FGD	1 FGD	4 IDIs	1 IDI	2 FGD 5 IDIs 15 respondents
<b>Patients</b>	3 IDIs 4 mixed FGD	3 FGD	1 FGD	8 IDIs	8 FGD 11 IDIs 85 respondents
<b>TOTALS*</b>					23 FGD 31 IDIs 221 respondents

<sup>^</sup>Although this FGD took place in Region 4, the participants came from all regions, because of rural Medex who were visiting Georgetown to take part in a professional event.

\*An additional five interviews with policymakers are not reflected in the matrix, but are included in the totals.

### III. KEY FINDINGS: PRESCRIBERS

This section of the report addresses the attitudes and feelings of prescribers, a category of medical workers responsible for prescribing injections to patients. Most often, these workers are medical doctors. The discussion with members of this key audience focused on the following areas:

- 1) beliefs about injections – such as perceptions of their efficacy and risks as well as perceived attitudes of clients toward injections
- 2) disposal of sharps, needlestick injuries and feelings surrounding them
- 3) sources of information
- 4) job-related satisfaction and frustrations, hopes and dreams, and relationships with patients

The main objective of collecting insights on the subjects listed above was to explore the following:

- current practices and attitudes;
- possible barriers to behavior change, both external and internal, and
- possible motivating factors, both external and internal.

### INJECTIONS

#### DISPOSABLE NEEDLES ARE STANDARD

Consistent with our findings in the provider-focused section of this

report, disposable needles and syringes seem to be commonplace in Guyana, and medical doctors said they understood the importance of using a new needle for every patient:

*“Try to open the needle in front of a patient.”*

*“At the private clinic and so especially at my clinic, I tell the nurses, open the syringes, open the needles in front of the patients.”*

*“Every injection is used from a sterile pack.”*

#### DIVIDED OPINIONS ABOUT PATIENT PREFERENCES

Many of the medical doctors we interviewed said they strongly believed that their patients almost uniformly preferred injections to other forms of treatment because they perceived them to be a faster and superior way of delivering relief. According to our respondents, patients were willing to make additional efforts, such as going to a different doctor or using a private clinic, to make sure they had an injection:

*“In Guyana there is the conception that the injection is better medication and it works fast. And this has a lot to do with the education of the population. I work at a private hospital also, when you work there and sometimes you say the patient don’t need an injection, get a tablet, sometimes they insist and they force you, they ask you, you don’t have an injection? I need an injection to feel better fast.”*

*“They [patients] believe that if they have an injection, their ailment will be cured, and if you give them a tablet, it wouldn’t help. Most of them would go to the doctor and say, “Doctor, I want*

*an injection for this particular illness...some medical doctor friends, they’d put sterile water, you know, if the patient so demands that, they’ll give them sterile water.”*

*“They think injection is better, if the child has a cold, they want you to give an injection.”*

*“Patients love it, if you do not give it; they feel treatment is not completed.”*

*“The general public needs to know about the risks associated with the injection, when patients do not get it at the hospital, they would go to the private doctors.”*

Some of the doctors we interviewed said that this belief in the superiority of injections is particularly pronounced in older patients who felt that their treatment was not complete unless they have a shot:

*“The older people who come, if you give them a tablet and you don’t give them an injection, they ask you for their injection. They feel comfortable when they get that shot. That is their training.”*

*“Older patients believe it is a quick way of getting rid of the pain.”*

*“In Guyana, old people like injections.”*

At the same time, a sizable number of respondents (fewer than those who believed patients preferred injections, but too many to dismiss) said that patients, in fact, disliked injections, feared them, and preferred oral medication whenever possible:

*“People don’t like injections. It is liked more by Indo-Guyanese than by Afro-Guyanese. Afro-Guyanese are scared*

like hell. They feel that it works better, especially people from the country.”

“Most of us won’t really like to have an injection, but they would accept it if the doctor said you need this. There are some of those who would ask if you have it in tablet form.”

“An acutely ill patient with a pain or a fracture will prefer an injection but those who are relatively well when you say I will give you an injection they will ask what about a tablet.”

“I heard stories about that in other parts of our country, but I can’t validate that. But I can speak for Linden, and in my experience, Lindenites are not programmed to want injections. As a matter of fact, some of them they have a morbid fear of injections.”

#### **PRESCRIBERS’ ATTITUDES TOWARD INJECTIONS**

When questioned about their own belief about the efficacy of injections, respondents said that they had no special preferences for one form of treatment over the other and made the choice of treatment based on the condition of the patient and not on personal choices:

“I think once the diagnosis is appropriate it does not matter whether IV or oral medicine is the best.”

“Injections are not the first line of treatment, it has to be indicated. I would not give an injection to a patient who comes in just like that. It doesn’t merit it.”

A few respondents stated that oral medication was frequently an attractive choice of treatment:

“In my practice it [injection] is more uncomfortable and time consuming than with tablets.”

“Most of the time the oral medication is cheaper, you don’t have to go four or five times a day sticking the patient to give medication. In that way it is better to give the oral. If it is available early or if it’s appropriate to give in the situation, yes.”

“The worldwide tendency is to reduce their [injections] use...but my concern is what we are going to do with severely ill patients.”

“If we get some more sophisticated drugs available [we can increase prescriptions of orals]. You know, that variety that you get from North America...then of course, you can go up the ladder.”

“We have to protect ourselves against possible blood transmission disease...whenever it is possible, we use oral medication.”

Despite the fact that reports of placebo injections with sterile water were commonplace (as they were during interviews with providers), most respondents said they did not yield to patient pressure and only did what was medically indicated. Furthermore, a few respondents said that any hospital-wide guidelines on appropriate prescription of injections would impinge on doctor’s authority and should be avoided:

“I have to stick to my knowledge... I can’t do something that I know is wrong.”

“I think we are doing what is supposed to be done.”

“All the doctors know when to use and when not to use injection. If the hospital does that then they will be interfering with your job. It is up to the doctor.”

“To say that you will give a guideline for an injection is tough. I would say that you use it for very acute and serious conditions. But any could be acute and serious depending on how you visualize it.”

A very limited number of doctors trained overseas (specifically in Latin America and Cuba) said injections are a preferred choice of treatment because they worked faster:

“Yes, injectables are much faster and so because of that there are times when you have to use injections, where tablets would be a much slower process. It’s the same thing, but injections go right into the muscle or into the vein, and it is a faster effect. So that is why we use injections. It’s not really a question of preference, more a case of necessity.”

“General condition and how fast you want relief.”

#### **DISPOSAL**

##### **NO STANDARD PROCEDURE**

Similar to our findings during focus group discussions with providers, procedures used by the prescribers for the disposal of sharps were varied and depended largely on the individual circumstances in each facility. Overall, respondents said they were aware that needles and sharps require a special disposal mechanism, but did not show much awareness about what happened to used needles and sharps once they left the clinic:

*“Discarded in containers, do not recap.”*

*“We have a special container.”*

*“Recap with one hand.”*

*“They tape it up and they take it away somewhere. To the incinerator, I hope.”*

*“I am not really sure where it goes.”*

*“We use bleach bottles, we don’t have the fancy disposable things.”*

*“In my private clinic it is placed in a bleach bottle and burn when filled.”*

*“Some doctors bring theirs to be burned at the hospital.”*

*“We have a system in place where they put them in colored bags and take them away but where they take them I don’t know.”*

### **NEEDLESTICK INJURIES**

Reports of needlestick injuries were common, although not as prevalent compared to the respective findings of our focus group discussions with providers of injections:

*“Three cases, one immediately after the nurse administered the injection.”*

*“I had at least one.”*

*“When I got stuck it was about 3 am...I was angry.”*

### **PEP GUIDELINES**

While we did not encounter any uniformity with regard to PEP guidelines in different medical facilities, prescribers said they were aware of standard precautions that needed to be

observed and followed the accepted protocol:

*“Yes, standard procedures, wash clean, use bleach and report to the supervisor, samples should be taken from you.”*

*“You let it bleed a bit, wash, notify the supervisor, take the specimen from the patient and yourself, and then if the patient’s specimen is negative, then you can stop drinking the ARV. You had to drink that two hours after you got stuck. If the patient is positive, you have to continue and pray to God.”*

### **THE ROLE OF OTHER HOSPITAL STAFF**

Interestingly enough, many prescribers said they felt that other categories of medical workers, such as nurses and medical waste handlers, needed to be better educated and trained in handling disposal of sharps, and very few said that doctors might be in need of such booster training:

*“We need training on safe needle and other sharps disposal and training and equipment for the disposal guys.”*

*“The nursing system needs to be trained about the disposal of sharps.”*

*“Nurses need to be trained more and with proper supervision, there is no training on standard waste disposal.”*

*“I think the training should be more for the garbage man so that they would know exactly where he should carry the thing so that they would know the seriousness of the thing. If you throw the needles in the garbage, they would not collect it. They won’t even pick up the garbage. When I was in Lamaha St., one nurse disposed of syringe and needles in the*

*garbage and the garbage man refused to carry it.”*

*“I suppose the new practitioners should have this training because young doctors don’t know how to dispose of needles. You know how needles are disposed at the GPHC? That I never knew. Nobody told me how it was disposed; there was no format to say these needles are going here.”*

### **SOURCES OF INFORMATION**

Responses on the sources of information utilized by prescribers were diverse and depended mainly on the individual circumstances of medical doctors; no source seemed to be favored over the others. Books and journals were the most frequent choice, and doctors who worked in urban or semi-urban areas relied on the Internet a lot more than those who worked in the rural localities.

*“Computer and recent books and ask other doctors.”*

*“The Internet is my second home.”*

### **JOB-RELATED SATISFACTION AND FRUSTRATIONS**

#### **HELPING PATIENTS IMPROVE**

Medical doctors said they saw themselves as prominent figures in their community who are doing vitally important work. They stated that they did not consider themselves well-compensated, and a large part of their satisfaction on the job comes from the feeling that they are helping patients and doing good work.

*“Job satisfaction I get from the people, not from the system.”*

*“It makes me feel good to see a child in my office and next morning I see him with his mother and the mother does not recognize me, but the child says that is the doctor. It has fulfilled all my frustration.”*

*“You see the patient coming in on a stretcher and a few days later walking going home.”*

## **RESOURCE CONSTRAINTS**

Because prescribers said so much of their job-related satisfaction comes from the feeling that they did a good job, they stated their understandable frustration with the limitations of resources and staff (due to many medical workers leaving Guyana to find work overseas) that they said precluded them from doing a good job:

*“Sometimes working under pressure you can’t provide the type of service that you wish to, and that is very serious. And that is something that has been going on for some time, and the pressure on the doctors is great and some doctors don’t do the right thing because of the pressure. Doctors are human beings and sometimes you can’t do more than you can do.”*

*“I think one of the things that hurt me, and most doctors, is that there is no attempt made to return, even to retain even a modicum of our trained nursing staff, so we are virtually working with people who have just come out of nursing school and it keeps going, going all the time.”*

*“Another thing that limits us is that there is no set data on how illnesses are running in Guyana. There is nothing formalized and structured. For example, if I wanted to know how many cases of malaria in Region 8, there are no figures available.”*

*“There is no scientific examination on illnesses, especially as it relates to a particular use of drug.”*

*“Things are not perfect, more equipment and facilities are needed.”*

## **COMMUNICATION WITH PATIENTS**

### **QUALITY OF PROVIDER/PATIENT RELATIONSHIP**

Many prescribers said they had open and comfortable relationships with their patients. They also stated that setting this relationship on a right footing is their responsibility, and said that making patients comfortable and inspiring confidence is a part of being a good doctor:

*“I have learnt that once you can get the confidence of the patient, the patient basically opens up.”*

*“That’s a skill. You have to make that patient comfortable and they will talk. If they are not comfortable, they will not tell you anything. Interact with them emotionally, discuss the problem, then that patient will tell you much more than they will tell someone else. They feel more confident in confiding in you.”*

Most prescribers said they did not object to being asked questions and clarifications about their prescribed choice of treatment. They stated that this type of patient/doctor interaction is a more effective approach to treatment:

*“That’s their right; they’re supposed to tell me that. They’re supposed to have a feedback, otherwise what’s the use taking drugs if they wouldn’t use it, and that’s a wastage, yes, we encourage that.”*

*“Patients are free to talk to you, you get better results and they can operate with you.”*

*“I feel good [about patients asking questions] because it means that the patient is actively involved in the discussion between doctor and patient. That happens a lot at the maternity ward...I feel well because the patient is actively involved and that is good.”*

*“With things like that, I would sit them down and try to convince them.”*

A few prescribers said that a more active involvement of patients in their interaction with providers is a recent trend.

*“This is a different generation, people are more educated, people stand up and challenge doctors about drug effects, and one of the things and maybe some of us are uncomfortable with, which is a good thing, is that patients sometimes know more about their particular illness than you do.”*

*“People are asking, asking questions more and more.”*

This opinion, however, was not shared by all respondents – two doctors trained in Cuba said that asking questions was not typical of Guyanese patients:

*“Not much question from patients in Guyana; they seldom ask questions, you find you have to ask them and let them respond to you.”*

*“Patients do disagree sometimes but not often.”*

## SUMMARY

- Prescribers said they considered themselves important figures in their communities who do valuable work. They stated that they are working under heavy constraints, and derived most of their satisfaction from helping their patients improve their health and feeling that they are doing a good job.
- The majority of medical doctors we interviewed said that patients across Guyana, particularly older people, had a strong preference for injections compared to other forms of treatment, and were prepared to go out of their way to make sure they get one, even if it meant going to a private doctor and paying more.
- The doctors we interviewed said they would be happy to answer more questions and provide more explanations to their patients. They said that a higher number of questions indicated interest and involvement on behalf of the patient, which was seen as a positive factor.
- Prescribers stated that their choice of treatment was dictated only by what is medically necessary. With a few exceptions, they did not say that injections were a preferred choice of treatment, and reported that their choice of treatment was driven by what they thought was right, not by what patients preferred.
- We did not find much uniformity in the sharps disposal procedures in the facilities where prescribers worked. These were guided by individual circumstances in each facility, and prescribers were not widely aware of what happens to used sharps once they left the facility.
- While PEP procedures at different facilities seemed to vary, prescribers had a fairly good understanding of standard precautions and reported following them despite the lack of standard guidance.
- Prescribers said that other categories of hospital workers, such as nurses and medical waste handlers, needed more training in safe disposal of sharps. They did not indicate that members of their own group might have a need for more training in this area.

Current behavior/attitude	Desired behavior/attitude	Barriers to change	Motivating factors	Recommended BCC interventions
Go along with patients requesting injections	Actively counsel patients to consider oral medication	Belief that injections are better Perceived patients' preference Poor communication skills	Belief that oral medication works just as well Fear of needlesticks Desire to do what is right	<u>Shorter-Term</u> - Training in client-prescriber and prescriber-provider communication skills * - Job aids on safe disposal/needlestick prevention <u>Longer-Term</u> - Advocacy with Ministry of Health and professional associations for new guidance on safe and appropriate injections - Outreach through professional publications and professional meetings <i>*This assumes that prescribers have been trained or know about the safe and appropriate use of injections</i>
Ad hoc disposal procedures	Place all dirty needles in sharps containers WITHOUT recapping Encourage nurses to do the same	Containers not available Insufficient knowledge	Good professional practice Fear of needlesticks Belief that needlesticks are preventable	<u>Shorter-Term</u> - Job aids on safe disposal <u>Longer-Term</u> - Advocacy with Ministry of Health and professional associations for guidance on disposal - Outreach through professional publications and professional meetings

Ad hoc post-exposure practices	Follow international PEP procedures	Lack of clear guidance Lack of ARV drugs	Fear of HIV infection	<u>Shorter-Term</u> - Job aids on PEP <u>Longer-Term</u> - Advocacy with Ministry of Health and professional associations for clear PEP guidance - Outreach through professional publications and professional meetings
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## IV. KEY FINDINGS: PROVIDERS

This section of the report addresses the attitudes and feelings of providers – a category that has been loosely defined to include medical personnel physically administering injections to patients, such as nurses, Medex and dentists. The discussion with members of this key audience focused on the following areas:

- 1) beliefs about injections – such as perceptions of their efficacy and risks as well as perceived attitudes of clients toward injections
- 2) disposal of sharps, needlestick injuries and feelings surrounding them
- 3) sources of information
- 4) job-related satisfaction and frustrations, hopes and dreams, and relationships with patients

The main objective of collecting insights on the subjects listed above was to explore the following:

- current practices and attitudes;
- possible barriers to behavior change, both external and internal; and
- possible motivating factors, both external and internal.

## INJECTIONS

### DISPOSABLE NEEDLES ARE STANDARD

Consistently with the findings of the baseline survey, disposable needles were a standard practice in Guyana. We did not encounter any mentions of reuse of needles. It also appeared that patients were aware of the importance of clean needles, and nurses and Medex said they were frequently asked to demonstrate sealed packages:

*“Our needles are sealed and you can’t use them back.”*

*“There aren’t any risks with using the needle because needles cannot be recapped, so I don’t have any risks.”*

*“One and two patients come in and ask to see the needle open in front of them, and I would tell them do not be scared and open it in front of them.”*

### NO EXPRESSED PREFERENCES FOR INJECTIONS

Nurses and Medex did not say they had any strong preferences for injections as a means of treatment. They stated that the choice of treatment should be dictated solely by the nature of the problem, and they did not feel that injections were over- or underprescribed at their facilities. They also said they had no problems with letting patients know that their condition did not warrant an injection:

*“In nursing they train about five rights of injections, so you know when patients should or shouldn’t get an injection...we wouldn’t go wrong and you would try your best to stick to the five rights of injection.”*

*“There is no overprescription or underprescription because the treatment is based on observation and doctor.”*

*“From the perspective of a health provider there are advantages and disadvantages of giving an injection and we need to know when we need to use it and when we don’t.”*

*“You have to let them know that injection is not the only medicine for the problem.”*

*“I would give a tablet if the condition suits a tablet. You have to be careful with needle sticks.”*

### PERCEIVED EFFICACY OF INJECTIONS

Without exception, and in somewhat of a contradiction to the findings discussed above, all interviewed nurses and Medex said that injections produce a faster and stronger effect than oral medications.

*“Injection is good because it is direct to the blood stream.”*

*“It works better and it goes through your system faster.”*

*“Most oral medication takes longer to digest...I find if the patient is angry and they get worked up, if you give them that injection, it takes, like, five minutes before it works, rather than 10 to 15 minutes.”*

*“Sometimes you flex and give them a tablet, but you make sure you tell them it will take longer.”*

### COMPLIANCE ISSUES

In addition to perceived efficacy of injections, respondents said that the patients are much more likely to forget about taking tablets, and

thus injections were a better choice when compliance with a treatment regimen was an issue.

*“Taking pills, people lose their sequence, people forget. With injections you do not forget, with an injection you get it and that’s it. If you have to take five or ten shots you can take it and you would not forget.”*

*“Mothers on family planning prefer injections because they feel that they would forget the tablets.”*

*“The handling of disease would be better if people took more injections. Because then people would not be lying to themselves, they would be following the doctors’ instructions.”*

#### **BELIEF THAT PATIENTS PREFER INJECTIONS**

Many respondents said that patients preferred injections, particularly when they were in significant pain, and thought injections worked better:

*“Most of them believe in injections. You have people believing that if they have injections they get better faster.”*

*“Old people feel that as long as they get an injection in this hip, this hip will stop hurting.”*

*“Patients with arthritis believe that when they get injection, the pain is better.”*

*“I feel it is not only in Guyana, I think across the world a client might say give me an injection quick and done, because I am not able to take all these tablets. The preference comes from what they might hear from mommy, daddy or a friend.”*

In several groups, respondents shared similar stories of patients who insisted on injections and felt

better after getting one, even though it contained nothing but water:

*“I had a case when a girl came and threw herself down at the doctor, and the doctor said give her some sterile water, and when I did she got up and she was fine. All she wanted to know was that she got a bore and she was fine.”*

*“The patient eats the orange [after being told not to] and then experiences pain and starts crying out to the nurse for an injection. So the doctor instructs the nurse to inject the patient with sterile water, and when the patient got the injection, the patient felt better.”*

*“The nurse wanted to give [the patient] tablets but she just wanted the injection. So they filled the syringe with sterile water and she stopped crying.”*

Several Medex who operated in rural areas said that patients were willing to go to extra lengths, such as seeing a different doctor and paying more, just to get an injection. They also said that private doctors exploited that belief to make more money:

*“More people in Guyana believe that injection is top-notch treatment, and that comes from private practice.”*

*“Some people believe that with injection you would feel better and when the hospital does not give it, they would go to outside doctors.”*

*“Private doctors collect more by giving out injections, and some patients do not care about the type of medication given.”*

*“If you go over the road to a private office, quick time, you get an injection*

*and you are relieved. The fact is that their mind is programmed that they can easily accept a large fee for injection. It is because they were taught all their life to believe that injection is good. Therefore, they accept that and they pay. If you have to pay ten thousand dollars for tablets, they would make a fuss, but not for an injection.”*

#### **PERCEIVED DRAWBACKS OF INJECTIONS**

Compared to universal perceived advantages of injections, their perceived drawbacks were relatively few, and included the need to restrain children, and some pain-related objections from patients:

*“You would have to use some techniques to get the child to not be scared.”*

*“Some patients are fearful of injection.”*

*“Some complain that it burns.”*

#### **DISPOSAL**

##### **NO STANDARD PROCEDURE**

After interviewing nurses and Medex across the regions, it became clear that every hospital and health center had its own procedure (formal or informal) for disposal of sharps based on available resources and there were no universal standards. In addition, the respondents overall did not have a clear idea of what became of needles and sharps after they were removed from their facilities. Complaints about disposal of sharps were also varied and had to do with overflow or collapsing of containers:

*“We have a sharp container and when it is full you have to cap it and then the senior health visitor would come and take it.”*

*“We used to discard in sharp containers, now a small ice bucket, which causes the needles to fall out when filled, and have to be emptied in box.”*

*“The new ice bucket being used can cause needles to stick you – you have to open the top and place the needles inside.”*

*“When boxes are filled, someone takes it away and the boxes are reused.”*

Georgetown hospital has the most comprehensive system for segregating medical waste in Guyana, but the nurses there said they were not completely happy with their disposal practices:

*“One of the problems I have experienced sometimes is when the boxes are almost filled and you keep pushing stuff into it and needle comes out of the box... Sometimes it’s not quite filled so you try to shake it down and a needle comes out of the box. I had one nurse who got stuck like that; she lifted it up to take it back and it stuck her finger because it was pushing out of the box. Before they used to have these hard plastic containers but nowadays they give you boxes.”*

*“What has been happening is that if you give an injection and some is left in the needle and it goes against the box, it will get soft and come through.”*

*“I feel that they should get rid of those boxes and bring back the plastic containers.”*

The nurses and medical workers at other facilities, such as Linden and

Bartica hospitals, said they had to improvise:

*“We have to make our own sharps containers. Sharps are sometimes disposed of in bags because there are no containers. There are not enough gloves and masks.”*

*“Disposable containers are usually taken on ‘outreach’ trips, but when boxes are filled, they can become wet and the needles would pass through the box.”*

*“I make a mock container with an empty Marvex and put them in there and put some bleach in there and then throw the needles in there...the cleaners take it out. I am happy with the way I dispose of needles, but I do not know what happens to them out there. They should bring one of those furnaces that they use for needles in the U.S.”*



**An impromptu sharps container in Bartica Hospital, Region 7**

Reports of training were also not uniform – for instance, rural Medex and nurses in Region 6 indicated that disposal of sharps was a part of their training, but we did not encounter that elsewhere.

References to any job aids were also inconsistent:

*“We have guides to show how to dispose of all sharps.”*

*“In wards, they used to put aids on the walls but now it is not allowed.”*

## RECAPPING/NO RECAPPING

There doesn't seem to be a universal belief that needles should not be recapped. We have encountered reports of both practices.

*"We place rubber stoppers (over the needle) and cover it."*

*"We are not allowed to recap at all."*

A dentist in Region 7 recapped with two hands in front of the interviewer and said:

*"I would never recap a needle while looking at the patient or talking to anybody. I would say, stop for one minute, and I would go to my procedure."*

## NEEDLESTICK INJURIES

Every group of injection providers we interviewed, *without exception*, brought up needlestick injuries as a fact of life in their work. Reports of being stuck were common:

*"I was stuck more than once."*

*"I was stuck twice and once was by a child."*

*"I had a...psychotic patient, and I stuck him, put the syringe down, and by the time I turned my back, he took it and he stuck me."*

*"I cannot do nothing about that, it just happens."*

Nurses and Medex said that needlestick injuries were common, and while many brought it up in a seemingly nonchalant manner, further probing revealed deep-seated feelings of fear, vulnerability and dread:

*"I was stuck accidentally by a needle but I pray to God that nothing happens."*

*"The last time I got stuck I got an instant headache."*

*"The last time I was stuck I felt terrible."*

*"In some cases nurses get stuck and then they are scared to go and check to see if they are positive because there is a nurse I know that died from being accidentally stuck."*

*"I felt very angry because I did not deserve that, you know I was trying to do this person a favor, and then their stupidity, ignorance or whatever, they moved their heads because they saw the needle; they just jumped. I had to explain to them that when you come to the dentist...you just sit there and just watch the doctor, do nothing."*

*"My major problem is when nurses get stuck from needles used by infected patients. It is easy for you to tell me that nothing will happen but I am the person who will have to deal with this worry waiting for the next couple of months to find out if something really did happen."*

*"We are at risk all the time; we are not exempt, it is going to happen one day or another. I carry my medication in my pocket everyday. I am afraid to get stuck with a needle. I am afraid of everything; AIDS, hepatitis, or any other disease a person might have...I am very afraid of HIV; I do not know what kind of disease the person might have but if you get stuck with a dirty needle you are prone to get anything."*

## THE ROLE OF OTHER HOSPITAL STAFF

Nurses who worked in Region 4 hospitals said they felt that doctors

were contributing to the problem of accidental injuries by not being careful with the needles:

*"Some doctors stick needles in patient's beds and the nurse after observing it there would have to remove it. I told the doctor he had to be careful because the nurse or the patient could have been stuck."*

*"I find that doctors are less careful than nurses are. They would do a procedure and have the needles there and leave in the container, and you might just go pick it up."*

*"I think that doctors should be one of the target persons in any exercise. They are the ones that are left out for whatever reason and they don't comply. And when you tell them about whatever, they don't comply."*

Hospital-based nurses also stated that maids and porters were not sufficiently trained and needed more education:

*"You might tell the cleaner but they might not be as educated as you and might go to that bin without gloves on, and that is my concern...They should have workshops for those persons to sensitize them so they can know the dangers they are exposed to."*

*"I think they are not very well-educated at all about these things...I know of cases where the waste from the isolated patients are put in the same bag with the other waste and you have to be there to tell them: don't do that. They definitely need more exposure in that area."*

## PEP GUIDELINES

We discovered that while few facilities (with the exception of Georgetown hospital) have formal rules for the steps to be followed after accidental needlestick injuries,

nurses and Medex were aware of the steps to be followed:

*“Everybody knows that it is to be squeezed and then cleaned it and you report it to the senior supervisor.”*

*“Squeeze the finger, place in Marvex, report to the supervisor and start ARV treatment immediately.”*

*“It works very well because it protected my mother, and she was stuck twice accidentally, and once by an AIDS patient and she kept checking and checking and nothing up to this day.”*

*“I have not seen any [rules in the hospital] but I made my own rules. There should be a list here and everybody should be given a pamphlet and keep in their pocket.”*

But even where the guidelines were in place, some nurses said it did not make it safer for them:

*“It won’t protect you, it just helps you to know your status if you didn’t know it before.”*

Nurses and Medex routinely named HIV, hepatitis B and malaria amongst risks of needlestick injuries.

#### **REPORTS OF NEEDLES LYING AROUND**

These are not frequent, but they did come up occasionally:

*“Yes, we have seen needles on the floor when maids are cleaning the wards.”*

*“They found some along the avenue on Thomas St., but I think it was in the garbage, and the people roaming the street picked it up and were trying to sort out the garbage and left it.”*

*“I had an occurrence like that with my son...he picked [the needle] up and said mommy, look at the needle they gave me at the hospital.”*

#### **SOURCES OF INFORMATION**

These are determined largely by the location where nurses and Medex practiced. Those who work in rural areas said they were more likely to depend on communications from the Ministry of Health, as well as books and libraries. Urban nurses said they often used the Internet. But the most trusted sources were still printed books and journals.

*“Ministry passes information down to the health center.”*

*“We talk to the senior health visitor.”*

*“I go to the library and see if there are any books.”*

*“Refresher course should be offered to nurses.”*

*“At our hospitals we get nursing journals and they are there for everybody.”*

#### **JOB-RELATED SATISFACTION AND FRUSTRATIONS**

##### **SEEING THE PATIENTS IMPROVE**

Working as a nurse or a Medex worker in Guyana, regardless of regional and facility-related differences, is a challenging, difficult and almost always underpaid path. Medical workers routinely put in very long hours and have to cope with their job with very limited resources. Migration to other countries is common, as is the nursing shortage across the country. Despite these challenges,

many nurses and Medex we interviewed across the country pointed without hesitation to the opportunity to care for patients and help bring them back to health as the greatest source of satisfaction and happiness on the job.

*“I like nursing a patient back to health. Seeing them come in almost at death’s door and seeing them walk out of the hospital.”*

*“When you put the babies on the scale and the babies have the right weight, it is like yes, you have done good. You feel good about it, you feel rewarded in a special way.”*

*“You feel so satisfied because you know that whatever treatment you give to that patient, it works, and you are satisfied, and you feel good about it.”*

#### **BEING APPRECIATED BY PATIENTS**

Low salaries and frequently dismal working conditions leave nurses and Medex little chance to feel appreciated by the government or the society in large. Against that backdrop, it is not surprising that almost all respondents in this category stated that receiving appreciation and gratitude from patients they helped makes their job worthwhile for them. This was particularly pronounced in rural areas where nurses are respected and known figures in their community health centers as opposed to a large urban hospital:

*“Patients would meet you on the road and they tell you that what you have given to them really works, and that makes you feel good.”*

*“It’s so rewarding, it gives you the courage to go on. You feel*

*comfortable going in (to work) because you know that patients will be there early and they say thanks to their nurses.”*

*“I would say the only satisfaction you get from nursing is the patient-to-nurse relation.”*

*“I feel good when I get encouragement and people appreciate my work.”*

*“I like the patients to be very appreciative of my work.”*

### **GIVING A GOOD NAME TO THEIR FACILITY**

Rural nurses we interviewed said they felt strongly that their good work reflected directly on the reputation and standing of their health center within the community and the Ministry of Health system, and were happy when they felt they contributed to the good reviews their facility enjoyed:

*“It feels good to know that ...your health center is on the Ministry list as it has completed all requirements and it had no malnourished babies.”*

*“What makes you (satisfied) is that the word is getting around because people come from out of your area to your health center.”*

### **RESOURCE AND STAFF CONSTRAINTS**

Heavy migration of medical personnel has left Guyana with fewer nurses to carry the same load of patients, and nurses across all regions brought up the shortage of staff as one of their frustrations. Equipment and shortages of medicine were more of a problem for rural rather than urban

workers, and were mentioned in a less emotional context:

*“We are really pressed for staff. It is really rough and at times we have to cope with it.”*

*“Staff migration is impacting the overload, too many patients per nurse.”*

*“We have water problems and we have to fetch water.”*

*“Sometimes you have a shortage of medicine.”*

### **LACK OF RESPECT**

Appreciation from patients and other medical staff is one of the few sources of satisfaction that make the job tolerable for nurses and Medex. Above all, nurses said they wanted to be respected and appreciated by those they work with. When that appreciation was missing, or when the nurses said they felt disrespected by their doctors, patients or peers in other hospitals, they said it was near the top of their job-related concerns. The theme of disrespect from doctors came up particularly strongly during interviews with hospital-based nurses:

*“Superiors have a way of penalizing you in front of the patients and this cause the patients not to have respect for you...nurses are treated like servants.”*

*“I had an experience where I went to the patient and I gave them instructions and one patient said to the other, you don't have to listen to her, you have to listen to what the doctor said.”*

*“Nurses in Georgetown hospital do not treat nurses from out of system as*

*if they came from the same profession, and it is very bad.”*

*“I feel it is happening because as nurses we are not respected in society.”*

*“We want persons to understand that we are professionals and we were trained just like doctors were trained.”*

## **HOPES AND DREAMS**

### **EMPLOYMENT ABROAD**

When asked about their plans and hopes for the future, leaving Guyana and seeking better circumstances elsewhere came up very frequently with urban nurses in Regions 4 and 6.

*“Five years from now I will not be here. I am starting my R.N. programme in September, and after that I am gone. There is no greener pastures in Guyana, we all know that.”*

*“On a plane, and hopefully before five years.”*

*“We still work for a meager salary so people are migrating.”*

*“Nurses are not leaving because they don't like the place. It's the money.”*

On the contrary, many nurses and Medex based in health centers and rural areas said they felt a strong connection with their community and rarely spoke of leaving.

*“I'll be here, I see myself still in nursing and doing more work in nursing.”*

*“Next five years I will be doing the same thing. I enjoy working with people and they come to me for me to help them.”*

## **FURTHER EDUCATION AND ADVANCEMENT**

Regardless of plans to stay or leave Guyana, many nurses and Medex across all regions said they wanted to continue their education and become better at their job. Improving professionally and increasing job-related knowledge was mentioned frequently as a goal for both rural and urban medical workers:

*“I want to become a medical doctor.”*

*“In the next five years I see myself as a registered nurse right here at Linden.”*

*“I would like to have my degree in nursing.”*

*“I want to improve in maternal and child care and be better at caring for mothers and children.”*

## **COMMUNICATION WITH PATIENTS**

### **A RIGHT APPROACH FOR EVERY PATIENT**

All providers said they acknowledged the importance of good communication between patients and medical staff. Importantly, what emerged during our discussions was that they felt it was their responsibility to make the patients comfortable in order to establish and maintain these lines of communication. Most nurses and Medex said they knew how to approach patients and were fully capable of forming a right relationship with them.

*“It’s how you approach them. If you don’t approach them in a nice manner, they would not want to interact and they would not want to confide in you.”*

*“You get what you give; if you harsh to the patients they would behave the same way towards you.”*

*“When you get to work, put your troubles away. You must be smiling, and I know it is hard to do, but you have to.”*

*“I live in the area and I know how to approach them.”*

*“You have to set standards and create openness...you have to be the one to be open to them.”*

### **TAKING PATIENTS’ PROBLEMS TO HEART**

*“Their concern is your concern...you must think about them as if the child is yours.”*

*“I put myself in the position of the patient. I have suffered from malaria four times, and from that day I put myself in the position of a patient and I feel how other patients feel.”*

*“In this whole nursing situation you have to be a mother, father and everything.”*

### **CONFIDENTIALITY**

Nurses and Medex all said confidentiality in a nurse-patient relationship was important:

*“You have to let them know that you are confidential because confidentiality is a greater part of nursing.”*

*“Once you reassure them that you’re confidential, then they feel more comfortable and they talk to you.”*

### **THE NEED TO PROVIDE EXPLANATIONS**

The nurses said they had no objection to patients’ questioning

them or asking for more information. On the contrary, they said that explaining treatment to patients was a big part of their job, and they welcomed the opportunity to answer questions and provide justification for the prescribed treatment:

*“They may take your advice, and it does not work, and they would come back and say, well, nurse, that thing that you told me, it did not work, and you will explain to them why...you have to give them a justifiable reason.”*

*“Patients have a right to refuse or disagree, and the nurses should inform the doctor...Doctors should inform patients about the treatment.”*

*“If they disagree, then I tell them I will inform the doctor when he comes. I won’t push the patient to take it.”*

*“You have to let them know that you are the medical provider and you know best.”*

## **SUMMARY**

- Nurses and Medex stated they saw themselves as important professionals and vital figures in their communities. They expressed a strong need to be respected by their peers, patients and society at large, and said that a big part of their job satisfaction came from being appreciated and respected. They indicated a strong reaction to any perceived belittlement or disrespect by colleagues or patients. Providers based in urban areas were more likely to want to move to another country for better prospects, while rural nurses and Medex

usually reported closer ties to their communities and hoped for professional development and improvement at the original communities.

- Most nurses and Medex we interviewed said they cared deeply about their jobs, and seeing their patients improve and return to health was a major motivation of their professional lives.
- Many providers said they had personal experiences with needlestick injuries and were terrified of the risk of infection, especially HIV.
- While claiming that their choice of patient’s treatment was dictated only by medical necessity, nurses and Medex consistently said injections

were a faster and stronger way of delivering medication, especially for pain relief. They also stated that patients shared that perception and although patients were somewhat uncomfortable with the needles, the nurses said that the patients preferred injections to tablets to the degree that occasionally drove them to make unreasonable demands.

- The respondents said that good relationships and communication with patients were paramount, and that they were quite capable of finding a right approach to establish effective connections with patients. They also stated that it was a part of their professional duty to explain treatment to the patient and

overcome their objections, if necessary.

- Disposal of sharps was an issue – many respondents we interviewed, including nurses in GPCH (which has a more comprehensive system in place for segregating medical waste), said they were dissatisfied with one or more aspects of the disposal procedures and felt that they were not protected from risk well enough.
- Respondents said that continued training and education were an integral part of their professional aspirations.

Current behavior/attitude	Desired behavior/attitude	Barriers to change	Motivating factors	Possible BCC intervention
Go along with patients requesting injections	Counsel patients to consider oral medication	Belief that injections are better Perceived patients’ preference Poor communication skills	Belief that oral medication works just as well Fear of needlesticks	<u>Shorter-Term</u> - Training in client-provider communication skills to support best practices in prescription of injections* - Job aids on avoiding needlestick injuries <u>Longer-Term</u> - Advocacy with Ministry of Health and professional association for guidance on safe and appropriate use of injections - Articles in professional publications, outreach at professional meetings <i>*This assumes that providers have been trained or know about the safe and appropriate use of injections</i>
Impromptu disposal procedures Recapping	Place all dirty needles in sharps containers WITHOUT recapping	Containers not available Habit of recapping Belief that recapping reduces risks	Good professional practice Fear of needlesticks Belief that needlesticks are preventable	<u>Shorter-Term</u> - Job aids on proper disposal procedures including no recapping* <u>Longer-Term</u> - Advocacy with Ministry of Health and professional association for guidance on proper disposal/no recapping* - Articles in professional publications, outreach at professional meetings <i>*This assumes that providers have been trained in safe disposal practices and no recapping</i>

Ad hoc post-exposure practices	Follow international PEP procedures	Lack of clear guidance Lack of ARV drugs	Fear of needlesticks Belief that needlesticks are preventable	<u>Shorter-Term</u> - Job aids on PEP procedure <u>Longer-Term</u> - Advocacy with Ministry of Health and professional association for clear PEP guidance and treatment accessibility - Articles in professional publications; outreach at professional meetings, personal testimonies
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## V. KEY FINDINGS: PATIENTS

This section of the report addresses the attitudes and feelings surrounding the use of injections held by patients or clients of medical facilities. The discussion with members of this key audience focused on the following areas:

- 1) beliefs about efficacy and risks of injections;
- 2) beliefs about disposal of medical sharps and used needles
- 3) sources of health-related information
- 4) personal hopes and dreams
- 5) relationships with healthcare providers

The main objective of collecting insights on the subjects listed above was to explore the following:

- current practices and attitudes;
- possible barriers to behavior change, both external and internal; and
- possible motivating factors, both external and internal.

### BELIEFS ABOUT INJECTIONS

Consistent with our findings during focus group discussions with doctors and nurses, patients said they were aware of the dangers of using dirty injection needles, and stated that they pay attention to make sure their needles were

always new and taken from the sealed package. They also said they believed doctors might be cutting a few corners to avoid using new needles for every patient, and that made them even more likely to insist on new needles every time. This finding was consistent across all regions, rural and urban alike:

*“Most doctors use the same needles, so I ask them to open it in front of me.”*

*“I afraid I get AIDS because you get AIDS from a dirty needle with blood. I would ask them for a new needle.”*

*“I would want to see it open in front of me from a sealed package so that I would know that it has never been used before because I’m so scared of injections.”*

*“Yes, they would have the needle in a plastic. It is always a new syringe.”*

*“If I am to take injections, I have to see everything that is used.”*

### PREFERENCES

During our focus group discussions, two prominent and conflicting themes consistently emerged in the comments the respondents made across all regions (the only exception to this finding is the seeming preference for non-injectables in the Amerindian population). These themes typically emerged at the same time and in the same groups, and in fact, frequently from the same respondent, so no regional pattern was observed.

- The first was a very strong belief in the efficacy of injections compared to pills due to two reasons: perception of faster and stronger relief that injections

bring compared to pills, and the perceived convenience of having a single shot at the clinic compared to having to take multiple pills at home. This perception of superiority of injections vs. tablets sometimes leads to patients choosing to go to a private doctor or clinic to increase their chances of getting an injection.

- The second was a strong aversion to injections that stemmed from prior bad experiences and side effects of poorly done injections (such as pain, burning, swelling), as well as emotional dislike of being pricked by a needle.

### FASTER AND STRONGER RELIEF

This theme emerged consistently across all regions where we interviewed the participants. One after one, the respondents said they believed injections brought immediate relief compared to tablets, and that injections were seen as a “real”, “serious” treatment as opposed to pills. This view also seemed to be reinforced by the members of the participants’ social networks; quite a few of them reported that their friends and family advised them to stick with injections.

*“I don’t like tablets, injections work faster.”*

*“If my child has a serious problem right away, I wouldn’t want any tablets. I would want an injection that can work fast.” (Linden)*

*“I rather injections because it is more powerful and it helps fast.”*

*“Tablets going to work more slowly and injections work faster.” (G’town)*

*“Better than pill, it is more effective.”*

*“Straight to the bloodstream. It’s fast and quick.” (Bartica)*

*“I rather injections than tablets because it works faster.”*

*“Sometimes if you go with a high fever to a public hospital, they don’t normally give you injection. If you take a chance and go to the private hospital, they will give you.”*

*“So I ask myself why they can’t give you at the public hospital. It is the same thing, why can a private doctor prescribe an injection and not here?”*

*“For example, they say that injection works better than the tablet.”*

*“Because you take an injection and it goes to the blood stream right away.” (Region 6)*

*“Tablet takes more time to melt in your body.”*

*“It is experience, because with my sickness, when I get a tablet it don’t work, and when I get the injection.”*

*“Because when I use the injection, like for example if I am sick, in half of an hour I feel better. And the tablet would take time.”*

*“I still prefer some fast relief, so I take the injection.” (Region 6)*

### **CONVENIENCE**

The second reason behind the patients’ stated preference for injections is a perceived convenience of injections compared to oral medication. The respondents said that having to

remember to take tablets several times a day can be a burden, whereas taking a single shot in a clinic took care of their health problems on the spot without any need for further medication.

*“You don’t have to drink it 3 or 4 times a day.”*

*“Have injections one time, tablet is every day.”*

*“When you take the injection and you go home, you don’t have to remember the time you have to take the pill.” (Region 7)*

### **PAINFUL INJECTIONS WITH SIDE EFFECTS AND RESULTING PREFERENCE FOR OTHER METHODS**

As noted above, many respondents said they had bad experiences with injections, and now preferred tablets and other forms of treatment:

*“I prefer the tablets. The injection is too hot, but it works faster.”*

*“Sometimes how the nurses will give you an injection, it can hurt for days.” (Region 10)*

*“You don’t like it. You feel pain, it is scary.”*

*“Tablet is less painful.”*

*“Pills because injections might not be sterile and you can get diseases.”*

*“It makes you bleed.”*

*“I frighten injections because when I had an injection before it hurt me bad.”*

*“Some people, because of the pain, prefer the tablet.”*

*“When my child got an injection, her hand had a big bump for months.”*

*“I would first use a tablet, I can’t stand injections.” (Region 6)*

*“I don’t like people boring my skin.”*

*“The injection is too hard. I prefer to take the tablets.”*

*“I would drink the tablet, too, because they won’t be boring you. But I hear people say it [injection] works faster. I hear people talk about it, like friends, and so they said it works faster.” (Region 7)*

### **CONVENIENCE OF TABLETS**

As noted above, many respondents said that injections are a more convenient form of treatment because they freed the patients from the need to remember to take several pills on a set schedule. However, a few respondents said that they found tablets more convenient than injections. These respondents were residents of very remote rural areas who said that coming to the clinic to just have a shot is inconvenient, and that tablets would be a more realistic course of treatment.

*“Even if the doctor writes down an injection, I tell him it’s hard to come over, he gives me a tablet.”*

*I think that [the tablet] is the better way, because if you live far away, and you can’t make it, they should give you the medication that you could use at home.” (Region 7)*

### **BELIEFS ABOUT DISPOSAL OF USED NEEDLES**

A finding that emerged during our focus group discussions with the patients was that most of them paid attention to the needles and

syringes before getting a shot because they were aware of the dangers of dirty needles and concerned that the needle used for their shot is new and taken out of a sealed package. However, once the injection was complete, they were, by and large, no longer aware of where that needle went after they saw it discarded into a bin.

Consistently with our findings during focus group discussions with the nurses and Medex, disposal practices that the respondents reported observing varied depending on specific medical facilities. Respondents said they were aware of the potential risks of improperly discarded used needles, and once probed, they said they were concerned about the risks it can pose to their communities, and especially to children who respondents thought were at risk of infection from playing with discarded needles. Even though they did not know exactly what happened to used needles, the patients said they wanted to be certain that they and their children are safe from the risks inherent to used sharps.

#### **DIFFERENT DISPOSAL PROCEDURES**

*“They throw it in the sharp boxes.”*

*“They recap after they used it and throw in the waste paper basket.”*

*“I have seen it overflow, gloves and everything.”*

*“I usually see when the nurses give an injection, after they finish with the syringe, they usually put the needle in a container and snap it.”*

*“They got a thing where when they finish giving you the injection, they put it in and break.”*

*“I see them throw it in a bin, when they are finished, I don’t know where they burn it or throw it.”*

#### **DESIRE TO BE SAFE**

*“The needles and syringes that we have here, they are left in the mortuary until someone comes to collect it. The disposal boxes; the porters have easy access to it and they can pick it up. People are all around and they can also pick it up. The waste disposal at this hospital is not up to standard.”*

*“They should have, as you say, some box because people come in and anything can happen, and now you see children coming in.”*

*“They don’t bury it; they just throw it outside, children pick up and play with it, it is dangerous.”*

*“I don’t know, I am concerned. It should be buried.”*

*“They should put a big ‘X’ on the container which means danger. Bury it.”*

#### **DISPOSAL OF MEDICAL WASTE ONCE IT LEAVES THE FACILITY**

Consistent with the themes emerging during discussions of disposal of used sharps and needles in the hospitals, participants said (after probing) they felt strongly that used needles and sharps need to be disposed of in the manner that makes them inaccessible to people in their communities, especially children. Respondents also stated their concern for garbage removal workers who may not be aware that the trash bags contained contaminated sharps and

can get stuck by one of them. A fair number of participants reported sightings of used needles and syringes in their communities, which they attributed mostly to scavengers – those were mentioned on numerous occasions by many respondents, including doctors, nurses and medical waste handlers.

*“I think we should have a special place for disposal which should be off limits to the public, right. I don’t think that hospital waste should be disposed of in the normal garbage disposal, you understand? Along with, not only injection needles, there might be other things that may be highly contaminated also...the waste is supposed to be actually properly taken care of and disposed of, not in the normal public dump. If you know, we have people scavenging our dumpsites that they might find things that wasn’t useful to others...so in the same thing, if you dump these things in the same dump and people become infected and cause an outbreak in our society. So hospital waste, I think, should be disposed by special people.”*

*“All types of people will be scavenging through the waste. Hospital waste should be taken care of, should be incinerated or there should be a special dumpsite under tight security.” (Linden).*

*“It’s dangerous, you can get ugly diseases.”*

*“Yes, they (people who throw syringes away) are careless, especially the malaria patients, and children would pick it up and play with them.”*

*“They (garbage removal workers) don’t know who used the needles and then they stick themselves and they can get diseases.” (Amerindians)*

*“(I’ve seen needles) all over the place, in the garbage, in the dump, in the bin and people complain that when they collect garbage, they would, they don’t burn them.”*

*“I hear on the news that they find them in some alleyway. They should put a law on anybody or hospital that they find needles lying around.”*  
(Region 4)

*“Sometimes at the big tree you might see some needles, after they finished with it, like they come and dump it.”*

*“Actually a lot of school children would like to pick up the needle or when they fight, pick up the needle and they don’t really know what is in the needle. Some boys like to go around drums and things and some of them may take it up and someone could die.”*

*“I think they should burn it or put it somewhere where people can’t come into contact with it. Especially the little children.”* (Region 6)

*“I know a time I saw a child with a syringe, but sometimes he got it from a pile, but not from the public hospital.”* (Region 7)

## **SOURCES OF INFORMATION ON HEALTH-RELATED SUBJECTS.**

When asked about their preferred sources of information on health topics, the participants named a broad array of choices that we felt was predicated largely on where they lived. Respondents who lived in urban areas mentioned TV, radio and newspapers, while those who were based in remote rural areas brought up visits to the health workers or government-sponsored outreach visits. No

source was prominent enough to be singled out, although personal contacts with a doctor or a healthcare provider came up most often.

## **HOPES AND DREAMS**

The hopes and dreams about the future expressed by the participants can be loosely grouped into two distinct categories.

*Younger people, both male and female, said they hoped for better achievement, education and self-improvement. Reports of wanting to become a lawyer or a doctor were common:*

*“Excelling in study.”*

*“Studying hard and passing all exams.”*

*“Studying to become a surgeon.”*

*“My goal is to be healthy, stay focused and improve my life.”*

*“Hopefully I can improve my studies and my health for my baby. Mostly improve myself.”*

*Respondents who were somewhat older and had families said they cared about the well-being of their children more than anything else. Concerns about their own health were only instrumental to being able to care for their children and see them grow:*

*“I want to see my children grow.”*

*“I want to be healthy so that I could teach my children.”*

*“Education is important so that my children could get a proper education so that they could go further. I want my children to go further.”*

*“I am asking and praying to the Almighty that I will feel stronger, feel better in the more physical sense and be able to show my children the way that they would take my footsteps and even be better than me.”*

## **RELATIONSHIPS AND COMMUNICATION WITH HEALTHCARE PROVIDERS**

Many young respondents, particularly those from *remote rural areas*, brought up their concerns of confidentiality and fears that their conversations with doctors would not remain as private as they would like:

*“I am really scared so if I tell them they tell my parents.”*

*“I feel comfortable because he [the doctor] didn’t tell my parents.”*

*“I only talk to the doctor once I feel ... comfortable talking and you get to learn more and I gain something.”*

*“If you get a sick, the whole town would know that you are sick and I think that should be confidential.”*

*“They might talk to me nice, but they would not go out there and speak good about me if they know I am HIV positive.”*

## **COMMUNICATION WITH PROVIDERS AND PRESCRIBERS**

While respondents had a lot to complain about the shortcomings of medical care in their respective communities referring to such factors as long waits, indifference of nurses and doctors, and shortage of medication in general, they said they usually had working, cordial relationships with their doctors and nurses. This was particularly pronounced in the rural areas where the respondents were likely to have personal ties to

medical providers in their respective communities:

*“He tells me what to do, how to care for myself, what to eat and what not to eat. He talks to me very nice.”*

*“They don’t be annoyed, they will sit and listen to you. You see, in accordance to what you tell them, that is how they treat you.”*

*“I have no problems with nurses. They are all my friends.”*

Many respondents said they had no problem with asking their doctor for more information and explanation of the treatment he or she prescribes:

*“I do find out, the doctor said I should.”*

*“If you don’t explain everything and tell them, they can’t know. It’s your body, you have to say how you feel, how the treatment reacts, when you take it.”*

*“I want to get well, so I talk.”*

*“If you don’t know and you ask them to explain, they explain to you. Like if you don’t know how to read, they read it and explain it to you.”*

*“In regards to the few times I have hospitalized, I have no problems with the doctors and nurses. I never had any problem.”*

*“When me don’t want a thing, I ask them for another and me get it.”*

At the same time, importantly, when questioned about their willingness to challenge the doctor’s advice or ask for alternative treatments, many respondents said that although they had no problem with asking

questions or seeking a more detailed explanation, contradicting the doctor’s advice on treatments would be inappropriate. They said they saw doctors as trained professionals who were supposed to know what they were doing. This trend was observed across rural and urban areas in all regions:

*“Some of them might want to ask why you come to me if you know what treatment you are supposed to get.”*

*“I do not think it is right that you ask a doctor for another treatment because he give you that medication because he know that is what you are supposed to get.”*

*“It’s not what we prefer, it’s what the doctor prescribe to you to help you. I really feel that the doctor should prescribe something that he knows. The doctor is the doctor and he should prescribe what is best for you. You must not predict or tell the doctor I want this. The doctor will know if aspirin is good for you or whether panadol is good for you or if any other tablet is good for you.”*

*“They are doctors, they know what they are giving you.”*

*“He is the last man to make the decisions.”*

*“You trust in their experience so you don’t really be interested.”*

*“It’s not what we prefer, it’s what the doctor prescribe to you to help you.”*

*“I personally feel that a doctor studied his field and he knows what he’s doing.”*

One of the common complaints about medical doctors from the respondents had to do with the

feeling that they do not have enough time to communicate with the doctor:

*“Some of them don’t have any patience. I don’t complain or anything because for instance when you are speaking, they already write. They just jotting down what they want to. I feel most of them don’t listen. And the next case with the Cuban and Chinese, they need someone to translate.” (Linden)*

*“Some of them by the time you start talk they already write.”*

*“Before you can explain they done write up your information and they don’t take time to explain.”*

*“When you go to the practitioners, they never tell you what they are writing on your card or explain what is happening. At one time we used to call them the ‘right away doctors.’ There were some Korean doctors, and when you go into the doctor, since you start talking, they start writing, and by the time you finish, you just say yes, doc, what is the prescription.”*

We did not encounter many stories of differences in approaches between public and private doctors. There can be a number of explanations for this lack of differences. First, in many rural areas public doctors have a private practice, so in reality the same practitioner wears two hats, and the patients recognize that.

The few complaints we heard about the doctors’ unwillingness to suggest alternative treatments came from remote rural areas of Amerindian hinterlands and from Region 10:

*“There are some doctors, that when they give you the medication, you*

can't ask them this is for what and they don't want to help."

"You don't get a chance, what they do they give you."

"When you ask them for another treatment, they sometimes get upset."

## SUMMARY

- Patients said they did not have any difficulty in communicating with their doctors and nurses, which included asking them for explanations or for more information. At the same time, the respondents said that "doctor knows best", which made them unwilling to contradict the doctors' advice or ask for an alternative medication or choice of treatment. Patients from rural areas seemed to have closer and more personal relationships with their healthcare providers.

- Patients' responses made it clear they were aware of the risks inherent in using dirty needles and tried to ensure that every needle used by their health provider came out of a fresh package.
- Patients' responses indicate a divided attitude toward injections. On one hand, they almost unanimously said that injections bring faster and stronger relief than oral medication, and were therefore a better choice than tablets. This preference sometimes resulted in patients choosing to go to a private clinic or a doctor where they believe they can get an injection easier than in a public facility. On the other hand, patients said they had a strong aversion to injections as an invasive, skin-penetrating treatment that often produced painful and unsightly side effects.
- Patients did not indicate a high level of awareness of methods for disposal of medical waste, including sharps. However, when probed, they said they were concerned about medical waste being disposed with the rest of the garbage in unsecured locations, and especially about the possibility of children getting in contact with used needles. They said that medical waste should be discarded in a way that would make it inaccessible to people in the community.
- We encountered many reports of sightings of used needles outside of medical facilities, especially in the rural areas. Patients said that scavenger activity was responsible for most of these accidents, but felt strongly that this should not be happening.

Current behavior/attitude	Desired behavior/attitude	Barriers to change	Motivating factors	Possible BCC intervention
<p>Believe that injections bring faster and stronger relief</p> <p>Belief that injection is a "proper" treatment vs. a tablet</p> <p>Accept injections without question</p>	<p>Raised awareness of oral medication as an acceptable choice of treatment</p> <p>Increased demand for oral medication</p> <p>Reduce doctor- and clinic-shopping to get an injection</p>	<p>Strong belief in faster and stronger relief brought by injections</p> <p>"Doctor knows best" attitude</p> <p>Some fear of contradicting providers</p> <p>Private doctors and facilities readily offering injections</p>	<p>Belief that oral medication works just as well</p> <p>Fear of injections</p> <p>Fear of infection</p> <p>Belief that "doctor knows best" if doctors begin prescribing more oral medications</p>	<p><u>Shorter-Term</u></p> <ul style="list-style-type: none"> <li>- Materials (such as posters and brochures) in clinics and doctor's offices supporting the use of oral medication</li> <li>- Training of medical providers in communication skills to improve their ability to communicate the benefits of oral medication to patients</li> </ul> <p><u>Longer-Term</u></p> <ul style="list-style-type: none"> <li>- Articles by medical doctors/health officials in print media supporting the use of oral medication</li> <li>- Radio/TV talk shows with medical professionals integrating messages that "oral medication works just as well"</li> </ul>

## VI. KEY FINDINGS: WASTE HANDLERS

This section of the report addresses the attitudes and feelings of medical waste handlers – a category that has been loosely defined to include personnel responsible for handling medical waste, including sharps, *within* the hospitals and health centers - i.e. from the time the sharps are discarded by nurses and doctors to the time when processed or semi-processed waste is finally disposed of either onsite or through transfer to the municipal or public waste management system. For this audience, the team decided to arrange separate group discussions for waste handlers who worked in hospitals vs. those who worked at health centers, as we assumed their work conditions would be different. This distinction also mirrors the urban/rural grouping

we used for other target audiences.

In the hospitals, medical waste handlers are typically referred to as maids and porters.

The discussion with members of this key audience focused on the following areas:

- 1) practices and perceptions related to disposal of sharps
- 2) practices and perceptions related to needlestick injuries and PEP
- 3) awareness of risks and perception of safety on the job
- 4) hopes for the future and perception of job satisfaction

The main objective of collecting insights on the subjects listed

above was to explore the following:

- current practices and attitudes;
- possible barriers to behavior change, both external and internal; and
- possible motivating factors, both external and internal.

### DISPOSAL OF SHARPS: PRACTICES AND PERCEPTIONS

Consistent with our findings during focus group discussions with nurses and Medex, procedures employed for the disposal of sharps differed dramatically across different medical facilities and regions, and depended largely on the specific circumstances of each individual hospital or health center.



**Used sharps and needles can be seen clearly in this picture of the open-air dump at a hospital backyard**

**REGION 4 HEALTH CENTERS**

*“Sharps are usually placed in a bag and then they come and take them away.”*

*“I usually tape them up and then the ambulance comes and takes them to the incinerator.”*

**REGION 4 HOSPITALS**

*“There is a special area for injection, there are containers for disposal. At the end of the day that container is locked and placed in a colored bag...that bag is placed in a special bin where nobody else has access.”*

*“The bin is in a special area. Every morning there is a special truck to collect this. The other garbage goes in the other bag.”*

**REGION 10 HOSPITAL**

*“They would give color-coded bags and sharps containers.”*

*“Burn in incinerator, when it burns, they empty the remains into bags, the ash and so, and send to the dump.”*

**REGION 6 HEALTH CENTERS**

*“Safety box, taped and send to New Amsterdam hospital; it is stored under a table, heavy duty gloves are used at the health center.”*

**NEW AMSTERDAM HOSPITAL**

*“Some needles are taken off and placed in containers, when filled, the porters are called to remove it, I would put on a latex glove and empty the container into a bucket, then into a cardboard box.”*

What was similar across all the regions and facilities was the feeling of dissatisfaction with the level of safety of sharps disposal and the sense that more should be done to assure safety and proper disposal:

**REGION 4 HEALTH CENTERS**

*“Before we used to burn them but the needles don’t burn.”*

*“It is not safe even for the driver.”*

**REGION 10 HOSPITAL**

*“Fire don’t burn enough to destroy the needles. The incinerator and the heat it carries is not enough to burn them, so we put them in the mortuary and lock them up and on Monday the town council comes and uplifts the boxes and take it to the burn site in the mines.”*

**REGION 6 HEALTH CENTERS**

*“Sometimes the nurses make mistake and instead of putting it in the box, it ends up on the floor and I would pick it up with my hands and put it in the box and burn it outside after put the remains in a pit toilet.”*

*“Nurses place the needle in the box and tape the top, when in hurry, does not use glove, yellow gloves are used.”*

**NEW AMSTERDAM HOSPITAL**

*“Sharps are discarded once a week, but at present the incinerator not working, at old hospital used to burn all waste.”*



**Small incinerator at a hospital’s backyard**

## NEEDLES IN THE ENVIRONMENT

Similarly to needlestick injuries, almost every group of medical waste handlers we interviewed reported sightings of used needles and sharps outside of areas designated for their disposal (except Mercy Hospital, a private facility in Georgetown).

### Region 4 Hospitals

*"I saw a needle left stuck on the bed."*

*"The needles are where they are not supposed to be."*

*"This does not happen at Mercy. We don't have a big hospital and the nurses would have to adhere to the rules."*

*"Yes, I see children would try to go to the boxes and try to open them."*

### Linden Hospital

*"Needles are about... whilst moping there are needles on the floor. Sometimes they don't check to make*

*sure the needle gets into the box and they fall outside."*

*"I find sharps about the place, in all the wards."*

### New Amsterdam Hospital

*"Needles are found on the ground, mostly in the morning."*

Most respondents said this was caused either by the careless actions of the medical personnel or by substandard disposal equipment, such as the boxes that got soft easily when in contact with moisture.

### Region 4 Hospitals

*"I saw [sharps] outside of the box in the ward... I felt disappointed. The bags, the disposal bags are not strong enough, they burst if you don't handle them properly."*

*"Nurses and doctors have no respect for rules. They do not use the sharp boxes. The sharps boxes are usually empty and the sharps can be found in the bags."*

### Linden Hospital

*"I have reported several times to the office. Remember that we are all human. The nurses, some are genuine, some are careful; some are here for the money. Some come and work genuinely thinking about others. So when some people work, you find the sharps on the floor, sharps thrown about carelessly, and when other people work, you would find nothing around... I would put them in the dust pan and put them in the bin they are supposed to be disposed in."*

*"The containers are available. The nurses are just careless."*

*"The porters encounter sharps because the nurses place that sharps in the waste bins."*

### Region 6 Health Centers

*"Needles stick out of the box."*

*"Boxes are weak."*

*"When the rain falls, the building leaks and wet the boxes."*



**Semi-secured storage of burnt waste at a hospital backyard**

## NEEDLESTICK INJURIES

Based on our discussions with medical waste handlers, it appears that needlestick injuries are common, and most maids and porters across all regions and facilities said they have had personal experiences with needlesticks or know someone who has been stuck. The respondents cited several reasons why injuries occurred, including restless patients, unsafe containers and human error:

*“One time I was doing it on a girl and she moved and I stuck myself. I squeezed my finger and then soaked it in bleach and then I told the sister.”*

*“Sometimes the needles after being placed in the box can still bore you. It has never happened to me, but I know it can happen.”*

*“I am afraid, I got bore seven times. I even got bore on my knee.”*

*“I know, twice (getting stuck), but HIV wasn’t prevalent, and I read about people getting stuck with HIV so you always have to be safe. Sometimes you get stuck and you don’t even know. Especially handling the boxes, you can hold it wrong or needles may be sticking out.”*

*“Over the years porters have been injured with the needles, I was stuck several times.”*

*“Porter got stuck after a patient has been injected; nothing was done.”*

### POST-EXPOSURE PROPHYLAXIS

Most maids and porters we interviewed said they had at least some knowledge of what they had to do in case of accidental needlestick injury. We discovered

that most of the time, these steps were not codified in any official regulations; the knowledge came mostly from conversations or formal talks with nurses and Medex. Most respondents said the first thing they would do after getting stuck would be to contact their supervisor who would then instruct them on further steps:

*“We just go to our supervisor, she squeezed the fingers and then you go to the administration and a doctor.”*

*“Nurses will discuss what to do in case of accidents, report to the supervisor, then being sent to the New Amsterdam Hospital for an injection.”*

*“No written rules, but nurses would say what to do.”*

*“Go visit the doctor or go home if you have sick leave pending.”*

*“If a needle sticks, you squeeze the spot and put mentholated wash with soap and water or bleach, a booklet was given at the HC.”*

### AWARENESS OF RISKS AND PERCEPTION OF SAFETY

Most waste handlers we interviewed said they were fully aware of the fact that their job entails risks on a daily basis, even if the exact nature of risks wasn’t clear. Almost all respondents mentioned HIV/AIDS, but the knowledge of other diseases was vague, and most of them said that they can be infected with whatever the patient had:

*“You can get TB also.”*

*“You can get venereal disease also, because if someone has it and you get stuck with the needle.”*

*“If it sticks someone, they can be infected with HIV, hepatitis B and others, e.g. the needle used on a HIV patient and left exposed.”*

*“HIV, sugar, anything else the person had. Sugar, coughs, TB.”*

### PERCEPTION OF SAFETY

Based on our interviews, the feelings of safety on job amongst medical waste handlers were varied and ranged from deep despondency to a positive, can-do attitude. Most respondents said that they were at least somewhat endangered and need to be very careful, even if they had protective gear and several vaccinations:

*“I feel unsafe because it if sticks me and when you try to complain, they say they don’t know who it is.”*

*“It’s not safe. They throw stuff in any bag, any one of the bags. They do not stick to the color-coded bags. You have to hope that there are responsible persons working in the wards. If needles are seen sticking out, they try to cap it. The nurse uses anything that is close to them.”*

*“How do you keep safe? Wear gloves. Keep your head on.”*

### Linden Hospital

*“[We had vaccinations for] hepatitis, yes, the tetanus also. But we still have to be careful, that’s why I say to my people to put on masks and gowns.”*

*“I don’t feel unsafe. My administrator already advised me, that this is what we have to work with, so I work within those means. There are still other people in my section who need*

long boots, and that is very important.”

“When I go uplift them [boxes], there are times when the needles bore through the box. That’s where the safety comes in. You know, have to hold it and be careful.”

#### **Region 6 Health Centers**

“You have to protect yourself, be careful and wear your gloves and pay attention to the box, so it will not overflow.”

#### **New Amsterdam Hospital**

“We are not safe; the key word on this job is survival.”

“Not scared that you would get AIDS, but it is not healthy to work under these conditions.”

“No protective gear given - just the regular boots and latex gloves.”

#### **INADEQUATE GEAR**

Most waste handlers we interviewed said they had to use at least some kind of safety gear. However, further probing revealed that most of the time, they were not entirely happy with their protection for several reasons. Some of it, such as tall boots, was ill-fitting and made them trip and fall, so porters and maids ended up avoiding it. Some of it, such as rubber yellow gloves, resulted in skin rashes. Thinner gloves, such as disposable latex, did not go as high up the elbow, and were easily pierced:

“We need stronger gloves. The ones that go to your elbow are the safest. They would rather use disposable gloves because the other type gets smelly and gives them itches.”

“Latex glove is worn to do all the work.”

“Sometimes rubber gloves were used, but now you do not get it.”

“The glove burst easy.”

“The glove burn your hands, the yellow plastic ones are not used often.”

“Needles can bore through the glove.”

#### **TRAINING**

The picture that emerged after focus group discussions with waste handlers at several medical facilities across Guyana was that of an ad hoc approach to training porters and maids in handling medical waste safely and avoiding risks. Many respondents, regardless of location and prior training, said they needed more training in minimizing risks inherent in their job.

#### **Region 4 Health Centers**

“Orientation session included training on protection and general sanitation rules. There has been no training since the initial training. Most persons use their knowledge and common sense.”

“I think they should teach us more on that, how to dispose, how to prevent ourselves from getting bore. The ministry should get somebody to teach us that.”

#### **Georgetown Hospital**

“Staff and patients disregard waste handling rules [this statement implies that rules do exist] and expects them to always do the work.”

#### **Mercy Hospital**

“The problems are minimized since they have fliers and notices available for proper waste handling for both staff and patients.”

“Over at Mercy we have fliers, instructing a person what to do and how to go about disposal of the gloves, the different wears.”

#### **Linden Hospital Complex**

“The only training we receive so far is we had the breaking the chain of infection like solid waste management, how to protect yourself.”

“I had...waste disposal, breaking the chain of infection, how to protect yourself from being stuck...I think the entire hospital was trained, the entire staff at that time.”

#### **New Amsterdam Health Centers**

“No one in the group was trained.”

“Special training is required on how you can protect yourself when disposing of waste.”

#### **HOPES FOR THE FUTURE AND JOB-RELATED FEELINGS**

##### **PROFESSIONAL GROWTH**

Many waste handlers reported that they liked working in the medical field and planned to advance their education to become a healthcare worker. Many respondents also said that they had much respect and admiration for nurses and Medex they worked with, and thought of them as role models:

“I would like to go further...before I started working at the health center I used to volunteer at Georgetown

*hospital in the HIV ward. I would like to do nursing.”*

*“I would like to do the care for the elderly because I get along good with the old people and when they come to clinic and don’t see me, they ask for me.”*

*“Admire nurses and Medex; they reach out to people.”*

#### **FAMILY**

Older respondents said their hopes and dreams were focused on health and advancement of their children and families:

*“My children and would like to elevate myself more.”*

*“My children, my job, my home and my health.”*

*“Health and strength are most important.”*

#### **DESIRE TO BE RESPECTED**

Many waste handlers we interviewed said that their job was important for the smooth operation of their facility and proper care of the patients, and many of them had additional responsibilities (such as checking patients in and helping with paperwork) in addition to cleaning.

*“All of us are equal in our own category. The people out there look on us as cleaners but for me, I look to my very own important role... We fulfill our day, as in any vehicle, if one spark plug ain’t working, the vehicle can’t move, as small as it might be. Doctors can’t function, nurse can’t function, lab can’t function, theatre can’t function.”*

*“And if there weren’t cleaners then the place would not have been clean, so you have to appreciate everyone.”*

*“I would like people to see me as a very important person because without us patients would not be comfortable.”*

However, although many respondents said they had good relationships with their nurses and Medex, a large number of respondents said that they were not accorded enough respect and importance. Many waste handlers we interviewed stated that to a certain extent, they were marginalized and perceived as “garbage people”, and certainly as inferior, by the patients and their colleagues.

*“Rubbish, that’s what they consider you.”*

*“Hostile is their attitude, and how they would usually respond to you.”*

*“Whenever official visit, does not talk with them, only nurses and Medex, problems at the center are only reported to nurses.”*

*“Years ago you could talk with nurses, maids are not allowed to sit in the wards. As head, I take complaints, but management does not help.”*

#### **DESIRE TO BE SAFE**

Many waste handlers we interviewed said that this feeling of disrespect also translated into disregard for their safety on the part of the hospital management, nurses and doctors. Specifically, waste handlers lack appropriate, well-fitting safety gear. Doctors and nurses are routinely careless with their sharps and medical waste but expect maids and porters to clean them up, even

though it subjects waste handlers to unnecessary risks. Respondents said these issues were exacerbated by the fact that they felt powerless to bring these complaints to the attention of doctors and nurses to press for change:

*“We are waste on the site; you are not allowed to disagree or express your feelings, the nurses have a bad attitude, it’s bad, maids and porters not counted.”*

*“[If I complain,] only lip service and victimization would follow.”*

*“I might even get suspended.”*

*“I want to be safe in my job, better working conditions... things like long boots, gloves; right now I am using my own boots.”*

*“We need better protection at the health center... more protective gear, yellow gloves.”*

#### **RELATIONSHIPS WITH DOCTORS AND NURSES**

Despite the feelings of disrespect and disregard for their safety on behalf of other staff reported earlier in this section of the report, many respondents said that they admired doctors and nurses they worked with, and some said they had no trouble communicating with them by bringing any problems to the attention of their supervisors:

*“If I have problems, report to administrator and she takes it up. It’s OK to ask doctors questions.”*

*“You can go and talk to your supervisor, any problems, you can go and discuss.”*

*“I am comfortable with supervisor and can talk with the seniors.”*

## SUMMARY

- Medical waste handlers said their jobs were important for effective operation of their hospitals and health centers. However, many of them stated they were not given proper respect by their coworkers, such as doctors or nurses, because of their “lowly” status and association with garbage.
- Waste handlers said that doctors and nurses routinely disregarded the rules for safe disposal of sharps and created additional risks for porters and maids by discarding needles in a careless manner. Importantly, although many respondents reported having good relationships with doctors and nurses, they said they did not feel that they can communicate their dissatisfaction to these

workers without repercussions due to their perceived low status.

- Procedures and available equipment for disposal of sharps varied across different hospitals and health centers. Regardless of specific details, most respondents said that the equipment they use is not as safe as it should be, and broke down frequently (bursting bags, soggy boxes, etc.). Reports of needles found around the facilities were common and usually attributed to faulty equipment or careless actions of doctors and nurses.
- Most waste handlers said they knew that their job placed them at risk of HIV infection, although awareness of other potential infection risks is inconsistent. Many of them said they did not feel safe on

the job, and most underscored the need to use protective gear, although they were not entirely satisfied with the protection that their gear provided. Some respondents said they needed more training on handling the risks they face on a daily basis.

- Reports of needlestick injuries were common across all regions and medical facilities. Many respondents said they were aware of the steps they need to follow after getting stuck, although most of the times this guidance was not formal and has been imparted through talks with nurses and doctors.

Current behavior/attitude	Desired behavior/attitude	Barriers to change	Motivating factors	Possible BCC intervention
Neglect to use existing safety gear	Always use protective gear	Perceived inconvenience Heat Side effects (such as rash) Ill-fitting gear	Fear of infection Fear of needlesticks	<u>Shorter-Term</u> - Job aids reminding porters and maids of the need to use protective gear properly <u>Longer-Term</u> - Peer education on use of protective gear, universal precautions and PEP - Advocacy with facility management to ensure purchase of proper protective gear
Improvised disposal procedures Unsafe disposal actions (such as picking up needles with hands, etc.) Keep quiet when nurses or doctors disregard safe disposal practices	Follow proper disposal procedure (once equipment is in place and training is complete) Communicate the expectation that safe disposal procedure must be followed to nurses and doctors if the latter neglect the rules	Containers not available Lack of communication skills and self-efficacy when talking to perceived superiors	Fear of infection Fear of needlesticks Belief that needlesticks are preventable Belief that they are capable of communicating with doctors and nurses in a constructive manner without repercussions (increased self-efficacy)	<u>Shorter-Term</u> - Job aids supporting proper handling of sharps containers (i.e. no opening, no reusing, etc.)* - Training in assertiveness and communication skills <i>*This assumes that containers are available and that waste handlers have been trained to use them.</i>

Ad hoc post-exposure practices	Seek PEP procedures	Lack of clear guidance Lack of ARV drugs	Fear of infection	<p><u>Shorter-Term</u></p> <ul style="list-style-type: none"> <li>- Job aids supporting PEP guidance*</li> </ul> <p><u>Longer-Term</u></p> <ul style="list-style-type: none"> <li>- Advocacy to promote adoption of PEP guidance to apply to facilities nationwide, including availability of ARV drugs</li> </ul> <p><i>*This assumes that clear PEP guidance has been issued and that waste handlers have been trained about the steps it involves; and that ARV drugs are available</i></p>
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## VII. KEY FINDINGS: WASTE CARRIERS

This section of the report addresses the attitudes and feelings of waste carriers – a category that has been loosely defined to include those responsible for removing and handling all waste (including, but not specifically dedicated to medical waste) in a given location. Typically, members of this key audience group are employed by the public or municipal waste management service and handle all types of waste generated in their location, including household, commercial and other waste.

The discussion with members of this key audience focused on the following areas:

- 1) practices and perceptions related to disposal of medical waste
- 2) practices and perceptions related to needlestick injuries and PEP
- 3) awareness of risks and perception of safety on the job
- 4) feelings related to the job and hopes for the future

The main objective of collecting insights on the subjects listed above was to explore the following:

- current practices and attitudes;
- possible barriers to behavior change, both external and internal; and

- possible motivating factors, both external and internal.

### PRACTICES AND PERCEPTIONS ON REMOVAL OF MEDICAL WASTE

#### PRACTICES IN DISPOSAL OF MEDICAL WASTE

Consistent with our findings during focus group discussions with other key audiences such as providers, prescribers, and medical waste handlers, the respondents reported a wide variation in the specific procedures they followed to pick up and dispose of medical waste. The general pattern that emerged usually included one or more of the following steps: 1) a pick-up of bagged or otherwise packed waste from medical facilities, 2) its removal to the dump site, and 3) either make-shift incineration or burial at the dump site.

*“We carry it to the dump heap and dump it out, and then a man is there, he burns it.”*

*“Needles and syringes, we would burn that... We stack up some wood, put the needles and syringes, put some more wood and then light it. And we make sure someone is around to make sure everything burns. Because we don't have an incinerator.”*

*“In the mornings they will send the trucks out to get the medical waste, then it will come, right now they stop burning it. They bury it in the dumpsite.”*

The respondents' remarks did not suggest a clear pattern of segregating sharps from all other medical waste at hospitals – it seemed that while some of them made an effort to segregate sharps

and needles, these efforts were not thorough nor commonplace:

*“No, they dump all the rubbish, just the needles they may put in something.”*

*“We have a needle box, so when they use the needle and syringes, they put it inside. So when the box is full, they notify us so we go and get it burnt.”*

*“Sometimes they do (place sharps in designated bags), sometimes they don't, they have careless workers.”*

#### DUMP SITE

Most of the removed garbage, based on the responses we encountered, ended up at the town dump site. The waste carriers we interviewed made it clear that in many cases, the dump site presented an additional risk because of the possibility of encountering loose needles. Most of these sites were unsecured and accessible to anyone. Reports of scavenging at dump sites were common, and the respondents said that the main reason that needles may be seen out at dump sites had to do more with scavenging than unsafe packaging of waste at hospitals.

*“Once in a while (in the dump) you will see needles.”*

*“The dumpsite is exposed for anybody because it is not protected.”*

*“All of us would go there. Scavengers, too.”*

*“The junkies used to access needles in the past due to how the needles were disposed of by the hospital.”*

*“People live off of the dumpsite. They go in the bags to see what is inside.”*

*“Junkies know that certain facilities generate medical waste and they take it to some area where they can go through it.”*

*“The dumpsite is not secure; minimal security, so we are relying on the conscience of waste pickers and we constantly teach them to stay away from medical waste. I personally say to them from time to time when I go there; informal education. I know them and they know me. Sanitation workers receive formal training, they are part of my staff and receive formal education, including on medical waste.”*

### **DISSATISFACTION WITH DISPOSAL PROCEDURE**

As noted above, we encountered reports of differing procedures used to dispose of medical waste; the similarity across all regions and respondents was their dissatisfaction with the level of safety and effectiveness that their current procedure involved. The reason for the dissatisfaction was attributed mostly to the careless behavior of medical workers who, according to the respondents, did not take enough efforts to ensure that all hazardous waste, especially sharps, was properly and safely

packaged for its further disposal. So the respondents said that they were either placed at more risk than necessary, or were exposed to seeing things (like unsecured body parts) that they should not have to see.

*“We notify them about the bags; some of the porters complain, because in the morning, when they go around, some needles are on the ground and that is very dangerous, because they are working with patients with syringes and needles. We don’t have an incinerator, but we have a container, an iron container where we store the garbage and then on Friday mornings, town council picks it up and dispatches it.”*

*“The nurses don’t always put the needles in the bag and sometimes you go to pick up the bag and you get bore.”*

*“We told them that if they put it in those five hundred milligram table bottle and they lock it, it would be more safe. But they are throwing it in the drum just so that you can see.”*

*“Sometimes when the nurse is working at nights a syringe or needle may fall on the ground. As soon as*

*the porter sees that he will come and move it...yeah, I pick it up with my hands or the nurse will pick it up sometimes.”*

*“Aside from the source...we are not satisfied with segregation of the waste. Biological, food, sharps...we are not comfortable with the way they segregate it now.”*

### **NEEDLES IN THE ENVIRONMENT**

We did not encounter an overwhelming number of reports of needles found on the streets in the communities where the waste carriers we interviewed lived. The respondents reported seeing needles on the streets a few times that they attributed mostly to drug users’ activity:

*“Sometimes you have the drug addicts who sometime use the needles and there are the diabetics who take the treatment themselves and they use the needle and throw it in the bin. So you do meet up with needle.”*

*“One or two or three in every district.”*



**Georgetown incinerator (no longer functioning)**

## NEEDLESTICK INJURIES

Based on the reports of the respondents, it appears that the sight of needles and needlestick injuries are a fairly common occurrence. The waste carriers we interviewed said they were aware that getting stuck by a needle was something that required immediate attention, and many reported that the first thing they did was to contact a doctor. Reports of colleagues and other workers who got stuck were also fairly common:

*“They’ve been complaining that they see sharps everywhere. Once we got a report that one was stuck. We sent the person to the doctor; he was not infected.”*

*“I bore the long boots already, but it did not go right through and I made a complaint to the pharmacy and then I came and made a complaint to the boss lady and she made a complaint to the pharmacy.”*

*“He (the manager) told me to go to the hospital (after I got stuck.)”*

*“Right now they have the Prashad Hospital, workers go there and they have to handle the bags with care because needles are pushed out from the bags. I got bore several times a year and when I go to the hospital, they take a yellow thing and rub it...I went to Prashad Hospital, I was carried in a room, then nurse put some liquid on the finger and I was sent home.”*

*“I got stuck twice.”*

*“I know a man who got bore and died a few months after. He was a sanitation worker here. He had gloves on, but when he picked up the bag to throw it in the car patrol, the needle*

*bore him and he suffered for a few months, then he died...Nobody knows because the Council did not take an AIDS test for him...if he was taking good care. Or if he was educated...he didn’t know the seriousness of what was going on.”*

*“If you see a needle and put your hand there, that is carelessness. You know the bags have needles in it, why handle the bags. He had on gloves yeah. Then it means that the gloves are a waste of time. Because if you have on gloves and you’re still getting bore. The gloves can’t protect you from an injection needle because it is not steel, any metal can bore it.”*

### PEP

None of the waste carriers we interviewed reported having formal workplace guidance or regulations on what should be done after a needlestick injury occurs. However, many respondents said they knew that a needlestick injury was a serious matter that required medical attention, and some of them were able to describe, without being prompted, many of the steps that are usually prescribed in a formal PEP guidance. It appeared that their management was supportive and responsive to these needs as many respondents said they were sent to the doctor once they reported their injuries to their supervisors.

*“I think the first thing if you get stuck you should squeeze it, then you wash it out then you put bleach on it, then you report it to the supervisor.”*

*“If you have any accident, they send you to the doctor.”*

*“Because you know HIV patients use syringes and needles. You will have to take an HIV test to know which needle bore you.”*

*“There is a reporting system. The supervisor is contacted, then a report is made to the deputy mayor, the personnel officer is brought in, and the employee is taken to the hospital. The accident is recorded.”*

*“The minute it is reported, we send the person directly to the medical officer and we make arrangements at the Georgetown hospitals for them to be taken there. We have that in place...They know they have to report it.”*

## AWARENESS OF RISKS AND PERCEPTION OF JOB SAFETY

### AWARENESS OF RISKS

Most waste carriers we interviewed said they were aware of the fact that handling needles and sharps was dangerous and could result in infection, and this theme, when it emerged, was often discussed in a highly emotional tenor. HIV/AIDS was mentioned almost always when the risks were discussed; other diseases varied. The respondents felt that their job was dangerous in general, and that they encountered many risks on a daily basis while handling garbage.

*“You ain’t feel safe because when you dump it out, you could walk in another day or two and a needle can bore your foot too. Or bore anybody, because people are there [at the dump site] whole day.”*

*“You see, the needle is dangerous and you do not know what the test is about. They test for many things and you go and handle the same needle they use for HIV and you think it is nothing and you get bore and two and three days after you are home with your children and suddenly start feeling sick, and you take it for nothing but then you now have AIDS,*

now your wife find out you have AIDS, she is going to think you have somebody outside or something.”

“[The risks are] very high; people who are involved in the medical field should go the extra mile in making sure that needles are disposed of properly.”

“Besides the obvious risks like needle pricks; you can catch AIDS, HIV, hepatitis or even STDs. The list goes on and on. Other diseases: like malaria.”

“A lot of transmitted diseases. Like HIV from people who use drugs. Syphilis, all kinds of things can pass on to you.”

#### **PROTECTION**

All respondents reported that they have been issued with some kind of safety gear to use daily in their work, which typically included gloves, boots, and sometimes masks and gowns. Although they were not entirely satisfied with the quality or the level of protection it afforded, it was clear that they understood the importance of having protective gear in their line of work:

“Be careful, take your time and ...with the type of gloves you use, handle with care so that the needles don’t stick you.”

“We get safety boots and long boots and gloves.”

“The town council workers have been taught to use protective equipment and always be cautious when dealing with sharps or any other hospital waste.”

“Thick gloves, in most cases, depending on the waste that is to be collected, that would determine the

type of gloves. Respirators, when needed, and long boots. That’s about it.”

“You should wear your protective clothing and they would insist that in certain things you wear your mask, gloves and boots. That would be some of the rules in place now.”

“At least you have your respirator, your gloves, your boots and that is your safety.”

#### **DISSATISFACTION WITH GEAR**

As noted above, many waste carriers we interviewed thought that the protection gear they had did not protect them adequately enough. One common complaint was that the boots and the gloves are not made of the fabric that would provide effective protection against needlesticks. The gloves were frequently not long enough or not thick enough.

“We should have thicker gloves.”

“We don’t get the proper gear for what we have to face up with. They give a worker a dust mask and tell him that is a respirator. The small dust mask is only for dust.”

“When the vehicle leaves to go to the hospital, the council will provide gloves, plastic gloves and canvas gloves. They don’t provide respirators.”

“The yellow one [glove] you can only use that for about 15 minutes (above wrist)...they got some that the people in town does use, sometimes when you sweat it itches your hand.”

#### **PERCEPTION OF JOB SAFETY**

Most waste carriers we interviewed said that they did not feel safe while working, at least not

entirely safe. There was a feeling that their job puts them in contact with many hazards, and that although it was dangerous and sometimes stomach-turning, they still had to do it.

“For the years you must feel unsafe because you don’t know what infections...I would say that the things you have to see your minds would turn. But you have to work. If I don’t do it, nobody would. Some people come to the job, some new people, and when they go there and see it, they walk off the job.”

“You are exposed...to everyone. Because of something dumped in the garbage bin and you have to handle it.”

“Any disease, germs can contaminate you. In those days, but now they bag it off and probably you are a bit safer now.”

#### **REFUSAL TO PICK UP NEEDLES**

As mentioned above, all respondents were clearly aware of the risks of coming in contact with needles, and also said that the medical personnel is not doing enough to protect sanitation workers from the risks of handling needles and sharps. One theme that indicated the respondents’ awareness of these risks was their occasional reported refusal to handle sharps in the garbage if they felt that those who generated the waste disposed of them in a careless and unsafe manner. It was not entirely clear whether these refusals were a matter of policy, an act of frustration, or just gamesmanship, but the respondents said they wished to avoid the risks of handling sharps.

“[Question: When you told the pharmacy to dispose of their

needles in a plastic bottle, how did they take it?] They said yes, they will do it, but yet they do the same thing [throw needles away with the rest of the garbage without putting it in the bottle first.]. We told them many times and yes they continued to do the same thing. Then we stopped picking up the garbage. [A private contractor took over.]”

“No, we did not refuse to pick up the garbage from the pharmacy, the main thing is if you have no needles, we pick it up, and once there are needles exposed in the garbage, we would not pick it up because it is not safe to us.”

“We told them that are not picking it up unless it is safe. We ease off from it.”

“In any of my guys see a needle, they would definitely not go near it; because that is carelessness to the highest degree.”

## **TRAINING**

Most respondents said they did not have any training except what was offered on the job. Many of them said that they needed more education about the risks they are facing on a daily basis, and that perception was shared by their supervisors, and by waste management officials.

“Since I start working with the company, I started working as a garbage man up to now and I never had training, just how you come on you had to know the work on your own.”

“They should be given more training in safety. The hospital staff should also be trained on how to dispose of their waste.” (Supervisor at a private garbage removal company in Region 7.)

“If management would call the workers and keep a seminar and educate them, the workers would know when they go out there they can talk if they see something wrong.”

“They can be motivated by being educated because when they know, they act differently.” (Supervisor at a private garbage removal company in Region 7.)

## **WHAT NEEDS TO BE DONE**

Many waste carriers we interviewed said they felt very strongly that needles and sharps should not be discarded along with other waste. They stated that the hospitals needed to dispose of them separately in a manner that would bring other people into as little contact with sharps as possible. Burning, melting, or pulverizing was often mentioned, and the respondents clearly wanted to avoid handling needles if they could:

“What I think is that there should be a machine to dissolve these things or to burn and melt. To destroy them completely.”

“They should put the waste like needles should be separate from bandages and foodstuff.”

“All syringes should go in a special receptacle. I think they should start with education starting from the people who visit the clinics to the people who use the services.”

“I would like to see every ward where they are using sharps with sutures or whatever, to have containers at the ward. As soon as they use it, put it in the container, and close it or tape it, and have it in a special container, put it in a holding area and send it out separately. We don’t want sharps and other waste to go to the holding area

together, because it is very likely that sharps will be where they’re not supposed to be.”

“When sanitation workers are collecting, they should know that okay, this bag is pathological, this bag has infectious, this container is sharps, in other words, what we did in Georgetown, we built them a structure containing bio, food, commercial type waste, so you are not going to one compartment for all kinds of waste. So that the sanitation workers, they should know that this is lethal, this is hazardous, and this is not so dangerous, and this is commercial, anyone can touch it. They must know first why they have to segregate it, and all hospitals should build such a structure.”

## **FEELINGS RELATED TO THE JOB AND HOPES FOR THE FUTURE**

### **PERCEIVED DISRESPECT**

One of the most prominent themes that consistently came up during focus group discussions with municipal carriers was their perception of disrespect and low regard that society held for them. Across all regions, the respondents said that because their job was connected to handling waste, people in their communities viewed them as “garbage men” with little regard for their well-being or self-esteem. According to the respondents, that view was manifested by careless treatment of household waste (for instance, leaving it loose and not packed in bags before collection, which made removal a filthy job) or abusive behavior:

“In the same way, the tax payers will look at you with different eyes, think of you that you are collecting garbage.

*They have you in that scale that you are a garbage man.”*

*“For example, some of my workers in my area when people throw out their garbage and the bag bursts, and they tell them it should not be like that, are told that is what they are paid for, clean up the place. They are showing you that you are nothing.”*

*“Yes, we feel we are doing a good job, but some mornings when you go out people frustrate you. You know, you go out to pick up their bins and meet with those bad things and when you tell them they turn back and abuse you and hurtful words.”*

*“If they are not regarding their collectors, what will they do with us? Their workers working directly for them, they don’t have respect for, us who are not working for them.”*

Some respondents reported good relationships with their supervisors, and said that their management would be supportive of them if they wanted to complain about unsatisfactory working conditions. They mentioned that when conflicts occurred, they would be more likely to bring it up with their supervisor than with the source of conflict:

*“If you feel that the members of the community were wrong they say come and complain, she (my supervisor) deals with the matter and we get satisfaction.”*

*“The most they can do is get back here and talk to their supervisor; they talk to the head of the department or section. Then the Council will have to take it to speak with the administrator of the hospital.... They wouldn’t listen to these collectors like this.”*

*“We did this (complained) several times and they talked to the hospital and in couple of weeks, things were back to square one [previously mentioned dissatisfactory condition].”*

### **SELF-RESPECT**

Despite the treatment that they perceived as disrespectful, many respondents stated that they were doing a job that was important for the well-being of their communities, and deserved respect.

*“Certain times we decide not to work a day or two, and you see all the garbage there.”*

*“I told them [residents of the town] they have to show them respect because if they were not there to collect their waste, who would?”*

*“At least at the end of the day and when they look at the amount of garbage they collected and they know that if they did not, then fifty percent of that garbage would have ended in the river; because that’s how most people dispose of their garbage.”*

### **HOPES FOR THE FUTURE**

Many waste carriers we interviewed said they hoped that the future will bring some improvement to their position in life. To some, improvement meant getting more education, to some, being able to provide for their families. To our surprise, in quite a few responses the participants wished for better and safer working conditions:

*“I would go with the improvement part and a bit more training, things would be better.”*

*“I need a lot more time to get myself educated. I don’t have the time in order to commence my studies, and you have to find the time. Your education is what is going to take you through life. So I know I need a lot of upgrading.”*

*“I would like to own my own land and house and provide for my family in terms of what they need for their betterment.”*

*“Actually the same thing you have to get improvements, get proper things for the worker to do the job.”*

*“Definitely a more positive environment. We are being taken for granted.”*

A private garbage removal contractor operating in Region VII said the following about his workers:

*“They care about money and the ability to take care of their families.”*

### **SUMMARY:**

- Waste carriers (who are mostly public sanitation workers) said their jobs were important for the well-being of their communities. However, many of them said they felt disrespected and disregarded by the community because of their “lowly” status and association with garbage, as well as by the kinds of things they saw in the garbage that people expected them to handle.
- Waste carriers said the medical staff routinely disregarded the rules for safe disposal of sharps and creates additional risks for sanitation

workers by exposing them to sharps and needles.

- While respondents said that they could easily communicate their frustration to their supervisors, they did not feel that it would make much difference in the behavior of the medical staff at facilities that generated the waste.”
- Procedures followed by different municipalities for disposal of sharps varied; the common thread was the reported dissatisfaction of sanitation workers with the way the medical waste was disposed and packaged for pick-up. Accounts of needles and sharps found in medical waste were common.
- Respondents did not report an overwhelming number of incidents when needles were found on the streets or

elsewhere in the community. However, they said needles were often seen at dump sites, which they attributed to scavengers and drug users who opened the bags to look for items they could use.

- Most sanitation workers were aware that contact with needles and sharps placed them at risk of HIV infection, although awareness of other potential infection risks is inconsistent. Many of them said they did not feel safe on the job, and most underscored the need to use protective gear, although they said they were not entirely satisfied with the protection that their gear provided. Many of them said they need more training on handling the risks they face on a daily basis.
- Reports of needlestick injuries were common across all

regions. Many respondents said they were aware that a needlestick injury required immediate medical attention and must be brought to their supervisor’s attention; some were aware of the steps they need to follow after getting stuck, although most of the time this guidance was not formal.

- Members of the waste management community, both line workers and supervisory staff, said they were deeply dissatisfied with the way medical waste was presently being handled, and stated that they wanted to see a system introduced that would limit, or eliminate their contact with sharps and needles.

<b>Current behavior/attitude</b>	<b>Desired behavior/attitude</b>	<b>Barriers to change</b>	<b>Motivating factors</b>	<b>Possible BCC intervention</b>
Don't always use existing safety gear	Always use protective gear	Perceived inconvenience Heat Side effects (such as rash) Ill-fitting gear	Fear of infection Fear of needlesticks	<u>Shorter-Term</u> - Job aids reminding to use protective gear properly - Workshops/talks led by waste management supervisors <u>Longer-Term</u> - Peer education on proper use of protective gear - Advocacy for budget allocations for purchase of properly fitting and better protection gear

<p>Unsafe disposal actions (such as sticking hands in garbage bags, etc.)</p>	<p>Follow proper disposal procedures (once hospital-based equipment is in place and training is complete) Communicate the expectation that safe disposal procedures must be followed to nurses and doctors if the latter neglect the rules</p>	<p>Containers not available Lack of communication skills and self-efficacy when talking to perceived superiors</p>	<p>Fear of infection Fear of needlesticks Belief that needlesticks are preventable Belief that they are capable of communicating with doctors and nurses in a constructive manner without repercussions</p>	<p><u>Shorter-Term</u> - Job aids supporting proper disposal of medical waste that contains sharps (packaged in containers)*  <u>Longer--Term</u> - Outreach to hospital management by waste management supervisors to reinforce the need for better segregation of waste before pick-up <i>*This assumes that containers are available and that waste carriers have been trained to use them – to the extent that they have to</i></p>
<p>Ad hoc post-exposure practices</p>	<p>Increase awareness of PEP procedure Increase compliance with PEP procedure</p>	<p>Lack of clear guidance</p>	<p>Fear of infection</p>	<p><u>Shorter-Term</u> - Job aids supporting PEP procedure* <u>Longer-Term</u> - Advocacy to promote adoption of industry-wide PEP procedure and availability of ARV drugs <i>*This assumes that a clear PEP procedure has been adopted and that waste carriers have been trained about the steps it involves</i></p>

## VIII. COMPARATIVE ANALYSIS: QUANTITATIVE VS. QUALITATIVE HIGHLIGHTS

This section of the report provides a comparative analysis of preliminary findings of a quantitative study implemented in 51 selected sites in Guyana, including public health centers or hospitals and 12 private providers or facilities. The survey sample represented a cross section of demographics, geographic settings and key audiences that was similar to what we explored during this qualitative assessment through via focus group discussions and in-depth interviews.

Although the focus of the quantitative study was more closely related to assessing the appropriateness of commodity management, injection practices and waste management procedures available at the facilities in question, some avenues of investigation were nevertheless close to the subjects explored during this qualitative assessment, and it is therefore illuminating to compare results to see if there were any similarities and discrepancies between the two assessments. Brief results of this comparison are listed below.

### SIMILARITIES

*Disposable needles and syringes have become a standard for providers and an expectation for the clients.*

Quantitative results show that 92% of the interviewed clients recalled that the needle and the syringe for their last injection were taken out of the sealed packet in front of them. This is consistent with the

findings of the qualitative assessment on the provider, prescriber and client groups.

*Disposal of medical waste at most facilities is ad hoc and not subject to standardized procedures.* According to the quantitative findings, most facilities (93%) perform some kind of segregation of their waste, but only 13% have formal guidelines on this segregation. This finding echoes our qualitative assessment that discovered a wide variation in waste disposal practices across the regions and medical facilities that were dictated more by individual circumstances in every region than by standard procedures.

*PEP guidance is informal or non-existent.* Although a significant number of respondents interviewed during the qualitative assessment could name the steps to be taken after a needlestick injury, few reported that their facilities had a formal PEP procedure. The survey discovered that only 12% of facilities had procedures for PEP.

*Awareness of disease transmission caused by used needles emphasizes HIV and downplays other diseases.* In the course of our qualitative assessment we discovered that members of all key audiences were quick to mention HIV as a major risk related to handling used needles, but awareness of other diseases, such as hepatitis, was low and inconsistent, even though the risk of hepatitis infection through needlestick injuries is ten times higher than HIV (WHO, 2003). Quantitative findings indicate that while 80% of waste handlers named HIV as a major risk, hepatitis B and C were named only by 10% and 0% respectively. Similarly, 97% of prescribers were concerned about HIV, but only

26% and 35% were concerned about hepatitis B and C respectively.

*The use of protective gear by waste handlers is inconsistent.* During the qualitative assessment, we encountered many reports of waste handlers who avoided wearing their gear because it was ill-fitting, not sturdy enough and resulted in side effects like rashes. Similarly, the quantitative assessment reported that only 65% and 28% of waste handlers respectively wore closed-toe shoes and puncture-resistant gloves. Although no reasons were cited, patterns of inconsistent use of protective gear by waste handlers emerge from both assessments.

*Waste handlers receive little or no training.* Only 19% of waste handlers interviewed during the survey reported having any job-related training. This is consistent with qualitative findings where many respondents in the waste handler group reported having either very little or no training that would equip them to deal with the risks they faced on a daily basis.

### DIFFERENCES

Reports of *needlestick injuries* were commonplace and numerous during focus group discussions and in-depth interviews with providers, prescribers and waste handlers. However, in the course of the survey, only 22% of facilities reported occurrences of needlestick injuries, and only 20% of providers and 30% of waste handlers reported being stuck. Potential reasons for this discrepancy may include:

- the fact that the survey questions were restricted to

injuries in the last 12 months, or

- inherent differences between methodologies (i.e. the assumption that one may speak more freely during a focus group discussion.)

The most intriguing difference between the two assessments has to do with reports of clients' preferences for injections vs. other forms of treatment. During the qualitative assessment, a large number of respondents reported a strong preference for injections based on their perceived efficacy and strength. The survey results, however, showed that only 17% of clients reported such a preference. A possible reason for this discrepancy may be that the survey questions were restricted to fever, while the focus group discussions explored the general perceptions of injections that were not tied to any particular illness (although the questions about medications preferred in case of fever were also asked, the discussion naturally veered toward the patients' attitudes toward injections in principle). Based on these factors, we feel that a direct comparison of results in this subject area may not be feasible; however, this seeming contradiction in patient and provider reported attitude toward injection use should be taken into account during planning and implementation of interventions.

At the same time, 36% of prescribers interviewed during the survey reported that their patients preferred injections to other treatments in case of fever. The qualitative findings also indicated that prescribers believed that their patients strongly preferred injections, and while 36% is not an insignificant number, we expected it

to be higher based on the prominence of this theme in the focus group discussions. Possible explanations may have to do with a smaller sample in the qualitative assessment (14 vs. 37) or again, the fact that in the survey this question was limited to febrile illnesses.

Finally, during the quantitative survey, 19% of clinic attendants and porters reported observing sharps around the waste disposal site or health center. While insights discovered during qualitative studies are hard to quantify, it appears that the accounts of sharps found outside of safety bins, particularly in hospital settings, came up fairly often during focus groups with hospital waste handlers – more often than the indicator of 19% would suggest. Possible explanations may include different settings where sharps were observed, or the factors related to communication dynamics in groups.

## IX. CONCLUSIONS AND RECOMMENDATIONS

The results of this assessment clearly show that while the healthcare sector in Guyana has moved beyond the reuse of needles, disposal of medical waste and specifically sharps is an acute issue that calls for interventions in the form of strengthening commodity management systems

and services as well as behavior change communication strategies. If these are in place, the GSIP team will have a great opportunity to move Guyana closer to safe and appropriate injection standards, as well as to reduce needlestick injuries and resulting HIV transmission rates among healthcare workers.

Based on the findings of this assessment, FHI believes that BCC interventions should place a special

emphasis on providers and prescribers who make decisions about treatment on a daily basis – decisions that clients, based on their reported opinions, are largely happy to leave to them. Under these circumstances, interventions tailored to the needs of healthcare workers will be likely to deliver practical, tangible results to meet GSIP objectives. In addition, suggested BCC interventions may include:

### SHORTER TERM (MAY BE SITE-SPECIFIC)

Providers	<ol style="list-style-type: none"> <li>1. Development of training modules to improve communication skills. These training modules will be focused on doctor/nurse and nurse/patient contexts, and contain exercises and role plays tailored to providers' needs. The modules for this training will be developed based on FHI's in-house experience and expertise in training healthcare providers and adaptation of tested SIGN toolkit interventions. These training modules will need to be adapted to the needs and realities of Guyana's health workers through ongoing collaboration with stakeholders to ensure buy-in and acceptance of this training.</li> <li>2. Training sessions based on the modules described above.</li> <li>3. Job aids on safe and appropriate injection practices, post-exposure prophylaxis and safe sharps disposal. These aids can take the form of wall charts, cue cards and posters to be displayed in medical facilities, and should be adapted to the needs of specific facilities and stakeholders in Guyana.</li> </ol>
Prescribers	<ol style="list-style-type: none"> <li>1. Development of training modules to improve communication skills. These training modules will be focused on doctor/nurse and doctor/patient contexts, and contain exercises and role plays tailored to prescribers' needs. The modules for this training will be developed based on FHI's in-house experience and expertise in training healthcare providers and adaptation of tested SIGN toolkit interventions. These training modules will need to be adapted to the needs and realities of Guyana's health workers through ongoing collaboration with stakeholders to ensure buy-in and acceptance of this training;</li> <li>2. Training sessions based on the modules described above.</li> <li>3. Job aids on safe and appropriate injection practices, post-exposure prophylaxis and safe sharps disposal. These aids can take the form of wall charts, cue cards and posters to be displayed in medical facilities, and should be adapted to the needs of specific facilities and stakeholders in Guyana.</li> </ol>
Patients	<ol style="list-style-type: none"> <li>1. Materials on safe and appropriate injection use. These can include posters, brochures and pictures to be displayed at medical facilities or distributed through community outreach carried out by local non-government organizations.</li> <li>2. Articles in print media and broadcast programming (such as radio scripts, TV talk shows and news items) promoting safe injection and proper disposal practices.</li> </ol>
Waste handlers	<ol style="list-style-type: none"> <li>1. Development of training modules to improve communication skills. These training modules will be focused on nurse/waste handler context, and contain exercises and role plays tailored to waste handlers' needs. The modules for this training will be developed based on FHI's in-house experience and expertise in training healthcare providers and adaptation of tested SIGN toolkit interventions. These training modules will need to be adapted to the needs and realities of Guyana's health workers through ongoing collaboration with stakeholders to ensure buy-in and acceptance of this training.</li> <li>2. Training sessions based on the modules described above.</li> <li>3. Job aids on safe disposal and work safety (including post-exposure prophylaxis). These can include posters, wall charts, stickers, etc. to be used at various job locations.</li> </ol>

Waste carriers	1. Job aids on safe disposal and work safety (including post-exposure prophylaxis). These can include posters, wall charts, stickers, etc. to be used at various job locations.
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**LONGER-TERM (MAY BE SITE-SPECIFIC OR NATIONWIDE)**

- Advocacy activities targeting Guyana’s Ministry of Health to promote adoption and dissemination of new guidance on safe and appropriate injections, disposal of sharps and post-exposure prophylaxis;
- Advocacy activities targeting professional medical, nursing and dental associations to promote safe and appropriate injections, disposal of sharps and post-exposure prophylaxis;
- Articles in professional publications for doctors promoting fewer prescriptions of injections and the importance of safe disposal practices;
- Articles in professional publications for nurses promoting safe disposal practices and reduction of needlestick injuries;
- FHI will explore potential areas of collaboration with NGOs and FBOs to include entertainment, theatre and drama as channels for conveying messages about injection safety;
- Personal testimonies of doctors who decided to prescribe fewer injections and

nurses who follow safer disposal practices to reduce the number of needlestick injuries;

- Peer education on the use of safety gear among waste handlers and waste carriers.

Please note that the suggestions above are meant to be a starting point for further discussions aimed at selecting the appropriate plan of interventions. Final recommendations will be based on the results of site visits scheduled in February/March and consultations with essential stakeholders and local GSIP team and key project consultants, as well as budgetary limitations. These decisions will be guided by the specific needs of each pilot site and other programming elements as appropriate. As always, it will be critically important that the team works closely with the stakeholders to ensure buy-in and acceptance of the interventions.

## **APPENDICES**

- I. DETAILED SCHEDULE OF FOCUS GROUP DISCUSSIONS AND IN-DEPTH INTERVIEWS**
- II. FOCUS GROUP FACILITATOR GUIDES FOR ALL AUDIENCES**
- III. CONSENT FORM AND PARTICIPANT INFORMATION SHEET**

## APPENDIX I

### DETAILED SCHEDULE OF FOCUS GROUP DISCUSSIONS AND IN-DEPTH INTERVIEWS

	Region IV		Region VI		Region VII	Region X	Total
	MOH GUM (urban, mixed, Afro-G., Indo-G.)	GPHC Infectious wards (urban, mixed, Afro-G., Indo-G.)	New Amsterdam Hospital STI Clinic & OPD (urban, Afro-G.)	Skeldon Hospital (rural, Indo-G.)	Bartica Hospital and health Center (rural, Amerindian, some Indo-G. and Afro-G.)	Linden Hospital and referral clinics (urban, Afro-G., some Amerindian)	
<b>Target population</b>							
<b>Prescribers</b>							
Urban/Public	1 FGD, 5 (GPHC)		1 DI, 2 (N.A. hosp.)	1 DI, 2 (Skeldon hosp.)			
Rural/Public							
Urban/Private	1 DI, 2					1 DI, 3 (Linden hosp.)	
Rural/Private							
							1 FGDs 9 IDIs Total: 14
<b>Providers</b>							
Rural Nurses (*)	1 FGD, 8 (Reg. 4 HC)		1 FGD, 7 (N.A. hospital)			1 FGD, 11 (Linden hospital)	
Urban Nurses	1 FGD, 8 (G'town hospitals)		1 FGD, 7 (N.A. hospital)				
Urban Dentists	1 FGD, 5 (G'town)				1 DI, 1 (Bartica hospital)		
Rural Medex	1 FGD (health-center based, recruited from all regions), 9						
							6 FGDs 1 IDI Total: 49

\* Note that the rural nurses will not necessarily come from two identified facilities in Region IV, but rather from the rural parts of Region IV.

	Region IV		Region VI		Region VII	Region X	Total
	MOH GUM (urban)	GPHC Infectious wards (urban)	New Amsterdam Hospital STI Clinic & OPD (urban)	Skeldon Hospital (rural)	Bartica Hospital and health Center (rural)	Linden Hospital and referral clinics (urban)	
<b>Waste handlers</b>							
Urban	<u>1 FGD, Reg. 4 hospital-based – urban (12)</u>		<u>1 FGD, N.A. hospital, 8</u>		<u>1 FGD, 8 (Bartica hospital)</u>	<u>1 FGD, 5 (Linden hospital)</u>	
Rural	<u>1 FGD, Reg. 4 HC-based- rural (9)</u>		<u>1 FGD, Reg. 6 HC-based, 11</u>				
							<b>6 FGD Total: 53</b>
<b>Waste carriers</b>							
Urban	<u>1 FGD, 5 (G'town City Council)</u>		<u>1 FGD, 5</u>		<u>IDI, 3 (Bartica City Council)</u>	<u>IDI, 1 (Linden Town Hall)</u>	
Rural					<u>IDI, 1 (private)</u>		
							<b>2 FGD 5 IDIs Total: 15</b>

	Region IV		Region VI		Region VII	Region X	Total
	MOH GUM (urban)	GPHC Infectious wards (urban)	New Amsterdam Hospital STI Clinic & OPD (urban)	Skeldon Hospital (rural)	Bartica Hospital and health Center (rural)	Linden Hospital and referral clinics (urban)	
<b>Patients (to be recruited from the recent hospital/clinic visitors)</b>							
Urban males under 25			1 FGD (mixed, 7)				
Urban males over 25							
Urban females under 25	1 IDI (3)						
Urban females over 25							
Rural males under 25	1 FGD (Amerindians, all regions, 13)			1 FGD, 4			
Rural males over 25	1 FGD (Amerindians, all regions, 9)					1 IDI, 3	
Rural females under 25	1 FGD (Amerindians, all regions, 8)		1 FGD, 12		1 FGD, 7	1 IDI, 5	
Rural females over 25	1 FGD (Amerindians, all regions, 11)						
							<b>8 FGD 11 IDIs Total: 85</b>

**TOTAL: 23 FGDs and 31 IDIs**

**TOTAL RESPONDENTS: 221**

**Breakdown by audiences:**

Prescribers: interviewed approximately **14 respondents**

Providers: interviewed approximately **49 respondents**

Patients: interviewed approximately **85 respondents**

Waste handlers: interviewed approximately **53 respondents**

Waste carriers: interviewed approximately **15 respondents**

(There were **5 IDIs with policy-makers** not reflected in the matrix above)

## APPENDIX II

### FOCUS GROUP FACILITATOR GUIDES FOR ALL AUDIENCES

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#### FOCUS GROUP GUIDE FOR PRESCRIBERS

##### **Note to Moderators:**

In your focus groups, please keep in mind that our objectives with prescribers are to find out the following:

*Professional motivations and concerns.* What motivates them? What's important to them? What do they want?

*Dynamics and power structure of communication with patients.* How do they talk to patients? How open are they to patients expressing their preferences and wishes?

*Feelings, beliefs and perceptions about injections and choice of treatment.* How do they think and feel about injections?

*Perceptions of patients' feelings about injections.* What do they think patients think and feel about injections.

*Awareness of risks associated with injections.* What do they know about adverse consequences and risks associated with injections?

*Environmental factors that encourage or restrict prescription of injections.* What in their clinic or hospital encourages them or prohibits them from prescribing injections?

*Disposal practices.* What do they do with needles after injections?

*Awareness of risks associated with used needles and disposal.* What do they know about adverse effects of used needles found in hospitals?

*Sources of information.* Where do they go for information in their field?

##### **Introduction:**

“Welcome and thank you for taking the time to talk to us this morning/afternoon/evening. My name is \_\_\_\_\_ and our team is working on the project that explores healthcare in Guyana. With your help, the results of this study will benefit the entire country and hopefully, help improve the quality of healthcare for all Guyanese people.

“We would like to ask you a few questions about your thoughts and feelings on practicing medicine in your community, as well as your experiences in communicating with your patients. We are also interested in your feelings and thoughts about prescribing injections.

“There are no right and wrong answers because we are interested in your opinions and feelings, so please feel free to say what's on your mind. Your answers will be kept in the strictest confidence; in fact, no answers would be connected to a specific person.

“Please feel free to start discussing the answers when you hear the question. We will try our best to make sure that everyone has a chance to contribute to the discussion. You don’t have to wait for me to ask for your opinion, but please don’t interrupt others when they are speaking.

“We would like to tape-record our discussion so we can capture everything that is said. We would like to reassure you that everything you say will be kept completely confidential; no one will know that any particular participant said a particular thing. Do I have your permission to use the tape recorder?

“(If everyone agrees.) Okay, since I have everyone’s agreement, I will turn it on now. Please be sure to speak one at a time so that a tape recorder will catch all comments. (If someone disagrees.) Okay, instead of using the tape recorder, we will be taking notes.

“Please be sure to speak one at a time so that everyone can hear you. Feel free to disagree with someone else’s opinions– remember that no answers are wrong or foolish. Everyone’s opinions, feelings and participation are very important to this discussion. This discussion will be kept confidential. Anything you say in this room is private. Does anyone have any questions before we begin?”

### **Warm-up:**

*(Goal: to make the participants feel comfortable with answering questions related to their practice)*

### **Where were you trained and how long have you been practicing?**

- Training institution
- Practicing in this area

### **What kinds of patients do you encounter on a typical day?**

### **How do you/your peers feel about practicing medicine in your community?**

- What is being done and said that makes them feel that way?
- What are some of their concerns about providing healthcare in this area?

### **!Note to moderator!**

This may be a good place to transition to questions about hopes for prescribers’ practice/profession. The appropriate moment in the discussion can occur later or earlier, so please be aware of the moment and look for ways to steer the discussion towards these subjects while retaining the natural flow of the conversation.

### **Hopes for Your Practice/Facility/Profession/Health of Your Clients and Your Health**

*(Goal: to explore deeper motivations of prescribers to connect these to project goals and inform the development of messages based on key benefits perceived by those providers.)*

- Where and how do you see yourself professionally in five years’ time? What are some of the professional goals you would like to achieve by that time?

- What are the things that are important for achieving that professional goal? Please explain in more detail.
- What are some of the things that are most important to your professional satisfaction at this point in your life?
- What are some of the concerns that professionals like you are facing today?
- Imagine a doctor who you would like to be like. It can be someone you know, or a hypothetical figure. What is he or she like? Why is this person a role model?
- How would you like your patients to think of you? Can you tell me more details?
- How would you like your professional peers to think of you?

**!Note to moderator!**

If you get answers along the lines of “to be a good doctor”, please probe for deeper insights, such as “what does a “being good doctor” mean to you?” We need to get at specific qualities and characteristics so that we can then connect desired behavior to desired qualities.

**Communication with Patients**

*(Goal: to understand the dynamics of communication between patients and providers, including the power in the relationship, with specific examples of how these power inequalities manifest themselves during the interaction.)*

**Tell me a little about how you communicate with your patients**

- In your opinion, how freely do patients discuss their problems with you? Can you tell me more about that? What are the things they do or say that make you feel that way? Can you tell me about any examples?
- How do you feel about patients questioning or disagreeing with your advice and prescription? What about patients who ask you follow-up questions or want more explanation of your reasons for prescribing a treatment? What about patients who ask for an alternative to the treatment or prescription that you recommended? Can you tell me more? Please tell me about any examples of when this may have happened. What did they say? What happened then?
- What would make you more or less likely to agree with the alternative treatment or prescription that the patient is asking about or demanding?
- Are there any differences in the ways you communicate with different types of patients, such as men, women or children? What are they? Can you tell me about the reasons for these differences?
- What determines the quality of your communication with your patients? What do you think makes them comfortable while talking to you? What do you think makes them uncomfortable while talking to you?

## **Feelings and Perceptions of Injections**

*(Goal: to understand how providers feel about injections and why they feel that way; to understand if and why they consider injections to be effective, and different from other types of medications; to understand the decision-making process that goes on before an injection is prescribed.)*

Now I would like to speak with you about your experiences and feelings about prescribing medications, especially injections.

**When a patient has a fever, what form of medication (pill, injection, capsule, liquid) do you prescribe and why?**

- What form do you prefer? What form does the patient prefer to receive? Please explain.

**What procedure do you follow when you prescribe a shot to the patient?**

**!Note to moderator!**

If the doctors don't give their own injections, follow with:

What procedure does your nurse/provider follow?

**What are your concerns about using needles?**

**!Note to moderator!**

After participants name a specific concern, follow up with: "Can you tell me more about that?"

If they name a particular characteristic of needles, such as "old", "used" or "dirty", ask about that specific quality, i.e.:

"What are your concerns about " \_\_\_\_\_ " needles used for injections?"

**In your opinion, for what diseases or specific health conditions are injections most effective? Can you tell me more about that? How did you form that opinion?**

**In your opinion, what groups of patients (women, men, elderly, children, etc.) tend to be prescribed injections more often than others?**

- Can you tell me more about that? What are the reasons for that?

**In your opinion, what are the advantages of injections over other forms of medication, if any?**

**!Note to moderator!**

Probe – don't lead - for reasons related to efficacy, ease of administration, convenience, patient compliance issues, etc.

- How did you form that opinion?

**In your opinion, what are the disadvantages or risks to using injections (and IV-fluids) compared to other forms of medication, such as a pill?**

- Can you tell me more about that? Probe for additional costs associated with offering injections, extra work, shortage of supplies, etc.
- How did you form that opinion?
- What are the risks associated with using needles?

**!Note to moderator!**

Probe for awareness of specific blood borne diseases, and do not prompt or lead to answers, wait for them to name these diseases.) If they name a particular disease, ask:

What else? What other diseases?

- Under what circumstances would you prefer to prescribe a treatment other than an injection? What do you think are the circumstances when injections should not be given? Can you explain this to me in more detail? Please give me any examples you can think of when you chose not to prescribe an injection.
- What would you choose if you could prescribe the same medication through an injection as well as through a pill? Why? How did you form that opinion?
- In your opinion, what patients or groups of people should not be given injections? Can you explain this in more detail? How did you form that opinion?

**How do you decide when to prescribe an injection versus other methods?**

- Can you tell me more about that? How did you form that opinion?

**(For doctors in private practice only) Is the injectable form of medication more expensive, less expensive or the same as the cost of the oral form?**

**What types of injectables do you use more often?**

**To your knowledge, do people get injections outside of medical facilities?**

- Why does this happen?
- Who gets these injections?
- Who administers them?

**How do you think patients feel about receiving injections? Can you explain this in more detail?**

- What do they like about getting injections? Can you explain this in more detail? Please give me any examples you can think of patients expressing a preference or asking for injections. What kinds of patients are likely to demand or prefer injections?
- What happens if you disagree with patient’s request or demand for an injection? Please tell me more about this. Any examples?
- What do they dislike about getting injections? Can you explain this in more detail? Please give me any examples you can think of patients refusing or being reluctant to have an injection? What kinds of patients are likely to refuse injections?
- What happens if you disagree with this refusal? Please tell me more. Any examples of that happening?

***Environmental Constraints***

*(Goal: to explore if any factors in the prescribers’ environment encourage or restrict the use of injections.)*

**What factors in your health facility or hospital promote or constrain the prescription of injections?**

- Probe for differences between private and government practice, if applicable.
- Did you ever believe that injections are overprescribed or underprescribed? What made you feel that way? How did you form this opinion?

**How can rational prescribing of injections be promoted?**

- What are the professional guidelines on prescribing injections? What organization typically develops such guidelines?
- (If no guidelines exist.) What do you think these guidelines should say about the appropriate use of injections?

***Disposal of Syringes and Needles***

*(Goal: to understand how needles are disposed of in hospitals, and to explore prescribers’ awareness of risks associated with used needles.)*

**What happens to syringes and needles after they are used?**

- Probe for a detailed description of disposal procedure.

- How do you think used syringes and needles should be discarded? Why?
- What do you think are the results/consequences of used needles and syringes lying around in a hospital or medical facility? Please tell me about any examples of medical personnel getting injured by used needles that you may have heard about. How did it happen? How did you feel about it?
- After disposable needles became common, what kind of training did you receive to handle standard disposal of syringes and needles safely?

**!Note to moderator!**

if no training was received, follow with:

What kind of training do you think is necessary to ensure safe disposal of syringes and needles?

- Please describe any regulations that exist in your hospital or medical facility on the disposal of used needles and syringes. Please also describe any regulations that explain the steps to be followed after being accidentally stuck by a needle or a sharp instrument. How do you feel about these regulations? How adequate do you feel they are in assuring protection against needlestick injuries? Can you tell me more about that?
- What can be done to improve needle disposal practices in your hospital/medical facility? Who or what organization should be in charge of improving these practices?
- How do you feel about used needles or syringes discarded in your neighborhood or community? Please share examples, if any, of the times when you may have seen used needles or syringes lying around outside. How did it happen? How did you feel about it? Why?
- What do you think are the results/consequences of used needles and syringes lying around in communities/neighborhoods? Please tell me about the time when you may have heard of someone picking up used needles or playing with them or handling them.
  - What diseases can be carried that way?

**!Note to moderator!**

Probe for awareness of specific blood borne diseases, and do not prompt or lead to answers, wait for them to name these diseases.) If they name a particular disease, ask:

What else? What other diseases?

- What are your concerns about waste disposal/waste management in this area? Tell more about that. Can you give me any examples?

**Information-Seeking Behavior**

*(Goal: to understand where, how and why providers obtain information on health-related subjects.)*

**Where do you go for health-related and medical information?**

- What is the most trusted source?
- How do you stay current on developments in your field?
- What source are you most likely to consult if you are looking for information in your field? Tell me more about that.

**Any other comments you would like to share?**

**Do you have any questions for us?**

**!Note to moderator!**

**Thank participants for their help and reassure them of confidentiality once again.**

## FOCUS GROUP GUIDE FOR PROVIDERS

### Note to the moderator:

In your focus groups, please keep in mind that with providers, our objective is to find out the following:

*Professional motivations and concerns.* What do they want? What do they aspire to? What is important to them?

*Communication with patients.* How freely and openly do they think patients talk to them? How open are they to patients expressing a different preference or choice of treatment?

*Feelings, beliefs and perceptions about injections and choice of treatment.* What do they think and how do they feel about giving injections?

*Perceptions and feelings of needlestick injuries.* What do they know and how do they feel about getting stuck by a needle?

*Perceptions of patients' feelings about injections.* What, in their opinion, do patients feel and think about injections?

*Awareness of risks associated with injections.* How much do they know about adverse effects associated with handling needles?

*Environmental factors that encourage or restrict prescription of injections.* What in their hospital or health center promotes or prohibits the use of injections?

*Awareness of risks associated with used needles and disposal.* How much do they know about risks they facing during disposal of needles?

*Disposal practices.* How do they dispose of needles?

*Sources of information.* Where do they go for information?

### Introduction:

“Welcome and thank you for taking the time to talk to us this morning/afternoon/evening. My name is \_\_\_\_\_ and our team is working on the project that explores healthcare in Guyana. With your help, the results of this study will benefit the entire country and hopefully, help improve the quality of healthcare for all Guyanese people.

“We would like to ask you a few questions about your thoughts and feelings on providing medical care in your community, including giving injections. We are also interested in your feelings and experiences in communicating with your patients.

“There are no right and wrong answers because we are interested in your opinions and feelings, so please feel free to say what’s on your mind. Your answers will be kept in the strictest confidence; in fact, no answers would be connected to a specific person.

“Please feel free to start discussing the answers when you hear the question. We will try our best to make sure that everyone has a chance to contribute to the discussion. You don’t have to wait for the moderator to ask for your opinion, but please don’t interrupt others when they are speaking.

“We would like to tape-record our discussion so we can capture everything that is said. We would like to reassure you that everything you say will be kept completely confidential; no one will know that any particular participant said a particular thing. Do I have your permission to use the tape recorder?”

“ (If everyone agrees.) Okay, since I have everyone’s agreement, I will turn it on now. Please be sure to speak one at a time so that a tape recorder will catch all comments. (If someone disagrees.) Okay, instead of using the tape recorder, we will be taking notes.

“Please be sure to speak one at a time so that everyone can hear you. Feel free to disagree with someone else’s opinions– remember that no answers are wrong or foolish. Everyone’s opinions, feelings and participation are very important to this discussion. This discussion will be kept confidential. Anything you say in this room is private. Does anyone have any questions before we begin?”

### **Warm-up:**

**Introduction - Please tell me a little bit about how long you’ve been a nurse, where you trained, and where you work.**

**What kinds of patients do you encounter on a typical day?**

**How do you feel about working in this community?**

- Can you explain this in more detail?

### **!Note to moderator!**

This may be a good place to transition to questions about hopes for prescribers’ practice/profession. The appropriate moment in the discussion can occur later or earlier, so please be aware of the moment and look for ways to steer the discussion towards these subjects while retaining the natural flow of the conversation.

### ***Hopes for Your Practice/Facility/Profession/Health of Your Clients and Your Health***

*(Goal: to explore deeper motivations of providers to connect these to project goals and inform the development of messages based on key benefits perceived by those providers.)*

- How do you see yourself professionally in five years’ time? What are some of the professional goals you would like to achieve by that time?
- What are the things that are important for achieving that professional goal
- What are some of your concerns and challenges?
- What are some of the things that are most important to your professional satisfaction at this point in your life? Probe for details.
- Who is your role model? It can be a real or a hypothetical figure. What is he or she like? Why?
- How would you like your patients to think of you? Can you tell me more details?

- How do you want your professional peers to think of you?

**!Note to moderator!**

If you get answers along the lines of “to be a good nurse/dentist, etc.”, please probe for deeper insights, such as “what does being a “good nurse/dentist, etc.” mean to you?” We need to get at specific qualities and characteristics so that we can then connect desired behavior to desired qualities.

**Communication with Patients**

*(Goal: to understand the dynamics of communication between patients and providers, including the power structure, with specific examples of how these power inequalities manifest themselves during the interaction.)*

**Tell me a little about how you communicate with your patients**

- In your opinion, how freely and openly do patients discuss their problems with you? Can you tell me more about that?
- How important do you think is communication between yourself and a patient? And why?
- Are there any differences in the ways you communicate with different types of patients, such as men, women or children? What are they? Can you tell me about the reasons for these differences?
- How do you feel or disagreeing with patients question or disagree with the prescription? What about patients who ask you follow-up questions or want more explanation about the treatment they are about to receive? Can you tell me more? Please tell me about any examples of when this may have happened.
- What do you think makes them comfortable while talking to you? What do you think makes them uncomfortable while talking to you?

**Feelings and Perceptions of Injections**

*(Goal: to understand how providers feel about injections and why they feel that way; to understand if and why they consider injections to be effective, and different from other types of medications; to understand the decision-making process that goes on before an injection is prescribed.)*

Now I would like to speak with you about your experiences and feelings about providing treatment, especially injections.

**When a patient has a fever, what form of medication (pill, injection, capsule, liquid) are they given?**

- What form do you or the prescriber you work with prefer to give? What form does the patient prefer to receive? Please explain?

**What procedure do you follow when a patient comes in with a prescription for an injection?**

**What are your concerns about using needles?**

**!Note to moderator!**

After participants name a specific concern, follow up with: “Can you tell me more about that?”

If they name a particular characteristic of needles, such as “old”, “used” or “dirty”, ask about that specific quality, i.e.: “What are your concerns about people using “\_\_\_\_\_” needles for injections?”

**In your opinion, for what diseases or specific health conditions are injections most effective? Can you tell me more about that? How did you form that opinion?**

**In your opinion, what groups of patients (women, men, elderly, children, etc.) tend to be prescribed injections more often than others?**

- Can you tell me more about that? What are the reasons for that?

**In your opinion, what are the advantages of injections and IV fluids?**

- Probe for reasons related to efficacy, ease of administration, patient compliance issues, convenience, etc.
- How did you form that opinion?
- When should the patient be given an injection compared to other types of treatment? Can you explain this to me in more detail?

**In your opinion, what are the disadvantages or risks of using injections and IV fluids?**

- Can you tell me more about that?
- How did you form that opinion?
- What are the risks associated with using needles?

**!Note to moderator!**

be for awareness of specific blood borne diseases, and do not prompt or lead to answers, wait for them to name these diseases.) If they name a particular disease, ask:

What else? What other diseases?

- Can you explain this to me in more detail? Please give me any examples you can think of.
- What do you think should be chosen if the same medication can be given through an injection as well as through a pill? Why? How did you form that opinion?

- When do you think should the patients not be given injections? In your opinion, what patients or groups of people should not be given injections? Can you explain this in more detail? How did you form that opinion?

**What types of injectables do you use more often?**

**To your knowledge, do people get injections outside of medical facilities?**

- Why does this happen?
- Who gets these injections?
- Who administers them?

**How do you think patients feel about receiving injections? Can you explain this in more detail?**

- What do they like about getting injections? Can you explain this in more detail? Please give me any examples you can think of patients asking for injections.
- When are the patients likely to demand or ask for injections? What kinds of patients are likely to demand injections?
- What happens if you or the prescriber you work with disagree with this demand or request? Please tell me more about this. Any examples?
- What do patients dislike about getting injections? Can you explain this in more detail? Please give me any examples you can think of patients refusing or being reluctant to have an injection? What kinds of patients are likely to decline injections?
- What happens if you or the prescriber you work with disagree with this refusal? Please tell me more. Any examples of that happening?

***Environmental Constraints***

*(Goal: to explore if any factors in the providers' environment encourage or restrict the use of injections.)*

**What factors in your health facility or hospital promote or constrain the prescription of injections?**

- Probe for differences between private and government practice, if applicable.
- Do you believe that injections are overprescribed or underprescribed? What made you feel that way? How did you form this opinion?

**!Note to moderator!**

(If participants have strong opinions on the subject, follow with:)

What do you think these guidelines should say about the appropriate use of injections?

## How can rational prescribing of injections be promoted?

- What are the professional guidelines on prescribing injections? What organization typically develops such guidelines?

### **!Note to moderator!**

If the answer is that no such guidelines exist, please follow with:

What do you think these guidelines should say about the appropriate use of injections?

## ***Disposal of Syringes and Needles***

*(Goal: to understand how needles are disposed of in hospitals, and to explore providers' awareness of risks associated with used needles.)*

## What happens to syringes and needles after they are used?

- Probe for a detailed description of disposal procedure.
- How safe do you feel when you are disposing of these needles? Can you tell me more about this?
- What kind of training did you receive to handle disposal of syringes and needles safely?

### **!Note to moderator!**

if no training was received, follow with:

What kind of training do you think is necessary to ensure safe disposal of syringes and needles?

- Please share examples, if any, when you may have seen used syringes or needles lying around in hospitals or doctor's offices. How did it happen? How did you feel about it?
- What do you think are the results/consequences of used needles and syringes lying around in a hospital or medical facility?

### **!Note to moderator!**

Probe for awareness of specific blood borne diseases, and do not prompt or lead to answers, wait for them to name these diseases.) If they name a particular disease, ask:

What else? What other diseases?

- Please tell me about any examples of medical personnel getting injured by used needles that you may have heard about. How did it happen? How did you feel about it?
- How do you think used syringes and needles should be discarded? Why?
- Please describe any regulations that exist in your hospital or medical facility about the disposal of used needles and syringes. Please also describe any regulations that explain the steps to be followed after being accidentally stuck by a needle or a sharp instrument. How do you feel about these regulations? How closely are they being followed? How adequate do you feel they are in assuring your protection against needlestick injuries? Can you tell me more about that?
- What can be done to improve needle disposal practices in your hospital/medical facility? Who or what organization should be in charge of improving these practices?
- Please describe any experiences that you or someone you know have had in seeing used needles improperly disposed of.
- Please share examples, if any, of the times when you may have seen used needles or syringes lying around outside. How did it happen? How did you feel about it? Why?
- What do you think may happen if used needles and syringes are lying around in your community/neighborhood? Please tell me about the time when you may have heard of someone picking up used needles or playing with them or handling them.

**!Note to moderator!**

Probe for awareness of specific blood borne diseases, and do not prompt or lead to answers, wait for them to name these diseases.) If they name a particular disease, ask:

What else? What other diseases?

- What are your concerns about waste disposal/waste management in this area? Tell more about that. Can you give me any examples?

**Information-Seeking Behavior**

*(Goal: to understand where, how and why providers obtain information on health-related subjects.)*

**Where do you go for health-related and medical information?**

- What is the most trusted source?
- How do you stay current on developments in your field?
- What source are you most likely to consult if you are looking for information in your field? Tell me more about that.

**Any other comments you would like to share?**

**Do you have any questions for us?**

**!Note to moderator!**

**Thank participants for their help and reassure them of confidentiality once again.**

## FOCUS GROUP GUIDE FOR WASTE HANDLERS

### Note to the moderator:

Please keep in mind during your focus groups that what we want to find out about waste handlers is the following:

*Personal hopes for the future, aspirations and concerns about their health.* What do they want? What do they care about? What's important to them?

*Awareness of risks of handling used needles.* What do they know about the risks they run by handling needles?

*Perceptions and feelings of needlestick injuries.* How do they feel about getting stuck by a needle? How much do they know about how dangerous that is?

*Perception of occupational risks.* How much do they know about the risks inherent to their job?

*Perception of personal safety on the job.* How safe do they feel on the job and why?

*Communication with medical personnel.* How openly and freely can they talk with doctors and nurses?

### Introduction:

“Welcome and thank you for taking the time to talk to us this morning/afternoon/evening. My name is \_\_\_\_\_ and our team is working on the project that explores healthcare in Guyana. With your help, the results of this study will benefit the entire country and hopefully, help improve the quality of healthcare for all Guyanese people.

“We would like to ask you a few questions about your thoughts and feelings about your work. We are interested in your opinions and experiences in disposal of medical waste, and your feelings about your interaction with doctors and nurses. We would also like to talk to you about your feelings and thoughts about handling medical waste.

“There are no right and wrong answers because we are interested in your opinions and feelings, so please feel free to say what's on your mind. Your answers will be kept in the strictest confidence; in fact, no answers would be connected to a specific person.

“Please feel free to start discussing the answers when you hear the question. We will try our best to make sure that everyone has a chance to contribute to the discussion. You don't have to wait for the moderator to ask for your opinion, but please don't interrupt others when they are speaking.

“We would like to tape-record our discussion so we can capture everything that is said. We would like to reassure you that everything you say will be kept completely confidential; no one will know that any particular participant said a particular thing. Do I have your permission to use the tape recorder?

“ (If everyone agrees.) Okay, since I have everyone's agreement, I will turn it on now. Please be sure to speak one at a time so that a tape recorder will catch all comments. (If someone disagrees.) Okay, instead of using the tape recorder, we will be taking notes.

“Please be sure to speak one at a time so that everyone can hear you. Feel free to disagree with someone else's opinions— remember that no answers are wrong or foolish. Everyone's opinions, feelings and participation are

very important to this discussion. This discussion will be kept confidential. Anything you say in this room is private. Does anyone have any questions before we begin?

**Warm-up:**

**How long have you worked in this hospital/health center/other medical facility?**

**What kind of training did you have to go through to work here?**

**How important do you feel your job is to the proper functioning of this hospital (and/or medical facility)?**

**!Note to moderator!**

This may be a good place to transition to questions about hopes for the future. The appropriate moment in the discussion can occur later or earlier, so please be aware of the moment and look for ways to steer the discussion towards these subjects while retaining the natural flow of the conversation.

**Hopes for the Future**

*(Goal: to explore the hopes and aspirations of waste handlers in order to connect these to project goals and inform the development of messages based on key benefits perceived by this target audience.)*

- How do you see yourself in five years' time? What are some of the goals you would like to achieve by that time?
- What are the things that are important for you in achieving these goals? Please explain in more detail.
- What are some of the things that are most important to you at this point in your life? Probe for details.
- Imagine someone who you would like to be like, someone you respect a lot. What is he or she like?

**Feelings and Perceptions of Risks of Handling Needles**

*(Goal: to explore the awareness of risks connected with handling used needles among waste handlers; to understand the perception of needlestick injuries, and to fully understand which risks they are facing daily in their job.)*

Now I would like to speak with you about your experiences and feelings about handling used needles and syringes.

**What happens to syringes and needles after they are used?**

**!Note to moderator!**

Probe for a detailed description of disposal procedure and specific steps undertaken by waste handlers.

- If the waste is taken to the storage site and then picked up by a waste management company:
  - Where is this storage site located?
  - Who has access to it?
  - What happens if the waste is not picked up?
- If the needles are burnt on site:
  - What happens after they are burnt?
  - What happens when the disposal facility doesn't work?
  - Please share examples, if any, when you may have seen used syringes or needles lying around in hospitals or doctor's offices. How did it happen? How did you feel about it? Why?
  - What do you think might happen if used needles and syringes are lying around in your hospital or medical facility?
  - How safe do you feel when you are disposing of needles? Can you tell me more about this?

**!Note to moderator!**

If they mention feeling unsafe, probe for specific reasons why.

- What are the consequences/effects of handling used needles?
- How do you keep yourself safe while on the job?

**!Note to moderator!**

We are looking for things like protective clothes, gloves, footgear, etc. After an item is named, ask:

How well do you think it protects you?

- Please tell me about any incidents you may have heard about of people in your field getting stuck by a used needle or a sharp instrument. How did it happen? How did you feel about it?
- What are the consequences of such injuries?

**!Note to moderator!**

If disease is named as a consequence, probe for the list of specific diseases like HIV, hepatitis, etc. without leading. If a specific disease is named, ask:

What else? What other diseases?

- Please describe any rules that exist in your hospital or medical facility on the disposal of used needles and syringes. Please also describe any regulations that explain the steps to be followed after being accidentally stuck by a needle or a sharp instrument. How were you informed about these regulations? How do you feel about these regulations? How closely are they being followed? How adequate do you feel they are in assuring your protection against needlestick injuries? Can you tell me more about that?
- How do you think used syringes and needles should be discarded? Why?
- Please share examples, if any, of the times when you may have seen used needles or syringes lying around outside. How did it happen? How do you feel about used needles or syringes discarded in your neighborhood or community? Why?
- What do you think are the results/consequences of used needles and syringes lying around in your community/neighborhood? Please tell me about the time when you may have heard of someone picking up used needles or playing with them or handling them.

**!Note to moderator!**

Probe for awareness of specific blood borne diseases, and do not prompt or lead to answers, wait for them to name these diseases.) If they name a particular disease, ask:

What else? What other diseases?

- What are your concerns about waste disposal/waste management in this area? Tell more about that. Can you give me any examples?
- What can be done to improve needle disposal practices in your hospital/medical facility? Who or what organization should be in charge of improving these practices?

**Communication in the Workplace**

*(Goal: to understand the dynamics of communication between waste handlers and providers, prescribers and hospital administrators to explore the degree of ease with which waste handlers can bring up their concerns.)*

**Please tell me about the relationship between yourself and doctors, nurses and other medical staff.**

**Tell me a little about how you communicate with doctors, nurses and hospital administrators:**

- How openly and freely can you talk to the doctors, nurses, or supervisors at your facility? What are the things they do or say that make you feel that way? Can you tell me about any examples?
- Do you feel that your opinions and concerns are being listened to? Please tell me about some examples when you felt your concerns and opinions were respected. Please tell me about some examples when you felt your concerns and opinions were dismissed. What happened?

**Any other comments you would like to share?**

**Do you have any questions for us?**

**!Note to moderator!**

**Thank participants for their help and reassure them of confidentiality once again.**

## FOCUS GROUP GUIDE FOR WASTE CARRIERS

### Note to the moderator:

Please keep in mind during your focus groups that what we want to find out about waste handlers is the following:

*Personal hopes for the future, aspirations and concerns about their health.* What do they want? What do they care about? What's important to them?

*Awareness of risks of handling used needles.* What do they know about the risks they run by handling needles?

*Perceptions and feelings of needlestick injuries.* How do they feel about getting stuck by a needle? How much do they know about how dangerous that is?

*Perception of occupational risks.* How much do they know about the risks inherent to their job?

*Perception of personal safety on the job.* How safe do they feel on the job and why?

### Introduction:

“Welcome and thank you for taking the time to talk to us this morning/afternoon/evening. My name is \_\_\_\_\_ and our team is working on the project that explores healthcare and waste management in Guyana. With your help, the results of this study will benefit the entire country and hopefully, help improve the quality of healthcare and safety in communities for all Guyanese people.

“We would like to ask you a few questions about your thoughts and feelings on disposal of medical waste in your community. There are no right and wrong answers because we are interested in your opinions and feelings, so please feel free to say what's on your mind. Your answers will be kept in the strictest confidence; in fact, no answers would be connected to a specific person.

“Please feel free to start discussing the answers when you hear the question. We will try our best to make sure that everyone has a chance to contribute to the discussion. You don't have to wait for the moderator to ask for your opinion, but please don't interrupt others when they are speaking.

“We would like to tape-record our discussion so we can capture everything that is said. We would like to reassure you that everything you say will be kept completely confidential; no one will know that any particular participant said a particular thing. Do I have your permission to use the tape recorder?

“ (If everyone agrees.) Okay, since I have everyone's agreement, I will turn it on now. Please be sure to speak one at a time so that a tape recorder will catch all comments. (If someone disagrees.) Okay, instead of using the tape recorder, we will be taking notes.

“Please be sure to speak one at a time so that everyone can hear you. Feel free to disagree with someone else's opinions— remember that no answers are wrong or foolish. Everyone's opinions, feelings and participation are very important to this discussion. This discussion will be kept confidential. Anything you say in this room is private. Does anyone have any questions before we begin?”

## **Warm-up:**

**How long have you worked at this job?**

**What kind of training did you have to go through to do it?**

**How important do you feel your job is to this community?**

### **!Note to moderator!**

This may be a good place to transition to questions about hopes for the future. The appropriate moment in the discussion can occur later or earlier, so please be aware of the moment and look for ways to steer the discussion towards these subjects while retaining the natural flow of the conversation.

## ***Hopes for the Future***

*(Goal: to explore the hopes and motivations of waste carriers in order to connect these to project goals and inform the development of messages based on key benefits perceived by this target audience.)*

- How do you see yourself in five years' time? What are some of the goals you would like to achieve by that time?
- What are the things that are important for achieving these goals? Please explain in more detail.
- What are some of the things that are most important to you at this point in your life? Probe for details.
- Imagine someone who you would like to be like, someone you admire. It can be a real or a hypothetical person. What is he or she like? What do you like about them?

## ***Feelings and Perceptions of Risks of Working with Medical Waste***

*(Goal: to explore the awareness of risks connected with working with medical waste; to understand awareness of presence of needles/sharps in the medical waste they handle; to explore perception of needlestick injuries, and to fully understand which risks the waste carriers and the community may be facing because of inadequate waste disposal practices.)*

Now I would like to speak with you about your experiences and feelings about waste disposal.

**Please describe what happens with waste after you/your company picks it up from a hospital or medical facility?**

*Probe for a detailed description of disposal procedure and specific steps undertaken by waste carriers.*

*Sample questions:*

- Where is this dumping site/incinerator located?

- Who has access to it?
- What happens if the incinerator is not working or is not used?
- What happens to the waste at the incinerator?
- To your knowledge, what does this medical waste consist of?

**!Note to moderator!**

Probe for awareness that they are handling sharps, but please don't lead.

- How safe do you feel when you are handling medical waste? Can you tell me more about this? What makes you feel safe/unsafe? Moderator: probe for specific factors that produce the feeling of safety or lack of safety.
- How do you keep safe from injuries on the job? Please describe any safety gear or equipment you have to use on the job.

**!Note to moderator!**

Things like protective clothes, gloves, footgear, etc. After an item is named, ask:

How well do you think it protects you?

- What can happen during handling medical waste?

**!Note to moderator!**

If earlier responses show they are aware that medical waste contains sharps:

How about used needles?

- Please tell me about any incidents you may have heard about of people in your field getting stuck by a used needle or a sharp instrument. How did it happen? How did you feel about it?
- What are the consequences of such injuries?

**!Note to moderator!**

If disease is named as a consequence, probe for the list of specific diseases like HIV, hepatitis, etc. without leading. If a specific disease is named, ask:

What else? What other diseases?

- Please describe any rules that may exist at your company/agency specifically for handling used needles and syringes. How were you informed of these rules or regulations? How do you feel about them? How closely are they being followed? In your opinion, how well do they protect you? Can you tell me more about that?
- Please share examples, if any, of the times when you may have seen used needles or syringes lying around outside. How did it happen? How do you feel about used needles or syringes discarded in your neighborhood or community? Why?
- What do you think might happen if used needles and syringes are found in your community/neighborhood? Please tell me about the time when you may have heard of someone picking up used needles or playing with them or handling them.

**!Note to moderator!**

Probe for awareness of specific blood borne diseases, and do not prompt or lead to answers, wait for them to name these diseases.) If they name a particular disease, ask:

What else? What other diseases?

- How do you think used syringes, sharp medical objects and needles should be discarded? Why?
- What can be done to make your job safer? Who or what organization should be in charge of improving these practices?

**Any other comments you would like to share?**

**Do you have any questions for us?**

**!Note to moderator!**

**Thank participants for their help and reassure them of confidentiality once again.**

## FOCUS GROUP GUIDE FOR PATIENTS

### Note to the moderator:

In your focus groups, please keep in mind that our objectives with patients are to find out the following:

*Personal hopes, aspirations, concerns about future health.* What do they want for themselves and their families? What do they aspire to? What is important to them?

*Communication with providers and prescribers.* How openly and freely, in their opinion, can they talk to their doctors?

*Perceptions and beliefs about injections.* How do they feel about getting injections and what do they think about how injections work?

*Awareness of risks of injections and dirty needles.* What do they know about adverse effects of using dirty needles?

*Feelings and beliefs about disposal of used needles.* What do they know and how do they feel about used needles and their disposal?

*Awareness of risks of handling dirty needles in the environment.* What do they know about adverse effects of needles found outside?

*Sources of information on health-related subjects.* Where do they go for medical information?

### Introduction:

“Welcome and thank you for taking the time to talk to us this morning/afternoon/evening. My name is \_\_\_\_\_ and our team is working on the project that explores healthcare in Guyana. With your help, the results of this study will benefit the entire country and hopefully, help improve the quality of healthcare for all Guyanese people.

“We would like to ask you a few questions about your thoughts and feelings on receiving medical care in your community and your experiences in communicating with doctors and nurses. We would also like to talk to you about your experiences receiving medications or injections at places where you receive medical care and services.

“There are no right and wrong answers because we are interested in your opinions and feelings, so please feel free to say what’s on your mind. Your answers will be kept in the strictest confidence; in fact, no answers would be connected to a specific person.

“Please feel free to start discussing the answers when you hear the question. We will try our best to make sure that everyone has a chance to contribute to the discussion. You don’t have to wait for me to ask for your opinion, but please don’t interrupt others when they are speaking.

“We would like to tape-record our discussion so we can capture everything that is said. We would like to reassure you that everything you say will be kept completely confidential; no one will know that any particular participant said a particular thing. Do I have your permission to use the tape recorder?

“(If everyone agrees.) Okay, since I have everyone’s agreement, I will turn it on now. Please be sure to speak one at a time so that a tape recorder will catch all comments. (If someone disagrees.) Okay, instead of using the tape recorder, we will be taking notes.

“Please be sure to speak one at a time so that everyone can hear you. Feel free to disagree with someone else’s opinions– remember that no answers are wrong or foolish. Everyone’s opinions, feelings and participation are very important to this discussion. This discussion will be kept confidential. Anything you say in this room is private. Does anyone have any questions before we begin?”

**Warm-up:**

***Hopes for the Future***

*(Goal: to explore deeper ambitions and hopes of participants in order to make a connection between project goals to inform subsequent message development)*

- Where and how do you see yourself in five years’ time? What are some of the things you would like to achieve by that time?
- What are the things that are important for achieving that goal? Please explain in more detail.
- What are some of the things that are most important to you at this point in your life?
- What are some of the concerns that people like you are facing today?
- Imagine someone you would like to be like, someone you admire. What is this person like?

**What are your concerns about your health? Tell me more.**

**How do you feel about healthcare in your community?**

- Why do you feel this way?
- What is being done and said that makes you feel that way?

**Where do you go when you get sick?**

**!Note to moderator!**

Probe for different types of facilities, such as hospitals, doctor’s office, community nurses, informal providers, etc.

- How do you decide where to go for medical help?

**If more than one provider of the same type is available in your area, how do you choose which one to go to? (When I say “provider” I mean a doctor, nurse or medex who provides medical care in your community.)**

**!Note to moderator!**

When respondents refer to certain qualities of the provider (“attentive”, “dismissive”, “rude” etc.), probe for: “What does he/she do or say to make you feel this way?” “Can you explain a bit more?”

### **Communication with Health Providers**

*(Goal: to understand the dynamics of communication between patients and providers, including the power structure with specific examples of how these power inequalities manifest themselves during the interaction.)*

#### **How openly and freely can you talk to your medical provider (doctor or nurse)?**

- What are the things they do or say that make you feel that way? Can you give me an example of a time when you felt you couldn’t discuss your concerns with your provider? What about an example of a time when you felt you could discuss your concerns freely? What makes you feel comfortable talking to your doctor or nurse? What makes you uncomfortable talking to your doctor or nurse?
- Are there differences in the way you talk to your doctor compared to a nurse, informal healers and others? Can you explain the reasons for these differences?
- How do you feel about asking your doctor or nurse for more explanations about the type of procedure or treatment they prescribe?
- How do you feel about asking your doctor or nurse or medex about alternative treatments? Can you explain this to me in more detail? What kinds of things does your provider say or do that make you feel that way? Can you give me an example of that? What did you say to them? How did they respond? What happened then?

### **Feelings and Perceptions of Injections**

*(Goal: to understand how people feel about injections and why they feel that way; to understand if and why people consider injections to be effective, and different from other types of medications; to understand the place of injections in the order of preferred treatments, and to explore awareness of diseases that can be transmitted through dirty needles.)*

Now I would like to speak with you about your experiences and feelings about receiving medications, especially through injections.

#### **When you or one of your family members has a fever, what form of treatment do you get (pill, injection, capsule, liquid)?**

What form do you prefer? Please explain?

#### **How do you feel about receiving injections? Can you explain this in more detail?**

**When you are given an injection, do you see the doctor or nurse removing the syringe from a sealed packet? How do you feel about these needles?**

**What are your concerns about using injection needles?**

**!Note to moderator!**

After participants name a specific concern, follow up with: “Can you tell me more about that?”

If they name a particular characteristic of needles, such as “old”, “used” or “dirty”, ask about that specific quality, i.e.:

“What are your concerns about “\_\_\_\_\_” needles used for injections?”

**In your opinion, for what diseases or specific health conditions do injections work better? Can you tell me more about that? How did you form that opinion?**

**In your opinion, what are the advantages of injections compared to other forms of treatment?**

- Would you ever prefer an injection to other types of treatment? Can you explain this to me in more detail?

**!Note to moderator!**

Probe for reasons related to effectiveness, quickness of action, stronger medicine, etc.

- What makes you say that?

**In your opinion, what are the disadvantages of using injections compared to other forms of treatment?**

- How did you form that opinion?
- Tell me about the time, if any, when you or someone you know had a bad experience with an injection.
- What would you choose if you could take your treatment through an injection as well as a pill, and why? What makes you say that?
- When do you think injections should not be given? Can you explain this in more detail? What makes you say that?
- In your opinion, what groups of people should not be given injections? Can you explain this in more detail? What makes you say that?
- If there is an additional cost to the injection, do you think it is worth the money? Why or why not?

**How do you think a doctor decides whether or not to give an injection?**

- Are there any differences in how men, women or children are prescribed injections? Why does that happen?
- Do you think that people ever tell their doctor whether they prefer a tablet over an injection or an ointment? Do you think that makes any difference to a doctor?

## **Disposal of Syringes and Needles**

*(Goal: to explore awareness of the needle disposal issue, to understand how people feel about needles disposed in hospitals and in their communities, and to explore awareness of needle disposal and its risks outside of hospitals and medical facilities.)*

### **What do you think happens to syringes and injection needles after they are used?**

- Where do you they end up? What makes you say that?
- How do you feel about used syringes or injection needles lying around in hospitals or doctor's offices? Please share examples, if any, when you may have seen this. How did it happen? How did you feel about it? Why?
- Please tell us about any time when you may have seen used injection needles or syringes lying around outside in your neighborhood. How did it happen? How did you feel about it? Why?
- What do you think might happen in case any used injection needles and syringes are lying around? Please tell me about any time when you might have heard of someone picking up used injection needles or playing with them or handling them.

### **!Note to moderator!**

Probe for awareness of specific blood borne diseases, and do not prompt or lead to answers, wait for them to name these diseases.) If they name a particular disease, ask:

What else? What other diseases?

- How do you think used syringes and injection needles should be discarded? Why?
- What are your concerns about garbage disposal in this area? Tell more about that. Can you give me any examples?

## **Information-Seeking Behavior**

*(Goal: to understand where, how and why people obtain information to form opinions on health-related subjects.)*

### **Where do people in this community get information on health related topics?**

- What is the most trusted source of health information?
- Where do you most often come across health-related information? (TV, radio, newspapers, doctors, hospitals, neighbors, friends, relatives)
- Where are you most likely to look for health-related information? Tell me more about that.

### **Any other comments you would like to share?**

### **Do you have any questions for us?**

**!Note to moderator!**

**Thank participants for their help and reassure them of confidentiality once again.**

## APPENDIX III

### CONSENT FORM AND PARTICIPANT INFORMATION SHEET

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Participant Consent Form

Guyana Safe Injection Project

Principal Investigator: \_\_\_\_\_

#### Research Goals

We would like to talk to you about taking part in discussion group(s) and personal interviews conducted by the Guyana Safe Injection Project staff to help us understand how injections practices can be made better and safer for all Guyanese people. We will be asking you questions about your thoughts and experiences about healthcare in Guyana, communication between doctors, nurses and patients, and about the injections that you may experience or prescribe.

#### Your role in this study:

If you agree to participate in a focus group discussion, you will be a part of the group consisting of 6 to 10 participants. If you agree to take part in in-depth interviews, you will be talking to a researcher one on one.

Your participation is completely voluntary and there is no penalty for refusing to participate. Your refusal to participate will not affect any health care benefits that you normally receive. You can stop your participation at any time.

#### How you were identified

We are asking you to participate in this research because we are interested in talking to people who practice and receive medical care in Guyana.

#### Possible risks and benefits

There is a small chance that some people feel uncomfortable talking in groups. Otherwise, there is no risk associated with your participation. If you decide to participate, you will be helping us to understand how injections practices can be made better and safer for all Guyanese people.

#### Confidentiality

Everything you say in this room remains strictly confidential. No one except the group leaders and other group members will know that you took part in this research. The groups and interviews will be tape recorded with voices only. Note-takers will write down opinions and what the group thought during the session. We will not record your name or any other personal information about you. Your opinions and thoughts will be reflected in the final report without any identification by name. We ask that participants not reveal outside the group information they may have heard in the group.

#### Contacts for questions

Feel free to talk to your group leader or interviewer if you have any questions.

I volunteer to participate and have been given a copy of this form. I understand that my participation is voluntary and I can stop at any time.

Signature \_\_\_\_\_

Date: \_\_\_\_\_

Researcher's signature \_\_\_\_\_

Date: \_\_\_\_\_

**Participant Information Sheet (to be filled out for all participants)**

Date:	
Location of IDI/FGD:	
Time:	
FGD or IDI:	
Gender:	
Age:	
Occupation:	
<b>Providers/prescribers/ waste workers only:</b>  Work in: (location)	
<b>Patients only:</b>  Town/Village of Residence:	
Marital status:	
No. of children, if any:	
Ethnicity:	