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STIGMATIZATION AND DISCRIMINATION OF HIV-POSITIVE PEOPLE BY PROVIDERS OF GENERAL MEDICAL SERVICES IN UKRAINE

NOVEMBER 2007

This publication was produced for review by the U.S. Agency for International Development (USAID). It was prepared by staff of the USAID | Health Policy Initiative, Task Order I.

The USAID | Health Policy Initiative, Task Order 1, is funded by the U.S. Agency for International Development under Contract No. GPO-I-01-05-00040-00, beginning September 30, 2005. Task Order 1 is implemented by Constella Futures, in collaboration with the Centre for Development and Population Activities (CEDPA), White Ribbon Alliance for Safe Motherhood (WRA), and World Conference of Religions for Peace (WCRP).

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The views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the U.S. Government.

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ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
ART	antiretroviral therapy
DHS	Demographic Health Survey
HIV	human immunodeficiency virus
HPI	Health Policy Initiative
IPPF	International Planned Parenthood Federation
IWG	Interagency Working Group
NGO	nongovernmental organization
PLHIV	people living with HIV
SPA	Service Provision Assessment
STI	sexually transmitted infection
TB	tuberculosis
UNAIDS	Joint United Nations Program on HIV/AIDS
USAID	United States Agency for International Development

Executive Summary

HPI conducted a survey in Ukraine to test indicators and questions regarding HIV/AIDS-related stigma and discrimination at the facility/provider level. The survey in Ukraine was coordinated with an already planned survey of client satisfaction so that the analysis could examine the relationship between clients and providers. This research examined HIV/AIDS-related stigma and discrimination by providers of general medical services in three regions in Ukraine: Donetsk, Kherson, and Mykolayiv. HPI contracted local organizations to carry out the surveys, and between October 10, 2006–July 10, 2007, 336 respondents (168 doctors and 168 nurses) were interviewed.

The research revealed various levels of stigma and discrimination among providers of HIV/AIDS medical services in the three oblasts. For example,

- Most respondents reported receiving training regarding HIV/AIDS at their work, but only half of the respondents said that their knowledge is sufficient.
- Although maintaining the confidentiality of a patient's HIV status is extremely important, almost half of the surveyed providers believe that a patient's status should be made known to others.
- Almost one-third of the respondents believe that HIV-positive people should be given medical treatment separately from other patients. They link this opinion to the need of preventing the spread of the infection among other patients and the staff.
- Respondents believed that there should be compulsory HIV testing for sex workers, injecting drug users, men who have sex with men, and people who exhibit high-risk behavior.
- Some of the respondents demonstrate stigma regarding HIV-positive patients and HIV-positive medical workers. This was shown by the respondent's views on treating PLHIV separately and barring HIV-positive medical staff from practicing medicine.

In conclusion, this field test has shown merits of the various questions for assessing the extent of stigma and discrimination among medical providers, but there is still work to be done, both in further refining the index questions, and in reducing stigmatization and discrimination within the medical profession.

I. ORGANIZATION OF RESEARCH AND METHODS

Under the POLICY Project, a methodology for an index measuring HIV/AIDS-related stigma and discrimination was developed and implemented in four countries. The results showed that few studies reported on the set of consistent indicators required to construct the index—thus revealing a need to gather these indicators across countries in a rigorous fashion.

POLICY held extensive consultations with the USAID-funded Interagency Working Group (IWG) on stigma and discrimination and a similar effort spearheaded by the Joint United Nations Program on HIV/AIDS (UNAIDS) and the International Planned Parenthood Federation (IPPF). Each organization agreed on a final draft index, focusing on stigma at the community level, provider/facility level, and among PLHIV.

UNAIDS and IPPF took the lead on gathering data for the PLHIV component. The USAID | Health Policy Initiative (HPI), Task Order 1, took the lead on the community-level and provider/facility-level components. ORC/Macro was approached and agreed to include questions on community-level stigma and discrimination in the core Demographic and Health Surveys (DHS) and on facility/provider-level stigma and discrimination in the Service Provision Assessments (SPAs). To supplement the available information on stigma and discrimination at the facility/provider level, HPI fielded surveys in Kenya and Ukraine to further test the indicators and questions.

Thus, the purpose of this research was to examine HIV/AIDS-related stigma and discrimination by providers of general medical services in three regions in Ukraine: Donetsk, Kherson, and Mykolayiv. Conducted from October 10, 2006–July 10, 2007, the work had three main phases: preparation, field research, and data analysis.

During the preparatory phase, experts from HPI developed the methodology and adapted the existing Stigma Index to the Ukrainian context. HPI trained members of the Ukrainian charity association, Coalition of HIV-Service Organizations, on the data collection process. Representatives of three nongovernmental organizations (NGOs)—Health of the Nation, Vykhid, and Mangust—also attended the training. Subsequently, interviewers from the Health of the Nation and Vykhid were trained to conduct the interviews. The field research phase, undertaken from December 30, 2006–April 16, 2007, included collecting information through a standardized questionnaire that respondents completed. During the third phase, HPI analyzed the data collected and submitted a draft report to the Health of the Nation, Vykhid, and Mangust. The report helped them to identify practical recommendations to reduce stigma and discrimination by medical service providers.

Sample Selection

To obtain a sample of HIV-positive people accessing general medical services related to tuberculosis (TB), drug addiction, sexually transmitted infections (STIs), pregnancy, and so forth, the following institutions were selected:

- Regional narcological dispensary
- Inter-regional center for maternity and child care (a maternity hospital)
- Inter-regional center for maternity and child care (an antenatal clinic)
- Regional TB dispensary
- Regional dermatovenerologic dispensary
- City hospital No. 1, contagious isolation department
- Regional clinic territorial association chest surgery department

These institutions were selected for the following reasons:¹

- The proportion of drug users among the total number of formally registered HIV-positive people in Ukraine in 2006 was 44.3 percent.
- The proportion of women of childbearing age (15–49) among formally registered HIV-positive people in Ukraine was 40.8 percent.
- Tuberculosis (pulmonary and extrapulmonary) is the most widespread among AIDS-indicative diseases, both among those whose disease was initially diagnosed as HIV (61.5%) and those who were under dispensary surveillance (60.6%).
- In addition to injecting drug users, most-at-risk groups include those who may also have STIs (e.g., female sex workers and their clients and men who have sex with men).
- When surgery is needed, HIV-positive people receive these services in surgery departments of hospitals, just like everyone else.

The samples of doctors and nurses working in the above medical institutions were selected randomly. The random choice method was used to avoid the influence of subjective factors. Part-time and managerial or administrative employees were not included in the samples. A total of 16 respondents, eight doctors and eight nurses, were surveyed in each medical institution in each region. Respondents unavailable on the first attempt were approached again; in the end, all the selected respondents participated in the survey for an overall refusal rate of zero.

Social and Demographic Features of the Sample

A total of 336 respondents, 168 doctors and 168 nurses, were surveyed. The average age of the respondents was 42 (ages ranged from 20 to 70 years old), and 79 percent of respondents were female. The average lifetime professional experience of the respondents was 19 years (experience ranged from six months to 50 years). The average professional experience of the respondents at their particular institutions was 13 years. The educational background of respondents was related to their occupation; 50 percent had received a higher education (all doctors) and 50 percent had received specialized secondary education (all nurses).

In the following analysis, percentages for responses to the various questions are calculated based on the total number of answers given, which may be less than the full sample of 336; the number of responses for each question is given in brackets following each percentage cited (e.g., N=332).

II. TRAINING OF PROVIDERS OF MEDICAL SERVICES ON HIV/AIDS

When asked whether training on HIV/AIDS (workshops, lectures, training sessions) is provided at the workplace, 83 percent of respondents answered affirmatively (N=333). About the same number of doctors and nurses reported receiving HIV/AIDS training, which mostly related to the following:

- General issues about HIV/AIDS
- HIV prophylactics

¹ Data taken from “HIV-infection in Ukraine,” *Information Bulletin* № 27, 2007.

- Etiology of HIV
- HIV transmission
- Diagnostics
- Treatment
- HIV/AIDS-related legislation
- Psychological counseling for patients with HIV/AIDS
- Antiretroviral therapy (ART)
- Ministry of Health orders 120 and 415
- Prevention of vertical HIV transmission
- Prophylactics of infection at the workplace
- Voluntary HIV testing and counseling
- HIV/AIDS clinical presentation
- Patients' recuperation
- First aid at accidents with blood present
- Prevention of infection at medical institutions

Respondents said that only on rare occasions did training topics include the reduction of HIV/AIDS-related stigma among providers of medical services, deontology, and/or the tolerant treatment of people living with HIV (PLHIV).

For a subjective assessment of their personal knowledge of HIV/AIDS, the respondents were asked, "Do you consider your knowledge of HIV/AIDS sufficient?" Forty-nine percent of respondents answered affirmatively (N=334); of the 51 percent who did not consider their knowledge sufficient, 55 percent of respondents were doctors and 45 percent were nurses.

Thus, a majority of respondents reported receiving training on HIV/AIDS at their workplaces, but only about half of the respondents believe their level of knowledge is sufficient. The main training topics included medical aspects of HIV/AIDS, as well as procedures for HIV treatment, diagnostics, and prophylactics. Respondents reported occasionally receiving training on stigma reduction and/or tolerant treatment of PLHIV.

III. FEAR OF HIV INFECTION AMONG PROVIDERS OF MEDICAL SERVICES AND STEREOTYPES REGARDING INFECTION AT WORK

One main type of HIV/AIDS-related stigma considered in this survey is the fear of HIV infection—shown as either a fear of everyday contact, a reluctance to implement professional duties, or avoiding contact with PLHIV. A specific characteristic of this type of stigma is that it may translate into actual discrimination if it results in particular behaviors (for example, evasion of contact with an HIV-positive individual). To identify this type of stigma, respondents answered whether they were afraid of particular types of contact (see Table 1).

Table 1 Fear of Contact with PLHIV

Fear of HIV infection	Not afraid		Do not know		Afraid		N-validated total
	%	N	%	N	%	N	
Giving an injection to an individual with HIV or AIDS	74	245	11	35	16	52	332
Assisting in childbirth when the woman lives with HIV or AIDS	43	135	20	64	37	116	315
Dressing the wounds of an individual with HIV or AIDS	61	200	9	29	31	101	330
Conducting surgery or suturing an individual with HIV or AIDS	46	151	14	45	40	129	325
Putting a drip in an individual with HIV or AIDS symptoms	67	224	6	20	27	89	333
Having contact with the sweat of an individual with HIV or AIDS	68	227	9	29	23	76	332
Having contact with the saliva of an individual with HIV or AIDS	55	184	13	42	32	106	332

Although many respondents, ranging from 43 to 74 percent, reported not being afraid of these types of contact, it is notable that so many replied that they were afraid. Although HIV is not transmitted through sweat or saliva, 23 and 32 percent of respondents, respectively, responded that they were afraid of having contact with these fluids. This percentage is quite high and reveals a fear of infection through everyday contact with PLHIV.

Respondents were then asked whether they agreed with a series of statements (see Table 2). Providers continued to express a certain level of discomfort when they work with or have everyday contact with HIV-positive people. About 24 percent (N=330) of respondents either agreed or strongly agreed that they avoided touching the clothing and belongings of PLHIV, while between 38 percent and 43 percent of respondents said that they would not feel comfortable working with/using the same bathroom as an HIV-positive colleague, giving medical assistance to someone who is HIV positive, or performing surgery on someone whose HIV status is unknown.

Table 2 Fear of Infection from Interactions with HIV-infected People

Statements related to fear of infection	Strongly agree		Agree		Disagree		Strongly disagree		N-validated total
	%*	N	%*	N	%*	N	%*	N	
Avoid touching clothing/belongings	3	10	21	68	56	186	20	66	330
Comfortable assisting/being assisted	18	59	44	143	30	98	8	27	327
Comfortable performing surgical/invasive procedures with unknown HIV status	17	56	40	129	37	120	6	19	324
Comfortable providing health services	17	55	41	136	35	116	7	23	330
Comfortable sharing a bathroom with a colleague	16	53	45	149	28	92	11	36	330

Fear and lack of knowledge help form stereotypes about HIV/AIDS, which in turn reinforce HIV/AIDS-related stigma. One stereotype revealed by this research related to the providers' assessment of their own risk of HIV infection when fulfilling their professional duties. About 68 percent (N=328) of respondents either agreed or strongly agreed that most HIV-positive healthcare workers become infected on the job, while an even higher percentage, 79 percent (N=330) agreed or strongly agreed that the most frequent mode of contracting HIV among healthcare workers is through work-related exposure. According to the Ukrainian HIV/AIDS Center,² however, only three cases of HIV infection at work among providers of medical services have been registered since HIV/AIDS was detected in Ukraine.

Thus, the research has revealed an apparent stereotype among doctors and nurses about the possibility of contracting HIV when fulfilling professional duties. This increases the perception of each person's own risk of infection, which in turn can increase the fear of working with HIV-positive patients. The research has also demonstrated that about one-third of respondents are afraid of contact with the saliva, sweat, and personal belongings of HIV-positive patients.

IV. CONFIDENTIALITY AND DISCLOSURE OF PATIENT HIV-STATUS DETAILS

Respondents were asked about breaches of confidentiality regarding PLHIV in their medical institutions. About 4 percent of respondents (N=333, 13 in total) stated that confidentiality breaches had occurred; those respondents also reported disclosing patients' status to other medical workers so that they would be careful when performing manipulations. The respondents indicated the following reasons for disclosing a patient's status:

- Low level of health protection in the country
- Low wages
- The risk of working with HIV-infected patients is not compensated either by a higher wage or by social guarantees provided by the state

Some respondents stated that, because of insufficient financing and a low level of protective measures provided for healthcare workers, doctors and nurses who have contact with HIV-positive patients should be able to protect themselves from the outset.

When asked "Do you disclose the HIV status of a patient to anyone other than the patient?," approximately 23 percent of respondents answered positively (N=333). When asked to list to whom they disclosed this information (apart from the HIV-positive patient), answers included doctors and other medical workers, guardians, parents (especially when the patient was underage), relatives, doctor in charge, chief doctor, senior nurse, medical staff who will work with the patient, doctors on duty, the sanitary and epidemiological service if this is the first time HIV was detected, and the AIDS center for registration and treatment of the patient. Thus, in general, usually the patient's status is disclosed to other medical staff, the sanitary and epidemiological service, and the patient's relatives. In their clarifications, respondents stated that a patient's status was disclosed when the patient was in a coma—"...to protect everybody during medical examination and manipulations" and because of the high risk of being infected through contact.

² "HIV-infection in Ukraine" *Information Bulletin* № 27. 2007.

When asked whether a health provider should inform someone else about a patient’s HIV status, 42 percent of respondents (N=333) answered affirmatively. In most cases, respondents said that the following authorities and groups of people should be informed about a patient’s HIV status: the sanitary and epidemiological service, the AIDS center, medical staff providing services to the patient, the head of the department in a hospital, the patient’s relatives, and parents of underage individuals.

Thus, almost half of the providers who responded believe it is important to disclose a patient’s status to third parties. The explanations included insufficient logistics and financial support to medical staff and giving healthcare workers the chance to avoid risk of HIV infection. Note that the survey did not ask whether the patient had agreed to the disclosure of his/her HIV-positive status to third parties.

V. MORAL VALUES AND STIGMA BEHAVIOR OF PROVIDERS OF MEDICAL SERVICES

Regarding moral values, manifestations of HIV/AIDS-related stigma include accusations, blaming, and shame because of the HIV-positive status of an individual. To assess this type of stigma, the respondents were asked about the extent of their agreement with the statements in Table 3.

Table 3 HIV/AIDS-related Stigma Based on Values and Morality

Statements related to values and morality	Strongly agree		Agree		Disagree		Strongly disagree		N-validated total
	%*	N	%*	N	%*	N	%*	N	N
HIV is a punishment from God	8	26	13	42	51	167	28	92	327
HIV-positive people should be blamed for bad behavior	3	9	16	53	65	215	16	52	329
HIV-positive people should be ashamed of themselves	1	3	5	16	72	236	22	72	327
Promiscuous men are the ones that spread HIV in our society	20	67	59	194	18	61	2	8	330
It is sex workers who spread HIV	12	41	43	141	41	135	4	13	330
I would feel ashamed if I were HIV positive	8	25	32	104	49	158	11	35	322
I would feel ashamed if any of my relatives were HIV positive	5	16	18	59	62	202	15	47	324
Only injecting drug users cause the spread of HIV	4	14	16	53	67	221	13	44	332

One-fifth of providers believe that HIV is a punishment from God, while 19 percent believe that HIV-positive people should be blamed for misbehavior. These beliefs are clear manifestations of moral judgments.

Another manifestation of moral-based stigma is blaming and searching for a culprit; this reinforces existing stigma by connecting it with particular groups of people, which, in turn, causes the perception that HIV/AIDS is only a problem for those people. Because HIV cases among most-at-risk groups are becoming more common in Ukraine, this perception is becoming more typical. According to the survey results, 79 percent of providers of medical services believe that sexually promiscuous men are a source of HIV-infection, while another 55 percent of providers agree that sex workers spread HIV. A total of 20 percent of respondents think that only injecting drug users cause the spread of HIV.

Yet another aspect of HIV/AIDS-related stigma is the feeling of shame associated with someone's HIV-positive status. Although only 6 percent of respondents agreed that HIV-positive people should be ashamed of themselves, 40 percent of respondents agreed to the statement, "I would feel ashamed if I were HIV positive." In addition, 23 percent of respondents reinforced this type of stigma by agreeing to the statement, "I would feel ashamed if any of my relatives were HIV positive." Thus, shame is evident because of HIV infection but also because of others' reactions to the infection.

In summary, the majority of providers of medical services blame particular groups of people (sex workers, sexually promiscuous men) for spreading HIV. This perception poses a possible barrier to overcoming the HIV epidemic in Ukraine, as the rest of the population might believe they are safe from contracting HIV. Furthermore, although the vast majority of providers of medical services do not believe that HIV-positive people should be ashamed of themselves, more than one-third of respondents would be ashamed if they themselves were HIV positive.

VI. KEEPING PEOPLE SEPARATE BECAUSE OF THEIR HIV-POSITIVE STATUS

When asked whether it was reasonable to treat HIV-positive patients separately, about 33 percent (N=334) answered affirmatively. Various explanations included the following:

- Risk to themselves
- Risk to other patients
- Risk to HIV-positive patients from other patients (the immune systems of PLHIV are weak)
- Prevention of contact with blood in prenatal, delivery, and postnatal periods
- No assurance of 100 percent disinfection of medical instruments

In elaborating, respondents pointed to a low level of support in the medical sphere and insufficient protection of medical staff:

- Medical staff wages should be higher.
- It is difficult to prove that an infection occurred at a workplace.
- HIV transmission has not yet been studied completely.
- Providers of medical services do not have sufficient information and protective means.
- HIV tests results are often delayed, making it impossible to know right away whether infection has occurred.

Some of the respondents explained that HIV-positive patients need special treatment:

- Specific features of their immune system should be taken into account.
- They need expensive medicines.
- HIV-positive people should be treated by specialists in this area.

- Contact between healthy and sick patients should be minimized.
- HIV-positive people would feel more comfortable if treated separately.
- HIV-positive people are anti-social individuals.
- HIV-positive patients often have sexual contact with HIV-negative patients
- Most HIV-positive patients are drug addicts, who are not socially adapted.
- Many patients do not accept HIV-positive patients and refuse to stay in the same ward with them.
- HIV-positive people should receive treatment in better equipped medical institutions, where staff will have good social guarantees and respective wages.
- In a separate institution, it is easier to protect the interests of an HIV-positive person.

Some respondents indicated that when other patients learn that HIV-positive patients are staying in the hospital, conflicts sometimes arise and it takes time and effort to settle them, so separate treatment is necessary. It should be mentioned, however, that the information about a patient's HIV-positive status is supposed to be confidential and should not be disclosed to other patients. Also, some respondents believe that PLHIV should be treated separately to prevent sexual contact between patients. Some respondents believe that HIV-positive patients "...do not always behave themselves properly."

In summary, one-third of respondents think that HIV-positive people should be treated separately for the following reasons: prevention of infection among other patients and medical staff; insufficient supply of doctors and nurses with protection means; high level of stigma from other patients in certain occasions; and the possibility of providing better medical treatment to PLHIV in specialized hospitals.

When asked whether it is necessary to reduce the duration of hospital stays by offering HIV-positive patients more medical assistance at home, about 15 percent (N=325) of respondents answered affirmatively, based on the following reasons:

- HIV-positive and HIV-negative patients are staying in hospitals in close contact.
- It is possible to limit the duration of stay of HIV-positive people in hospitals, if this does not affect the patient's health—but only if this is justifiable from a social viewpoint.
- PLHIV often need special care or treatment at home.
- HIV transmission has not yet been properly studied, but every person is concerned with his/her health and the health of other people.
- Receiving assistance at home reduces the chance of infecting other people in surgery departments, where there is contact with human biological fluids.
- Home care would reduce the duration of stay in a continuous isolation ward.

One respondent was explicit about why hospital stays should be limited: "Because of insufficient supplies of protective means, everyone has to buy everything he needs himself, from gloves to overall; so let them die at home and infect their relatives, not nurses and paramedics who are not paid for working with HIV-positive patients, do not have means of protection, and should not be obliged to care for HIV-positive people." Others believed it is in the interest of HIV-positive patients and/or the safety of other patients and medical staff.

Most respondents, however, did not think that hospital stays of HIV-positive patients should be limited. Respondents stated, "A patient should stay in a hospital as long as it is needed for his/her recovery regardless of his/her HIV-status" and "HIV-positive people should not be isolated."

When asked who provides HIV-positive hospital patients with food, personal hygiene services, and so forth, in most cases, respondents answered that it is medical staff (often nurses, sometimes assistant nurses and doctors). Respondents indicated that relatives sometimes give such assistance as well; and, in a

few cases, patients take care of themselves. When asked who provides these services to HIV-negative hospital patients, the respondents' answers were similar. In both cases, they stated nurses and assistant nurses perform these tasks because this is their primary duty.

Finally, respondents were asked whether they agreed with the statement, "HIV-positive doctors and nurses should not practice medicine." About 26 percent (N=330) of respondents either agreed or strongly agreed, demonstrating stigma related to both HIV-positive patients and HIV-positive medical staff.

VII. COMPOUND STIGMA AND COMPULSORY HIV TESTING

The issue of compound stigma—related to both HIV status and some other characteristic of an HIV-positive person—was explored through questions about compulsory HIV testing for other groups in society experiencing stigma, such as injecting drug users (see Table 4).

Table 4 Compulsory HIV Testing of Some Societal Groups

Compulsory HIV testing	No		Yes		N-validated total
	%	N	%	N	N
Are patients provided with pre-test counseling in your medical institution?	14	43	86	265	308
Are patients provided with post-test counseling in your medical institution?	16	49	84	254	303
Is compulsory HIV testing necessary for sex workers?	4	12	96	323	335
Is compulsory HIV testing necessary for injecting drug users?	7	24	93	312	336
Is compulsory HIV testing necessary for men who have sex with men?	4	15	96	321	336
Are there any other groups of people who, in your opinion, are supposed to have compulsory HIV testing?	33	105	67	210	315
Is it necessary to institute compulsory tuberculosis diagnostics/testing for all HIV-positive patients?	15	50	85	281	331
Should there be compulsory HIV testing for all patients who need medical treatment?	33	111	67	224	335

The percentage of respondents who believe compulsory HIV testing is necessary for most-at-risk groups (sex workers, injecting drug users, men who have sex with men) is extremely high. Note, however, that many respondents also said that pre- or post-test counseling are offered in their medical institutions.

To explore the issue of compound stigma further, respondents were asked whether they agreed that these groups deserved the same level and quality of medical care as other patients; 89 and 82 percent (N=326/329) either agreed or strongly agreed that injecting drug users and sex workers deserve the same level of care, respectively. Furthermore, about 95 percent of providers (N=330) either disagreed or strongly disagreed with changing services to an HIV-positive patient if they discovered that the patient is a former convict. Those respondents that agreed with changing the services said it is "because such a patient belongs to a risk group," "because of the need for doctor's consultancy and a check for

tuberculosis,” or “because an active form of tuberculosis is possible.” Thus, there appears to be only a small group of providers that expresses this type of stigma; and this relatively low level of stigma should not have an adverse effect on the quality and scope of the medical services offered.

A total of 67 percent of respondents (N=315) believe that additional groups of people should be required to test for HIV:

- Surgeons because of the risk of infection
- Organ, blood, or tissue donors
- Pregnant women and those planning a pregnancy
- Providers of medical services (especially those who have contact with human biological fluids)
- All marginalized groups (former convicts, the homeless, alcoholics, and drug addicts)
- Husbands of pregnant women
- Workers of institutions for children (kindergartens, schools)
- Those who intend to marry (because of the risk of marrying an HIV-positive individual and having a healthy family)
- Medical staff, public catering staff, and educators (because of close contact with other people working with bodily fluids, such as saliva, tears, sweat, and blood)
- Foreigners who come to Ukraine legally, and people who seek to obtain Ukrainian citizenship
- Refugees and illegal migrants, as they are potentially hazardous within their group and to other people around them
- People who have a high temperature for a long time (in order to establish HIV cases)
- Workers of the transport sector
- Miners, meat sellers, and other retailers (because many of them have contact with blood and because of a low level of morality)
- Sexually promiscuous people
- People who are frequently sick with pneumonia (as they belong to a risk group)
- Those working in the service industry because of the potential of maliciously spreading HIV
- Patients with STIs (as they belong to risk groups)
- Barbers (because of close everyday contact)
- Blood transfusion recipients and people sick with hepatitis B and C
- People with an unidentified diagnosis (as they may potentially be infected)
- Sales workers (to prevent infection in cases when they have their skin damaged and they give cash to a buyer)
- Everybody
- Long-distance drivers
- Convicts
- Public service employees (because of contact with food and people)
- Patients with AIDS symptoms
- People who need surgery (to better protect doctors—it affects treatment strategies)
- All paramedical personnel (to protect themselves and patients)
- Waiters and train conductors (because of direct contact)

Although groups of society traditionally believed to be at risk of HIV infection are listed above, other groups—such as workers in the sectors of education, public catering, sales, and train operation—were also included. The explanations reveal that some of the respondents have incorrect knowledge of the modes of HIV transmission. They believe that these groups are at a high risk of infection because of everyday contact with large groups of people and goods/food and/or that these groups could transmit the infection to other people. Additional groups of society included those at risk because of behavioral

practices, as well as those who do not exhibit high-risk behavior, including the public in general. The fact that many respondents think of themselves as members of a most-at-risk group shows their feeling of vulnerability.

Approximately 85 percent (N=331) of respondents agreed that TB testing/diagnostics should be compulsory for all HIV-positive patients. Given the TB epidemic in Ukraine and the high susceptibility of HIV-positive patients to the disease, active measures aimed at detecting TB among PLHIV are justified and reasonable. The only caveat here is the use of the word “compulsory” with respect to diagnostics/testing. Any forced diagnostics/testing for tuberculosis is inadmissible from the Ukrainian legal viewpoint, even when a patient is HIV positive.

While adequately assessing the risk of tuberculosis among PLHIV, most of the respondents indicate a pessimistic forecast for treatment. Thus, 58 percent of respondents (N=310) believe that TB among PLHIV is an incurable disease. This is not correct. International and national standards for medical treatment of joint HIV/TB infection indicate that tuberculosis among PLHIV is curable. It is possible that the incorrect forecasts negatively affect treatment of TB, resulting in lower levels and scope of medical care—possibly limiting care to palliative measures only.

Overall, 67 percent of respondents (about an equal number of doctors and nurses) think that compulsory HIV testing is necessary for all patients who ask for medical assistance, implying that this opinion is quite widespread. When providers were asked specifically whether all patients at their medical institutions should be tested, 58 percent of respondents agreed. This means that over half of providers want to be aware of the HIV status of their patients.

In summary, a majority of providers believe compulsory HIV testing is necessary—both in relation to patients in general and, to a lesser degree, their patients in particular. These opinions can lead to negative outcomes, including testing without a patient’s consent or knowledge, or testing that is not in compliance with approved HIV testing procedures. Note, however, that most respondents also said that pre-testing and post-testing HIV counseling is provided in their medical institutions.

VIII. DISCRIMINATORY ACTIONS COMMITTED BY PROVIDERS OF MEDICAL SERVICES WHEN PERFORMING THEIR PROFESSIONAL DUTIES

For this research, an act of discrimination was defined as any active manifestation of stigma—not only acts or omissions that breach the legal rights of PLHIV. Thus, this view of discrimination encompasses actions that are not normally considered acts of discrimination. Sometimes, unsubstantiated (illegal) exemptions or constraints in medical institutions (for example, a refusal to provide medical assistance) are considered to be acts of discrimination. A broader definition includes important stigmatizing actions—for example, spreading rumors about a patient’s status among the staff and other patients, social or physical isolation, and the overuse of protective means during contact with an HIV-positive person. It is difficult to explore these actions, as people are aware of the negative consequences of discrimination and, in some cases, of its illegality, and thus do not acknowledge its existence by giving socially desirable answers.

To investigate acts of discrimination by doctors and nurses, the survey included questions related to behavior toward PLHIV (see Table 5). When asked whether HIV-positive people’s rights for medical treatment had been breached, almost 100 percent of respondents (N=329) replied “No.” Further probes, however, revealed that rights were indeed sometimes breached.

Table 5 Acts of Discrimination

Acts of discrimination toward PLHIV	No		Yes		N-validated total
	%	N	%	N	N
Have HIV-positive people's rights for medical treatment ever been breached in your medical institution?	99	327	1	2	329
Do you use any additional protective means when giving medical assistance to HIV-positive people and people sick with AIDS?	67	214	33	106	330
Would you put a protective mask on before contact with an HIV-positive person?	62	205	38	127	332
Would you put a protective mask on before an examination of an HIV-positive patient if you are ill at that moment?	15	50	85	285	335
Have you ever told an HIV-positive woman that she should not have children?	88	292	12	38	330
In your medical institutions, do you offer the same services (for example, same scope of examination, including use of instruments; same department, same bedclothes) to both HIV-positive and HIV-negative women?*	6	9	94	137	146
In your medical institutions, do you offer same services (for example, same scope of examination) to both HIV-positive and HIV-negative patients?	3	10	97	321	331

*This question was asked to staff members of medical institutions offering reproductive health services.

For example, when asked about the universal protective means generally used in their facilities, respondents listed items such as disposable medical instruments, gloves, special cloths, protective glasses and masks, disinfection, quartz, aprons, overalls, protective screens, and disposable syringes and droppers. Some respondents gave more general answers, such as observing sanitary and epidemiological regimens, individual protection, working according to the standards, and prophylactics; these answers do not present a clear understanding of which means were used. Note that apparently some of the respondents thought the question was linked to working with HIV-positive patients, as in their responses, they mentioned HIV/AIDS medical kits, zidovudine, and antiretroviral therapy. Some respondents said that no protective means were used during the consultancy; but they noted using gloves, disposable instruments, and HIV kits when examining a patient, operating on a patient, or helping with delivery.

In summary, universal precautions are used extensively in facilities. When interacting with HIV-positive patients, however, about 33 percent of respondents report using additional protective means, including disposable syringes, disposable gloves, protective glasses and masks, aprons, overalls, disinfection, individual protective measures, and an additional pair of gloves. This behavior indicates that about one-third of respondents are demonstrating discrimination. In addition, about 38 percent of respondents think it is necessary to put on a protective mask during contact with an HIV-positive person, with nurses accounting for about 52 percent of that total. Note, however, that the majority of respondents (85 percent) will put on a protective mask to protect the HIV-positive patient if they are sick at the time.

The results in Table 5 show that most medical institutions report offering the same services (for example, the same scope of examination) to both HIV-positive and HIV-negative patients; 94 percent in reproductive health facilities answered affirmatively, and 97 percent in facilities providing general medical services answered affirmatively. However, about 12 percent of medical service providers have told an HIV-positive woman that she should not have children—despite the risk of transmission from mother to child being very low if antiretroviral therapy is provided in a timely fashion.

In general, respondents report no breaches of the rights of PLHIV in their medical institutions. Further probes, however, revealed that about one-third of respondents use additional protective means when providing medical assistance to HIV-positive patients, and 38 percent of respondents would put on a protective mask during contact with an HIV-positive patient. However, most respondents (85 percent) said they would also use a mask to protect an HIV-positive patient if they are sick at the time.

IX. ACTS OF DISCRIMINATION THAT OCCURRED IN A MEDICAL INSTITUTION IN THE LAST 12 MONTHS

To further explore whether discriminatory acts are occurring, respondents were asked whether they had observed acts of discrimination committed by others when it was known that the patient is or might be HIV positive (see Table 6).

Table 6 Actual Acts of Discrimination in Their Medical Institution over the Last Year

Examples of acts of discrimination	No		Yes		N-validated total
	%	N	%	N	N
HIV-positive people were given less scope of assistance than other patients.	96	312	4	14	326
Additional measures were taken to sterilize instruments used for HIV-positive patients.	62	193	38	118	311
Some of the patients were required to pass HIV testing before a planned operation.*	35	71	65	131	202
During a noninvasive examination of a patient suspected of having HIV, protective gloves were used.	23	73	77	250	323
Do you know about any cases when patients were denied certain services (procedures/manipulation) in your medical institution because the patients were HIV positive?	91	297	9	28	325
Do you know about any cases when patients in your medical institution were sent to another medical institution because they were HIV positive?	88	286	12	38	324
Do you know of any cases when a patient was tested for HIV without his/her consent?	95	311	5	15	326
Did you hear rumors among medical staff about the HIV-positive status of a patient, when this patient is treated in your medical institution?	83	272	17	56	328

* This question was asked to staff members of medical institutions offering surgery services.

The data indicate that 77 percent of respondents observed others using rubber gloves during noninvasive examinations of a patient suspected of having HIV. More than one-third of the respondents (38 percent) reported observing others using additional means of sterilizing instruments when examining HIV-positive patients.

A majority of respondents (65 percent) reported observing patients being required to have an HIV test before a planned operation; this is a clear manifestation of discriminatory practices based on HIV status in the medical institutions providing surgery services.

A small number of respondents (12 percent) noted cases when HIV-positive patients were sent to another medical institution because of their HIV-positive status. However, respondents justified their actions because of the need to cure concomitant diseases in other specialized institutions or AIDS centers.

Five percent of respondents observed HIV testing occurring without the patient's consent. About 17 percent also reported hearing rumors among the medical staff about the HIV status of a patient, violating disclosure procedures.

In summary, a majority of respondents use gloves for the noninvasive examination of HIV-positive patients and employ additional measures to sterilize instruments used to examine HIV-positive patients. Respondents also observed patients being required to pass an HIV test before a planned operation and heard rumors among medical staff about the HIV status of patients, violating disclosure procedures.

X. CONCLUSIONS AND LESSONS LEARNED

The research revealed various levels of stigma and discrimination among providers of HIV/AIDS medical services in the three oblasts. For example, although maintaining the confidentiality of a patient's HIV status is extremely important, some respondents reported hearing rumors regarding a patient's status among the medical staff. In addition, almost half of the surveyed providers believe that a patient's status should be made known to others, such as medical staff treating an HIV-positive patient, staff at AIDS centers, a patient's relatives, and parents of underage patients. Explanations for informing third parties of a patient's HIV status related to insufficient logistics and financial support of medical staff and the prevention of HIV infection. Note, however, that the research did not include the consideration of whether patients consented to the disclosure.

Another indication of stigma and discrimination was revealed by the extent to which patients are treated differently than other patients. Almost one-third of the respondents agreed that HIV-positive people should be given medical treatment separately from other patients. Reasons included the prevention of HIV transmission among patients and staff; insufficient protective means for doctors and nurses; a high level of stigma from other patients; and at times, the possibility of offering better medical assistance to HIV-positive patients in specialized hospitals. In addition, about one-third of respondents use additional protective means when giving medical services to HIV-positive patients, while 38 percent of respondents said they would put on a protective mask during contact with an HIV-positive patient. Note, however, that most respondents (85 percent) said they would also use a mask to protect an HIV-positive patient if they themselves were sick at the time. Also, the majority of respondents think the duration of hospital stays of HIV-positive patients should not be limited because of HIV status.

Respondents also appear to have some feelings of shame and blame regarding HIV/AIDS. For example, some respondents blame particular groups of people (sex workers and injecting drug users) for spreading HIV. This perception poses a possible barrier to overcoming the HIV epidemic in Ukraine, as the rest of

the population might believe they are safe from contracting HIV. At the same time, although providers of medical services generally do not think that HIV-positive people should be ashamed of themselves, more than one-third said they would be ashamed of themselves if they were HIV positive.

Some of the stigma and discrimination observed may be related to incorrect and/or insufficient information on HIV/AIDS. Although most respondents receive training on HIV/AIDS at their work, only half of the respondents believe their knowledge is sufficient. Respondents said that only on rare occasions do they receive training on stigma reduction, deontology, and the tolerant treatment of PLHIV; most of their training relates to the medical and legislative aspects of HIV/AIDS, HIV diagnostics, and treatment and prophylaxis procedures. Furthermore, doctors and nurses have a stereotypical opinion that providers of medical services frequently contract HIV when performing their professional duties—and, therefore, they themselves are at high risk of becoming infected, which can result in a fear of working with HIV-positive patients. About one-third of respondents are afraid of contact with the saliva, sweat, clothes, and personal belongings of HIV-positive patients. Thus, further training on HIV/AIDS for providers would probably be beneficial for both providers and HIV-positive patients.

Lessons Learned

Once the tool was adapted to the country and the interviewers and data entry personnel were trained, fielding the survey was a straightforward process. The survey's length was acceptable, and there were a sufficient number of open-ended questions so that respondents could expand on their answers and add relevant details. Note that it is extremely important to do the initial preparatory work (i.e., adapting the tool, appropriate training) in order for the rest of the process to proceed smoothly. Other lessons learned include the following:

- **It is important to have large enough sample sizes to both draw conclusions and disseminate results.** One initial problem in designing the index was that stigma, in particular community-level stigma, could not be adequately measured using a small survey but instead needed to be part of a nationally representative survey. This issue was addressed by persuading ORC/Macro to include various questions on stigma and discrimination in the DHS and SPAs. We also learned that facility/provider-level surveys need to have a large enough sample so that individuals cannot be identified; the findings for oblast-level AIDS centers cannot be disseminated, as concerns were expressed about violating respondents' confidentiality and privacy.
- **Working collaboratively with other agencies can be challenging, yet is ultimately rewarding.** For this activity, HPI acted as a liaison between ORC/Macro and the IWG. On both sides, there were myriad agendas, opinions, and personalities. Achieving agreement among all of the actors was challenging, but the effort paid off because ORC/Macro accepted the IWG's recommendations. It would not have been credible for HPI alone to issue a set of recommendations to ORC/Macro.
- **Stigma serves as a barrier and needs to be addressed.** Aside from the survey findings, the fact that results from the AIDS centers in Ukraine could not be disseminated shows that the issue of stigma and discrimination remains a serious one.

In conclusion, although significant progress has been made toward finalizing a stigma index, there is still work to be done. In approximately five years, when a sufficient number of DHS and SPAs have fielded the new set of questions, the results, along with those from comparable surveys (such as HPI's Kenya and Ukraine facility/provider-level surveys and the IPPF's PLHIV-level survey), should be collated and analyzed. In the meantime, further work could be done along the following lines of inquiry:

- Check for internal consistency of responses to explore the validity of the new questions and recent surveys; and
- Combine and compare the results from the customer satisfaction surveys and the facility/provider-level surveys in Ukraine, which were specifically designed to sample the same facilities.

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