GETTING TO "STIGMA-FREE" HIV SERVICES IN DOMINICA

Survey Results

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ACKNOWLEDGEMENTS

EXECUTIVE SUMMARY

Background

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

In response, the National AIDS Response Programme of the Ministry of Health of Dominica, with assistance from HPP and other partners, is developing and testing a comprehensive S&D-reduction programme in health facilities that will provide lessons learned to share with the rest of the Caribbean region. The programme includes two key elements: 1) strengthening capacity of health facilities and health facility staff to provide S&D-free services and 2) collecting data to inform programme design, policy at the health facility and national levels, ongoing learning, and to support evaluation. This report focuses on the initial stage of this second element—collection of baseline data from the health delivery system in Dominica.

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

Methodology

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

The study team used a standard survey methodology. After the results were available, a participatory approach was used to analyse and interpret the study findings. A workshop was conducted with a diverse group of key stakeholders in the health sector in Dominica. After reviewing and discussing the results of the survey, these participants developed recommendations based on the findings.

The sample for the survey was drawn from all adults working in a public health facility at the primary, secondary, or tertiary level, across all categories of workers (both technical and non-technical), as well as from the private sector. The survey was implemented through a combination of a self-administered questionnaire and in-person interviews in cases where respondents were not comfortable with or able to complete a self-administered questionnaire.

In total, input from 335 respondents, including support administrative staff, medical personnel, cleaning/auxiliary staff, pharmacists, and technicians, formed the basis of this report. Frequencies for key results areas (training, infection concerns, health facility environment, health facility policies, opinions about people living with HIV [PLHIV] and key populations, caring for pregnant women living with HIV) of all the questions asked are presented by these broad job categories.

Results

Exposure to training

Respondents in general did not report having been involved in any significant training initiatives in the previous 12 months. Medical and related personnel most commonly reported attending training programmes related to their field, such as HIV treatment and care and patients' informed consent, while a wider range of staff across both the medical and non-medical fields reported exposure to programmes in such areas as infection control and universal precautions.

Infection concerns

The level of concern about becoming infected with HIV while caring for patients living with HIV varied according to the degree of interaction with body fluids that a given procedure required. Medical staff reported the highest level of worry about more invasive procedures such as suturing wounds, drawing blood, inserting IV drips, and dressing wounds, with reported worry ranging from 40.9 per cent (giving an injection) to 63.8 per cent (suturing wounds). Overall, respondents reported lower levels of fear with non-invasive procedures that pose no risk of HIV transmission, such as taking the temperature (3.8% overall) and touching the clothing of a PLHIV (9.6% overall), with slightly higher levels of concern among auxiliary staff (6.3% and 13%) than other groups of staff. Taking unnecessary or selective protective measures (e.g., only with PLHIV) is a reflection of the infection concerns among staff. For example, almost one in three respondents (31.6%) identified the use of double gloves when caring for a patient living with HIV as a measure they use.

Health facility environment

Staff members were asked to report on instances in which they had observed both discriminatory and positive behaviours occurring in their facility in the past 12 months. Some discriminatory practices were very uncommon, such as referral of PLHIV to other health facilities (6.9% of staff members reported observing this), while others were much more common, such as the use of extra infection-control measures when treating PLHIV (52.5%). Close to half of those surveyed (47.5%) reported that they thought workers at their health facility would be hesitant to work alongside a co-worker living with HIV, regardless of their duties. The most common observed behaviour was a positive one: 60.3 per cent of respondents reported instances where extra support or care was provided to PLHIV or people thought to be living with HIV.

Health facility policies

Just over 47 per cent of staff interviewed cited the presence of an anti-discrimination policy to protect PLHIV in their facility. Interviews indicated that health facilities were both fairly well-equipped and possessed an environment that was supportive of staff providing care safely to PLHIV.

Opinions about PLHIV

Nearly half of respondents agreed that PLHIV did not care if they infected others, while just over one in three said that PLHIV could have avoided becoming infected with HIV. Others linked PLHIV with irresponsible behaviour and having multiple sexual partners. Almost two thirds of respondents agreed that PLHIV should be allowed to have babies if they so wished. Half of respondents indicated that they would

be ashamed if they were to become infected with HIV, while 68.1 per cent stated they would be ashamed if a family member were living with HIV

Most staff indicated they would be willing to provide services to key populations. Those respondents who expressed preferences not to provide services identified multiple explanations, including: lack of training in working with key populations, increased risk of exposure to service providers (except when working with immigrants and women who have sex with women), and the perceived immoral behaviour of many key populations.

Pregnant women living with HIV

Roughly half of respondents (facility staff who provide care to pregnant women) expressed concern about HIV transmission when assisting during the labour and delivery of women with HIV or whose HIV status is unknown. Most respondents rejected the claim that women with HIV are bad mothers and while most respondent disagreed with the statement "It can be appropriate to sterilize a woman living with HIV, even if it is not her choice," 15.8 per cent did agree, and 13.7 per cent did not answer the question. About one in five respondents reported observing an HIV test being performed on a pregnant woman without her informed consent in the past 12 months in their facility.

Discussion—Participatory Analysis

To facilitate a participatory analysis process and collective development of recommendations based on the data, a participatory analysis workshop was conducted in April 2013 with 27 key stakeholders from the health sector in Dominica. During the one-day workshop, stakeholders reviewed the summary data tables and discussed their implications. The discussion and recommendations developed during the workshop provided the basis for developing the country-led strategy for planning to reduce stigma in health facilities.

Infection concerns

Workshop participants noted that the concern reflected in the data about becoming infected with HIV when caring for PLHIV through both non-invasive and more invasive procedures indicates an unwarranted level of unease among health facility staff. Workshop participants suggested that health facility staff members are influenced by the communities where they live (fears and misconceptions are still prevalent) and may be influenced by peers (especially medically trained staff). They also noted the high turnover of staff as a factor in whether staff members had received training in S&D, coupled with the reality that many staff do not attend training sessions. Participants called for new and creative ways to deliver recurrent training.

Health facility environment

Workshop participants noted an unacceptably high level of observed stigmatising practices that run counter to the Hippocratic Oath and a general good code of professional conduct, can inadvertently disclose a patient's HIV status, and waste resources. They also noted that S&D within health facilities towards patients also affected health facility staff themselves and their willingness to be tested for HIV and seek care within the health system.

Health facility policy

Workshop participants were puzzled that almost half of respondents said that their health facility has policies to protect PLHIV from discrimination because there are currently no specific facility-level policies in place. Participants explained this inconsistency as possibly due to the presence of an unwritten code of conduct and set of expectations within health facilities about how personnel should conduct their work. In response to just over half of the survey respondents citing lack of access to post-exposure

prophylaxis (PEP) in their health facility, despite PEP being available in all health facilities, participants called for more and broader training on accessing PEP.

Opinions and willingness to treat

In response to higher reported levels of stigma among non-medical staff, participants wondered if cleaning and auxiliary staff really held more stigmatised attitudes, or whether this could be a reflection of response bias—suggesting that other (more educated) staff members knew the appropriate answer to these types of questions and replied accordingly.

Participants involved in the analysis suggested that health facility workers may feel less ashamed if they became infected with HIV than if a family member did, because, as a health facility worker, they can explain transmission through a "less stigmatised" mode or may be better equipped to hide their HIV status.

Some participants held that one can prefer not to provide services to key populations while still providing good services. Others contested that non-verbalised opinions and intent can influence the actual provision of services, making preference a strong proxy for action.

Pregnant Women Living with HIV Participants were dismayed by results of the survey questions focusing on pregnant women living with HIV. Discussion focused on the need to find more effective education strategies to address the rights of women living with HIV and focus more on human rights.

Recommendations

Implement S&D-reduction trainings to address needs identified in the survey data

- Frame trainings and health worker education in the context of social justice and equality within a framework of human rights.

- Adopt participatory training approaches focused on real-life scenarios.

  o Address fear-based stigma, given the disconnect between supposed knowledge of HIV transmission and the fear of HIV transmission expressed in the data.

  o Conduct more thorough discussions focused on real-life scenarios and the specific fears facility staff hold about a particular task they may need to perform.

- Increase understanding and correct use of universal precautions.

- Expand knowledge of pre-exposure prophylaxis among all facility staff.

- Address attitudes and moral judgment associated with PLHIV and key populations.

  o Trainings should promote empathy and help staff members understand that outright discrimination is a barrier to health services, and that more subtle judgments also discourage clients from accessing services.

- Provide tailored training to all cadres of staff.

Develop policy and facility-level codes of conduct

- Develop facility-level codes of conduct.
- Develop workplace policies specific to the health sector.

ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
ANC	antenatal care
HARP	HIV and AIDS Response Programme
HIV	human immunodeficiency virus
HPP	Health Policy Project
MSM	men who have sex with men
PANCAP	Pan Caribbean Partnership Against HIV and AIDS
PEP	post-exposure prophylaxis
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
PWID	people who inject drugs
S&D	stigma and discrimination
TG	transgender
UNAIDS	United Nations Joint Programme on HIV/AIDS
USAID	United States Agency for International Development
UWI	University of the West Indies
UWIHARP	University of the West Indies HIV/AIDS Response Programme

BACKGROUND

HIV-related stigma and discrimination (S&D) are widely recognised in the Caribbean region and globally as critical barriers to HIV prevention, care, and treatment, particularly for key populations who often experience additional stigmas beyond HIV. Stigma and discrimination keep people from seeking HIV testing, disclosing their HIV status, practicing prevention, accessing care, and adhering to treatment, while frequently causing human rights violations. Recognising the importance of reducing S&D for an effective and efficient response to HIV, the Caribbean region is taking the lead in developing a way forward. The Pan Caribbean Partnership Against HIV and AIDS (PANCAP), with support from the USAID-funded Health Policy Project (HPP) and other regional partners, has recently developed *The PANCAP Stigma Reduction Framework for HIV and AIDS: National Actions to Reduce HIV-Related Stigma & Discrimination and Improve Health Outcomes* (2012), which provides guidance on developing national strategies for action to address S&D.

The PANCAP HIV framework highlights the importance of the health and development sector in building an understanding and evidence base for decision making and action in a comprehensive response to S&D. Responding to and learning about HIV-related stigma also strengthens understanding more broadly about stigma and health services. While S&D occur in all spheres of life including in the family, workplace, community, schools, places of worship, and healthcare facilities, experiences of S&D in healthcare facilities are particularly detrimental to the health and overall well-being of individuals and society.

In response, the National AIDS Response Programme of the Ministry of Health of Dominica, with assistance from HPP and other partners, is developing and testing a comprehensive S&D-reduction programme in health facilities that will provide lessons learned to share with the rest of the region. The programme includes two key elements: 1) strengthening the capacity of health facilities and health facility staff to provide S&D-free services and 2) collecting data to inform programme design, policy at the health facility and national levels, ongoing learning, and to support evaluation.

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

This report focuses on the initial stage of this second element—collection of baseline data from the health delivery system in Dominica. These baseline data provide a foundation on which to design evidence-informed S&D-reduction programming and evaluate change over time. Implementation of this survey also contributes to a global effort to develop a standardised tool and indicators for measuring S&D among health facility staff, providing a Caribbean perspective to the process that also includes sites in St. Kitts & Nevis, China, Egypt, Kenya, and Puerto Rico.

Technical Approach: Measurement for Strengthening S&D-Reduction Programming in Health Facilities

The design of study and the survey instrument built on regional and global best practice experience for S&D-reduction programming in health facilities and measured key areas for programmatic intervention at both the individual and facility levels. Specifically, interviews were conducted with a representative sample of all levels of health facility staff (medical and non-medical) working in different types of health facilities, and information was collected in the following key areas for programmatic intervention: fear of HIV transmission through work-based exposure to people living with HIV (PLHIV); opinions about PLHIV, in particular pregnant women living with HIV; and the health facility environment. Data were also collected to assess levels of S&D, experiences with secondary S&D, potential discrimination against health facility staff living with HIV, and willingness to provide treatment to stigmatised populations.

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

Opinions about PLHIV
Negative opinions about the moral character or behaviours of PLHIV and key populations may underlie S&D in health facilities, manifesting in ways that are often inadvertent and unrecognised as stigmatising behaviour (e.g., body language, tone of voice, language, gossip). Understanding common stigmatising opinions held by facility staff provides information on the types and prevalence of different attitudes, allowing S&D-reduction programming to tailor sensitisation and training accordingly.

Health facility environment
Best practice has shown that successful S&D-reduction programmes in health facilities include a focus on strengthening the health facility environment to ensure a safe and supported work space for staff, which strengthens their ability to provide stigma-free services. This includes attention to both the physical environment (ensuring that staff members have the information, supplies, and equipment necessary to practice universal precautions and prevent occupational transmission of HIV and other infectious diseases) and the health facility policy environment. For example, developing and enforcing specific policies related to the care of patients living with HIV or key populations that protect the safety and health of patients, as well as health facility staff. S&D in health facilities not only affects clients, but may also affect the willingness and comfort level of staff to be tested for HIV, work alongside staff living with HIV, and seek treatment for HIV.

Observed S&D
Surveys of S&D rarely ask respondents if they themselves have engaged in stigmatising or discriminatory behaviour, because direct questions on sensitive topics are often liable to elicit unreliable responses. Therefore, measuring levels of S&D is generally done through an indirect question that asks respondents if they have observed various acts of stigma or discrimination occurring in their facility during a given time frame (e.g., past 12 months). This question may also be prone to unreliable responses but is assumed to be less so than a direct question. It may also provide a conservative estimate (undercount) of S&D if there are forms of S&D occurring that are not easily observed by other staff in the facility.

Secondary stigma

Staff in health facilities who are known to provide care and services to PLHIV may experience S&D by association, both within and outside the facility. While this may be more of an issue in much higher HIV prevalence settings, we thought it important to explore this trend in the context of Dominica. If health facility staff are experiencing, or fear experiencing, secondary S&D, this may affect their willingness to care for and interact with clients living with HIV. It is also important to address this issue with staff to provide support for coping with and challenging secondary S&D.

Willingness to provide treatment

Lastly, stigmas that are related to or often associated with HIV—for example towards men who have sex with men (MSM), sex workers (SW), immigrants or people who use drugs—are also important to measure, as they dissuade those groups most in need of health services from seeking care.

METHODOLOGY

The study team used a standard survey methodology. After the results were available, a participatory approach was used to analyse and interpret the study findings. A workshop was held with a diverse group of key stakeholders in the health sector in Dominica, and these participants developed recommendations based on the findings.

Sample Selection and Implementation of Fieldwork

The sample for the survey was drawn from all adults working in a public health facility at the primary, secondary, or tertiary level, across all categories of workers (both technical and non-technical), as well as from the private sector. A multistage sampling approach was adopted. In each of the selected healthcare facilities, the workers were stratified at the level of the broad occupation classification: technical and non-technical. The former included senior technical/professional staff (including specialists), other technical staff, and senior administrative staff. The latter included all other administrative staff and ancillary staff. [1] Within each stratum, quota sampling was reapplied in the selection of respondents for the survey. This approach was based heavily on the proportions of the occupation categories that fall under each broad heading, ensuring that the key occupations were represented among those selected to respond to the survey.

Prior to beginning fieldwork, a two-day briefing session was held for the field personnel. The briefing session focused on the identification and selection of respondents as stipulated by the sampling approach and classification of occupations. This was followed by a detailed briefing on the questionnaire and accompanying forms, as well as confirmation of allocated quotas for the health facilities.

The survey was implemented through a combination of a self-administered questionnaire and some in-person interviews in cases where respondents were not comfortable or able to complete a self-administered questionnaire. Survey interviewers were drawn from the National AIDS Response Programme and the wider Ministry of Health in Dominica.

Data Capture

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

Analysis Process

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

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[1]Technical staff will include: those classified as Professional (Chief Medical Officer, Principal Nursing Officer, health planners, doctors, PS, directors of services, lab techs, programme coordinators, etc.); those classified as Other Technical (nurses, nursing assistants, environmental &insect vector officers);and those classified as Senior Administrative Staff (Medical Records Technician, Accounts Officer, Executive Officer, Finance Officer, Manager Medical Stories). Non-Technical staff will include: Other Admin Staff (clerk, telephone operator, orderly, and Medical Supply Officer); Elementary Occupations (cleaners, laundry, seamstress, messengers).

The data were analysed to assess the presence and levels of the following: immediately actionable drivers of S&D (e.g., fear of casual transmission of HIV and attitudes towards PLHIV); observed S&D; experience of secondary S&D; and facility environment supportive of non-stigmatising and discriminatory care. This level of analysis provided basic information to assess the situation and needs in the health facilities and what type of programming is most needed.

Ethical Clearance and Consent Processes

Ethical approvals for the study were obtained from the Ethics Committee of the Ministry of Health, Dominica.

Signed informed consent forms were collected from each respondent. The consent form explained:

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

Respondents' Profile

A total of 335 respondents formed the basis of the analysis that follows. These respondents covered a range of job classifications in the health sector, grouped under four major headings: support administrative staff, medical personnel, cleaning/auxiliary staff, and pharmacists including laboratory and other technicians. The results (frequencies) for the following key results for all the questions asked (on training, infection concerns, health facility environment, health facility policies, opinions about PLHIV and key populations, caring for pregnant women living with HIV) are presented below, by these broad job categories. The specific sample sizes (number of respondents) are also included in the tables for each question. In cases where numbers differ within the table, there was either a non-applicable response category for that particular question or non-response.

Table 1: Number and Type of Health Facilities Sampled

Facility Type	Count (n)	Percentage
National referral hospital	207	61.8%
Health centre	100	30%
Private clinic	3	1%
District hospital	26	7.8%
Clinic	16	4.8%
Other	9	2.7%
Sub-district hospital	0	0
Pharmacy	4	1%
Private hospital	3	1%

Table 1 provides a breakdown by type and number of facilities where the respondents were based. The total number of types of facilities exceeds 100 per cent, as some practitioners work at multiple facilities.

RESULTS

Exposure to Training

The survey investigated exposure to training among healthcare providers (see Table 2.1). Respondents in general were not found to be involved in any significant training initiatives during the previous 12 months, with 35.8 per cent receiving training on infection control and universal precautions; 28.7 per cent on patients' informed consent; 20.3 per cent reported attending training programmes covering S&D; 17.3 per cent on treatment and care; and 11.3 per cent on HIV counselling and testing.

Medical personnel were more inclined to attend training programmes related to their field, such as HIV treatment and care, and patients' informed consent, while a wider range of staff across both the medical and non-medical fields reported exposure to programmes in areas such as infection control and universal precautions.

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

Training Areas		Support Admin. Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Position Not Given	Total
Sample size (n)		19	228	58	25	5	**335**
HIV stigma and discrimination	Yes	5.3	25.4	8.6	16.0	0	20.3
	No	84.2	66.7	86.2	68.0	60.0	71.0
	Not stated	10.5	7.9	5.2	16.0	40.0	8.7
Gender sensitivity	Yes	5.3	11.4	1.7	8.0	0	9.0
	No	78.9	73.2	89.7	76.0	60.0	76.4
	Not stated	15.8	15.4	8.6	16.0	40.0	14.6
HIV care and treatment	Yes	0	21.9	6.9	16.0	0	17.3
	No	78.9	67.5	86.2	72.0	60.0	71.6
	Not stated	21.1	10.5	6.9	12.0	40.0	11.0
Infection control and universal precautions	Yes	26.3	35.5	44.8	32.0	0	35.8
	No	57.9	53.5	51.7	52.0	60.0	53.4
	Not stated	15.8	11.0	3.4	16.0	40.0	10.7
Patients' informed consent, privacy, and confidentiality	Yes	26.3	32.9	12.1	36.0	0	28.7
	No	63.2	57.5	79.3	48.0	60.0	60.9
	Not stated	10.5	9.6	8.6	16.0	40.0	10.4

Training Areas		Support Admin. Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Position Not Given	Total
HIV counseling and testing	Yes	15.8	14.5	0	8.0	0	11.3
	No	68.4	74.6	89.7	76.0	60.0	76.7
	Not stated	15.8	11.0	10.3	16.0	40.0	11.9
Prevention of vertical transmission (mother to child)	Yes	2.4	11.1	7.7	0.0	0.0	8.1
	No	83.3	74.4	76.9	84.8	85.7	77.2
	Not stated	14.3	14.6	15.4	15.2	14.3	14.7
Prevention of HIV transmission between adults	Yes	9.5	18.1	26.9	9.1	0.0	16.3
	No	78.6	69.3	57.7	81.8	85.7	71.3
	Not stated	11.9	12.6	15.4	9.1	14.3	12.4
Youth-friendly health services	Yes	4.8	7.5	3.8	9.1	0.0	6.8
	No	81.0	77.4	76.9	78.8	85.7	78.2
	Not stated	14.3	15.1	19.2	12.1	14.3	15.0
Other training	Yes	7.1	2.5	3.8	3.0	0.0	3.3
	No	61.9	60.8	46.2	48.5	57.1	58.3
	Not stated	31.0	36.7	50.0	48.5	42.9	38.4

Infection Concerns

Respondents were asked to indicate their level of concern about becoming infected with HIV while caring for patients living with HIV (Table 2.2). This concern varied according to the degree of interaction with body fluids that a given procedure required. Respondents reported the lowest levels of fear with less invasive procedures such as taking the temperature (3.8% total across all staff categories) and touching the clothing of a patient living with HIV (9.6% total across all staff categories), with slightly higher levels of concern among auxiliary staff (6.3% and 13.6%). Medical respondents reported the highest level of worry about more invasive procedures such as suturing wounds, drawing blood, inserting IV drips, and dressing wounds, with reported worry ranging from 40.9 per cent for giving an injection to 63.8 per cent for suturing wounds.

Taking unnecessary or selective (e.g., only with PLHIV) protective measures is a reflection of the infection concerns among staff (Table 2.3). One in three respondents (41%) cited using gloves during all aspects of patient care and service provision, with higher levels recorded among the non-medical personnel, especially auxiliary staff (95%). While mask usage was generally low (9%), auxiliary staff stood out with 38.9 per cent reporting that they took this measure. The use of double gloves was also identified by almost one in three respondents (31.6%), while 20.1 per cent identified the use of other precautionary measures.

Table 2.2 Areas of Concern aboutHIV Exposure by Job Category(by Percentage)

Areas of Concern		Support Admin Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Position Not Given	Total
Took the temperature of a patient living with HIV	n	8	180	16	6	2	212
	Not worried	75.0	95.0	81.3	100.0	100.0	93.4
	Worried	0	3.9	6.3	0	0	3.8
	Not stated	25.0	1.1	12.5	0	0	2.8
Touched the clothing of a patient living with HIV	n	9	191	22	15	2	239
	Not worried	77.8	88.0	86.4	100.0	50.0	87.9
	Worried	11.1	9.9	13.6	0	0	9.6
	Not stated	11.1	2.1	0	0	50.0	2.5
Cleaned the operating room or exam area after a patient living with HIV was seen	n	8	159	21	7	2	197
	Not worried	62.5	69.8	90.5	42.9	50.0	70.6
	Worried	0	25.8	9.5	42.9	0	23.4
	Not stated	37.5	4.4	0	14.3	50.0	6.1
Did a physical exam on a patient living with HIV	n	6	177	2	4	2	191
	Not worried	66.7	79.7	.0	75.0	50.0	78.0
	Worried	0	18.1	0	0	0	16.8
	Not stated	33.3	2.3	100.0	25.0	50.0	5.2
Gave an injection to a patient living with HIV	n	5	176	2	6	2	191
	Not worried	60.0	57.4	0	33.3	0	55.5
	Worried	.0	40.9	0	66.7	50.0	40.3
	Not stated	40.0	1.7	100.0	0	50.0	4.2

Areas of Concern		Support Admin Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Position Not Given	Total
Dressed the wounds of a patient living with HIV	n	7	172	2	5	2	188
	Not worried	57.1	52.9	0	40.0	50.0	52.1
	Worried	14.3	45.9	0	40.0	0	43.6
	Not stated	28.6	1.2	100.0	20.0	50.0	4.3
Inserted a central line/IV drip in a patient living with HIV	n	5	145	2	4	2	158
	Not worried	20.0	42.1	0	0	0	39.2
	Worried	20.0	55.2	0	75.0	50.0	53.8
	Not stated	60.0	2.8	100.0	25.0	50.0	7.0
Drew blood from a patient living with HIV	n	5	151	2	13	2	173
	Not worried	40.0	40.4	0	61.5	0	41.0
	Worried	20.0	57.6	0	38.5	50.0	54.3
	Not stated	40.0	2.0	100.0	0	50.0	4.6
Sutured the wounds of a patient living with HIV	n	5	149	2	3	2	161
	Not worried	20.0	35.6	0	0	0	33.5
	Worried	40.0	63.8	0	66.7	50.0	62.1
	Not stated	40.0	0.7	100.0	33.3	50.0	4.3

Table 2.3 Precautionary Measures Adopted by Job Category

Measures Adopted		Support Admin Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Position Not Given	Total
Avoid physical contact when providing care/services for a patient living with HIV	n	8	179	20	13	2	222
	Yes	12.5	5.0	25.0	0	0	6.8
	No	75.0	91.6	70.0	100.0	0	88.7
	Not stated	12.5	3.4	5.0	0	100.0	4.5
Wear gloves during all aspects of the patient's care when providing care/services for a patient living with HIV	n	9	185	29	11	2	227
	Yes	55.6	33.5	95.0	63.6	0	41.0
	No	22.2	64.3	5.0	36.4	0	55.5
	Not stated	22.2	2.2	0	0	100.0	3.5
Use masks during all aspects of the patient's care when providing care/services for a patient living with HIV	n	9	185	18	11	2	225
	Yes	11.1	6.5	38.9	0	0	8.9
	No	77.8	89.7	55.6	100.0	0	86.2
	Not stated	11.1	3.8	5.6	0	100.0	4.9
Wear double gloves when providing care/services for a patient living with HIV	n	9	187	20	13	2	231
	Yes	11.1	32.6	50.0	7.7	0	31.6
	No	77.8	64.2	40.0	92.3	0	63.6
	Not stated	11.1	3.2	10.0	0	100.0	4.8
Wear goggles during all aspects of the patient's care when providing care/services for a patient living with HIV	n	9	179	16	11	2	217
	Yes	0	3.4	18.8	0	0	4.1
	No	77.8	94.4	68.8	100.0	0	91.2
	Not stated	22.2	2.2	12.5	0	100.0	4.6
Use other measure when providing care/services for a patient living with HIV	n	9	178	18	12	2	219
	Yes	22.2	20.8	16.7	16.7	0	20.1
	No	66.7	71.3	77.8	83.3	0	71.7
	Not stated	11.1	7.9	5.6	.0	100.0	8.2

Health Facility Environment

In spite of the strides made in forging a comprehensive response to HIV in both the health and non-health sectors in Dominica, respondents in this study reported numerous instances of discrimination associated with the provision of care for PLHIV who present at healthcare facilities. Staff members were asked to report on instances in which they had observed several discriminatory, as well as a few positive supportive, behaviours occurring in their facility in the past 12 months. These included

- Staff unwilling to provide care
- Staff providing substandard levels of care
- Staff talking badly about PLHIV
- Staff disclosing a client's HIV status without the client's permission
- Staff using extra infection control precautions
- Staff referring patients living with HIV to other health facilities.
- Staff confronting or educating others about mistreatment
- Staff providing extra support or care

The percentage of staff members observing these practices was significant (Table 2.4). The least-observed practice was referral of PLHIV to other health facilities, reported by 6.9 per cent of staff members. The percentage of staff who reported observing other discriminatory practices in the past 12 months was significantly higher, ranging from 18.8 per cent (disclosing a patient's HIV status without the patient's consent) to 52.5 per cent (use of extra infection control measures).While reported most among the medical personnel, this practice was also observed by significant percentages of the non-medical personnel. Other practices observed include facility staff talking badly about PLHIV (35.2%) and refusal of care to PLHIV (20.3%) among all staff, with a slightly higher percentage of medical staff (26%) reporting that they had observed staff unwilling to care for a PLHIV. The highest level of observance (60.3%) pertained to instances where extra support or care was provided to patients living with or thought to be living with HIV. This was consistently high across all of the key occupation classifications. It is worth noting that on average, just under 3 per cent of the respondents did not answer these questions.

Reports of experiencing secondary stigma were not very high among the respondents (Table 2.5). The highest form of secondary stigma experienced was being talked about badly because of caring for PLHIV, at 7.3 per cent.

Respondents were also asked three questions to gauge how staff felt about how friendly the work environment in their facilities is for staff living with HIV (Table 2.6). On the issue of taking an HIV test, just over one half (58.8%) reported that workers at their facility would hesitate to have the test due to fear of other people's reactions if the test were positive. This result was consistently high, and highest among medical personnel (61.4%). Fewer respondents felt that there was hesitancy among staff to work alongside PLHIV (47.5%). The highest levels of reluctance were expressed about the willingness of a healthcare worker with HIV to seek care at the respondent's facility. Overall 78.2 per cent felt that there would be some degree of hesitancy, consistent across the various job categories and particularly high among medical (80.3%) and auxiliary personnel (79.3%).

Table 2.4 Observed Practices in Health Facility by Job Category

Observed practices		Support Admin Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Position Not Given	Total
	n	19	228	58	25	5	335
Health facility staff unwilling to care for a patient living with HIV	Never observed	89.5	71.9	87.9	96.0	100.0	77.9
	Observed	5.3	25.9	12.1	4.0	0	20.3
	Not stated	5.3	2.2	0	0	0	1.8
Health facility staff providing poorer quality of care to a patient living with HIV than to other patients	Never observed	84.2	71.1	77.6	96.0	100.0	75.2
	Observed	10.5	26.8	22.4	4.0	.0	23.0
	Not stated	5.3	2.2	0	0	0	1.8
Health facility staff talking badly about people living with or thought to be living with HIV	Never observed	84.2	55.3	75.9	84.0	80.0	63.0
	Observed	10.5	43.0	22.4	16.0	20.0	35.2
	Not stated	5.3	1.8	1.7	0	0	1.8
Health facility staff confronting or educating someone who was mistreating or speaking badly about people living with HIV	Never observed	42.1	51.3	72.4	76.0	60.0	56.4
	Observed	52.6	44.3	27.6	16.0	20.0	39.4
	Not stated	5.3	4.4	0	8.0	20.0	4.2
Health facility staff disclosing a patient's HIV status without the patient's permission	Never observed	63.2	75.4	91.4	88.0	80.0	78.5
	Observed	31.6	21.9	8.6	8.0	0	18.8
	Not stated	5.3	2.6	0	4.0	20.0	2.7

Observed practices		Support Admin Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Position Not Given	Total
Health facility staff using extra infection control precautions when caring for a patient living with HIV	Never observed	57.9	36.0	56.9	68.0	80.0	43.9
	Observed	36.8	60.1	41.4	32.0	0	52.5
	Not stated	5.3	3.9	1.7	0	20.0	3.6
Health facility staff workers providing extra support or care for patients living with or thought to be living with HIV	Never observed	26.3	32.9	44.8	52.0	60.0	36.4
	Observed	63.2	63.6	55.2	48.0	20.0	60.3
	Not stated	10.5	3.5	0	0	20.0	3.3
Health facility staff workers sending or referring patients living with HIV to other health facilities	Never observed	94.7	88.6	93.1	100.0	100.0	90.7
	Observed	0	8.8	5.2	0	0	6.9
	Not stated	5.3	2.6	1.7	0	0	2.4

Table 2.5 Instances of Secondary Stigma Experienced by Job Category

Instances of Secondary Stigma		Support Admin Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Position Not Given	Total
Experienced people talking badly about you because you care for patients living with HIV	n	15	192	53	18	4	282
	Never observed	93.8	87.1	96.2	100.0	80.0	89.8
	Observed	6.3	9.0	3.8	0	0	7.3
	Not stated	0	3.8	0	0	20.0	3.0
Been avoided by friends because you care for patients living with HIV	n	16	194	51	17	3	281
	Never observed	93.8	92.3	100.0	100.0	80.0	94.0
	Observed	6.3	3.8	0	0	0	3.0
	Not stated	0	3.8	0	0	20.0	3.0
Been avoided by colleagues because you care for patients living with HIV	n	16	194	52	18	3	283
	Never observed	100.0	93.3	98.1	100.0	60.0	94.3
	Observed	0	2.9	1.9	0	0	2.3
	Not stated	0	3.8	0	0	40.0	3.4
Been assumed to be HIV positive because you care for patients living with HIV	n	16	209	53	18	5	301
	Never observed	100.0	92.8	98.1	100.0	60.0	94.0
	Observed	0	2.9	1.9	0	0	2.3
	Not stated	0	4.3	0	0	40.0	3.7

Table 2.6 Hesitancy of Health Workers in an HIV Environment by Job Category

Areas Identified		Support Admin Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Position Not Stated	Total
	n	19	228	58	25	5	335
How hesitant are healthcare workers in this facility to take an HIV test due to fear of other people's reactions if the test is positive?	Not hesitant	36.8	33.8	43.1	56.0	20.0	37.0
	Hesitant	57.9	61.4	55.2	44.0	60.0	58.8
	Not stated	5.3	4.8	1.7	0	20.0	4.2
How hesitant are healthcare workers in this facility to work alongside a co-worker living with HIV regardless of their duties?	Not hesitant	36.8	43.0	44.8	48.0	60.0	43.6
	Hesitant	52.6	46.9	53.4	40.0	20.0	47.5
	Not stated	10.5	10.1	1.7	12.0	20.0	9.0
How hesitant do you think a healthcare worker living with HIV would be to seek healthcare in this facility?	Not hesitant	26.3	13.6	17.2	36.0	0	16.4
	Hesitant	68.4	80.3	79.3	64.0	80.0	78.2
	Not stated	5.3	6.1	3.4	0	20.0	5.4

Health Facility Policies

Just over 47 per cent of staff interviewed cited the presence of an antidiscrimination policy to protect patients living with HIV in their facility. Although a significant portion of the respondents were unaware of the presence of such a policy (35.5%), more than one half (57.9%) of the staff members interviewed made reference to the likelihood of ramifications for not following policies to protect patients living with HIV. This was consistently recorded across job categories. A significant 72.8 per cent of the respondents indicated that they were exposed to some degree of training in protecting the confidentiality of patients' HIV status in the past 12 months. Medical (80.3%) and pharmacist/technician personnel (72%) were more likely to have been trained on confidentiality considerations, while 42.1 per cent of the administrative staff reported having no training in these areas.

Over one half of the respondents (52.8%) indicated that there was access to post-exposure prophylactic medications at their facility, while 23 per cent said there was not and 18.2 per cent did not know (Table 2.7).

Interviews indicated that health facilities were both fairly well-equipped and offered an environment that was supportive of staff providing care safely to patients living with HIV. Furthermore, 79.4 per cent of the respondents felt that facilities were adequately equipped to reduce the risk of becoming infected and 76.7 per cent identified the presence of standard procedures to reduce such risks. Almost all respondents (93.4%) endorsed their responsibility to maintain the confidentiality of PLHIV while 87.2 per cent said it was not obvious to everyone which patients in their facility had HIV (see Table 2.8).

Table 2.7 Views on Policy and Work Environment in the Facility by Job Category

Statements on Policy and Environment		Support Admin Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Position Not Stated	Total
	n	19	228	58	25	5	335
My health facility has policies to protect patients living with HIV from discrimination	Yes	36.8	44.7	63.8	36.0	80.0	47.5
	No	15.8	16.2	1.7	8.0	0	12.8
	Do not know	42.1	33.8	34.5	52.0	20.0	35.5
	Not stated	5.3	5.3	0	4.0	0	4.2
I will get in trouble at work if I do not follow the policies to protect patients living with HIV	Yes	68.4	56.6	63.8	40.0	100.0	57.9
	No	5.3	14.9	1.7	12.0	0	11.6
	Do not know	21.1	21.9	32.8	44.0	0	25.1
	Not stated	5.3	6.6	1.7	4.0	0	5.4
Since I have been working at my institution, I have been trained in protecting the confidentiality of patients' HIV status	Yes	52.6	80.3	50.0	72.0	80.0	72.8
	No	42.1	14.9	43.1	24.0	20.0	22.1
	Do not know	0	1.3	6.9	0	0	2.1
	Not stated	5.3	3.5	0	4.0	0	3.0
You have access to post-exposure prophylactic medications in your health facility	Yes	21.1	56.6	48.3	64.0	0	52.8
	No	52.6	21.5	22.4	16.0	20.0	23.0
	Do not know	15.8	16.7	22.4	16.0	60.0	18.2
	Not stated	10.5	5.3	6.9	4.0	20.0	6.0

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

Statements on Policy and Environment		Support Admin Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Not Stated	Total
	n	19	228	58	25	5	335
There are adequate supplies (e.g., gloves) in my health facility that reduce my risk of becoming infected with HIV	Agree	84.2	76.8	84.5	84.0	100.0	79.4
	Disagree	10.5	21.5	13.8	12.0	0	18.5
	Not stated	5.3	1.8	1.7	4.0	0	2.1
There are standardised procedures/protocols in my health facility that reduce my risk of becoming infected with HIV	Agree	78.9	74.6	82.8	76.0	100.0	76.7
	Disagree	15.8	21.5	13.8	16.0	0	19.1
	Not stated	5.3	3.9	3.4	8.0	0	4.2
At my health facility, it is obvious to everyone which patients are living with HIV	Agree	5.3	9.2	6.9	8.0	0	8.4
	Disagree	89.5	87.3	87.9	84.0	80.0	87.2
	Not stated	5.3	3.5	5.2	8.0	20.0	4.5
No matter my views or feelings, it is my professional responsibility to maintain the confidentiality of patients living with HIV	Agree	94.7	94.3	91.4	88.0	100.0	93.4
	Disagree	0	3.5	5.2	8.0	0	3.9
	Not stated	5.3	2.2	3.4	4.0	0	2.7
I would never test a patient for HIV without the patient's informed consent	Agree	84.2	86.0	82.8	92.0	60.0	85.4
	Disagree	5.3	11.0	3.4	4.0	20.0	9.0
	Not stated	10.5	3.1	13.8	4.0	20.0	5.7

Opinions about PLHIV and Other Risk Groups

Respondents were asked to indicate their level of agreement with a number of statements and opinions about PLHIV (Table 2.9). A significant number (41.8%) of respondents agreed that PLHIV did not care if they infect others, while just over one in three (39.4%) said that PLHIV could have avoided HIV. These views, while receiving greater support from the lower-skilled staff, were also supported by medical and related support staff. Far fewer respondents, 7.8 per cent, saw HIV as a punishment or the result of a sinful life, while 6.9 per cent felt that PLHIV should be ashamed of themselves. The latter views were supported more among the lower-level staff (20.7% and 19% respectively). However, more respondents agreed with statements linking HIV to having multiple sexual partners (29.3%) and irresponsible behaviour (37.3%). Notably, 63 per cent of respondents agreed that PLHIV should be allowed to have babies if they so wished; there were consistently high levels of agreement with this opinion across all the job categories.

Nearly half (49.6 %) of the respondents indicated that they would be ashamed if they were to become infected with HIV. Administrative and medical staff reported being more likely to be ashamed (63.2% and 51.8% respectively) than non-technical (auxiliary) members of staff (36.2%). Even more respondents said they would be ashamed if one of their relatives were to be infected (68.1 %). Here too, administrative staff (78.9%) and medical personnel (71.9%) were more likely to report shame than the other categories. A majority (72.5%) of the staff interviewed indicated that they could imagine themselves in the same situation as PLHIV in their health facility (see Table 2.10).

Respondents were asked their personal preference for providing services to several key populations. Overall, only a small number of respondents indicated they would prefer not to provide services to the following groups: 12.1 per cent of respondents preferred not to provide services to people who inject drugs (PWID); 12.7 per cent preferred not to provide services to MSM; 10.8 per cent were not prepared to provide service to SW and 10.2 per cent to transgender (TG) persons. Of all the groups, support and administrative staff stated the strongest preference not to provide services to PWID (15.8%), MSM (26.3%), and SW (15.8%).

Those respondents in favour of withholding services consistently identified lack of training in working with specific populations as the reason for not wanting to provide services to these groups (results are not shown given the small sample sizes). The perception that providing services exposed providers to higher risk of disease was among the key reasons given for all the groups, except immigrants and women who have sex with women. The perceived immoral behaviour of this latter group, as well as MSM, PWID, SW, and TG persons was also among the more popular reasons given for the reluctance to provide services to these groups.

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

Opinions		Support Admin Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Not Stated	Total
	n	19	228	58	25	5	335
PLHIV could have avoided HIV if they had wanted to	Agree	36.8	35.5	65.5	20.0	20.0	39.4
	Disagree	63.2	60.1	32.8	80.0	60.0	57.0
	Not stated	0	4.4	1.7	0	20.0	3.6
HIV is punishment for bad behaviour	Agree	0	5.7	20.7	0	20.0	7.8
	Disagree	100.0	92.1	77.6	100.0	80.0	90.4
	Not stated	0	2.2	1.7	0	0	1.8
Most PLHIV do not care if they infect other people	Agree	31.6	36.4	75.9	20.0	40.0	41.8
	Disagree	68.4	61.0	24.1	72.0	60.0	55.8
	Not stated	0	2.6	0	8.0	0	2.4
PLHIV should feel ashamed of themselves	Agree	0	4.4	19.0	0	40.0	6.9
	Disagree	100.0	94.3	79.3	100.0	60.0	91.9
	Not stated	0	1.3	1.7	0	0	1.2
Most PLHIV have had many sexual partners	Agree	15.8	26.8	53.4	8.0	20.0	29.3
	Disagree	84.2	70.6	46.6	92.0	80.0	69.0
	Not stated	0	2.6	0	0	0	1.8
People get infected with HIV because they engage in irresponsible behaviours	Agree	36.8	32.0	60.3	36.0	20.0	37.3
	Disagree	63.2	65.4	39.7	60.0	80.0	60.6
	Not stated	0	2.6	0	4.0	0	2.1

Opinions		Support Admin Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Not Stated	Total
Getting HIV is the result of living a sinful life	Agree	5.3	3.1	29.3	.0	20.0	7.8
	Disagree	94.7	94.7	70.7	100.0	80.0	90.7
	Not stated	0	2.2	0	0	0	1.5
PLHIV should be allowed to have babies if they wish	Agree	57.9	67.1	51.7	52.0	80.0	63.0
	Disagree	31.6	29.8	39.7	48.0	20.0	32.8
	Not stated	10.5	3.1	8.6	0	0	4.2

Table 2.10 Opinions about Becoming Infected with HIV by Job Category

Opinions about Becoming Infected with HIV		Support Admin Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Not Stated	Total
	n	19	228	58	25	5	335
I would be ashamed if I were infected with HIV	No	36.8	43.4	63.8	44.0	40.0	46.6
	Yes	63.2	51.8	36.2	48.0	60.0	49.6
	Not stated	0	4.8	0	8.0	0	3.9
I would be ashamed if someone in my family were infected with HIV	No	21.1	24.6	43.1	40.0	40.0	29.0
	Yes	78.9	71.9	56.9	52.0	60.0	68.1
	Not stated	0	3.5	0	8.0	0	3.0
I can easily imagine myself in the same situation as patients living with HIV	Yes	73.7	71.5	81.0	56.0	100.0	72.5
	No	26.3	22.8	19.0	32.0	0	22.7
	Not stated	0	5.7	0	12.0	0	4.8

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

Opinions Related to Providing Services to At-risk Populations		Support Admin Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Not Stated	Total
I would prefer not to provide services to: PWID	n	19	228	56	23	5	331
	Agree	15.8	12.7	12.5	4.3	0	12.1
	Disagree	78.9	82.0	85.7	95.7	80.0	83.4
	Not stated	5.3	5.3	1.8	0	20.0	4.5
I would prefer not to provide services to: MSM	n	19	228	56	24	5	332
	Agree	26.3	11.4	16.1	8.3	0	12.7
	Disagree	68.4	82.9	82.1	91.7	80.0	82.5
	Not stated	5.3	5.7	1.8	0	20.0	4.8
I would prefer not to provide services to:SW	n	19	228	56	24	5	332
	Agree	15.8	10.1	12.5	8.3	20.0	10.8
	Disagree	78.9	84.6	85.7	91.7	60.0	84.6
	Not stated	5.3	5.3	1.8	0	20.0	4.5
I would prefer not to provide services to: TG	n	19	228	56	24	5	332
	Agree	10.5	10.1	14.3	4.2	.0	10.2
	Disagree	84.2	83.8	83.9	95.8	80.0	84.6
	Not stated	5.3	6.1	1.8	0	20.0	5.1
I would prefer not to provide services to: women who have sex with women	n	19	228	53	24	5	329
	Agree	21.1	6.6	9.4	8.3	20.0	8.2
	Disagree	73.7	88.6	86.8	91.7	80.0	87.5
	Not stated	5.3	4.8	3.8	0	0	4.3

Opinions Related to Providing Services to At-risk Populations		Support Admin Staff	Medical Personnel	Cleaning/ Auxiliary Staff	Pharmacist/ Technicians	Not Stated	Total
I would prefer not to provide services to: immigrants	n	19	228	53	24	5	329
	Agree	5.3	3.9	0	4.2	0	3.3
	Disagree	89.5	91.2	96.2	95.8	80.0	92.1
	Not stated	5.3	4.8	3.8	0	20.0	4.6
I would prefer not to provide services to: sexually active unmarried youth	n	19	228	53	24	5	329
	Agree	5.3	5.7	0	4.2	0	4.6
	Disagree	89.5	89.5	96.2	95.8	80.0	90.9
	Not stated	5.3	4.8	3.8	.0	20.0	4.6
I would prefer not to provide services to: pregnant women living with HIV	n	19	228	53	24	5	329
	Agree	5.3	7.5	1.9	0	0	5.8
	Disagree	89.5	86.0	92.5	100.0	80.0	88.1
	Not stated	5.3	6.6	5.7	0	20.0	6.1

Pregnant Women Living with HIV

Pregnant women living with HIV are particularly vulnerable to stigma, and the consequences of stigma have potential additional negative impacts for the health of mothers and unborn children if stigma keeps women from accessing antenatal care (ANC), prevention of mother-to-child transmission (PMTCT) services and labour and delivery care. Among service providers who work with pregnant women in ANC, PMTCT, and labour and delivery, 53.3 per cent expressed some degree of worry about HIV transmission while assisting a woman living with HIV in labour and delivery. In cases where the woman's HIV status is unknown, 54.7 per cent were worried about assisting in labour, as illustrated in Table 2.12.

Respondents were next asked whether they had observed certain behaviours being carried out by other providers at their health facility in the past 12 months (Table 2.13). One in five respondents (20.2%) had observed others performing an HIV test on a pregnant woman without her informed consent, while 10.7 per cent observed instances where the pregnant patient's HIV status was shared with others without her consent. The use of additional infection-control measures with pregnant women living with HIV during labour was observed by 26.9 per cent of respondents. A key feature of this question is the percentage of "Not stated" responses for these questions, ranging from 12.8 per cent to 20.2 per cent.

Respondents were then asked to indicate whether they agreed with a number of stigmatizing statements pertaining to pregnant women living with HIV (Table 2.14). There was a significant level of disagreement expressed by respondents to most of the statements. For example, 85.6 per cent disagreed with the statement that women living with HIV are unable to be good mothers. Pregnant women who refused testing as well as those who were living with HIV and did not adhere to the infant feeding guidelines were seen as irresponsible by 63.9 per cent and 72.9 per cent of respondents, respectively. On the issue of whether women living with HIV should get pregnant if they already have children, the response was split with 45.3 per cent in agreement and 44.2 per cent disagreeing. Responses were also mixed on the issue of disclosure, with 52.6 per cent of the respondents in support of divulging the pregnant woman's HIV status to family members, and 39.2 per cent disagreeing. On the issue of sterilization and women living with HIV, 15.8 per cent of respondents agreed with the statement that "it can be appropriate to sterilise a woman living with HIV even if this is not her choice," and 13.7 per cent declined to answer.

Table 2.12 Worry Associated with Assisting with Delivery by Job Category

Statement		Medical personnel
	n	75
The woman is living with HIV	Not worried	36.0
	Worried	53.3
	Not stated	10.7
The woman's HIV status is unknown	Not worried	34.7
	Worried	54.7
	Not stated	10.7

Note that only medical staff who specifically assist in labour and delivery were asked this question.

Table 2.13 Observations over Past 12 Months by Job Category

Observations		Medical Personnel	Pharmacist/ Technicians	Total
	n	84	4	88
Performing an HIV test on a pregnant woman without informed consent	Never observed	66.7	75.0	68.2
	Observed	20.2	0	19.3
	Not stated	13.1	25.0	12.5
Neglecting a woman living with HIV during labour and delivery because of her HIV status	Never observed	81.0	75.0	81.6
	Observed	1.2	0	1.1
	Not stated	17.9	25.0	17.2
Using additional infection control procedures with a pregnant woman living with HIV during labour and delivery because of her HIV status	Never observed	54.8	75.0	54.0
	Observed	26.2	0	27.6
	Not stated	19.0	25.0	18.4
Disclosing a pregnant woman living with HIV's status to others without her consent	Never observed	76.2	75.0	77.8
	Observed	10.7	0	10.0
	Not stated	13.1	25.0	12.2
Making HIV treatment for a woman living with HIV conditional on use of family planning methods	Never observed	75.0	75.0	76.4
	Observed	4.8	0	4.5
	Not stated	20.2	25.0	19.1

Table 2.14 Levels of Agreement with Selected Statements by Job Category

Statements		Medical Personnel	Pharmacist/ Technicians	Total
If a pregnant woman is HIV positive, her family has a right to know	n	84	7	91
	Agree	50.0	57.1	50.5
	Disagree	40.5	42.9	40.7
	Not stated	9.5	0	8.8
Pregnant women who refuse HIV testing are irresponsible	n	84	7	91
	Agree	64.3	57.1	63.7
	Disagree	27.4	42.9	28.6
	Not stated	8.3	0	7.7
Women living with HIV are unable to be good mothers	n	84	7	91
	Agree	6.0	0	5.5
	Disagree	84.5	100.0	85.7
	Not stated	9.5	0	8.8
Women living with HIV who do not follow infant feeding recommendations for preventing transmission of HIV to their infant are irresponsible	n	84	6	90
	Agree	72.6	83.3	73.3
	Disagree	19.0	16.7	18.9
	Not stated	8.3	0	7.8
Women living with HIV should not get pregnant if they already have children	n	84	5	89
	Agree	45.2	40.0	44.9
	Disagree	44.0	60.0	44.9
	Not stated	10.7	0	10.1
A pregnant woman living with HIV should undergo antiretroviral therapy, even if this is not her choice, for the health of the baby	n	84	6	90
	Agree	69.0	100.0	71.1
	Disagree	21.4	0	20.0
	Not stated	9.5	0	8.9
It can be appropriate to sterilise a woman living with HIV, even if this is not her choice	n	84	5	89
	Agree	14.3	20.0	14.6
	Disagree	71.4	80.0	71.9
	Not stated	14.3	0	13.5

LIMITATIONS

There are several limitations to this study that affected sample selection and data collection.

Sample Selection

One of the key limitations of implementing studies of this nature in small island states is the small size of the staff across the various facilities and departments and an environment characterised by relatively high turnover as personnel migrate in search of better opportunities or move within and between jobs. This phenomenon posed a challenge for the initial sample selection as it affected the extent to which the list of persons from which the sample was to be drawn was up to date across job categories and within departments across facilities. This affected the proposed quotas allocated by facilities. In some instances, the number of personnel listed in facilities was not in alignment with the actual numbers at the facility across the various job categories.

In addition, a key feature of the health sector in Dominica (and the region) is the lack of clear distinction between practitioners who work in the public and private sectors. A significant proportion of persons who practice in the public sector also have a private practice. In the sample selection for our survey, double counting by type of facility occurred, as personnel were listed in both the private and public sectors.

Data Collection

Certain specific limitations arose during the conduct of the fieldwork and negatively affected the rate of completion, as well as the final number of completed interviews. They included the following:

- A significant number of "not stated" (respondent did not answer the question) responses to certain questions

- Time constraints of the staff, resulting in delayed completion of the fieldwork

- Difficulty getting higher level medical staff to complete the questionnaires, resulting in the staff having to return to the same respondents multiple times to obtain a completed questionnaire

- Inaccurate completion of some questionnaires, sometimes resulting in the questionnaires having to be redone or left as incomplete

DISCUSSION AND RECOMMENDATIONS

Discussion

This study represents the first effort to systematically measure S&D in healthcare facilities in Dominica, and provides an evidence base for a comprehensive approach to achieving stigma-free health services.

To facilitate a participatory analysis process and collective development of the recommendations based on the data, a workshop was conducted in April 2013 with 27 key stakeholders from the health sector in Dominica. During the one-day workshop, stakeholders worked in small groups of five to seven participants to review summary data tables and discuss their implications, as well as possible strategies to respond to the findings. They presented their deliberations to the larger group, including specific recommendations for action. The larger group then discussed and reached a consensus about these recommendations, which were documented by a note-taker. Written recommendations documented in the workshop were again vetted by email with workshop participants. The discussion and recommendations

developed during the workshop provided the basis for developing the country-led strategy for planning to reduce stigma in health facilities.

Infection concerns

Workshop participants, in reviewing the questionnaire data for infection concerns, noted that survey respondents expressed worry about contracting HIV when performing certain actions while caring for patients living with HIV and that worry increased with the level of physical invasiveness of the action, which could be expected. However, they found it surprising that any facility staff, and in particularly medical personnel, expressed concern that they could become infected with HIV by taking the temperature of a patient living with HIV (3.8% overall) or by touching the clothing of a patient living with HIV (9.6% overall). Even though these percentages represent small numbers, workshop participants thought it worth noting that anyone working in a health facility could be concerned about becoming infected with HIV in this way. While the level of worry expressed by survey respondents around more invasive actions, such as dressing a wound (43.6% overall) or giving an injection (40.3% overall), is less surprising it also merits attention, as it indicates an unwarranted level of unease in caring for patients living with HIV. Such fears can lead to staff providing nonverbal cues about a patient's HIV status, thereby unintentionally disclosing the patient's status to others.

Workshop participants discussed why these levels of unwarranted fears still exist and suggested a confluence of factors. Health facility staff members are likely to be influenced by the communities they live in, where these fears and misconceptions about transmission are still prevalent. Facility staff may also be influenced by their peers, in particular medically trained staff. If they notice even one medically trained person behaving in a fearful way towards patients living with HIV (e.g., donning double gloves, avoiding touching), they will also become fearful, assuming that medically trained people have more knowledge. This type of behaviour is readily observable in facilities, as shown in the survey findings on use of precautionary measures in the past 12 months. For example, many survey respondents reported having observed the wearing of gloves during all aspects of caring for a patient living with HIV (41.0%) and wearing double gloves (31.6%) when providing care for a patient living with HIV.

Workshop participants also noted that the high turnover of staff, coupled with the reality that many staff do not attend offered training sessions, make it difficult to ensure that all staff are well-trained. Participants discussed the need to find new and creative ways to deliver recurrent training so that it is interesting and attractive, as well as to ensure that training on HIV transmission and prevention is included in the curriculum for the formation of health facility staff (e.g., in medical school or nursing school).

Health facility environment

Workshop participants noted that reported levels of observed stigmatising practices by survey respondents were unacceptably high (e.g., 25.9% of medical staff reporting they had observed health facility staff unwilling to care for a patient living with HIV in the past 12 months). They felt these actions run counter—at least for medically trained staff—to the Hippocratic Oath and a general good code of professional conduct. The group also noted that these types of behaviours (e.g., using extra infection control precautions when caring for a patient living with HIV) not only create a situation where a patient's status can be inadvertently disclosed, but also waste resources. They noted that the implications of these types of stigmatising and discriminatory behaviours are far-reaching, and lead to poor respect for confidentiality, contravene human rights, negatively impact access to services, undermine the credibility of the health services, and foster a lack of trust in the health system.

In addition, workshop participants noted that S&D within health facilities towards patients also affects health facility staff themselves and their own access to and willingness to be tested for HIV and seek care within the health system. It is not surprising that health facility staff would be reluctant to get tested or

seek care within the health facility where they work, given the reported unwillingness of colleagues to work alongside a PLHIV—47.5 per cent said they thought healthcare workers in their facility would be hesitant to work alongside a coworker living with HIV and 9.0 per cent chose not to answer the question.

There was little discussion about secondary stigma, as the data provided little evidence of it (7.3% overall). However, it was noted that fear of secondary stigma is a reality and could have an impact on a provider's practice, as patients may choose not to use a provider if they know or believe that he or she is treating PLHIV.

Health facility policies

Workshop participants found it interesting that 47.5 per cent of survey respondents said that their health facility has policies that protect PLHIV from discrimination. However, the consensus among workshop participants was that there are no specific facility-level policies in place. Discussion ensued about respondents' interpretations of this question and speculation about what policies survey respondents may have been referring to when answering yes. The group came up with two possible explanations. The first suggested explanation was that survey respondents, thinking that there should be a policy and that they just didn't know about it, answered yes even though they didn't know. The second possible explanation was that survey respondents were referring to a national policy or general workplace policy rather than a specific facility policy.

A similar discussion ensued about the 57.9 per cent of respondents who said they would get into trouble at work if they did not follow the policies to protect PLHIV. While there may not be written policies and consequences, participants said, there is an unwritten code of conduct and set of expectations within the health facilities about how personnel should conduct their work, and respondents may have been referring to this unwritten code or understanding. They noted that health facility staff know how they should conduct themselves, so if they are not doing their job as expected they will feel badly about it; this might have led them to answer "yes" to this question.

The second area of discussion for this set of questions was PEP. Only 52.8 per cent of survey respondents cited having access to PEP in their health facility, despite the fact that PEP is available in all health facilities. The discussion of reasons for this disconnect centered on the need for more and broader training and a potential concern about having to be tested for HIV as part of the protocol for accessing PEP. It is not surprising that staff members would worry about having a test as part of accessing PEP at their health facility, given the reported perception that many staff would be unwilling to work alongside a colleague living with HIV, combined with a desire not to be treated in one's own facility.

Opinions and willingness to treat

Overall the workshop participants did not seem surprised at the data for this set of questions. They remarked on the differences by category of worker, noting that members of the cleaning and auxiliary staff were more likely to agree with stigmatising statements. Some wondered if cleaning and auxiliary staff really held more stigmatising attitudes, or if this could be a reflection of response—i.e., other (more educated) staff knew the appropriate responses to these types of questions and replied accordingly. Other workshop participants pointed out the high level of agreement in the data with some of the stigmatising statements across all categories of staff. For example, 39.4 per cent of the survey sample agreed that PLHIV could have avoided HIV infection if they had wanted to, while 41.8 per cent agreed that most PLHIV do not care if they infect other people.

A discussion ensued in the workshop about whether measuring attitudes really provides a good measure of stigma. Some workshop participants felt that one can have stigmatising attitudes but not act on them through discriminatory behaviour, arguing that it is possible to hold a non-favourable opinion or attitude about a certain behaviour or group of people, but still provide good care. Others noted that it is important

to measure attitudes when trying to understand stigma and how to reduce it, because attitudes and opinions often influence behaviour in ways that people are not conscious of, such as body language. Often acts of S&D are unintentional and occur through actions that individuals do not know are stigmatising or discriminatory, but are perceived as stigmatising or discriminatory by patients. Therefore measuring, understanding, and becoming more aware of the attitudes and opinions that underlie stigmatising and discriminatory behaviour, while ensuring that they do not manifest themselves in the provision of care, is an important step in providing stigma-free services. This was recognised as important and necessary to address alongside the fear of HIV infection.

The workshop participants noted that the three measures of shame on the questionnaire had quite varied responses. The first, "PLHIV should feel ashamed of themselves," had a low level of agreement (6.9% overall), while the second, "I would be ashamed if I were infected with HIV," had a much higher level of agreement (49.6% overall), and the last, "I would be ashamed if someone in my family were infected with HIV," had the highest level of agreement (68.1%). While few survey respondents agreed with the first statement (others should be ashamed), when asked if they themselves would be ashamed, agreement was high. In a discussion about why more survey respondents said they would be ashamed if a family member had HIV, one explanation was that health facility staff have the potential ability to explain transmission through a "less stigmatised" mode than their family members would, given the risk of being infected through work exposure. Alternatively, some said, health facility staff may be better able to hide their own HIV status than that of a family member, so shame would be less of an issue.

The last set of questions in this section of the survey focused on preferences for providing services to certain groups of people. There was some surprise among workshop participants that so few respondents indicated a preference not to treat specific groups, like MSM, PWID, and SW. Some workshop participants thought that the question may be subject to social desirability response bias. Since refusing to treat anyone goes against the Hippocratic Oath and is a human rights violation, asking a respondent if they have actually refused treatment to someone is not likely to yield a reliable response. Others questioned whether measuring preference to provide services to a certain group is a good measure in a study on S&D. The discussion revolved around whether these questions really measure discrimination as one can prefer not to provide services to certain people but still provide good services. Others, however, felt that it was a valid measure for this kind of study, because opinions and intent can influence the actual provision of services, so this kind of measure can be a strong proxy measure and provide useful data to begin discussions and design interventions to reduce stigma.

Pregnant women living with HIV

Overall the workshop participants viewed the results from this set of questions as shocking and in need of serious attention, particularly the result that 14.3 per cent of medical personnel agreed with the statement, "It can be appropriate to sterilise a woman living with HIV, even if this is not her choice," and another 14.3 per cent chose not to provide an opinion. Discussion focused on the need to find more effective education strategies to address the rights of women living with HIV and focus more on human rights.

Recommendations

Implement S&D-Reduction Trainings to Address Needs Identified in the Survey
Workshop participants provided a detailed set of training recommendations including how, who, and when trainings should be delivered for staff.

Frame trainings and health worker education in the context of social justice and equality within a framework of human rights.
The participants underscored the need for training to be framed in the context of social justice, equality,andhuman rights. They felt that this was consistent with professional socialisation. For example, the Hippocratic Oath and the nurses' professional code of conduct promote the concept of "health for all." Trainings and professional socialisation need to emphasise and be explicit about stigma-free health services as the basis of "health for all." In particular, they emphasised need to apply the rights-based approach when designing trainings and education related to services for women living with HIV. Stemming from discussions around the data for ANC, PMTCT, and delivery, participants recommended that this area receive specific attention.

These principles build on promoting worker pride in quality services. Workers want to do a good job and have a professional environment, and can work towards providing stigma-free services as a standard. Workers should understand and be held accountable for patient confidentiality.

Adopt participatory training approaches focused on real-life scenarios.
Participants identified the need to adopt new approaches to the delivery of training—that training should be more participatory and should speak to topics in greater depth to address fear-based stigma, given the disconnect between supposed knowledge of HIV transmission and the fear of HIV transmission expressed in the data.

Cursory overviews of prevention and transmission risk in particular need to be expanded with more thorough discussions focused on real-life scenarios and the specific fears facility staff hold about a particular task they may need to perform. These more in-depth programmes would be developed with specific attention to the survey findings on infection concerns. For example, misconceptions should be addressed about the true risks associated with tasks such as providing injections, delivery care for pregnant women presumed to be HIV positive, and touching of the clothes or skin of PLHIV.

Increase understanding and correct use of universal precautions.
Participants noted the inconsistent application of universal precautions stemming from the need to better understand transmission risks associated with tasks that health and auxiliary workers perform. Training should dispel misconceptions about the effectiveness of "extra precautions" such as double-gloving for patients presumed to be HIV positive. There is a need for staff to understand the consequences of double-gloving—including the increased chance of breakage and therefore greater risk to healthcare worker safety—and how it can break confidentiality by disclosing to others that a patient is living with HIV.

Expand knowledge of post-exposure prophylaxis to all facility staff.
Staff recommended increased training on PEP in response to the survey results highlighting a lack of awareness about PEP. Participants recommended training all health facility staff on PEP protocols and where and how to access it.

Address attitudes and moral judgment associated with PLHIV and key populations.
In addition to addressing the fear of HIV transmission that can cause stigmatising behaviours, participants recommended a focus on the more deeply rooted moral judgment associated with PLHIV and key populations. While acknowledging the existence of moral judgment and harmful attitudes among

healthcare workers, participants concluded that they had a duty to promote sexual and reproductive health rights in the health system. They recommended that stigma training for staff should address the conceptual understanding of the process of stigmatisation, with an aim to understand the underlying moral judgment that can inadvertently display itself in the behaviour of facility staff. For example, participants felt that the trainings should emphasise the ramifications of nonverbal cues to other health facility staff and patients about patients' presumed HIV status. The trainings should promote a greater understanding of links between provider behaviours and client access. Trainings should promote empathy and help staff understand that outright discrimination is not the only barrier to health services; more subtle judgments also discourage clients from accessing services.

Provide tailored training to all cadres of staff.
The workshop participants urged that training and education should target all staff, but must be tailored to various cadres and should address fear of transmission. Staff experience different types of exposure risk in the work place while engaged in different tasks. Training must be tailored to these differences in job category, as well as different levels of education and prior exposure to information. Timing of the delivery of the training should also differ according to on-the-job tasks and baseline levels of knowledge about HIV transmission.

Institutionalise and incentivise training and education.
Participants offered ideas on how to institutionalise the training programme. For example, they suggested integrating it into pre-service training for on-boarding new staff, orientation, continuing education, and/or staff meetings. Recognising that staff members often do not attend trainings currently offered, they noted that it must be compulsory or tied to incentives, such as licensure, recertification, or appraisal systems. They suggested the selection of workers should consider empathy as a criterion for selection, reinforced by the appraisal system and the key results area for staff, perhaps even an award praising staff members who uphold standards including non-stigmatising service delivery. They suggested rewarding good role models using strategies that may have worked in other settings.

Policy development and facility-level codes of conduct

In addition to institutionalising trainings geared towards reducing stigma at the individual level, the workshop participants highlighted the need to develop anti-stigma policies, situated in human rights frameworks that would reinforce stigma-free health services. They outlined a range of policies that would reinforce positive conduct at the individual, facility, health system, and national levels. They recommended formulating policies to protect PLHIV and key populations from discrimination.

Develop facility-level codes of conduct.
They proposed developing facility-level codes of conduct that would be transparent, promote the "health for all" principles, and be tied to a patient bill of rights. A functional confidentiality and redress system would reinforce patient rights and stigma-free health services.

Develop workplace policies specific to the health sector.
Currently a workplace policy does exist for the public sector, but workshop participants felt that one needed to be specifically applied or understood as relevant in the health sector.

Data collection and ongoing measurement to monitor stigma

Participants said that the research findings were very compelling. They urged that others should see and use the data and that the health system should continue to monitor progress through measurement. They suggested integrating this research into existing data collection systems, such as the annual symposium on surveillance.

ANNEX A. TABLES WITH EXPANDED BREAK-OUT OF RESPONSE CATEGORIES

Table 3.1 Areas of Concern about HIV Exposure(by Percentage)

	Not Worried	A Little Worried	Worried	Very Worried	Not Applicable	Not Stated
	%	%	%	%	%	%
Took the temperature of a patient living with HIV	80.5	1.2	0.4	1.6	13.8	2.4
Touched the clothing of a patient living with HIV	85.0	5.7	2.0	1.6	3.2	2.4
Cleaned the operating room or exam area after a patient living with HIV was seen	56.3	13.4	3.2	2.0	20.2	4.9
Did a physical exam on a patient living with HIV	60.6	9.8	2.0	1.2	22.4	4.1
Gave an injection to a patient living with HIV	43.1	24.4	5.3	1.6	22.4	3.3
Dressed the wounds of a patient living with HIV	39.8	24.8	6.5	2.0	23.6	3.3
Inserted a central line/IV drip in a patient living with HIV	25.3	23.7	8.6	2.4	35.5	4.5
Drew blood from a patient living with HIV	29.0	25.7	9.8	2.9	29.4	3.3
Sutured the wounds of a patient living with HIV	22.0	24.9	11.8	4.1	34.3	2.9

Table 3.2 Precautionary Measures Adopted

	Yes	No	Not Applicable	Not Stated
	%	%	%	%
Avoid physical contact when providing care/services for a patient living with HIV	6.1	79.8	10.1	4.0
Wear gloves during all aspects of the patient's care when providing care/services for a patient living with HIV	37.7	51.0	8.1	3.2
Use masks during all aspects of the patient's care when providing care/services for a patient living with HIV	8.1	78.5	8.9	4.5
Wear double gloves when providing care/services for a patient living with HIV	29.6	59.5	6.5	4.5
Wear goggles during all aspects of the patient's care when providing care/services for a patient living with HIV	3.7	80.5	11.8	4.1
Use other measure when providing care/services for a patient living with HIV	17.9	63.8	11.0	7.3

Table 3.3 Observed Practices in Health Facility

	Never	Once or twice	Several times	Most of the time	Not stated
	%	%	%	%	%
Health facility staff unwilling to care for a patient living with HIV	77.9	14.6	5.1	.6	1.8
Health facility staff providing poorer quality of care to a patient living with HIV than to other patients	75.2	14.6	7.2	1.2	1.8
Health facility staff talking badly about people living with or thought to be living with HIV	63.0	23.6	9.6	2.1	1.8
Health facility staff confronting or educating someone who was mistreating or speaking badly about PLHIV	56.4	23.6	10.7	5.1	4.2
Health facility staff disclosing a patient's HIV status without the patient's permission	78.5	13.7	3.3	1.8	2.7
Health facility staff using extra infection control precautions when caring for a patient living with HIV	43.9	21.2	18.8	12.5	3.6
Health facility staff workers providing extra support or care for patients living with or thought to be living with HIV	36.4	23.9	21.8	14.6	3.3
Health facility staff workers sending or referring patients living with HIV to other health facilities because the	90.7	5.4	.9	.6	2.4

Table 3.4 Instances of Secondary Stigma Experienced

	Never	Once or Twice	Several Times	Most of the Time	Not Applicable	Not Stated
	%	%	%	%	%	%
Experienced people talking badly about you because you care for patients living with HIV	81.2	3.9	2.4	.3	9.6	2.7
Been avoided by friends and family because you care for patients living with HIV	84.2	2.4	.3	.0	10.4	2.7
Been avoided by colleagues because of your work caring for patients living with HIV	83.9	1.5	.3	.3	11.0	3.0
Been assumed to be HIV positive because you care for patients living with HIV	84.5	1.8	.0	.3	10.1	3.3

Table 3.5 Hesitancy of Health Workers in an HIV Environment

	Not Hesitant	A little Hesitant	Somewhat Hesitant	Very Hesitant	Not Stated
	%	%	%	%	%
How hesitant are healthcare workers in this facility to take an HIV test due to fear of other people's reaction if the test is positive?	37.0	22.7	20.6	15.5	4.2
How hesitant are healthcare workers in this facility to work alongside a co-worker living with HIV regardless of their duties?	43.6	18.8	20.0	8.7	9.0
How hesitant do you think a healthcare worker living with HIV would be to seek healthcare in this facility?	16.4	13.7	15.5	49.0	5.4

Table 3.6 Views on Policy and Work Environment in the Facility

	Yes	No	Do Not Know	Not Stated
	%	%	%	%
My health facility has policies to protect patients living with HIV from discrimination	47.5	12.8	35.5	4.2
I will get in trouble at work if I do not follow the policies to protect patients living with HIV	57.9	11.6	25.1	5.4
Since I have been working at my institution, I have been trained in protecting the confidentiality of patients' HIV status	72.8	22.1	2.1	3.0
Do you have access to post-exposure, prophylactic medications in your health facility?	52.8	23.0	18.2	6.0

Table 3.7 Levels of Agreement with Statements on Policy and Environment

	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Stated
	%	%	%	%	%
There are adequate supplies (e.g., gloves) in my health facility that reduce my risk of becoming infected with HIV	37.6	41.8	15.8	2.7	2.1
There are standardised procedures/protocols in my health facility that reduce my risk of becoming infected with HIV	29.3	47.5	14.0	5.1	4.2
At my health facility, it is obvious to everyone which patients are living with HIV	2.4	6.0	49.0	38.2	4.5
No matter my views or feelings, it is my professional responsibility to maintain the confidentiality of patients living with HIV	75.2	18.2	1.2	2.7	2.7
I would never test a patient for HIV without the patient's informed consent	53.1	32.2	6.3	2.7	5.7
PLHIV should be allowed to have babies if they wish	18.5	44.5	20.3	12.5	4.2

Table 3.8 Opinions Related to People Living with HIV

	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Stated
	%	%	%	%	%
PLHIV could have avoided HIV if they had wanted to	14.3	25.1	44.8	12.2	3.6
HIV is punishment for bad behaviour	2.4	5.4	37.6	52.8	1.8
Most people living with HIV do not care if they infect other people	10.7	31.0	48.4	7.5	2.4
PLHIV should feel ashamed of themselves	2.4	4.5	45.7	46.3	1.2
Most people living with HIV have had many sexual partners	6.9	22.4	46.9	22.1	1.8
People get infected with HIV because they engage in irresponsible behaviours	8.1	29.3	44.5	16.1	2.1
Getting HIV is the result of living a sinful life	2.1	5.7	41.5	49.3	1.5

Table 3.9 Opinions about Becoming Infected with HIV

	Yes	No	Not Stated
	%	%	%
I would be ashamed if I were infected with HIV	46.6	49.6	3.9
I would be ashamed if someone in my family were infected with HIV	29.0	68.1	3.0
I can easily imagine myself in the same situation as patients living with HIV in this healthcare facility	72.5	22.7	4.8

Table 3.10 Opinions Related to Providing Services to At-risk Populations

	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Stated
	%	%	%	%	%
I would prefer not to provide services to: PWID	3.0	9.1	58.3	25.1	4.5
I would prefer not to provide services to: MSM	4.2	8.4	59.0	23.5	4.8
I would prefer not to provide services to: SW	4.5	6.3	62.7	22.0	4.5
I would prefer not to provide services to: TG	4.2	6.0	61.7	22.9	5.1
I would prefer not to provide services to: women who have sex with women	3.3	4.9	64.1	23.4	4.3
I would prefer not to provide services to: immigrants	1.2	2.1	63.8	28.3	4.6
I would prefer not to provide services to: sexually active unmarried youth	1.5	3.0	62.0	28.9	4.6
I would prefer not to provide services to: pregnant women living with HIV	0.6	5.2	59.9	28.3	6.1

Table 3.11 Worry Associated with Assisting with Delivery

	Not Worried	A Little Worried	Worried	Very Worried	Not Applicable	Not Stated
	%	%	%	%	%	%
The woman is living with HIV	31.5	29.2	10.1	7.9	12.4	9.0
The woman's HIV status is unknown	31.5	19.1	16.9	11.2	12.4	9.0

Table 3.12 Observations OverPast 12 Months

	Never	Once or Twice	Several Times	Most of the Time	Not Stated
	%	%	%	%	%
Performing an HIV test on a pregnant woman without informed consent	68.2	6.8	6.8	5.7	12.5
Neglecting a woman living with HIV during labour and delivery because of her HIV status	81.6	1.1	0	0	17.2
Using additional infection control procedures with a pregnant woman living with HIV during labour and delivery because of her HIV status	54.0	8.0	3.4	16.1	18.4
Disclosing a pregnant woman living with HIV's status to others without her consent	77.8	6.7	2.2	1.1	12.2
Making HIV treatment for a woman living with HIV conditional on use of family planning methods	76.4	2.2	1.1	1.1	19.1

Table 3.13 Levels of Agreement with Selected Statements

	Strongly Agree	Agree	Disagree	Strongly Disagree	Not Stated
	%	%	%	%	%
If a pregnant woman is HIV positive, her family has a right to know	17.6	33.0	26.4	14.3	8.8
Pregnant women who refuse HIV testing are irresponsible	26.4	37.4	20.9	7.7	7.7
Women living with HIV are unable to be good mothers	4.4	1.1	37.4	48.4	8.8
Women living with HIV who do not follow infant feeding recommendations for preventing transmission of HIV to their infant	25.6	47.8	14.4	4.4	7.8
Women living with HIV should not get pregnant if they already have children	7.9	37.1	33.7	11.2	10.1
A pregnant woman living with HIV should undergo antiretroviral therapy, even if this is not her choice, for the health of the baby	32.2	38.9	15.6	4.4	8.9
It can be appropriate to sterilise a woman living with HIV, even if this is not her choice	4.5	10.1	37.1	34.8	13.5