A Rapid Appraisal of

HIV-related Stigma and Discrimination

Reduction Interventions

in Selected Health Facilities in Ghana

Quality Health Partners
Engender Health
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Acronyms and Abbreviations

ANC	Antenatal care
ART	Antiretroviral therapy
COP	Chief of Party
COPE	Client-Oriented, Provider-Efficient Services
DCOP	Deputy Chief of Party
FSW	Female sex workers
FY	Fiscal year
HIP	High-Impact Package (of HIV and AIDS interventions)
MARP	Most-at-risk populations for HIV infection
MSM	Men who have sex with men
NACP	National AIDS/STI Control Programme
OPD	Outpatient Department
QHP	Quality Health Partners (project of USAID/Ghana)
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
SHARP	Strengthening HIV/AIDS Response Partnerships (project of USAID/Ghana)
STI	Sexually transmitted infection
TB	Tuberculosis
USAID	U.S. Agency for International Development
VCT	Voluntary Counseling and Testing

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1.0 EXECUTIVE SUMMARY

This report is the result of a rapid appraisal of the Quality Health Partners (QHP) project's interventions to reduce HIV/AIDS stigma at hospitals in Ghana. Funded by USAID, QHP project has since FY 06 collaborated with the Strengthening HIV/AIDS Response Partnership (SHARP) project and the National AIDS/STI Control Programme (NACP) to implement a package of tools and interventions dubbed the High-Impact Package (HIP!). Because AIDS stigma has been identified as one of the principal obstacles to HIV prevention and to the scaling up of testing and treatment worldwide, QHP included stigma reduction training of health workers as part of its program to improve quality of care and uptake of prevention, care, and treatment services with a focus on populations with high-risk behavior, such as men who have sex with men (MSM), female sex workers (FSW), and people living with HIV (PLHIV).

This rapid appraisal is based on a sample of six QHP supported HIP hospitals and clients using their services for evidence of prevalence of stigma and discriminatory attitudes and practices among staff, and of the effectiveness of the HIP training in reducing stigma and discrimination. The purpose is to identify lessons that could be applied to improve the existing program or to be adopted for future scale up. The study is not a complete impact evaluation because there was no baseline study. The appraisal was conducted using structured qualitative interview guides targeted at clients and health staff at six selected sites, and PLHIV support groups' key informants available at these sites, and was completed over a six-week period from November 2008 to January 2009.

Objectives

- To assess to what extent HIV stigma in the health care setting impacts on quality of care and client satisfaction;
- To assess whether "anticipated" HIV stigma in the health care setting is still a significant impediment to uptake of prevention, testing, treatment, and care services among most-at-risk populations for HIV infection (MARPs) in Ghana;
- To assess the nature and level of implementation of stigma reduction measures after the COPE exercises, training program on "Reducing HIV-Related Stigma and Discrimination and Improve Infection Prevention," and follow-up activities at select HIP facilities; and
- To obtain service providers' and clients' perspectives on the existence, or the extent, of any changes in HIV stigma over the timeframe in which stigma reduction interventions have been implemented at health facilities under the facility-based component of the HIP initiative.

Results

- The majority of clients perceive the units within hospitals that are primarily responsible for HIV care as welcome refuges from outside discrimination and stigma.
- Clients report high levels of overall satisfaction with services at health facilities, especially HIV units, specifically regarding the friendliness and attitudes of doctors, nurses, pharmacists, and non-clinical workers.
- The majority of clients and health workers report declines in the major drivers of stigma, especially in reduction of fears about casual transmission and reduction of moralizing attitudes, but clients still fear the possibility of indirect disclosure due to the location of HIV units and the possibility of being seen by community members.

- Clients report that HIV-related stigma has declined in other units of the hospital but still negatively impacts quality of care.
- "Anticipated" HIV stigma or fear of HIV stigma by health workers does not appear to be a primary obstacle to uptake of testing, treatment and care services for the majority of MARP**.**
- The HIP interventions reportedly increased health workers' willingness to care for PLHIV.
- Both health workers and clients report a decline in discriminatory practices towards PLHIV, such as putting HIV-infected clients on the floor or in broken beds, during the time frame of this project.

Limitations

- Health workers conducted on average two additional formal training sessions of other workers to reduce stigma, but not all workers at any facility have received training.
- There is an insufficient critical mass of heath workers trained in certain key departments, such as the outpatient departments (OPD) and the inpatient wards, to dramatically reduce levels of HIV stigma and discrimination in these departments, especially in the larger hospitals.
- Institutional and structural changes largely did not occur as a result of this project.
- Newly hired or newly transferred workers may "reintroduce" stigmatizing attitudes and behaviors to the workplace as a result of not having benefited from pre-service (or in-service) stigma reduction training such as is part of the HIP interventions.

Recommendations

1. Maintain stigma and discrimination reduction training content and activities because quality is high. Incorporate more follow-up activities and refresher trainings to enhance retention of material and implementation of activities.
2. Prioritize the issues that MARP identify as the primary obstacles to uptake of health prevention and care services for further HIV stigma reduction activities, such as restructuring HIV units to protect clients from the risk of indirect disclosure.
3. Continue to emphasize and strengthen linkages between stigma reduction activities targeting health facilities and those targeting communities.
4. In addition to "scaling up" stigma reduction activities within service sites, begin creating sustainable structures for stigma reduction by reaching out to pre-service training and district health management teams to ensure stigma reduction interventions are in the budget.

2.0 INTRODUCTION

HIV/AIDS stigma has been identified as one of the principal obstacles to HIV prevention and to the scaling up of testing and treatment worldwide. Until recently, HIV stigma was considered too complex and culturally specific to be addressed on a large scale. Recent research, however, has identified three immediately actionable drivers of HIV stigma that are remarkably consistent across contexts (UNAIDS, 2008; DFID, 2008):

- lack of awareness and knowledge of HIV-related stigma and discrimination;
- fear of acquiring HIV through everyday contact with infected people; and
- linking people living with HIV with behaviors considered improper or immoral.

In addition, stigma keeps some people from seeking treatment until they have reached an advanced stage of disease, often with CD4 cell counts at 50 cells/mm³ or below, when treatment is less likely to be successful (Kalichman and Simbayi 2003, Valdiserri 2002, UNAIDS 2004). Fear of stigma, also known as "anticipated stigma," falls more heavily on vulnerable populations, such as women and the poor, who are often at greater risk of HIV acquisition (Wolfe et al. 2008, Parker and Aggleton 2003). Unfortunately, often the high-risk groups most in need of access to HIV services are those with the highest levels of fear about the stigma they might experience in health facilities (Wolfe et al. 2008). Studies show that stigma interventions at health facilities can change health workers' attitudes and behaviors towards PLHIV (Brown et al. 2003).

The underlying drivers of HIV stigma may be addressed by:

- creating an awareness of what stigma is and the benefits of reducing it;
- fostering motivation for change;
- addressing fears and misconceptions about HIV transmission;
- discussing "taboo" topics including gender, violence, sexuality and injecting drug use; and
- providing skills to challenge stigma and change behavior (Nyblade, et al. 2003, 2005).

Ghana's national HIV prevalence is 1.9%, with considerable variation of prevalence at the regional level. Eastern Region reports the highest prevalence at 4.2%, while certain urban areas, such as the mining town of Obuasi, report prevalence as high as 5.0% and above (NACP 2008). In addition, sex workers and MSM experience relatively high levels of prevalence (30.5% and 25% respectively) (SHARP 2006 and 2007). Although no population-based study of HIV stigma in Ghana has been conducted, consistent anecdotal evidence suggests that HIV stigma is as significant a barrier to prevention, testing and treatment in Ghana as in other countries. In order to achieve Ghana's targets for prevention, testing and treatment, it is important to undertake effective stigma reduction programs.

In mid-2006, QHP, in partnership with the SHARP project, the Ghana Sustainable Change Project and the NACP, launched the HIP Initiative to complement the ongoing national scale-up of comprehensive HIV and AIDS services. HIP seeks to improve clinical quality of ARV and comprehensive HIV and AIDS service delivery, while at the same time addressing the issue of stigma and improve facility-community linkages. Stigma affects health worker, other caregiver, general public and client attitudes toward HIV and PLHIV, and therefore impacts on how HIV-related services are delivered at health facilities and client care-seeking behaviour.

To address the issue of stigma, the HIP package includes: (1) stigma reduction and infection prevention training for clinical and non-clinical health workers (tailored for each group); (2) infection prevention training for family or friends who are caregivers for clients on admission at facilities; and (3) COPE action plans that contain steps intended to address facility-specific issues related to stigma (e.g., to improve privacy, confidentiality and client-provider interaction).

As at December 2008, 27 hospitals delivery ART services had benefited from the introduction of HIP interventions, with a cumulative target of 30 to be reached and followed-up by mid-2009. The facilities were phased in between mid-2006 and the present, beginning with the larger, higher volume teaching and regional hospitals, with the addition of regional and district hospitals over time. Ten hospitals were initiated in 2006-2007; 15 in 2007-2008 (for a total of 25); and five are being added in 2008-2009.

2.1 Rapid Appraisal Objectives

This rapid appraisal seeks to assess the effectiveness of the QHP-supported HIP interventions to reduce stigma within HIV services in Ghana. The objectives were:

a) to assess to what extent HIV stigma in the health care setting impacts on quality of care and client satisfaction;
b) to assess whether "anticipated" HIV stigma in the health care setting is a significant impediment to uptake of prevention, testing, treatment and care services among MARPs in Ghana;
c) to assess the nature and level of implementation of stigma reduction measures after the COPE exercises, training on "Reducing HIV-Related Stigma and Discrimination and Improve Infection Prevention," and follow-up activities at select HIP facilities; and
d) to obtain service providers' and clients' perspectives on the existence, or the extent, of any changes in HIV stigma over the timeframe in which stigma reduction interventions have been implemented at health facilities under the HIP interventions, the facility-based portion of which has been led by QHP.

3.0 STUDY DESIGN AND METHODOLOGY

3.1 Site Selection

Six sites out of the 25 in which the intervention took place were selected for this appraisal according to the following criteria:

1. Highest potential program impact, that is, the places in which HIV prevalence is highest and/or number of people living with HIV/AIDS is greatest in the country.
2. Coverage of different regions, making sure to include at least one site from the north (Northern, Upper East and Upper West Regions), two sites from the middle zone of Ghana (Ashanti, Brong Ahafo, Eastern and the northern half of Volta Region), one site from the south outside of Greater Accra (Western, Central, and the southern half of Volta Region), and two sites from Greater Accra.
3. Coverage of different types of institutions in order to include at least one district hospital, one regional hospital and one teaching hospital.
4. Time of implementation of training.

A variety of institution types were included in this rapid appraisal in case type of institution had some influence on quality of care for PLHIV. Sites where the training had been conducted recently (within the last three months) were excluded, as there would not have been time for these hospitals to conduct follow-up activities towards their action plans to reduce stigma. The six sites chosen (see Table 1, below) enable coverage of all four criteria listed above.

3.2 Methods for Key Informant Interviews

The appraisal team conducted structured interviews of the following target populations:

- clients; and
- both clinical and non-clinical staff at the facilities.

Although the direct target group of the stigma reduction intervention was the workers at health care facilities, the intended indirect beneficiaries are the clients, PLHIV and members of high-risk groups.

In addition, semi-structured interviews were conducted with key informants from high-risk populations of FSW, MSM and of PLHIV. The reason for interviewing representatives from these groups was to find out whether fear of stigma at health facilities is preventing members of high-risk groups from accessing care. These interviews are important because they provide some insight into the perspectives of those who are not necessarily accessing care, whereas the client interviews focus on those who are already using the system. In addition, these interviews took place away from the health care facility itself, in case people were more comfortable speaking openly about health facilities when they were not actually at the health facility.

3.3 Selection of Subjects for Interviews, Exclusion Criteria and Refusals

3.3.1 Clients

It was planned to interview at least 10 clients at each health facility. At one site, Obuasi Government Hospital, the smallest hospital selected, it was not possible to interview 10 clients because of low client numbers. Obuasi does not have a specific day designated as clinic day, hence clients come everyday with overall lower numbers on any specific day. Therefore only

seven clients were interviewed at Obuasi. Greater numbers of clients were interviewed at other sites in order to have a large sample size (see Table 2, below).

Table 1. Sites Selected

FACILITY	REGION	INSTITUTION TYPE
1. Tamale Teaching Hospital	Northern (north)	Teaching hospital
2. Obuasi Government Hospital	Ashanti (middle)	District hospital
3. Koforidua Regional Hospital	Eastern (middle)	Regional hospital
4. Effia Nkwanta Regional Hospital	Western (south)	Regional hospital
5. Tema General Hospital	Greater Accra	District hospital
6. Korle-bu Teaching Hospital	Greater Accra	Teaching hospital

Except in the case of Obuasi Government Hospital, which does not have a designated clinic day, interviews took place on clinic days for HIV positive outpatients in order to maximize opportunity of interviewing clients. Clients were randomly selected according to their place in the queue. Clients normally arrive early because the health facilities operate on a "first come, first served" basis. A number was chosen based on the number of clients present at clinic opening in order to achieve a total of 10 interviews; if, for example, 50 clients were present, every fifth client in the queue was invited to be interviewed until 10 clients had been interviewed. The exclusion criteria for the study were:

- any patient under the age of 18; and
- an inability to speak any of the Ghanaian languages spoken by team members (English, Twi, Fante, Ga, Ewe, Dagbani, and Hausa).

There were no exclusions. Individual refusal rates were low with only one refusal due to poor health. But three clients terminated their interviews before they were completed, citing lack of time. In the case of terminated interviews, the next eligible client was selected. The three partial interviews were included in our quantitative analysis for the parts completed. (See Table 2, below, for a complete list of complete and partial interviews conducted at different sites.) Depending on patient flow and organization of space at the different facilities, clients were interviewed either immediately before or after a visit with the doctor, nurse or pharmacist. Most clients were coming for ART monitoring, but a few were HIV positive, not yet on treatment and coming for CD4 cell counts. Interviews lasted between 30 and 45 minutes per respondent.

Table 2. Number of Interviews at Each Site

Name of Institution	Number of full interviews	Number of partial interviews	Number of full + partial interviews
Effia Nkwanta	11	1	12
Koforidua	10	0	10
Korle Bu	10	1	11
Obuasi	7	0	7
Tamale	11	0	11
Tema	11	1	12
TOTAL	**60**	**3**	**63**

3.3.2 Health Workers

The interviews with health workers were based on a convenience sample of at least 10 workers trained through HIP, of which at least three were non-clinical (receptionist, maintenance, etc.). Because of low numbers of clinical staff and high patient load, it was not practical to try to randomize health workers. The appraisal team used the list of workers trained and systematically worked through the list. Because some workers were not scheduled to work that day or were off-site for workshops or had been transferred to other hospitals, the team normally had to work its way through the entire list to find 10 workers willing and available to be interviewed. In addition, some interviews were cut short because workers needed to return to their posts. A total of 72 health workers were interviewed; of these, 62 interviews were complete. Information from partial interviews was included for quantitative analysis.

3.3.3 Key Informants

The team conducted semi-structured interviews with key informants/representatives from seven associations of PLHIV and high-risk groups, notably MSM and FSWs, in Accra, Takoradi, Tamale and Koforidua. It collaborated with the SHARP project to arrange interviews with representatives from these associations in each of the areas where the selected health facilities are located. The representatives were therefore a convenience sample and serve as a proxy for the membership in their groups.

Finally, members of high-risk groups and members of PLHIV associations were interviewed directly. After an initial key informant interview, representatives from four organizations invited the team to meet with their members and ask questions informally of the group. Three organizations are associations of PLHIV that were holding support group meetings. The fourth organization was a FSW support group linked to SHARP in Koforidua. Since there was no group meeting scheduled, unstructured individual interviews were held with members available at their field location.

3.4 Interview Guides/Questionnaires

3.4.1 Clients and Key Informants

In order to effectively measure stigma at health facilities from a client's perspective, the team followed the recommendations of the Tanzania Stigma-Indicators Field Test Group (USAID 2005), a project funded by USAID. The key domains for stigma from a client's perspective include the related values of shame, blame and judgment, and enacted stigma or discrimination. The team used the indicators and accompanying questions from USAID's Working Report Measuring HIV Stigma: Results of a Field Test in Tanzania (June 2005) in its interview guide in order to capture those domains. In addition, questions related to client's overall satisfaction with services were also included. The interview guide for clients covers the following topics:

- Client satisfaction with health care services and with providers and staff at health facilities (questions 5, 8-10);
- Clients' perceptions of health workers' stigmatizing attitudes or anticipated stigma from health workers (questions 6 and 12);
- Clients' experience of "enacted stigma" or discrimination in the health facility (questions 11 and 14); and
- Client willingness to refer others who might have HIV for services (question 16).

The key informant guide is an adaptation of the client guide.

3.4.2 Health Workers

The main drivers of stigma from a health worker's perspective include fear of casual transmission and attitudes towards disclosure of a client's HIV status, in addition to the related values of shame, blame and judgment, and enacted stigma or discrimination. The interview guide for health workers includes the same questions about shame, blame and judgment, and enacted stigma as the interview guide for clients, but also includes questions about fear of casual transmission (see question 6) and attitudes towards disclosure (questions 14-16). Again, the team used the indicators and accompanying questions from USAID's Working Report Measuring HIV Stigma: Results of a Field Test in Tanzania (June 2005) in its interview guide in order to capture those domains. Questions were also asked about whether health workers had implemented the key stigma reduction strategies they agreed upon during their training sessions in order to assess whether the program was fully implemented. (See Appendix for copies of the three interview guides.)

3.4.3 Persons with High-Risk Behaviors

The team conducted unstructured group interviews of PLHIV and unstructured individual interviews with nine FSW with questions about the following items:

- whether HIV stigma influences quality of care;
- whether fear of stigma inhibits their access to health care; and
- whether they experience stigma or discrimination at health facilities due to HIV status or to being perceived as MSM or FSW.

3.5 Confidentiality and Consent

The team cooperated with health facility staff in order to ensure that a confidential space was available in which to conduct the client interviews. Informed consent was explained and obtained prior to all interviews with clients, workers, key informants and MARPs. (the Oral Informed Consent for Surveys/Interviews is shown in the Appendices).

3.6 Limitations of Methodology and Problems Encountered

3.6.1 Study Design

The lack of a baseline study on stigma in Ghana or a control group for the present study is a limitation of this rapid appraisal. It is therefore not possible to make definitive conclusions about the impact of the stigma intervention itself on stigmatizing attitudes or behaviors among health workers without a control group or a pre-intervention appraisal for comparison. Furthermore, the expansion of access to ART is associated with a decline in HIV stigma, but not with the complete elimination of HIV stigma (Wolfe 2008). Declines in stigma cannot necessarily be attributed to a stigma intervention alone. The stigma intervention took place in the context of expanding access to ART in Ghana; hence some decline in HIV stigma would be expected as treatment access expands. In addition, NACP undertook various trainings during the last two years for workers involved in HIV care, such as trainings on HIV counseling and testing, and on PMTCT. Although none of the trainings specifically focused on stigma reduction, these trainings did provide information about modes of transmission, which was reinforced through the HIP stigma reduction training. To address this limitation respondents were asked questions to assess if they perceived a reduction in stigma since the time of the QHP/HIP stigma reduction training.

The persistence of some stigmatizing attitudes towards PLHIV does not necessarily suggest failure of the stigma interventions because the stigma attached to high-risk groups is embedded in broader structural problems related to poverty and inequality that require multi-faceted interventions (Parker and Aggleton 2003). Moreover, the QHP/HIP interventions were limited in resources and scope. In order to understand the impact of the intervention on HIV stigma, it would be necessary to include a control group, which is beyond the scope of this study.

Health workers' expectations and fears that the study would affect the program's continuation or the possibility of future programs may have also potentially influenced workers' responses to questions.

3.7 Methods for Analysis of COPE Action Plans

The analysis is based on the problems identified in the HIV Units of 16 hospitals throughout the country that had developed or updated COPE Action Plans following staff participation in a QHP organized training on HIV Stigma Reduction. A desk review of the COPE plans was done to note stigma related problems identified and to ascertain the extent to which the problems have been or are being addressed.

3.8 Methods for Analysis of Stigma Reduction Training Data

Pretest and post-test results of 26 training sections from 18 facilities (including one training of trainers) involving 713 participants were collated and analyzed. Mean participant scores that best reflect attitudes, values and comfort level related to HIV/AIDS and working with people who are living with HIV/AIDS constituted the basis of comparison between pretest and post – test scores.

3.9 Methods for Analysis of Rapid Appraisal Instruments

Because stigma has more than one cause, the qualitative and quantitative data were analyzed according to the major domains or drivers of stigma:

- shaming and blaming attitudes;
- fear of casual transmission; and
- fear of disclosure and perceptions of "enacted stigma" or discrimination in health facilities.

This was done to identify which of the factors declined following the implementation of the HIP program and which, if any, still remain. All client interviews from the six facilities were aggregated and the qualitative data manually analyzed; basic computations on the quantitative data were performed using a calculator. All health worker interviews from the six facilities were similarly aggregated and the same procedures used as above.

4.0 RESULTS

The results section begins with an overall picture of perceptions of stigma within hospitals and communities and overall satisfaction with health services and workers. It then moves to the specific drivers of stigma and proceeds through each of them. Finally the section presents results

of specific questions that were part of the objectives, including results from COPE action plans and pre-test and post-test scores from trainings conducted.

4.1 Overall Picture: Stigma Within Versus Outside of Hospitals

Some clients now regard the health care units where they receive most of their routine care related to HIV as refuges from the stigma and discrimination in their communities and at home. Both the staff and the fellow patients apparently create a welcoming atmosphere for these clients.

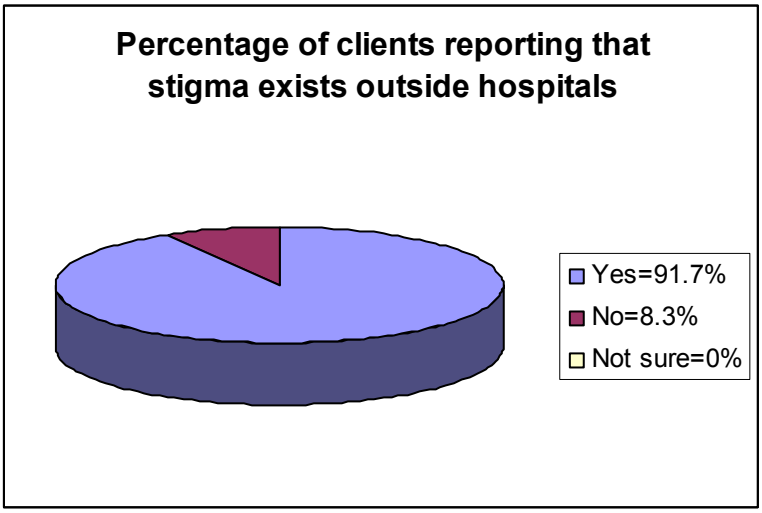
> *Compared with stigma outside the facility, there's nothing here. I used to worry that people here would be like they are in the community, but they are not.*
>
> (Female client, 36 years, Korle Bu)
>
> *The health workers treat us like their family members.*
>
> (Female client, 36 years, Tema General)
>
> *We are happy to come here. Sometimes we don't want to go home. We enjoy when we meet; we see ourselves as brothers and sisters. And the staff are nice.*
>
> (Female client, 41 years, Effia Nkwanta)

However, according to 91.7% of clients, stigma remains a major problem that clients face in their communities (see Figure 1, below). Stigma outside of health facilities manifests itself in a variety of ways:

- landlords eject tenants from their homes;
- families abandon or refuse to care for infected family members;
- customers refuse to buy food or services such as hairdressing from infected vendors; and
- community members gossip and point fingers at those suspected of having HIV.

Stigma has a strong effect on the livelihoods and economic security of PLHIV who sometime lose their homes and businesses.

Figure 1.



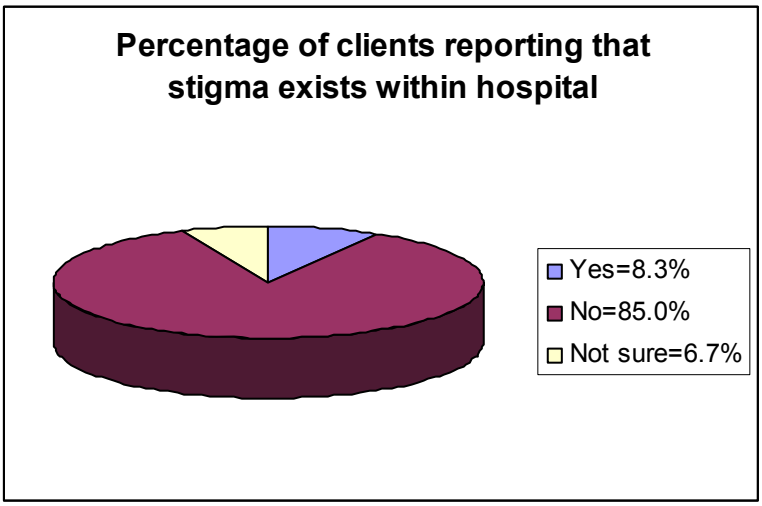
Some people think that we were sexually too active so we brought the disease upon ourselves, so they don't want to have anything to do with us.
(Male client, age 39, Tema General)

My family rejected me. They even thought that when I greet them they will get infected.
(Female client, 41 years, Effia Nkwanta)

If you sell food, the public won't buy from you.
(Female client, age 51, Korle Bu)

A hairdresser had to relocate because her customers suspected her of having HIV and stopped visiting her salon.
(Female midwife, Gynecological Theatre, Tamale)

Figure 2.

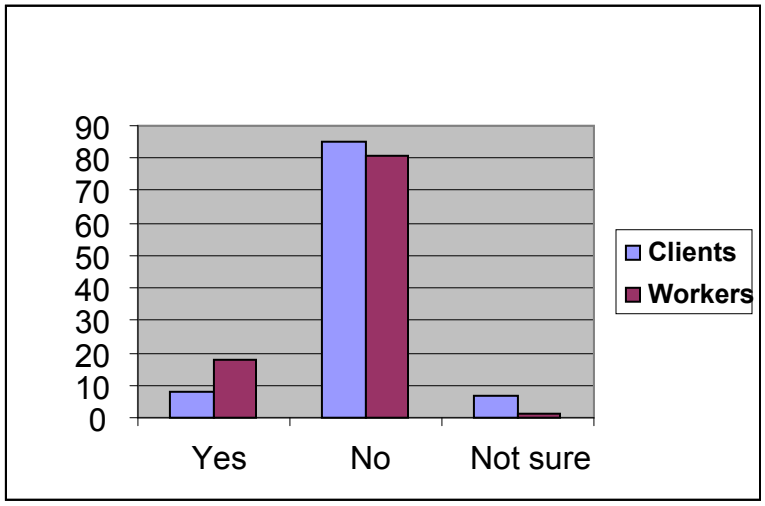


In contrast to the overwhelming majority of clients who report stigma in communities and families, a minority of clients interviewed (8.3%) reported that stigma exists within the hospital, especially at the units devoted to care of PLHIV (see Figure 2, above).

A higher percentage of workers (17.9%) than clients (8.3%) reported that stigma exists within health care facilities (see Figure 3, below). The result is somewhat surprising because one would expect workers to present a more favorable picture of their work environment than clients. One possible explanation is that workers are more aware than clients that stigma may exist in practices throughout the entire hospital, whereas clients were unsure about what happens in many of the departments outside the HIV services. In fact, a higher percentage of clients than workers (6.7% versus 1.5%) reported that they are not sure whether stigma exists in the hospital.

During interviews, some clients mentioned that they only come for ART monitoring. Furthermore, workers are often rotated through the hospital and therefore seemed to feel more comfortable commenting on the hospital as a whole than clients.

Figure 3. Percentage of Clients and Workers Who Think Stigma Exists Within the Hospital They Attend or Work



4.2 Clients Report High Levels of Overall Satisfaction

Overall Satisfaction

The majority of clients (87.3%) report that they are either somewhat or very satisfied with the services at the health facility where they were interviewed. Most respondents said they are satisfied because their health has improved, suggesting that client reports of satisfaction are influenced by their physical wellbeing. A significant minority (30% or 18 out of 61 respondents) spontaneously mentioned the friendliness of doctors, nurses, pharmacists and other staff as the reason why they are satisfied with services.

The way the staff talk to me makes me feel very happy.

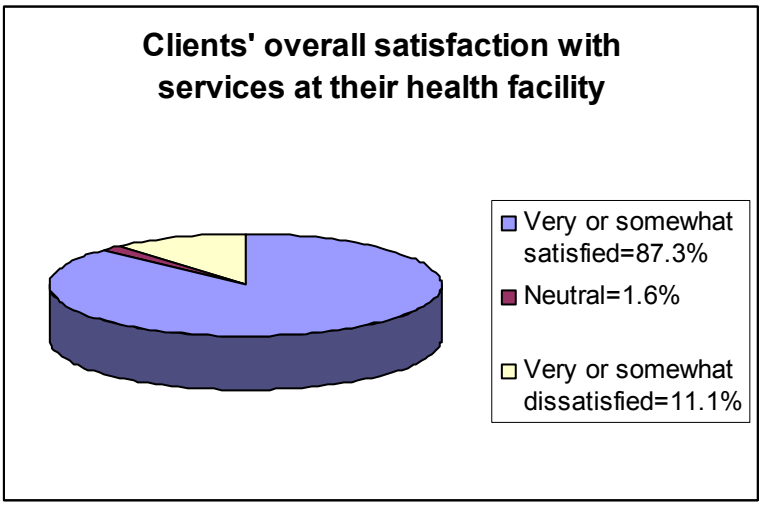
Female client, age 43, Koforidua

[I am satisfied] because of the way the nurses and doctors treat us. They advise us. They comfort you. Sometimes you will even forget about it [HIV].

Female client, age 37, Tema General

A significant minority (11.1%) reported that they were either somewhat dissatisfied or very dissatisfied; only one of 63 respondents was neutral (see Figure 4, below).

Figure 4.



Clients expressed dissatisfaction primarily as the result of long queues, which apparently have worsened recently because of the availability of ART. More and more PLHIV are accessing services without a commensurate increase in the number of health care providers. In addition, others cited the lack of space at HIV units, which is particularly a problem at Effia Nkwanta, as well as health workers' angry reactions when clients miss appointments. (See Section 4.5 for further discussion of the issues surrounding missed appointments.)

Perceptions of Friendliness of Doctors, Nurses, Pharmacists and Non-Clinical Staff

Both doctors and pharmacists received high ratings in terms of friendliness from clients, with 93.5% and 93.4% totally agreeing that doctors and pharmacists, respectively, are friendly and welcoming to them. Clients commented on how doctors will chat and joke with them and explain everything thoroughly. Clients also praised pharmacists for making medicines available to them even when they could not pay. The majority of clients praised nurses and non-clinical staff as well, but not as many as compared with doctors and pharmacists. Nearly 84% of clients totally agreed that nurses are friendly and welcoming to them, while 82.2% of clients responded the same about non-clinical staff. A few clients commented that security personnel and non-clinical staff at the HIV units were helpful in showing clients around and even playing with the clients' children while they waited to see a doctor.

Clients' and health workers' perceptions of the friendliness of staff are strikingly consistent (see Table 3, below). For example, approximately the same percentages totally agree about the friendliness of doctors (93.5 and 95%), nurses (83.9 and 81%), pharmacists (93.4 and 96.2%), and non-clinical staff (82.2 and 80.4%).

Table 3. Views of Clients and Workers on How Friendly and Welcoming Different Categories of Health Workers Are to Clients with HIV (%)

	Doctors		Nurses		Pharmacists		Non-clinical staff	
	C	W	C	W	C	W	C	W
Totally Agree	93.5	95	83.9	81.0	93.4	96.2	82.2	80.4
Somewhat Agree	6.5	3.3	12.9	11.1	4.9	3.7	15.5	15.7
Somewhat disagree	0	1.7	3.2	7.9	1.6	0	2.2	2.0
Totally disagree	0	0	0	0	0	0	0	2.0
N=	62	60	62	63	61	53	45	51

C=Clients W=Workers
Total percentages do not necessarily add up to 100% due to rounding.
The value for N varies because some respondents reported no contact with certain types of workers.

Levels of dissatisfaction were fairly low (see Table 3, above). The primary reason clients offered for their dissatisfaction with services was having experienced lower quality of care due to HIV status or frustration at the way they are treated when they miss appointments (see section 4.5). Several of these clients had been admitted as inpatients and had negative experiences there or elsewhere in the hospital, as demonstrated in the following examples:

Those who are admitted are stigmatized by the nurses, but not those who come for [ART] monitoring. A sister who was admitted could not even walk. Sometimes she needed only water for a drink and she would ask the nurses for water. I was admitted to the hospital for six months and was not cleaned. I had to wait for my sister to come from home to bathe and clean me.

(Male client, age 42, Korle Bu Teaching Hospital)

The sick person on the ward, that's where the problem is. There's no problem with ART outpatients. No problem.

(Nurse at TB Unit, Obuasi Government Hospital)

Whereas virtually all of the workers whose primary responsibility is the care of PLHIV received training in stigma reduction, only the minority of workers in the rest of the hospital received the training. Workers and clients in all six sites reported that untrained hospital workers engaged in the following stigmatizing behaviors and attitudes towards clients living with or suspected of having HIV:

- neglect;
- isolation;
- refusal to care for or treat;
- negative, disparaging remarks; and
- disclosure of status to others without consent.

In addition to the wards, the OPD is also a problem area for HIV-related stigma, with reports of individual doctors or nurses avoiding contact and thereby failing to care for clients suspected of having HIV. Units that do not normally receive HIV training, such as eye clinics and other specialties, were listed as problem areas. An additional problem reported is that apparently some staff members try to avoid care of PLHIV and force all care of PLHIV onto the few staff

members trained and committed to this kind of care, as the comments from the nurse at Tema General and the midwife at Tamale suggest (see text box below). In addition, because care of PLHIV and stigma reduction is not a routine part of pre-service training, newly recruited doctors and nurses do not necessarily have the interest or skills to care for these patients.

A medical officer refused to attend to an HIV client at the OPD. Also, due to rotations every three months, some nurses refuse to be rotated to the Fevers Unit (which handles HIV clients). There is the fear of transmission, and general discrimination. At the records office, people are not comfortable working with them. They don't complete their records and the clients are sometimes unaccompanied to the Fevers Unit from OPD for admissions.

(Nurse, chest clinic, Tema General)

It is difficult to find volunteers to do testing for HIV.

(Midwife, antenatal clinic, Tamale)

Some nurses are afraid of the disease. Last year in May, sometime in one screening day, I realized that a patient who had been in the queue for a long time hadn't been attended to by her fellow nurses because they didn't want to screen the HIV client.

(Nurse, eye clinic, Korle Bu Teaching Hospital)

T*he staff members at OPD and other departments are not friendly.*

(Female client, 48 years, Effia Nkwanta)

Not all doctors are interested in HIV, and HIV is not a part of medical school education right now. It's a problem.

(Doctor, HIV unit, Effia Nkwanta)

We know that HIV should be incorporated into our normal clinical services, but it takes time. Try to do pre-service training. So by the time they come out of school they already know something about HIV. More hands need to be trained in stigma reduction.

(Doctor, HIV unit, Koforidua)

Workers who do not have the training still try to avoid HIV clients out of fear, because they do not know the modes of transmission.

(Midwife, labour ward, Tamale)

4.3 The Major Drivers of Stigma

4.3.1 Moralizing Attitudes

One of the major drivers of HIV stigma is the blame and shame associated with its modes of transmission, especially sexual transmission. Worldwide and in sub-Saharan Africa HIV stigma manifests itself in disparaging remarks and attitudes about "deviant" or "promiscuous" sexuality, often with the assumption that women who contract HIV are prostitutes or promiscuous (Ogden and Nyblade, 2005). Men can also be targets of stigmatizing attitudes about promiscuous sexuality.

Table 4. Client and Health Worker Views on Whether Health Workers at Their Health Facility Would Agree With Specific Stigmatizing Statements Towards PLHIV

	People with HIV/AIDS should be ashamed of themselves		HIV is a punishment for bad behavior		PLHIV are to blame for bringing disease to community		It is mainly women prostitutes that spread HIV	
	C	W	C	W	C	W	C	W
Yes	3.3	3.2	5	8.1	5	6.5	15	19.4
No	90	96.7	86.7	91.9	91.7	93.5	85	80.6
Not sure	6.7	0	8.3	0	3.3	0	0	0
N=	60	62	60	62	60	62	60	62

C=Clients W=Workers

Total percentages do not necessarily add up to 100% due to rounding.

The value for N varies because some respondents reported no contact with certain types of workers.

The majority of clients and workers do not think that health workers at their facilities harbor negative attitudes towards PLHIV (see Table 4, above). Clients' and workers' perceptions were fairly similar, with less than 10% of both groups reporting that health workers think people with HIV/AIDS should be ashamed of themselves or that PLHIV are to blame for bringing disease to the community.

A significant minority (15% and 19.4%, respectively) of clients and workers, however, report that health workers think it is mainly FSW that spread HIV. In interviews a few female clients mentioned that health workers indirectly asked them if they were sex workers by asking if "they had gone to Abidjan," a question they found offensive as this phrase is used as a euphemism for sex work.[1] One health worker mentioned that other health workers used code words to refer to women they suspected of being sex workers, such as saying "she wears big earrings." A few male clients also commented that health workers assumed that they were promiscuous. One nurse said that she worries about contracting HIV from her husband: "You can't trust men. All women are at risk of contracting HIV." It is possible that health workers project these fears about unfaithful husbands onto their clients. Several clients, both male and female, expressed fears that health workers made judgments about their sexual behavior based on their HIV status.

4.3.2 Fear of Casual Transmission

The majority of health workers report that they do not fear being infected by taking care of, drawing blood, or touching PLHIV, but a significant minority report fears about touching the sweat of or sharing a washroom with PLHIV. All workers report that they are comfortable touching a person who is HIV positive and virtually all (98.4%) say they do not fear helping or caring for PLHIV.

[1] Abidjan was formerly a receiving area for migrants from Ghana and the center of West Africa's HIV/AIDS epidemic where many of the first cases of HIV in Ghana had spent time as sex workers.

Perhaps surprisingly, however, more workers fear touching the sweat of and sharing a bathroom with PLHIV than fear drawing the blood of PLHIV (see Table 5, below). This discrepancy can be explained as the result of two things:

- workers fear that not all information about HIV transmission is definitively known and believe that new information may become available; and
- mixed messages from different sources about hepatitis B transmission, some of which suggest that hepatitis B can be transmitted via sweat and had therefore raised a few workers' concerns about HIV.

Two workers at two different facilities reported that some expatriate physicians warned workers about the dangers of hepatitis B from sweat and encouraged them to use gloves for noninvasive procedures on all patients. Universal precautions are supposed to provide protection against both HIV and hepatitis B and do not call for the use of latex gloves for noninvasive procedures. Although the number of workers expressing confusion due to hepatitis B is small, a significant percentage (17.7%) of workers expressed some fear of coming into contact with sweat (see Table 5, below). There is therefore a need to issue guidance to all staff including expatriates about universal precautions and further reinforce Ghana's national guidelines and the HIP training on universal precautions.

By contrast, workers know that HIV is transmitted through blood and that they should wear gloves when drawing blood. They are confident about the information they are receiving regarding blood transmission, but wary about the potential unknown dangers of body fluids.

> *There's some HIV in saliva. Maybe it's in the sweat too and we'll find out later.*
> (Nurse, Female Ward, Obuasi Government Hospital)
>
> *They say that no one has gotten it that way [from sharing a bathroom], but if you touch the fluid, you might get it. If there's diarrhea there, then it's fearful.*
> (Nurse, Antenatal Clinical, Tamale Teaching Hospital)
>
> *Sweat is a body fluid so I am afraid of touching it.*
> (Pharmacist, Korle Bu Teaching Hospital)

4.3.3 Fear of Indirect Disclosure

Fear of indirect disclosure of status by being seen in HIV units by the general public or workers from other departments is a major obstacle to the uptake of counseling and testing, treatment and care services. This risk of indirect disclosure is a crucially important issue to clients and members of high-risk groups interviewed. One effect of this fear of disclosure is that some people choose to attend facilities far from home in order to avoid being seen by the community.

> *People are afraid to attend clinic because of the community, not because of the staff at the hospital.*
> (Key informant, Hope Movement PLWHIV support group, Accra)
>
> *Some of my friends will go to Central Hospital because they may know somebody at Zongo clinic and would not be comfortable if the person knows their status.*
> (FSW, Koforidua)

From the clients' perspective, the location of the HIV unit can facilitate stigma and discrimination, because the general public can see them entering or exiting the unit and guess their status. This problem is especially acute at four of the facilities studied:

- Effia Nkwanta;
- Tema General;
- Korle Bu; and
- Tamale.

Only Koforidua and Obuasi hospitals have facilities for outpatient ART clients that protect clients from indirect disclosure through the location of the facility. At Koforidua, the Data Center is housed within the facility that provides VCT and ART monitoring. Consequently, clients seen entering the building are not automatically suspected of being HIV positive, because they might be visiting the Data Center. At Obuasi, HIV clients are mixed with other clients and there is no specific HIV clinic day, which keeps other community members from guessing a HIV client's status. At other facilities, however, HIV units are housed separately in "Fevers Units" or next to the STI clinic, so that everyone who enters is suspected of having HIV. In addition, waiting rooms are not large enough for all clients to sit inside. Clients who wait outdoors risk being seen by community members.

> The *problem is the people coming to the hospital to visit other patients, those who have given birth. If they see you (coming to the Fevers Unit), they will say you have HIV. Also people come to deal with the mortuary, they see you and talk about you. You will not feel comfortable. You will not be happy.*
>
> (Female client, age 37, Tema General)
>
> *The OPD is too close to the ART centre so when people who know you visit the OPD and see you around the ART centre, they spread the news that one is infected.*
>
> (Female client, 45 years, Effia Nkwanta)
>
> *The STI clinic is very close to the lab area. As soon as people see you enter the STI clinic, the workers at the lab start pointing fingers at you.*
>
> (Female client, 37 years, Tamale Teaching Hospital)
>
> *At the hospital gate before you enter the Fevers Unit those workers at the gate pass certain comments.*
>
> (Female client, age 40, Korle Bu Teaching Hospital)

4.3.4 Perceptions of Enacted Stigma or Discrimination

The majority of both clients and workers report that they have not seen or heard about stigmatizing behaviors by health workers. The most encouraging news is that there was complete agreement among clients and workers that no one is refused care because of HIV status (see Table 6, below). Similarly, less than 10% of clients and workers reported that clients with HIV received less care than other patients; as already discussed, they pointed out problems in the wards rather than HIV units. Problem areas included:

- testing for HIV without consent;
- unwarranted use of latex gloves; and
- gossip and breach of confidentiality.

Testing for HIV without Consent

Some clients expressed confusion about what it meant to be tested for HIV without their consent and then explained their situation, that they were counseled after (rather than before) being tested. These clients were not necessarily reporting a problem; some of them seemed not to know that they were supposed to be counseled first. Clients' lack of understanding may explain why relatively few of them compared with workers (1.7% versus 14.5%) reported that clients were tested for HIV without their consent. In fact, fully 12.9% of clients said that they were not sure if the practice happened (see Table 6, below). The practice apparently happens at all hospitals, but more workers at Tamale Teaching Hospital reported problems, partly owing to its reliance on expatriate staff members who reportedly order HIV tests before undertaking certain procedures.

Use of Latex Gloves

Using latex gloves for noninvasive procedures, which is not prescribed by universal precautions, is another consistent problem reported by 11.5 and 16.1% of clients and workers respectively (see Table 6, below). In Section 4.3.2, health workers' fears of exposure to body fluids such as sweat and their subsequent desire to wear gloves for protection are discussed.

Gossip and Confidentiality

A large percentage (27.4%) of workers reported that other health workers gossip about clients' HIV status (see Table 6, below). Typically, workers reported that gossip occurs on the wards, but it can occur anywhere in the hospital.

> *They [workers] look in the client's file to find out HIV status.*
>
> Nurse, female ward, Koforidua Hospital

Of the six hospitals visited, only Obuasi Government and Effia Nkwanta Hospitals kept clients' HIV status separate from the folders that were kept with the HIV counselors at these institutions, with limited access to others. At other institutions, a code is used and kept within the file, so a client's HIV status can be known to any nurse or health worker who has access to patient files.

During the interviews a few nurses explained that staff that had not undergone the HIP stigma reduction training did not understand the idea of universal precautions. Therefore they thought it was important to inform the next shift at handover about clients' HIV status so that nurses could protect themselves. Health workers might use a term only understandable to themselves and not to other clients, such as saying that a patient is "seroreactive." In these cases, health workers see themselves as informing other staff members about an important issue, not as "gossiping."

Table 5. Percentage of Health Workers Who Feel Comfortable With Performing Procedures On or Having Contact With PLHIV

	Comfortable with PLHIV	Comfortable touching PLHIV	Comfortable sharing washroom with PLHIV	Do not fear touching sweat of PLHIV	Do not fear drawing blood of PLHIV	Do not fear caring for person with PLHIV
Totally agree	87.1	100	82.3	82.3	90.0	98.4
Somewhat agree	8.1	0	8.1	9.7	4.1	0
Somewhat disagree	3.2	0	3.2	1.6	2.0	1.6
Totally disagree	1.6	0	6.5	6.5	4.1	0
N=	62	62	62	62	49	62

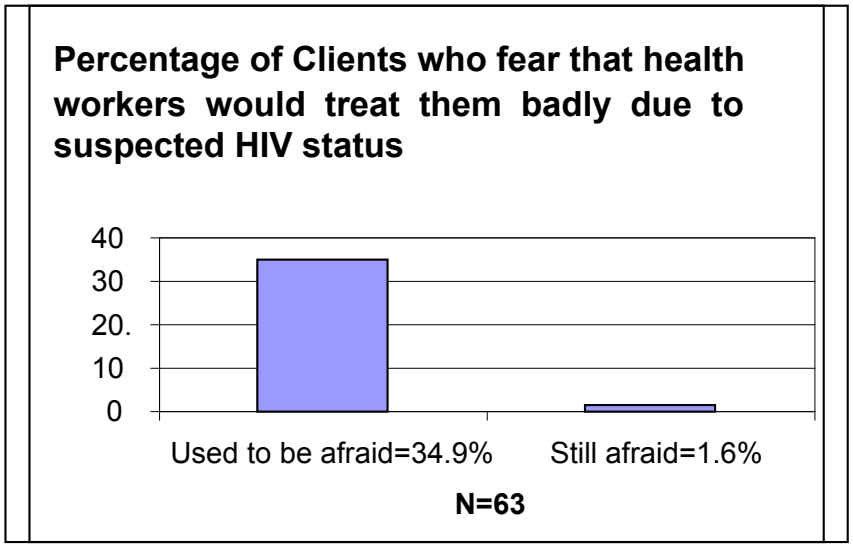
Total percentages do not necessarily add up to 100% due to rounding.
The value for N varies because some respondents' job responsibilities did not include drawing blood.

Interestingly, relatively few clients (3.2%) reported that workers gossip about HIV status, one of the few major discrepancies between clients' and workers' perceptions in this entire study (with 27.4% of health workers saying that health workers gossip about client status). It may be that clients are simply unaware of the amount and extent of health workers' gossip about HIV status. It may also be an issue of interpretation: clients are more concerned about gossip within their communities, not among workers who are not part of their daily lives at home.

> *I live far from here. How can they gossip about me?*
>
> Male client, age 37, Koforidua Hospital

Clients expressed greater concerns about disclosure of status to communities and quality of care than about whether workers gossiped among themselves. Clients' fear of indirect disclosure of status if they are seen entering or exiting HIV units by community members is discussed in section 4.3.3.

Figure 5.



It should be emphasized that 65.1% of respondents said that they had never been afraid of health workers treating them badly.

4.4 Outpatient Clients Report They No Longer Fear They Will Be Treated Poorly By Health Workers Because of Their HIV Status

Clients report reduced fear of being treated badly by health workers because of their HIV status apparently owing to the HIP stigma reduction training. All but one client out of 63 interviewed reported that they are not currently afraid that health care workers will treat them badly because of HIV status. That one client explained that she is still afraid "because those who have full blown AIDS are neglected at the wards at the hospital." This comment again draws attention to the ongoing problems with inpatient care as opposed to routine outpatient ART clients. By contrast, 22 patients (34.9%) said that they used to be afraid that health workers would treat them badly if the workers thought they had HIV (see Figure 5, above). The remaining two-thirds reported that they were never afraid of being treated badly by health workers.

The preceding findings suggest that HIP stigma reduction interventions have contributed to a decline in clients' fear of health workers. A few clients specifically mentioned that health workers' attitudes at the HIV units towards them had changed; therefore they were no longer fearful. As one client who was diagnosed 13 years ago and had been attending Korle Bu ever since explained: "In the beginning I was afraid. Previously the HIV counselors were not very friendly, but now they are friendly."

Other clients, especially those diagnosed within the last two years, never directly experienced bad treatment from health workers but feared bad treatment because of HIV stigma. Their initial contact with the HIV counselors was therefore positive.

I was afraid that they were going to take photographs of us and put us on TV. But when I came here, they encouraged us and told us it would be confidential. So now I am not afraid.
(Female, 44 years, Effia Nkwanta client for two years)

Approximately 22% of clients also reported that people in their community are afraid to go to hospitals or clinics because they think health workers will treat them badly due to HIV status.

Asked whether people in their community are afraid to go to clinics because they think health care workers will treat them badly if they have HIV, 22% of clients responded affirmatively.

Some people in my community think that the doctors would yell at them or maltreat them when they seek medical help from the hospital.
(Female client, 44 years, Obuasi)

Most clients, however, emphasized that others avoid hospitals and clinics because they fear the diagnosis, not the health workers. In addition, many community members apparently believe that being diagnosed with HIV will hasten death, because the person will become upset by the diagnosis itself. Nonetheless, news about the availability of ART at hospitals is spreading within some communities, making a visit to the hospital a less frightening experience.

Initially because there was no treatment people were afraid. But now that drugs are available people are coming to the clinic.
(Female client, 45 years, Effia Nkwanta)

Table 6. Percentage of Clients and Workers Who Report that They Have Seen or Heard About Stigmatizing Behaviors Towards PLHIV

	Testing a client for HIV without their consent		Health workers gossiping about client's status		Client with HIV receiving less care than other patients		Client being refused care because of HIV status		Health workers using gloves for noninvasive procedures	
	C	**W**	**C**	**W**	**C**	**W**	**C**	**W**	**C**	**W**
Yes	1.7	14.5	3.2	27.4	4.9	6.5	0	0	11.5	16.1
No	85.5	79.0	95.2	71.0	90.2	91.9	100	100	85.2	80.6
Not sure	12.9	6.5	1.7	1.6	4.9	1.6	0	0	3.3	3.2
N=	62	62	62	62	61	62	61	62	61	62

C=Clients W=Workers

Total percentages do not necessarily add up to 100% due to rounding.

The value for N varies because one respondent did not complete that part of the interview.

4.5 "Anticipated" HIV Stigma Does Not Appear to be the Primary Obstacle to Uptake of Testing, Treatment and Care Services for the Majority of MARPs

According to key informants and MARPs interviewed, fear of being treated badly by health workers is not the primary obstacle to accessing HIV services at health facilities. All nine FSW interviewed at Koforidua reported positive experiences with the health workers at Koforidua Hospital, where they had gone for HIV testing and counseling, and STI services. They specifically mentioned a couple of HIV counselors by name as friendly and one described two of the counselors (who underwent the HIP training) as "lovely."

However, because the women interviewed were young and relatively new to sex work (between the ages of 18 and 23, typically with only two years' experience in sex work), they were generally healthy. They had no experience of ART services, AIDS-related complications and inpatient care. Therefore their experiences are not representative for FSW as a whole.

According to these informants, the major obstacles to the uptake of VCT, care and treatment services for MARPs are:

- fear of testing positive;
- fear from sex workers and MSM of being treated poorly by other PLHIV; and
- lack of knowledge of the availability of ART at public hospitals.

My friends are all scared of being tested (for HIV)—that they might die early from worrying. They are not aware of services related to ART. I'm trying to encourage my friends to do the test.
*(*FSW, Koforidua)

4.6 Reductions in Stigma Attributed to the HIP Training

Health workers attributed declines in stigma to the impact of the QHP/HIP training**.** Health workers frequently mentioned that the stigma reduction training had helped rid themselves of stigmatizing attitudes and behaviors, primarily because they no longer feared casual transmission. Fear of infection had previously led to neglect and avoidance of patients, refusal to treat patients, isolation of patients and gossiping about a client's HIV status.

If a patient is growing lean, or has rashes, someone will say, "Oh, don't go near him." But now it's better. Before I was educated on this, from the way a certain patient looks, I would think he has HIV and I was afraid. Now I know you can eat with the person, care for the person, just don't have blood contact.
(Health extension worker, Obuasi Government Hospital)

Before I went for the training, I used to discriminate against people. Why? Because of fear of infection. But it was due to ignorance. I thought I could get infected by touching and talking to people.
(Male security chief, Tema General)

Before the training, we were not conversant with modes of transmission. We thought that even being close to clients could lead to infection. As soon as nurses knew the status of the client, they called for their discharge.

(Nurse, STI clinic, Obuasi Government Hospital)

There are big changes as a result of the stigma training. Health workers used to point at them, saying, "This is an HIV person." Now they're no longer saying, "Oh, that's an HIV person." Other workers wouldn't even come to the STI unit or the TB unit. This was a problem. Now there's a change, a drastic change.

(Nurse, Effia Nkwanta Hospital)

Presently there is a great change as a result of the various trainings on HIV stigma reduction. However, some immature nurses, especially the young ones, still discriminate against patients suspected of having HIV even without being tested. There was an incident when a nurse asked a colleague whether a client had been tested for HIV. Since the client's status was unknown, she refused to go near her.

(Nurse, Korle Bu Teaching Hospital)

Supervisors reported that the stigma reduction training improved quality of care of PLHIV among those trained. Health workers at all six institutions recommended that the training should be conducted for all staff because it increases the number of staff willing to care for PLHIV, especially for health care unrelated to HIV. For example, PLHIV may need to consult an eye doctor or other specialists who were sometimes reluctant to provide care for PLHIV.

In the promotion interviews that I conducted yesterday, there was a difference between those who were trained and those who were not trained in terms of knowledge of care of PLHIV.

(Director of Nursing Services, Tamale Teaching Hospital)

Workers' perceptions of change due to the HIP stigma reduction training are suggestive of the effectiveness of the training in reducing stigmatizing attitudes and behaviors towards PLHIV. The changes cannot be attributed to the QHP/HIP efforts alone, because workers received other kinds of training on HIV, although none specifically on HIV stigma. As mentioned before, the training took place in the context of expanded access to ART, which is also associated with stigma reduction. Despite these limitations, it is fair to say that the HIP stigma reduction training contributed to reducing stigma among health workers who received the training: attitudes and behaviors towards PLHIV changed and their self-reported fears of casual transmission of HIV were reduced.

4.7 Follow-up Activities at Health Facilities to Further Reduce Stigma: Successes and Limitations

The HIP stigma reduction training programs organized at the health facilities were generally successful. Mean pre-test and post-test scores of 713 health providers that participated in stigma reduction trainings showed a marked improvement in perception modification and knowledge gain. For instance, increased levels of comfort in providing health care services to HIV positive clients including surgical and invasive procedures were noted. Furthermore, overall mean scores showed an 11% point increase in knowledge gain-from 76% at pretest to 88% at post-test (See Appendix for table on detailed participant scores). The trainings also included developing of

action plans to disseminate the information and skills gained at the stigma reduction training more widely within the facilities to further reduce stigma and discrimination.

QHP/HIP addresses quality improvement in health care facilities using a tool called COPE (Client-Oriented, Provider-Efficient Services) that has been specifically adapted for ART services in Ghana. COPE is intended to help continuously improve the quality, efficiency, and client-responsiveness of the services provided at the facilities. The COPE quality improvement process includes self-assessments, client interviews, record reviews and client flow analysis (when feasible). The findings from these are brought together in an action plan developed by the health care facility staff. The action plan is developed to address problems identified during the COPE exercises and as part of the stigma reduction training. Through a discussion process the staff discuss, consolidate and prioritize the problems and recommendations. The resulting action plan for the facility includes:

- a list of priority problems to be addressed;
- the root causes of each problem;
- the actions recommended to resolve or diminish each problem;
- the staff members responsible for implementing the recommended actions; and
- the completion date for each action.

Fifteen out of the 16 sites (94%) that developed or updated COPE action plans following training on stigma reduction listed stigma or discrimination directly as a problem (for a list of sites, see Health Care Facilities with COPE Action Plans, in the Appendices). The problem statements listed in these action plans clearly voiced concern about staff and their attitudes, as well as problems with the location, setting and signage for VCT and ART monitoring units (for a complete list of problem statements, see Problem Statements Related to Stigma and Discrimination Prior to Implementation of the Action Plans, in the Appendices). Clients seen entering these buildings were suspected of having HIV and subject to gossip, stigma and discrimination.

4.7.1 Successes of Action Plan Implementation

Key health workers identified as responsible for implementation of action plans reported which parts of action plans were successfully implemented and which were not. The successes included:

- formal training of other workers in stigma reduction **BUT** these follow-up trainings have typically only been done two times and more is required to achieve wider coverage of facilities;
- ending discriminatory practices such as putting HIV-infected clients on the floor or on broken furniture;
- changing signage to protect client confidentiality; and
- posting charts for post-exposure prophylaxis (PEP) and implementing procedures.

4.7.2 Limitations of Implementation of Action Plans

Health workers encountered the following problems or were unable to implement the following changes.

- Due to time limitations during the workday, trainees only partially disseminated information to other health workers so that many workers remain untrained or uninformed.
- There was an insufficient critical mass of heath workers trained in certain key departments, such as the OPD and the inpatient wards, to dramatically reduce levels of HIV stigma and discrimination in these departments, especially in the larger hospitals.
- Institutional and structural changes, such as the relocation or restructuring of HIV units to protect clients from the risk of indirect disclosure, largely did not occur as a result of this project (except in the case of Koforidua with NACP support).[2]
- Facility-wide availability and adoption of existing GHS/NACP policies and guidelines to protect HIV-infected workers' jobs and to protect clients' rights to confidentiality largely did not occur.

4.8. A Few Problems External to the Program Negatively Impacted Program Effectiveness or Implementation

- Newly hired or newly transferred workers may "reintroduce" stigmatizing attitudes and behaviors to the workplace as a result of not having benefited from pre-service (or in-service) stigma reduction training such as is part of the HIP interventions.
- Insufficient numbers of doctors and nurses are involved in HIV care, which negatively impacts quality of care and client satisfaction. The availability of ART has increased patient numbers without commensurate increases in numbers of health workers. Health workers report that stigma is only one reason for the lack of interest in HIV care; another reason is the perception that HIV care is not a financially lucrative field and represents "extra work."
- Hospital management did not lend full support to implementation of all aspects of action plans for a variety of reasons, including limitations of resources.
- Some clients expressed concern over the requirement that they disclose their status to at least one friend or family member because of lack of trust; many clients expressed concern about how health workers respond with anger when clients miss appointments. Both of these concerns fall in the realm of ART adherence strategies. In order to make sure that clients have adequate support to adhere to their medications, many ART programs encourage clients to disclose their status to one trusted person who can then serve as a support partner. There is a need to coordinate ART adherence strategies with HIV stigma reduction activities to maximize adherence without jeopardizing client confidentiality or satisfaction.

As part of adherence counseling, clients are encouraged to bring a trusted family member or friend to the hospital and disclose their status to that person as a support partner prior to initiating treatment. A few clients reported that this person, usually uninfected, violated their confidentiality and informed others. These clients suggested that other HIV-infected clients

[2] QHP's current workplan includes modest amounts of funding to assist facilities to implement some of these changes, i.e., to support the cost of minor renovations, furniture, etc. Major structural changes or renovations are beyond QHP's mandate.

would make more appropriate support partners than uninfected family members and friends, but they were either unaware that they could choose these people or had not yet met other HIV-infected clients when they were asked to bring a friend or family member.

Second, clients report that when they miss appointments, doctors, nurses or pharmacists "yell" at them, which clients perceive as demeaning and ineffective.

> *Some [doctors] are very kind and some are not nice, especially if you default the doctors speak very harshly and sometimes yell at you and throw your folder at you. Usually people come out of the consulting room in tears.*
>
> (Female client, age 40, Korle Bu)

These complaints were consistent at all facilities visited. Clients said that health workers did not understand their reasons for missing the necessary appointments to refill their ART prescriptions, while health workers expressed frustration that clients did not understand the potential deleterious consequences of interrupting treatment. It may be useful to facilitate a health provider/client dialogue on strategies for enhancing adherence that is less frustrating to both and less corrosive of the provider-client relationship than current practices. QHP and SHARP projects both aim at building stronger linkages between communities and health facilities; it might be useful to increase focus on adherence strategies as part of this process of strengthening ties.

5.0 CONCLUSIONS AND RECOMMENDATIONS

By implementing best practices in stigma reduction, the HIP training and action plans have helped decrease health workers' reported fear of infection and therefore increased their willingness to care for PLHIV. The HIP training also focused on other drivers of stigma:

- moralizing attitudes;
- fear of disclosure; and
- enacted stigma or discrimination.

Clients and workers alike do not report significant problems with moralizing attitudes or discrimination at HIV units responsible for outpatient ART monitoring and care. Clients do, however, report that the way HIV services are organized, often in a separate unit where everyone entering is suspected of being HIV positive, leaves them vulnerable to indirect disclosure of their status to the community. This fear of indirect disclosure remains a significant barrier to the uptake of HIV prevention, care and treatment services. In hospital units other than HIV units, stigma and discrimination remain a problem that negatively impact care and services, primarily because many workers have not yet received stigma reduction training.

Short to Medium Term

1) Maintain training content and activities because quality is high, but incorporate more follow-up activities and refresher training to enhance retention of material and implementation of activities.
   - Expand information and activities that focus on reducing stigma for clients who are sex workers or MSM.

- Whenever possible, expand training from two days to three days to allow more time for activities, discussion and questions.
- Include a follow-up half-day refresher session after one year to enhance retention of material.
- Ensure all employees, not only health providers, are included in the training based on content that is appropriate to their role in the facility.
- Ensure all new employees (including expatriate staff) receive the training.
- Ensure that planned quarterly follow-up meetings occur to monitor progress towards and problems encountered in implementation of action plans.
- Offer certificates or other forms of recognition to facilities and managers that achieve certain goals on their action plans.

2) Strengthen linkages between stigma reduction activities targeting health facilities and those targeting communities.

3) Prioritize the issues that MARPs identify as the primary obstacles to uptake of care for further HIV stigma reduction activities.
   - Recommend and/or liaise with the NACP to support where feasible physical structures that provide VCT and ART services to ensure client confidentiality and protect them from the risks of indirect disclosure.
   - Provide relevant updates to MARPs to address self-stigma related attitudes and actions during community-facility dialogue meetings.
   - Develop and conduct training sessions for PLHIV associations on stigma reduction towards FSW and MSM.

Medium to Long Term

4) In addition to "scaling up" stigma reduction activities within HIV service sites, begin creating sustainable structures for stigma reduction by also reaching out to pre-service training institutions.
   - Use the HIP HIV stigma reduction training as a model to develop a package for pre-service training for all nurses, doctors and health workers in Ghana.
   - Liaise with Ministry of Health, Nurses and Midwives Council, Medical and Dental Council, and the training institutions to implement pre-service HIV stigma reduction training for all doctors, nurses and health workers and/or integrate it with other HIV-related training that may be taking place or planned.
   - Coordinate with NACP and Ghana Health Services to incorporate knowledge of HIV care, including specific content on stigma, as a required component of promotion interviews.

6.0 APPENDICES

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Data Collection Tools:

a) Questionnaire for Health Workers
b) Questionnaire for Clients
c) Questionnaire for High Risk Groups
d) Oral Consent Form

Questionnaire for Health Workers

First obtain oral consent (see oral consent form).

Questions

1. Record worker's gender. M/F

2. How long have you been working at this health care facility?
   Years Months

3. Please tell about your work here at this facility. Which of the following best describes your job?

   Doctor focusing on HIV care
   General Practitioner
   Nurse
   Nurse assistant
   Midwife
   Pharmacist
   Counselor
   Receptionist
   Cashier
   Maintenance worker
   Other (specify) _____

4. Have you participated in any HIV stigma reduction training?
   Yes No (if no, continue to question 5)

   a. If yes, do you recall when the training was done?

   b. What are some of the topics that were covered at the training?

   c. Do you remember any of the activities in action plans developed at the training that were agreed to be done to reduce stigma and discrimination at your facility? Please mention as many as you can remember.

d. Which of these activities or actions have been done at your facility?

e. Which of the activities were not done and why?

5. Tell me if you agree or disagree with the following statements:

a. You are comfortable having HIV infected clients at this facility?

Totally Agree Somewhat agree Somewhat disagree Totally Disagree

b. You are comfortable touching a person who is HIV-positive?

Totally Agree Somewhat agree Somewhat disagree Totally Disagree

c. You are comfortable using the same washroom as people who have HIV?

Totally Agree Somewhat agree Somewhat disagree Totally Disagree

d. You do not fear touching the sweat of a person with HIV or AIDS?

Totally Agree Somewhat agree Somewhat disagree Totally Disagree

e. You do not fear drawing blood drawing the blood of a person living with HIV or AIDS?

Totally Agree Somewhat agree Somewhat disagree Totally Disagree

Not applicable

f. You do not fear helping or caring for a person living with HIV or AIDS?

Totally Agree Somewhat agree Somewhat disagree Totally Disagree

6. How would you describe the attitudes of the people who work at this facility to people living with HIV or AIDS?

7. Please tell us how you respond to the following statements:

a. The doctors at this facility are welcoming and friendly to clients living with HIV/AIDS.

Totally agree Somewhat agree Somewhat disagree Totally Disagree

Probe: If somewhat disagree or strongly disagree, please describe the situation.

b. The nurses at this facility are welcoming and friendly to clients living with HIV/AIDS.

Totally agree Somewhat agree Somewhat disagree Totally Disagree

Probe: If somewhat disagree or totally disagree, please describe the situation.

c. The pharmacists at this facility are welcoming and friendly to clients living with HIV/AIDS.

Totally agree Somewhat agree Somewhat disagree Totally Disagree

Probe: If somewhat disagree or totally disagree, please describe the situation.

d. The non-clinical staff (receptionist/records, cashier, security etc) at this facility are welcoming and friendly to clients living with HIV/AIDS.

Totally agree Somewhat agree Somewhat disagree Totally Disagree

If somewhat disagree or totally disagree, please describe the situation.

8. In the past 12 months, have you seen or observed the following happen in this health care facility because a client known or suspected of having HIV/AIDS:

a. was tested for HIV without their consent?
Yes No Not sure

b. experienced Health care providers gossiping about a client's HIV status?
Yes No Not sure

c. received less care/attention than other patients
Yes No Not sure

d. was refused care because of his/her status?
Yes No Not sure

e. experienced health workers using latex gloves even for noninvasive procedures such as taking blood pressure or weight?
Yes No Not sure

9. How do you think most people working in this clinic would answer the following questions?

a. People with HIV/AIDS should be ashamed of themselves?
Yes No

b. HIV is a punishment for bad behavior?
Yes No

c. People with HIV/AIDS are to blame for bringing disease to the community?
Yes No

d. It is mainly the women prostitutes who spread HIV in our community?
Yes No

10. Have you ever heard the word 'stigma'?
Yes No Not sure

11. Does stigma occur in [name of health facility]?
Yes No Not sure

Probe: If yes, Please give me some examples of stigma in [name of health facility]

12. Does stigma occur outside health facilities?
Yes No Not sure

Probe: If yes, please give me some examples of stigma outside health facilities.

13. If a person learns that he/she is HIV positive, but is not yet showing signs and symptoms of AIDS, should this remain a personal secret, a family secret, or should it be known to the community?
Probe: why?

14. Do you know anyone at this facility who has HIV but has yet to show the signs and symptoms of AIDS?
Yes No

15. How did you find out this person is infected with HIV?

The infected person told me her/himself
Family member of infected person told me
Community member told me
General gossip/rumors
From health care provider where the person tested
Read from his/her hospital file

16. Are you aware of any policies to protect people living with HIV/AIDS at your facility?
Yes No

17. Are these policies followed?

Yes No
Probe: if no, why not?

18. Please tell us any recommendations you might have to improve services for people living with HIV/AIDS at this facility.

19. What are your plans for the future?

Questionnaire for Clients

First obtain oral consent (see oral consent form).

Questions

1. Can you please tell me your age? [If not at least 18 years of age or over, please terminate the interview and thank the client.]

2. Record client's gender. M/F

3. How long have you been coming to this health care facility?

4. How often do you come here?

Less than once a month
Once a month
Once a week

5. Have services changed since you first started coming here?
Yes No Don't know (if no or don't know, go to b)

Are services better or worse than before?

Much Better Somewhat Better Somewhat worse Much worse

Probe: How are they better or worse? Why do you think they are better or worse?

6. Tell me if you agree or disagree with the following statements.

a. You used to be afraid that health care workers would treat me badly if they thought I had HIV.

Agree Disagree

b. Even now you are afraid that health care workers will treat you badly if they think you have HIV.

Agree Disagree

c. People in your community are afraid to go to clinics because they think health care workers will treat them badly if they have HIV.

Agree Disagree

7. Today what kind of care have you received or are you planning to receive at [name of health care facility]?

HIV counseling and testing	Yes/No
CD4 count	Yes/No
ART monitoring	Yes/No
Antenatal care	Yes/No
Delivery and childbirth	Yes/No
Postnatal care	Yes/No
Malaria treatment	Yes/No
Other (please specify) _____	

8. We are interested in your experiences at [name of health care facility]. Overall, how satisfied are you with the services and care you receive?

Very satisfied Somewhat satisfied Neutral Somewhat dissatisfied Very dissatisfied

Probe: Why?

9. How would you describe the attitudes of the people who work at [name of health care facility] to people like you?

10. Please tell us how you respond to the following statements:

a. The doctors at [name of health care facility] are welcoming and friendly to me.

Totally agree Somewhat agree Somewhat disagree Totally Disagree

Probe: If somewhat disagree or totally disagree, please describe the situation.

b. The nurses at [name of health care facility] are welcoming and friendly to me.

Totally agree Somewhat agree Somewhat disagree Totally Disagree

Probe: If somewhat disagree or totally disagree, please describe the situation.

c. The pharmacists at [name of health care facility] are welcoming and friendly to me.

Totally agree Somewhat agree Somewhat disagree Totally Disagree

Probe: If somewhat disagree or totally disagree, please describe the situation.

d. The non-clinical staff (receptionist/records, cashier/Security, etc) at [name of health care facility] are welcoming and friendly to me.

Totally agree Somewhat agree Somewhat disagree Totally Disagree

If somewhat disagree or totally disagree, please describe the situation.

11. In the past 12 months, have you seen or heard that the following happen in this health care facility because a client was known or suspected of having HIV/AIDS?

a. Testing a client for HIV without their consent
Yes No Not sure

b. Health providers gossiping about a client's HIV status
Yes No Not sure

c. A client receiving less care/attention than other patients because he/she was suspected of having HIV/AIDS?
Yes No Not sure

d. A client being refused care or driven away because he/she was suspected of being HIV positive?
Yes No Not sure

e. Health Workers wearing or using latex gloves even for noninvasive procedures such as taking blood pressure or weight?

Yes No Not sure

12. Do you think most people working in this clinic believe that:

a. People with HIV/AIDS should be ashamed of themselves?

Yes No

b. HIV is a punishment for bad behavior?

Yes No

c. People with HIV/AIDS are to blame for bringing disease to the community?

Yes No

d. It is mainly women prostitutes who spread HIV in our community?

Yes No

13. Have you ever heard the word 'stigma'?

Yes No Not sure

14. Does stigma occur in [name of health facility]?

Yes No Not sure

Probe: If yes, Please give me some examples of stigma in [name of health facility]

15. Does stigma occur outside health facilities?

Yes No Not sure

Probe: If yes, please give me some examples of stigma outside health facilities.

16. If one of your friends or family members thought that she or he had HIV/AIDS, would you recommend that he/she comes to this facility for care?

Yes No Not sure

Probe: Why or why not?

17. Please tell us any recommendations you might have to improve services at [name of health facility].

18. Please tell us any plans you might have for the future.

Semi-Structured Interview Guide for Key Informants
(Questionnaire for High Risk Groups)

First obtain oral consent (see oral consent form).

Questions

1. Can you please tell me your age? [If not at least 18 years of age or over, please terminate the interview and thank the client.]

2. Record client's gender. M/F

3. Can you please tell me which organization your represent? Tell me a bit about the organization (number of members, years in operation, etc.)

4. Can you tell me about some of the activities that your organization does or have with the (name of) health facility?

5. We are interested in your members' experiences at health care facilities. Can you tell me whether you think most of your organizations' members would agree or disagree with the following statements:

a. People used to be afraid that health care workers would treat them badly if they thought one had HIV.

Totally Agree Somewhat Agree Somewhat disagree Totally Disagree

b. Most of the members of your organization say that people in their communities are afraid to go to clinics because they think health care workers will treat them badly if they have HIV.

Totally Agree Somewhat Agree Somewhat disagree Totally Disagree

c. Most of the members of your organization are afraid that health care workers will treat them badly if they think that they (members) have HIV.

Totally Agree Somewhat Agree Somewhat disagree Totally Disagree

6. Are most of the members of your organization willing to be tested for HIV?
   a. Yes No Don't Know.

   b. If not, why not?

7. Do most of your members obtain their health care from (name of) facility?

a. Yes No

b. If yes, Why there?

c. If no, where else do they go?

d. Why do they go there?

8. How would you describe the attitudes of the people who work at [name of health care facility] to the members of your organization?

9. In the past 12 months, have you or your members seen, observed or heard about any of the following happen in this health care facility?

a. A client being tested for HIV without their consent?

Yes No Not sure

b. Health providers gossiping about a client's HIV status?

Yes No Not sure

c. Someone receiving less care/attention than other patients because he/she was suspected to be HIV positive?

Yes No Not sure

d. Someone receiving less care/attention than other patients because he/she was suspected to be a sex worker?

Yes No Not sure

e. Someone being refused care or driven away because of suspicion that he/she was HIV positive?

Yes No Not sure

f. Someone being refused care or driven away because of suspicion that he/she was suspected to be an MSM (Men who have sex with other men)?

Yes No Not sure

g. Health worker using/wearing latex gloves even for noninvasive procedures such as taking blood pressure or weight?

Yes No Not sure

10. Have you ever heard the word 'stigma'?

Yes No Not sure

11. Does stigma occur in [name of health facility]?

Yes No Not sure

Probe: If yes, Please give me some examples of stigma in [name of health facility]. Do you know when this occurred?

12. Does stigma occur outside health facilities?

Yes No Not sure

Probe: If yes, please give me some examples of stigma outside health facilities. When did this occur?

13. If one of your friends or family members thought that she or he had HIV/AIDS, what health care facility would you recommend and why?

14. Please tell us any recommendations you might have to improve services for your members at health care facilities.

Oral Informed Consent for Surveys/Interviews[3]

[Text in brackets and italics needs to be inserted based on the specifics of the study.]

Title of study: **Rapid Appraisal of health facility HIV related Stigma and Discrimination Reduction Intervention**

Principal Investigator: Laura McGough_____

This interview is for a study that is being done by Engender Health.

This study will gather information on how to improve health services for people seeking HIV services.

The interview will include questions on health workers' attitudes towards people living HIV/AIDS. It will take most people about 45 minutes to answer the questions.

The names of people who agree to participate will not be recorded without their permission.

Your participation is voluntary and there is no penalty for refusing to take part. If you do not take part, it will not affect any health care that you would normally receive. You may refuse to answer any question in the interview or stop the interview at any time.

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this study have been explained to the volunteer.

_____ _____

Signature of Person Obtaining Consent Date

[3] Adapted from Family Health International.

Schedule for Site Visits for Stigma Evaluation Study

Tema General

Thursday Nov. 27 (clinic day)
Friday Nov. 28 (health care workers)

Obuasi Government

Sunday Nov. 30 Travel to Kumasi and overnight in Kumasi
Monday Dec. 1 (clinic day) (stay in Kumasi)
Tuesday Dec. 2 (clinic day) (travel to Koforidua by mid-afternoon and overnight in Koforidua)

Koforidua

Wednesday Dec. 3 (clinic day) (overnight in Koforidua)
Thursday Dec. 4 (health care workers) (return to Accra and overnight in Accra)

Friday Dec. 5 National holiday (Farmer's Day)
Monday Dec. 8 National holiday

Korle Bu

Tuesday Dec. 9 (health care workers)
Wednesday Dec. 10 (clinic day)

Effia Nkwanta (Takoradi)

Wednesday Dec. 10 (travel to Takoradi in late afternoon and overnight in Takoradi)
Thursday Dec. 11 (clinic day) (overnight in Takoradi)
Friday Dec. 12 (finish interviews morning and travel to Accra)

Tamale

Thursday Dec. 18 (morning flight 6 am plus health worker interviews) (overnight in Tamale)
Friday Dec. 19 (clinic day) (overnight in Tamale)
Return flight to Accra on Saturday morning Dec. 20

Health Care Facilities with COPE Action Plans

1. Bolgatanga Regional Hospital
2. Donkorkrom Presby Hospital
3. Effia Nkwanta Regional Hospital
4. Koforidua Regional Hospital
5. Korle-Bu Teaching Hospital
6. Kumasi South Hospital
7. Nkwanta District Hospital
8. Obuasi Government Hospital
9. Police Hospital
10. Regional Hospital-Wa
11. Ridge Regional Hospital
12. St Francis Xavier
13. Sunyani Regional Hospital
14. Tamale Teaching Hospital
15. Tarkwa Government Hospital
16. Tema General Hospital

Problem Statements Related to Stigma and Discrimination Prior to Implementation of the Action Plans

Staff Attitudes and Need for Training

- Poor staff attitude towards clients.
- There is no in-service training activity on HIV related stigma and clients rights.
- There is a lack of knowledge among all staff on stigma and discrimination related to HIV and AIDS and infection prevention.

Facility-based Policies and Services

- The physical design, location and signage of counseling and testing (CT) units increase clients' fear of stigma due to entering these buildings.
- No formal policy by the facility forbidding discrimination against all clients including PLHIV.
- No effort had been made by the facility to reduce HIV and AIDS-related stigma and discrimination internally and in the community.

Discrimination

- It is difficult for MARGs (sex workers, MSM) to access ART.
- HIV+ clients are isolated without any good cause.
- Clients are afraid to come for HIV counseling and testing.
- The use of different cards for HIV+ clients stigmatizes them.

Family planning services are not available to HIV clients including those on ARVs.