

Perceived Stigmatization and Discrimination by Health Care Providers toward Persons with HIV/AIDS

Miz-Hasab Research Center,
Addis Ababa, Ethiopia
in collaboration with
IntraHealth International, Ethiopia, Addis Ababa

Research Team:

Miz-Hasab Research Center: Hailom Banteyerga, Principal Investigator; Aklilu Kidanu, Research Coordinator; Frehiwet Abebe, Researcher; Martha Alemayehu, Researcher; Beiza Fiseha, Researcher; Asham Asazenew, Researcher

IntraHealth: Cristina Ruden, Yetnayet Asfaw, and Abebe Shibru



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INTERNATIONAL INC
Affiliate, University of North Carolina at Chapel Hill

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
FGM	Female Genital Mutilation
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
IEC/BCC	Information, Education Communications/Behavior Change Communications
MOH	Ministry of Health
NGO	Nongovernmental Organization
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
RVI	Retro Viral Infection
SPSS	Statistical Package for Social Sciences
STI	Sexually Transmitted Infection
TB	Tuberculosis Basils
TV	Television
UNDP	United Nations Development Program
VCT	Voluntary Counseling and Testing

Executive Summary

Background and Study Aims

The Acquired Immune Deficiency Syndrome (AIDS) pandemic in Ethiopia is rapidly eroding the progress that the government has made in education, health care, and economic development. As of 2004, the adult Human Immunodeficiency Virus (HIV) prevalence rate in urban areas was estimated at 12.6 percent, with a lower prevalence rate (2.6%) in rural areas. Many socioeconomic factors contribute to the spread of HIV in Ethiopia, including widespread poverty, high unemployment, and limited health care coverage.

The spread of HIV/AIDS is endangering Ethiopia's already precarious health care system. Providers find it difficult to deliver services to patients in poorly equipped and understaffed health facilities. In addition, stigmatization and discrimination directed by health care providers toward individuals with actual and perceived HIV infection are major barriers in prevention and treatment. Although HIV/AIDS-related stigmatization reportedly occurs in a variety of social settings, stigmatizing attitudes and behaviors appear to be particularly entrenched in the health care environment. For persons living with HIV/AIDS, stigmatization and discrimination may increase social isolation and worsen health care access barriers. Provider stigma may also discourage individuals from getting tested for HIV, thereby limiting the scope and effectiveness of prevention efforts.

To date, empirical research on health care providers' perceptions of HIV/AIDS patients and their care has been limited. IntraHealth, an international nongovernmental organization (NGO) working in the health sector in Ethiopia, recognized that formative research on provider attitudes about people living with HIV/AIDS (PLWHA) is a prerequisite to designing interventions to lessen stigma. IntraHealth subcontracted the Miz-Hasab Research Center to conduct a study exploring provider perceptions of HIV/AIDS stigmatization and discrimination. The primary aims of the study were to consider perceived types and causes of stigmatization, and develop recommendations for intervention and advocacy activities that address HIV/AIDS stigmatization and discrimination in health care settings.

Methods

The study included 12 public sector health facilities participating in the Hareg Project, a program funded by the United States Government to scale up Prevention of Mother-to-Child Transmission (PMTCT) services. We included one hospital and one health center in each of six regions: Addis Ababa, Oromia, Amhara, Tigray, Beni Shangul-Gumuz and Somali state.

We used qualitative and quantitative methods to assess perceived stigmatization. Data for the study included: (1) in-depth key informant interviews with medical

professionals (doctors, nurses, health assistants, laboratory technicians) and nonmedical staff (guards and front office personnel) working in the 12 facilities; (2) focus group discussions (one per facility) to further explore provider attitudes and perceptions; (3) in-depth interviews with a small number of clients at Voluntary Counseling and Testing (VCT) and PMTCT clinics; (4) structured provider surveys to supplement the data generated by the interviews and focus group discussions; and (5) structured facility surveys (one per facility) to obtain information about HIV/AIDS caseloads and facility infrastructure.

Results

Participants

For the provider component of the study, we interviewed 105 key informants (71 medical informants and 34 nonmedical staff informants), capturing additional information from 85 providers in the focus group discussions and 170 providers in the structured surveys. For the client component, 105 clients agreed to be interviewed. Most providers who participated in the survey were nurses (44%), followed by health assistants (15%), physicians (11%), laboratory technicians (11%), junior nurses (10%) and medical assistants (5%).

Caseload

The health facility surveys indicate that all 12 facilities are handling a significant number of HIV-related cases. The six hospitals participating in the study reported that roughly half of their beds were occupied by persons with HIV or AIDS.

Perceived Types of Stigmatization and Discrimination

Providers and clients described a variety of ways in which health care providers are perceived to react to and stigmatize persons living with HIV/AIDS (and patients suspected of having HIV). These include charting and labeling, gossip, verbal harassment, avoidance and isolation, and referrals for testing.

Charting and labeling: Providers in all 12 facilities reported writing “RVI” (retroviral infection) in patients’ medical records as a reminder to take precautions when treating patients with diagnosed or suspected HIV infection. Informants also described various nonclinical terms used to refer to individuals with HIV/AIDS. Many clients reported being aware of these categorizations, suggesting that the labels made them uncomfortable and sometimes dissuaded them from seeking further services.

Gossip: Medical informants described gossip as a way for providers to notify each other of a patient’s serostatus but admitted that gossip could extend to

anyone with clinical symptoms similar to those seen in AIDS patients. Nonmedical staff reported that it was easy for them to gossip because of their access to medical information. Facility personnel agreed that it was difficult to maintain confidentiality, and some clients complained that lack of confidentiality had discouraged them from returning for care.

Verbal harassment: Some clients with HIV infections described encounters with VCT counselors who had harassed rather than counseled them. VCT clients also recounted negative experiences giving blood in the laboratory.

Avoidance and isolation: Many health care providers reported that they would prefer not to work in VCT and PMTCT or to provide services to PLWHA and AIDS patients. Some providers argued in favor of isolating patients with HIV infections on separate wards and/or in separate facilities. Although most providers admitted fearing for their own safety, some professionals told stories about HIV/AIDS patients who had not received needed care. Clients living with HIV/AIDS stated that they were aware of health care providers' fears, particularly if the clinical encounter involved bleeding.

Referrals for testing: Providers reported referring clients with symptoms such as continuous diarrhea, coughing, fever or opportunistic infections to VCT without offering any counseling. Providers acknowledged that assuming an individual to be HIV-positive on the basis of general symptoms could be stigmatizing; however, they reported that in many cases it was impossible not to harbor suspicions. Providers noted that the practice of referring individuals with possible HIV infection to VCT sometimes traumatized unsuspecting clients.

Perceived Causes of Stigmatization and Discrimination

Study participants discussed a number of attitudes, beliefs and structural factors that they viewed as contributing to stigmatizing attitudes and behaviors. These included attitudes and beliefs about PLWHA, beliefs about transmission, working conditions, perceived risk of workplace infection, lack of training and refresher courses, the client-provider relationship, inability to address clients' needs, and lack of professional satisfaction.

Attitudes and beliefs about PLWHA: Some providers described individuals infected with HIV as "immoral," "irresponsible," and addicted to drugs or alcohol. Informants suggested that adulterous and promiscuous people, female sex workers, and unemployed youth were the groups most vulnerable to HIV/AIDS. More than a third of survey respondents described PLWHA as "different" (38%)

or “irresponsible” (35%), almost half blamed PLWHA for being infected and one-fifth indicated that PLWHA deserved to be infected.

Beliefs about transmission: Health providers’ incomplete knowledge about HIV/AIDS transmission contributed to their reported discomfort in treating individuals with HIV infection. Even experienced providers reported fearing that HIV/AIDS could be transmitted through casual contact, through ordinary body fluids such as sweat or by eating food handled by PLWHA. Some clinicians questioned the reliability of the scientific consensus regarding modes of transmission.

Working conditions: Hospitals and health centers were described as understaffed, ill-equipped, overcrowded and poorly maintained. Study participants suggested that HIV/AIDS had made the health care environment even more unbearable. Providers complained of poor salaries, lack of supervision, lack of basic supplies such as gloves, and burnout. The introduction of VCT and PMTCT services has further increased workloads and exacerbated dissatisfaction. Approximately three-quarters of survey respondents perceived the lack of medical supplies, equipment and other resources as significant problems affecting the quality of services provided to PLWHA. Almost all of the health workers we interviewed reported wanting a different job.

Perceived risk of workplace infection: Most (81%) of the providers participating in our survey agreed that their jobs placed them at risk for HIV infection, while key informants and focus group participants described the general climate of fear that appears to pervade health facilities. Providers linked their fear of workplace infection, in turn, to stigmatization of PLWHA. To avoid infection, some providers reported wearing two pairs of gloves but noted that patients sometimes were offended by the elaborate precautions.

Lack of training: Some counselors indicated that they lacked adequate training and felt unable to give satisfactory answers to their clients. Informants reported frustration at clients’ superior access to current information. Others complained that administrative staff was more likely to receive training than personnel working directly with patients. Only one-fourth of survey respondents reported receiving training on HIV/AIDS counseling and testing during the past year.

Client-provider relationship: Medical informants admitted perceiving clients with HIV/AIDS as “overly demanding” and “easily dissatisfied.” Some counselors reported being physically threatened by clients whose test results had identified HIV infection. According to staff and providers, patient-initiated conflicts with providers are not infrequent.

Inability to address clients' needs: Informants suggested that the complex problems presented by AIDS patients causes providers to feel a sense of helplessness about providing care; these perceptions of powerlessness, in turn, can provoke a backlash that leads providers to stigmatize clients. Providers reported frustration at seeing clients who would benefit from Antiretroviral Therapy (ART) but are unable to afford it. Providers also noted that many PLWHA require but cannot afford extra nutritional support.

Lack of professional satisfaction: A number of providers reported that it was professionally unrewarding to treat AIDS patients. Describing efforts to help AIDS patients as “hopeless,” some providers suggested that scarce hospital beds should be reserved for patients with curable conditions.

Summary and Recommendations

Our findings highlight a number of attitudes and beliefs about HIV/AIDS and persons living with HIV/AIDS that are perceived to contribute to provider stigmatization and discrimination. Our study also indicates that working conditions in health facilities shape provider attitudes and behavior and contribute to stigmatization by fostering a strong sense of workplace insecurity. Deficiencies within the health care system that were perceived to increase infection risks include inappropriate infrastructure, supply shortages, staff shortages and lack of training. Our results further suggest that provider stigmatization and discrimination toward persons with HIV and AIDS may have a considerable impact on Ethiopia's public sector health services. Consequences identified by study participants include effects on clients' screening and treatment decisions, on client-provider interactions, on health facilities' ability to offer quality services and health workers' decision making regarding their profession.

Because working conditions were blamed for much of the perceived stigmatization and discrimination against PLWHA, providers requested sweeping improvements to ensure the supply of medical commodities and equipment and enhance their safety. Health workers also requested better compensation (including life insurance), improved staffing ratios and more training to address the misconceptions that lead to stigmatization. Study participants noted the need to work closely with families, community organizations and NGOs to lessen stigma, control the spread of HIV infection and provide care and treatment.

To address the problem of stigmatization and its impact on HIV/AIDS prevention and treatment, we offer two sets of recommendations. Our short-term recommendations focus on performance improvement training; strengthening collaboration between health care providers, families, communities and NGOs;

ensuring access to medication for clients and providers; ensuring access to nutritional support; and mobilizing leadership. However, it is clear that little progress can be made in addressing HIV/AIDS in the absence of efforts to improve underlying social and structural conditions in Ethiopia. Thus, interventions must be designed with the awareness that HIV/AIDS is very much linked to poverty. In addition, a new vision of health care must emerge that enables Ethiopia's health care system to address HIV/AIDS in its broader social context. The occurrence of stigmatization and discrimination in the health care system will not diminish until communities and health facilities undergo a profound social and structural transformation.

1. Introduction

The AIDS pandemic in Ethiopia is swiftly eroding the progress that the government has made in the areas of education, access to health care and economic development. Figures from 2004 estimate the adult prevalence rate at 4.4 percent, with huge urban and rural disparities: 12.6 and 2.6 percent, respectively. In 2004, there were 244,384 new HIV infections reported, 132,000 new cases, 124,178 AIDS-related deaths and cumulatively over 600,000 children orphaned as a result of AIDS (Ministry of Health, AIDS in Ethiopia [5th ed.]).

Various socioeconomic factors contribute to the spread of HIV. The average per capita annual income is US\$100, unemployment is high and health care coverage is low. The country has been ravaged by war and famine, resulting in massive population displacement and poverty. Cultural norms also influence sexual practices and play a role in patterns of HIV transmission. Studies by Ethiopia's National AIDS Council (2001) show that over 90% of HIV infections are the result of unprotected sex with multiple partners. It is not uncommon for Ethiopian men to have sexual relations with multiple partners while denying women the right to negotiate safer sex or to insist on monogamy (United Nations Development Program (UNDP) & Miz-Hasab Research Center, 2004). Cultural practices related to female genital mutilation (FGM), circumcision and body cutting further exacerbate the spread of HIV, as does the use of unsterilized medical equipment.

The rapid spread of HIV/AIDS is endangering Ethiopia's already precarious health care system. Providers find it difficult to deliver services to patients in poorly equipped and understaffed health facilities. The shortage of protective gear, disposable syringes and other infection control tools prevents health care providers from fully implementing universal precautions. In addition, stigmatization and discrimination directed by health care providers toward individuals with actual and perceived HIV infection are major hurdles in the fight against HIV/AIDS. Although Ethiopian researchers have found that HIV/AIDS-related stigmatization and discrimination occur in families, communities and a variety of social institutions, stigma appears to be particularly entrenched in health care settings (Hailom et al., 2003).

Health care providers' attitudes and behaviors toward persons living with HIV/AIDS (PLWHA) are shaped, at least in part, by cultural norms about sexual behavior and sexual risk and by broadly held beliefs about HIV and other sexually transmitted infections (Nyblade et al., 2003). Many health care providers continue to fear casual transmission of HIV, and numerous HIV/AIDS patients report experiencing stigma (Hailom et al., 2003). Even among the most experienced clinicians, the fear of contagion remains a serious problem and, in turn, is a major source of HIV/AIDS stigmatization.

For persons living with HIV/AIDS, stigmatization and discrimination may increase feelings of social isolation and depression, or worsen health care access barriers. Health providers' stigmatizing attitudes may also discourage individuals from getting tested for HIV, thereby reducing their chances of getting the care they need and limiting the scope and effectiveness of prevention efforts. Moreover, health care professionals may be insensitive to patients' concerns about stigmatization or may fail to adequately protect patient confidentiality.

As the number of Ethiopians living with HIV/AIDS grows, access to health care and treatment are becoming increasingly central to disease prevention efforts. Although stigmatization and discrimination are recognized as barriers in addressing HIV/AIDS, empirical research on health care providers' perceptions about HIV/AIDS patients and their care has been limited. This study explores health care providers' attitudes about HIV/AIDS-related stigmatization and discrimination. We consider provider perceptions regarding types and causes of health care stigmatization, as well as the perceptions of clients and discuss strategies to counteract the problem of stigmatization.

2. Methods

2.1 Literature Review

HIV-related stigmatization refers to all unfavorable attitudes, beliefs and policies directed toward people perceived to have HIV/AIDS, as well as toward the significant others, loved ones, close associates, social groups and communities associated with infected individuals (Herek et al., 1999). Goffman (1963) focuses on public attitudes toward persons who possess an attribute that falls short of societal expectations. In the presence of stigmatization, the person with the attribute is “reduced in our minds from a whole and usual person to a tainted, discounted one” (Ibid., p. 3).

Herek and colleagues (1999) elaborated on Goffman’s work, describing three categories of stigmatization that are relevant to HIV/AIDS:

- **Abominations of the body** (e.g., the physical disfigurement sometimes caused by AIDS).
- **Blemishes of individual character** (e.g., the “high-risk” label attached to sex workers, drug addicts, alcoholics and the sexually promiscuous).
- **Tribal stigma regarding race, nation and religion** (e.g., blaming foreigners, Christians, Amharas, etc. for spreading HIV/AIDS).

In addition, Herek and colleagues (1999) have suggested that HIV-related stigmatization may be *instrumental* (reflecting the fear and apprehension that are often associated with deadly and transmissible illnesses), *symbolic* (expressing attitudes toward the social groups or “lifestyles” associated with the disease), or *courtesy* (stigmatizing people associated with HIV/AIDS issues or HIV-infected people). All three types of HIV/AIDS stigmatization and discrimination can reinforce existing social prejudices and worsen community relations. HIV-positive individuals, their loved ones and even their caregivers may be rejected within their social circles and communities, subjected to violence or forced out of their homes or jobs (Herek et al., 1999).

HIV/AIDS shares a number of attributes with other opportunistic infections that have been found to cause a high degree of stigmatization. First, the person with the disease is held responsible for being ill. In the case of HIV, infected individuals are blamed for acting irresponsibly by failing to take steps to avoid infection. Second, the disease is progressive and incurable, as with HIV, which may progress slowly or quickly but ultimately is fatal. Third, the public holds a variety of views about the disease’s origins and modes of transmission. Where HIV is concerned, transmission continues to be poorly understood even by experienced health professionals. Finally, the disease’s symptoms cannot be concealed when opportunistic and clinical symptoms emerge. Although

individuals with asymptomatic HIV may be able to hide their infection temporarily, the onset of HIV-related illness is generally obvious and may be disruptive to social interactions (Herek et al., 1999).

Hailom and colleagues (2003) note that health care providers may be particularly likely to discriminate against PLWHA because they not only share stigmatizing community attitudes and norms but may also believe that working with HIV/AIDS puts them personally at risk. One small-scale Ethiopian study (Bebratu, 2000) that explored the attitudes and behaviors of physicians and nurses toward PLWHA found that more than four-fifths of physicians (85%) and nurses (83%) reported fearing that they were at risk of HIV infection because of their work. In addition, 62% of physicians and 43% of nurses reported being uncomfortable taking blood from PLWHA, and 70% of physicians and 43% of nurses reported discomfort assisting in surgery. The study also revealed a minimal use of universal precautions in the obstetrics (13.2%) and surgery (9%) departments, although reported use of precautions was high (83%) in labor and delivery. Half of physicians and nurses participating in the study reported fearing contagion despite their use of universal precautions.

2.2 Study Background

IntraHealth is an international NGO working in the health sector in Ethiopia. Recognizing that HIV/AIDS stigmatization and discrimination on the part of health providers are hindering care and support services for PLWHA and undermining efforts to curtail the spread of HIV, IntraHealth has acknowledged the importance of understanding providers' perceptions. Formative research on provider attitudes about persons with HIV/AIDS is a prerequisite to designing interventions to lessen health care provider stigma.

With this in mind, IntraHealth subcontracted the Miz-Hasab Research Center to conduct a study on health care provider perceptions of HIV/AIDS stigmatization and discrimination in 12 health facilities participating in the Hareg Project. The Hareg Project, a program funded by the United States government to scale up Prevention of Mother-to-Child Transmission (PMTCT) services, is a subcomponent of the US-funded Ethiopian Emergency AIDS Plan. The Hareg Project was designed to contribute to the national effort to reduce mother-to-child transmission of HIV. IntraHealth supports this goal by improving access to and use of PMTCT, counseling and testing services; strengthening maternal and child health services at the health facility level; enhancing community capacity; and alleviating stigma and discriminatory practices.

2.3 Goals and Objectives

The general aim of our study was to document and understand health care providers' perceptions of HIV/AIDS-related stigmatization and discrimination. Our specific objectives were the following:

- Document providers' perceptions regarding types of health care stigma;
- Explore providers' perceptions regarding the causes of health provider stigma; and
- Develop recommendations for intervention and advocacy activities that address HIV/AIDS stigmatization and discrimination in health care settings.

2.4 Research Design and Data Collection

The study included one hospital and one health center in each of six regions: Addis Ababa, Oromia, Amhara, Tigray, Beni Shangul-Gumuz and Somali state. The hospitals and health centers are listed in [Annex 1](#). All facilities included in the study were government owned.

We used both qualitative and quantitative methods to assess perceived stigmatization from a variety of perspectives. Study methods included: in-depth interviews (to obtain qualitative and some quantitative information from key informants with specific characteristics); focus group discussions (which targeted groups with similar backgrounds or characteristics and allowed exploration into participants' attitudes and perceptions); and structured surveys, which provided additional quantitative data. All participants provided verbal consent to participate in the study.

We conducted in-depth key informant interviews with medical and nonmedical informants working in the 12 selected health facilities. A total of 105 key informants were interviewed, including 71 medical informants (doctors, nurses, health assistants and laboratory technicians) ([Annex 2](#)) and 34 nonmedical staff informants ([Annex 3](#)). In selecting interview participants, we focused on staff and professionals working in wards and services where they were likely to have regular contact with PLWHA. Working in consultation with facility directors and matrons, we selected heads of facilities, department heads (especially those directing HIV/AIDS-related counseling and prevention services, and medical and surgical wards), heads of nursing and laboratory sections, and senior nurses and health assistants. Nonmedical informants included guards and personnel working at the card and registrar sections of a facility. The interviews lasted from one to two hours.

Although we primarily sought to understand providers' perceptions of stigmatization and discriminatory practices, we also conducted in-depth interviews with clients, which allowed us to gain some insight into how clients perceive provider stigma and to check client views against those expressed by providers. We interviewed 105 clients randomly selected at voluntary counseling and testing (VCT) and prevention of mother-to-child transmission (PMTCT) clinics ([Annex 4](#)) who were willing to participate in the study. Many of the clients we approached were reluctant to be interviewed.

One focus group discussion was conducted in each facility with medical directors, heads of departments, nurses, health assistants and laboratory technicians ([Annex 5](#)). A total of 85 providers participated in the 12 discussions, with an average of six to eight participants per group. The focus group discussions lasted from two to three hours.

Finally, to supplement the qualitative data we administered two types of structured surveys. Twelve facility surveys (one per facility) were completed by the facility managers ([Annex 6](#)). We also administered 170 structured provider interviews lasting 30 to 40 minutes ([Annex 7](#)). The survey respondents were proportionally selected according to the size of the health facility. The sample ranged from 7 to 25 respondents per facility, with referral hospitals having the most and health centers having the fewest respondents.

During a one-month preparatory phase, we developed and pilot tested the interview guides and survey instruments to ensure that they were easy to administer, consistent, and relevant. Six experienced researchers from the Miz-Hasab Research Center collected all data over a 40-day period. The principal investigator conducted most of the key informant interviews and facilitated the focus group discussions. The research team held daily briefings to review the data collection process.

Both the qualitative and quantitative data collection procedures addressed the following general topics:

- The knowledge base of health providers regarding communicable diseases in general, and Sexually Transmitted Infections (STIs) and HIV/AIDS in particular;
- The courses of action available to health providers when treating HIV/AIDS patients;
- The major source of fears and facility constraints that providers face when dealing with HIV/AIDS patients;
- What it means to treat HIV/AIDS clients;

- The resource gaps that providers face when addressing the needs of HIV/AIDS clients;
- What the identified resource gaps mean with regards to providers' ability to offer services; and
- Providers' work experiences and the prevailing conditions in health facilities.

2.5 Data Analysis

Data from the key informant interviews were captured through notes taken during the interviews. The focus group discussions were tape-recorded while a note-taker recorded additional information. The focus group discussions were transcribed verbatim, and the focus group transcripts and notes from the in-depth interviews were translated from Amharic into English. Next, we read the notes and transcripts and developed coding categories for perceived types and causes of health provider stigmatization and discrimination toward HIV/AIDS patients, while also coding comments about strategies to lessen health provider stigma. We used NUDIST 4 software to code the transcripts and generate reports of coded text segments. As we coded the data and discovered crosscutting themes, some coding categories were modified.

We used Statistical Package for Social Sciences (SPSS) software to analyze the survey data. The quantitative data are presented primarily in graphical form in this report.

Analysis and report-writing were carried out over a one-month period.

3. Results

3.1 Study Participants

One-fourth (27%) of the health workers who participated in the structured provider interviews had worked in the health care profession for over ten years and half of participants had worked in health care for less than five years. Most survey respondents were nurses (44%), followed by health assistants (15%), physicians (11%), laboratory technicians (11%), junior nurses (10%) and medical assistants (5%). Almost all survey respondents (97%) reported being permanent employees of the facility.

No sociodemographic information was collected in the key informant interviews with providers, staff, or clients.

3.2 HIV/AIDS-Related Caseload

The results of the health facility surveys indicate that all 12 facilities are handling a significant number of HIV-related cases. Although the statistics obtained from the facilities were incomplete and do not represent the health care system as a whole, they suggest that the burden posed by HIV in the country is substantial (Table 1).

Table 1 Percent of selected hospital and health center patients testing positive for HIV

Health Facility (Dates)	Client Population	Number and Percent Testing Positive
Adama Hospital (2003-2004)	VCT clients (including pregnant women)	31% (588 of 1869 tested)
Assosa Hospital (2003)	Hospital-wide	~15%
Assosa Hospital (2003)	VCT clients	18% (128 of 692 tested)
Axum Hospital (2003)	VCT clients	19% (215 of 1109 tested)
Axum Hospital (study period)	VCT clients	17% (128 of 751 tested)
Axum Hospital (study period)	“Suspected victims”	(90%) (9 of 10)
Axum Hospital	Tuberculosis Basils (TB) cases	~50%
Bahr Dar Felege Hiwet Referral Hospital (2004)	VCT clients	31% (328 of 1075 tested)
Tecele Haimanot Health Center, Addis Ababa (as of April 2004)	HIV testing (non-PMTCT)	19% (18 of 93 tested)
Tecele Haimanot Health Center, Addis Ababa (as of April 2004)	HIV testing (pregnant women)	14% (19 of 133 tested)
Zewditu Hospital, Addis Ababa	VCT clients (including pregnant women)	30%
Zewditu Hospital, Addis Ababa	TB & VCT services	17%

All six hospitals participating in the study reported that roughly half of their inpatient beds were occupied by persons living with HIV/AIDS (Table 2). The Axum, Adama, Karamara and Zewditu Hospitals also reported that 60% to 70% of TB patients were HIV-positive, as were most malaria patients in Asossa Hospital.

Table 2 Estimated percentage of hospital inpatients with HIV/AIDS

Hospital	Inpatients with HIV/AIDS (%)
Adama Hospital	50%
Asossa Hospital	40%
Axum Hospital	60%
Bahr Dar Felege Hiwet Hospital	60%
Karamara Hospital	60%
Zewditu Hospital (medical ward)	60%

3.3 Perceived Types of Stigmatization and Discrimination

In our key informant interviews and focus group discussions, both providers and clients described a variety of ways in which health care providers are perceived to react to and stigmatize PLWHA and patients who are suspected of having HIV. These include charting and labeling, gossip, verbal harassment, avoidance and isolation, and referrals for testing.

3.3.1 Charting and Labeling

All 12 health facilities use the label of RVI (retroviral infection) in the patients' medical records to flag AIDS patients and those suspected of HIV infection. Health care providers reported using the RVI notation as a reminder to take precautionary infection control measures while providing services to the client. As one provider noted,

We suspect people to be HIV cases on a clinical basis: loss of weight, continuous diarrhea, etc. If a doctor suspects that a patient has AIDS, he notes on his card, "RVI"; we then take care of ourselves when we treat such a patient. When such clients prove to be AIDS-infected, we advise them to leave the hospital and get support from Mission Charity, an NGO operating in the town. (Jijiga Hospital, key informant, medical, female)

Some clients who had not previously suspected HIV infection and who had not received any counseling reported learning about their infection status by observing providers' reactions to the RVI label in their chart. According to one physician, clients would prefer that health providers not record specific remarks on their medical cards.

Clients ask us to avoid the special code and remarks we write on their card. There are clients who ask us if they can take their cards home after getting services. They do not want people to read the details we write about their illness on the cards. (Bahir Dar Felege Hiwet Hospital, key informant, medical, male)

In addition to the RVI label, informants described nonclinical terms used to identify individuals with HIV/AIDS. In one health center, for example, a key informant noted that TB patients suspected of being HIV-positive were referred to as *TB with a deck* (Addis Ababa Health Center, medical, female). In another facility, a staff member reported that people with HIV/AIDS were called *Tesfa Goh*, the name of a local association of PLWHA (Adama Hospital, key informant, nonmedical, male). An informant in a third facility noted that providers used the names of opportunistic infections and symptoms such as *Almaz Balechera* (herpes zoster) to designate HIV/AIDS patients (Axum, Wukro Health Center, medical, female). Most clients reported being aware of these categorizations and suggested that the labels made them uncomfortable. One male client observed, “If somebody loses weight and comes for an injection, they show him their disgust” (Adama Health Center). Clients suggested that these reactions sometimes discouraged them from seeking further health services or continuing with their medications.

3.3.2 Gossip

Health providers admitted to gossiping about suspected and confirmed HIV/AIDS-infected individuals, openly discussing anyone with clinical symptoms similar to those seen in AIDS patients. Providers also agreed that it was difficult to maintain confidentiality, particularly because community members and other patients clearly recognize the clinical symptoms of HIV/AIDS. Medical informants described gossip as a way for providers to notify each other of a patient’s serostatus. Nonmedical staff acknowledged that it was easy for them to gossip because of their access to medical information.

Clients reported hearing and seeing staff and other patients gossiping and communicating nonverbally about suspected HIV/AIDS cases. Some clients complained that lack of confidentiality regarding their serostatus had discouraged them from returning to a health facility for medical advice. A male client at the Assosa VCT stated, “One way or the other the result of a test will become known to others. *Wef ende ageru yechoha!* [It is said that a bird shouts according to its locality, which means there is nothing secret.]”

Health providers noted that gossip sometimes centered on whether a fellow provider or staff member might be RVI. A provider reported,

I have a friend who is a health provider and serves on night duty with me. Some of our colleagues who suspect her to be HIV-positive ask me not to take night duty with her. They even advise me not to share the same bed during duty. (Bahir Dar Health Center, key informant, medical, female)

3.3.3 Verbal Harassment

Some clients with HIV infections described encounters with VCT counselors who had harassed rather than counseled them. PLWHA of low socioeconomic status (e.g., food and beer vendors) reported being mistreated and insulted by counselors for being perceived vectors of HIV transmission to other segments of the community. One woman living with HIV/AIDS stated,

The counselor who works in Dawn of Hope disgraced me by saying “You sell tella [local beer] and transmit the virus to men”. I cried a lot because she hurt my feelings very much. (Bahir Dar, Mekdim member, key informant, PLWHA, female)

VCT clients also recounted negative experiences giving blood in the laboratory. Clients described laboratory technicians who had displayed surprise or even disgust when the client volunteered to get tested for HIV. A woman who went to a health center to be tested commented as follows:

The person who took my blood was surprised when he saw me volunteering to give my blood for HIV testing. He wondered about my readiness to give my blood. He showed a feeling of disgust and fear, 'Betam defar neh. jegena neh. Le HIV meremera dem leteset neow, yegermal.' [You are a daring person! You are indeed a hero. You are to give a blood test for HIV, amazing!] He was scared to see my blood when it started flowing out. He used a piece of cloth cotton and dripped it in alcohol. He instantly gave it to me. He shouted at me, saying, “Rub it and press it with the cotton!” I was worried to see the provider so disgusted and scared of my blood. I wondered how he would react if I became HIV-positive. (Addis Ababa Health Center, key informant, client, female)

3.3.4 Avoidance and Isolation

Many of the health care providers who participated in the focus groups and in-depth interviews reported that they would prefer not to work in VCT and PMTCT or to provide services to PLWHA and AIDS patients. Some providers stated that the nature of HIV/AIDS-related illness and the danger that HIV infection poses to caregivers made stigmatization of PLWHA and AIDS patients virtually inevitable. One senior physician described the fearful attitude of his colleagues, noting, “I know health providers who do not touch a patient with HIV infections” (Bahir Dar Felege Hiwot Referral Hospital, key informant, medical, male).

In light of these fears, providers commented on the importance of knowing patients' serostatus to protect themselves from becoming infected with HIV. A male medical doctor at Assosa Hospital observed,

Health providers, especially those working in the delivery room, fear HIV infection. They even refuse to give service and leave everything to the counselor. They want to know the serostatus of a pregnant woman before they assist her during birth.

Some providers conceded that the avoidance strategy could have serious consequences for patients:

If nurses are advised to use gloves while caring for a patient, they suspect that the patient could be an AIDS case. Some disappear and avoid nursing such patients. AIDS patients suffer and die without receiving even minimal nursing care. (Jijiga Hospital, key informant, medical, female)

Many other providers told stories about HIV/AIDS patients who had not received the care they needed. A medical person at Axum Hospital noted that when a patient bleeds, providers may “refuse to touch the patient and do not try to stop the bleeding” (focus group discussion, male). A female clinician who participated in a health center focus group described a dramatic situation she had witnessed at a hospital:

A pregnant woman was admitted to the delivery room at Karamara Hospital. The nurses knew that she was HIV-positive. The woman was shouting and laboring, but nobody dared to help her. She gave birth by herself. I was not on duty. I just happened to be there. I tried to help her. I cut the cord and cleaned her. The baby died instantly and the woman died the following day due to continuous bleeding. Health providers in most instances avoid a bleeding HIV-positive woman during delivery. (Jijiga Health Center, focus group discussion, medical, female)

Some providers in the 12 health facilities argued in favor of isolating patients with HIV infections on separate wards and/or in separate facilities, going so far as to declare that isolation should be legally required. In some instances, providers evoked the safety of non-HIV-infected patients as a rationale for having separate wards, also citing complaints by non-infected individuals about being forced to share the same ward as AIDS patients:

It is unfair to affect other inpatients for the sake of not stigmatizing AIDS patients. AIDS patients have to be identified and separated. (Bahir Dar Hospital, key informant, medical, male)

Persons living with HIV/AIDS interviewed for this study appeared to be aware that some health care providers try to avoid contact with them, particularly if the clinical encounter involves bleeding. One woman described her experience as follows:

Once, a person who lives in front of my house stabbed me on my head with a knife and called me aidsam [a person with AIDS]. A policeman took me to the hospital for treatment and examination. The health providers tried to avoid me, for they knew that I live with the virus. (Bahir Dar, Mekdim member, key informant, PLWHA, female)

3.3.5 Referrals for Testing

Because of the prevalence of HIV infection (estimated at 50% in many medical wards), providers who participated in our study reported a high perceived risk of contagion. Clinicians noted that when they encountered patients with conditions such as TB and herpes zoster, they frequently assumed that the patient had HIV/AIDS. Although some providers acknowledged that suspecting people to be HIV-positive on the basis of general symptoms could be perceived as an act of stigmatization, they suggested that it was impossible not to harbor suspicions. As a result, providers reported referring clients with symptoms such as continuous diarrhea, coughing, mouth or body sores, rapid weight loss, fever or opportunistic infections to VCT without offering any prior counseling.

Providers stated that the practice of referring individuals with possible HIV infection to VCT often traumatized unsuspecting clients. A counselor remarked, "Doctors ask patients to go to room 44, which gives VCT services," further commenting that "clients get shocked when they know that room 44 is a VCT center" (Adama Hospital, key informant, medical, female). Consequently, some providers reported experiencing an ethical quandary about whether or not to refer suspected individuals for testing. A provider reflected,

I advise the patients with opportunistic infections to take HIV blood tests, but I get confused about whether I am right or wrong in doing so because the patients get tense and are shocked, as if they have just been told that they have got the virus. (Bahir Dar Hospital, key informant, medical, male)

3.4 Causes of Stigmatization and Discrimination

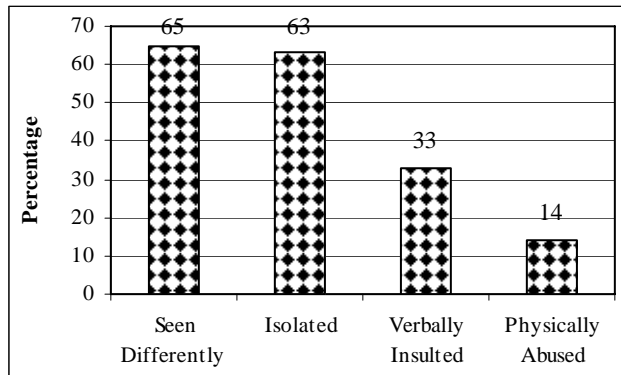
In addition to describing perceived types of stigmatization and discrimination, study participants discussed a variety of attitudes, beliefs and structural factors that they viewed as contributing to stigmatizing attitudes and behaviors. These include attitudes and beliefs about PLWHA, beliefs about transmission, working conditions, perceived risk of workplace infection, lack of training and refresher

courses, the client-provider relationship, inability to address clients' needs, and lack of professional satisfaction.

3.4.1 Attitudes and Beliefs about PLWHA

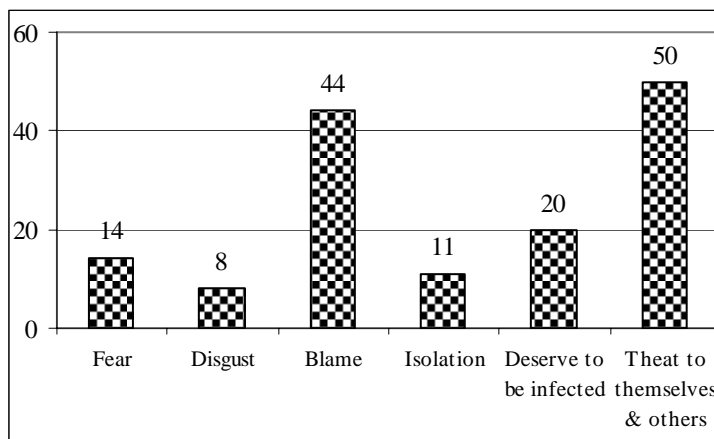
The majority of health care providers who participated in the survey agreed that it is common for communities to stigmatize persons known or suspected to have HIV/AIDS (see Figure 1). Roughly two-thirds of the providers surveyed reported that PLWHA are “seen differently” and are socially isolated in their communities. A significant number of respondents also stated that PLWHA are verbally and even physically abused by family and other community members.

Figure 1: Providers' Perceptions of Community Stigmatization of PLWHA



Health care providers share many community norms, values and beliefs about “acceptable” and “unacceptable” behaviors. Not surprisingly, therefore, providers expressed beliefs about HIV/AIDS-infected individuals and so-called “risk groups” that were similar to the beliefs attributed to community members. More than a third of the providers who participated in our structured interviews described PLWHA as “different” (38%) or “irresponsible” (35%). As shown in Figure 2, some providers openly admitted that they feared PLWHA, and half of the survey respondents considered PLWHA to be a threat to their health. Almost half blamed PLWHA for being infected and one-fifth indicated that PLWHA deserved to be infected.

Figure 2: Providers’ Attitudes toward PLWHA



Our survey results also highlighted a variety of other negative attitudes held by health care providers about PLWHA.

- Almost half (46%) of providers reported being afraid to treat clients with opportunistic infections and more than a third (36%) stated that they feared contact with any suspected PLWHA, irrespective of their health condition.
- Almost two-fifths (38%) of respondents stated that any person with an opportunistic infection was a PLWHA.
- Half of providers reported that PLWHA should be given less attention than other patients.

In the in-depth interviews and focus groups, providers described individuals infected with HIV as “immoral,” “irresponsible,” and likely to engage in socially unacceptable behaviors such as alcoholism or drug addiction. As one nurse-counselor commented,

Those who contract HIV are those who have multiple sexual partners and practice unsafe sex, those who are irresponsible and ill mannered. (Bahir Dar Hospital, counselor and nurse)

Clinicians further suggested that adulterous and promiscuous people, female sex workers and unemployed youth were the groups most vulnerable to HIV/AIDS. A medical worker in the Adama Hospital described his views about those infected with HIV:

When I see people coming to VCT, I imagine that they must have been promiscuous and practiced sex with many partners. I think those who come to be tested are those who suspect themselves to be HIV-positive. [...] The main factor for the expansion of HIV is unprotected sex. Many HIV-infected persons are irresponsible. (Adama Hospital, key informant, medical, male)

A female medical doctor in one of the health centers commented as follows on the shared belief system of community members and health care providers regarding persons with HIV/AIDS:

Sexual relation in this community is viewed as something unaccepted before marriage and a person with HIV/AIDS is said to be promiscuous, bringing shame and disgrace to the family and relatives. You see families trying to avoid their loved ones because of HIV, which is really saddening. Providers are not any different from the community. (Addis Ababa Health Center, key informant, medical, female)

3.4.2 Beliefs about Transmission

Health providers' incomplete knowledge about HIV/AIDS was perceived to be another factor contributing to stigmatization and discrimination. In fact, providers displayed a surprising lack of clarity regarding modes of HIV/AIDS transmission, sometimes questioning the efficacy of standard precautionary measures. A number of providers, including senior medical doctors, reported fears that HIV/AIDS could be transmitted through casual contact, through ordinary body fluids such as sweat, or by eating food handled by PLWHA. A female provider in a health center reported warning her children not to eat raw meat, suggesting that meat cut by a butcher with HIV could transmit infection. In our provider survey, 16% of respondents reported that they would not buy food from a grocery operated by a PLWHA. Some clinicians questioned the reliability of the scientific consensus regarding modes of transmission.

One nurse-counselor expressed her doubts as follows:

I suspect some clients to be HIV-positive just by looking at some symptoms. HIV-positive people have opportunistic infections most of the time: mouth infections, darkening of the skin, and loss of weight. Even the community suspects patients with such symptoms to be HIV-positive. Then, they stigmatize and discriminate against them. I would not be surprised if they discriminate against PLWHA because no one knows all modes of transmission for sure. What is said not to allow transmission today may be said to be a way of HIV transmission tomorrow. (Bahir Dar Health Center, key informant, medical, female)

Another informant, a physician, also suggested that some modes of HIV transmission might not yet have been discovered, and speculated that airborne transmission might occur under some circumstances. This provider reported feeling ill at ease treating individuals with HIV infection. Similarly, a nurse-counselor in a health center stated that she worried whenever she was required to touch the body of a patient with HIV or AIDS because she feared transmission of the virus through the patient's sweat.

3.4.3 Working conditions

Health care providers described working conditions in public sector health facilities that are unimaginably bad. Hospitals and health centers were reported to be understaffed, ill-equipped and poorly budgeted, with overcrowded and poorly maintained inpatient wards. According to study participants, HIV/AIDS has made the working environment even more unbearable. Although most health care providers learn about communicable disease risks in their professional training and are aware of recommended infection control precautions, informants described a health care system that lacks even the basic resources needed to adequately protect providers from the risk of HIV infection.

Most study participants complained of widespread burnout and overload. Providers stated that facility directors are failing to evaluate staff needs in relation to the area of coverage and the client volume served, describing staff shortages in inpatient care as well as in counseling and testing services. Informants also noted that many PLWHA admitted to hospitals are abandoned or have no relatives to assist them, resulting in longer inpatient stays that create a bigger burden for providers. On medical wards, the problem of overcrowding appears to be particularly severe at the Felege Hiwot Referral Hospital at Bahir Dar and Axum St. Mary Hospital. A provider at Axum Hospital explained,

Nothing has been done to improve the service of the health facility. In the medical room, 46 beds are available but there are only ten providers (eight health assistants and two nurses). When a malaria

epidemic happens the client flow is not manageable. Besides, all of us are not available every day. We work in shifts and only three health providers are available at a time in the medical ward. (Axum Hospital, key informant, medical, male)

Informants reported that the introduction of VCT and PMTCT services has further increased workloads and exacerbated provider dissatisfaction. Counselors described the difficulty of accommodating the numerous individuals seeking VCT services:

Here in the VCT, there are only two of us, and one client may take up to 40 minutes. We counsel up to 30 clients and it creates a heavy workload that leads to burnouts. (Bahir Dar Hospital, key informant, medical, male)

Study participants also noted that the workload increases brought about by the addition of HIV-related services have not been accompanied by salary increases or performance incentives. As one woman complained,

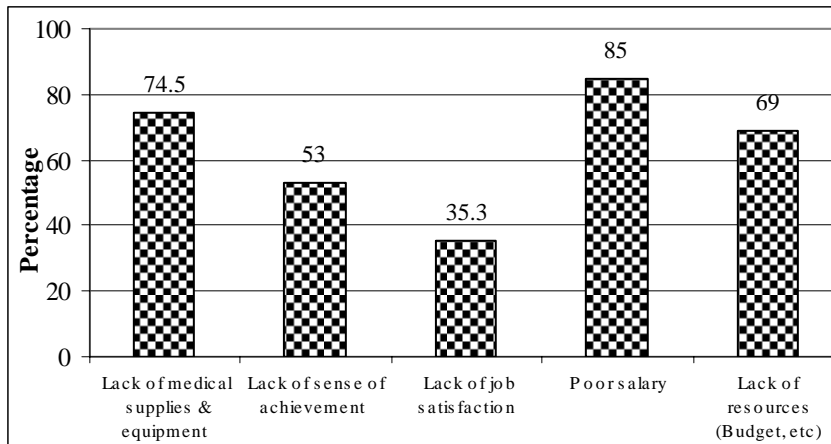
The salary of health providers has to be raised. I have worked for 15 years and I have not seen any improvement in my life. I cannot support my family with this salary. Moreover, there is no training, but there is a heavy workload. Now I am leaving this work and quitting the hospital and going to a private clinic. In the MCH, there are two nurses. About 20 pregnant women come daily, and many children come for vaccinations. For newly pregnant women, we give counseling and take blood for HIV testing. I handle the results and this makes the workload immense and life difficult. (Axum Hospital, key informant, medical, female)

Survey respondents reported frequently being shifted from one service to another to cover the needs of clients, sometimes over the course of a day. Movement between medical wards, family planning services, HIV/AIDS counseling and testing, STI counseling and testing, TB care, Antiretroviral (ARV) treatment and palliative care for PLWHA contributed to providers' perceptions of being overstretched, and also was reported to lessen continuity of care.

Yet another area of frustration identified by providers pertains to the absence of direct supervision. Study participants commented that decision-makers tend to rely on feedback from written reports, which may be inaccurate or unreliable, rather than directly evaluating staff workload and performance. Consequently, providers suggested, decision makers lack insight into working conditions and fail to give positive feedback to providers when they do a good job.

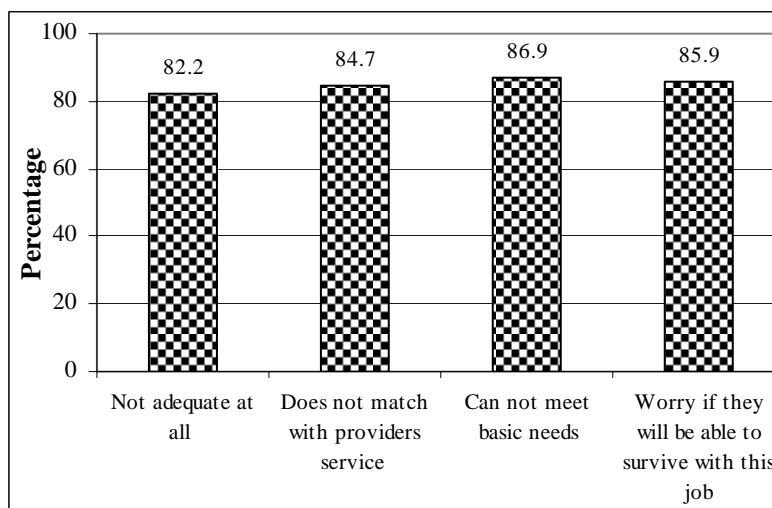
In our structured survey, we asked respondents to identify factors affecting the quality of health care services in the context of the HIV/AIDS epidemic (see Figure 3). Approximately three-quarters of respondents pointed to the lack of medical supplies and equipment and the lack of resources and budgets as significant problems. Other factors cited included the absence of any sense of professional achievement with AIDS patients (53%) and an overall lack of job satisfaction (35.3%).

Figure 3: Provider Perceptions of Factors Affecting Quality of Services



Over 85% of survey respondents reported dissatisfaction with the salaries they receive (Figure 3), although recent graduates (the remaining 15%) appeared to consider their income acceptable. We also asked survey respondents to rate their monthly salaries in relation to the services they perform (Figure 4). More than four-fifths of respondents indicated that their salaries are inadequate, do not compensate them for the work they do, do not allow them to meet basic needs and cause them to worry about being able to survive.

Figure 4: Provider Perceptions of Salary Received



In the context of poor working conditions and the increasing number of clients with HIV-related problems, key informants noted that many providers have begun resigning from their jobs and leaving the health care profession. One informant stated,

It used to be rare to hear about providers leaving their job but now it is becoming very common. Providers in the medical ward are heard saying, 'It is better to work in a kiosk than work in the medical ward.' (Bahr Dar Hospital, focus group discussion, medical, male)

3.4.4 Perceived Risk of Workplace Infection

Health care providers reported that their fear of workplace infection (a fear sometimes bordering on a state of panic) was a major cause of stigmatization toward PLWHA and AIDS patients. Many of the problems already cited regarding working conditions were perceived to increase providers' infection risks. These include a lack of universal precaution supplies (e.g., gloves) and sanitary supplies (e.g., disinfectants); a lack of awareness among support staff regarding infection control measures; fears about contamination of equipment by custodians; and the unavailability of retroviral prophylaxis for providers who are incidentally exposed. Providers also noted that supply requests generally have to be processed by the administrative bureaucracy, making it difficult to obtain requested items on a timely basis.

Almost all of the health care workers we interviewed reported wanting to have a different job. In focus group discussions, some providers stated that they were too afraid of PLWHA to be able to empathize with them. Providers described infected individuals as a source of danger to those treating them and commented on their fears of contracting an incurable infection that they personally had seen result in severe suffering and physical disfigurement. One medical provider explained his fears in the following way:

There is no infection that scares me as does HIV.[...] If I am found to be positive the first thing that will come to my mind is the suffering I may undergo before I die as I see it with AIDS patients here. I use gloves but I still fear contamination. (Assosa Hospital, focus group discussion, medical, male)

Most (81%) of the health providers participating in our structured survey agreed that their jobs placed them at risk for HIV infection. Roughly a third of survey respondents suggested that infection could result from lack of access to protective equipment and sanitary commodities (34%), assisting in delivery and surgery procedures (29%), or casual transmission (30%). Almost one-fifth (17%) cited needle pricks and administering injections as possible sources of workplace

transmission. A senior surgeon who participated in a focus group discussion explained providers' fears and described the working conditions that expose health providers to HIV infection:

If you see the surgical practices we perform, we are all vulnerable and we are all at risk and we consider ourselves to be carpenters. Because the gloves cannot fully protect us, we are usually vulnerable. We contaminate our hands and sometimes blood splashes in our eyes. We are at risk every time we perform a surgical procedure. There is scarcity of gloves. Sometimes we see needles thrown away anywhere instead of being placed in standardized disposal containers. (Jijiga Hospital, focus group discussion, medical, male)

In addition to personal fears, health care providers noted that their family members feared for their loved ones' safety on the job. Women working as nurses and health assistants described their husbands' fears, while other providers reported being "nagged" by family members and parents to look for a different job. One female health provider working in a facility where staff members had died of AIDS reported that her husband was insisting that she look for office work. Several other providers reported knowing colleagues who had died from AIDS. As a result, a general climate of fear appears to pervade many hospitals and health facilities, as suggested by the following remarks:

We are exposed to this infection more than any other and we are just waiting till we show the symptoms. Three of my friends have already died; there is needle pricking while taking blood. Even the custodians do not like to work in the laboratory and medical ward, and I am hoping to be transferred to another section. (Bahir Dar Hospital, key informant, medical, male)

In an attempt to avoid infection, some health providers reported taking extra precautionary measures such as wearing two pairs of gloves. However, as the following individual's remarks suggest, providers then face the dilemma of how to protect themselves without stigmatizing patients, who may be offended by the use of elaborate precautions:

We have started using two or more gloves. I don't know whether you think such an overprotection of providers stigmatizes clients or not, but it is a reality. As far as I am concerned, clients must be stigmatized by seeing providers using two or three gloves one over the other. (Bahir Dar Hospital, focus group discussion, medical, male)

Although fearing for their personal safety, some providers also expressed concerns about the consequences of medical supply shortages for patients. As one hospital provider noted, "Getting materials anytime from

the store is not possible, we are allowed to order what we want only after 2 o'clock in the afternoon. Thus, we fail to serve the patients immediately when they need help. Thus, patients and attendants get angry with providers" (Adama Hospital, key informant, medical, male). Another hospital-based provider described the impact of supply shortages as follows:

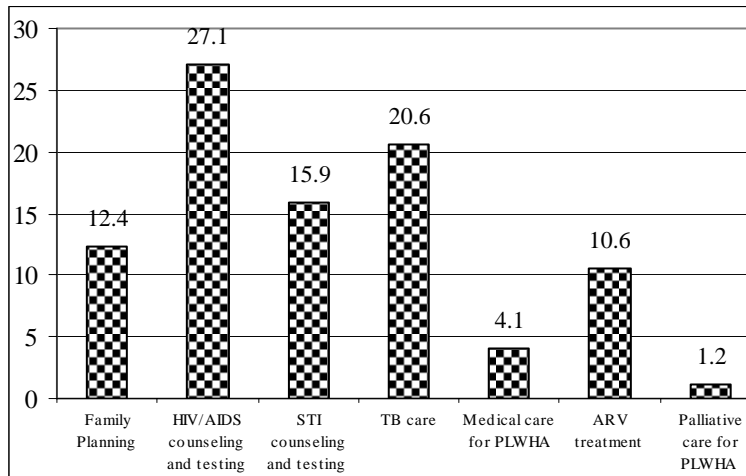
We sometimes cover wounds with bandages in the absence of plaster or we may run short of reagents. I am not satisfied with my work at all. That is why I always have a very bad headache. I use the same bed for delivery services for different pregnant women, even knowing that the preceding woman was HIV-positive. This is because of the material problems that we have. I really feel bad, I even cry thinking about a client's vulnerability. (Assosa Hospital, focus group discussion, medical, male)

3.4.6 Lack of Training and Refresher Courses

Key informants who worked as counselors noted that working with HIV/AIDS requires providers to remain up-to-date as new information about HIV develops. However, all counselors indicated that they lacked adequate refresher training and felt unable to give satisfactory answers to their clients. Informants reported frustration at clients' often superior access to current information. As one health worker stated, "The major problem is when clients come with information that we do not have" (Assosa Hospital, key informant, medical, male). Others, particularly in the Jijiga, Adama and Assosa facilities, complained that administrative staff was more likely to be given opportunities to attend workshops or training than personnel working directly with patients.

Survey respondents confirmed some of the perceptions shared by key informants and focus group participants about lack of training (Figure 5).

Figure 5: Provider Training Received in Selected Services



For example, while one-fourth of respondents (n=46) reported participating in training on HIV/AIDS counseling and testing during the past year, very few recalled receiving training on antiretroviral therapies (n=18) or basic medical (n=7) or palliative (n=2) care for AIDS patients. Moreover, we found few apparent differences in the attitudes of providers who did and did not receive training on HIV/AIDS counseling and testing (Table 3). The only exception was that a higher proportion of providers who had received training reported feeling that “people appreciate their service to PLWHA” (48% versus 27%).

Table 3 Attitudes of providers with and without training in HIV/AIDS counseling and testing

Categories of questions	With training		With no training	
	#	%	#	%
Clients coming for ART, VCT and PMTCT services are responsible persons	31	67.4	81	75.2
Suspect AIDS on seeing clients with opportunistic infections	21	45.7	57	46
Feel suffering when seeing clients with opportunistic infections	6	13	22	17.7
Feel like treating and helping clients with opportunistic infections	15	32.6	36	29
Feel people appreciate their service to PLWHA	22	47.8	34	27.4
Feel people may suspect them of being a PLWHA because of their service to PLWHA	5	10.9	10	11.7
Would buy food from a PLWHA grocery	34	73.9	83	68
Feel fear when they see a PLWHA seeking treatment	6	14.6	22	19.6
Feel compassion when they see a PLWHA seeking treatment	35	85.4	90	80.4

3.4.7 Client-Provider Relationship

Providers described many aspects of the client-provider relationship perceived to contribute to health worker burnout and stigmatization of patients with HIV/AIDS. As discussed previously, many medical informants admitted holding negative attitudes about clients with HIV/AIDS, describing them as “overly demanding” and “easily dissatisfied” patients who ask for “special treatment.” Providers also agreed that clients seeking counseling often tried to conceal the truth, making client-provider communication more difficult. A female counselor explained some of the difficulties of responding to patients with HIV/AIDS:

PLWHA insist that they should be given priority and be treated as they come, or else threaten to report [providers] to authorities. Some are not educated; others are educated – say, doctors, lawyers and judges. They fear stigmatization, and do not want to be seen by others here. They do not want to stand in line and wait for their turn. In fact, they go to the tearoom, and we call them from there. Although we tell them that the clinic gives other services apart from ART, they do not listen and do not want to be seen waiting in front of the clinic. They do not want to mix with other clients. They fear the community because of stigmatization and discrimination. They isolate themselves, and this is a problem. No matter how much care we give them, they do not appreciate it. They react negatively. (Adama Hospital, focus group discussion, medical, female)

Some counselors reported being physically threatened by clients whose test results had identified HIV infection. One provider explained the dangers as follows: “Some [clients] do not accept their [test] results and some insult us. Some come with pistols and try to intimidate us” (Addis Ababa Hospital, key informant, medical, male). A counselor in another locality reported similar risks:

Here, I am the only counselor. There was one other counselor working in the VCT. A Somali client came and took the test and it was positive. Then, instead of listening to the advice of the counselor, the client warned him that if he disclosed the result to the client’s wife he would kill him. The counselor was so shocked that he started shouting in the streets ‘a man with a pistol is trying to shoot me.’ The counselor was transferred to another hospital. (Jijiga Hospital, key informant, medical, female)

Just as providers admitted to negatively labeling patients, informants conceded that PLWHA, in turn, sometimes complained about specific providers. According

to staff and providers, patient-initiated conflicts with providers are not infrequent, and clients sometimes insist that administrators assign them to a different provider. A staff informant explained,

We try to make the service for PLWHA quick and effective. Of course, some of the PLWHA complain that health providers are not interested in giving them service. Some ask for a different provider, because they feel they were not treated well. (Addis Ababa Health Center, key informant, nonmedical, male)

Some providers suggested that clients' negative attitudes are the result of clients' denial and inability to accept their positive serostatus. Providers described incidents where HIV-positive clients had accused counselors of reporting false results or fabricating results.

3.4.8 Inability to Address Clients' Needs

As many study participants observed, public sector clients with HIV/AIDS are typically very poor people lacking the resources to avail themselves of treatment options. One provider explained the problems faced by impoverished patients as follows:

The clients here are very poor. Some come from the rural areas and work as housemaids, laborers and the like. They want free medication. There is no one to care for them. They do not want to go back to their home community. They are even unable to pay for a card or other minimal charges. They come here for treatment of opportunistic infections. Some of the drugs they need are not available here. They are asked to buy these drugs from private pharmacies, and they complain about this. (Addis Ababa Health Center, key informant, medical, female)

Perhaps unsurprisingly, providers described the work of counseling PLWHA as stressful, noting the difficulties of listening to "the secrets of individuals and their problems all the time" without being able to "provide a solution" (Axum Hospital, key informant, medical, female). Informants suggested that the seemingly infinite problems presented by AIDS patients cause providers to feel a sense of helplessness about providing care; these perceptions of powerlessness, in turn, can provoke a backlash that leads providers to stigmatize clients. An informant explained the feelings of hopelessness that some counselors have about their work:

It is really painful to listen all the time to people's problems. I always regret joining this profession. Most of the clients are poor

and I cannot help them. Sometimes I think, if I could only pull them out from this poverty. I buy milk with my money for two babies, but I cannot buy milk for ten other children who are desperate. You see, counseling means listening to the painful experiences of people who are living with the virus. (Bahir Dar Hospital, key informant, medical, female)

A focus group participant working in the PMTCT described the dilemma of balancing medical advice with clients' life situations:

I think it is hard to advise HIV-positive mothers not to breastfeed their babies. Most HIV-positive women are economically poor and unable to afford cow's milk. I know a baby born to a HIV-positive mother would die of starvation if I advised the mother not to breastfeed, because she cannot afford to buy other food such as cow milk's or powdered milk. (Axum Hospital, focus group discussion, medical, female)

Health providers reported frustration at seeing an increasing number of clients who likely would benefit from ART but are unable to afford the monthly cost of 250-570 Birr (roughly US\$30-65). Study participants noted that some clients start and then discontinue medication for financial reasons, while other clients blame providers for taking "money allocated for their treatment." Providers also noted that many PLWHA require extra nutritional support but "cannot afford to eat a balanced diet." A male provider at Axum St. Mary Hospital observed that 80% of the pregnant women coming to PMTCT were undernourished and often refused to take the HIV blood test because of their inability to purchase medications or supplementary food for their babies. Some providers complained about the lack of material and financial support for PLWHA, noting the inability of nongovernmental organizations such as the Red Cross and Organization for Social Services AIDS (OSSA) and indigenous PLWHA associations to meet the growing demand for support. One provider commented,

The care and support for PLWHA is poor. For example, clients who need care and support are sent to PLWHA associations such Tesfa Goh, where they may not be readily accepted. Some who need hospital care do not get a bed and they come back to the counselors repeatedly. The counselors feel helpless and frustrated. (Addis Ababa Hospital, key informant, medical, female)

3.4.9 Lack of Professional Satisfaction

Related to their perceived inability to meet PLWHA' medical and social needs, a number of providers reported feeling that it was professionally unrewarding to

treat AIDS patients. Describing efforts to help AIDS patients as “hopeless,” providers suggested that in many “terminal” cases they were merely postponing a patient’s death by a few months and prolonging the patient’s suffering. A health provider elaborated as follows:

Caring for an AIDS patient is challenging and makes you feel hopeless. For example, my brother died of HIV/AIDS. We did our best to help him, but could not prevent him from dying. [...] Many health providers think that caring for an AIDS patient is a waste of time and resources. I know a patient who refused to disclose his status, for fear that the doctors may not give him the attention he needs as a patient. (Addis Ababa Health Center, key informant, medical, female)

Some providers suggested that there was little point in even hospitalizing AIDS patients, commenting that scarce hospital beds should be reserved for other patients with more hopeful prognoses. A senior provider explained,

It is right to reserve hospital beds for patients who can be cured. HIV/AIDS patients who occupy hospital beds stay a long time, until they die, denying others the benefits of hospitalization and the possibility of being cured. (Bahir Dar Hospital, key informant, medical, male)

Although aware that proper care for HIV-positive individuals can delay the onset of AIDS, a few providers described ART as a “waste of drugs” for patients with opportunistic infections. In the words of a male medical professional at the Jijiga Health Center, “I don’t think an HIV-positive person with opportunistic infections can live a healthy life even if he gets ART.”

4. Summary of Major Findings

Our findings highlight a number of attitudes and beliefs about HIV/AIDS and persons living with HIV/AIDS that were perceived to contribute to provider stigmatization and discrimination.

- **Beliefs about HIV/AIDS:** Regardless of treatment, providers perceive the end result of HIV infection as death. As a result, many providers reported that helping AIDS patients is a waste of resources and time and is not professionally rewarding. Because inpatients with HIV/AIDS often occupy hospital beds for a long period of time, providers also blamed PLWHA for preventing health professionals from closely attending to other patients with curable conditions.
- **Attitudes about PLWHA:** Some providers described people who become infected with HIV as irresponsible and immoral. Because HIV/AIDS is also viewed as easily transmissible, providers described PLWHA as threats to themselves and society. Many providers admitted trying to avoid treating even those patients only suspected of having HIV/AIDS.
- **Community perceptions:** Providers participating in our study admitted to being influenced by community perceptions about HIV/AIDS infections. Ironically, providers themselves reported fearing stigmatization and discrimination. Although many providers described concerns about the possibility of workplace infection, few saw any value in taking an HIV test and learning their serostatus.

Second, our findings indicate that working conditions in health facilities are perceived as a major source of provider stigmatization against clients with HIV infections. Providers described a strong sense of insecurity resulting from the perceived risk of workplace infection. Our qualitative and quantitative data identified numerous problems within the health care system that shape providers' fears about working with HIV/AIDS patients.

- **Inappropriate infrastructure:** The rooms and staff assigned to PMTCT and VCT services were not designed for those purposes, making it difficult to ensure confidentiality and deliver satisfactory services to clients.
- **Supply shortages:** Health facilities operate with critical shortages of essential medical supplies (especially protective equipment and tools) and sanitary commodities.
- **Staff shortages:** Health providers are overworked and reports of worker burnout are common. In some facilities, the same counselor takes the

blood, carries it to the laboratory, collects the blood test from the laboratory and discloses the result to the client.

- **Inadequate compensation:** Health workers complain of poor salaries and a lack of incentives and salary increments (salary increases which are tied to years of work, job performance and acquired skills and trainings). They report that they are not compensated for the extra work that they do.
- **Information gaps:** Due, in part, to the lack of adequate training, there is a perception that clients often know more than counselors regarding HIV/AIDS. Counselors report being challenged by clients and feeling helpless when clients know more than they do.
- **Absence of medical and financial protection:** Providers lack freely available post-exposure retroviral prophylaxis and life insurance to protect their families in the event that they become infected with HIV.

In addition to the influence of poor working conditions on provider attitudes and behaviors, our study's results suggest that provider stigmatization and discrimination toward persons with HIV and AIDS may have a considerable impact on Ethiopia's public sector health services. The variety of perceived consequences identified by our study includes effects on clients' screening and treatment decisions, client-provider interactions, health facilities' ability to offer services and health workers' decision making in regards to their profession.

Providers suggested that the perception of health facilities as a stigmatizing environment affects individuals' **screening decisions**. In some instances, the perceived stigma may discourage individuals who suspect that they have HIV from getting an HIV test, resulting in low frequentation of VCT clinics. For counselors, the daunting economic and social conditions faced by people living with the virus have made counseling a difficult and thankless task.

At the level of the **client-provider relationship**, many health care providers openly admitted trying to avoid treating patients suspected of having HIV/AIDS. Providers agreed that PLWHA should be given home care rather than "wasting" facility resources on patients who cannot be cured. Because health providers admitted to reacting to clients' clinical symptoms with fear, it is not surprising that clients, in turn, described a loss of confidence in health providers. Clients reported experiencing greater stigmatization and discrimination in health facilities than in the communities in which they lived.

At the level of **health facilities**, our results suggest that stigmatization may threaten the ability of hospitals to continue operating important services. Informants suggested that many providers refuse to work in the medical, emergency, surgery, and labor and delivery wards. Health facilities also are reportedly experiencing difficulty staffing PMTCT and VCT services.

Our results further suggest that the **health profession** may be seriously undermined by workers' decisions to abandon health care. Many providers working as nurses and health assistants reported a desire to change their profession, and some had already started attending night school to move into other fields. Providers at all levels openly admitted advising relatives and children not to join the health care profession.

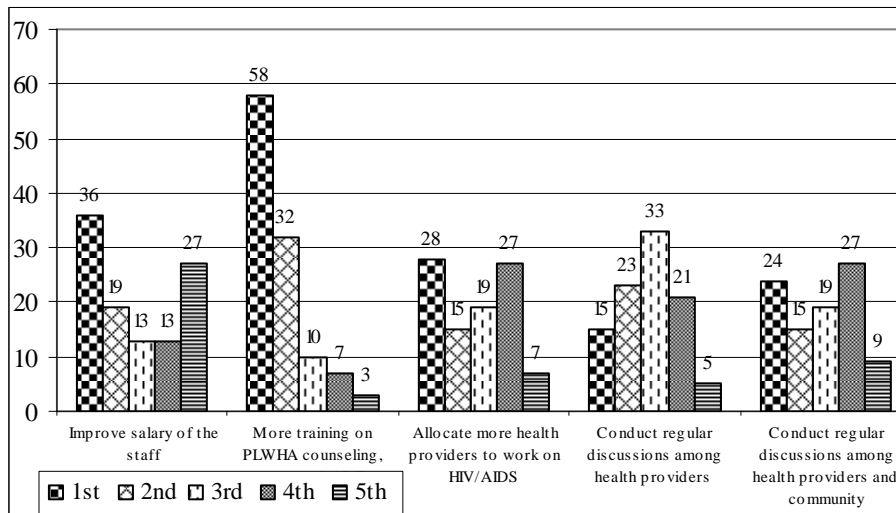
Finally, study participants suggested that poverty increases providers' sense of helplessness and frustration, particularly because many clients cannot afford to fill their prescriptions. This frustration may eventually be a catalyst for provider stigma and discrimination. As the number of patients eligible for ART increases, so does the number of clients forced to discontinue their medication for financial reasons. Providers noted that most patients hope for free medication and repeatedly ask them for assistance.

5. Provider Recommendations

Although the stigma and discriminatory attitudes reported by providers toward clients with HIV infections appear to be significant and their consequences substantial, providers participating in our study nonetheless expressed hope that prevailing attitudes could be changed. Even while acknowledging their discriminatory practices against persons with HIV/AIDS, many providers suggested that they would be willing to take steps to alleviate stigma.

Because working conditions in health facilities were blamed for much of the perceived stigmatization and discrimination against PLWHA, study participants suggested a number of concrete measures to lessen stigma and improve the quality of health services for PLWHA (Figure 6). Providers requested sweeping improvements to ensure the supply of medical commodities and equipment and enhance the safety of providers. Study participants also requested better salaries and compensation (including life insurance), improved staffing ratios and more training. Providers agreed that training and discussions about HIV/AIDS among staff and with communities are essential to address the misconceptions that lead to stigmatization and discrimination.

Figure 6: Providers' Views on How to Improve Services



The apparent lack of a training effect on providers' attitudes about HIV/AIDS patients and PLWHA (Table 3) suggests that it may be important to carefully consider training content and the manner in which training is delivered. One key informant commented that training would be most effective if it were facility-centered and offered on a continuous basis (for example, offering regular discussions on HIV-related cases and developments). Other Ethiopian studies also have suggested that "one-go" training has little effect on providers' attitudes

and behaviors. Most of the physicians (79%) and nurses (85%) surveyed by Bebratu (2000) reported that their HIV/AIDS-related training had inadequately prepared them to treat HIV, and sizeable proportions of physicians (78%) and nurses (72%) reported having difficulty managing AIDS patients.

Nonetheless, responses to the provider survey suggest that providers have positive self-efficacy to do their jobs if working conditions improve. Most providers described themselves as capable of providing good services (84%), confident in the skills and knowledge needed to do their work (90%) and able to cope with new challenges (83%). However, while almost all respondents (89%) agreed that health care institutions play an important role in caring for persons with AIDS, many providers also indicated that the burden of care should be shared by families (80%), communities (77%) and partners or spouses (70%). Study participants noted the need to work closely with families, community organizations and NGOs to control the spread of HIV infection and provide care and treatment to AIDS patients.

6. Discussion

As deaths due to AIDS and positive test results for HIV become “normal” events in Ethiopia, the belief that HIV infection is unstoppable also appears to have become commonplace. Laboratory technicians participating in our study reported that they expect that all blood samples coming from VCT services to be HIV-positive. As a result, many of the providers and clients who participated in our study conveyed a sense of helplessness. This attitude, in combination with provider stigmatization and discrimination, are significant factors limiting the country’s ability to confront the challenges of HIV/AIDS prevention and treatment.

In response, we offer two sets of recommendations, the first requiring immediate action and the second focusing on longer-term social and structural changes.

6.1 Short-term Recommendations

IntraHealth, in collaboration with cooperating health facilities and the Ministry of Health, can implement several strategies to lessen stigmatization and discrimination and increase the number of clients seeking HIV-related services such as PMTCT, VCT and treatment of opportunistic infections. Our recommendations focus on performance improvement training; strengthening collaboration between health care providers, families, communities and NGOs; ensuring access to medication for clients and providers; ensuring access to nutritional support; and mobilizing leadership.

6.1.1 Strengthening Provider Performance

Study participants agreed on the importance of continuous training on HIV/AIDS for medical and nonmedical health facility staff, including nurses, midwives, health assistants and laboratory technicians. To address the major sources of perceived stigmatization and discrimination, our study identified six key areas of training. Three training topics focus on provider attitudes and beliefs (beliefs about HIV/AIDS transmission and prevention, risk groups and sex and sexuality), two focus on health care practices related to HIV/AIDS (universal precaution measures and care and support for PLWHA), and one focuses on administrative skills (resource and information management).

- **Beliefs about HIV/AIDS transmission and prevention:** Many health care providers, including doctors, continue to fear casual transmission of HIV/AIDS. Guided by our ethnographic data, intensive training should be developed for health facility providers and staff addressing the nature of the virus, how it is transmitted, and what can be done to prevent transmission. To achieve meaningful behavior change, we recommend a

participatory training approach (rather than didactic training) that encourages providers to actively reflect on their beliefs about transmission and plan activities based on their beliefs. Participatory training is grounded in adult learning principles, using the participant's existing knowledge and experiences as the foundation for skills enhancement. Training techniques that foster active participation include case studies, role plays, panel discussions and group presentations.

- **Beliefs about risk groups:** According to our study, providers believe that sex workers, youth and unemployed individuals who are addicted to drugs or are promiscuous are the groups most vulnerable to HIV/AIDS, and that married couples and people with better education and standards of living are not at risk. Training is needed to highlight the concept of shared vulnerability and the fact that the HIV/AIDS pandemic has affected every sector of society. Training also should emphasize the importance of shared care and support for PLWHA, involving community leaders, religious leaders, association leaders and PLWHA themselves.
- **Beliefs regarding sex and sexuality:** Health providers reported sharing community norms and beliefs about sex and sexuality. Oftentimes there is a wide gap between societal ideals regarding “acceptable” sexual behavior and actual practices. Ongoing conversations that encourage community members and providers to openly discuss this divide in thought and practice are needed to shed light on common sexual practices and help debunk the myth that only “socially and sexually deviant” members of society are vulnerable to HIV/AIDS.
- **Universal precaution measures:** Almost all (81%) of the providers who responded to our survey perceived a high risk of infection because of their work. Some of the factors viewed as contributing to workplace risks included the fear of equipment contamination by nonmedical staff, the shortage of commodities needed to fully implement universal precautions and patient perceptions that gloves are stigmatizing. Some providers reported using gloves selectively. Training on universal precautions should be offered to both medical and nonmedical staff; in addition, health facilities should provide all the commodities needed to ensure universal precautions.
- **Care and support for PLWHA:** Our findings indicate that many providers view caring for PLWHA as a waste of time and resources. Provider training should promote the concept that caring for PLWHA is a part of prevention, to the extent that appropriate care encourages other individuals to take the HIV test, use PMTCT services and seek treatment. PLWHA who receive adequate care and support are likely to be in the vanguard in the fight against HIV/AIDS. In addition, training should help

providers identify and understand both patient and provider attitudes about HIV/AIDS and PLWHA; this understanding will strengthen providers' ability to counsel and manage AIDS patients.

- **Management of resources and information:** The facility survey indicated that the management of resources and information is poor in most government-operated health facilities. None of the facilities surveyed were able to provide current and correct information on their programs, services, or resource use. Managers and directors reported difficulties in planning programs and services, allocating available manpower and resources, and performing record keeping. Training should be provided to health facility administrators and providers on the development and implementation of Health Management Information Systems whereby providers can accurately forecast supply demands and secure adequate resources. Mechanisms need to be established that enable providers to be continually updated on current information and technologies regarding HIV/AIDS. Finally, training should aim to strengthen on-site stock management and resource flow at the facility level. Enhancing these capacities will alleviate many frustrations encountered by providers and decrease stigmatization.

6.1.2 Strengthening Community-Wide Collaboration

Study participants agreed that health facilities should work closely with the families of PLWHA as well as communities and the nongovernmental organizations (NGOs) that give care and support to PLWHA. At the **family level**, health care providers noted that many families “dump” relatives suffering from AIDS in health facilities and disappear because they do not know how to provide care at home. Almost all providers agreed on the importance of promoting home-based care. IntraHealth can support practical education for families on how to care for persons with HIV/AIDS, as well as help develop family counseling services.

Second, IntraHealth can support efforts to create effective linkages between **health providers, communities and NGOs**. As a first step, communities need information and education regarding HIV prevention and support for PLWHA. It is also essential to define the specific roles of each entity and identify opportunities for partnering. For example, health care providers might focus on caring for PLWHA and orphans, while communities and NGOs could ensure that PLWHA and orphans receive practical and social support (e.g., community support groups for PLWHA; HIV/AIDS clubs performing home-based care activities; and IEC/BCC activities in communities, schools and workplaces).

6.1.3 Ensuring Access to Medication

Access to ART and the drugs needed to treat opportunistic infections remains a serious problem for both clients and providers. Most HIV/AIDS patients coming to public sector facilities cannot afford to pay for ART or other drugs. Providers report experiencing considerable frustration watching drugs expire because they are not allowed to give the drugs out free of charge, even when asked by clients in need. Ways need to be found to make medicines available at no cost to low income clients with HIV infections.

Where providers are concerned, study participants reported that they are not eligible to receive free post-exposure retroviral prophylaxis. In the case of a needle prick or other possible source of workplace contamination, providers stated that they must buy their own retroviral prophylaxis and wait three months to see if they have become HIV-positive. Access to prophylaxis at no cost would likely alleviate some of the distress experienced by providers working in medical wards, delivery rooms and surgeries or administering IVs and taking blood.

6.1.4 Ensuring Access to Nutritional Support

Although adequate and high-quality nutrition is an important component of treatment for HIV/AIDS, most clients are too poor to maintain a balanced diet. Health facilities need to collaborate with other groups to ensure that nutritional assistance is a part of the social and material support provided to PLWHA. Pregnant women and HIV-positive mothers require particular help, as they often discontinue use of PMTCT services due to the cost of supplementary food for infants.

6.1.5 Mobilizing Leadership

Because stigmatization and discrimination by health care providers were perceived as a reflection of attitudes prevalent in wider society, reducing stigma may require changes in the attitudes and behaviors of policy makers and political leaders. Leaders at all decision-making levels need to be convinced of the symbolic value of their public statements and behavior and should be encouraged to make a firm commitment to lessen stigmatization and discrimination. As one example, providers working at the Zewditu Hospital VCT clinic reported that the volume of clients increased substantially after the mayor of Addis Ababa took an HIV test on television.

6.2 Long-term Recommendations

In addition to the more immediate recommendations outlined above, it is clear that little progress can be made in addressing HIV/AIDS in the absence of efforts to improve underlying social and structural conditions in Ethiopia. First, interventions must be designed with an awareness that HIV/AIDS is very much linked to poverty. Second, a new vision of health care must emerge that enables Ethiopia's health care system to optimize patients' and providers' needs. IntraHealth (along with other interested organizations) can play a role in empowering health facilities and communities to address HIV/AIDS in its broader social context.

6.2.1 Alleviating Poverty

Prevention activities, which are the only meaningful way to stop HIV/AIDS, should be rooted in an understanding of the complex socioeconomic factors that promote risky practices. In this study, most PLWHA had migrated from rural to urban areas to look for jobs. Many of our study participants were women (either housewives or house maids), and they tended to occupy the lowest rung on the economic ladder in their receiving communities. Although study participants had been exposed to IEC/BCC messages on HIV/AIDS transmission and prevention, information will not be effective in the absence of environmental changes that enable vulnerable groups such as the poor to make lasting changes to their behavior. Some recommendations to change the living conditions of PLWHA and those at risk include: guiding PLWHA associations in developing income-generating projects; providing small grants to community-based organizations that provide care and support; encouraging and supporting the foundation of community support groups that can share concerns and pool their resources; helping to improve women's access to credit; and providing marketable skills training to community members.

6.2.2 Health Care System Reform

The number of hospitals and clinics in Ethiopia is disproportionately small compared to the size of the country's population. Moreover, as our study results demonstrate, HIV/AIDS has made conditions in health facilities worse than ever, severely straining scarce resources, raising providers' frustration levels and probably aggravating the problems of stigmatization and discrimination. Caring for HIV/AIDS patients is very expensive, and most AIDS patients are poor. However, many PLWHA in Ethiopia die without ever even reaching a health facility. Several fundamental changes in the health care system hold the promise of broadening access to care and making that care more responsive to patients' needs.

First, the health care system needs to be community-centered. A community orientation ensures that health care initiatives address a given community's actual needs and foster a sense of ownership. This type of system not only has the potential to increase access to primary care but also can offer additional opportunities to increase community members' knowledge of HIV/AIDS. To the extent that community members and providers become more informed about HIV/AIDS prevention and transmission and learn how to support PLWHA, attitudes towards those infected and affected are likely to change. It is particularly important to strengthen the efforts of community health extension workers in the fight against HIV/AIDS. Specifically, efforts must be made to enhance their knowledge and skills, strengthen their capacities to carry out community mobilization strategies and establish and reinforce their linkages with local NGOs.

Second, health facilities must be substantially upgraded. Existing facilities are poorly managed, poorly equipped, undersupplied, under budgeted and situated in inadequate physical structures with limited space. Increases in budgets and staffing, improvements to facilities and wider availability of medications will allow facilities to make the shift toward a community-centered system. More training and follow-up are needed to implement and strengthen Health Management Information Systems and improve the managerial skills of health facility administrators and providers.

Third, reforming the health care system means addressing the practical and professional needs of providers. Many facilities are staffed by workers who suffer from burnout and a lack of incentives. Providers in our study complained about low salaries, the lack of training or refresher courses and the lack of life insurance to protect their families in the event of HIV-related illness and death. These factors were reported to exacerbate the problems of stigmatization and discrimination. Our results suggest that reform efforts should address the needs of all levels of personnel (e.g., nurses, health assistants, laboratory technicians), with a focus on health workers in areas such as surgery, emergency and medical wards, and labor and delivery.

6.3 Limitations

Our study design has several limitations that should be considered when interpreting our findings. First, our data were collected from just 12 government-owned health facilities, six of which were health centers. No private or nongovernmental health facilities were included in our sample. Hence, we cannot generalize our findings to the entire country's health care system, nor can we speak to possible stigma in the private health care sector.

Second, although our sample was drawn from six of the country's nine regions, study participants do not necessarily represent different cultural groups. For

example, providers working in the Jijiga Hospital and the Jijiga Health Center and those working in the Assosa Hospital and the Assosa Health Center were mostly Amharas and Oromos. Thus, we were unable to identify possible ethnic and regional variations in providers' attitudes and behaviors. However, community-based studies conducted in Ethiopia, Tanzania and Zambia found little variation in the types and causes of HIV-related stigmatization and discrimination by country or region (Nyblade et al., 2003).

Third, the quantity and quality of data available for our facility survey was extremely limited. Most health facilities maintain inadequate records, with management information systems that are poorly organized and arbitrary. Because responses to the facility survey were unreliable and incomplete, we were unable to obtain accurate and comprehensive information on staffing, training, capacity building, and caseloads.

Fourth, all providers and nonmedical informants participating in the study spoke Amharic very well, and Somali providers often used English and Amharic interchangeably. However, the translation of interviews from Amharic to English was challenging in that some stigmatizing expressions in Amharic are not directly translatable; we had to look for equivalents.

Finally, it is possible that some providers may have supplied socially desirable responses and underreported their stigmatizing attitudes and practices. However, the fact that the Miz-Hasab Research Center is a nongovernmental organization may have made it easier to establish trust with study participants. In addition, some aspects of our study design, including the triangulation of data sources and the use of in-depth qualitative research methods that allow for intensive probing, probably increased the trustworthiness of our data and findings.

6.4 Conclusions

The multifaceted nature of HIV/AIDS has made it paramount to develop a new disease control and prevention paradigm. It has become important to understand the cultural, social, and economic factors that contribute to the spread of HIV/AIDS so that interventions can be developed that address the epidemic's root causes. Moreover, the values, norms, beliefs and attitudes that exacerbate poverty fuel the spread of HIV/AIDS.

The providers who participated in our study suggested that HIV/AIDS stigmatization and discrimination among health care providers is rooted in community norms. Specifically, community members' attitudes and beliefs about sexuality and sexually transmitted infections, HIV transmission and so-called high-risk groups were viewed as strong influences on health care providers' attitudes and behavior. The occurrence of stigmatization and discrimination in the health care system will not diminish until communities and health facilities undergo a profound social and structural transformation.

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Annexes

- 1. List of HAREG PMTCT Project Sites (health facilities)**
- 2. Key Informant Interview: Health Provider**
- 3. Key Informant Interview: Nonmedical Staff**
- 4. Key Informant Interview: Client**
- 5. Focus Group Discussion Guide: Health Care Providers**
- 6. Facility Survey**
- 7. Provider Survey**

**Annex 1: List of HAREG PMTCT Project Sites (health facilities)
Participating in Study.**

Zewditu Memorial Hospital
Tecele Haimanot Health Center
Adama Hospital
Adama Health Center
Bahr Dar Felege Hiwet Hospital
Bahr Dar Health Center
Axum St. Mary Hospital
Wukro Health Center
Assosa Hospital
Assosa Health Center
Karamara Hospital in Jijiga
Jijiga Health Center.

Annex 2: Key Informant Interview: Health Provider

Introduction

Good morning! I am _____ and I work for _____ (Note taker/observer introduces himself/herself).

We are here today to discuss about HIV/AIDS in the context of the health facility. We are interested in all your ideas, comments and suggestions. There are no right or wrong answers. All comments, both positive and negative, are welcome. Please feel free to disagree. All comments are confidential and used for research purposes only. Your names will not be recorded to protect your confidentiality. We will be happy to answer any questions you have at the end of the discussion.

Please tell me about your work and responsibility? (Probe for medical care he/she gives, what is like to work in the facility; difficulties faced.)

A. Priority

What are the most common diseases and health complaints here? What is the major killer disease? What do you think is the health priority in the facility and what about HIV/AIDS?

Do you think treating AIDS patients is worthwhile as compared to other patients? (Probe how, why or why not?)

B. Perception of Communicable Diseases

1. Tell me what you used to believe about communicable diseases before you joined the health profession? What do you think about people having communicable diseases/ parents and close relatives say about communicable diseases? What do they say are serious communicable diseases? What about people contracting a communicable disease? What about STI?
2. As a health provider, tell me what you know about communicable diseases? Probe for types of communicable diseases and treatments, and ask for the most dangerous types of communicable diseases?
3. What do you do when you treat patients with communicable diseases? What does your training as a health provider tell you about treating patients with communicable diseases?

4. What do you think about STI/HIV/AIDS?
5. When you see a patient with a communicable infection, what comes to your mind first? (Probe if fear of contracting the infection comes first, or if saving the life of the patient.)
6. What comes to your mind first when you see a person coming for HIV test and PMTCT? (Probe if the provider thinks that the person may be HIV positive and contemplates of the difficult life awaiting the person, if he/she worries about possible contraction of the infection assuming that the person is likely to be positive because the person must have had multiple sexual relation; if she/he appreciates the desire of the person to know his/her sero status and being a responsible person, etc.)

C. HIV/AIDS Knowledge

1. Would you tell me the difference between HIV and AIDS? How can one contract the infection?
2. How prevalent is HIV in the community? Which ones are common infections? (Probe for numbers and how many by specific age groups and sex, marital status). How many of the clients here are HIV positive? How do you know their status? (Probe: open about it, on chart, signs & symptoms) Is there a system/protocol for identifying people known or suspected to have HIV/AIDS?
3. Is there anything you do to prevent the spread of HIV/AIDS? (Probe for availability of information (IEC/BCC activities), commodities like condom, VCT, PMTCT and TB tests).
4. What do you think are the conditions in the site that play a role in the spread of HIV/AIDS?

D. Services

1. What complaints do PLWHA come for? What treatment/care is available?
2. Do patients have to pay for services? Do AIDS patients have to pay for services? (Probe for drugs & medicines, for gloves, etc.).
3. Is there a system/protocol for identifying people known or suspected to have HIV/AIDS? (Probe for the symptoms and protocols). Is there

- anything being done from the health point of view to change the health services in the facility? What treatment/care is available? What are the complaints of people coming for HIV testing and treatment?
4. Are there challenges in caring for PLWHA? (Probe: do PLWHA need special care, nothing can do for them?). Of the PLWHA treated here, how did they get HIV?
 5. Do you think your facility has enough resources (staff, equipment, medicines, money, etc) to treat both PLWHA and other clients? If not, how do you manage? (Probe for different levels of care to different types of clients) Why?
 6. Tell me about some of your patients. How do you usually get involved with someone who has HIV/AIDS? (Probe for any specific examples) Probe: Does the individual ask for help, does the family ask for help, do you hear about it from someone and then go to the household to offer help?
 7. How are the people you work with usually treated by family members? (Probe: what do they say/do? Supportive, etc?) Has this changed over time? Has your involvement with the family/PLWHA affected this? How are the people you work with treated by friends/neighbors? (Probe: what do they say/do? Supportive, etc?); by employer (if applicable); by religious group, etc
 8. In your opinion, what kind of care and treatment should health workers provide to PLWHA? For whom do you think that care and support is easy to give? Why?
 9. Do you think that the existing institutional set up and the patient flow is conducive for some one to be tested? Why? Why not? (Probe for reasons behind.)

E. Attitude towards HIV/AIDS and PLWHA

1. How does the staff talk about clients with HIV/AIDS? What do they say? Do they gossip about them? Do you think that all health personnel should know the sero-status of someone who is HIV positive in your health institution?
2. What are the particular concerns or needs there from a provider standpoint when caring for PLWHA? (Probe for sense of helplessness or

- burn out). Are they met? (e.g. Are gloves and needles readily available, supply for drugs and testing reagents for TB, STI, opportunistic infections, HIV testing reagents, AFB gram positive, etc). (Probe for worries about own status, and secondary stigma; Try to get at whether fears have to do with lack of protective equipment, knowledge about HIV/AIDS, etc)
3. What fears do health care workers have about treating PLWHA? (Probe for worries about own status, and secondary stigma; try to get at whether fears have to do with lack of protective equipment, knowledge about HIV/AIDS, etc).
 4. How does your family and friends feel about your caring for PLWHA? (Same probes).
 5. Tell me about caring for PLWHA (Probe for any specific examples)
 - What kinds of care & support do you give? How often?
 - What are benefits/difficulties of caring for PLWHA?
 - How did you feel initially about caring for PLWHA? Did that change over time?
 6. How does the staff talk about clients with HIV/AIDS? What do they say? Do they gossip about them?
 7. Are there challenges in caring for PLWHA? (Probe: do PLWHA need special care, nothing can do for them?)
 8. Of the PLWHA treated here, how did they get HIV?
 9. What do you think about those who contract HIV? probe for issues related to morality, social norms, sex and sexuality, promiscuity; Probe for the usual risk group by gender, age, occupation, and behavior; probe of PLWHA are useful and is worth to give them care and support.

F. Understanding HIV Related Stigma and Discrimination

1. Stigma and discrimination has been discussed in the media and various conferences. would you tell me what HIV/AIDS related stigma mean to? What HIV/AIDS related discrimination mean to you?
2. Are there local names for, HIV, AIDS, stigma and discrimination? What do you say here?
3. How do HIV related stigma and discrimination manifest in your facility? What are the consequences you observed of stigmatizing and discriminating PLWHA and AIDS patients? What did you observe happening in your work on HIV/AIDS? What is being done to tackle this problem? What do you think needs to be done in future? Probe for possible intervention needed at individual, health facility and community levels.)

G. Comments:

Please write your comments about the health provider's reaction towards HIV/AIDS, and those living with the virus and those seeking VCT, PMTCT services and those seeking bed treatment. Please comment on any observed stigma and what the cause of the stigma many be (fear, social norm, etc) and what needs to be done to help such provider of the observed stigma if any. Please comment on any positive attitude such as being compassionate towards PLWHA and AIDS patients.

Annex 3: Key Informant Interview: Nonmedical Staff

Introduction

Good morning! I am _____ and I work for _____ (Note taker/observer introduces himself/herself).

We are here today to discuss about HIV/AIDS in the context of the health facility. We are interested in all your ideas, comments and suggestions. There are no right or wrong answers. All comments, both positive and negative, are welcome. Please feel free to disagree. We would like to have many points of view. All comments are confidential and used for research purposes only. Your name will not be recorded to protect your confidentiality. We will be happy to answer any questions you have at the end of the discussion.

A. Background Related Questions

Tell me about your duties and responsibilities in the site? How long has it been since you started working in this site?

B. HIV/AIDS Knowledge Related Questions

1. What are the ways you think HIV/AIDS is spread? (Probe for misconceptions such as casual touch, sharing food and the like).
2. How widespread do you think HIV/AIDS is in the area? (Probe: Are there people in this community who have HIV or AIDS and are open about it/have told people about it but are not visibly ill? Are there people who are visibly ill? Are there people who have died? (Either suspected or known to have had HIV).
3. What do you think contract HIV infection? (\Probe by behavior, social status, gender, age, occupation and if they think of the usual risk group)
4. Do you feel that you are at risk of contracting HIV? If yes, how? If not why not?
5. What are the ways you think are effective for protecting from HIV infection? (Probe if the modes of prevention mentioned are accessible for people in the area say condom, VCT, PMTCT if mentioned).
6. How do people in the site know that someone died due to AIDS or someone is ill because of AIDS? Does the means of getting information match with the tradition, culture and religious practices? (Probe for formal and informal communication mechanisms—posters/leaflets/radio or

television (TV) spots, messages from informal talks/conversations with family, friends, and neighbors).

7. Who do members of the community say brings HIV/AIDS to the site? (Probe for gender, age wise, mobile people, merchants, sex workers)?
8. What information are people getting about HIV/AIDS? What access do they have to (i) information (personal counseling), (ii) VCT, (iii) Care and support, (iv) Traditional medicine, (v) Modern medicine/drugs?

C. Attitude towards HIV/AIDS and PLWHA

1. What do people fear about HIV? Why? (Probe about fears of transmission, secondary stigma, or tainted reputation/being associated with negative attributes).
2. How do people in the site come to know about people who have HIV/AIDS? (Probe: open about status? Illness? Behavior? Gossip?).
3. Do PLWHA try to hide their status? Probe why/why not? (Listen for mention of services denied, ill treatment, or other consequences of disclosure).
4. Should PLWHA tell others they have HIV? (Who? Why?).
5. What do friends and neighbors say about PLWHA? (Probe to get differences in who says this and who is this said about—i.e. Do women and men get treated differently? How do friends and neighbors treat PLWHA? (Same probes).
6. What about their own families; what do they say? (Same probes; probe for close family and other relatives).
7. What support and help do they give? Why? (Try to get at what obligation friends and neighbors feel/don't feel for PLWHA).
8. Do they isolate or ostracize? How? Why? (Try to get at why this behavior may be allowed).
9. How about their own families? How do they treat family members with HIV/AIDS? (Same probes; probe for close family and other relatives).
10. What support and help do they give? Why? (Try to get at what obligations family members feel/don't feel for PLWHA).

11. What do people say about the family (probe for wife/husband; children/parents, other relatives) of someone with HIV/AIDS? How is the family treated? (Same probes for gender and age).
12. What do you feel about health providers nursing AIDS patients? (Probe for suspecting them that they could be infected any secondary stigma, and what he/she feels touching, eating with such health providers?)
13. Do employees of the health facility discuss HIV/AIDS? (Probe what usually comes out in the discussion, probe for fears of casual transmission, probe what they say about VCT, PMTCT, Care and treatment of AIDS patients).
14. What preventive measures are taken against HIV/AIDS in the facility? (Probe if there are regular lessons on HIV transmission, use of condoms, and supporting people to avoid premarital sex, use of multiple sexual partnership, use of sex for income or receiving any form of economic benefit, VCT).
15. What do you feel when you see suspected or actual PLWHA coming for treatment to the facility? (Probe for fears, sympathy, hatred, disgust, any kind of feeling; and probe if it is useful to treat APLWHA including AIDS patients.)

Annex 4: Key Informant Interview: Client

Introduction

Good morning! I am _____ and I work for _____(Note taker/observer introduces himself/herself).

We are here today to discuss about HIV/AIDS in the context of the health facility. We are interested in all your ideas, comments and suggestions. There are no right or wrong answers. All comments, both positive and negative, are welcome. Please feel free to disagree. All comments are confidential and used for research purposes only. Your name will not be recorded to protect your confidentiality. We will be happy to answer any questions you have at the end of the discussion.

A. Background

Would you please introduce yourself? (Probe for age, marital status, employment background, education, religion and ethnicity, number of children, age of last child).

B. Knowledge on HIV/AIDS

1. Would you tell me what you know about HIV/AIDS? (Probe for transmission, prevention, care and support including treatment of opportunistic infections, use of ART, difference between HIV and AIDS, and who contracts HIV and why.)
2. How and when do you first learn about HIV/AIDS? (Probe for source of information, such as media, neighbors, health providers, school, public meeting?)
3. Would you tell men about your way of life? (Probe for sexual behavior, mobility, type of employment, drinking habit.)

C. Experience of Stigma and Discrimination in a Health Facility

1. Would you tell me about the services you receive here? (Probe for counseling, treatment for any infection if appropriate, management at the VCT/PMTCT by health providers; and if appropriate ask on how the client learned about his/her HIV status and experiences around this, including for how long he/she has known her/his sero status.)
2. What do you think are the problems that PLWHA and AIDS patients face apart from the illness at the facility? (Probe for provider stigma, say attitude exhibited towards PLWHA and AIDS patients: During testing, on

learning of sero status, counseling services pre and post test, care and treatment, attitude of providers, what worries providers while nursing them, what language they use say, insult, hatred, distancing, anything that angers the PLWHA.)

3. How difficult is disclosing one's sero status to a health provider? Why?
4. Ask for more stigma and discrimination at health facility: who do you think stigmatize more: doctors, nurses, health assistants, pharmacists, administrative and support staff? Why?
5. Who do you think is given priority in the facility: AIDS patients or other non-AIDS\ patients? (Probe for why?)
6. What do you think health providers feel about PLWHA and AIDS patients? (Probe for any negative and positive feeling.)
7. What needs to be done to mitigate stigma and discrimination in health facilities? Probe for (i) Open discussions in the facility involving staff and clients, (ii) Educating health providers on HIV/AIDS and on giving care and treatment to PLWHA and AIDS patients, (iii) Introducing law to punish stigmatizers and discriminators and any other.

D. Understanding Stigma and Discrimination

1. Stigma and discrimination has been discussed in the media and various conferences. Would you tell me what HIV/AIDS related stigma mean to? What HIV/AIDS related discrimination mean to you?
2. Are there local names for, HIV, AIDS, stigma and discrimination? What do you say here?
3. How do HIV related stigma and discrimination manifest in your facility? What are the consequences you observed of stigmatizing and discriminating PLWHA and AIDS patients? What did you observe happening in your work on HIV/AIDS? What is being done to tackle this problem? What do you think needs to be done in future? (Probe for possible intervention needed at individual, health facility and community levels.)

E. Comments

Describe what you think of the client/s feeling about HIV/AIDS and services received at the health facility and being PLWHA.

Annex 5: Focus Group Discussion Guide: Health Care Providers

Introduction

Good morning! Welcome to our group discussion. I am _____ and I come from _____ (Note taker/observer introduces himself/herself).

We are here today to discuss about HIV/AIDS in the context of the health facility. We are interested in all your ideas, comments and suggestions. There are no right or wrong answers. All comments, both positive and negative, are welcome. Please feel free to disagree with one another. We would like to have many points of view. We want this to be a group discussion, so you need not wait for me to call on you. All comments are confidential and used for research purposes only. Your names will not be recorded to protect your confidentiality. We will be happy to answer any questions you have at the end of the discussion.

A. Priority

1. What are the most common diseases and health complaints here? What is the major killer disease? What do you think is the health priority in the facility and what about HIV/AIDS?
2. Do you think treating AIDS patients is worthwhile as compared to other patients? (Probe how, why or why not?)

B. Perception of Communicable Diseases

7. Tell me what you used to believe about communicable diseases before you joined the health profession? What do you think about people having communicable diseases/ parents and close relatives say about communicable diseases? What do they say are serious communicable diseases? What about people contracting a communicable disease? What about STI?
8. As a health provider, tell me what you know about communicable diseases? Probe for types of communicable diseases and treatments, and ask for the most dangerous types of communicable diseases?
9. What do you do when you treat patients with communicable diseases? What does your training as a health provider tell you about treating patients with communicable diseases?

10. What do you think about STI/HIV/AIDS?
11. When you see a patient with a communicable infection, what comes to your mind first? (Probe if fear of contracting the infection comes first, or if saving the life of the patient.)
12. What comes to your mind first when you see a person coming for HIV test and PMTCT? (Probe if the provider thinks that the person may be HIV positive and contemplates of the difficult life awaiting the person, if he/she worries about possible contraction of the infection assuming that the person is likely to be positive because the person must have had multiple sexual relation; if she/he appreciates the desire of the person to know his/her sero status and being a responsible person, etc.)

C. Knowledge of HIV/AIDS

1. Tell me what you know about HIV/AIDS? (Probe for transmission, prevention, care and support to PLWHA and AIDS patients, difference between HIV AND AIDS and main route of infection.)
2. How problematic is care and treatment for PLWHA? (Probe the worries and fears of health providers and what they think of PLWHA, if they think they are giving the treatment because they are required to or if they think PLWHA can be useful and productive citizens.)

D. Attitudes toward HIV/AIDS and PLWHA

1. What kind of people get HIV/AIDS do you think? (Probe why they think so?)
2. How do you see these groups of people you mentioned above? (Probe if there is change of attitude as time passed)
3. Do you think people infected with the virus should openly disclose their status? (If yes why and if no why not?)
4. How fast is the news spread about someone suspected to have HIV/AIDS within the health facility? (Probe how it is done and why it is done?).
5. Do you think that all health personnel should know the sero-status of someone who is HIV positive in your health institution?

E. Attitudes: Care and Treatment toward PLWHA

1. What words do people in the health facility use to talk about HIV/AIDS and people living with HIV/AIDS?
2. Who do you blame more for being infected with HIV, women or men? (Probe why)
3. What do you think members of the community say about health providers who nurse AIDs patients and work in the VCT and PMTCT services? (Probe for any secondary stigma, such as suspecting such health providers to be infected too)
4. Are there things PLWHA can or cannot do? Should or should not do? Why? Who decides what they should or should not do?

F. Testing and Disclosure

1. What kind of people come her for HIV/AIDS medical test? (If yes what kind of people and why, if not why? And where do they go for test).
2. What do people say about those who go for VCT? (Probe why)
3. Would someone going for a test tell anyone before they went? Who? Why?
4. Would a person who has been told after a test that he has HIV be likely to share this information with anyone? (Probe: With who? spouse? Other family members in his household? Other relatives? Neighbors? People in the village? At work? At church/mosque? Probe: why would he/she (or would he/she not) share his HIV status? Why with some and not with others? What fears would he have about sharing his status? (Probe: With who? What about if he was told he does not have HIV? Would he share this information? With who? Why?).
5. Are there times when someone's HIV status is disclosed to others' without his/her consent? Why? (Probe to see if this is justified.)
6. Do you think that the existing institutional set-up and the patient flow is conducive for someone to be tested? Why or why not? (Probe for reasons behind?)

G. Care and Support

1. What is the role of health providers in care and support? Do you give care and support to PLWHA, AIDS patients? Where do people living with HIV/AIDS turn to for care and support?
2. Does support and care change over time? With how ill a person is? (Probe for differences from other illnesses. Are there differences in who and how PLWHA are cared for compared to say malaria, cancer, TB etc? Why?).
 - What do PLWHA need? Is it easy/difficult to get the support and care they need? Why?
 - Are all PLWHA supported and cared for in the same way? Why? (Probe: for difference of contracting the virus, socio economic status, gender)
3. In your opinion, what kind of care and treatment should health workers provide to PLWHA? For whom do you think care and support is easy to give? Why?

H. Understanding Stigma and Discrimination

1. Stigma and discrimination has been discussed in the media and various conferences. Would you tell me what HIV/AIDS related stigma mean to? What HIV/AIDS related discrimination mean to you?
2. Are there local names for, HIV, AIDS, stigma and discrimination? What do you say here?
3. How do HIV related stigma and discrimination manifest in your facility? What are the consequences you observed of stigmatizing and discriminating PLWHA and AIDS patients? What did you observe happening in your work on HIV/AIDS? What is being done to tackle this problem? What do you think needs to be done in future? (Probe for possible intervention needed at individual, health facility and community levels.)

I. Comment

Please write your comments on the Focus Group Discussion (FGD) and the stigma observed in health providers in the process of the discussion. Please write what you think needs to be done on the basis of discussion to mitigate HIV related stigma in health providers.

Annex 6: Facility Survey

FACILITY IDENTIFICATION

1. Name of Facility: _____

2. Facility Location

Region: _____

Zone: _____

Wereda: _____

Town: _____

3. Type of Facility

1. Referral hospital

2. Hospital

3. Health center

4. Health post

6. Other

If Other specify: _____

4. Operating Authority

1. Government

2. Non-governmental organization

3. Private

4. Other

HEAD OF FACILITY CONSENT

Researcher: Introduce yourself to the head of the facility.

Hello. I am representing the Miz-Hasab Research Center. We are carrying out a survey on HIV/AIDS related health services sponsored by IntraHealth, USAID. We would be interested to talk to you about your work particularly what you feel working with suspected and actual PLWHA.

This information is completely confidential. You may choose to stop the interview at any time.

Do you have any questions for me at this time?

Do I have your agreement to participate?

Yes. Continue.

No.

Stop Interview.

INTERVIEWER'S SIGNATURE

(Indicates respondent's willingness to participate)

DATE

Section 1.1 Resources			
	QUESTIONS	CODE CLASSIFICATION	GO TO
111	Does this facility have electricity? (from any source)	YES..... 1 NO 2	→113
112	Is the electricity always available during the times when the facility is providing services or is it sometimes interrupted? IF SOMETIMES INTERRUPTED: On how many days during the past week was the electricity NOT available for TWO (2) OR MORE HOURS?	ALWAYS AVAILABLE 1 SOMETIMES AVAILABLE..... 2 # OF DAYS NOT AVAILABLE PAST WEEK _____	→113
113	What is the most commonly used source of water for the facility at this time?	PIPED 1 PROTECTED WELL/BOREHOLE 2 UNPROTECTED WELL / BOREHOLE 3 RIVER/LAKE /POND..... 4 OTHER _____ 5 (SPECIFY) NO WATER SOURCE..... 00	→115
114	Is this water source available on-site?	YES, ON-SITE 1 NO 2	
115	Is there a waiting area for clients, where they are protected from sun and rain?	YES..... 1 NO 2	
116	Is there a toilet (latrine) in functioning condition which is available for use of clients?	YES..... 1 NO 2	
117	Does this facility have a working phone or short-wave radio?	YES..... 1 NO 2	
118	Does this facility have a generator?	YES..... 1 NO 2	
119	ASSESS GENERAL CLEANLINESS OF FACILITY A FACILITY IS CLEAN IF THE FLOORS ARE SWEEPED, COUNTERS/TABLES ARE WIPED AND FREE FROM OBVIOUS DIRT OR WASTE. A FACILITY IS NOT CLEAN IF THERE IS OBVIOUS DIRT/WASTE/BROKEN OBJECTS ON FLOORS OR COUNTERS	FACILITY CLEAN 1 FACILITY NOT CLEAN 2	

Section 1.2 Staff					
NO.	QUESTIONS	CODE CLASSIFICATION			GO TO
121	Is there a trained health provider present at the facility at all times (24 hours/day)	YES	1		➔ 123
		NO	2		
122	Is there a trained health provider available on call at all times after hours?	YES	1		
		NO	2		
123	Now I have some questions about the number of staff who are trained in providing care to HIV/AIDS cases (management of HIV/AIDS clients including medical care, palliative care, counseling and psychological care)				
	TRAINING	Physicians	Nurses	Health Assistants	Others
	A.) Medical care of PLWHA				
	B.) Administering ARV-DRUGS				
	C.) Palliative care				
	D.) Counseling and psychological care				
	E.) Laboratory related training to HIV/AIDS				
	F.) Testing and disclosure of results				
	G) OTHER (SPECIFY) _____				

Section 1.3 Administration				
NO.	QUESTIONS	CODE CLASSIFICATION		GO TO
131	Does this facility have a formal system for reviewing management or administrative issues?	YES.....	1	
		NO	2	
		DON'T KNOW	8	
132	Does this facility have any system for determining client opinion about the health facility or services? IF YES, CIRCLE ALL METHODS FOR ELICITING CLIENT OPINIONS THAT ARE USED	SUGGESTION BOX.....	1	➔ 134
		CLIENT SURVEY FORM.....	2	
		CLIENT INTERVIEW	3	
		OTHER _____	4	
		(SPECIFY)		
		NO CLIENT FEEDBACK	5	
		DON'T KNOW	6	
133	In the past 3 months have any changes been made in the program as a result of client opinion? IF YES, DESCRIBE THE CHANGES MADE.	YES, _____	1	
		(SPECIFY)		
		NO	2	
		DON'T KNOW	8	
134	When was the last time a supervisor from OUTSIDE visited this facility?	WITHIN THE LAST 6 MONTHS	1	IF 2 OR 3: ➔ Section 1. 4
		NOT WITHIN THE LAST 6 MONTHS	2	
		NEVER SUPERVISED FROM OUTSIDE FACILITY	3	

135	The last time within the last 6 months that a supervisor from outside the facility visited, did the supervisor:	YES	NO	DK
	A) Check some registers/books?.....	1	2	8
	B) Discuss problems?	1	2	8
	C) Discuss policy/administrative issues?.....	1	2	8
	D) Discuss technical protocols/practices/issues?.....	1	2	8
	E) Hold an official staff meeting?.....	1	2	8
	F) Check the facility's financial situation (cash-book, bank account records)?	1	2	8
	G) Do anything else?	1	2	8
	H) OTHER _____ (SPECIFY)	1	2	8

Section 1.4 Patient Referrals			
NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
141	Is there a referral form, which is sent with referrals from this facility? IF YES, ASK TO SEE THE FORM. (IF THE FACILITY IS THE REFERRAL FACILITY, THEN CIRCLE "4" FOR REFERRAL FACILITY.	YES, FORM SEEN 1 YES, FORM NOT SEEN 2 NO 3 THIS IS A REFERRAL FACILITY ... 4 DON'T KNOW 8	} → 151
142	Do you use this form for EACH referral or only for patients with specific diagnoses?	Each referral.....1 For specific diagnoses only (specify)22 Form is occasionally used.....3 We don't use the form..... 4	
143	Which ambulance service do you use if you have to refer patients in an ambulance?	Own ambulance1 Call facility ambulance 2 Call private ambulance service3 Call district ambulance4 Patient arrangement5 Other (specify):6	
144	How much does the patient pay for an ambulance transport from your facility to the facility?	AMOUNT:	

Section 1.5 Laboratory and X-Ray			
PLEASE REPORT ABOUT THE AVAILABILITY OF THESE DIAGNOSES-SPECIFIC TESTS			
NO.	QUESTIONS	CODE CLASSIFICATION	GO TO
151	Does this facility provide blood tests to confirm the diagnosis of MALARIA?	YES1 NO2 DON'T KNOW.....8	
152	Does this facility provide sputum tests to confirm the diagnosis of TUBERCULOSIS?	YES1 NO2 DON'T KNOW8	
153	Does this facility provide blood tests to confirm the diagnosis of HIV?	YES1 NO2 DON'T KNOW.....8	
154	Does this facility test each HIV patient for the diagnosis of Tuberculosis?	YES1 NO2 DON'T KNOW.....8	

155	Does this facility provide X-Rays to confirm the diagnosis of TUBERCULOSIS?	YES1 NO.....2 DON'T KNOW.....8	
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Section 2. Curative Care Services			
Section 2.1 Inpatient Care, Availability and Use			
NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
201	Does this facility routinely admit inpatients for treatment?	YES.....1 NO.....2	IF NO, →206
202	How many beds do you have to provide inpatient care?	NBR BEDS	
203	Average number admits per day	NRR INPAT ADMITS	
204	What is the average bed occupancy rate	Occupancy Rate in %	
205	What is the average bed occupancy rate by AIDS patients	occupancy rate in %	

Section 2.2 Outpatient Consultations and Case Mix			
NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
206	Does this facility offer curative outpatient care?	YES.....1 NO.....2	IF NO, →231
207	Average number of visits for curative care per day	_____ DON'T KNOW998	
208	Record the average number of visits by children per day	_____ DON'T KNOW 998	
209	Record the average number visits by adults per day	_____ DON'T KNOW 998	
210	Record the average number of clients treated for TB per day	_____ DON'T KNOW.....998	
211	Record the average number of clients treated for HIV/AIDS per day	_____ DON'T KNOW.....998	

Section 2.3 STI and HIV/AIDS Services			
231	Does this facility offer any services related to diagnosis, treatment or supportive services for STIs, or HIV/AIDS?	YES NO.....	IF NO, → Part 4
232	Does this facility offer STI services?	YES NO.....	
233	Does this facility offer any services related to HIV/AIDS?	YES NO.....	IF NO, → Part 4

Part 1. VCT SERVICES							
NO.	QUESTIONS	CODING CLASSIFICATION			GO TO		
234	Does this facility offer voluntary counseling and testing (VCT) for HIV?	YES..... NO.....			→240		
235	Are VCT services offered in a special clinic or through general outpatient services?	SPECIAL CLINIC..... GENERAL OUTPATIENT..... OTHER..... (SPECIFY)					
236	When a VCT client is found to be positive, indicate how often clients are referred elsewhere for the following services:	REFERRED			DON'T KNOW		
		ALWAYS	SOMETIMES	RARE/ NEVER			
	a) MEDICAL FOLLOW-UP	1	2	3	8		
	b) DIAGNOSIS FOR TB	1	2	3	8		
	c) HOME-BASED CARE SERVICES	1	2	3	8		
237	Is there a register where VCT client information is recorded? If yes, may I see it	YES, REGISTER SEEN..... YES, REGISTER NOT SEEN..... NO REGISTER KEPT.....			→239 →239		
238	How recent is the date of the most recent entry?	WITHIN THE PAST 7 DAYS..... > 7 DAYS.....					
239	Record the average number of clients who received VCT per day	NUMBER OF HIV CLIENTS..... DON'T KNOW.....998					
Part 2. OTHER HIV/AIDS SERVICES							
NO.	QUESTIONS	CODING CLASSIFICATION			GO TO		
240	Does this facility provide any diagnostic, follow-up, or treatment for HIV/AIDS, apart from VCT?	YES..... NO.....			→NEXT SECTION		
241	FOR EACH OF THE FOLLOWING HIV/AIDS RELATED SERVICES, INDICATE IF THE FACILITY PROVIDES THE SERVICE, REFERS ELSEWHERE, OR DOES NOT PROVIDE THE SERVICE OR REFERRAL.						
		PROVIDE SERVICE			REFER ELSE WHERE	NO SERVICE/ REFER	DON'T KNOW
		OUT PATIENT	IN PATIENT	BOTH OUT & IN			
	a) Tuberculosis diagnose & treat	1	2	3	4	5	8
	b) Concurrent infections diag & tx	1	2	3	4	5	8
	c) Palliative management	1	2	3	4	5	8
	d) Family planning services	1	2	3	4	5	8
	e) Counseling on prevention of mother to child transmission	1	2	3	4	5	8
	f) Psycho-social services	1	2	3	4	5	8
	g) Counseling/training for home care	1	2	3	4	5	8
	h) Anti-retroviral Therapy	1	2	3	4→243	5→243	8→243
242	# CLIENTS WHO RECEIVED ANITRETROVIRAL THERAPY PER DAY	_____			DON'T KNOW 998		

Part 3. PMTCT SERVICES			
243	Does this facility give PMTCT services?	1. Yes 2. No	2 → Part 4
244	Are PMTCT services offered in a special clinic or through general outpatient services?	1. Special clinic 2. General outpatient 3. Other (specify)	
245	Do you think that the existing institutional set up is conducive for PMTC services?	1. Yes 2. No	1 → Part 4
246	If no, why	1. Shortage of trained manpower on PMTCT 2. Shortage of laboratory facilities and reagents 3. Shortage of health educators 4. 4 Other specify	

Part 4. DRUG MANAGEMENT			
NO.	QUESTIONS	CODING CLASSIFICATION	GO TO
300	Does this facility determine the amount of each medication required and order this amount	DETERMINES OWN NEED AND ORDERS..... 1 NEED DETERMINED ELSEWHERE 2	→ 302
301	IF DETERMINED ELSEWHERE: Do you always receive a standard fixed supply or does the amount you receive vary with the activity level that you report?	AMOUNT BASED ON ACTIVITY LEVEL..... 1 STANDARD FIXED SUPPLY 2 DON'T KNOW 998	→ 304 → 304 → 304
302	If amount of each medication ordered is determined by this facility how do you decide how much of each vaccine to order?		
	a) ORDER TO BRING STOCK TO FIXED LEVEL 1	
	b) ORDER SAME AMOUNT EACH TIME REGARDLESS OF EXISTING STOCK 2	
	c) VARY AMOUNT OF ORDER DEPENDING ON PRIOR UTILIZATION AND EXPECTED FUTURE ACTIVITY 3	
	d) NO SPECIFIC SYSTEM FOR DETERMINING AMOUNT 4	
	e) OTHER (SPECIFY) _____ 5	
	f) DON'T KNOW 6	

303	<p>IF the order for medications is placed by this facility, how do you decide when to order the medications?</p> <p>a) ORDER WHENEVER STOCK LEVELS FALL TO PRE-DETERMINED MINIMUM LEVELS</p> <p>b) THERE IS A FIXED TIME WHEN MEDICATION ORDERS ARE SUBMITTED. THIS IS EVERY ___ MONTHS</p> <p>c) STOCK DOES NOT HAVE TO BE BELOW A SPECIFIED LEVEL. THE FACILITY CAN PLACE AN ORDER WHENEVER THERE IS BELIEVED TO BE A NEED.</p> <p>d) OTHER (SPECIFY)_____</p> <p>e) DON'T KNOW</p>	<p>1</p> <p>2</p> <p>3</p> <p>4</p> <p>5</p>	
304	<p>During the past 3 months, have you always, sometimes or almost never receive the amount of each medication that you order (or that you are suppose to routinely receive)?</p>	<p>ALWAYS..... 1</p> <p>SOMETIMES 2</p> <p>ALMOST NEVER 3</p>	

Annex 7: Provider Survey

FACILITY IDENTIFICATION

1. Name of Facility: _____

2. Facility Location

Region: _____

Zone: _____

Wereda: _____

Town: _____

3. Type of Facility

1. Referral hospital

2. Hospital

3. Health center

4. Health post

6. Other

If Other specify: _____

4. Operating Authority

1. Government

2. Non-governmental organization

3. Private

4. Other

PROVIDER CONSENT

Researcher: Introduce yourself to the Provider:

Hello. I am representing the Miz-Hasab Research Center. We are carrying out a survey on HIV/AIDS related health services sponsored by IntraHealth, USAID. We would be interested to talk to you about your work particularly what you feel working with suspected and actual PLWHA.

This information is completely confidential. You may choose to stop the interview at any time.

Do you have any questions for me at this time?

Do I have your agreement to participate?

Yes. Continue.

No.

Stop Interview.

INTERVIEWER'S SIGNATURE
(Indicates respondent's willingness to participate)

DATE

PROVIDER INTERVIEW

Section 1. Provider Training, Position and Experience

No.	QUESTIONS	CODING CLASSIFICATION	GO TO
101	In what year did you start working in this facility?	Year: _____ (European calendar) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
102	How many years of education did you complete?	_____ Years <input type="text"/> <input type="text"/>	
103	What is your current technical qualification?	Physician.....1 Medical asst2 Nurse.....3 Midwife.....4 Auxiliary nurse.....5 Other.....6 If other: _____	
104	Is the position that you hold at this facility one of the established positions?	Yes1 No2	→ 106
105	In No, in what role are you working at this facility?	Temporary.....1 On secondment.....2 No position.....3 Other.....4 If other: _____	

SERVICE	106. Do you personally provide (SERVICE) to patients at this facility?	107. How many hours on average per week do you provide (SERVICE)?	108. During the past one year have you received any in-service training on this service?	109. During the past year how many days of training on this topic have you received?
a. Family Planning	Yes.....1 No.....2→108	_____ Hours	Yes.....1 No.....2→106b	_____ Days
b. HIV/AIDS counseling and testing	Yes.....1 No.....2→108	_____ Hours	Yes.....1 No.....2→106c	_____ Days
c. STI counseling and testing	Yes.....1 No.....2→108	_____ Hours	Yes.....1 No.....2→106d	_____ Days
d. TB Care	Yes.....1 No.....2→108	_____ Hours	Yes.....1 No.....2→106e	_____ Days.
e. Medical care for PLWHA	Yes.....1 No.....2→108	_____ Hours	Yes.....1 No.....2→106f	_____ Days
f. ARV treatment	Yes.....1 No.....2→108	_____ Hours	Yes.....1 No.....2→106g	_____ Days
g. Palliative care for PLWHA	Yes.....1 No.....2→108	_____ Hours	Yes.....1 No.....2→201	_____ Days

Section 2. Supervision on Providers giving HIV/AIDS Related services

No.	QUESTIONS	CODING CLASSIFICATION	GO TO
201	Are you supervised when you give HIV/AIDS related services	Yes.....1 No.....2	→203
202	How many times in the last 6 months have you been supervised?	No. of times: _____	
203	Do you receive feedback from your supervisor?	Yes.....1 No.....2	
204	Is the supervision supportive or evaluative?	Supportive.....1 Evaluative.....2	
205	Do you feel you learned from the supervision?	Not at all.....1 to some extent.....2 Yes a lot.....3 other (specify) _____	

Section 3. Motivation and Job Satisfaction

Now I would like to answer you some questions about what motivates you to do your work and about your job satisfaction. Please remember that your responses will not be used in any way to judge your work, and will not be revealed to your supervisor or any other person. There are no right or wrong answers. I am simply interested to know what you think and feel.

I am going to read out some statements. For each statement I would like you to use a scale of 1-5 (with 1 indicating strong disagreement and 5 indicating strong agreement) to indicate how much YOU agree or disagree with the statement.

Enumerator should provide respondent with a simple tool in own language showing how the scale works.

Enumerator please circle the number corresponding to the respondents answer for each question.

No	QUESTION	1=Strongly Disagree 2=Disagree 3=No opinion 4=Agree 5=Strongly Agree
		1 2 3 4 5
3.1 Pride		
301	This health facility has a good reputation in the community	1 2 3 4 5
302	It is a source of pride to get a job at this facility	1 2 3 4 5
303	The majority of workers in this health facility are proud to work here	1 2 3 4 5
304	Workers at this health facility pride themselves on providing good services to patients	1 2 3 4 5

3.2 Financial reward						
310	The effort that workers at this facility put into this job is reflected in our pay	1	2	3	4	5
311	My job offers adequate pay compared with similar jobs	1	2	3	4	5
312	The income I receive is a fair reflection of my skills, knowledge and training	1	2	3	4	5
313	The income that I receive from working at this facility more than covers my basic needs such as food transport and accommodation	1	2	3	4	5
314	With this job I have no worries about how to support myself and my family	1	2	3	4	5
3.3 Perceived self-efficacy						
320	I am confident about my ability to handle my work	1	2	3	4	5
321	I effectively cope with any new challenges that occur in my work life	1	2	3	4	5
322	I feel that at work things are going the way I would like them to	1	2	3	4	5
323	I feel that I have control of things concerning my work	1	2	3	4	5
324	I have received sufficient training to be able to perform my job well	1	2	3	4	5
3.4 Resource availability						
330	A fundamental reason I do not do my job properly is that I do not have the equipment, supplies and/or materials I need	1	2	3	4	5
331	I have the necessary materials, supplies and equipment to do a good job.	1	2	3	4	5
332	This health facility provides everything I need to do my job effectively	1	2	3	4	5
333	Lack of resources at this health facility hinders the delivery of quality care	1	2	3	4	5
3.5 Self-perceived Conscientiousness						
340	I am always reliable and dependable at work	1	2	3	4	5
341	My work is consistently of a high quality	1	2	3	4	5
342	I am a hard worker	1	2	3	4	5
343	I am punctual about coming to work	1	2	3	4	5
344	I spend my time at work on work-related activities	1	2	3	4	5
345	I am rarely absent from work	1	2	3	4	5

The next few questions that I want to ask you are about your satisfaction with your job. For each question please indicate the number that best describes how satisfied you are: from (1) not at all satisfied to (5) very satisfied.							
3.6 General Job Satisfaction			1=Not at all Satisfied 2=Dissatisfied 3=No opinion 4=Satisfied 5=Very Satisfied				
			1	2	3	4	5
350	All in all, how satisfied are you with your job?		1	2	3	4	5
351	How satisfied are you with your chances to accomplish something worthwhile?		1	2	3	4	5
352	How satisfied are you with the chances you have to learn new things?		1	2	3	4	5
353	How satisfied are you with the chances you have to do something that makes you feel good about yourself as a person?		1	2	3	4	5

Section 4. Attitudes towards communicable diseases

	Questions	Coding categories	
401	Beliefs you had about any communicable disease before you became a health provider	<ol style="list-style-type: none"> 1. Bad people contract a communicable disease 2. Communicable disease is sent by God to punish sinners 3. Any person can be infected with a communicable disease. 4. Other (specify) 	
402	Beliefs about STI	<ol style="list-style-type: none"> 1. Bad people contract STI 2. STI is a punishment against adulterous people 3. Any person can contract STI 4. Other (specify) 	
403	Beliefs you have about any communicable disease as a health provider	<ol style="list-style-type: none"> 1. Patients with communicable disease threaten the health of health providers. 2. Patients with communicable disease have to be given love and support 3. Patients that contract communicable diseases are dirty. 	
404	Beliefs you have as a health provider towards STI.	<ol style="list-style-type: none"> 1. Patients with STI threaten the health of health providers. 2. Patients with STI have to be given love and support. 3. Patients that contract STI are irresponsible. 4. Any person can contract STI. 	

405	Beliefs you have as a health provider towards HIV/AIDS.	<ol style="list-style-type: none"> 1. Patients with HIV/AIDS threaten the health of health providers. 2. Patients with HIV/AIDS have to be given love and support. 3. Patients that contract HIV/AIDS are irresponsible. 4. Any person can contract HIV. 	
406	What comes to your mind when you see a client asking for VCT or PMTCT service?	<ol style="list-style-type: none"> 1. The danger of the health provider being infected with HIV. 2. The client is likely to be HIV positive. 3. The client must have been promiscuous. 4. The client is a responsible person. 	
407	What comes to your mind when you see a client with opportunistic infections?	<ol style="list-style-type: none"> 1. AIDS 2. Death 3. Suffering 4. Hopelessness 5. Time wasting 6. Treating and helping the patient 7. Hope 	

Section 5. Attitudes and Behavior towards People Living with HIV/AIDS

	Questions	Coding Categories	Skip Patterns
501.	If a person learns that he/she is infected with the virus that causes AIDS, should the person be allowed to keep this fact private or should this information be available to the community?	Be kept private1 Made available to the community.....2 Don't know/not sure3	→503 →504
502.	If kept private, why? (Check all that apply)	Personal problem1 2 People would act differently towards The person if they found out1 2 That person would be isolated /neglected/avoided if others found out1 2 No one would care for that person if others found out1 2	} →504
503.	If made available to the community, why? (Check all that apply)	This person is a threat to others /could infect others1 2 This person needs to be isolated1 2 This person needs the care and support of the community1 2 This person gives lesson to others1 2 Others.....1 2 If other, specify	

504.	In your community, how do people find out if someone from the community has HIV/AIDS? (Check all that apply) What are some other ways?	The infected person discloses his/her status1 2 From general rumors1 2 From the HIV+ person's family1 2 From the HIV+ person's employer1 2 From the HIV+ person's friends/neighbors1 2 From the health center/health worker where the person got tested1 2 The person looks ill and has lost a lot of weight1 2 Other1 2 If other, specify	
505.	Do people in your community behave differently toward people suspected of having HIV/AIDS or families affected by HIV/AIDS treated differently?	Yes1 No2 Don't know8	→507 →507
506.	Can you give some examples of how people suspected of having HIV/AIDS or families affected by HIV/AIDS might be treated differently? (Check all that apply)	Neglected, isolated, avoided1 2 Verbally abused, teased1 2 Physically abused1 2 Not allowed to go to work/school1 2 Not allowed to go to church/mosque1 2 Not allowed to be in public places1 2 Property is taken away1 2	
507	If people know that you treat PLWHA and AIDS patients, what would they do to you?	Isolate you.....1 Appreciate for your work.....2 Suspect you that you could be PLWHA.....3 Isolate your family members.....4 Don't know.....8	

Note: For multiple response questions 1 = Checked/mentioned: 2 = Not checked/not mentioned

	Questions	Coding Categories				Skip Patterns
		(1) Very	(2) Somewhat	(3) A little	(4) Not at all	
508.	People have many different feeling when they think about people who have AIDS. As I read each of the following feelings, please tell me how you personally feel:					
	a. Angry at them (person with AIDS)?					
	b. Afraid of person with AIDS?					
	c. Disgusted by the person with AIDS?					
509	I am going to read a couple of statements that people have made. As I read each one, please tell me how much you agree or disagree.	(1)Agree strongly	(2)Agree somewhat	(3)Disagree somewhat	(4)Disagree strongly	
	1. "People with AIDS should be legally separated from others to protect the public health"					
	2. "People who got AIDS through sex or drug use have gotten what they deserve"					
510	If you knew that a shopkeeper or food seller had the HIV virus, would you buy food from them?	Yes 1 No 2 Not sure 3				
511	If a member of your family contracted HIV/AIDS, would you want it to remain a secret?	Yes 1 No 2 Not sure 3				→513 →514

512	If yes, why would you want it to remain a secret? (Check all that apply)	Family members would be blamed1 2 Family member would find it difficult to get access to care and treatment1 2 Family member would be neglected, isolated, avoided1 2 Family member would be verbally abused, teased1 2 People would blame entire family1 2 People would stop interacting with entire family1 2 Other1 2 If other, specify _____	→514
513	If no, why would it be okay if it were not a secret? (Check all that apply)	Family member would be able to receive the care and support he/she needs1 2 Family member would be able to seek counseling1 2 Other1 2 If other, specify _____	
514	Do you think a person with HIV/AIDS should get the same, more or less health care than someone with any other chronic disease?	Same..... 1 More 2 Less 3 Other4 If other, specify _____	
515	If a relative of yours became sick with the virus that causes AIDS, would you be willing to care for him/her in your household?	Yes..... 1 No..... 2 DK/Not sure3	
516	How much do you agree/disagree about the following statements:	1. Strongly agree 2. Agree 3. Disagree	
	1. For most people with HIV, it is their own fault that they got HIV	1 2 3	
	2. People with HIV/AIDS should be ashamed of themselves	1 2 3	
	3. People with HIV/AIDS can remain productive members of society	1 2 3	
	4. People with HIV/AIDS have nothing to feel guilty or ashamed about	1 2 3	
	5. People with HIV/AIDS are blamed for bringing the disease into the community	1 2 3	
	6. Our society does not do enough to help people with HIV	1 2 3	
	7. People who say they are HIV/AIDS are brave and strong	1 2 3	
	8. People with HIV/AIDS present a threat to their own and their families health	1 2 3	
	9. People with HIV/AIDS deserve sympathy	1 2 3	
	10. People with HIV/AIDS deserve treatment and care	1 2 3	
	12. The family of the person with HIV/AIDS is also blame	1 2 3	
	13. The family is cursed and should be avoided & isolated	1 2 3	
	14. People with HIV/AIDS are promiscuous	1 2 3	
	15. Women get HIV because they are prostitutes	1 2 3	

517	In your opinion, where should people with HIV/AIDS go for care and support? (Check all that apply)	Family 1 2 Partner 1 2 Neighbors/friends/Community 1 2 Health facilities 1 2 Do not need care and support1 2 Don't know1 2 Other.....1 2 If Other, specify_____	
518	In your opinion, should health care facilities provide care for people with HIV/AIDS?	Yes1 No2 Maybe3 Don't know8	

	Questions	Coding Categories				Skip Patterns
519	Do you believe that it would be easy for a person with HIV/AIDS to receive care and support?	Yes1 No2 Maybe3 Don't know8				
520	In your opinion, who is deserving of care:	(1)Yes	(2) Maybe	(3) No	(8) Don't know	
	1. Man with HIV					
	2. Woman with HIV					
	3. HIV+ person who is a prostitute					
	4. HIV+ person who is a unmarried man					
	5. HIV+ person who is a unmarried woman					
	6. HIV+ person who is a married man					
	7. HIV+ person who is a married woman					
	8. HIV+ person who is a mother					
	9. HIV+ person who is a child					
	10. HIV+ person who is a homosexual					
	11. HIV+ person who is a drug user/addict					
	12. HIV+ person who is a religious/ community leader					

Note: For multiple response questions 1 = Checked/mentioned: 2 = Not checked/not mentioned

Section 6. Perception of Own Risk and HIV Testing

	Questions	Coding Categories	Skip Patterns
601.	Do you think that people with HIV/AIDS are different from you?	Very different1 Somewhat different2 Not different3	→603
602.	How are people with HIV/AIDS different from you? (in what way) (Check all that apply)	Since they have the virus1 2 Since the virus is contagious1 2 Since there is no cure1 2 Other1 2 If Other, specify_____.	
603.	Do you think you can get AIDS?	Yes.....1 Maybe.....2 No.....3 Don't know4	} → 606
604.	If yes, is it because?	Of your work.....1 Your partner.....2 Don't know.....8	
605.	If you think because of your work, is it because	Of casual transmission1 Protective equipments such as gloves are not readily available..... 2 Other3 If Other, specify_____	} →607
606.	What do you feel when an HIV/AIDS patient comes to you for treatment?	Fear1 Hatred 2 Shame.....3 Sympathy/compassion..... 4	
607.	What would you do if you thought you had HIV/AIDS? (Check all that apply)	Get tested1 2 Be angry 1 2 Be depressed1 2 Blame partner1 2 Worry1 2 Get sick1 2 Live a healthy life1 2 Change lifestyle1 2 Think about suicide1 2 Isolate myself from family and community1 2 Fearful of other's reaction1 2 Other1 2 If Other, specify_____.	
608.	If you got tested, would you share your test results with anyone?	Yes1 No2	→610
609.	If yes, with whom would you share the test results? (Check all that apply)	With partner1 2 With parents1 2 With family1 2 With neighbors1 2 With employer1 2 With friends1 2 With religious leader1 2 Other.1 2 If other, specify	}

610.	<p>If no, why wouldn't you share with results with others?</p> <p>(Check all that apply)</p>	<p>Partner would be shattered/angry1 2</p> <p>Fear of neglect, isolation avoidance1 2</p> <p>Fear of verbally abuse, teasing1 2</p> <p>Fear of being physically abused1 2</p> <p>Fear of death1 2</p> <p>I would not receive any care and support.....1 2</p> <p>Would be kicked out of the house1 2</p> <p>People would think that I am bad/immoral1 2</p> <p>People would think that I am gay 1 2</p> <p>People would think that I am promiscuous1 2</p> <p>Other.1 2</p> <p>If other, specify</p>	
611.	<p>If you had HIV/AIDS or suspected you had this disease, who would be the main person to take care of you?</p>	<p>Partner1</p> <p>Parents2</p> <p>Family (extended)3</p> <p>Natal family4</p> <p>Friends5</p> <p>Neighbors6</p> <p>No one7</p> <p>Don't know8</p>	
612.	<p>Would your family be treated differently, if you had or were suspected of having HIV/AIDS?</p>	<p>Yes1</p> <p>Maybe.....2</p> <p>No.....3</p> <p>Don't Know8</p>	} →END
613.	<p>If Yes, in what main ways would your family be treated differently?</p> <p>(Check all that apply)</p>	<p>They would be avoided.....1</p> <p>They would be blamed2</p> <p>They would not be allowed at places of worship3</p> <p>They would not be allowed to work/go to school.....4</p> <p>People would sympathize with them5</p> <p>People would offer them care and support6</p> <p>Other7</p> <p>If Other, specify_____.</p>	

Section 7. Ways forward to improve service delivery

What do you think is needed to improve the service delivery on HIV/AIDS, put in priority order the following suggestions by putting numbers 1 onwards?

- 7.1_____ Improve the salary of staff working on HIV/AIDS
- 7.2_____ Give more training on medical care, ARV treatment, palliative care and counseling and psychological treatment.
- 7.3_____ Allocate more health providers to work on HIV/AIDS related services
- 7.4_____ Conduct regular discussions among health providers on HIV/AIDS related services and experiences.
- 7.5._____ Conducting discussions among health providers and the communities where clients come from
- 7.5 _____ Other (specify) _____

Comments

INTERVIEWER COMMENTS: Describe what you think of the provider, whether she/he does have a serious problem of stigma or not towards suspected and actual PLWHA, and what you think could be the causes of the stigma observed in the health provider; or if the provider is compassionate and confident in her/his HIV/AIDS related care services