STIGMA-FREE HEALTH FACILITIES

MANUAL

TBILISI, 2020

UNFPA

TANADGOMA
თანადგომა

The manual is prepared within the frame of joint UNFPA/UNDP innovative initiative exploring key hindering factors for low uptake of HIV testing through Behavioural Insights (BI) prism and funded by the UNAIDS.

The manual is developed with technical and financial support of UNFPA Georgia Country Office in close collaboration with the National Center for Disease Control and Public Health (NCDC&PH).

Citations: Stigma-Free Health Facilities. Manual. Informational Medical Psychological Center Tanadgoma. Authors: Mzia Tabatadze, Kakhaber Kepuladze.

STIGMA-FREE HEALTH FACILITIES

Manual

2020, Tbilisi, Georgia

CONTENTS

ABBREVIATIONS AND ACRONYMS

HIV	Human Immunodeficiency Virus
ARV	Antiretroviral
GF	The Global Fund
NCDC	National Center for Disease Control and Public Health
TSMU	Tbilisi State Medical University
MSM	Men who have sex with men
IDU	Injecting Drug Users
PHC	Primary Health Care
S&D	Stigma and Discrimination
SW	Sex Workers
CCM	Country Coordination Mechanism
AIDS	Acquired Immunodeficiency Syndrome
WHO	World Health Organization
MOH	Ministry of Internally Displaced Persons from the Occupied Territories, Labour, Health and Social Affairs of Georgia
EECA	Eastern Europe and Central Asia
IBBS	Integrated Biological and Behavioural Surveillance Survey
KAP	Knowledge Attitude Practices
MICS	Multiple Indicator Cluster Survey
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund

QUICK REVIEW OF THE PROGRAM

The manual “Stigma-Free Health Facilities” was developed within the framework of project "Support to Healthy Lifestyle and SRH Education", under partnership agreement between Center for Information and Counseling on Reproductive Health - Tanadgoma and UNFPA.

One of the directions of the agreement is “Evidence-Based HIV Services for Key Populations”. For this purpose UNDP and UNFPA are implementing a joint initiative to meet two specific objectives:

1. To support stigma-free medical services in the healthcare sector for people living with HIV and key populations.

2. To design and implement randomized control trial to popularize HIV testing among youth and key populations by identifying and minimizing HIV testing barriers.

In 2020 UNFPA and Tanadgoma interviewed people living with HIV, key populations, and healthcare personnel to learn about contributing factors, motivators, and barriers for HIV testing. Qualitative research findings, along with additional evidence and internationally recognized practices, laid the foundation to generate the “Stigma-Free Health Facilities Manual”.

Within the partnership framework, it is planned to improve the professional skills of the management and the general staff of health facilities to reduce HIV-associated stigma. Piloting of the manual recommendations and further monitoring of the process in selected health facility will allow the accumulation of practical experience and evidence so that the interventions are popularized and institutionalized nationwide.

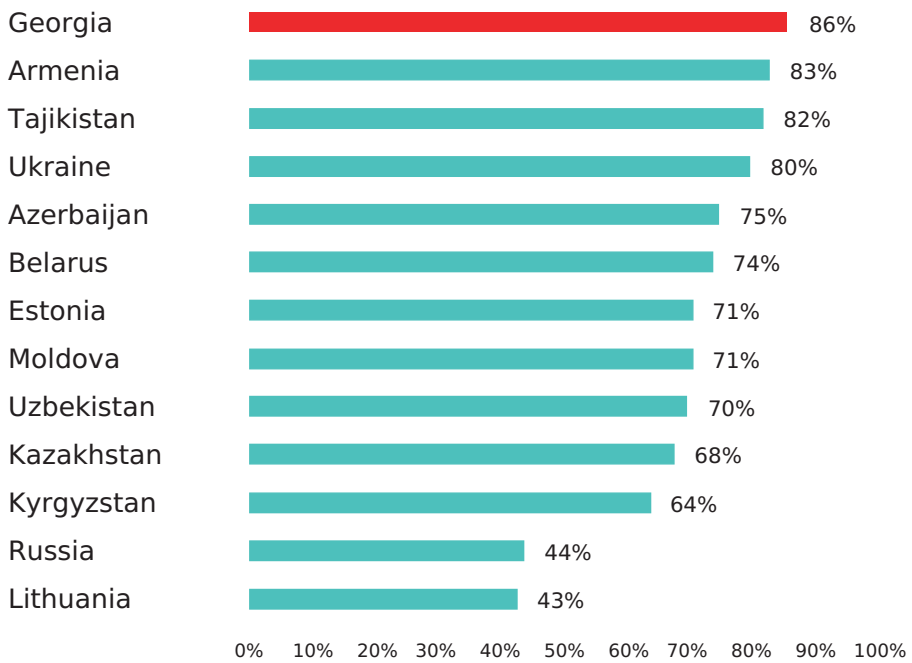
As a part of the initiative, UN agencies and Tanadgoma work closely with NCDC, AIDS Center, academic institutions, and civic society and community organizations.

Like other EECA countries, Georgia has reached significant progress in advancing the treatment and care services for people living with HIV, which directly relates to achieving viral suppression and improvement of health of individuals on treatment. But this important achievement is obstructed by the fact that out of estimated number of people living with HIV (9100 persons) more than a third (35%, 3150 infected)1 is unaware of their HIV positive status.

Local and international experts are emphasizing that Georgia is among countries that have failed to reach the UNAIDS goals (90-90-90) by 2020, and reaching 2030 goals (95-95-95) seem less likely precisely because of the low rates of detecting people living with HIV.

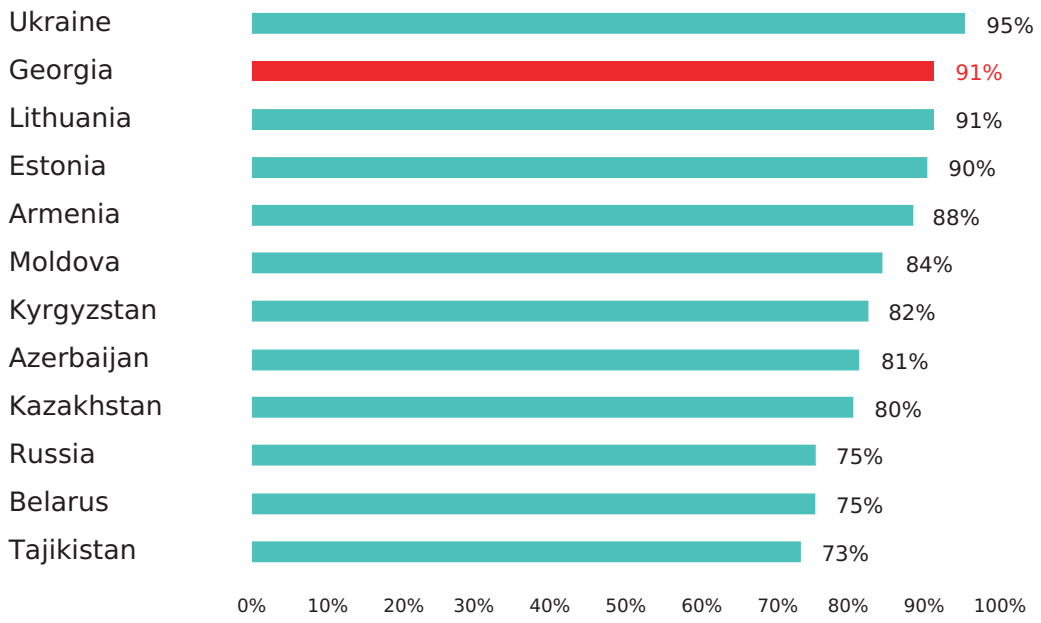
EECA country data analysis shows that Georgia is a leading country in terms of treatment enrollment and this indicator brings Georgia closest to achieve the specific objective of 2020 (factual 86% vs goal 90%);[1] and the viral suppression rate among persons in therapy has brought Georgia to an ambitious goal in 2020 (factual 91% vs goal 90%).

Graph 1: Georgia's position in the EECA region by the treatment enrollment indicator.



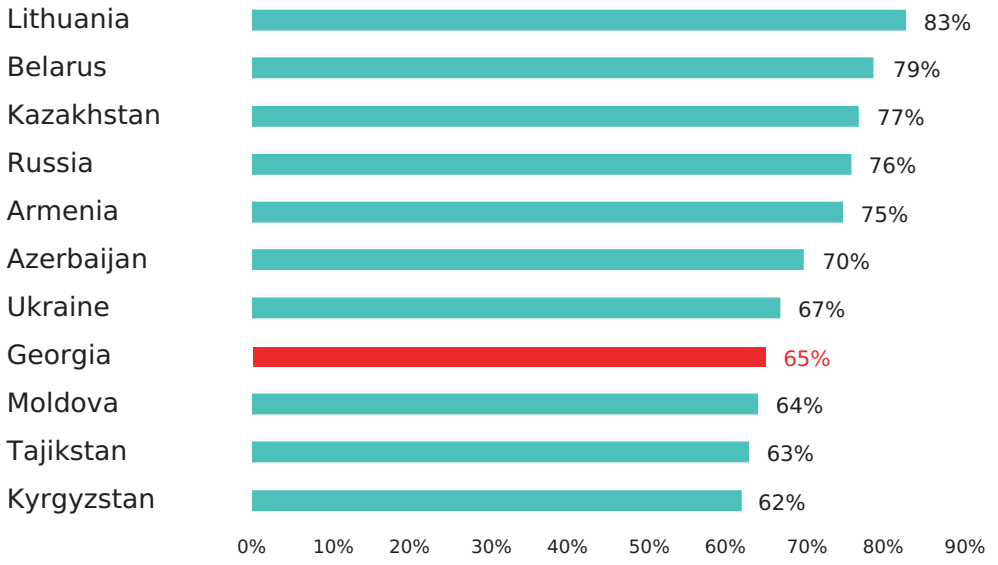
1. Unpublished. Tengiz Tsertsvadze. Infectious Diseases, AIDS and Clinical Immunology Research Center (IDACIRC). Presentation at CCM meeting. July 31, 2020.

Graph 2: Georgia's position by the Viral Suppression Rate Among Individuals in Therapy



With the success of the second and third indicators in the treatment cascade, detecting people living with HIV remains a serious challenge in the country. According to the national AIDS center data, as of 2020, this indicator puts Georgia behind neighboring countries.

Graph 3: Georgia's position according to the detection rate of people living with HIV



Studies confirm the low number of HIV testing referrals. Even though the indicator of testing has improved for the last few years, it remains lower than desired. Specifically:

- MSM: In three major Georgian cities (Tbilisi, Batumi, Kutaisi), only slightly more than half of the interviewed MSM have confirmed to have taken a test for the last 12 months[2];
- Female Sex-Workers: Indicator of having been tested for HIV during the last year among female sex workers is even lower[3];
- Injecting Drug Users: Testing indicator for IDUs varies significantly from city to city, but the average country value indicates that despite the increased risk, only a third has been tested for HIV during the last year (33% (24.3-38%))[4];
- General Population: Results of the general population study were even more severe. According to the Multiple Indicator Cluster Study (MICS6)[5] conducted jointly by UN agencies, only 1 out of 20 men say they took HIV test within 12 months before the interview. The numbers are slightly higher among women, which is probably due to the routine HIV screening program for pregnant women.
- Youth: According to the MICS6, indicator of HIV testing during the last year is unavailable, although the study shows that only 0.8% of youth between age 15-17 notes to have ever taken an HIV test.

Table 1 HIV testing rates among target populations of various studies.

წელი	Research target group	Has been tested during the past year and knows the result
IBBS 2018	Men who have sex with men	52.1% - Tbilisi
		51.1% - Batumi
		51.6% - Kutaisi
IBBS 2018	Female Sex Workers	31.5% - Tbilisi
		58 % - Batumi
IBBS 2017	Injecting Drug Users	33% - Tbilisi
		44.5% - Batumi
		27.8% - Zugdidi
		56.5% - Gori
		27.6% - Telavi
		60.8% - Kutaisi
		(33% (24.3-38%)) - Georgia
IBBS 2019	General population	7.9% - Women
		5.1% - Men

Thus the disturbingly low rates of HIV testing is one of the main challenges and, in response, one of the strategic priorities for the country is detection of people living with HIV. The latest will be possible only by improving accessibility, attractiveness and quality of HIV testing services, including expanding target testing, among other things.

2. HIV risk and prevention behaviors among Men who have Sex with Men in Tbilisi, Batumi and Kutaisi, Georgia. Bio-Behavioral Surveillance Survey. 2019. Curatio International Foundation. Center for Information and Counseling on Reproductive Health - Tanadgoma. With GFATM financial support.
3. Integrated Bio-behavioral surveillance and population size estimation survey among Female Sex Workers in Tbilisi and Batumi, Georgia Study Report. 2017. Curatio International Foundation. Center for Information and Counseling on Reproductive Health - Tanadgoma. With GFATM financial support.
4. HIV risk and prevention behaviors among People Who Inject Drugs in seven cities of Georgia. 2017. Curatio International Foundation. Bemoni Public Union. With GFATM financial support.
5. MICS6, Georgia, 2018.

National HIV/AIDS strategy[6], AIDS program of the Global Fund and other strategic documents confirm that HIV testing services for high-risk groups have been arranged in specialized medical facilities as well as NGOs for 2 decades. To improve detection, in the next round the expansion of the mobile laboratory network that currently offers HIV testing in various cities during the fieldwork has been actively implemented.

During the last few years, after initiation of the National Hepatitis C Elimination program in Georgia[7], integrated screening component for HIV infection, Tuberculosis and viral hepatitis has been gradually introduced in the primary healthcare. During the first 7 months of 2020 (Jan – July) total of 62,000 tests have been conducted within the integrated screening program, and 36 HIV cases have been identified (6 seropositive persons per 10,000 tested persons).[8]

With an aim to expand and popularize HIV testing, the HIV self-testing implementation began in 2020 following the National Strategic Plan6.

Thus, the expansion of HIV testing, detecting people living with HIV, and timely enrolling them in treatment and care services is the country's declared priority, and to reach this goal, it is imperative to evaluate obstacles for testing, especially in healthcare facilities that are becoming new players in HIV counseling and testing services provision. To expand the network of stigma-free medical facilities it is important to have a tool that can aid healthcare officials, facilities management and staff to improve testing services.

The expansion of HIV testing services and strengthening technical abilities of healthcare facilities is expected to help the country fulfill objective 3.3 of the Sustainable Development Goals (SDG)[9], which specifically highlights the government's responsibility to end the AIDS epidemic by 2030.

Thus, development of this manual is in full accord with country's international commitments, declared priorities of the government, and represents a step towards fulfilling this important assignment.

METHODOLOGY AND PROCESS OF THE MANUAL DEVELOPMENT

Few methods were used to develop the manual within the UNFPA project framework:

- Desk Review aimed at revising the literature, publications, or policies and regulations, strategic documentations and studies available in Georgia and globally.

- Qualitative Research – based on Behavioural Insights principles, the research studied HIV testing barriers and factors motivating and hindering HIV testing on individual, social or institutional levels. The research was conducted among various target groups: healthcare staff; injecting drug users; sex workers; men who have sex with men; people living with HIV. Research findings provided information for the recommendations in this manual.

- Experts' opinion analysis – was ensured through including the interested parties in the work process and considering their feedback.

6. Georgian National HIV/AIDS Strategy. 2019-2022. http://www.georgia-ccm.ge
7. National Program of Hepatitis C Elimination. April, 2015. https://www.MoH.gov.ge/ka/528/
8. Unpublished. Tengiz Tsertsvadze. Infectious Diseases, AIDS and Clinical Immunology Research Center (IDACIRC). Presentation at CCM meeting. July 31, 2020.
9.https://sustainabledevelopment.un.org/content/documents/10680SDG%20Voluntary%20National%20Review%20Georgia-.pdf 17.08.2020

TARGET AUDIENCE

The manual created to reduce HIV testing barriers in healthcare facilities has several target audiences:

- Ministry of Health (MoH): Recommendations given in the manual should be implemented both on a systemic as well as medical facilities' levels. Thus, the Ministry of Health has a critical role in popularizing and institutionalizing the process.

- Healthcare Facilities' Administration: To create a stigma-free environment at an institutional level and support services tailored to human needs, healthcare facilities should review the recommendations given in the manual and plan activities accordingly. Under the healthcare facilities are considered both primary healthcare and hospital sector;

- Healthcare Facilities' Staff: people in direct contact with service recipients. This target audience is not limited to healthcare staff – doctors, nurses, or lab technicians; it should include everyone who may have come in contact with the visitor from his/her first moments of visiting a health facility; e.g. receptionist, cashier, institution lawyer, public affairs officer, etc.

- Non-Governmental Organizations Providing HIV Services: Although this manual was designed specifically to reduce HIV testing barriers in healthcare facilities, securing the main principles recommended by the manual is relevant for any organization regardless of their legal status. Therefore, the manual can be a useful resource for Non-Governmental Organizations too.

- Various stakeholders of the Healthcare Field (Medical Universities, Nursing Schools, Different Specialty Clinics): Although the groups listed are not the primary target audience, the manual may become an additional source of information and knowledge on HIV/AIDS, stigma, and medical ethics for medical university or nursing school students (pre-service education). Based on the fact that stigma is also associated with various health conditions, certain sections of this manual may serve as a useful source for the administration of any multi-profile or specialized healthcare facility (such as TB center, STI clinics, mental health centers, etc).

- Non-healthcare stakeholders - Journalists, community activists and human rights defenders: The manual can potentially provide journalists and mass media representatives interested in the subject with important information. Besides educational function, the manual can serve as a tool aiding activists and rights defenders to advocate for stigma-free health services.

MANUAL STRUCTURE

Goals and objectives for developing the manual are listed in the initial sections of the document, followed by a revision of the literature within the desk review. The revision has 2 parts: (1) The analysis of international studies, publications and policies on HIV related stigma in general; (2) Review of the literature available in Georgia, with special accent on specific research conducted in 2020 to study HIV testing barriers and motivating factors.

The next part reviews causes and types of manifestation of HIV-related stigma and discrimination, specifically in healthcare facilities; also, it presents the best examples of international practices and guiding principles to reduce S&D in the healthcare system.

Recommendations section offers the audience the list of activities whose effectiveness is based on international experience and research evidence. To implement each recommendation, the following parts of the text explain in detail the importance of the problem and describe, what activities are recommended and what may be the technical approaches to their implementation.

The last part of the document, presented as 5 appendixes, lists various practical resources, such as the facility assessment tool; staff questionnaire; sample of the code of conduct; menu of health staff training; and tool for patients' survey.

DESK REVIEW

HIV associated Stigma and Discrimination is one of the leading barriers to HIV testing. However, other complex factors exist on various levels (politic, institutional, individual or social) and determine the decision of a person to refer to HIV testing service, learn his/her HIV status, and engage in treatment services.

Unfortunately, research opportunities in Georgia are generally limited, hence no research-based information exists regarding the extent of Stigma and Discrimination in healthcare facilities. Also, no study evaluating the knowledge, attitude, or practice of healthcare staff concerning HIV/AIDS, has been found. Since such data is unavailable in Georgia, in the section below we briefly cover the situation in other countries and use it as a guiding material to learn the extent of negative impact of HIV-related stigma not only on an individual level but also in terms of fighting the AIDS epidemic in the country.

REVIEW OF INTERNATIONAL LITERATURE

The prevalence of HIV-related stigma and its impact have been studied actively around the world since the 1990s. This process contains various elements. The study is conducted to measure the general HIV-related stigma index, its qualitative parameters, and results, and to have a deeper view of its sectoral differences. To better understand the aims and activities needed for stigma reduction in the country (or any type of geographic area), certain studies are conducted in various segments of social functions (stigma at the workplace, stigma in the community, stigma in education institutions, stigma in healthcare provider facilities, etc).

By conducting various interviews (using various tools) the quality and level of HIV-related stereotypical, preconceived notions are evaluated. Such studies confirm the high level of HIV-related stigma among the general population of the EECA region:[10] almost half of the interviewed population in 8 countries of the region would not buy vegetables from the vendor who, according to their information, is HIV infected.

At the beginning of the 2000s the study of stigma and its outcomes in healthcare facilities became an important topic because surveys clearly demonstrated the severity of the problem in this segment. Stigma towards an HIV positive person in healthcare facilities uncondi

10. https://www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf

tionally discriminates against patients on various levels and violates their rights. As a result, people who have had stigmatizing experience avoid an additional visit to health facilities and treat medical staff with mistrust. This complicates the monitoring of their health condition, hinders effective implementation of HIV prevention, care, and treatment programs, which reflects negatively on the infection prevalence data and weakens the epidemiological control. Because of their status, people living with HIV become vulnerable as patients, and often stigma transforms into an action – discrimination/basic rights violation.

Appropriate studies conducted in various countries support the above statement. These studies are refined from year to year; the effectiveness of methods and tools is enhanced, which allows us to talk more accurately about reasons and procedures causing and consolidating stigma in healthcare facilities.

In recent years, various studies have been conducted in Eastern Europe and Central Asia (EECA) region; data has been collected and analysis has been conducted determining the current extent of HIV-related Stigma and Discrimination. For instance, in 2018, a review about barriers to HIV-related services for people living with HIV and other vulnerable groups (IDU, SW, MSM) in the region was published[11], covering various countries: Azerbaijan, Kazakhstan, Kyrgyzstan, Russia, Uzbekistan, Estonia, Armenia, Belarus, Latvia, Lithuania, Tajikistan, Moldova, and Ukraine. In every country listed HIV related Stigma and Discrimination has been named as one of the main barriers. This explains the existing challenges at any stage of the HIV/AIDS services cascade – prevention, case detection, engagement in treatment services, treatment adherence and viral suppression.

Throughout various time periods, "Stigma Index" and other relevant studies were conducted in countries of the ECCA region, which determined national specifics of the extent of HIV-related stigma. "Stigma Index" study is conducted among people living with HIV and describes forms, levels and outcomes of Stigma and Discrimination manifestation. Evaluating quantitative data allows us to clearly picture the scope and severity of the problem.

For example, below is the data from studies conducted in several countries.

STIGMA INDEX FROM THE HIV RISK POPULATIONS' POINT OF VIEW

Kazakhstan, Stigma Research[12] („Stigma Index"), 2015.

- 27.6% of the interviewed said they had been denied medical services (including dental service) at least once during the last 12 months because of their HIV status;
- 1.8% were denied to be included in family planning services;
- 3.2% were denied reproductive and sexual health services;
- 21.3% were recommended not to consider having children;
- 8.5% of HIV positive pregnant women were offered an abortion;
- 26.5% of research participants were forced to be tested (including HIV test) to receive required medical treatment.

11.https://toolkit.hivjusticeworldwide.org/ru/resource
12.https://capla.asia/images/KAZAKHSTAH_Stigma_Index_report_ENG_17_05_2017.pdf

Kyrgyzstan, Stigma Research[13] („Stigma Index"), 2015.

- 9.1% of the interviewed said they had been denied medical services (including dental service) at least once during the last 12 months because of their HIV status;
- 4.3% were denied reproductive and sexual health services;
- 39.3% were forced to be tested (including HIV test) to receive medical treatment.

Belarus, Stigma Research[14] („Stigma Index"), 2013.

- 17.9% of the interviewed said they had been denied medical services (including dental service) at least once during the last 12 months because of their HIV status;
- 18.9% were denied to be included in family planning services;
- 4.6% were denied reproductive and sexual health services.

Estonia, Stigma Research[15] („Stigma Index"), 2012.

- 8% of respondents were denied medical services because of their HIV status;
- 4% were denied to be included in family planning services;
- 2% were denied reproductive and sexual health services.

Latvia, Stigma Research[16] („Stigma Index"), 2018

- 16.4% mentioned having a "bad" experience while receiving basic medical services (Stigma / Discrimination);
- 30.2% mentioned medical staff violating either their or other person's confidentiality in their presence.
- 2.1% mentioned being forced to take HIV tests to receive medical treatment.
- 6.6% of the interviewed in reproductive health facilities were given suggestion not to have children;
- 15.8% of pregnant women with HIV positive status were offered an abortion.
- 46.5% are trying not to disclose their HIV status while receiving medical services;
- Only less than a third of the interviewed persons (28.7%) is sure that their medical information is completely confidential in healthcare facilities.

14.https://capla.asia/images/Kyrgizstan_Stigma_Index_Russian_Final.pdf
15.https://www.belaids.net/wp-content/uploads/2016/11/45_report_LZHV.pdf
16.https://www.gnpplus.net/assets/wbb_file_updown/3348/Stigma%20Index%20-%20Estonia.pdf
17.https://www.stigmaindex.org/wp-content/uploads/2019/11/Latvia-Stigma-Index-Report-2019.pdf

Moldova, Stigma Research („Stigma Index")[17], 2018

- 2.4% of the interviewed were denied state-provided medical services because of their HIV status;
- Only 0.9% mentioned having been denied reproductive and sexual health services.

As the data shows, the Stigma and Discrimination problem in health facilities is pressing in many countries. The situation is relatively better in Moldova (except for left bank of Dniester River). Notably, despite the generally high level of stigma in the country, the number of human rights violations while receiving health services remains low, probably due to the number of important activities aimed to reduce S&D in healthcare services recently implemented in Moldova.

STIGMA INDEX – FROM THE VIEWPOINT OF HEALTHCARE PERSONNEL

HIV related stigma is also studied in healthcare facilities through interviewing clinical, support, and administrative staff, or through monitoring the work. Such studies are limited and rarely examine quantitative parameters, and qualitative information is mostly acquired in the context of the medical staff's knowledge and attitudes towards HIV-positive patients. Such studies are not systematic in our region and could only be conducted on the level of a specific city, area, or facility. For better understanding, few indicators from studies done in various countries/cities are listed below.

Tajikistan: In 2018 a sociological survey[18] was conducted in Tajikistan to reveal forms of HIV-related Stigma and Discrimination among employees of various institutions. Active staff of various healthcare facilities also participated in this survey. Data verifies the severity of HIV-related stigma.

- 45% of all respondents say that there is a stigmatizing approach in the country towards people living with HIV, and in this regard, the most vulnerable are women and children.
- 74% refuses to purchase grocery products from HIV infected vendor.
- Only 62.5% of medical staff expressed willingness to treat people living with HIV like other patients, this means that more than a third of the medical staff will not provide services to vulnerable populations.
- Only 50% of the medical staff believe that HIV-positive employees should be allowed to continue their professional duties.

Chuvashia (Russia): In 2011 results of a survey[19], conducted among the medical staff (doctors and nurses) of Chuvashia's (Russian Federation) few multidisciplinary clinics were published.

- The majority of the medical staff (69.3%) believes that HIV-positive people lead "an indecent lifestyle" (they are mainly drug users (69.3%), sex-workers (69.7%), and 'homosexuals' (69.7%)).

17.https://www.stigmaindex.org/wp-content/uploads/2019/11/Moldova_PLHIV-Stigma-Index_2018.pdf
18.RESULTS OF SOCIAL SURVEYS TO IDENTIFY FORMS OF STIGMA AND DISCRIMINATION OF PEOPLE LIVING WITH HIV IN TAJIKISTAN Ruziev M.M., Bandaev I.S., Son I.M., Raupov F.O. 2018

- The use of degrading 'tags' by respondents towards the people living with HIV was quite evident: "deadly disease" spreaders (58.8%), "victims of the epidemic" (43.8%), and discarded parts of the society (Society waste) - (22.4%).

Expressing stigma towards people living with HIV by the staff of medical facilities is a global problem and data from various countries confirms the magnitude of this challenge. Unethical treatment of infected persons by medical staff is described in developed as well as in developing countries. The majority of studies show that lack of information about HIV infection and the fear of cross infection from an HIV-positive person while providing medical services are the main determinants of the discriminating behaviour by the medical staff.

Canada: Refusal of medical services occurs mainly in dental clinics. Therefore, the 2011 Canadian[20] survey, which engaged over 4000 dentists, calls for attention. A third of the participants (32%) states to have treated a patient, during the past year, while being aware of his/her HIV positive status; every sixth dentist (16%) stated that he/she would have denied treatment to an HIV-positive patient. Lack of ethical responsibility (odds ratio=9.0), low HIV awareness, and fear of contracting an infection at the workplace were main predictors for the treatment denial.

Nigeria: In four states of Nigeria, during the interview of 1000 healthcare specialists[21] (who have worked directly with HIV-positive patients), 43% of respondents stated to have witnessed their colleagues denying HIV-positive patients admittance into the clinic at least once.

STIGMA TOWARDS AFFECTED PERSONS / VULNERABLE POPULATIONS

Numerous research and literature confirm that the stigma and discrimination are predominantly acute towards not only HIV-positive persons but also towards the key populations at increased risk of transmitting the infection (IDU, SW, MSM, prisoners, migrants, etc). The existing stigmatizing attitude towards them explains why these populations limit their referral to medical services, including HIV testing.

Because of the stigma, the trust to the healthcare staff remains low, and this reason prevents open interactions between healthcare staff and vulnerable populations. This, in its turn, complicates preventive interventions; presents a significant obstacle for timely detection; weakens the engagement of the infected persons into treatment and care services and worsens treatment adherence and, hence, the treatment outcome. This problem is systemic and appears in nearly every country.

- Indonesia: According to the survey among Injecting Drug Users[22], 40% of the interviewed state not to seek HIV testing services mainly because of the stigma;

- Jamaica survey[23] revealed that in 2002 two thirds of newly diagnosed cases were discovered at the late stages of infection – this phenomenon was explained by widespread stigma and homophobia;

19. A.V. GOLENKOV, A.A. SHCHERBAKOV, SPHERES OF HIV-INFECTED PATIENTS DISCRIMINATION (BASED ON RESULTS OF MEDICAL WORKERS QUERYING), 2011
20. G M McCarthy, J J Koval, and J K MacDonaldSchool of Dentistry, University of Western Ontario, London. gmccarth@julian.uwo.ca "Factors associated with refusal to treat HIV-infected patients: the results of a national survey of dentists in Canada.", American Journal of Public Health 89, no. 4 (April 1, 1999): pp. 541-545. https://doi.org/10.2105/AJPH.89.4.541
21. Reis, C., et al., Discriminatory Attitudes and Practices by Health Workers toward Patients with HIV/AIDS in Nigeria
22. Ford, K., et al., Voluntary HIV Testing, Disclosure, and Stigma Among Injection Drug Users in Bali, Indonesia.
23. White, R.C. and R. Carr, Homosexuality and HIV/AIDS stigma in Jamaica

- In Botswana, according to a survey[24], 40% of ARV therapy patients received a diagnosis in the late stage of the disease, because patients have postponed a visit to HIV testing services due to the stigma.

Also, in Eastern Europe and Central Asia region, the high level of stigma towards the key groups associated with increased risk of HIV infection is confirmed by analyzing surveys and routine data of rights violations[25]. This is a significant problem for the region and determines the degree of effectiveness of HIV programs. Therefore, the subject of Stigma/Discrimination towards key populations was allowed a unique place in the technical manuals (IDUIT[26], MSMIT[27], SWIT[28], TRANSIT[29]), for implementing and practical use of comprehensive HIV programs, produced with the support of UN agencies, which describes the specifics of the problem and optimal ways to fight it for particular groups (IDU, MSM, SW, Trans people). It should be emphasized, that HIV-related stigma towards key populations is multi-faceted (multistigma), which aggravates its consequences and enhances discrimination and rights violation opportunities.

Stigma towards certain groups could form a tolerant attitude for rights violations. It could be used to legitimize and support discriminatory practices. Criminalizing the key groups is closely related to high-level Stigma and Discrimination towards them. This, in turn, reduces the access to medical services (quality services) for members of these groups.

The 2002-2013 study of HIV-related Stigma and Discrimination reduction interventions[30], which covered the experiences of high as well as low prevalence countries of almost every region (except the Eastern Europe and Central Asia region), showed that the Stigma/Discrimination indicator declined fastest in the countries with clear public policies and willpower, with set strategy and detailed regulations. The following intervention categories proved to be most effective in stigma reduction: informing, skills building, quality counseling and support, direct inclusion of affected communities in process. This allows us to choose the optimal course for a specific strategy and plan effective actions.

SHORT REVIEW OF GEORGIA SURVEYS

As mentioned above, a comprehensive survey on causes and degrees of Stigma and Discrimination in healthcare facilities in Georgia is yet to be conducted. Also, until 2020 there was practically no published data on testing barriers in Georgia, and analyzing the problem relied mainly on existing practical experiences and expert opinions. However, in 2020 NGO Tanadgoma, with financial support of UNFPA, conducted two surveys studying specifically causes of low referral of HIV testing and analyzed motivating factors and barriers which affect testing decisions. These surveys are:

- Demand for and uptake of HIV testing among youth in Georgia[31]- (Hereinafter – Youth Survey)

- Perceptions and views of PLHIV, Key Populations and healthcare personnel on the factors influencing HIV testing behaviours[32].

24. Wolfe, W., et al., Effects of HIV-related stigma among an early sample of patients receiving antiretroviral therapy in Botswana
25. http://ecuo.org/wp-content/uploads/sites/8/2019/01/bazovaja-ocenka-2.0-web.pdf
26. https://www.inpud.net/sites/default/files/IDUIT%205Apr2017%20for%20web.pdf
27. https://www.unfpa.org/sites/default/files/pub-pdf/MSMIT_for_Web.pdf
28. https://www.nswp.org/sites/nswp.org/files/SWIT_en_UNDP%20logo.pdf
29. https://www.undp.org/content/undp/en/home/librarypage/hiv-aids/implementing-comprehensive-hiv-and-sti-programmes-with-transgend.html
30. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3833106/
31.Demand for and uptake of HIV testing among youth in Georgia. Qualitative Research Report. Authors: Lela Kurdghelashvili, Tamar Sirbiladze, Nino Tsereteli, etc. Center for Information and Counseling on Reproductive Health - Tanadgoma. With financial support of UNFPA. Georgia, 2020.
32.Perceptions and views of PLHIV, Key Populations and healthcare personnel on the factors influencing HIV testing behaviours. Qualitative Research Report. Authors: Lela Kurdghelashvili, Nino Tsereteli, etc. Center for Information and Counseling on Reproductive Health - Tanadgoma. With financial support of UNFPA. Georgia, 2020.

The two surveys mentioned above were conducted among various target populations, and findings laid the foundation to generate this manual along with internationally recognized evidence and recommendations.

DEMAND FOR AND UPTAKE OF HIV TESTING AMONG YOUTH IN GEORGIA, 2020[31]

The study conducted among the youth of age 18-24 aimed at the following:

- 1. To study individual and structural barriers stipulating low demand on and referral to HIV testing among young people;
- 2. To study local context related to HIV/AIDS and HIV testing from the perspective of youth behaviour change communication and develop recommendations for planning and implementing behavioural intervention strategies.

115 young people participated in the study, including vulnerable and at-risk youth. A total 10 focus groups discussions and 15 in-depth interviews were conducted. The study was administered in 5 cities – Tbilisi, Batumi, Zugdidi, Gori and Telavi.

The youth study was based on social cognitive (learning) theory[33], which is considered as a tri-component model. The latest implies that human behaviour is a collective result of interactions between personal factors (characteristics), foreign factors, and behaviour.

The study conducted among young people pinpointed the following main barriers for HIV testing:

- The anticipation of society's negative attitude towards an HIV positive person and HIV related stigma.
- Young people lacking information about HIV testing services. Unawareness of free and anonymous testing service locations.
- Fear of anonymity and confidentiality breach.
- Non-friendly personnel and incompetent environment.
- Limited geographic accessibility of HIV testing services, especially in rural areas. The remoteness of testing centers and travel-related time or financial factors.

Examining testing barriers in healthcare facilities specifically was not the purpose of the study, and barriers pointed out by the young people probably apply to HIV testing services in general, regardless of tests being taken at NGOs or in medical facilities.

33.Social Cognitive (Learning) Theory (SCT; Bandura 1986)

PERCEPTIONS AND VIEWS OF PLHIV, KEY POPULATIONS AND HEALTHCARE PERSONNEL ON THE FACTORS INFLUENCING HIV TESTING BEHAVIOURS [32]

The survey conducted in 2020 among the target populations, aimed to study the following:

- Perceived vulnerability.
- Perceived severity of disease.
- Perceived benefits of testing and HIV status awareness.
- Motivators for HIV testing.

The survey also studied respondents' experience with recent testing services, including S&D manifested in healthcare facilities, and gathered information on which model of HIV testing is the most preferable.

The survey showed that respondents had more or less correct assessment of vulnerability towards infection, and the majority understands what benefits the HIV status awareness may have individually, as well as socially and publicly. Respondents refer to HIV infection as a manageable disease and the severity of the disease for them is mainly associated not necessarily with health threats but rather with infection-related social challenges. When talking about the severity of the disease respondents point out HIV-related fears deriving from society's stigmatizing and discriminating attitudes. Fear of the future - being cast out of friendship, family, society, fear of losing a job – turned out to be the main restraining factor implied the most by the respondents, which makes people avoid testing services and prefer not to know their status. Presumably, these are the main barriers to testing, which explains the low demand for testing in Georgia.

Although members of the healthcare staff, who participated in the survey, deny facts of unethical, stigmatizing attitude or discriminative treatment, representatives of the risk populations have a different view. Respondents state that staff often conveys degrading attitude.

> **In the best case they are indifferent, in the worst case – they make us feel that we are undesirable patients.**
>
> **HIV positive respondent**

Study shows that in terms of keeping patient confidentiality, the trust level towards healthcare staff is low; the idea of HIV positive patient being subjected to "gossip" or judgement among other staff members is not entirely disclaimed.

The facts of HIV testing without informing a patient were also mentioned. Turns out doctors in certain facilities do not secure their privacy while communicating HIV test results. Inefficient infrastructure and unsatisfactory sanitary conditions in healthcare facilities were named as barriers as well. The non-private environment during HIV counseling appeared to be a significant barrier, when an additional staff member may be present in the room.

Respondents mentioned geographic barriers and pointed out that testing services are less accessible in regions. Yet the respondents from regions in the same survey noted that they prefer to do testing in a big city, because in small towns and regions "everyone knows each other", and they do not think the information will be kept confidential. Therefore, it may not be reasonable to extend HIV testing services to small cities until the general level of S&D in the country declines.

Various target groups of the survey expressed different views regarding the competence of the healthcare staff: staff members state that they have completed sufficient training and are certified; however, members of HIV risk populations speak of the staff's inadequate knowledge. But despite varied reviews, the majority of interviewees from every target group recognizes the importance of improving the consulting skills of the healthcare staff and training them on stigma related topics.

Minimizing the testing barriers identified in the study has become the basis of developing specific recommendations in this manual.

STUDY OF BEHAVIOURAL INSIGHTS

In 2020 within the joint initiative of UNDP and UNFPA, for the first time in Georgia, a survey based on behavioural science – fundamentals of behavioural insights - was administered. This study collected over 200 narratives about HIV testing experiences from people who either conducted the test or were well informed of the HIV testing experiences of someone close to them. Unfortunately, the data analysis of the study was not yet completed when the manual elaboration progressed. Full account of the study will be published at the end of 2020 and it will be available to all stakeholders. "Behavioural insights" study will likely offer some new and important observations and findings. Therefore, it is probable that changes and amendments in the manual may be required which is a natural process since this manual is a lively document requiring occasional revision and renewal.

HIV ASSOCIATED STIGMA IN HEALTHCARE SYSTEM: THEORETICAL BASIS AND CONCEPTUAL FRAMEWORK

Ecological Model

HIV testing barriers determine human behaviour and attitude towards healthcare services, which is often manifested by low referrals to the needed medical services. The latter has a negative impact on the state of the population's health and causes severe social-economic outcomes nationally as well as globally.

The health (social) ecological model,[34;35] has been acknowledged by a variety of scientists. It states that several factors interact and determine human health and behaviour. Various specialists use the ecological model and adapt it to the specifics of their field. This model identifies that determinant factors of behaviour are multi-faceted, and they interact on different levels.

The ecological model means there are environmental factors and influences, which interact and affect the outcome - human behaviour - on different levels to nourish individual and public health. To better understand the social-ecologic model, let us review its main aspects below:[36]

34.Social and Behavioral Theories. National Institute on Health. Office of Behavioral and Social Sciences Research http://www.esourceresearch.org/Default.aspx?TabId=736
35. Ecological Model. The American College Health Association (ACHA)
36.https://www.healthyteennetwork.org/wp-content/uploads/2015/06/TipSheet_IncreasingOurImpactUsingSocial-EcologicalApproach.pdf

Social Determinants of Health: This is the combination of, on one hand, the circumstances in which people are born and live, and on the other, the systems put in place to support health in a specific environment. These circumstances are, in turn, shaped by a broader set of systems such as national policies, economy, and social policies.

Social-Ecological Model can help identify and provide a better understanding of how health or social problems are generated, developed, and sustained within one link where various subsystems[37] interact and influence one another. Below is the list of these subsystems:

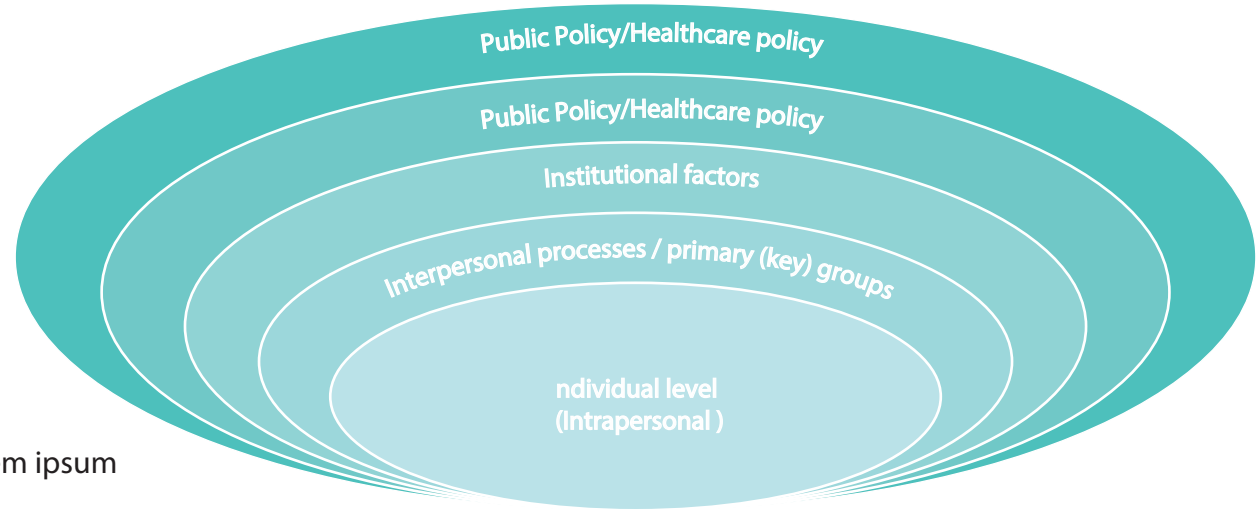
Levels in Social-Ecological Model	Quick Explanation
Public Policy	Local, national or international policies and laws; also, policies that set healthcare related restrictions; define healthcare funding; situate laws and regulations focused on health environment, etc.
Society and Community	Relationships among organizations, institutions or various unions, and civil society networks within defined boundaries of norms and practices.
Institutional level	Regulations, rules and specifics of operations/practices of formal and informal institutions and organizations.
Interpersonal processes / primary (key) groups	Formal and informal social networks and social support groups, including family and friends; also, social contact while performing various traditions and rituals, etc
Individual/Intrapersonal level	Characteristics of an individual, such as knowledge, attitudes, behaviour, self-perception, habits and skills. Important factors are gender, religious identity, racial/ethnic identity, sexual orientation, economic status, values, goals, expectations, genetics, resiliency, coping skills, etc.

37. McLeroy, Bibeau, Steckler & Glanz, 1988

The ecological model points out that any attempt aimed at changing human behaviour (e.g. HIV testing) must consider social determinants of health - every factor determining individual behaviour in a specific environment. Therefore, activities should be planned and implemented according to each level of the model.

For visual illustration, below presented is the ecological model[38], determining human behavior linked to HIV-related stigma and testing.

Figure 1: Ecological model determining HIV testing related behaviour



Lorem ipsum

This manual aims not at the situational analysis of each sub-system of ecological model, but rather at assisting the formation of stigma-free environment on institutional level - in heathcare system/medical facilities, to minimize institutional barriers, to motivate people seek timely medical services – including testing for HIV infection - every time they have a need.

However, the removal of institutional barriers greatly depends on pubic policies of the country. Hence, this manual offers to analyze the present situation in Georgia on level of Public Policies – top of ecological model.

PUBLIC /HEALTHCARE POLICY

Country laws – Georgian constitution, antidiscrimination and other laws are based on human rights and gender equality.[39] However exceptions occur in particular laws as well as law amendments. For instance, punishment oriented substance abuse legislation obstructs drug users from HIV testing as well as general HIV/AIDS services.

38. Adapted from McLeroy, K. R., Steckler, A. and Bibeau, D. (Eds.) (1988). The social ecology of health promotion interventions. Health Education Quarterly, 15(4):351-377. Retrieved May 1, 2012, from http://tamhsc.academia.edu/KennethMcLeroy/Papers/81901/An_Ecological_Perspective_on_Health_Promotion_Programs.

39. Gender assessment for HIV/AIDS and tuberculosis National Response. County Case Report. Prepared by Mzia Tabatadze. Tbilisi, Georgia. 2019. TGF Project. NCDC. Health Research Union.

HIV/AIDS law in Georgia[40], also public health, medical practices and patient rights laws are based on protecting internationally recognized basic human rights. HIV/AIDS law provides universal access, freewill, confidentiality of personal information, and also very vigorously secures every constitutional right for the people living with HIV (right to education, right to employment, etc). Yet this law has discriminatory articles: HIV status disclosure to partner is mandatory. Also, spreading the infection (passing or attempting to pass the infection knowingly) is criminal offence[39].

Both articles mentioned above create barriers for HIV testing: part of the patients may prefer not to know their own status to avoid responsibility; others may take test anonymously, but not show up in specialized clinic for registering. Part of society and activists note that existence of particular HIV/AIDS law is already discriminating.[41]

Though there are no legal restrictions of gender identity or sexual orientation on legislative level de facto environment is discriminative.

Since society's support for LGBTQ+[42] community is low realizing rights for this community often becomes subject for political speculations in the country. In an attempt to present LGBT persons as enemies and to demonstrate fabricated threats to the marriage institution, during 2017 pre-election period political parties and various groups initiated constitutional amendment, which defined family as a union between a man and a woman. This initiative was followed by protest from certain civil society groups,[43] which stated that initiated amendment opposes ideas of human freedom and rights and would amplify problems of discrimination and marginalization of LGBT persons. The joint protest letter mentioned "that the issue of equality of marriage was never raised by LGBT community and organizations as part of the country's legal and political agenda. In the current institutional homophobic conditions, LGBT persons are expelled from public spaces and are subject to discrimination and systematic violence that prevents them from enjoying their fundamental rights guaranteed by the Constitution. In these conditions, the majority of LGBT persons give less priority to the right to marriage".

According to the statement made by LGBT organizations on February 8, 2017, "taking into consideration the violent conditions, LGBT persons mostly have to hide their sexual orientation and/or gender identity in order to avoid expected violence, persecution and harassment. Therefore, the right to marriage, even if legalized, will become an unusable opportunity for the majority." [44]

In opinion of LGBT rights-defender organizations, manipulating with such topics strengthens discriminative practices and causes systematic marginalization of LGBT community.

According to the Georgian legislation, prostitution is an administrative offense punishable by fining. Engaging minors in prostitution, forcing into prostitution (threat, blackmail, deceive) and letting house or residence for prostitution is a felony punishable by criminal code. Therefore, identifying sex-work as administrative offense presents a barrier for persons engaged in sex-work – men, women, transgender – to seek HIV infection related medical attention, primarily HIV testing, in timely manner. Legal environment in case of sex workers encourages discriminative and stigmatizing attitudes towards them when they refer to healthcare facilities.

40.Georgian Law on HIV/AIDS https://matsne.gov.ge/ru/document/download/90088/3/en/pdf
41.Civil Society Forum. February, 2020. Tbilisi, Georgia.
42.Lesbian, Gay, Bisexual, Transgender, Queer persons.
43.https://emc.org.ge/ka/products/ngo-ebis-gantskhadeba-kortsinebastan-dakavshirebuli-sakonstitutsio-tsvlilebebis-shesakheb
44.www.women.ge

Therefore, although legal environment is less discriminative, preventive activities – to reduce phobic attitudes in society and encourage formation of tolerant environment – are not priorities in the country. It is less likely to see the elimination of barriers to access ton specific services until these problems are resolved.

STIGMA AND DISCRIMINATION IN HEALTHCARE FACILITIES (GENERALLY)

S&D in healthcare facilities is a global phenomenon and there are numerous scientific surveys and policy documents covering these issues, explaining the importance to study causes and possible solutions of this problem, and ascertaining what types of interventions can bear positive effect.

Study conducted in Thailand indicates that S&D, including in healthcare system, is the main obstacle for improvement of HIV testing, treatment and treatment adherence.[46] In the same country, a study among MSM and transgender populations found that HIV-related S&D has negative effect on populations at risk and they avoid HIV testing or using rectal microbicides. A survey of HIV positive persons linked S&D with low adherence to treatment.

There is also an article on systematic analysis of 42 studies,[47] which covers S&D at health facilities. Surveys conducted in numerous countiers show that S&D in healthcare system is a global problem and it is often associated with various human conditions or behaviours such as substance use, non-conformal sexual conduct, engagement in commercial sex, etc; in addition, S&D manifested in health system is not specific to HIV/AIDS, but also to other conditions, such as tuberculosis (TB), cancer, mental illness (MI), etc. Therefore, this manual, which offers recommendations to reduce stigma in health facilities, may come handy to other specialized facilities as well.

Health related stigma is especially dangerous as it has negative impact on people's decision to timely seek medical services. Manifestation of S&D in health facilities is documented in many countries in the world, yet in Georgia there are only reports pointing out the existence of the problem, registering/documenting specific facts does not take place or such information is inaccessible.

There is a wide range of stigma manifestation both by scale and severity in health system: such manifestations could be: outright denial of services; provision of sub-standard care; physical and verbal abuse; or using derogatory names (labeling), making patients who seek treatment wait longer, passing their care off to junior colleagues, etc.

46.Srithanaviboonchai, K., Stockton, M., Pudpong, N., Chariyalertsak, S., Prakongsai, P., Chariyalertsak, C., Smutraprapoot, P., & Nyblade, L. (2017). Building the evidence base for stigma and discrimination-reduction programming in Thailand: development of tools to measure healthcare stigma and discrimination. BMC public health, 17(1), 245. https://doi.org/10.1186/s12889-017-4172-4

47.Nyblade, L., Stockton, M.A., Giger, K. et al. Stigma in health facilities: why it matters and how we can change it. BMC Med 17, 25 (2019). https://doi.org/10.1186/s12916-019-1256-2 https://doi.org/10.1186/s12916-019-1256-2

CAUSES OF STIGMA AND DISCRIMINATION

Publications describe S&D causes – e.g. drivers - in healthcare facilities being classified into three groups[48]:

- Limited recognition or inadequate assessment of S&D problem.
- Lack of sufficient knowledge about HIV transmission; fear of acquiring HIV through casual contact with PLHIV.
- Moral judgments and values.

Negative attitudes, fear, lack of awareness about particular disease in general, as well as about medical ethics, also, about S&D represent factors contributing to S&D. It should be mentioned also, that irrational fear of being infected is usually present in connection to any disease, which is clinically difficult to manage and has severe outcomes for health.

Healthcare staff may themselves[48] become victims of S&D in heath system. Discriminative attitude of health personnel towards PLHIV could be because of fear of losing the job if they contract the infection. Therefore, HIV positive health staff becomes vulnerable themselves and may conceal their health status and be reluctant to timely access to needed care.

TYPES OF S&D MANIFESTED IN HEALTHCARE SYSTEM

- Healthcare facilities may have range of discriminatory practices such as tagging (flagging) patients' files to distinguish them from the files of patients with other diagnosis.
- Refusing to provide medical service, keeping clients waiting longer, or referring clients unnecessarily to other healthcare facility staff or facilities;
- Verbal abuse, gossip, scolding, name calling (labelling).
- Differential approaches while providing services, such as giving PLHIV advises which degrade their reproductive rights; demanding abortion; suggestions on necessity of contraceptive use; etc.
- Isolating clothing/dishes of patients living with HIV; isolated waiting areas, wards or entrances (when there is no clinical need to do so).
- Forcing patients to get tested (on HIV or Tuberculosis) without counselling, and sometimes without providing the results of the tests to the patients.
- Disclosing HIV status of clients to the third party without the consent (even to the family members; other healthcare staff).
- Excessive (unnecessary) safety measures - equipment (gloves or masks).

48.Carr, D., R. Kidd, M. Fitzgerald, and L. Nyblade. 2015. Acheiving a Stigma-free Health Facility and HIV Services: Resources for Administrators. Washington, DC: Futures Group, Health Policy Project.
ISBN: 978-1-59560-095-0 https://www.healthpolicyproject.com/pubs/281_SDAdministratorsGuide.pdf

S&D IMPACT ON PATIENTS/CLIENTS IN HEALTH FACILITIES

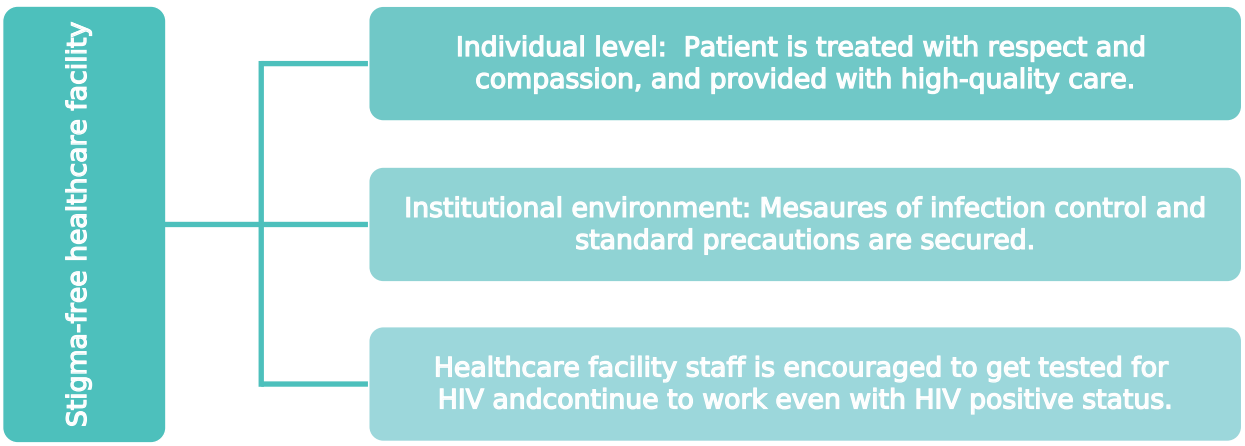
- Because of anticipated HIV S&D people try to avoid healthcare facilities, even when they correctly perceive the necessity of service.
- Avoid receiving preventive services needed; they are especially afraid to be tested. Reasons may vary from fear of knowing diagnosis to fear of diagnosis being revealed. This may result in late detection of illness and subsequently negative health results.
- Not disclosing important information (because of fear of judgement, because of mistrust), which may be useful for a proper diagnosis or course of treatment.
- Patients travel outside of their communities to access ARV medications; sometimes travel is impossible which worsens the ARV treatment adherence. In addition, patient waists time and money in order to avoid coming in possible contact with acquaintances.
- Avoid going to a health facility even for delivery - for fear of disrespectful treatment.
- Avoid disclosing their serostatus to sexual partners for fear of losing them.

STIGMA-FREE HEALTH FACILITIES

The Health Policy Project[49] defines a stigma-free health facility as the place where PLHIV and any other represenatives of the key populations are treated with respect and compassion, and provided with high-quality care. In a stigma-free facility, staff members also are able to protect themselves from HIV transmission in the workplace through the use of Standard Precautions, which the World Health Organization defines as the basic level of infection control precautions for all patients.

Additionally, in a stigma-free facility, facility staff feel confident about getting tested for HIV, and in case of infected status, their employment will not be jeopardized.

Figure 2: Stigma-Free Healthcare Facility



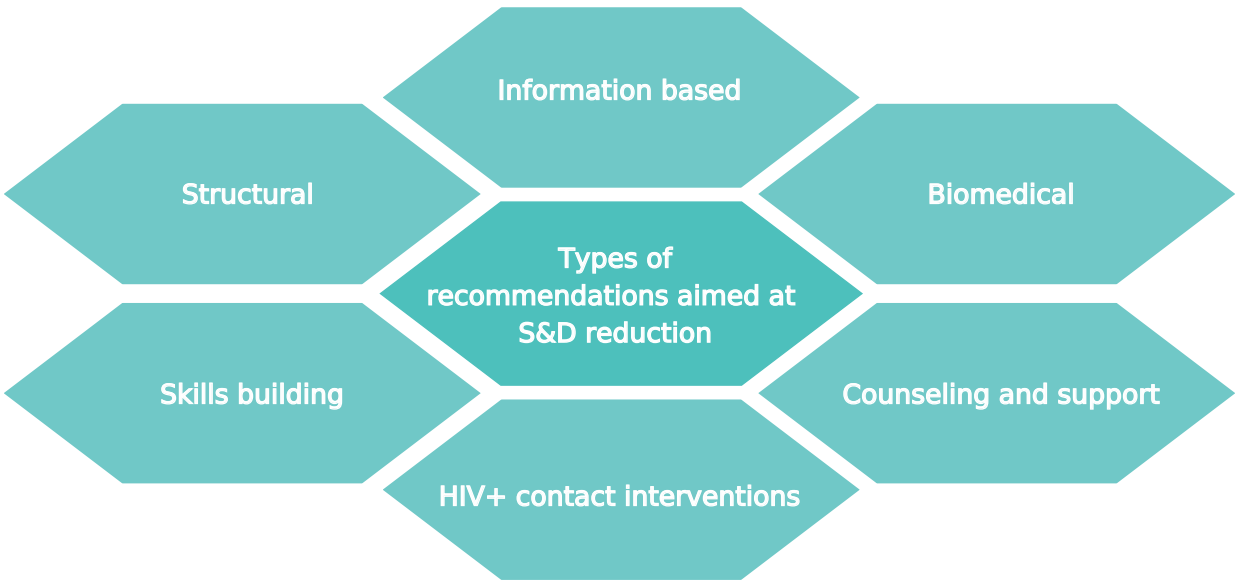
49.Carr, D., R. Kidd, M. Fitzgerald, and L. Nyblade. 2015. Acheiving a Stigma-free Health Facility and HIV Services: Resources for Administrators. Washington, DC: Futures Group, Health Policy Project.
ISBN: 978-1-59560-095-0 https://www.healthpolicyproject.com/pubs/281_SDAdministratorsGuide.pdf

VARIOUS LEVELS OF STIGMA REDUCTION INTERVENTIONS

Different sources describe connection between HIV related stigma and HIV testing barriers. Also the causal connection between stigma and testing has been determined and international organizations have issued recommendations on sigma reduction interventions. Activities should be planned and implemented on different levels – policy, society, healthcare facilities and individual level. Yet there is lack of published evidence evaluating how successful these interventions were in reality. [50]

Group of Ethiopian and Australian researchers analyzed[51] important sources (12 different systematic review of 12 guidelines and publications), in order to examine recommendations and interventions aimed at stigma reduction in healthcare facilities. Scholars recognized the importance of adopting recommendations in a simple summarized and usable format for healthcare facility staff and public health specialists. Therefore, interventions and recommendations developed to reduce S&D are categorized into the following:

Figure 3: Categories of interventions aimed at S&D reduction in healthcare facilities [51]



50. Thapa S., Hannes K., Cargo M., Buve A., Aro A.R. & Mathei C., Building a conceptual framework to study the effect of HIV stigma reduction intervention strategies on HIV testuptake: A scoping review, Journal of the Association of Nurses in AIDS Care (2017), doi: 10.1016/j.jana.2017.04.004.

51.Garumma Tolu Feyissa, Craig Lockwood, Mirkuzie Woldie, Zachary Munn; Reducing HIV-related stigma and discrimination in healthcare settings: a systematic review of guidelines, tools, standards of practice, best practices, consensus statements and systematic reviews https://www.dovepress.com/reducing-hiv-related-stigma-and-discrimination-in-healthcare-settings--peer-reviewed-fulltext-article-JMDH

Various intervention types are intended under each category. Below are examples of interventions for each approach:

Table 2: Categories of stigma reduction interventions

Information based approach	Providing information on HIV infection and HIV related stigma in writing or verbally to better inform interested parties and improve the knowledge.
Structural	Actions to improve infection control. Among them: required medical supplies, revision or arrangement of standard operations procedures; design and activation of internal policies and regulations of healthcare facilities.
Skills building	Empowerment of vulnerable populations on an individual level; it is important to realize how they feel in relation to HIV infection and what are their individual coping skills, so that these skills and problem solving can be improved.
Contact interventions	Interventions which can encourage direct interactions between healthcare staff and PLHIV. Example: PLHIV sharing personal stories and experiences with healthcare staff.
Counseling and support	Activities intended to minimize negative effect of S&D on PLHIV, their family members and/or other vulnerable populations.
Biomedical	Interventions providing universal access to prevention, treatment and care services.

Traditionally, S&D reduction programs in healthcare facilities mostly use information based approach, however the holistic method which combines the use of various level interventions is more reliable. Therefore, this manual recommends multifaceted approach. However, in view of the healthcare facilities' specific needs or available resources, certain interventions may be prioritized.

BEST PRACTICES: THE EFFECTIVENESS OF S&D REDUCTION INTERVENTIONS IN HEALTHCARE SYSTEM

Among strategies to reduce S&D in healthcare sector the best practice is described in India. Data collected in India by 2001 (qualitative and quantitative research results) pointed out the existence of stigmatizing and discriminating behaviour towards HIV patients in healthcare facilities. Main reason for this was the lack of knowledge of HIV transmission specifics, resulting in fear of being infested among the healthcare staff. Additionally, the personnel had an inadequate knowledge of treatment and care for such patients and of safety schemes.

To handle this problem NGOs together with New Delhi's three clinics implemented innovative approach[52]. Primarily on-sight studies were conducted to reveal factors contributing to stigmatization. Clinical and support staff, administration and patients participated in the study. As a result a control form (checklist) has been generated[53], to achieve friendly relationship with patients, which enabled health facility administration to measure and define the quality of provided medical service for PLHIV. While working on the checklist, "golden standards" from national and international guidelines were used, and so were PLHIV treatment, care and support strategies in light of securing human rights. Based on results an individual plan to improve quality of services for patients affected by HIV was produced for each healthcare facility. Main focus was on correcting HIV related knowledge of the facilities' personnel, skill building for clinical management of HIV positive patients, and improving counseling techniques.

Study showed steep improvement in the level of knowledge of healthcare staff, as well as indicator of attitude towards PLHIV patients as the result of the project[54].

The described approach is included in the UNAIDS "Best Practice"[55] collection and has been effectively used in measures to fight S&D in a range of countries. Although design and technical approach varied everywhere and it was to fit given settings and surroundings, the "knowledge-attitude" concept kept producing positive results. Among examples of the best practices can be listed programs in Nigeria[56], China[57], Vietnam[58], Chile[59], and Saudi Arabia[60].

Similar experience exists in our region as well, namely in Ukraine. In 2014-2015 the All-Ukrainian Network of PLWH[61] implemented a project "Tolerant medicine: reducing HIV-related stigma and discrimination towards representatives of high-risk groups in medical institutions in Kiev and the Kiev region." One of the main objectives of the project was to increase the level of knowledge and information among general personnel of pilot healthcare facilities (doctors, nurses) about HIV infection related subjects and sensitive topics of PLHIV groups. As a result of the 2-years interventions[62], the level of HIV related knowledge among trained med

52.Mahendra V., George B. and Gilborn L. (2002) Reducing stigma by promoting PLHA-friendly hospitals. XIV International AIDS Conference, Barcelona, Spain, July 2002
53.https://www.popcouncil.org/horizons/pfechklst.html.
54.George B., Jadhav S., Mahendra VS., Mudoi, R., Gilborn L. and Samson, L. (2002) Implementing a participatory and interactive training module to sensitise health care workers on HIV/AIDS issues: experiences from India. XIV International AIDS Conference, Barcelona, Spain, July 2002
55.https://data.unaids.org/publications/irc-pub06/jc999-humrightsviol_en.pdf
56.Ezedinachi ENU, Ross MW, Meremiku M, Essien EJ, Edem CB, Ekure E, et al. The impact of an intervention to change health workers' HIV/AIDS attitudes and knowledge in Nigeria: a controlled trial.
57.Wu S, Li L, Wu Z, Liang LJ, Cao H, Yan Z, et al. A brief HIV stigma reduction intervention for service providers in China.
Li L, Wu Z, Liang LJ, Lin C, Guan J, Jia M, et al. Reducing HIV-related stigma in health care settings: a randomized controlled trial in China.
58.https://www.icrw.org/wp-content/uploads/2016/10/Improving-hospital-based-quality-of-care-in-Vietnam-by- reducing-HIV-related-stigma-and-discrimination.pdf
59.Norr KF, Ferrer L, Cianelli R, Crittenden KS, Irarraizabal L, Cabieses B, et al. Peer group intervention for HIV prevention among health workers in Chile.
60.Al-Mazrou YY, Abouzeid MS, Al-Jeffri MH. Impact of health education on knowledge and attitudes of Saudi paramedical students toward HIV/AIDS.
61.https://network.org.ua/en/
62.https://network.org.ua/ru/umenshenye-stygmy-y-dyskrymynasyy-vych-polozhytelnyh-vazhnyj-etap-v-preodolenyy-epydemyy-vych-spyda-v-g-kyeve-y-kyevskoj-oblasty/

ical workers increased by 13%, the level of stigma caused by the fear of getting infected among medical workers decreased by 3 times (from 25% to 8%). 2020 interview conducted with the organization representative points out that cooperation between network and health facilities engaged in project continues and positive dynamic is present.

Interventions conducted in Moldova can be considered as the best practice[63]. From 2016 through cooperation of state HIV prevention program, Global Fund to fight AIDS, TB and Malaria and UN agencies, the inclusion of primary healthcare systems into HIV prevention programs has been achieved. General practitioners (family doctors) and nurses of ambulatory state clinics are conducting HIV screening tests and consulting general population on HIV prevention within the framework of state HIV prevention program. Personnel has had a proper training and has learned the specifics of working with key populations. Based on the referral system developed together with NGOs or by auto flow, HIV vulnerable populations refer to primary healthcare for counseling and testing. This has increased coverage and access to preventive services for the vulnerable groups. Along with this, youth-friendly clinics system, which provides general population, including KPs at the highest risk for HIV, with reproductive health and family planning services, has been integrated in HIV prevention program.

Friendly environment in these structures helps to establish stigma free communication between a client and a service provider. Such outline has proved to be attractive to PLHIV and other members of vulnerable groups, thus NGOs engaged in HIV prevention programs are actively cooperating with these structures directing their clients (beneficiaries) and conducting informative and educational meetings and training programs with beneficiaries collectively (medical structure personnel and NGO programs workers). As the result of these policy Moldova has the lowest manifestation of S&D in healthcare facilities among other countries of the region.

Thus, by analyzing causes of HIV related stigma and discrimination in healthcare facilities and systematic approach to them it becomes possible to change knowledge, attitude and behavior of the staff, which subsequently will assure provision of stigma-free, patient-oriented services. Precisely the knowledge and best practices accumulated in various countries laid foundation for recommendations provided in the manual.

63.Assessment of services strengthening, provided by NGOs working with key populations and relevant healthcare providers in the Republic of Moldova. 2019

Recommendation 1: Healthcare Facility Assessment/Scanning

Conduct the healthcare facilities evaluation/scanning in order to study the environment on institutional level. The study must cover readiness to implement infection control and universal precautions, and also the analysis of policies and internal regulations on institutional level in light of S&D and patients' rights protection.

Recommendation 2 Professional Re-Training of Healthcare Facility Staff

Conduct healthcare facility staff re-training on topics of HIV/AIDS, Stigma and Discrimination, and HIV-associated medical ethics. It is recommended to integrate professional trainings into continuous medical education programs.

Recommendation 3 Code of Conduct in Healthcare Facilities

Develop a code of conduct for the healthcare facility staff; implement its approval and dissemination.

Recommendation 4 Mechanisms of Monitoring and Response

Elaborate and activate mechanisms to monitor and respond to S&D policies' implementation in healthcare facilities. Determine mechanisms of patients' feedback provision and accountability to patients.

Recommendation 5 Integration of the S&D in Healthcare System Topic into IBBS Studies

Behaviour Surveillance Surveys, which are regularly and within certain time periods conducted in Georgia among main target populations (IDU, CSW, MSM, inmates), should gather information about S&D in healthcare facilities. The study instrument should be revised and specific standard questions should be added.

Recommendation 6 Stigma Index Survey

Conduct stigma index survey to evaluate scale of S&D directed at PLHIV or HIV-associated persons.

Recommendation 7 KAP Survey of Healthcare Staff

Conduct survey on Knowledge, Attitude and Practices (KAP) among the healthcare staff in light of S&D.

Recommendation 8 Direct Interaction of Healthcare Facility Staff and Groups Vulnerable to HIV to Increase Trust Between Them

Increase social contacts between healthcare staff and PLHIV to enhance trust; have vulnerable persons share their personal stories and experiences with the staff; implement numerous interventions which can encourage direct interaction between PLHIV and healthcare staff.

Recommendation 1: Evaluation/Scanning of Healthcare Facilities.

Conduct the healthcare facilities evaluation/scanning in order to study the environment on institutional level. The study must cover readiness to implement infection control and universal precautions, and also the analysis of policies and internal regulations on institutional level in light of S&D and patients' rights protection.

Implementation level: Healthcare Facilities

Priority level: High

Healthcare facility administration must show interest in S&D related conditions in the facility and it is recommended that they employ at least 2 types of surveys: (1) Staff interview, and (2) Institutional evaluation.

I. Preparation phase: S&D response advisory board: based on the size of the facility and considering available resources, the administration may decide to set up a special group for S&D response – an advisory board, which will preferably incorporate representatives of top management group as well as high and mid-level medical staff (doctors, nurses, lab workers). It is also important to invite an interested beneficiary(ies) on advisory board. In view of interests of vulnerable groups, it is expected that skilled representatives of NGOs and HIV/AIDS activists may volunteer as well. If the institution has a quality control or legal office/officer, their involvement in process is important. Advisory board is responsible to develop action plan for S&D response and monitor its accomplishment.

II. Staff Survey (Knowledge, Attitude and Practices): The elaboration of the action plan should be based on factual data analysis and evidence; thus, it is recommended to assess S&D scale in medical institution. Heads of institutions, according to their resources at hand, can choose a method of Standardized Brief Questionnaire (Appendix 1: Staff Survey). Main goal of this assessment is to gather information on staff knowledge, attitude and practices. Interview results will provide information for the response plan.

III. Assessment of the Institutional level: For this purpose, a checklist of potential factors which can potentially contribute to or, on the contrary, deter the extent of S&D manifestation in institutions, must be developed. During such assessment, the review of internal regulations is desirable. Besides, it is important to learn how well the facility provides safe environment for the patients as well as the staff.

The standard institutional assessment tool which has been created by the Health Policy project48 and successfully applied in several countries can be used as the basis by any health facility (Appendix 2: Institutional assessment tool).

IV. Identifying External Factors and Advocacy Messages: S&D can be the result of external factors. External factors mean that the facility cannot react to them fully on its own; however, the role of the health facility in cooperation with other concerned parties, is importand in tems of advocacy. It the process shows external factors for S&D (e.g. flaws in law or service standards), the group of advisors must direct this information to the officials of the health system. Depending on the problem, advocacy messages could be sent to human rights organizartions or public defender's (ombudsman) office. This process can have utmost importance because traditionally only interested communities and certain civil groups are involved in advocacy for HIV-related S&D topics, and activity of the healthcare staff has rarely (or never) been recorded; specialized service facilities for HIV/AIDS, TB, addiction are exception as they often plan and carry out public activities against S&D. Involvement of health facilities of various levels (primary healthcare, hospitals) into the process will increase the voice of advocacy and help to develop trust between patients and healthcare staff. The latter can become an important factor in reduction of HIV testing barriers.

Recommendation 2: Professional Re-training of Healthcare Facility Staff

Conduct healthcare facility staff re-training on topics of HIV/AIDS, Stigma and Discrimination, and HIV-associated medical ethics. It is recommended to integrate professional trainings into continuous medical education programs.

Implementation level: MoH, MoE, Healthcare Facilities.

Priority level: High

International experience demonstrates that one of the main reasons for HIV-related S&D in healthcare facilities is insufficient knowledge of HIV transmission routes and standard precautions during medical procedures. The experience from a lot of other countries shows that training of healthcare facility staff is an effective intervention for S&D reduction.

Re-training of the staff should imply training of facility administrators, managers as well as service provider doctors, nurses and lab technicians. It is also important to re-train technical support staff, such as receptionists, registry staff, cashiers/accountants, cleaners, security guards, drivers, etc, because each worker may have a direct or indirect contact with infected person or marginalized group. Therefore, staff member of each circle of the facility must share responsibility to contribute to building a stigma-free space in healthcare system.
Based on the fact that employee of each level needs different knowledge and skills, training modules should be designed according to the group specifics. Hence, it is advisable to have several modules:

- Module for healthcare facility administrators and managers
- Module for medical staff (doctor, nurse, lab technician)
- Module for technical support staff.

With the financial support of UNFPA currently training modules for health facilities are being developed. Document (Appendix 3: Specifics and Menu of Staff Training) presents in details what subjects should employee re-training programs cover.

64.See page 30 Best Practices: the Effectiveness of S&D Reduction Interventions in Healthcare System

ACTIVITIES FOR TRAINING INSTITUTIONALIZATION

It is recommended that the healthcare facility organizes HIV-related S&D learning courses for its staff. It is desirable that S&D training becomes an integral component of orientation package for new employees. Yet, in view of limited resources of healthcare (especially PHC) facilities in Georgia, it is less likely to launch this initiative on large scale. Hence, as an optional solution, the trainings should be accredited and institutionalized with support of appropriate ministries. This will stimulate (if not obligate) a healthcare facility, even in case of absence of resources, to require from staff completing the short-term educational program.

Post-graduate medical education does not function in Georgia and continuous education is sporadic. Healthcare staff trainings are mainly funded by donor organizations. To support long-term sustainability the e-learning has gained special attention during the past years, since it represents a cost-effective alternative to face-to-face trainings. In this light there is a significant initiative, implemented with the support of UNFPA[65], which included establishment of e-learning platform based at TSMU,[66] its sustainability guaranteed by the university. As of today, several of accredited e-learning programs on sexual and reproductive health, family planning and also on HIV/AIDS topics, prepared with financial and technical support of UNFPA, are available on this platform.

Considering the above statements, it is recommended to prepare online training module. As the next step, it is desirable to certify the training and integrate it into the e-learning platform of TSMU as partnership between MoH, MoE and administration of TSMU.

Additional activities can be implemented to support institutionalization:

- MoH which purchases services from healthcare facilities within universal healthcare, must demand from the organizations, interested in tender, to present within the application statistics of employees having completed the S&D training course. This approach will encourage health facilities to regularly require the staff to (at least) participate in e-learning classes.

- Healthcare facilities may decide to include the obligation to successfully accomplish the learning class within one month of employment in job description for hired employees. This will increase the demand for training.

- In a long-term perspective, the coordinated efforts together with MoH and academic circles of universities are important in order to integrate S&D learning program in higher medical education – both bachelor and master's degree learning curriculums. This approach will ensure the education of future professional cadres on HIV-related stigma, discrimination, patients' rights and other important topics of bio-medical ethics.

65.UNFPA Country Programme Evaluation: Georgia. Period covered by the evaluation: 2016-18. July 2019. Unpublished
66.TSMU electronic learning plartform www.cme.tsmu.edu.

Recommendation 3: Code of Conduct in Healthcare Facilities

Develop a code of conduct for the healthcare facility staff; implement its approval and dissemination.

Implementation level: MoH and Healthcare Facilities

Priority level: High
Code of Conduct: It is expected that action plan of medical facilities considers interventions specific for this particular facility and these activities may vary from facility to facility. Yet, there are interventions which should be implemented universally and shoud be reflected in action plan of any health facility. One of such high priority interventions is to develop code of conduct.

It is desirable to develop the code of conduct on national level involving MoH and patient community. Code of conduct determines behaviour standards of the healthcare staff and should be visibly displayed for every patient visiting the facility. Patients must feel safe and be aware that staff shares main principles of the code of conduct.
If MoH is unable to develop standard code of conduct which can be offered to every health-care facility, then the facility itself must develop wording for the code. Appendix to this manual offers practical advice about forms and contents of healthcare facility code of conduct. It also advises how to place/disseminate a code of conduct (Appendix 4: Code of Conduct for Healthcare Facilities).

Recommendation 4: Mechanisms of Monitoring and Response

Elaborate and activate mechanisms to monitor and respond to S&D policies' implementation in healthcare facilities. Determine mechanisms of patients' feedback provision and account-ability to patients.

Implementation level: Healthcare facilities

Priority level: High
In an ideal case, each healthcare facility striving to provide patients with stigma-free services should elaborate an action plan best matching institution's existing challenges. The action plan should have standard format which lists activities to be implemented, responsible persons and implementation time frame. The plan should be accompanied with monitoring system and measurable indicators.

In large institutions it is advisable to have a person or a committee in charge of monitoring issues.

nstitution specializing in HIV/AIDS services has greater chances that S&D manifestation is connected to HIV positive status of a patient or patients' belonging to certain vulnerable groups (LGBTQ+, SW, IDU, migrants, disabled persons, underaged girls, persons living or working in streets, etc.). In such cases, in order to review sensitive topics, it is advisable to invite into monitoring group a representative of NGO, civil society or risk groups who, if needed, can assure response or referring a patient to required services.

The manual (Appendix 2: Institutional assessment tool) presents a tool, in which the section 5 offers several key questions (5.1 through 5.11) to better evaluate the institutional monitor-ing system. In addition, each section of the checklist provided by the Institutional Assessment

Tool can be used as a pointer to determine types of guidelines, policies, regulations, or infection control and universal precautions to be implemented in healthcare facilities. Thus, this tool can be viewed as a roadmap to plan interventions.

Monitoring system in healthcare facility must consider routine activities as well as review of and response to specific patients/cases.

Two studies described in recommendations #1 and #2: Facility assessment (1) and Staff survey (2) can be considered as an example of Routine Monitoring method, which can analyze current situation in the facility in light of S&D and identify flaws.
Patient feedback, analysis and response are essential components in continuous cycle of healthcare service quality control and improvement. Therefore, studying patients' impressions must become an essential part of routine monitoring. There are various methods to achieve this goal:

- **Routine Survey of Patients** – periodic interview of service recipients at the facility using brief, standard instrument (As a template see Appendix 5: Tool for Routine Survey of Patients). Self-administered questionnaire can be handed to patients in waiting area, at registration or when they leave the facility after receiving the service. The questionnaire should be brief and should take patient several minutes to fill it out. It is important to organize private and neutral space where patient can be alone, free of staff's scrutiny. Completed questionnaires must be collected in a sealed box to secure honesty of answers. Brief descriptive statistics (quantitative indicators) of completed questionnaires must be prepared with certain frequency and presented at morning staff briefings or staff meetings.

- **Organizing patient panel or forum** – is recommended to be held with certain frequency in order to learn patients' expectations and needs for service improvement.

- **Focus Groups** and/or **In-Depth Individual Interviews with patients,** to help facility administration study patients' experience and plan steps for service improvement.

Study/Analysis of Individual Cases: Along with the routine monitoring, patients should be encouraged to share a specific example when staff demonstrated humiliating, stigmatizing or discriminating treatment towards them. Particular experience of a particular patient must be given special consideration and immediate response must follow. With this aim, it is vital to:

- In several spots of the facility place a message (e.g. patient memo) noticeably, stating that every patient has right to share his/her experience and complaints, verbally as well as in writing.

- Instruct patients to whom to refer to for submitting complaint or satisfaction notes. On patient's mem card indicate telephone number which patient can call to talk to person in charge. Right away briefly explain mechanism of complaint response and accountability to patients which exists in the facility.

- In the special space selected to receive written complaints have a pen and a form for patient thoughts; point out on the form that a patient has a choice to reveal his/her identity or to remain anonymous.

- Remind patients that if they want to follow up on specific complaint response they need to leave their contact information (telephone number or e-mail).

Monitoring group should analyze with certain regularity the results of monitoring activities' implementation and have obligation to prepare brief report on monitoring results. Operating procedures of person in charge/monitoring team should be described and approved in advance.

Also, facility administrations must strive to create **reinforcement system** - present staff with best practice or best employee if such occurs during the monitoring process.

Recommendation 5: Integration of S&D in Health System Topic into IBBS Studies.

Behaviour Surveillance Surveys, which are regularly and within certain time periods conducted in Georgia among main target populations (IDU, CSW, MSM, inmates), should gather information about S&D in healthcare facilities. The study instrument should be revised and specific standard questions should be added.

Implementation level: NCDC
Priority level: High

As described above (See Recommendation 1: Evaluation/Scanning of Healthcare Facilities. Recommendation 4: Mechanisms of Monitoring and Response) healthcare facilities are advised to conduct surveys to assess institutional environment, also to interview staff and activate inner monitoring mechanisms, if S&D occurs. However, besides surveys it is important to collect evidence from other interested respondents; in particular, it is necessary to gather data about the experience of people who came seeking services, as the view of vulnerable groups on stigmatizing environment and discriminating actions in healthcare facility may differ from the results of the questionnaires completed by the healthcare staff and facility administration.

Based on the fact that HIV-vulnerable populations become victims of S&D in healthcare sector especially frequently, it would be optimal to add 2 (at least) standard S&D questions in behaviour surveillance survey (IBBS) instrument. In Georgia IBBS studies are being conducted for almost 2 decades, once in 2-3 years among IDU, MSM, FSW and prisoners. Hence, the additional resource to research of this group members' real-life experience in view of S&D in healthcare facilities will not be needed, and this topic can be integrated into existing surveys.

The IBBS survey instrument[67] were reviewed while working on the manual and as it turned out no questions on S&D in healthcare facilities were included. There are no questions in general on the subject in MSM and IDU questionnaires. However, it should be noted that there is one question in survey instrument for FSWs[68]: 'HH1 - During the last 12 months, did you come across a case when you were denied medical services, because it was assumed that you were a sex worker?' Last research showed respondents' 1.5% in Batumi and 1.3% in Tbilisi confirming having such experience.

Considering the fact that resources needed to conduct surveys in the country are generally limited it would be regretful not to use the existing abilities. Hence, it is recommended to revise instruments and add 3 standard questions:

Considering the fact that resources needed to conduct surveys in the country are generally limited it would be regretful not to use the existing abilities. Hence, it is recommended to

67.Behavior Surveillance Survey with Biomarker Component
68.Integrated Bio-behavioral surveillance and population size estimation survey among Female Sex Workers in Tbilisi and Batumi, Georgia. Study Report. Prepared by Curatio International Foundation. Center for Information and Counseling on Reproductive Health, Tanadgoma. TGF-funded. 2017

revise instruments and add 3 standard questions:

- During the healthcare facility visit for the last 12 months, were you denied medical services because of the social status, HIV diagnosis or requesting the HIV-related service?
- During the healthcare facility visit for the last 12 months were you provided with lower quality/different quality service than other patients because of the social status, HIV diagnosis or requesting the HIV-related service?
- During the last 12 months, did you come across an episode when you needed medical services but did not seek medical help because of fear of anticipated S&D in the facility?

Stakeholders admit that IBBS questionnaires for every target group are quite long and interviewing respondents is, consequently, rather extensive process. Yet, we believe there is room for instrument optimization: there is a vast amount of meticulous questions in instruments, analysis and interpretation of which are paid little attention in the survey reports due to low practical use. During the revision of the instrument stakeholders must critically assess it and identify questions which do not provide new knowledge and cannot inform planning of any strategic interventions. In such case, it is recommended to substitute such questions with S&D questions.

Recommendation 6: Stigma Index Survey

Conduct stigma index survey to evaluate scale of S&D directed at PLHIV or HIV-associated persons.

Implementation level: MOH/NCDC
Priority level: High

HIV-associated S&D scale study has never been conducted in Georgia. While working on the manual we could not locate a trustworthy publication which would draw certain picture of the size and specific of the problem within country's healthcare system. Thus, it is recommended to conduct S&D index survey among PLHIV at least once every 3 years.

Stigma index survey was first initiated in 2008. It has covered over 100,000 interviews with PLHIV in more than 100 countries, including EECA (Latvia, Moldova). In 2018 the revised research tool (Stigma Index 2.069) was presented during the International AIDS Conference in Amsterdam, it has been translated into numerous languages and the resource is available upon request.

The Stigma Index is a joint initiative of Global Network of PLHIV – GNP+, the International Community of Women living with HIV - ICW and The Joint United Nations Programme on HIV/AIDS (UNAIDS). It studies S&D as a major obstacle to HIV treatment, prevention, care and support. The Stigma Index helps to improve workplace policies, and promotes the realization of human rights.

69.Contact data Contact GNP+ or e-mail plhivstigmaindex@gnpplus.net
70.https://www.stigmaindex.org/about-the-stigma-index/what-is-the-people-living-with-hiv-stigma-index/ 12.08.2020

Stigma Index is a standardized tool to collect evidence on how S&D impacts the lives of PLHIV. The group which developed the Stigma Index is urging countries to empower network of people living with HIV to implement studies. Yet, it is possible to find an independent research company, not involved in providing healthcare services, specialized HIV/AIDS services among them. This is important in order to collect honest and reliable data from respondents.

Recommendation 7: KAP Survey of Healthcare Staff

Conduct survey on Knowledge, Attitude and Practices (KAP) among the healthcare staff in light of S&D.

Implementation level: NCDC
Priority level: Medium

Quantitative research which can generate reliable basic data about knowledge, attitude and practice (KAP) of healthcare staff does not exist in Georgia. Without basic data country is unable to determine targets for the health system to reach. Conducting KAP surveys among healthcare employees with certain periodicity will enable health policy makers and researchers to assess gained progress and challenges.

In different types of healthcare facilities KAP survey may require adapting survey tool for various groups: for instance, knowledge, skills and perception of HIV transmission risks of primary healthcare facility staff might differ from hospital segment employees, especially the ones performing invasive procedures. Risk assessment and consequently S&D manifestation is likely to be different among dental facility staff or gynecology-obstetric facility doctors. Since healthcare system resources for the research are limited, as a first step the number one priority should be conducting KAP survey among family doctors/primary healthcare facilities' employees as far as HIV screening has been integrated into PHC during the last years, and in the future this intervention is intended to expend.

Recommendation 8: Direct Interaction of Healthcare Facility Staff and Groups Vulnerable to HIV to Increase Trust Between Them

Increase social contacts between healthcare staff and PLHIV to enhance trust; have vulnerable persons share their personal stories and experiences with the staff; implement numerous interventions which can encourage direct interaction between PLHIV and healthcare staff.

Implementation level: Healthcare staff, HIV affected groups, NGOs and community organizations.
Priority level: Medium

Direct interaction between healthcare staff and HIV-associated populations can be implemented beyond medical facilities, within various working groups and also during social campaigns/activities. Intervention implies that PLHIV or HIV-associated population representatives share personal stories with healthcare staff; or talk about different topics, thus finding common interests and values. During such meetings healthcare staff gets a chance to observe positive attitude of other people towards vulnerable persons, which helps them to overcome irrational fear and increase acceptability.

This method has proved to be successful in several countries. For instance, in Africa and U.S[71]. , where interventions aimed at S&D scale reduction within health sector and intended to aid direct interaction between health staff and vulnerable groups were implemented. Moreover, study conducted in India[72], showed positive changes in health staff's attitude towards PLHIV persons after an HIV positive person or other stigmatized group representative was invited as a trainer of at least one session.

Therefore, we can assume that enhanced social interaction improves acceptability and changes the attitude of healthcare workers towards vulnerable groups. This approach proved effective in terms of reducing HIV related stigma as well as TB related stigma. In this regard enhancing cooperation between healthcare facilities and NGOs becomes very important. The latest, besides activating referral system, envisages planning and implementing joint activities (e.g. field sessions for training) where stigmatized groups and healthcare staff interact socially inside as well as outside of the auditorium.

Recommendations to Develop Tools

During the process of planning activities to reduce S&D in healthcare facilities inclusion and participation of wide spectrum of interested parties must be guaranteed. Organizing group meetings, working in small groups and sharing preliminary decisions on wide scale for feedback is desirable.

Yet health facilities must consider the global experience and use it rationally. Hence, in this section we offer established instruments which have been successfully used in a variety of countries.

71. D. Scott Batey, Samantha Whitfield, Mazheruddin Mulla, Kristi L. Stringer, Modupeoluwa Durojaiye, Lisa McCormick, Bulent Turan, Laura Nyblade, Mirjam-Colette Kempf, and Janet M. Turan.AIDS Patient Care and STDs.Nov 2016.519-527. http://doi.org/10.1089/apc.2016.0223
72. Nyblade Laura, Srinivasan Krishnamachari, Mazur Amanda, Raj Tony, Patil Divya S., Devadass Dhinagaran, Radhakrishna Kedar, Ekstrand Maria L. HIV Stigma Reduction for Health Facility Staff: Development of a Blended- Learning Intervention. Frontiers in Public Health. Volume 6. 2018. https://www.frontiersin.org/article/10.3389/fpubh.2018.00165. ISSN 2296-2565

APPENDIX 1: STAFF SURVEY

One of the primary recommendations intends to evaluate the existing environment of healthcare facility in terms of S&D and to measure knowledge, perceptions and attitudes of the healthcare staff. There are several instruments intended for this. A questionnaire, developed and piloted by within the "Health Policy Project", implemented by USAID[73]– is significant among them. The standard tool of healthcare facility staff survey has been successfully launched in various countries.[74]

Using and, if necessary, adjusting this standard tool in Georgia is recommended. Standardization will allow us to evaluate existing situation in the healthcare system in Georgia and compare it to other countries.

The health facility staff survey must be conducted with clinical, as well as non-clinical staff. Self-administered as well as interviewer-administered interview method could be used. Yet the questionnaire is preferred to be simple, easy to understand, self-explanatory and anonymous.

Thailand experience[75] and medical facility staff survey manual points out that HIV related stigma in healthcare staff differs based on how rarely or regularly is the facility treating HIV patients. Hence, it is recommended to consider the following factors:

- HIV prevalence in the country – there is an opinion that countries with high prevalence have relatively low scale of S&D.
- While surveying healthcare staff and analyzing data it is advisable to make few strata, which are based on the following criteria: how many years has staff worked in the facility; how many HIV positive patients has staff treated (or how many HIV testing and counseling is done during the regular work-day); or what is the percentage of work-hours which the staff devotes to HIV-associated patients.
- It is also recommended to triangulate data because healthcare staff may not be honest and give so-called socially desirable answers during the survey. Therefore, along with the staff survey it is recommended to interview beneficiaries of the facility as well (especially when the facility has frequent contacts with HIV risk populations).

Main indicators with the healthcare staff:

It is recommended that the tool developed by The Health Policy Project in 2013,[76] recognized globally by international organizations, is used by the healthcare facility during staff survey. The tool has been successfully implemented in multiple countries and can be convenient for use in high as well as low prevalence countries.

73. Health Policy Project. 2013. "Measuring HIV Stigma and Discrimination Among Health Facility Staff: Standardized Brief Questionnaire." Washington, DC: Futures Group, Health Policy Project
74.ინსტრუმენტის პილოტირება მოხდა: China (N=300), Dominica (N=335), Egypt (N=300), Kenya (N=350), Puerto Rico (N=301), and St. Kitts and Nevis (N=307).
75.IHPP. HIV stigma and discrimination survey guidelines and procedures manual. Bangkok: IHPP, RIHES, Faculty of Medicine, Chiang Mai University, Chiang Mai Provincial Health Office, AIDS, TB, and STI Control Division, BMA, RTI International, USAID, UNDP, UNFPA, UNICEF, ILO, NAMC, DDC, MOPH, FAR, TNP+; 2014.
76.Health Policy Project. 2013. "Measuring HIV Stigma and Discrimination Among Health Facility Staff: Standardized Brief Questionnaire." Washington, DC: Futures Group, Health Policy Project http://www.healthpolicyproject.com/pubs/49_Standardized-BriefQuestionnaireMeasuringSD.pdf

There are few additional publications on piloting the tool, which resulted in adding/filtering certain question.[77] Below is the description of the tool. Yet globally accepted standard tool ready to view is available at the following website.

The tool explores few directions of the issue:

- Fear of HIV infection among healthcare facility staff.
- Stereotypes and prejudice/humiliation related to populations affected by HIV.
- Observed and secondary stigma and discrimination; and
- Institutional policy and work environment safety at healthcare facilities.

Tool contains 5 sections:

Section I: Main demographic data:

- Age
- Gender
- Occupation/employment
- Years of employment in healthcare
- (Respondent affiliated) Healthcare facility's specialization in HIV/AIDS topic
- Questions on professional contacts with HIV positive patients (during the past 12 months; or during a typical working week), based on the prevalence level
- Questions related to professional training on relevant topics (having attended training).

Section II: Infection Control

- Fear among the healthcare staff of being infected with HIV while at workplace (touched the clothing of infected patient; dressed the wounds; drew blood; took the temperature);
- The behaviour of healthcare staff and measures taken for avoiding HIV infection (avoids physical contact, wears double gloves, wears gloves during all types of service, uses any special infection-control measures not used in typical circumstances).

77. Srithanaviboonchai, K., Stockton, M., Pudpong, N., Chariyalertsak, S., Prakongsai, P., Chariyalertsak, C., Smutraprapoot, P., & Nyblade, L. (2017). Building the evidence base for stigma and discrimination-reduction programming in Thailand: development of tools to measure healthcare stigma and discrimination. BMC public health, 17(1), 245. https://doi.org/10.1186/s12889-017-4172-4

Section III: Healthcare Facility Environment

- Level of the facility touch in terms of HIV related services supply-demand. Has the respondent seen a PLHIV in the healthcare facility in the past 12 months?
- Has respondent witnessed stigmatizing attitude (e.g. observed stigma) of the staff in the past 12 months? Respondent has observed: a) Healthcare workers unwilling to serve a patient who might have HIV; b) Healthcare workers providing poorer quality of care to a patient living with HIV, compared to other patients; c) Healthcare workers talking badly about PLHIV or thought to be PLHIV.
- (Based of HIV prevalence level) Questions regarding attitude experienced by the healthcare staff from family members, friends, colleagues and people in general because they come in contact with PLHIV during professional duties.
- Attitude of the healthcare workers in the facility towards a colleague living with or thought to be living with HIV

Section IV: Healthcare Facility Internal regulations / Operational Policy

- How acceptable is it in this healthcare facility to test a patient for HIV without informing him/her?
- How likely will the employee get in trouble at work if he/she discriminates against PLHIV?
- How safe does the employee feel not to become infected at the workplace: a) There are adequate safety supplies in healthcare facility; b) There are standardized procedures/protocols in the facility that guarantee protecting employees from the risk of becoming infected with HIV.
- The healthcare facility has written guidelines to protect patients living with HIV from discrimination.

Section V: Opinions and Attitudes About PLHIV

Questions of this section determins attitude of healthcare staff not only towards PLHIV but also towards persons with different behaviour (IDU, MSM, and SW). Respondent must indicate degree of his/her agreement or disagreement with the provided statements.

- Common stereotypes and negative images about PLHIV. a) Infected people do not care if they infect other people; b) People living with HIV feel ashamed of themselves; c) People living with HIV have many sexual partners; d) People get infected with HIV because they engage in irresponsible behaviours; e) HIV is punishment for bad behaviour.
- A woman living with HIV should be have a right to have children if she wishes so.
- As a healthcare staff member, if I had a choice, I would prefer not to provide services to IDUs; afterwards all reasons that apply must be checked (IDUs put me at higher risk for disease; this group engages in immoral behaviour; I have not received training to work with this group).

- Same questions in regard to MSM (see question 20)

- Same question in regard to CSW (male or female) (see question 20).

The questionnaire also offers specific module for maternity houses or antenatal care, for providers of mother-to-child transmission prevention. The module contains 3 additional questions:

- How worried would a respondent be about assisting in labor and post-delivery care of a woman living with HIV?

- In the past 12 months, how often have you observed other staff members in your healthcare facility a) Performing an HIV test on a pregnant woman without her informed consent? b) Neglecting a woman living with HIV during labor because of her HIV status? c) Using additional infection-control procedures with a woman living with HIV during labor? d) Disclosing the HIV status of a pregnant woman to others without her consent? e) Offering treatment to a woman living with HIV conditional on her use of family planning methods?

- Respondent must indicate degree of his/her agreement or disagreement with the following statements: a) If a pregnant woman is HIV positive, her family has a right to know; b) Pregnant women who refuse HIV testing are irresponsible; c) Women living with HIV should not get pregnant if they already have children; d) It can be appropriate to sterilize a woman living with HIV, even if this is not her choice.

It is desirable that interested healthcare facility includes every standard question offered in the questionnaire. However, considering specifics, framework and other characteristics of the facility it is possible to add other type of questions. For instance, the following questions are recommended:

- How secure does respondent feel about his employment not being jeopardized if he/she becomes infected with HIV?

- It is may be also interesting to find out why (based on what) does he/she suppose so (with possible answers):
  a) There is a written contract (document) protecting employment rights of HIV infected health personnel;
  b) Solid proof (facts) of this exist in the facility.

APPENDIX 2: INSTITUTIONAL ASSESSMENT TOOL

Primary screening of healthcare facilities intends to evaluate policies, procedures and medical practices of the institution in terms of HIV related S&D environment.

The tool[78] is provided by The Health Policy Project. Any health facility based on its specifics can revise and adapt the tool. However, critically important indicators which can potentially describe a facility environment must be kept in the tool. Using standard tool has advantages as the results can be comparable to the similar survey results of various facilities. Also, facility managers will have opportunity to determine how well they suit globally accepted standards of 'The Good Practice'.

The tool contains 6 sections:

Section 1 **Service provision** – evaluates how well the facility provides equal access to health services for every patient.

Section 2 **Privacy and Confidentiality** - evaluates how well the facility guarantees client's privacy at any level of receiving service and how well is secured confidentiality and safety of client's information.

Section 3 **Infection Control and Universal Precautions** - evaluates the existing precautions in the facility to prevent and control transmission of nosocomial infections among staff and patients.

Section 4 **Health Facilities' Human Resources** – evaluates how systematic is continuous education of the healthcare staff on bioethics and HIV-related S&D themes.

Section 5 **Quality Assurance and Quality Control/Monitoring** – evaluates how regular and operational is the quality control monitoring system in the facility, including control on implementation of the established norms and mechanisms of patient feedback/complaint reception-review.

Section 6 **Institutional Policy/Internal regulations** – evaluates the extent to which the official documents of the institution document the established procedures and rules for observing basic principles of safe healthcare and medical ethics.

Institutional assessment methodology is described above (see Recommendations). The 5-points Likert scale can be used for the survey, where the given numbers from 1 to 5 refer to:

1- Strongly Disagree

2- Disagree

3- Undecided

4- Agree

5- Strongly Agree

78.Carr, D., R. Kidd, M. Fitzgerald, and L. Nyblade. 2015. Achieving a Stigma-free Health Facility and HIV Services: Resources for Administrators. Washington, DC: Futures Group, Health Policy Project.
ISBN: 978-1-59560-095-0 https://www.healthpolicyproject.com/pubs/281_SDAdministratorsGuide.pdf

Alternatively:

1- Never

2- Rarely

3- Sometimes

4- Often

5- (Almost) Always

Section 1	Service provision	1	2	3	4	5
	The facility provides equal access to services including:					
1.1	HIV positive persons			X		
1.2	Persons with different sexual orientation		X			
1.3	Other vulnerable groups – IDU, SW				X	
1.4	Examination, treatment, lab results for PLHIV are provided without delay.	X				
1.5	HIV patients are not referred for services available within the facility. (e.g. referring to another clinic for delivery while the facility has obstetric-gynecological services)	.	.	.	.	.
1.6	PLHIV are not isolated/placed in a separate room (unless there is a medical basis for isolation).					
1.7	HIV testing is voluntary					
1.8	HIV tests are not conducted without an informed consent of a patient.					

Section 2	Privacy and Confidentiality	1	2	3	4	5
2.1	Information about HIV test result is communicated only to the patient					
2.2	HIV test result is disclosed to a patient's parent, guardian or a third person only with presence of written consent of the patient.					

2.3	Information about HIV status is communicated only to the patient and treating doctor and is not shared with other (non-essential) staff.					
2.4	HIV consultation, or communication of HIV test result happens in a private environment or in an area where others may not easily overhear the information.					
2.5	Beds, wards, medical files, etc are not labeled in ways that would convey HIV status to other patients or staff.					
2.6	Healthcare records are stored in a secure location not accessible to third party, including doctors (not treating doctor) in common area.					

Section 3	Infection Control and Universal Precautions	1	2	3	4	5
3.1	Standard precautions of infection control are practiced in the same manner with all patients at all times.					
3.2	Biohazard waste management is practiced at all times by all staff following established standards.					
3.3	All staff is provided with free hepatitis vaccination.					
3.4	Post-exposure prophylaxis (PEP) is available at all times to all staff.					
3.5	All staff is informed about being entitled to free hepatitis vaccines and, if required, PEP.					
3.6	Essential medical or non-medical tools/supplies (disposable syringes, safe disposal bins, personal protection equipment – gloves, face masks, etc) for Standard Precautions are available at all times to all staff.					
3.7	The availability of standard precautions essential tools/supplies is actively communicated to staff.					
3.8	Standard Precautions procedures are printed / visibly posted in all departments.					

Section 4	Training of Healthcare Facilities' Human Resources	1	2	3	4	5
4.1	All staff is trained on patients' rights, the rights of infected persons and other key populations.					
4.2	All healthcare workers are trained in procedures of voluntary testing, counseling and informed consent.					
4.3	All healthcare workers are trained in the principles of confidentiality and patients' rights to confidentiality.					
4.4	All staff are trained on the basis of HIV and viral hepatitis transmission and prevention, infection control, Standard Precautions and PEP principles.					
4.5	Staff members are provided with possibilities of continuous training and skills on the topics listed above					

Section 5	Quality Assurance and Quality Control/Monitoring	1	2	3	4	5
5.1	The facility assigns a person in charge or a committee to monitor protection of patients' rights, adherence to HIV stigma-related policies and procedures.					
5.2	Adherence to voluntary testing principles and informed consent is regularly monitored.					
5.3	Confidentiality of the information system, health records and patient data is regularly monitored.					
5.4	Monitoring of confidentiality and privacy of patients' data is in place.					
5.5	The facility responds to any violation of policies/procedures or internal regulations.					
5.6	The facility not only reacts, but proactively tries to prevent patient rights violations, and manifestation of S&D.					

5.7	The facility management and/or supervisors encourage stigma-free environment and support staff members in providing non-stigmatizing services					
5.8	An effective mechanism which registers and addresses patient grievance and satisfaction is in place at the facility and operates around the clock.					
5.9	The information about patient feedback provision and/or appeal mechanism is visibly posted in each ward and all patient waiting areas.					
5.10	The facility regularly provides effective response to client complaints.					
5.11	The facility monitors infection control practices and an infection control team meets regularly.					

Section 6	**Institutional Policy/Internal Regulations**	**1**	**2**	**3**	**4**	**5**
6.1	The healthcare facility internal organizational documents (or internal regulations, operational manuals) specify the equal access to high quality and non-discriminative care for all patients, regardless of HIV/AIDS status, sexual orientation, or other personal and social characteristics.					
6.2	Facility has a set policy providing voluntary testing and informed consent from the patient.					
6.3	Facility has a policy providing privacy and confidentiality.					
6.4	Facility has guidelines that clearly define the team that serves patients with HIV, and therefore may have access to information about HIV positive status.					
6.5	Facility has clear guidance outlining procedures and time-lines for responding to cases in which procedures for prevention of stigma and discrimination and service stan-dards are breached.					

6.6	Facility has clear guidance and timelines for responding to patient complaints pointing out stigmatizing and discriminating treatment in the facility.					
6.7	Facility policy guarantees a safe working environment for healthcare workers.					
6.8	Healthcare staff is familiar with facility policy documents that promote a stigma-free environment and provision of non-discriminating services. Facility policy documents are, as appropriate, posted in all departments and patient waiting areas.					

When adapting the tool the country context should be taken into consideration. For instance, section 1, question 1.6 asks if PLHIV are isolated in the clinic. This question may seem irrelevant to the medical facility, since, in accordance with minister's decree on nosocomial infections[79], the facility must have "at least one boxed compartment for temporary isolation of infectious patients". Although the document does not specify 'infectious patients', by definition this includes HIV positive persons. Therefore, the isolation of PLHIV cannot serve as a legitimate measurement of S&D environment in a specific facility.

Similarly, section 2, question 2.2 may require an amendment for exception, because HIV/AIDS law in Georgia allows medical staff to notify spouse / sexual partner of infected person about his/her HIV positive status (partner notification).

Considering the context it is possible to add measurements. For instance, section 6 can assess whether the job description of medical staff specifically mentions obligations for: ensuring patient confidentiality, bio-medical ethics, or providing non-discriminating services. It is also possible to add a question to the tool, which studies the presence of human resource management policy which is non-discriminating and provides continuous employment of the medical staff if the latest becomes HIV infected. This is important, because, as mentioned in sources, sometimes medical staff is discouraged to treat HIV infected patient because of the excessive fear of transmission (instrumental stigma)[80]. Hence, the employment guarantee may reflect positively on their attitude towards HIV positive patients.

Lastly, piloting the standard tool in few medical facilities (preferably choosing different type/-profile facility) is desirable in order to identify the discrepancy between specific context and the tool, and, if needed, modify them.

79. Amendment to the order №01-38/ნ of the Georgian Minister of Labor, Health and Social Protection, of September 7, 2015, on "Approving surveillance, prevention and control procedures for nosocomial infections" https://matsne.gov.ge/ka/document/view/4102483?publication=0
80.Gilbert L. (2016). 'The mercurial piece of the puzzle': Understanding stigma and HIV/AIDS in South Africa. SAHARA J : journal of Social Aspects of HIV/AIDS Research Alliance, 13(1), 8–16. https://doi.org/10.1080/17290376.2015.1130644

APPENDIX 3: SPECIFICS AND MENU OF STAFF TRAINING

Main goal of training: to increase attendee knowledge/awareness of human rights issue in light of HIV/AIDS problem in order to strengthen equality, overcome HIV related stigma and eliminate discrimination.

Training objectives and learning topics should respond to the specifics of a particular training

Target Audience	Training objectives and learning topics
Decision Makers (MOH, Program Management Bodies)	Review best practices to fight stigma/discrimination in medical field on national, regional and international level. Determine, what political steps can be taken in present reality.
Healthcare Facility Administration/Management and Healthcare Staff	Increase awareness on key issues in medical and adjacent areas (social, legal); protecting principles of tolerance, non-discriminating approach, technologies for their practical application during provision of medical services.
Technical Support Staff of Healthcare Facility	Enable employee sensitizing in regards to HIV related stigma, discrimination and human rights topics, so that non-discriminating, non-judgmental communication with patients is achieved.
NGOs – Service Providers	Provide information/knowledge about multidisciplinary work principles on HIV related stigma/discrimination and human rights violation topics, effective use of existing resources and process monitoring techniques.

For healthcare facility staff training the Training Facilitator Guide can be used – prepared by the Health Policy Project and available in English[81]. Note that the guide can be considered a perfect manual for facilitators and training organizers; although it is recommended to adapt the guide considering the Georgian context and to develop training modules in Georgian language. Otherwise it is not likely for healthcare facilities to seek out enough resources for adaption of a 263-pages English language guide.

The guide points out which intensity and duration training suits which group – from few-hours sessions to several-days training performed either during a single time period or spread out over certain period of time. Despite its detailed recommendations, the guide suggests that each health facility study its conditions, discover specific needs and plan training in accordance to the existing resources.

[81] http://www.healthpolicyproject.com/pubs/281_SDTrainingGuide.pdf 15.08.2020

Training guide has 2 parts. Part one is a set of learning topics' menu that provide curricula options for different types of health facility staff - managers, doctors, nurses, support and technical staff, trainers. The guide presents 5 training modules (A-E) containing learning topics, specific case studies, reflection exercises, tests and other methodological support materials.

Recommended menu of learning topics:

- **HIV/AIDS Epidemic, History of Development** – factors contributing to formation and evolvement of stereotypes; understanding HIV related stigma/discrimination manifestation and its effects; ways of HIV infection transmission; including probability of transmission from various surfaces or through biological fluids (so-called QQR—Quantity, Quality, and Route of Transmission) 82.

- **Stigma and Discrimination, Stereotypes and Superstitions** – Basis of the problem, isolation and exclusion; judgement, humiliation and accusation of disobeying social norms; self-stigma; double stigma; associated stigma; the impact of stigma on HIV/AIDS epidemic; S&D impact of human health on individual and social level.

- **Stigma and Key populations, their specifics** – Characteristics of the main affected groups, specifics of stigmatization; possible negative impact of stigma on each group (PLHIV and stigma; MSM and stigma; IDU and stigma; women and stigma; migrants and stigma; etc); realizing positive meaning of harm reduction strategies among IDUs; pre-exposure prophylaxis; HIV/AIDS and pregnancy, HIV positive women and their reproductive rights, etc.

- **Principles of Sexual Orientation and Gender Identity (SOGI)** – significantly improves reflective differentiation of notions such as sexuality, sexual orientation, gender identity, gender expression, sexual behaviour. This contributes to correcting stereotypical views of sexuality and sexual behaviour and process of "fading" of stigmatizing attitudes, which is especially important for health service providers while communicating with representatives of some key populations (MSM, transgender, etc).

- **Stigma and Discrimination in Health System** – various forms of stigma manifestation in healthcare facilities, stigma and HIV positive health staff; basis of HIV transmission fear in healthcare facility and methods of overcoming it; infection control and universal precautions; fear of transmission through sharp medical objects; facility hygiene and disposal of biohazard waste; occupational exposition; post-exposure prophylaxis.

- **Country Policy Documents and Legal Rights** - law on HIV/AIDS, law on patient rights, law on medical practice, law for eradication of any kind of discrimination; appropriate sections of the administrative (civil) and criminal codes of Georgia, etc. Right to health; personal autonomy and privacy; information confidentiality and anonymity; right to receive information; informed consent of a patient.

- **Subjects of Professional Ethics and Deontology in HIV/AIDS Context** – helps to have correct communication with patients, inspires trust, dissolves fear for breach of confidentiality or disgracing treatment.

- **HIV Related Terminology and Politically Correct Vocabulary** – to establish basis of non-stigmatizing, non-degrading relationship with HIV positive or HIV associated population (key population) representatives.

- **Effective Communication Skills** – use of verbal and non-verbal communication techniques which significantly improves process of trust development from patients.

Additional topics for facility managers and persons in charge – besides learning topics listed above it is advisable to hold a session about this guide, with specific accent on tools which can aid persons in charge of the facilities to successfully plan and implement: a) Facility assessment to better analyze S&D situation; b) Staff interview; c) Re-training of staff; d) Developing/approving a code of conduct; e) Monitoring and patient complaint response mechanisms; etc.

Learning programs should incorporate very comprehensive materials, including:

- International agreements and conventions ratified by the country, on subjects of human rights and discrimination eradication (HIV/AIDS related or key population rights related);

- Important statistics (international, regional, national) on HIV/AIDS; on human rights violation regarding HIV/AIDS or key population rights;

- Relevant information provided by community organizations or NGOs and other unions (study results, shadow reports, protocols).

Suggestions for the text:

- Code of conduct clearly shows ethical norms and values of the facility: e.g. zero discrimination based on ethnicity, age, gender, religion, language, education, economic status, political affiliation, social status, different sexual behaviour, health status, etc.
- Outline values which patients wish to hear: patient-oriented, respect, dignity, equality, high quality medical care, confidentiality, etc.
- Emphasize as a separate point that their inclusion in treatment process is encouraged and verify that informed consent of a patient is important to you.
- In some samples the color poster of the code of conduct includes group photo of the staff followed by pledge phrase. For instance, “We, the employees of X facility do hereby vow …”. Photo of real employees has positive effect on viewers.
- For patients to provide feedback a hotline or authorized person’s telephone/e-mail must be displayed on the poster.
- The code of conduct may stress that ethics is a two-way process and is based on mutual cooperation and understanding between patient and facility. Therefore, address patients directly and tell them what your expectations of them are.
- It is recommended that a code of conduct/ethics be concise, easy to read and in short period of time.

There are few alternative ways of dissemination:

- Place it in various locations of the building. Especially in entrances or patient registration areas - the first contact place of a patient and an employer. Ideally small size posters should be placed in every office and waiting area where patients in queue can have enough time to get familiar with the facility ethics.
- If the facility has a website of social media profile place the code of conduct at this source as well.
- Give the staff training or S&D discussion theme in the facility a public coverage on the website or in social media.
- Turn the developing/approval of the facility “code of ethics” into a celebration, invite various interested parties, including representatives of vulnerable communities, civil society and activists, media etc. Let patients see that the facility is proud of this, which will facilitate trust between patients and the facility.

APPENDIX 5: TOOL FOR ROUTINE SURVEY OF PATIENTS

Below is presented the patient's survey tool devised around main principles of stigma-free services. For fast administering, it is best to provide answers' list in structured questionnaire, one of which will be checked by the patient at his/her own discretion. Simplest form of answer intended for every patient is 'yes', 'no', 'I don't know'. Yet other ordinal scale can be used, e.g. 'never', 'rarely', 'sometimes', 'often' or 'always'.

It is wise to leave an open space at the end of structured questionnaire for additional comments, if a patient decides to leave them.

Patient's routine survey tool[82]– adapted:

Principles	What shall be assessed by the patient?
Accessibility of Medical Services	In the facility every patient is provided with equal access to services regardless of personal characteristics, medical diagnosis or other social status.
Dignity and Respect	The staff treats patients with respect and never violates their dignity.
Quality Service	The facility offers patients competent and quality service.
Safe Environment	Safe environment is guaranteed in the facility.
Communication	There is an open and honest communication between the staff and patients.
Information	The staff provides a patient with comprehensive information regarding patient's health condition in a clear/acceptable form.
Inclusion and Participation	Patients participate in decision making together with the medical staff.
Patient's Consent	No procedures or examinations are conducted without the patient's consent.
Privacy	Medical service area provides for patient's privacy and autonomy.
Confidentiality	No medical information of the patient is shared with other party.
Feedback	Patient is able to provide the facility with a feedback on received services.
Accountability	The facility responds to patient's complaint and provides the complaining patient with this information.

82.Staff Guide: Using patient Feedback to improve healthcare services. HSE. https://www.hse.ie/eng/services/yourhealthservice/hcharter/ask/feedbackstaffguide.pdf

REFERENCES

Garumma Tolu Feyissa, Craig Lockwood, Mirkuzie Woldie, Zachary Munn; Reducing HIV-related stigma and discrimination in healthcare settings: a systematic review of guidelines, tools, standards of practice, best practices, consensus statements and systematic reviews
https://www.dovepress.com/reducing-hiv-related-stigma-and-discrimination-in-healthcare-settings--peer-reviewed-fulltext-article-JMDH

Health Policy Project. 2013. "Measuring HIV Stigma and Discrimination Among Health Facility Staff: Standardized Brief Questionnaire." Washington, DC: Futures Group, Health Policy Project

Carr, D., R. Kidd, M. Fitzgerald, and L. Nyblade. 2015. Achieving a Stigma-free Health Facility and HIV Services: Resources for Administrators. Washington, DC: Futures Group, Health Policy Project.
ISBN: 978-1-59560-095-0
https://www.healthpolicyproject.com/pubs/281_SDAdministratorsGuide.pdf
UNAIDS Indicators **https://indicatorregistry.unaids.org/**

Nyblade L, Jain A, Benkirane M, et al. A brief, standardized tool for measuring HIV-related stigma among health facility staff: results of field testing in China, Dominica, Egypt, Kenya, Puerto Rico and St. Christopher & Nevis. J Int AIDS Soc. 2013;16(3 Suppl 2):18718. Published 2013 Nov 13. doi:10.7448/IAS.16.3.18718
https://pubmed.ncbi.nlm.nih.gov/24242266/

Srithanaviboonchai, K., Stockton, M., Pudpong, N., Chariyalertsak, S., Prakongsai, P., Chariyalertsak, C., Smutraprapoot, P., & Nyblade, L. (2017). Building the evidence base for stigma and discrimination-reduction programming in Thailand: development of tools to measure healthcare stigma and discrimination. BMC public health, 17(1), 245.
https://doi.org/10.1186/s12889-017-4172-4

Global Health Facility Survey , WHO.
https://www.who.int/maternal_child_adolescent/documents/9241545860/en/

Bond, K. T., Frye, V., Taylor, R., Williams, K., Bonner, S., Lucy, D., Cupid, M., Weiss, L., Koblin, B. A., & Straight Talk Study Team (2015). Knowing is not enough: a qualitative report on HIV testing among heterosexual African-American men. AIDS care, 27(2), 182–188.
https://doi.org/10.1080/09540121.2014.963009

Golub, S. A., & Gamarel, K. E. (2013). The impact of anticipated HIV stigma on delays in HIV testing behaviors: findings from a community-based sample of men who have sex with men and transgender women in New York City. AIDS patient care and STDs, 27(11), 621–627.
https://doi.org/10.1089/apc.2013.0245

Fan, H., Fife, K. H., Cox, D., Cox, A. D., & Zimet, G. D. (2018). Behavior and health beliefs as predictors of HIV testing among women: a prospective study of observed HIV testing. AIDS care, 30(8), 1062–1069.
https://doi.org/10.1080/09540121.2018.1442555

Nöthling J, Kagee A. Acceptability of routine HIV counselling and testing among a sample of South African students: Testing the Health Belief Model. Afr J AIDS Res. 2013;12(3):141-150.
doi:10.2989/16085906.2013.863214

Ofori, Kennedy Nyeseh. (2019). Application of the Health Belief Model to HIV Testing and Counselling Among Youth Living in Selected Rural Communities in Ghana. International Journal of HIV/AIDS Prevention, Education and Behavioural Science. 5. 11-18. 10.11648/j.ijhpebs.20190501.12.

IHPP. HIV stigma and discrimination survey guidelines and procedures manual. Bangkok: IHPP, RIHES, Faculty of Medicine, Chiang Mai University, Chiang Mai Provincial Health Office, AIDS, TB, and STI Control Division, BMA, RTI International, USAID, UNDP, UNFPA, UNICEF, ILO, NAMC, DDC, MOPH, FAR, TNP+; 2014.

Nyblade, L., Stockton, M.A., Giger, K. et al. Stigma in health facilities: why it matters and how we can change it. BMC Med 17, 25 (2019).
https://doi.org/10.1186/s12916-019-1256-2
https://doi.org/10.1186/s12916-019-1256-2

Thapa S., Hannes K., Cargo M., Buve A., Aro A.R. & Mathei C., Building a conceptual framework to study the effect of HIV stigma reduction intervention strategies on HIV testuptake: A scoping review, Journal of the Association of Nurses in AIDS Care (2017), doi:**10.1016/j.jana.2017.04.004.**

MEASURING HIV STIGMA AND DISCRIMINATION AMONG HEALTH FACILITY STAFF; STANDARDIZED BRIEF QUESTIONNAIRE; prepared by the Health Policy Project. USAID. PEPFAR. March 2013.
http://www.healthpolicyproject.com/pubs/49_StandardizedBriefQuestionnaireMeasuringSD.pdf

UNAIDS. Global AIDS response progress reporting 2015. Geneva: World Health Organization and UNAIDS; 2015.

UNAIDS. UNAIDS strategy 2016–2021. Geneva: UNAIDS; 2015.

HO Secretariat. Draft global health sector strategies HIV, 2016–2021. Geneva: World Health Organization; 2016.

Social and Behavioral Theories. National Institute on Health. Office of Behavioral and Social Sciences Research **http://www.esourceresearch.org/Default.aspx?TabId=736**

Ecological Model. The American College Health Association (ACHA)
https://www.acha.org/HealthyCampus/HealthyCampus/Ecological_Model.aspx

Gender assessment for HIV/AIDS and tuberculosis National Response. County Case Report. Prepared by Mzia Tabatadze. Tbilisi, Georgia. 2019. TGF Project. NCDC. Health Research Union.

Georgian Law on HIV/AIDS Georgian Law on HIV/AIDS.
https://matsne.gov.ge/ru/document/download/90088/3/en/pdf

G M McCarthy, J J Koval, and J K MacDonaldSchool of Dentistry, University of Western Ontario, London. gmccarth@julian.uwo.ca “Factors associated with refusal to treat HIV-infected patients: the results of a national survey of dentists in Canada.”, American Journal of Public Health 89, no. 4 (April 1, 1999): pp. 541-545.
https://doi.org/10.2105/AJPH.89.4.541

Demand for and uptake of HIV testing among youth in Georgia. Qualitative research report. Authors: Lela Kurdghelashvili; Tamar Sirbiladze; Nino Tsereteli; et al. Center for Information and Counseling on Reproductive Health - Tanadgoma. With UNFPA financial support. 2020. Georgia

Perceptions and views of PLHIV, Key Populations and healthcare personnel on the factors influencing HIV testing behaviours. Qualitative Reseach Report. Authors: Lela Kurdghelashvili, Nino Tsereteli, et al. Center for Information and Counseling on Reproductive Health - Tanadgoma. With UNFPA financial support. 2020. Georgia

Georgia National HIV/AIDS Strategy. 2019-2022. **http://www.georgia-ccm.ge**

State program of hepatitis C elimination. 2015. April.
https://www.MoH.gov.ge/ka/528/

MICS6, Georgia, 2018
https://www.healthyteennetwork.org/wp-content/uploads/2015/06/TipSheet_ IncreasingOurImpactUsingSocial- EcologicalApproach.pdf

Population Size Estimation of Men Who Have Sex with Men in Georgia, 2018. Survey report, March 2019. Sex with Men in Tbilisi, Batumi and Kutaisi, Georgia. Bio-Behavioral Surveillance Survey. 2019. Curatio International Foundation. Center for Information and Counseling on Reproductive Health - Tanadgoma. With GFATM financial support.

HIV risk and prevention behaviors among Men who have Sex with Men in Tbilisi, Batumi and Kutaisi, Georgia. Bio-Behavioral Surveillance Survey. 2019. Curatio International Foundation. Center for Information and Counseling on Reproductive Health - Tanadgoma. With GFATM financial support.

HIV risk and prevention behaviors among People Who Inject Drugs in seven cities of Georgia. 2017. Curatio International Foundation. Bemoni Public Union. With GFATM financial support.

Nyblade Laura, Srinivasan Krishnamachari, Mazur Amanda, at al. HIV Stigma Reduction for Health Facility Staff: Development of a Blended- Learning Intervention. Frontiers in Public Health. Vol. 6. 2018. https://www.frontiersin.org/article/10.3389/fpubh.2018.00165; DOI=10.3389/fpubh.2018.00165. ISSN=2296-2565

Bandura A. Social Learning Theory. Oxford: Prentice-Hall (1977);
http://www.asecib.ase.ro/mps/Bandura_SocialLearningTheory.pdf

Unpublished. Tengiz Tsertsvadze. Infectious Diseases, AIDS and Clinical Immunology Research Center (IDACIRC). Presentation at CCM meeting. July 31, 2020.

National response to HIV/AIDS and Tuberculosis in Georgia from the perspective of gender needs. 2019. Author Mzia Tabatadze. NGO “Health Research Union”. With GFATM/NCDC financial support.

Amendment to the order №01-38/ნ of the Georgian Minister of Labor, Health and Social Protection, of September 7, 2015, on “Approving surveillance, prevention and control procedures for nosocomial infections” https://matsne.gov.ge/ka/document/view/4102483?publication=0

Gilbert L. (2016). 'The mercurial piece of the puzzle': Understanding stigma and HIV/AIDS in South Africa. SAHARA J : journal of Social Aspects of HIV/AIDS Research Alliance, 13(1), 8–16. https://-doi.org/10.1080/17290376.2015.1130644

People Living with HIV Stigma Index
https://www.stigmaindex.org/about-the-stigma-index/what-is-the-people-living-with-hiv-stigma-index/

D. Scott Batey, Samantha Whitfield, Mazheruddin Mulla, Kristi L. Stringer, Modupeoluwa Durojaiye, Lisa McCormick, Bulent Turan, Laura Nyblade, Mirjam-Colette Kempf, and Janet M. Turan.AIDS Patient Care and STDs.Nov 2016.519-527. **http://doi.org/10.1089/apc.2016.0223**

Staff Guide: Using patient Feedback to improve healthcare services. HSE.
https://www.hse.ie/eng/services/yourhealthservice/hcharter/ask/feedbackstaffguide.pdf
UNFPA Country Programme Evaluation: Georgia. Period covered by the evaluation: 2016-18. July 2019. Unpublished

International Documentation on Sexual Orientation and Gender Identity (SOGI)
https://outrightinternational.org/documentation/international-documentation-sexual-orientation-and-gender-identity-sogi

2020