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STI/HIV STIGMA AND DISCRIMINATION OF HEALTH PROVIDERS TOWARDS HIGH-RISK GROUPS IN GUATEMALA:

A Study of Knowledge, Attitudes and Practices



AUGUST 2008

This publication was produced for the United States Agency for International Development. It was prepared by the University Research Co., LLC/Calidad en Salud STI/HIV Stigma Study Team. The views in this study do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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ACRONYMS

AIDS	Acquired immunodeficiency syndrome
ARV	Antiretroviral therapy
HIV	Human immunodeficiency virus
FGD	Focus group discussion
FSW	Female sex worker
KAP	Knowledge, attitude, and practice
MOH	Ministry of Health
MSM	Men who have sex with men
NGO	Nongovernmental organization
PLWHA	Person living with HIV/AIDS
STI	Sexually transmitted infection
UNAIDS	United Nations Programme on HIV/AIDS
URC	University Research Co., LLC
VCT	Voluntary counseling and testing

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EXECUTIVE SUMMARY

INTRODUCTION

Stigma—along with its offshoot, discrimination—related to STI/HIV is a widespread problem fueling STI/HIV transmission and creating barriers to prevention, treatment, care, and support. UNAIDS defines stigma as the social process that marginalizes, devalues, and labels people because they are different and notes that stigma has important consequences for the way people come to view themselves (Aggleton and Parker, 2002). Discrimination, on the other hand, is considered enacted stigma; UNAIDS defines it as, “any form of arbitrary distinction, exclusion, or restriction affecting a person” (Aggleton and Parker, 2002).

In Guatemala, an estimated 61,000 people, less than 1% of population, are HIV-positive (USAID, 2008). High-risk groups, such as female sex workers (FSW), men who have sex with men (MSM), and persons living with HIV/AIDS (PLWHA) represent a portion of this population. For them, health centers serve as an important entry point to improve access to care, allowing them to seek necessary treatment. Health centers are also a vital component of Guatemala’s HIV/STI efforts to prevent further cases of transmission. However, health centers may be sources of stigma and discrimination against people with STI/HIV. In general, Guatemalan health providers have limited knowledge of STIs and HIV/AIDS. In addition, numerous acts related to health care provision and indicating stigma or discrimination have been observed, particularly against high-risk groups. These discriminatory behaviors are driven by negative attitudes that in turn are driven by beliefs and myths about STI/HIV, a lack of knowledge and skills to manage STI/HIV, and a lack of understanding of high-risk groups.

This study investigated the degree and nature of STI/HIV knowledge, stigma, and discrimination among health center providers in Guatemala, with a particular focus on high-risk groups.

OBJECTIVES

The study’s overall purpose was to determine the health care providers’ knowledge, attitudes, and practices (KAP) that relate to STI/HIV stigma and discrimination toward the three high-risk groups. The study’s specific objectives were defined as:

- Assess health providers’ knowledge of STI/HIV in the areas of: modes of transmission, prevention, and virology;

- Assess health providers’ stigmatizing attitudes toward people with STI/HIV and any reported STI/HIV discriminatory practices relating to STI/HIV care for the high-risk groups;
- Assess the knowledge, attitudes, and practices of high-risk groups as related to reported STI/HIV services offered/ received at selected health care centers; and
- Based on study results, make recommendations that could inform the design of a strategy to reduce STI/HIV-related stigma toward members of high-risk groups and thereby increase access to care.

METHODOLOGY

A cross-sectional study was designed to form a snapshot view of participant’s knowledge of, attitudes about, and practices toward STI/HIV and high-risk groups. Data were gathered from eight health centers in three Guatemalan regions: metropolitan, southeast, and northwest. Participants included 132 health care providers working in the health centers. These providers took part in focus groups discussions (FGDs) and interviews. Also participating were clients representing the high-risk groups.

RESULTS

Gaps in Knowledge of STI/HIV: The study findings show that the health providers have a basic knowledge of modes of transmission and prevention, but were less knowledgeable of STI/HIV virology. Gaps were identified when more technical questions, related to modes of transmission, prevention, and virology, were asked. Although the providers’ overall knowledge score of STI/HIV was good, one can infer that a deeper understanding of STIs and HIV is lacking.

Attitudes toward STI/HIV and High-Risk Groups: Findings indicate a prevalence of STI/HIV stigma and discrimination of health providers toward the high-risk groups. Although providers indicated a willingness to treat members of these groups, their attitudes and behavior signal negative beliefs indicative of stigma and discrimination. The findings underscore the health providers’ lack of awareness of their stigmatizing attitudes. Approximately 86% of them believed they did not need stigma and discrimination sensitivity training, further confirming a lack of awareness of their attitudes and behavior and need for change.

The negative beliefs identified in this study can be largely attributed to attitudes around sex-related morality, shame,

and blame toward STI/HIV and the high-risk groups. Health providers blamed these groups for having an STI/HIV caused by promiscuity and/or choice of lifestyle. The most stigmatizing attitudes targeted MSM. These negative attitudes were expressed not only by providers but also by members of other high-risk groups (notably FSW), who voiced their strong objection to an immoral choice of “lifestyle” these men had made.

Lack of Resources: Findings also show that essential resources, such as supplies, clinic and lab equipment, infrastructure, and human resource capacity, are lacking. Although health providers are trained in universal precautions, they cannot always practice such precautions because basic supplies like gloves and chlorine are lacking. Health centers as a whole face the obstacle of not having a proper waste disposal system. Lack of reagents for HIV/STI lab tests were another problem: Due to limited testing materials, health providers were selective in offering STI and HIV tests and sometimes failed to meet client demands. Where providers could not perform the test, they referred clients to private laboratories, often unaffordable to clients.

Patient confidentiality and privacy are also lacking in these health centers. Health providers expressed the need for private clinics or rooms for confidential treatment and counseling in order to provide better quality health care. Hygiene also needed improvement in health centers. Deficiencies in staff capacity, such as personnel shortages and lack of expertise in STI/HIV, also negatively affected the quality of health care. Given the nature of the work and weaknesses in human resources, providers were overwhelmed.

RECOMMENDATIONS

Stigma and discrimination by health providers prevent people from seeking needed care and enable future transmissions. Health providers in this study failed to see themselves as responsible for stigma’s manifestations or their attitudes as a barrier to care. A multi-pronged strategy to mitigate stigma and discrimination among health providers would curb the problem. Recommendations for such strategy include:

- Design innovative training on stigma and discrimination that incorporates participatory training methods and group action planning and includes health provider interaction with client groups.
- Use the study’s focus group transcripts to develop case studies to help health providers identify their own stigma

and discrimination, find common language for talking about stigma, learn how stigma manifests itself, and discuss stigma and discrimination. Examine the transcripts for contradictions, such as those between good intentions and stigmatizing behaviors.

- Develop clear behavioral guidelines to counter stigma and discrimination; these guidelines could be similar to those used to overcome medical barriers to family planning.
- Identify champions from both provider and client groups to advocate for reduced stigma and discrimination in health centers.
- Make use of existing tools and materials (such as the OASIS manual for sensitizing care of STI/HIV/AIDS and the Red Cross manual on stigma and discrimination) that focus on health providers to reduce STI/HIV stigma. Identify and design other appropriate materials as needed.
- In coordination with the MOH, ensure STI/HIV supplies (reagents, gloves, chlorine) needed to provide quality services and prevent infection are available. Establish systems to ensure compliance with bio-security norms and properly dispose of contaminated waste.
- Enhance practical knowledge of STI/HIV through training to reduce fear of casual transmission and strengthen gaps in knowledge.
- Improve the quality of health care through access to integrated care and use of the collaborative learning and improvement process currently underway.
- Implement anti-discriminatory policies where necessary in health centers.

I. INTRODUCTION

Stigma related to sexually transmitted infection (STI) and the human immunodeficiency virus (HIV) is a widespread problem, fueling STI/HIV transmission and creating barriers to prevention, treatment, care, and support. The United Nations Programme on HIV/AIDS (UNAIDS) defines stigma as a social process that marginalizes, devalues, and labels people because they are different and notes that stigma has important consequences for the ways individuals view themselves (Aggleton and Parker, 2002). Traditional definitions convey similar meanings and refer to stigma as a response to an undesirable attribute or condition, one that deeply discredits an individual in the eyes of society (Goffman, 1963). Discrimination, on the other hand, is the enactment of stigma; UNAIDS refers to it as “any form of arbitrary distinction, exclusion, or restriction affecting a person” (Aggleton and Parker, 2002).

Health centers are a vital component of Guatemala’s STI/HIV efforts. These health centers serve as an important entry point to care, allowing individuals to seek the treatment they need and preventing further cases of transmission. However, these facilities may be a source of stigma and discrimination against people with STI/HIV. In general, Guatemalan health providers have limited knowledge of STIs and HIV/AIDS, because they have not often attended such cases and/or have had little or no STI/HIV training. Negative attitudes about STI/HIV are driven by beliefs and myths about HIV, lack of knowledge and skills to manage HIV, and lack of understanding of people with STI/HIV. Numerous practices in health care settings may denote discrimination against or stigmatize persons affected by STI/HIV.

This study investigated the degree and nature of STI/HIV stigma, discrimination, and knowledge among health center providers in Guatemala. In addition to health care providers, it focuses on three groups at high risk for STI/HIV: commercial sex workers, especially female sex workers (FSWs); men who have sex with men (MSM), and persons living with HIV/AIDS (PLWHA).

II. OBJECTIVES

The study’s overall purpose was to determine the health care providers’ knowledge, attitudes, and practices (KAP) that relate to STI/HIV stigma and discrimination toward the three high-risk groups. The study’s specific objectives were defined as:

- Assess health providers’ knowledge of STI/HIV in the areas of: modes of transmission, prevention, and virology;
- Assess health providers’ stigmatizing attitudes toward people with STI/HIV and any reported STI/HIV discriminatory practices relating to STI/HIV care for the high-risk groups;
- Assess the knowledge, attitudes, and practices of high-risk groups as related to reported STI/HIV services offered/ received at selected health care centers; and
- Based on study results, make recommendations that could inform the design of a strategy to reduce STI/HIV-related stigma toward members of high-risk groups and thereby increase access to care.

III. METHODOLOGY

A. STUDY DESIGN AND PARTICIPANTS

A cross-sectional study was designed to form a snapshot view of participants’ knowledge of, attitudes about, and practices toward STI/HIV and high-risk groups. Data from the focus group discussions and the questionnaire enabled an analysis comparing qualitative and quantitative responses.

Data were obtained from eight health centers in three regions of Guatemala: metropolitan, southeast, and northwest (Table I). These health centers are among the 34 public health centers the University Research Co., LLC (URC)/Calidad en Salud supports in efforts to strengthen voluntary counseling and testing (VCT) of STI and HIV services in Guatemalan areas with high STI/HIV prevalence. The United States Agency for International Development (USAID) funds the URC-provided support and funded this study.

Table 1: Study Health Centers by Region and Department and Number of Health

Region	Department	Health Center	Health Providers (n = 132)
Metropolitan	Guatemala City	Zone 6	24
		Villa Canales	9
Northeast	Izabal	Amates	16
		Puerto Barrios	17
Southwest	Suchitepéquez	Mazatenango	15
	Retalhuleu	Quetzaltenango	20
	Quetzaltenango	Retalhuleu	14
	San Marcos	Tecún Umán	17

B. DATA COLLECTION

The study conducted FGDs with 132 health care providers working at these health centers. Both medical and administrative personnel participated, including doctors, health center directors, lab technicians, and secretaries. The study also conducted FGDs with client participants representing each of the high-risk groups. The FGDs were conducted in February and March 2008. After the FGDs were completed, the study used a questionnaire to interview 132 health care providers for further information on their KAP toward STI/HIV and the high-risk groups.

The FDG topics and the questionnaire addressed health care providers' STI/HIV-related KAP, stigmatizing behaviors and discriminatory practices, and perceptions of obstacles health centers face in offering high-quality STI/HIV services.

I. Focus Group Discussions

The FGDs were held with health providers from each participating health center and with 14 groups of clients representing the three high-risk groups. These sessions sought to assess health providers' knowledge, attitudes, and practices around STI/HIV-related stigma and to explore their attitudes and beliefs toward high-risk groups and STI/HIV. The FGDs with clients were designed to gain information on their STI/HIV-related experiences at health centers and reinforce or discount information from providers. Annex 1 provides the FGD instrument.

Each focus group was facilitated by a two-person team: a moderator and note-taker. The team was responsible for tape-recording each FGD and transcribing the discussion, ensuring accuracy. All FGD teams were trained in focus groups management techniques before study implementation, participated in a practice session, and were monitored by study supervisors.

Each focus group had at least seven participants to ensure breadth of discussion. Informed consent was obtained from all participants before each session. All discussions were held in a private room with the door closed to ensure confidentiality, encourage honest participation, and help participants feel at ease.

2. KAP Survey

After completion of the focus groups sessions, a survey questionnaire was designed to investigate health providers' knowledge, attitudes, and practices toward members of high-risk groups and the services providers give to such members. The questionnaire was based on information from the FGDs, a review of stigma and discrimination studies, and the author's knowledge of STI/HIV stigma and discrimination of health providers toward the high-risk groups. The questionnaire, which served as a guide for interviews with health care providers was validated prior to administration and is in Annex 2.

Data were gleaned from the interviews in April 2007 and enabled an assessment of providers' STI/HIV knowledge, attitudes, and practices toward high-risk groups as well as attribution of shame and blame toward STI/HIV and high-risk groups, perceived risk of infection, availability of protective gear, patient confidentiality and record keeping, and other key health center practices. Since the 132 providers had jobs providing direct or indirect contact with clients, this report uses these terms to distinguish between the responses of these two categories. "Direct providers" are those who had direct contact with STI/HIV clients from high-risk groups: medical doctors, professional and auxiliary nurses, lab technicians, social workers, and psychologists. "Indirect providers" are those who were not necessarily in direct contact with STI/HIV patients: maintenance personnel, secretaries, and administrative and financial staff.

For HIV knowledge questions on modes of transmission and prevention, providers were not given possible responses. The other KAP questions were closed ended and are reported accordingly. Data were measured by each KAP category: knowledge, attitudes, and practices. This report provides averages from both direct and indirect providers' responses.

C. DATA LIMITATIONS

Overlap exists among the groups of clients studied; for example, some PLWHA are MSM, and some MSM are male sex workers. Also, some client groups may be in closer contact with health services than others; for example, FSWs working in a business may have closer contact with health services than those who work on the street.

D. DATA ANALYSIS

The FGD data were analyzed using Ethnograph software v. 5.8, which allows organizing, managing, and coding segments of text (e.g., from FGD transcripts) and then searching for specific segments or combinations of segments to reveal patterns. Quantitative data were analyzed using Epi-info and Excel. Chi-squares were performed and p-values calculated to check the statistical significance of the differences between groups, particularly by provider type and health service site. Those differences found significant are noted in the presentation of findings.

IV. MAIN FINDINGS FROM FOCUS GROUP DISCUSSIONS

A. FEMALE SEX WORKERS

I. Sexual Prophylaxis

FSWs in Guatemala are required to regularly (i.e., every two–four weeks) attend health centers for sexual prophylaxis. They generally reported receiving good treatment in these visits in terms of interpersonal relations. Typical statements included:

"We are always welcome."

"We feel well because they do not mistreat us."

"The doctor is agreeable."

"Here we are treated well."

"I have been treated well."

Further discussion, however, led one group to report not being allowed to use the bathroom in the health center, which seems to counter health providers' reported knowledge, discussed below, that STI/HIV are not transmitted through use of bathrooms. Also, there were several reports of negative experiences from doctors who tend to be rough during the exams and give scant information of findings. Thus, FSWs said that respect and privacy should be provided during examinations, as should the right to prevent the presence of observers. They complained that they were sometimes charged for materials or exams. Another complaint was that doctors do not stay on schedule, a particular problem as FSWs have permission to attend health centers for a limited period. Finally, FSWs would like their check-ups to be more integral and not only gynecological, and they would like to receive more counseling. Their comments included:

"[Quality of care is] very bad, when I have asked for another exam—different from prophylaxis—they have not provided it."

"Only when it is very obvious that we have a cough or something does the doctor ask whether we are sick; otherwise, they just do prophylaxis with little conversation."

FSWs reported that generally doctors wear gloves during prophylaxis exams, though they seldom use a speculum. They tend to understand being scolded when, attending health centers in a group, they make a lot of noise, are drunk, or smoke. Thus, FSWs appear to differentiate between discrimination and institutional norms of conduct.

FSWs reported receiving from 15–60 condoms at health center visits, although shortages were also reported. Some had received contraceptive pills or micronutrient tablets (iron and folic acid).

FSW recognized some STIs and could name papiloma, hepatitis B, syphilis, chancres, and pubic lice, either from personal experience or reports from other women. To a lesser degree, they had obtained information from printed materials provided in health centers and nongovernmental organizations (NGOs). NGOs had given FSWs information regarding the correct use of

condoms and client negotiation. FSWs said that they cannot accept a client who will not use a condom. Peer education had also been occurring on the correct use of condoms and ways to negotiate their use with clients.

2. HIV Voluntary Counseling and Testing

Only one group of FSWs said that they went to the health center for HIV testing. The rest reported going to hospitals, private clinics, and NGO clinics. In most but not all groups, FSWs reported that they received counseling before and after the test and that they signed a consent form. Test results were received from an hour to 15 days later.

In one group, participants reported that they had seldom been tested because it was not required “either by business owners or the police.” In another group, the police were mentioned as the main barrier to attending health services as they try to bribe business owners and sex workers: The police offer to not enforce compliance in exchange for sexual favors.

If an FSW were found HIV positive, they reported, it was standard practice for the health provider to tell the business owner, so the worker would be required to stop working. Consequently, many HIV-positive FSWs went for health care where testing was not required. Other FSWs did not accept results; their co-workers recounted experiences of alcohol and drug abuse and even suicide as a consequence.

“How they do the testing is that they ask for our information, we sign a form. They ask us a lot of questions about what we know about HIV, how we take care of ourselves . . . before doing the test.”

3. Attitudes toward MSM and people with HIV

FSWs’ attitudes toward MSM were negative. They didn’t like “that type of man,” and they regarded male homosexuality as “incorrect,” “abnormal,” or “dirty.” Some said they try to avoid this group.

Their perception of PLWHA was more benevolent, and they did not report any reason to discriminate against or avoid them. Some had had personal experiences taking care of a PLWHA. These experiences made FSWs’ attitudes toward PLWHA more positive and helped convince them (FSWs) of the need to always use a condom.

Regarding commercial sex work, they manifested ambivalent feelings: Some said they knew it was “bad,”

but they could not quit due to economic needs. Some said it was a job like any other; others said that they were used to it and didn’t think much about it.

4. FSW recommendations

FSW recommended that the health center infrastructure be upgraded to improve confidentiality and privacy. They described health center hygienic conditions as appalling. The schedule should be more flexible, and health personnel should be on time. Also, FSWs think health centers need more supplies and medicines, and they would like to receive more counseling and group talks.

B. MEN WHO HAVE SEX WITH MEN

I. Health services

MSM participants had less experience with health services than the other groups, but many said they attend health centers because they are free and offer a range of services.

Men in two groups said that their health centers had recently implemented services for MSM with well-trained providers whom they trust and who are not shocked by MSM. They reported that they previously would not attend health centers because they felt discriminated against, laughed at, and automatically considered carriers of HIV or other STIs, and they were not given any medicines.

“We go there because services are without charge, and [we go] more now that we know there is health care specifically for MSM.”

Some MSM said that discrimination still occurred in health services and that health providers whose behavior is not professional should be sanctioned. Clients should also be able to report discrimination.

Sometimes MSM felt discriminated against because health providers treated them unkindly and did not distinguish differences among MSM. “Even those of us who are very feminine are addressed as men, even when we have identified ourselves as women.” Another said,

“We need endocrinologists, psychologists, and psychiatrists; many of us are alcohol or drug or sex addicts, and we need professional orientation. We would also like them to hire someone from our own community [of MSM], so that he provides good quality care, gives out test results, and counseling. Most health providers are heterosexual and some of them are homophobic, ‘machos’. . . . We

would like health workers to receive training about sexual identity, sexual orientation, and that they have better interpersonal relations and attitudes toward our community, so that there is no stigma and discrimination.”

Most MSM said that they did not receive enough counseling, calling particularly for assistance with alcoholism and drug abuse.

2. HIV Voluntary Testing and Counseling

Most MSM reported that they had had HIV tests in health centers and had received counseling before and after being tested. They also reported that interpersonal relations were amicable and confidential in most cases.

However, members of one NGO commented that the treatment they received in Social Security clinics and health centers was indifferent or moralistic. When they needed options to solve their health problems, they received no attention or were advised to change their way of life and find God/Jesus. They said that if they needed spiritual orientation, they would go to church, but that for a health provider to give religious advice is inappropriate. They also reported breaches in confidentiality of test results.

“The person who gives out test results and counseling is too preachy. For instance, if the result is positive, he will say ‘Hey, change, what you’re doing; it is wrong to be a sex worker, gay, or transgender. Change now and accept God.’ But we need professionals; we do not need a priest. We need professionals that are impartial, that won’t tell us what to do, but offer us a range of options . . . because what good it is to go to the health center if they are going to tell me to change my sexual identity and that because of it and my behavior I live with HIV.”

3. Attitudes toward FSWs

Some MSM said that they do not have a bad opinion of FSWs; as one put it: “They are working to survive.” Others said that there is a struggle between them and homosexuals/transsexuals who also perform commercial sex work. FSWs disdain them, calling them “sidosos” or “sick.” That came as no surprise to MSM: They said FSWs discriminate against them because: “Those in a closed business (bar) feel superior to those who work on the street.” MSM considered that in society’s and health providers’ discrimination scale, FSWs fare “a little better” than they. To support this view they noted that FSWs already have a regular

service in health posts (prophylaxis) while MSM do not. Finally, some MSM do not attend health centers because they have experienced contempt from FSWs.

4. Recommendations

Participants in these groups recommended that there be an emergency unit to attend cases quickly. Also, furniture and equipment should be newer and medicines available. Some of the capital city participants who had attended health centers in other locations mentioned that those facilities should offer a wider constellation of services, because referring a patient to a national hospital wastes the client’s time.

C. PERSONS LIVING WITH HIV/AIDS

1. Health Care and Treatment

Persons living with HIV/AIDS reported that they went to Social Security clinics and national hospitals more than to health centers for regular health care and antiretroviral drugs (ARVs). Health centers never had ARVs, and some neither complied with confidentiality nor treated PLWHA respectfully. In Social Security and specialized national hospitals, they reported, health providers are mostly amicable, so this group trusted them enough to make inquiries, ask for CD4 status, and get medicines. Even if Social Security sometimes doesn’t have medicine, they said, the health care was always good.

2. HIV Voluntary Counseling and Testing

Participants reported that they usually received VCT in private laboratories, national hospitals, and NGO clinics. Most of them agreed that they were tested without counseling before or after the test. They usually did not receive counseling until they were referred to an NGO or specialized national hospital.

These participants said that once test results were made known to health providers in regular health centers or hospitals, they discriminated against them, as did other patients. This was the main reason they tried to keep their diagnosis secret. They described discrimination as refusing to examine, giving the worst place in the health center, and postponing exams until late hours. Few reported receiving good treatment from hospital staff.

3. Recommendations

According to PLWHA, health center providers should be trained not only to provide medicines, but also to treat PLWHA with dignity. They said that health providers should

learn about confidentiality: Some PLWHA complained that health inspectors had visited their employers to report their HIV status and that this invasion of their privacy has caused them many problems and sorrow.

"I wouldn't go [to a health center], and I wouldn't tell them I am HIV positive, because I know this diagnosis would not be kept secret. [The quality of] health care will change the minute I say I am HIV positive, so I would never tell them."

PLWHA stated that for them to attend health centers, providers would have to be trained to give better quality care to them and the general population. They had noticed that poor people go to health centers, having no alternative, but they had to arrive early to get a number, and frequently the doctor would be late or absent. For PLWHA to use health centers, this practice would have to change, they said, because they could not wait all morning to be seen or to be told the doctor did not show up.

They asked that health providers give them quality care: Once they have AIDS, providers treat them as if they were "living their final days" and providing care would be wasteful. They think a system should be created by which providers who do not exhibit ethical or professional conduct toward PLWHA would be sanctioned or removed from their jobs.

PLWHA noted that it is important that health services have ARVs and other medicines for opportunistic infections. They should offer complete laboratory exams and pharmacy and dental care. Psychological services are important, too, and a meeting room where they could conduct support group sessions. Hospital and health center infrastructure should provide PLWHA with an independent entry or other way to avoid patients suffering other infections. They criticized physical spaces assigned to them at the Social Security hospital and clinics, which they considered inferior to other spaces.

4. Attitudes toward Other High-risk Groups

PLWHA's perception of sex workers is that they are "persons with all the rights and responsibilities of others." They think that for the most part these workers perform commercial sex out of economic need. Their perception is that sex workers are not treated right in health centers, and even when an FSW's attitude is hostile or even violent, health workers should be trained and able to deal with it in a professional manner.

PLWHA said that PLWHA "are persons like others, like heterosexuals, and their sexual preferences do not make them different." They think there is a lot of discrimination toward MSM everywhere, including in health services, where they are at a disadvantage when compared to FSWs who have sexual prophylaxis services while MSM do not. (Some PLWHA participating in this study were also MSM.)

"I think that MSM constitute a population that has many disadvantages in terms of free health care because, for instance, for FSWs there are specific programs. In the health center they serve FSWs periodically and if FSWs go to a hospital they're regarded more 'normal' than MSM. . . . I also think that they [MSM] are at a disadvantage in terms of counseling or information for other STIs. They cannot get counseling as easily as FSWs; it is more difficult for them because there are no specific programs for them."

D. HEALTH CARE PROVIDERS

I. Knowledge of STIs and HIV/AIDS

In general, the focus group discussions indicated that health care providers had basic knowledge about STIs and HIV, forms of transmission, preventive measures, and vulnerable groups. Providers also generally acknowledged the relationship between other STIs and HIV, consistent with what is reported in the section on interviews with providers. However, only one health provider mentioned that people who get tattoos can get HIV if one-use-only materials are not used, which is also consistent with interview findings.

The FGDs suggested that health providers probably lack deep knowledge about HIV/AIDS; most of them refer to ARVs as just "retroviral" treatment, suggesting that they probably are not aware that HIV is a retrovirus and that the drugs are antiretroviral. (The interview findings also indicate gaps in health providers' HIV/STI knowledge.)

Stigma was revealed in the following quote comparing AIDS and leprosy, a disease long associated with stigma and discrimination:

"We know that AIDS is the modern leprosy. I regard it so. AIDS is a disease acquired through sex and other ways: a cut, an infected needle. But, in brief, we are very scared to talk about it."

Another provider was aware of providers' lack of awareness about and sensitivity toward AIDS:

“Something very important is that to this date we have not accepted AIDS, and we discriminate against people with AIDS. Many of us say ‘I don’t discriminate,’ but until we have a patient or someone infected in our own family, we won’t really know if we are capable of coexisting with a person with AIDS.”

Health providers indicated that cases of STIs, HIV, and AIDS are under-registered. They thought that due to associated stigma, people prefer to go to pharmacies and self-medicate for STI rather than attend health centers. Providers attributed low demand for prophylaxis and low follow-up with PLWHA to people’s preference to obtain treatment where they are not known.

Health promotion/education for different stages of knowledge was mentioned as an important strategy.

“We have to work a lot on health promotion. Even where we have conducted health promotion, there are people who still doubt that [AIDS] is real. Some ask the simplest things, [but we cannot think] ‘they are so dumb, not to know.’ In addition, treatment is so costly that we would do better investing in health promotion and education and not in treatment.”

“Looking at the situation we live in, I think AIDS has to do with values; for instance, mutual faithfulness, sexual abstinence for adolescents and condom use are all measures we are trying to promote so that the pandemic will not continue spreading. Wherever we live we need to create awareness among the population and among ourselves so that we can prevent [AIDS]: [Prevention] depends only on us.”

“I think that health promotion and education is everybody’s responsibility and, for this component, using a condom is [the main] protection. [We have to] provide information on prevention and the reasons for using it. We now have a ‘friendly space’ in this health center where we explain all of these [issues] to young people. I think an informed person thinks twice. Abstinence is just for religious people. So we have to teach [young people] to avoid risky situations and risky behaviors, right? And STIs make us more vulnerable to HIV.”

“Using a condom constantly and correctly [is easier]; mutual faithfulness and abstinence are more difficult.”

2. Diagnosis and Treatment of STIs

Health workers reported providing STI diagnosis and treatment to most high-risk groups (FSWs and MSM), but also to adolescents and youth, housewives, and pregnant

women. One provider averred that FSWs have fewer cases of STI now than before due to successful efforts in this group to promote the correct and consistent use of condoms. Most health providers thought that services depend on availability of materials and supplies, and they preferred laboratory to syndromic diagnosis of STIs because the latter “does not allow you to identify the cause of the infection and thus limits counseling and follow-up.”

When providers described sexual prophylaxis, it was clear that FSWs who work in a closed business (a bar, night club, or other) are the main beneficiaries. This service generally consists of an examination of external genitalia to identify a visible STI (secretion, chancre, or papiloma) and a gynecological exam. All providers used gloves for this exam, but not all used a speculum, depending on the center’s resources. For prophylaxis, they provided 20–63 condoms, varying by account.

3. Voluntary Counseling and Testing for HIV

Health providers reported that HIV tests were not always performed because reagents were not available. Due to limited resources, they conducted testing only with specific groups: Some offered the test just to FSWs every three months. When they could not perform tests, they referred clients to private laboratories. Providers reported that counseling before and after testing was standard procedure as was providing condoms. Some said they always requested informed consent.

Reportedly, confidentiality was always practiced. Patients whose results were positive were referred to national hospitals or NGO programs. Providers think that follow-up of HIV-positive sex workers was complicated: They were advised to stop working, which they did not want to do, so they interrupted treatment, changed place of work, or moved to another department or country.

“[If they are HIV positive], we emphasize that they need to stop working; but the thing is, as they say, ‘How am I to earn my living? I have children.’ So that is the problem with them, even when they are positive they continue working. This is very difficult to control because they go from business to business or they simply stop coming here or move elsewhere”

In the case of pregnant women found HIV positive, capital city health providers said that following the treatment regimen was more feasible if the woman was in the first trimester; otherwise it was very

complicated. One obstacle was the long time it took to obtain results: from a few days to a month.

4. Perception of Risk of Acquiring HIV and Prevention

Providers were aware that they are at risk of HIV infection from an accident at work. They reported using universal precautions and specific preventive measures, such as wearing gloves and being careful with cutting instruments and needles. They also mentioned bio-security measures (using chlorine for disinfection) and thought that cleaning personnel take some precautions to avoid infection.

Providers commented they always had difficulties obtaining supplies: gloves, red bags or boxes, and chlorine. They had been trained in preventive measures, but could not put them into practice due to the lack of resources. They pointed out a still larger obstacle for the health centers: lack of a system for proper disposal of solid waste. Previously, centers received help from hospitals, but they didn't at the time of the study and did not know how to discard waste.

5. Attitudes toward People with STIs

Some providers said that from a professional point of view they should treat persons with STIs or HIV the same as others because the reasons for contagion have nothing to do with the provision of health services. They thought that lack of information was the major cause of STIs and HIV infection.

However, they distinguished between professional and personal views. Their personal perspective was that most people suffering from an STI had been unfaithful, especially men, who, given their "macho culture," had sex with commercial sex workers, did not wear a condom, and infected their wives. Very few providers mentioned rape as a cause of infection, signaling stigma associated with STIs.

"Maybe he has visited a bar, acquired an infection, from having multiple sexual partners."

"If someone has an STI, that makes us wonder and inquire if s/he has several partners and what kind of partners."

"Maybe they have visited bars and women from the street, who do not come here for treatment but who offer their services on the street."

Health providers had mixed feelings toward people with HIV. Some seemed very sensitive toward this group and their needs, saying that they had to give them a lot of trust and motivation so that they would follow their treatment. Others cautioned against a paternalistic attitude and said people with HIV should receive care and treatment like any other and that a provider's job is to help them cope with their disease. Still others confessed their fears to providing care.

"One should not discriminate against them. We have to give them loving care so that they don't feel bad and give them faith and psychological talks, and understand the process they are going through."

Lack of material and human resources was mentioned as another limitation to providing quality care to people with HIV.

Some providers conceded that they are afraid of sex workers because some of them are very aggressive. They also said they find it difficult to deal with them because they exhibit inappropriate behavior in health facilities: cursing, fighting among themselves, smoking, or even drinking. Also, FSWs want to be seen quickly, which is not always possible.

6. Attitudes toward MSM

Health providers reported that very few MSM attended health services, confirming what MSM themselves reported. They said that generally MSM were rejected by almost everybody, leading to "self-rejection," which in turn prevented them from going to health services. In addition, business owners were not required to send male sex workers to health centers for prophylaxis as was the case with female sex workers. One provider confided that he is "homophobic" and does not like to examine homosexuals.

7. Recommendations

To provide better quality care to persons with HIV, providers felt health centers should have a designated clinic or a room suitable to provide treatment and counseling with privacy. Also, they would need to have supplies, antiretroviral drugs, other medicines, and chemical reagents for laboratory tests. Personnel would need more training, tutoring, supervision and monitoring of their performance, and educational materials for counseling and talks. A system for

disposing of solid waste was also needed.

Annex 3 summarizes the opinions aired in focus groups discussions by type of group (FSW, MSM, PLWHA, and providers) regarding their attitudes toward the other groups and making special note of expressions suggestive of stigma (attitudes) or discrimination (behavior). It is apparent that health providers were characterized as stigmatizing and exhibiting discrimination by all other groups, especially MSM. However, stigma and discrimination also occurred between the other groups, particularly from FSWs toward MSM.

V. MAIN FINDINGS FROM THE PROVIDER QUESTIONNAIRE

A. CHARACTERISTICS OF HEALTH PROVIDERS

Table 2 shows the demographic characteristics of the health providers who were interviewed and answered the questionnaire's questions. This group included almost all personnel working and present at the selected health center at the time of the survey. Of these health

providers, 58% were female and 42% male. Their ages ranged from 18 to 68 years of age. Their jobs varied from administrative personnel to laboratory technicians to doctors. Nursing personnel (auxiliary and professional) comprised the largest group (30%), followed by administrative personnel at 20%, with medical doctors comprising a smaller percentage of this sample size at 11%.

For the purpose of analysis, providers were categorized into those having direct contact with STI/HIV patients ("direct providers") and those who do not have such contact ("indirect providers"). Direct providers included medical doctors, professional and auxiliary nurses, lab technicians, and social workers, while indirect providers were maintenance personnel, secretaries, and administrative and financial staff. Of the 132 health providers interviewed, 70 were direct providers (53%) and 62 indirect (47%). Some significant differences in sex and education level were found between these categories. Direct providers had significantly higher education levels than indirect providers and were significantly more likely to be female. Only 56% of health providers reported that in 2006 they had received any STI/HIV training, and only 40% of them had received STI/HIV training in counseling in 2006.

Table 2: Selected Health Provider Characteristics by Provider Type

Provider Characteristics	Direct (n=70)	Indirect (n=62)	Total (N=132)	P value
Gender				
Male	22 (31%)	34 (55%)	56 (42%)	**
Female	48 (69%)	28 (45%)	76 (58%)	
Education Level				
Primary	0 (0%)	6 (10%)	6 (5%)	**
Basic	8 (11%)	11 (18%)	19 (14%)	
Secondary/high school	25 (36%)	33 (53%)	58 (44%)	
Technical	12 (17%)	3 (5%)	15 (11%)	
Masters	19 (27%)	6 (10%)	25 (19%)	
Post-graduate	4 (6%)	0 (0%)	4 (3%)	
No education	0 (0%)	1 (2%)	1 (1%)	
Other	2 (3%)	2 (3%)	4 (3%)	
HIV Training (2006)	45 (64%)	29 (47%)	74 (56%)	
STI/HIV Counseling Training (2006)	36 (51%)	17 (27%)	53 (40%)	

*significant difference ($p > .05$),

**very significant difference ($p < .01$) between direct and indirect providers

B. HEALTH PROVIDER KNOWLEDGE OF STI/HIV

I. Modes of Transmission

Overall, providers scored high on knowledge of modes of STI/HIV transmission. They were very familiar with some modes, such as unprotected vaginal sex (100%), blood transfusions (98%), and mother to child transmission during pregnancy and childbirth (98%). Other modes were less known, such as via tattoos (83%) and through breast milk (93%). These scores include both prompted and unprompted answers (Table 3).

When looking at only unprompted answers, percentages were much lower, with blood transfusions and vaginal sex yielding the highest number of correct responses: 77% and 62%, respectively. Thus, health providers may have had more recognition than knowledge of STI/HIV transmission modes. For questions that did not prompt answers, correct response for modes of transmission yielded lower results. For example, only 43% of providers correctly indicated that blood and semen were not the only bodily fluids to transmit HIV (breast milk is often overlooked in this category). However, it is important to note that for this question, there was a significant difference in knowledge

between direct and indirect providers (66% versus 18%, respectively), demonstrating significant differences in the level of knowledge between these provider categories.

2. STI/HIV Prevention Strategies

Providers demonstrated good knowledge when asked about HIV prevention strategies. All indicated the correct and consistent use of a condom as a strategy to prevent HIV, while partner fidelity and abstinence were also high (98% and 95%, respectively). Other prevention strategies were less well known. For example, 86% said that STIs and HIV can be prevented with the same prevention and promotion tactics, and only 82% knew that a delay in the onset of sexual relations is a form of HIV prevention.

Providers also demonstrated good knowledge of appropriate health center practices. For instance, 98% said they comply with bio-security norms in the health care setting.

Again, it is important to note that these averages for prevention strategies included both prompted and unprompted answers. When looking only at unprompted answers, the averages are much lower. Finally, no

Table 3: Provider Knowledge of HIV Modes of Transmission, n = 132

Question	(Percentage Answered Correctly)			
	All Providers	Direct Providers	Indirect Providers	P Value
In what ways can HIV be transmitted? (Multiple responses allowed)				
Through mosquito bites (Correct answer: No)	96%	99%	97%	
Through public restrooms. (Correct answer: No)	98%	100%	95%	
Through Tattoos (Correct answer: Yes)	83%	84%	81%	
Through blood transfusions (Correct answer: Yes)	98%	97%	100%	
Through vaginal sex without protection (Correct answer: Yes)	100%	100%	100%	
Through oral sex without protection (Correct answer: Yes)	87%	91%	92%	
Through anal sex without protection (Correct answer: Yes)	97%	97%	95%	
From mother to child during pregnancy or childbirth (Correct answer: Yes)	98%	99%	95%	
From mother to child through breast milk (Correct answer: Yes)	93%	92%	93%	
Through utilization of contaminated equipment (Correct answer: Yes)	98%	99%	97%	
Blood and semen are the only bodily fluids to transmit HIV (Correct answer: No)	43%	66%	18%	**

*significant difference ($p > .005$),

**very significant difference ($p < .001$) between direct and indirect providers

significant differences between direct and indirect providers were found in reported health center practices, so data in Table 4 represent these categories combined.

3. STI/HIV Virology

Provider knowledge of STI/HIV virology was less than that of other topics: 66% answered correctly that an HIV-positive person does not necessarily have AIDS, but very significant differences occurred between direct and indirect providers (80% versus 50%, p value $< .01$). Knowledge of HIV re-infection was also low: Only 64% recognized the following statement as false: "If both partners are HIV positive, there is no need for them to use a condom during sexual relations." Again, a significant difference occurred between direct and indirect providers (77% versus 48%, p value $< .01$). Finally, even fewer (57%) recognized the following as false: "Persons infected with HIV will develop antibodies after one year of infection."

C. HEALTH PROVIDERS' ATTITUDES TOWARD STI/HIV AND HIGH-RISK GROUPS

I. Morality, Shame, and Blame

This study found negative attitudes toward STI/HIV and high-risk groups. Negative attitudes largely related to sex-related morality, shame, and blame. For example, most health providers expressed disapproval of the choice of lifestyle of both FSWs and MSM. Over half (54%) agreed with the statement, "Health centers should help female sex workers change their lifestyle choice," while 84% agreed with the statement, "Female sex workers are the type of people that need the most moral support to change their lifestyle." When asked to agree or disagree with "Prostitution should be prohibited to reduce the transmission of HIV and STI," 67% agreed.

Negative attitudes were also expressed toward MSM: 69% of providers agreed with the statement, "Homosexual men need psychological help to change their lifestyle."

Table 4: Provider Knowledge of STI/HIV Prevention Strategies, n = 132

Question	All Providers
What forms of prevention do you know? (Multiple responses allowed)	
Abstinence (Correct answer: Yes)	95%
Mutual fidelity (Correct answer: Yes)	98%
Delay onset of sexual intercourse (Correct answer: Yes)	82%
Correct and consistent use of condoms (Correct answer: Yes)	100%
Reduced number of partners (Correct answer: Yes)	90%
Compliance with bio-security norms (Correct answer: Yes)	98%
STI and HIV can be prevented with the same tactics (Correct answer: No)	86%

Table 5: Provider Knowledge of STI/HIV Virology, n = 132

Question	(Percentage Answered Correctly)			
	All Providers	Direct Providers	Indirect Providers	P Value
If both partners are HIV positive, they should not worry about using a condom during sexual intercourse.	64%	77%	48%	**
The body develops HIV antibodies after a year of infection.	57%	64%	48%	
If an individual is HIV positive, he or she also has AIDS.	66%	80%	50%	**
STIs facilitate the transmission of HIV.	83%	84%	82%	

*significant difference ($p > .005$),

**very significant difference ($p < .001$) between direct and indirect providers

Shame surrounding STI/HIV also emerged, with an interesting slant. Asked whether “Persons who have an STI infection should feel ashamed,” only 11% of health workers agreed, but when they were asked whether they themselves would feel ashamed for having an STI, 31% agreed.

Most (58%) health providers agreed with the statement, “All individuals who have an STI have many sexual partners,” a common stigmatizing belief linking STI to promiscuity. Note, however, that for this question a significant difference in levels of stigma was found between direct and indirect providers (49% versus 68%, $p < 0.05$).

Table 6 presents these data and generally indicates that providers blamed the choice of lifestyle of high-risk groups for infection.

2. Equality of Care

Although most health providers expressed dissent for the choice of lifestyle of the high-risk groups and blamed members of these groups for their infections,

when asked about the role of health care services, most providers expressed some form of sympathy and urged equality of care: 96% agreed that health centers should offer services to homosexuals, and 92% disagreed with the statement, “PLWHA should only be attended in hospitals, not health centers.”

3. Conclusions on Stigmatizing Beliefs and Attitudes

On average, a majority of health providers demonstrated positive attitudes toward STI/HIV and high-risk groups, though differences were seen between direct and indirect providers: Direct providers demonstrated more positive HIV/STI attitudes toward high-risk groups.

Health providers blamed members of high-risk groups for their STI/HIV due to promiscuity and/or choice of lifestyle. A compounding factor that can be linked to this blame was that for FSWs and MSM in particular, their lifestyle was viewed as immoral and needing change. Asked if they would feel shame if they had an

Table 6: Health Provider Attitudes toward STI/HIV and High-risk Groups, n = 132

Statement	n	Percentage Agreed
People with STIs should be ashamed of their infection.	14	11%
As a health provider, you would feel ashamed for having an STI.	41	31%
Prostitution should be prohibited to reduce STI/HIV transmission.	87	66%
Health centers should encourage sex workers to change their lifestyle.	71	54%
Female sex workers are responsible for AIDS in your health department.	19	14%
Female sex workers need a large amount of moral support to leave their work.	111	84%
HIV-positive sex workers should be prohibited from engaging in sex work.	106	80%
Female sex workers are very conflictive and bad-mannered individuals; therefore, they should not receive good treatment at health centers.	18	14%
Homosexuals require psychological help to change their lifestyle.	90	68%
There is no reason for people with STIs to be ashamed of their diagnosis.	93	71%
Homosexuals are responsible for AIDS in Guatemala.	10	8%
All people who have STIs have many sexual partners.	76	58%
Health centers should offer services to homosexuals.	126	96%
PLWHAs should only be attended in hospitals, not health centers.	122	92%

STI, providers indicated such shame would be much greater in their own case. Although they expressed sympathy for those who had an STI/HIV, this sympathy was intertwined with blame and stigmatizing attitudes they failed to recognize. As discussed in the review of FGDs, this blame affected the quality of health care services.

D. STI/HIV HEALTH CENTER PRACTICES WITH HIGH-RISK GROUPS

Health center practices were assessed to determine whether discrimination occurred in health centers. Health providers were asked about their own behavior as well as that observed or reported at the health center. All answers are based on reported, rather than study-observed, behavior (Table 7).

Reported practices queried in this part of the questionnaire can be interpreted in two ways. Health providers tended to report optimal practices; compliance with patient confidentiality and confidentiality in record keeping were reported as high; a large majority (98%)

reported STI/HIV tests to be performed only with patient consent; and STI/HIV results were reported to be given almost always (95%) with post-test counseling. When providers were asked whether they had observed or heard of a patient being denied services because he or she was HIV positive, a very large majority (99%) answered “No.” With regard to universal precautions, providers reported that gloves were used correctly during sexual prophylaxis exams (99%) and that they washed contaminated equipment (98%).

However, there were exceptions to these reports of optimal health care practices. Asked whether services offered to clients were contingent on their behavior, 84% of health providers said “No,” but significantly more indirect than direct providers asserted that care was provisional on client behavior (91% versus 76%). Only 41% of providers reported having observed male sex workers being cared for at their health centers (this number may be low simply because male sex workers do not come to the clinic).

Table 7: Provider-reported Health Center Practices, n = 132

Question	(Percentage Answered Correctly)			
	All Providers	Direct Providers	Indirect Providers	P Value
The health center maintained confidentiality of clients who took the HIV test.	94%	97%	90%	
Services offered by the health center are contingent on the behavior of the client in the service.	84%	91%	76%	*
In the last 12 months, have you been informed, heard, or observed occurrence of the following events. Answer (yes or no).				
Male sex workers were offered care.	41%	41%	40%	
Sexual prophylaxis was carried out in a private setting.	90%	90%	90%	
Gloves were used for gynecological exams during sexual prophylaxis.	99%	100%	97%	
Gloves were used to wash contaminated equipment.	98%	96%	98%	
Individuals suspected to be HIV positive were denied services.	99%	100%	97%	
The HIV test was carried out without pre-test counseling.	93%	94%	89%	
The HIV test was carried out without the consent of the patient.	98%	97%	97%	
HIV test results were returned to the wrong patient.	99%	100%	95%	
Medical care was given to people living with HIV/AIDS	89%	94%	86%	
Health service providers maintained confidentiality of HIV positive individuals.	97%	97%	95%	
HIV test results were returned without post-test counseling.	95%	99%	89%	

*significant difference (p > .005),

**very significant difference (p <.001) between direct and indirect providers

E. HEALTH PROVIDERS' REPORTED STI/HIV INFORMATION SOURCES AND NEEDS

Health providers' leading information source was training (71%), with a significantly higher number of direct providers than indirect providers having had such training (79% versus 69%, p value < 0.05). Trainings were following in frequency by television and radio (34% and 29%, respectively), with medical journals and conferences uncommon (18% and 4%, respectively).

Survey results also showed that a very high majority (86%) of providers do not believe they need training on stigma and discrimination. Most believed training on STI, prostitution, and human rights was not necessary. Of all the topics suggested, training on STI/HIV counseling was seen as the most needed; still less than a majority (39%) thought so, further confirming a lack of health provider awareness of their own attitudes and behavior and need for change.

VI. DISCUSSION AND CONCLUSION

A. GAPS IN HIV KNOWLEDGE

The participating health providers had basic knowledge of modes of transmission and prevention, with some gaps, but were less knowledgeable about HIV/STI virology, as indicated by both the interviews/ FGDs and questionnaire responses. For example, most were unaware that it takes six months to develop antibodies enabling detection of HIV. Even fewer answered correctly that an HIV-positive person does not necessarily have AIDS. Also, providers were all not entirely familiar with re-infection.

Although providers' overall knowledge score of STI/HIV was good, one can infer that a deep understanding of STIs and HIV was lacking. Less than half of providers and only 66% of direct providers knew that breast milk can transmit HIV. Qualitative data are also consistent with this conclusion. For example, most referred to ARVs as "retroviral" treatment, rather than antiretroviral treatment, evidencing that they were probably not aware that HIV is a retrovirus and that the drugs are antiretroviral.

B. ATTITUDES TOWARD STI/HIV AND HIGH-RISK GROUPS

Stigmatizing attitudes toward STI/HIV and high-risk groups were pervasive. The negative beliefs identified in this study

can be largely attributed to attitudes around sex, morality, shame, and blame toward HIV and the high-risk groups.

Providers blamed high-risk groups for having STI and/or HIV due to promiscuity and/or choice of lifestyle. The most stigmatizing attitudes targeted MSM. These negative attitudes came from not only the health providers but also from other client groups (notably FSW), who voiced strong objections to an immoral lifestyle. In a focus group session, a health provider reported homophobia and an unwillingness to care for members of this group. FSWs' attitudes were also surprisingly negative and unsympathetic: They expressed disgust with MSM's choice of lifestyle, which they consider "dirty and incorrect." Questionnaire responses underscore this assessment: A high majority of health providers agreed that homosexual men need psychological help to change their lifestyle. At the same time, most providers agreed that health centers should offer services to homosexuals.

Health providers linked shame with STI/HIV, especially for themselves. Although they expressed sympathy for someone with STI/ HIV, this sympathy was likely mixed with blame and stigmatizing attitudes of which they seemed unaware.

All groups had benevolent attitudes toward PLWHA. MSM felt that in society's or a health provider's discrimination scale, FSWs fared "a little better" than MSM. They noted that FSWs have a regular service in health centers (prophylaxis) while MSM do not. Also, some MSM did not attend health centers, having experienced contempt from FSWs at these facilities.

Members of an NGO commented that the treatment they receive in Social Security clinics and health centers is indifferent or moralistic. When they need options to solve their health problems, they receive no attention or are advised to change their way of life and find God/Jesus. They also reported breaches in the confidentiality of test results.

C. LACK OF RESOURCES

The findings highlight the lack of resources many health providers faced in terms of supplies, infrastructure, clinic and lab equipment, and human resource capacity.

FSWs recommended improving the health centers' infrastructure to ensure patient confidentiality and treatment. They described health center hygienic conditions as appalling and recommended improving them. Providers agreed and noted that

in order to provide better quality health care, health centers need a private clinic or a room suitable for providing confidential treatment and counseling.

Providers reported difficulties in obtaining such basic supplies as gloves and chlorine. Although trained in universal precautions, providers cannot always practice them for lack of resources. Lacking reagents for STI/HIV lab tests was reported as a major problem. Not having them, providers offered STI and HIV tests only to certain groups, often despite client demands. When they cannot perform tests, providers refer clients to private laboratories, probably an inadequate solution due to distance and cost.

Proper waste disposal is a serious challenge: Since hospitals stopped supporting a waste system for health centers, no other system has been established.

Finally, health center staff mentioned deficiencies in both the number of personnel and requisite expertise to accept high-risk groups: These staff feel weighed down with the nature of their work and the human resource shortages and weaknesses.

D. HEALTH CARE CENTER PRACTICES

Overall, providers received high scores for health center practices based on their answers to the questionnaire. It appears that either optimal practices are followed or health providers know what these practices should be and answered accordingly. Still, many FGDs expressed different information; for example, FSWs reported being denied use of health center public bathrooms and receiving rough treatment from doctors during gynecological exams.

Clients indicated a strong desire for more counseling, which they believe the health centers have failed to adequately provide. Most MSM reported that they felt they do not receive enough counseling, while FSWs reported counseling sessions to be far from comprehensive. Health providers, on the other hand, reported providing pre- and post-test counseling, requesting informed consent for testing, and offering condoms as standard practices.

Although PLWHA reported breaches in confidentiality of test results, providers reported that confidentiality was always practiced. Providers said that patients with positive results were referred to national hospitals or NGO programs for treatment and support.

Universal precautions were reported as practiced consistently to help prevent workplace infections. No discriminatory measures were reported as having been taken with the high-risk groups.

Men in two focus groups said that their area health centers had implemented services for MSM with well-trained providers whom they can trust and who are not shocked by homosexuality.

VII. RECOMMENDATIONS

Stigma and discrimination by health providers prevent people from seeking needed care and enable future transmissions. Health providers in this study failed to see themselves as responsible for stigma's manifestations or their attitudes as a barrier to care. A multi-pronged strategy to mitigate stigma and discrimination among health providers would curb the problem. Recommendations for such strategy include:

- Design innovative training on stigma and discrimination that incorporates participatory training methods and group action planning and includes health provider interaction with client groups.
- Use the study's focus group transcripts to develop case studies to help health providers identify their own stigma and discrimination, find common language for talking about stigma, learn how stigma manifests itself, and discuss stigma and discrimination. Examine the transcripts for contradictions, such as those between good intentions and stigmatizing behaviors.
- Develop clear behavioral guidelines to counter stigma and discrimination; these guidelines could be similar to those used to overcome medical barriers to family planning.
- Identify champions from both provider and client groups to advocate for reduced stigma and discrimination in health centers.
- Make use of existing tools and materials (such as the OASIS manual for sensitizing care of STI/HIV/AIDS and the Red Cross manual on stigma and discrimination) that focus on health providers to reduce STI/HIV stigma. Identify and design other appropriate materials as needed.

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- In coordination with the MOH, ensure STI/HIV supplies (reagents, gloves, chlorine) needed to provide quality services and prevent infection are available. Establish systems to ensure compliance with bio-security norms and properly dispose of contaminated waste.
 - Enhance practical knowledge of STI/HIV through training to reduce fear of casual transmission and strengthen gaps in knowledge.
 - Improve the quality of health care through access to integrated care and use of the collaborative learning and improvement process currently underway.
 - Implement anti-discriminatory policies where necessary in health centers.

ANNEX I: FOCUS GROUP GUIDES

GUÍA DE DISCUSIÓN PARA EL GRUPO FOCAL PARA HSH Y PVVS

1. ¿Por qué razones asisten al Centro de Salud? (Indagar qué servicios demandan)
2. ¿Por qué no asisten al Centro de Salud?
3. ¿Qué servicios tendría que ofrecer el Centro de Salud para que ustedes asistieran?
4. En el caso de haberse realizado la prueba de VIH en los Centros de Salud, ¿cuál ha sido su experiencia? (Indagar Consejería pre prueba: consentimiento informado y confidencialidad, Consejería post prueba: resultado negativo: orientación. Resultado positivo: seguimiento o referencia)
5. ¿Cómo reacciona el personal de salud cuando saben que ustedes tienen sexo con otros hombres? ¿Cómo reacciona el personal de salud cuando saben que ustedes viven con VIH o Sida? (Indagar si cambia la atención que les brindan y cómo se sienten con esas reacciones).
6. ¿Qué piensan de las trabajadoras del sexo? ¿Qué piensan de las personas que viven con VIH o SIDA? ¿Qué piensan de los homosexuales (HSH)? (Excluir al grupo focal que se está indagando)
7. ¿Qué piensan del personal de los Centros de Salud?
8. ¿Qué necesitaría saber y hacer el personal de salud para atenderlos o atenderlos mejor?
9. ¿Consideran necesario realizar cambios en el Centro de Salud para disminuir la discriminación hacia ustedes? (Indagar personal, infraestructura, horarios, insumos y medicamentos) ¿Cuáles/ Qué cambios?

ANEXO 2: KAP SURVEY QUESTIONNAIRE

Centro de Salud:	No. de cuestionario: /___/ ___/
Fecha: /__ __/ __ __/ __ __ __ __/	Hora de inicio: /__ /__ /: /__ / __/
Entrevistador/a:	Hora de finalización: /__ /__ /: /__ / __/

Buenos días (buenas tardes). URC/ Calidad en Salud en apoyo al Programa Nacional de Sida actualmente está realizando un estudio con el objetivo de investigar conocimientos, actitudes y practicas sobre ITS,VIH y Sida de los proveedores de los Centro de salud. Por esta razón solicitamos su colaboración para responder a este cuestionario. La información que usted brinde se manejará de manera confidencial y será utilizada en la elaboración de una propuesta de intervención, para mejorar la calidad de atención en los servicios de salud .El tiempo calculado para responder este cuestionario es de 30 minutos. De antemano muchas gracias por su colaboración.

RECUERDE ENCERRAR EN UN CÍRCULO EL NÚMERO DE LA RESPUESTA ELEGIDA POR LA PERSONA ENTREVISTADA.				
1	¿De qué maneras cree usted que se puede transmitir el Virus de Inmunodeficiencia Humana o VIH?	REPUESTA ESPONTÁNEA	RESPUESTA INDUCIDA	
	Picaduras de mosquitos.	1. Sí	1. Sí	2. No
	Por utilizar baños públicos.	1. Sí	1. Sí	2. No
	Por hacerse tatuajes.	1. Sí	1. Sí	2. No
	Por transfusiones de sangre.	1. Sí	1. Sí	2. No
	Por relaciones sexuales vaginales sin protección.	1. Sí	1. Sí	2. No
	Por relaciones sexuales orales sin protección.	1. Sí	1. Sí	2. No
	Por relaciones sexuales anales sin protección.	1. Sí	1. Sí	2. No
	De madre a hijo durante el embarazo o el parto.	1. Sí	1. Sí	2. No
	De madre a hijo durante la lactancia materna	1. Sí	1. Sí	2. No
	Por la utilización de jeringas contaminadas.	1. Sí	1. Sí	2. No
	Por accidentes laborales.	1. Sí	1. Sí	2. No
	Otra:	1. Sí		
	2	Con respecto al VIH ¿qué formas de prevención conoce?	REPUESTA ESPONTÁNEA	RESPUESTA INDUCIDA
Abstinencia.		1. Sí	1. Sí	2. No
Fidelidad mutua.		1. Sí	1. Sí	2. No
Retardo en el inicio de las relaciones sexuales.		1. Sí	1. Sí	2. No
Uso correcto y constante del condón.		1. Sí	1. Sí	2. No
Disminución del número de parejas sexuales.		1. Sí	1. Sí	2. No
Cumplir con normas de bioseguridad.		1. Sí	1. Sí	2. No
Otra:		1. Sí		

3	De acuerdo a su trabajo en el centro de salud, ¿qué poblaciones considera que están en más riesgo de tener una Infección de Transmisión Sexual o ITS?	<ol style="list-style-type: none"> 1. Amas de casa. 2. Mujeres trabajadoras del sexo. 3. Mujeres embarazadas. 4. Trabajadores del sexo. 5. Homosexuales. 6. Población migrante. 7. Adolescentes y jóvenes. 8. Otra.
4	¿Cuál es la relación entre las Infecciones de Transmisión Sexual o ITS y el VIH?	<ol style="list-style-type: none"> 1. No existe ninguna relación. 2. Las ITS facilitan la transmisión del VIH. 3. Tienen las mismas vías de transmisión. 4. Se pueden prevenir con las mismas tácticas de prevención y promoción. 5. Otra
5	En el Centro de Salud ¿para qué pacientes está recomendada la prueba de VIH?	<ol style="list-style-type: none"> 1. Pacientes con una ITS. 2. Pacientes con Tuberculosis 3. En el caso de una violación sexual. 4. Migrantes 5. Mujeres embarazadas 6. Mujeres trabajadoras del sexo. 7. Hombres trabajadores del sexo. 8. Pacientes con enfermedades oportunistas. 9. Otra:
6	Como trabajador (trabajadora) de salud ¿cuáles son las medidas que utiliza para protegerse de adquirir las ITS y VIH?	<ol style="list-style-type: none"> 1. Asumir que todos los pacientes son VIH positivos. 2. Evitar el contacto con objetos punzo cortantes que pueden esta contaminados. 3. Utilización de guantes. 4. Desinfección de áreas de trabajo con dilución de cloro. 5. Otro
7	De acuerdo a sus conocimientos ¿qué poblaciones considera que están en más riesgo de contraer el VIH?	<ol style="list-style-type: none"> 1. Amas de casa. 2. Mujeres embarazadas. 3. Mujeres trabajadoras del sexo. 4. Hombres trabajadores del sexo. 5. Homosexuales. 6. Población migrante. 7. Adolescentes y jóvenes. 8. Otra
8	En el Centro de Salud ¿cuáles son las razones por las que se brinda profilaxia sexual a las trabajadoras del sexo?	<ol style="list-style-type: none"> 1. Es un mandato del MSP. 2. Para controlar las ITS en el país. 3. No hay otra institución que las atienda. 4. Son una población de riesgo para la transmisión del VIH. 5. Siempre se ha hecho. 6. Otra
9	En su opinión ¿cuáles son las necesidades que deben ser atendidas en el Centro de Salud para ofrecer una atención de calidad en la profilaxia sexual?	<ol style="list-style-type: none"> 1. Incrementar el personal de salud. 2. Contar con espéculos. 3. Contar con guantes. 4. Contar con reactivos de VIH. 5. Contar con reactivos para el diagnóstico de ITS. 6. Contar con camilla ginecológica. 7. Contar con medicamentos para el tratamiento de ITS. 8. Ampliar la infraestructura del Centro de salud. 9. Capacitarnos en los temas de ITS, VIH y Sida. 10. Otro:

VOY A LEERLE VARIAS ORACIONES POR FAVOR INDÍQUEME PARA CADA UNA: SI ESTÁ DE ACUERDO O EN DESACUERDO CON LO QUE CADA UNA DICE.

10	Las personas que viven con VIH o Sida no tendrían que asistir a los centros de salud para que se les atienda sino solamente a los hospitales.	1. De acuerdo. 2. En desacuerdo.
11	Las personas que padecen una ITS deben sentir vergüenza por padecerla.	1. De acuerdo. 2. En desacuerdo.
12	Como proveedor de salud usted sentiría vergüenza por padecer de una ITS.	1. De acuerdo. 2. En desacuerdo.
13	Hay que prohibir la prostitución para reducir la transmisión de ITS y VIH.	1. De acuerdo. 2. En desacuerdo.
14	En el Centro de Salud se les debe recalcar a las trabajadoras del sexo la necesidad de que dejen esa vida.	1. De acuerdo. 2. En desacuerdo.
15	Las trabajadoras del sexo son responsables del SIDA en este departamento.	1. De acuerdo. 2. En desacuerdo.
16	Las trabajadoras del sexo son el tipo de personas que necesita mayor apoyo moral para dejar su forma de vivir.	1. De acuerdo. 2. En desacuerdo.
17	Debería prohibírseles a las trabajadoras del sexo VIH positivas seguir ejerciendo en el comercio sexual.	1. De acuerdo. 2. En desacuerdo.
18	Las trabajadoras del sexo son personas muy conflictivas y mal habladas por eso no se les puede tratar bien.	1. De acuerdo. 2. En desacuerdo.
19	El horario en que se atiende a las trabajadoras del sexo (profilaxia sexual) es el más adecuado para ellas.	1. De acuerdo. 2. En desacuerdo.
20	Los homosexuales son personas que necesitan apoyo psicológico para cambiar su estilo de vida.	1. De acuerdo. 2. En desacuerdo.
21	Los Centros de salud deben prestar servicios a los hombres homosexuales.	1. De acuerdo. . En desacuerdo.

POR FAVOR INDÍQUEME SI EL CONTENIDO DE CADA DE LAS ORACIONES QUE LEVOY A LEER ES FALSO O VERDADERO.

22	Si en una pareja ambos son VIH positivos no deben preocuparse por usar condón durante las relaciones sexuales.	1. Falso 2. Verdadero
23	La sangre y el semen son los únicos fluidos corporales por los que se transmite el VIH.	1. Falso 2. Verdadero
24	Se debe hacer la prueba del VIH a toda persona que padece una ITS.	1. Falso 2. Verdadero
25	El cuerpo tarda en desarrollar anticuerpos o defensas para VIH, pasado un año de la infección.	1. Falso 2. Verdadero
26	Las personas que padecen una ITS no tienen por qué avergonzarse de su diagnóstico.	1. Falso 2. Verdadero
27	En el Centro de Salud se guarda la confidencialidad de las personas que se han realizado las pruebas de VIH.	1. Falso 2. Verdadero
28	La persona VIH positiva tiene SIDA.	1. Falso 2. Verdadero
29	Las ITS facilitan la transmisión del VIH.	1. Falso 2. Verdadero
30	Los homosexuales son los responsables del SIDA en Guatemala.	1. Falso 2. Verdadero
31	Todas las personas que padecen una ITS tienen muchas parejas sexuales.	1. Falso 2. Verdadero
32	En el Centro de Salud el servicio que se les brinda a los usuarios depende de la manera en que ellos o ellas se comporten en el servicio.	1. Falso 2. Verdadero

EN LOS ÚLTIMOS DOCE MESES SE ENTERÓ, ESCUCHÓ U OBSERVÓ LA OCURRENCIA DE LOS SIGUIENTES EVENTOS. POR FAVOR RESPONDA SÍ O NO.

33	Se atendió a los hombres trabajadores del sexo.	1. Sí. 2. No.
34	Se realizó la profilaxia sexual en un ambiente privado.	1. Sí. 2. No.
35	Se utilizó guantes para el examen ginecológico en la profilaxia sexual.	1. Sí. 2. No.
36	Se utilizó guantes para lavar equipo contaminado.	1. Sí. 2. No.
37	A personas con sospecha de VIH se les negó la atención.	1. Sí. 2. No.
38	Se realizó la prueba de VIH sin brindar orientación.	1. Sí. 2. No.
39	Se realizó la prueba de VIH sin el consentimiento del paciente.	1. Sí. 2. No.
40	Se entregó el resultado de la prueba de VIH a otras personas que no era el paciente.	1. Sí. 2. No.
41	Se brindó atención médica a las personas viviendo con VIH o SIDA.	1. Sí. 2. No.
42	Los proveedores del servicio mantuvieron la confidencialidad de las personas VIH positivas.	1. Sí. 2. No.
43	Los resultados de la prueba de VIH se entregaron sin realizar una orientación.	1. Sí. 2. No.

44	MARCAR EL SEXO DE LA PERSONA ENTREVISTADA.	1. Femenino 2. Masculino
45	Cuénteme ¿cuál es su grado de escolaridad?	1. Primaria _____ 2. Secundaria _____ 3. Diversificado _____ 4. Técnico _____ 5. Licenciatura _____ 6. Postgrado _____ 7. Ningún grado académico. _____ 8. Otro:
46	¿Cuál es el cargo que desempeña dentro del Centro de Salud?	1. Médico (médica). 2. Enfermera (o) Graduada (o). 3. Auxiliar de enfermería. 4. Técnico (técnica) Laboratorista 5. Trabajadora social. 6. Técnico en Saneamiento ambiental. 7. Secretaria. 8. Otro:
47	¿Cuántos años de edad tiene?	/___/___/ años
48	¿Cuántos años tiene de trabajar en este centro de salud?	/___/___/ años
49	¿Hace cuánto años trabaja para el MSPAS?	/___/___/ años
50	¿Cómo se siente trabajando para el MSPAS?	
51	¿De qué maneras se informa sobre los temas de ITS,VIH y SIDA?	1. Radio 2. TV 3. Internet 4. Periódicos. 5. Revista médica. 6. Congresos. 7. Conferencia Internacional de SIDA. 8. Capacitaciones. 9. Otro
52	¿En el año 2006 recibió alguna capacitación sobre ITS,VIH y Sida?	1. Sí 2. No
53	¿En el año 2006 recibió alguna capacitación sobre orientación de ITS,VIH y Sida?	1. Sí 2. No
54	En relación a ITS,VIH y SIDA ¿en qué temas necesitan capacitarse los proveedores de este Centro de salud?	1. Estigma y discriminación. 2. Derechos humanos. 3. Orientación en ITS,VIH y SIDA. 4. Atención de ITS. 5. Relaciones humanas. 6. Prostitución. 7. Otro
Queremos reiterar nuestro agradecimiento por su valiosa colaboración en este estudio. Si usted quisiera hacer algún comentario es bienvenido.		

ANNEX 3: EXPRESIONES DE ESTIGMA (ACTITUDES) Y DISCRIMINACIÓN (ACCIONES) EN LAS OPINIONES DE LOS PARTICIPANTES DE GRUPOS FOCALES DE ESTUDIO

Qué opinan los (as) ...	Proveedores de Salud	Mujeres Trabajadoras de Sexo (MTCS)	Hombres que tienen sexo con Hombres	Personas con VIH (PVVS)
<p>Proveedores de salud sobre ...</p>		<p><u>Estigma</u> Las que no son MTS son “mujeres de una vida normal” Las personas con ITS tienen “desorganización educacional” (eufemismo) A veces tienen “temor” o “miedo” a atenderlas Sienten “diferente” que con la población en general Piensan que las ITS se dan más que todo en las MTS. Creen que la mayoría de ITS se debe a la infidelidad de los hombres y tener sexo con MTS, tener varias parejas Sólo mencionan relaciones con MTS y no mencionan las violaciones como causas de ITS y VIH</p> <p><u>Atributos negativos</u> agresivas, violentas, pelean entre ellas, trato difícil, no hacen caso, no colaboran, son exigentes, acostumbradas a ganar bien. Tienen problemas conductuales.</p> <p><u>Discriminación</u> Hacen énfasis en que si son VIH positivas “ya no deberían trabajar” en comercio sexual</p>	<p><u>Estigma</u> Alguno admitió sentir rechazo; otros dicen que los mismos HSH se sienten rechazados, inseguros, piensan que se van a burlar de ellos Se esconden, “bajo de agua”</p>	<p><u>Estigma</u> Alguno dijo que “el sida es la lepra moderna” y que tiene miedo de hablar de la enfermedad y es difícil saber “si uno puede convivir” con una PVVS; no se puede saber hasta que uno atiende un caso. Dijeron que otras personas les tienen asco Pero, en general, se mostraron sensibles.</p> <p><u>Discriminación</u> Se ponen “nerviosos” ante la posibilidad de infectarse. Son las mismas PVVS las que se sienten rechazadas, sienten que fue su error.</p> <p>Una participante dijo que debería haber una ley que les impidiera tener hijos</p>

Qué opinan los (as) ...	Proveedores de Salud	Mujeres Trabajadoras de Sexo (MTCS)	Hombres que tienen sexo con Hombres	Personas con VIH (PVVS)
<p>Mujeres Trabajadoras de Sexo (MTS) sobre ...</p>	<p>La mayoría dijo que son bien atendidas. Sin embargo, mencionaron algunas acciones discriminatorias.</p> <p>Discriminación Atienden mal: indiferencia, falta de interés, mal humor, enojo, regaño, brusquedad en exámenes, “manoseo”. Presencia de observadores causa vergüenza (VC); lugar poco privado (TU, REU). Niegan otros servicios que no sea profilaxis (falta de atención integral). No ofrecen otros servicios (TU). Personal de limpieza niega el uso del baño (TU). Limitado intercambio de información; no conversan. Le quitaron el libreto.</p>		<p>Estigma No es correcto lo que hacen (sexo anal, sexo oral) “Son sucios” (en sentido de prácticas y descuido en el arreglo personal) “Son shucos” (VC) Los llaman “huecos” (TU) “Quieren compararse y ser más que una mujer” (VC) “Ellos nos miran de menos a nosotras” (VC)</p> <p>Piden que les hagan profilaxis también (que no haya discriminación)</p>	<p>Estigma A algunas les da miedo Piensan que, sin son MTS ya no deben trabajar en el comercio sexual Creen que no se cuidaron Los compadecen: “pobrecitos” (TU, REU)</p>

Qué opinan los (as) ...	Proveedores de Salud	Mujeres Trabajadoras de Sexo (MTCS)	Hombres que tienen sexo con Hombres	Personas con VIH (PVVS)
<p>Hombres que tienen sexo con hombres (HSH)</p>	<p>Los HSH usan clichés para describir a proveedores: “replican el sistema patriarcal, machista, homofóbico”</p> <p>Estigma Trato “moralista”: les dicen que cambien su vida, que busquen a Dios; justifican que sean VIH positivos o asumen que son VIH positivos</p> <p>Discriminación Al sólo verlos los mandan a otra clínica Trato indiferente Los tratan como hombres aunque ellos se sientan mujeres Divulgan su diagnóstico “Se descontrolan”: se alteran, se burlan Limitado intercambio de información</p>	<p>Estigma Las MTS los llaman “sidosos” o “enfermos”, no los quieren, se burlan de ellos. Ellas mismas se discriminan las “de casa cerrada” se sienten más que las “de calle”. La sociedad las mira mejor que a ellos.</p> <p>Discriminación Están mejor que ellos porque ellos no reciben servicios de salud (profilaxis sexual)</p>		<p>No se encontraron muestras de estigma y discriminación, dijeron ser “solidarios” con esas personas</p>
<p>Personas con VIH (PVVS) ...</p>	<p>Estigma Justifican que sean VIH positivos por haber sido TCS; equiparan el VIH con tener sida</p> <p>Discriminación Mal trato: enojados, “asustados”, con temor, gestos, indiferencia No contacto físico No los atienden o los aíslan, los atienden tarde, les dan el peor lugar Informan sobre diagnóstico limitando su oportunidad de trabajo</p>	<p>Iguales en derechos y deberes que cualquier persona; se les debe tratar con normalidad</p>	<p>Son personas como cualquier otra. Son discriminados por toda la sociedad. No cuentan con servicios de salud pública</p>	

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