



## Understanding and Responding to Stigma and Discrimination in Health Facilities in Tanzania

### Introduction

Stigma and discrimination have been firmly established as key barriers that hinder HIV prevention and negatively impact all stages of the treatment cascade (Katz et al., 2013; Martinez et al., 2012; Wringe et al., 2007). From June 2017 to September 2018, the Health Policy Plus (HP+) project, funded by the U.S. Agency for International Development (USAID) and the U.S. President’s Emergency Fund for AIDS Relief (PEPFAR), worked with local partners in Tanzania to adapt and implement a total facility approach to reduce HIV-related stigma and discrimination in health facilities (see Figure 1). This adaptation to a generalized epidemic setting was the first of its kind, and included a new, additional focus on stigma toward youth. Endline data show a remarkable decline in stigmatizing attitudes and behaviors among facility staff.

HP+ partnered with the National AIDS Control Programme and local implementing partners Kimara Peer Educators and Promoters Trust and Muhimbili University of Health and Allied Sciences to adapt, implement, and evaluate a systematic approach to measuring and addressing the drivers and manifestations of HIV-related stigma and discrimination in Tanzania. The HP+ model, built on global best practices and adapted to the Tanzanian context, was implemented in two district hospitals in the Morogoro region: Kilosa and St. Francis-Bwagala (Turiani). The model focused on HIV-related stigma and discrimination toward people living with HIV and youth (ages 15-24) seeking HIV and other sexual and reproductive health services.

### Impressive Results

The intervention achieved significant reductions ( $p=.000$  for all items below) in stigmatizing attitudes and behaviors among facility staff, including:

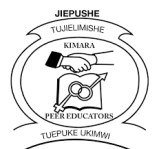
- ↓ 50% drop in worry about HIV transmission
- ↓ 50% drop in stigmatizing avoidance behaviors
- ↓ 34% fewer staff reporting hesitancy to test for HIV in their facilities
- ↑ 37% increase in confidence that HIV test results will be kept confidential

Decreased percentage of staff holding at least one stigmatizing attitude about:

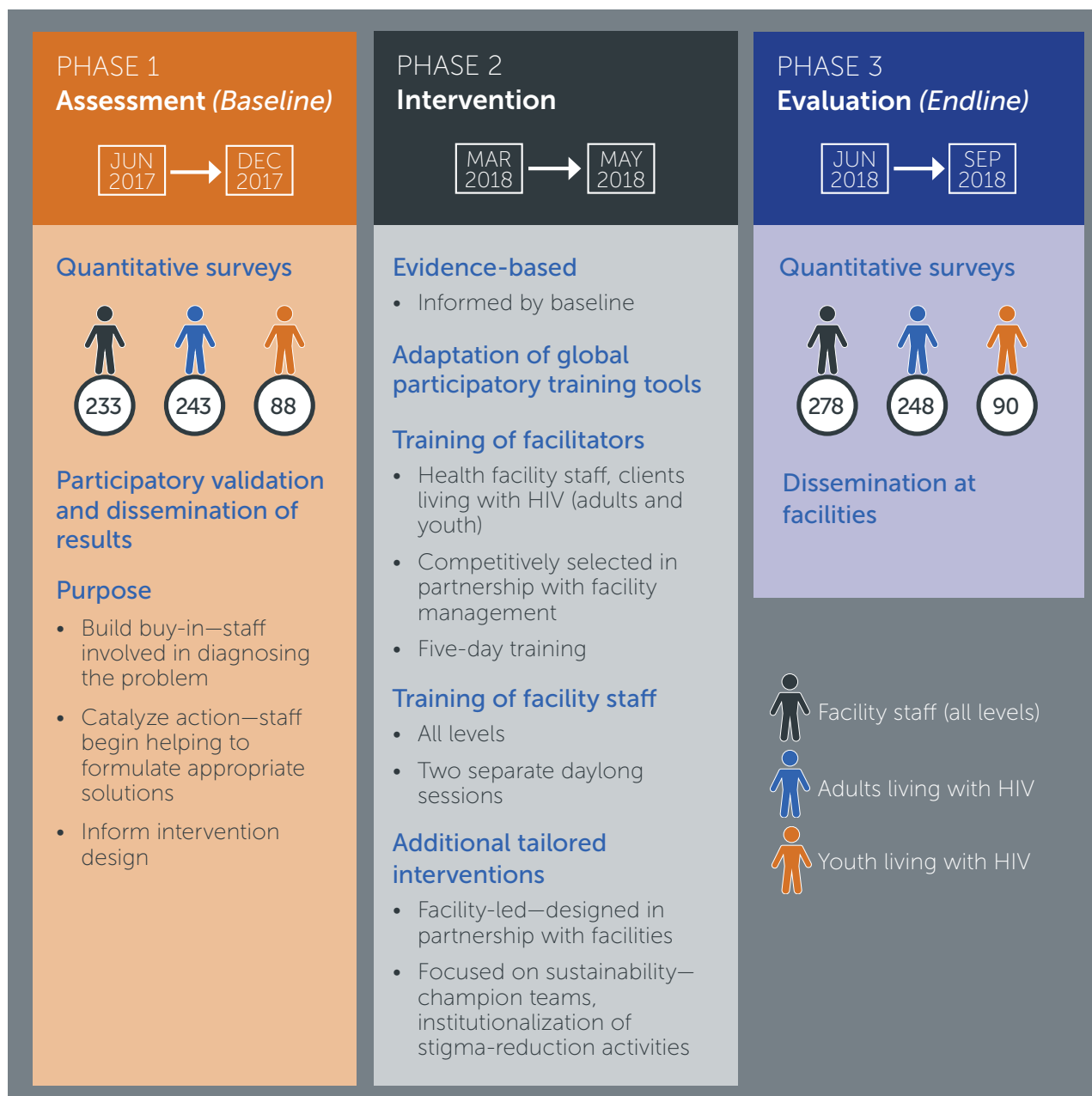
- People living with HIV ↓ 35%
- Women living with HIV ↓ 33%
- Sexually active adolescents ↓ 23%

Lower observed discrimination toward:

- People living with HIV ↓ 22%
- Unmarried pregnant adolescents ↓ 32%
- Pregnant women living with HIV ↓ 67%



**Figure 1. Three Phases of the Total Facility Approach**

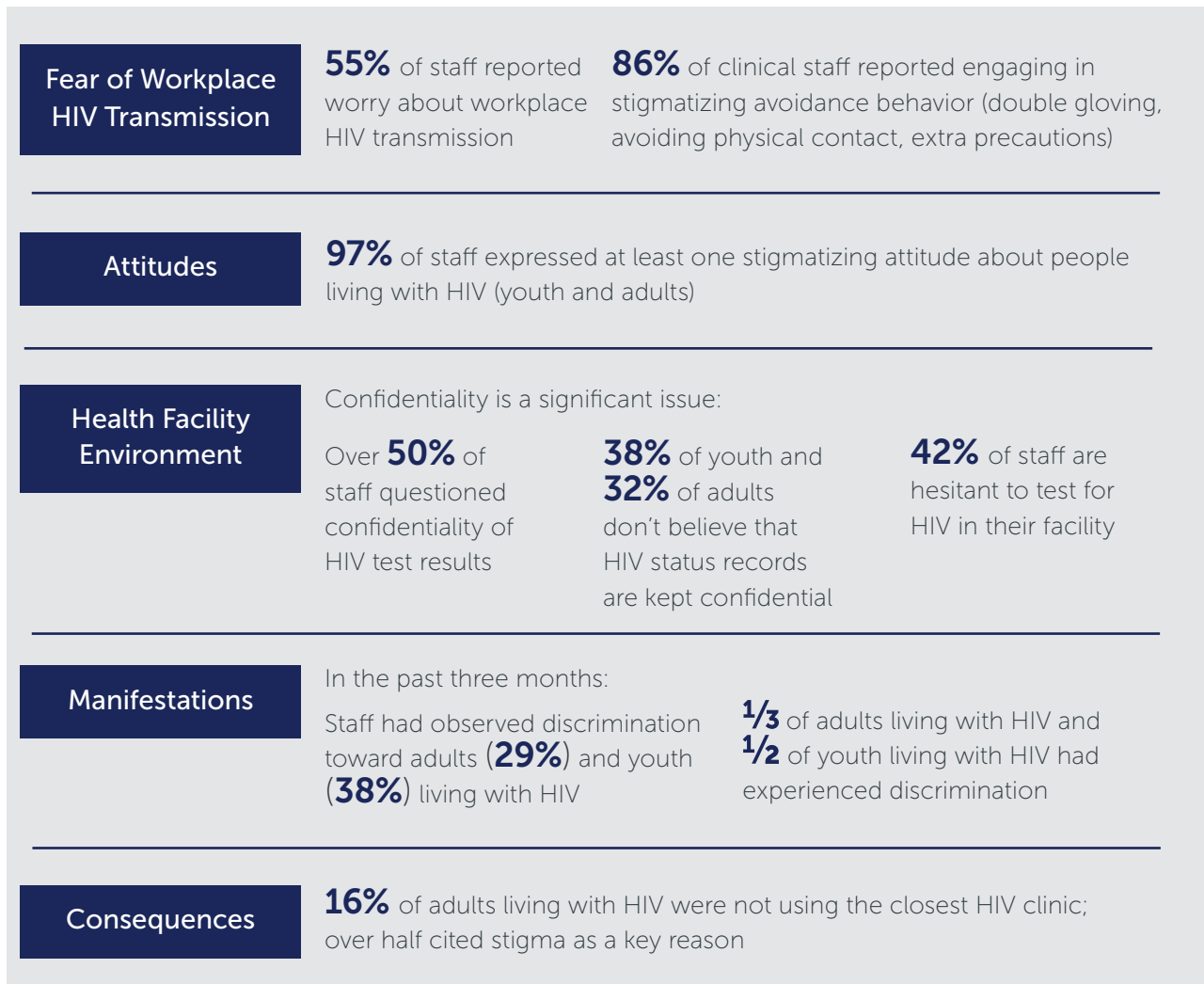


## Baseline Findings

Prior to the intervention, HP+ assessed the presence of stigma and discrimination in the two facilities by collecting baseline data from facility staff and clients living with HIV (adults and youth). Collection and participatory dissemination of baseline data informed and helped generate buy-in for intervention activities. In addition to basic demographics, staff questionnaires captured actionable drivers (health facility policies, fear of HIV infection, and attitudes toward

people living with HIV) and manifestations (selective and unnecessary use of infection control measures and observed discrimination toward clients) of stigma (Nyblade et al., 2009). Client questionnaires captured experienced, anticipated, and observed stigma. Baseline data suggested that intervention activities should focus on addressing concerns about workplace HIV transmission, stigmatizing attitudes, and the presence and enforcement of facility policies (see Figure 2).

**Figure 2. Baseline Findings, by Category**



## Intervention

The intervention promoted a sustainable response through capacity building, facility ownership, and youth engagement, and included the following components:

**Continuous engagement of facility management** promoted health facility ownership, helped to tailor intervention activities to each facility's specific context, and fostered a supportive environment for staff to engage in stigma-reduction interventions.

**Participatory dissemination and validation of baseline data** involved health facility staff in review and discussion of findings, problem identification, and solution

"Training health facility staff as facilitators led to much better results... Because they were our own staff, they were able to go and learn and then prepare sustainable trainings for their colleagues... Trainings were easier to understand and better received, because the facilitators know their fellow staff members and understand the facility context, and were able to plan the content accordingly."

Joseph Ngimba  
Medical Officer-In-Charge, Turiani

generation, guiding the development of intervention activities and establishing strong buy-in for and ownership of stigma-reduction interventions at health facilities.

**Adaptation of a participatory facilitators' guide** built on the guide developed by HP+'s predecessor, the Health Policy Project, drawing on two decades of implementing stigma-reduction trainings in nine countries (Kidd et al., 2015). In a two-day participatory workshop, stakeholders provided feedback on a draft set of training exercises (in Kiswahili) that were tailored to baseline findings and expanded to include stigma toward youth. Exercises were further refined during the training of facilitators. The final guide included 16 participatory exercises.

**Training of facilitators** built participatory facilitation skills and knowledge of 22 facilitators. Health facility staff and adult and youth clients living with HIV were selected through a competitive application process, in consultation with health facility management, to attend a five-day offsite training led by master trainers from Kimara Peer Educators (see Table 1). Following the training, facilitators returned to their health facilities for five days of onsite coaching—leading staff trainings as master trainers provided feedback and support—before carrying out the remaining trainings on their own.

**Participatory stigma-reduction trainings** were held for all facility staff, led by three-person teams composed of one facility staff member, one adult living with HIV, and one youth living with HIV. Trainings were held at the health facilities, in space donated by the facilities—a significant contribution of resources that demonstrated facility management's ownership of the activity. Staff were divided into training groups with a maximum of 35 participants per group, composed of staff from different levels and departments, which promoted

"I learned so many things. We were doing some things we thought were fine. Then, 'Wow!' It turns out these were actually hurtful forms of stigma and discrimination in our facility. The training taught us so many things, like... if I am about to help a patient, I must first ask myself, 'Who is this person that I am about to care for? And how can I provide care in such a way that I avoid introducing stigma and discrimination into my workplace, and so that I can improve the quality of care that I offer?' Now, this discrimination that we went to study—and that we taught others about—has disappeared. Where it has not been completely eradicated, it has been significantly reduced."

Dr. Mena Menasi Dilli  
In-Charge of Outpatient Department,  
Kilosa District Hospital

relationship-building and shared learning across divisions (see Table 2). Training schedules and group composition were designed in partnership with facility management to minimize disruption of service delivery. Participants attended two daylong trainings, held at least a week apart. This enabled participants to process and apply learning, observing instances of stigma and discrimination in the interim that they may not have previously noticed, and attend the second training with questions and ideas about how to tackle stigma in their facilities.

**Champion teams and additional activities.** Champion teams were identified in each facility and empowered by facility management to work collaboratively to reduce stigma and discrimination. Kilosa's 38-member champion team consisted of the in-charge and nurse from each of the hospital's 16 departments. At St. Francis-Bwagala

(Turiani), the 10 stigma-reduction training facilitators served as the champion team. Teams used recommendations from baseline data dissemination meetings and action planning conducted during stigma-reduction trainings to design and implement final action plans. Activities carried out by the

teams included declaring and drawing attention to facilities' commitment to stigma-free care via community TV and radio spots and promoting client engagement and accountability through the creation and display of codes of conduct, signboards, nametags, t-shirts, and reporting boxes.

**Table 1. Training Topic Areas and Exercises**

Topic	Corresponding Exercises	Actionable Drivers Addressed by Exercises
Create awareness of what stigma is in concrete terms	Identify stigma and discrimination through pictures; analyze stigma in health facilities	Awareness; facility environment
Understand and address fear of workplace HIV transmission	Partner work and utilization of Quality, Quantity, Route of Transmission information sheet on non-sexual transmission; role play to review standard precautions	Fear of HIV transmission; facility environment
Understand and address stigma faced by youth seeking HIV and other sexual and reproductive health services	Use individual reflection, small group work, and plenary discussion to explore stigma experienced by youth, provider comfort/discomfort serving youth, and ways to improve service delivery for youth clients	Awareness; attitudes
Build empathy and reduce distance (contact strategies)	Listen to firsthand experiences from adults and youth living with HIV; discuss experiences in health facilities; self-reflection	Awareness; attitudes; fear of transmission
Work to create change	Develop realistic strategies, a code of practice, and an action plan	Facility environment

**Table 2. Number of Staff Trained, by Intervention Facility**

	Kilosa District Hospital	St. Francis-Bwagala (Turiani) District Hospital	Total
Target	120 (69%)	120 (69%)	240
Full-time staff trained	175 (100%)	173 (100%)	348
Student and contract staff trained	95	93	188
<b>Total</b>	<b>260</b>	<b>266</b>	<b>526</b>

## Evaluation

### Methodology

Evaluation of the intervention focused on pre- and post-intervention trends among health facility staff, as, due to small sample size and the use of convenience sampling, the client sample lacked sufficient statistical power to detect pre/post changes. Client data, used to triangulate staff data, supports the findings. A representative baseline and endline were established for the study (see Figure 1). The results provide an immediate assessment of change, as endline data was also collected one to two months after the main intervention activities ended (facilities continued activities independently). Ideally, a repeat survey would be conducted to assess if observed changes are sustained.

### Selected Findings

All stigma indicators for facility staff showed statistically significant pre-to-post intervention changes. Specifically:

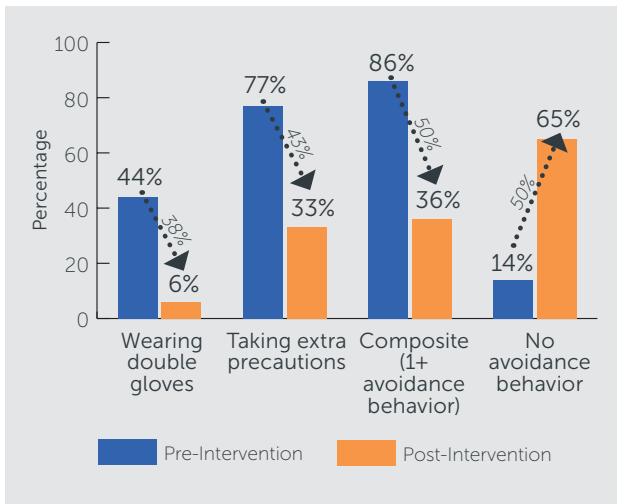
**Worry about HIV transmission and related stigmatizing avoidance behaviors** (self-reported)—unnecessary actions that stigmatize and disclose a person’s status—**both dropped**. Concern about contracting HIV when caring for clients living with HIV dropped significantly for all four tasks measured (touching clothing, dressing wounds, drawing blood, and taking temperatures). The composite, i.e. a concern about at least one of these tasks, dropped by 50 percent (from 55% to 5%;  $p=.000$ ). Stigmatizing avoidance behaviors dropped similarly (see Figure 3). Clients confirmed this drop. For example, 16.5 percent of adults and 25 percent of youth reported observing staff using double gloves pre-intervention, compared to 2.4 percent of adults and 2.2 percent of youth post-intervention.

“When we first started the training-of-trainers, we never expected to accomplish the kinds of things we are doing now... We expected that, like after most seminars, there wouldn’t be anything happening on an ongoing basis, but this was different. After we were trained, we were pushed to use what we learned to deliver this learning to the rest of the staff. Now we really believe in the participatory techniques that were used—we used the same techniques to facilitate trainings in our workplaces, and we are using them to remind each other and encourage each other.”

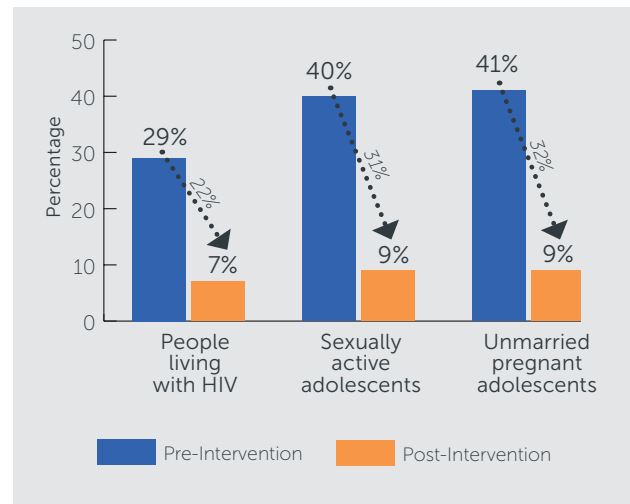
Zahir Nuru Songola  
Facilitator, Turiani District Hospital

Endline findings also showed **significant reductions in stigmatizing attitudes** among facility staff, as measured by levels of agreement with a series of attitudinal questions capturing judgment and shame toward people living with HIV, women living with HIV, and youth. The largest change was a 45 percent decline (from 80% to 34%;  $p=.000$ ) in agreement with the statement that “people living with HIV do not care if they infect others.” Composite indicators showed a 32 percent decline in stigmatizing attitudes about women living with HIV (from 91% to 58%;  $p=.000$ ) and a 23 percent decline in stigmatizing attitudes toward sexually active adolescents (from 97% to 74%;  $p=.000$ ). The only attitude that showed little change (22% pre-intervention; 21% post-intervention) was disagreement with the statement that “women living with HIV should be allowed to have babies.”

**Figure 3. Stigmatizing Avoidance Behaviors Used When Caring for Clients Living with HIV**



**Figure 4. Observed Discrimination, Composite, by Group**

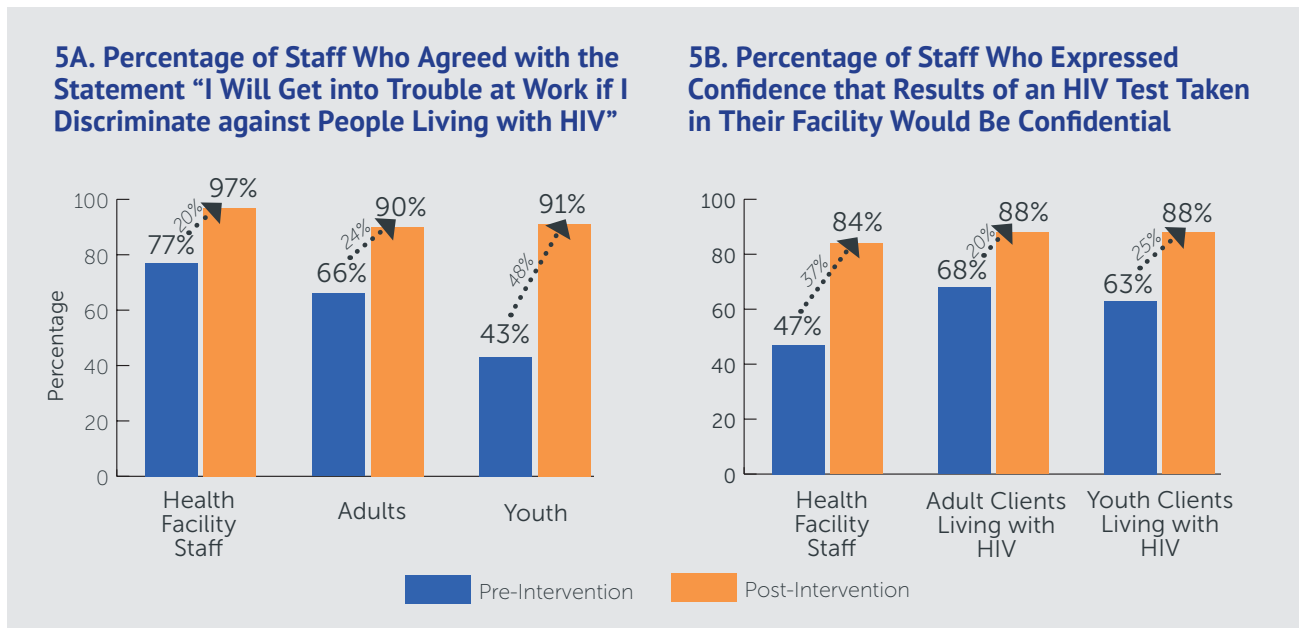


**Observed discrimination also declined** across all groups and acts of discrimination (see Figure 4). Staff were asked whether they had observed, in the past three months in their health facility, four different acts of discrimination toward clients living with HIV and three acts of discrimination toward different groups of youth. Acts of discrimination toward people living with HIV dropped by 22 percent ( $p=.000$ ), while observed discrimination toward sexually active adolescents and unmarried pregnant adolescents dropped by 31 percent and 32 percent, respectively ( $p=.000$ ).

**Experienced discrimination as reported by clients also dropped.** The share of clients reporting having experienced at least one of nine acts of discrimination over the past three months, ranging from verbal abuse to unauthorized disclosure of HIV status, declined 26 percent among youth (from 53% to 27%) and 13 percent (from 34% to 21%) among adults.

**Health facility environment also showed improvement.** Questions focused on three areas to determine whether the environment was conducive to delivering stigma-free services: safety procedures and availability of supplies; existence and enforcement of non-discrimination policies; and effects of stigma on staff. The percentage of staff reporting having adequate supplies to reduce risk of HIV infection increased from 79 to 97 percent ( $p=.000$ ) and the percentage reporting having access to post-exposure prophylaxis rose from 81 to 95 percent ( $p=.000$ ). Figures 5a and 5b highlight a few of the specific changes among staff and clients related to facility policies.

Stigma also affects facility staff as individuals, including acting as a barrier to seeking HIV testing or treatment. The hesitancy of staff to be tested for HIV in their facilities due to fear of others' reactions declined 34 percent (from 41% to 7%;  $p=.000$ ). Perceptions that colleagues living with HIV would be hesitant to seek treatment in their facility also declined, from 45 to 15 percent ( $p=.000$ ).

**Figure 5. Health Facility Staff Perceptions of Facility Environment**

### Addressing Stigma and Discrimination Toward Youth

Stigma and discrimination restrict the ability of youth to access HIV and other sexual and reproductive health services. Addressing this barrier is critical to improving prevention, linkage to care, and treatment adherence, and achieving HIV epidemic control. Tanzania’s HIV epidemic is concentrated among young people, especially girls and young women: in 2014, adolescents and young adults ages 15–24 accounted for 11 percent of people living with HIV and nearly one-third (30%) of new infections. Yet only one-third of this age group knows their HIV status (PEPFAR, 2018; Sanga et al., 2015).

#### Baseline findings

HP+’s baseline assessment revealed stigmatizing attitudes and behaviors toward youth by facility staff, as well as anticipated stigma among youth living with HIV. One quarter of youth respondents reported that staff wear double gloves when providing care and 28.6 percent reported delaying or avoiding HIV services due to anticipated stigma. Levels of observed discrimination toward sexually active adolescents and unmarried pregnant adolescents were higher than observed levels of discrimination toward people living with HIV.

#### A successful approach

HP+ achieved significant reductions in stigmatizing attitudes toward youth, as well as in observed discrimination (see Figure 5). Involving youth throughout the assessment and intervention was key to success. Each training included a panel of youth living with HIV.

Youth also:

- Helped to adapt the assessment questionnaire and participatory training guide
- Co-facilitated stigma-reduction trainings for facility staff as part of three-person training teams
- Worked alongside health facility staff to design and implement stigma-reduction activities in the health facility and beyond



The HP+ total facility approach to stigma and discrimination reduction achieved significant results in both facilities in Tanzania in which it was implemented. Post-intervention, the majority of clients interviewed reported observing positive changes in the behavior of facility staff. The success of the intervention can be attributed to a few key elements:

- **Relying on data** to measure and build consensus among facility staff about the scope of the problem, to design responses, and to evaluate change
- **Using participatory approaches** to adapt questionnaires and training tools, disseminate baseline data, and, perhaps most importantly, contribute to the methodologies used to conduct stigma-reduction trainings for facility staff
- **Focusing on facility involvement and ownership** to improve sustainability by institutionalizing stigma reduction in existing facility structures and processes
- **Using a competitive application process to identify facilitators** to contribute to the quality of trainings and facility-led interventions
- **Including all staff, both clinical and non-clinical**, in trainings and other facility-led stigma-reduction interventions
- **Addressing actionable drivers** of stigma and discrimination to achieve rapid yet lasting change

The approach used in the two health facilities in Tanzania's Morogoro Region can be readily adapted to other country contexts, while evidence generated and lessons learned can inform other stigma-reduction efforts—in health facilities, and beyond.

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## Authorship

This brief was authored by: L. Nyblade,<sup>1</sup> R. Mbuya-Brown,<sup>2</sup> A.N. Sabasaba,<sup>3</sup> M. Ezekiel,<sup>3</sup> P. Kiwia,<sup>4</sup> C. Stewart,<sup>1</sup> P. Mingkwan,<sup>1</sup> W.O. Akyoo,<sup>3</sup> W. Manyama,<sup>4</sup> S. Shoko,<sup>5</sup> G. Lija,<sup>5</sup> B. Rabel,<sup>5</sup> A. Ramadhani,<sup>5</sup> G. Somi,<sup>5</sup> M. Balampama,<sup>2</sup> S. Bowsky,<sup>2</sup> and J. Kraemer.<sup>1</sup>

Affiliation: <sup>1</sup> RTI International, <sup>2</sup> Palladium, <sup>3</sup> Muhimbili University of Health and Allied Sciences, <sup>4</sup> Kimara Peer Educators and Promoters Trust, <sup>5</sup> National AIDS Control Programme

## CONTACT US

Health Policy Plus  
1331 Pennsylvania Ave NW, Suite 600  
Washington, DC 20004  
[www.healthpolicyplus.com](http://www.healthpolicyplus.com)  
[policyinfo@thepalladiumgroup.com](mailto:policyinfo@thepalladiumgroup.com)

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