



CHART
CARIBBEAN HIV/AIDS REGIONAL TRAINING NETWORK

CHART Network Evaluation Studies:

Measuring progress towards impact

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Introduction

Globally over forty million persons are infected with the Human-Immunodeficiency Virus (HIV), and the implications for health, social and economic impact worldwide are tremendous. In the Caribbean region the challenge of tackling the problem of HIV/AIDS is two-pronged: containing the spread of the disease and addressing the needs of those infected with the virus. Addressing those needs became more urgent with the increased spread of HIV in the Caribbean; at the end of 2007, an estimated 230,000 people were living with HIV and AIDS in the Caribbean. Some 20,000 people were newly infected during 2007 and there were 14,000 deaths due to AIDS. The estimated HIV prevalence rate in the Caribbean in 2007 was 1.1% (UNAIDS 2008).

In the early part of this decade, as governments and NGOs scaled up activities to meet the demand for care it became apparent that there was a shortage of healthcare providers trained in HIV/AIDS in the Caribbean region. To address this need, the Caribbean HIV/AIDS Regional Training (CHART) Network was established for the purpose of contributing to systematic capacity development among institutional and community-based health care providers involved in prevention of HIV/AIDS and in the care, treatment and support of persons living with HIV and AIDS. The overall goal of the CHART Network is “to build the capacity of health care providers to deliver quality HIV care in accordance with national, regional and international standards so as to reduce the burden and impact of HIV/AIDS within the region”.¹

In order to improve the care and treatment of persons living with HIV/AIDS and their families, and to strengthen uptake of HIV prevention services and behaviours, training of health care workers is a top priority. Practitioners must keep up-to-date with the wide variety of manifestations of HIV and AIDS as well as with frequently changing treatment regimens. They must be updated on how to use new classes of antiretroviral drugs and drugs for prevention and treatment of opportunistic infections, monitor persons who are on antiretroviral therapy and refer patients appropriately. Now that PLWHA are receiving antiretroviral drugs,

¹ CHART Network Strategic Plan 2007-2011

practitioners must also be trained to recognize side effects of these drugs and to identify evidence of ARV resistance. The shock often associated with disclosure of the diagnosis and the emotional burden created by the disease call for special counselling skills, which have to be learned by both old and new providers. Finally, the entire community, including health care workers, must battle stigma and discrimination in their own attitudes as well as in others as they strive to deliver high quality care. As show in the logic model below, training has a direct implication for reducing the mortality and morbidity associated with AIDS.

Figure 1: The link between health provider training and reduced impact of HIV and AIDS

Inputs	Activities	Outputs	Outcomes [Providers and Health System]	Outcomes [General Population]	Impact
<ul style="list-style-type: none"> •Funding •Staff •Curricula •Information system •Monitoring and evaluation system 	<ul style="list-style-type: none"> •Training and mentoring health providers 	<ul style="list-style-type: none"> •#of people trained in HIV prevention, care, and treatment 	<ul style="list-style-type: none"> •Knowledge, skills, and attitudes in HIV prevention, care, and treatment increased •Quality of prevention, care, and treatment services increased 	<ul style="list-style-type: none"> •Knowledge, about prevention, care, and treatment increased •# of people accessing prevention, care, and treatment services increased •Condom use increased •Risk behaviour decreased 	<ul style="list-style-type: none"> •HIV transmission rates decreased •HIV incidence decreased •HIV morbidity and mortality decreased

Training events organized or conducted by the CHART Network reached a total of 16,592 health care providers between 2004-2009; these persons attended one or more of the training activities offered. Some training activities were funded entirely by the GF Round 3 grant, while others were undertaken by combining funds from GF Round 3 with funds from USAID and HRSA, which were provided through I-TECH.

In an effort to evaluate the outputs and outcomes of the providers trained by the CHART Network over the last 5 years, the CHART Regional Coordinating Unit conducted three evaluation activities. The activities were: 1) a study of the CHART trained physicians, 2) a study of the use of the knowledge and skills gained through training, and 3) a qualitative study among

persons living with HIV (PLHIV) and their perceptions of quality of care. This report will provide an overview of these studies conducted between July and October, 2009.

A Study among Physicians who have attended CHART training activities

Background

The Caribbean has been consistently described as the second most affected region worldwide, with an estimated adult HIV prevalence of 1.2% (USAID 2008). Further, in terms of disease-related deaths, HIV/AIDS has been found to be the leading cause of death among young adults. It has been estimated that 1.6% of women and 0.7% of men between the ages of 15 and 24 are infected with HIV in the Caribbean (USAID 2008). Other reports state that the 20 to 49 age group is most affected in the Caribbean, accounting for more than 65% of positive cases annually (USAID 2008).

The type of physician providing HIV care generally affects patients' access to adequate treatment, care and support. According to RAND (2006), there are three categories of physicians who provide support for person infected with HIV. These are: i) infectious disease specialists, who tend to treat a high volume of HIV-infected patients; ii) high-HIV-volume generalists (family practitioners); and iii) low-HIV-volume generalists. A survey of physicians conducted by RAND (2006) revealed that the high-HIV-volume generalists had knowledge about the disease that was nearly equivalent to that of the specialists. Collectively these physicians are termed "expert generalists". In contrast, the low-HIV-volume physicians tended to be less knowledgeable about the disease and its treatment procedures; making them "non-expert generalists". Participants who received their HIV care from expert generalists were significantly more likely to be receiving highly active antiretroviral therapy (HAART) than were patients of non-expert generalists.

In a study conducted in Barbados on stigma, discrimination, and HIV/AIDS knowledge among physicians, it was found that physicians who had graduated in 1984 or earlier had seen fewer HIV/AIDS clients, had lower levels of knowledge about the disease, were more likely to test for HIV/AIDS without consent, and were less likely to have ever attended education training courses on HIV/AIDS. It was also reported that only 53% of the physicians participating in the

study had attended an HIV/AIDS in-service training program between 1995 and 1999 (Massiah *et al.* 2004).

Additionally, the study noted that the knowledge of the clinical indications of the disease was low. Further, over 75% of the physicians did not think they had adequate counselling skills. It was also found that 95% of the physicians would not release HIV test results without a patient's consent, 33% would test, without consent, a seriously ill patient, and 15% would test, without consent, a patient they had to perform an invasive procedure if they perceived the patient to be high-risk such as gay men (Massiah *et al.* 2004). It was also concluded that physicians lacked up-to-date training to provide adequate treatment, care and support to PLHIV. It was acknowledged that patients not only required clinical support from the physicians, but also emotional factors needed to be considered in caring for PLHIV. It was suggested that these gaps can only be bridged by mandatory training for physicians within the public sector (Massiah *et al.* 2004).

In order to ascertain information on physicians trained by the CHART Network, a study² was conducted among Caribbean-based physicians that have attended training events organized by the CHART Network. The study was guided by the following objectives: 1) to determine whether CHART trained physicians are currently providing HIV care and treatment services; and, 2) to ascertain additional training needs for physicians.

Methodology

The study employed a quantitative approach which involved an online survey and telephone interviews as the means of data collection. The online survey was conducted utilizing the services of an internet based survey company which contacted participants via email. Where there was no available email address, participants were contacted by telephone.

² Data from a similar joint study between CHART and I-TECH was used in the analysis

Sampling

The sampling frame was based on self-identified cadres of CHART-trained physicians that were trained between 2004 – 2009. The sample was generated using the TrainSMART database and stratified by location (i.e. country of origin). The data gathered were entered into SPSS for coding, processing and analysis. Study response rate was 32%.

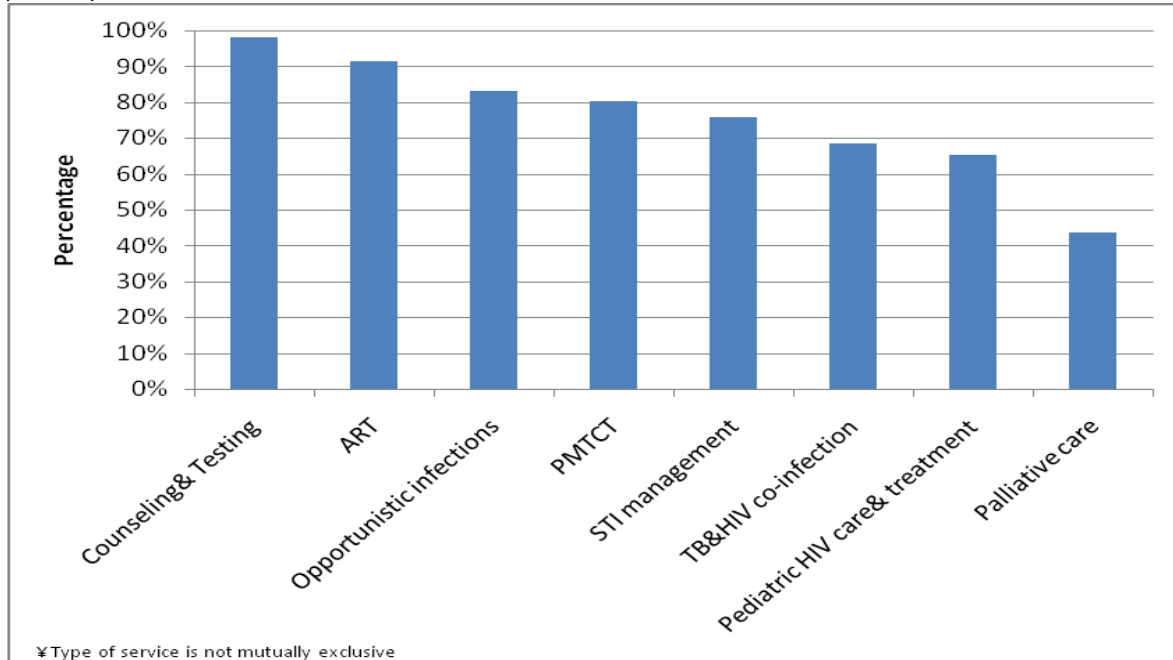
Findings

Physicians who responded to this survey were from Jamaica (61.2%), Bahamas (13.4%), the OECS (8%), Trinidad and Tobago (7%), Barbados (7%) and other Caribbean countries (4%). The majority of respondents reported working either at a government sponsored hospital (43.5%) or at a health care centre/clinic (32.6%). Eighty-four percent reported that their primary role in their facility was as a physician, while 11.4% reported their primary role as “administrator”, 3.2% as a “professor/educator”, and 1% as “other.”

Provision of care and treatment services

Close to 80% of physicians reported working at a facility that provides HIV care and treatment services and 73% reported currently providing care and treatment to PLHIVs. The predominant services offered at their facility included counselling and testing (98%), antiretroviral therapy (91.5%) and treatment for opportunistic infections (83%) (See Figure 1).

Figure 1: Types of services provided in facilities that offer HIV care and treatment services (N=555)



The average number of HIV positive patients being seen per month was 40, though the averages differed by country (see Table 1). Close to 72% of physicians in the survey reported that they had provided an HIV-related clinical consultation at their site and 58.6% reported that they provided HIV clinical consultations at another site.

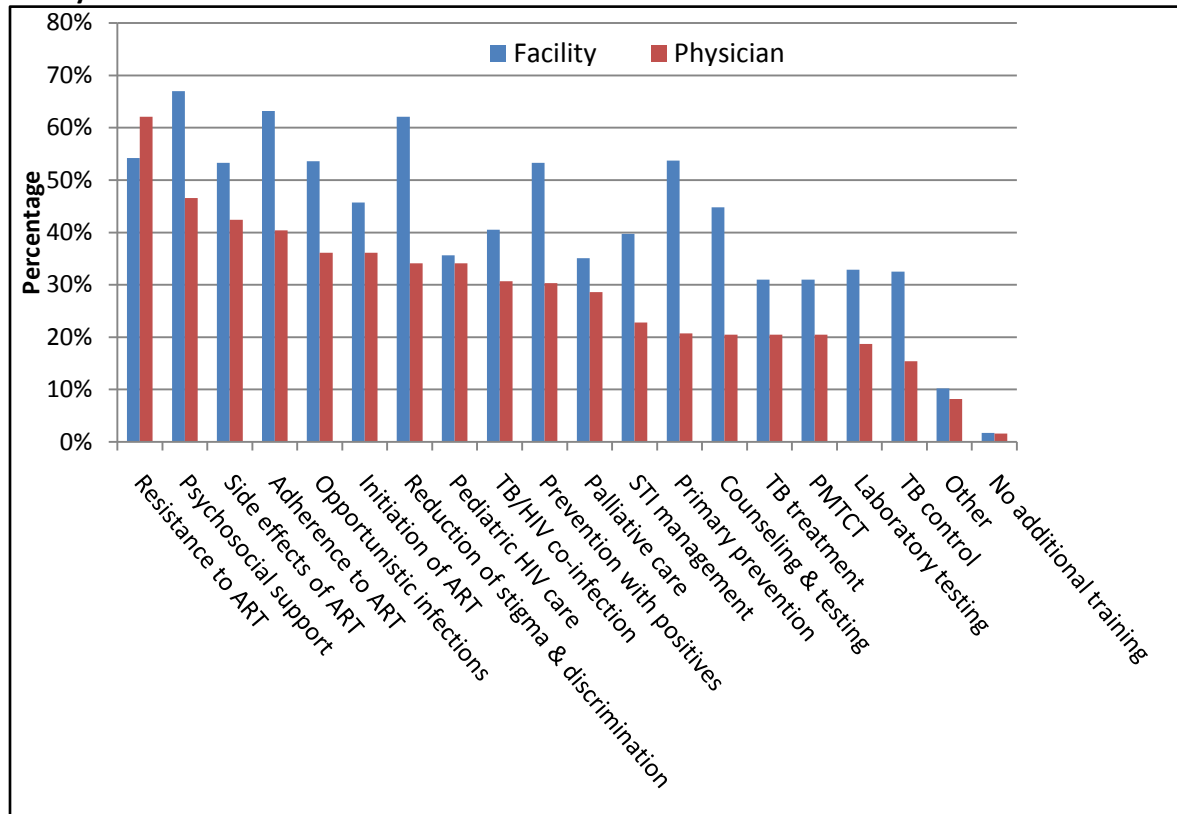
Table 1: Self-reported average number of patients seen per month by country

Country	Average Number of Patients
Jamaica	28
Trinidad and Tobago	113
Barbados	73
Bahamas	17
Guyana	190
OECS	41
Other Caribbean	28
All	40

Benefits of training and additional training needs

Ninety percent of physicians surveyed reported that they had used the skills and knowledge acquired through participation in the training received via CHART in their work activities. These respondents reported that taking part in CHART training activities had given them the ability to “speak with patients with care and understanding”, provide “counselling on voluntary testing and prevention” as well as assist in the “daily clinical management of HIV infected persons”. Respondents that reported not using the skills/knowledge obtained from training mainly worked in places that primarily referred HIV positive patients. Survey respondents were asked what types of additional training were needed for themselves and at their facility. The most requested training topics needed for their own benefit were: “recognizing and managing resistance to ART” (62%), “side effects of ART” (42%) and “psychosocial support for people infected or affected by HIV/AIDS” (47%). The top five training needs identified by physicians on behalf of the facility in which they work were: “psychosocial support for people infected or affected by HIV/AIDS” (67%), “how to reduce stigma and discrimination related to HIV/AIDS” (62%), “adherence to ART” (63%), “opportunistic infections” (54%), and “recognizing and managing resistance to ART” (54%) (See Figure 2).

Figure 2. Self-reported training needs reported by physicians for themselves and needed at their facility



Facility=team and environmental needs; Physician=personal technical needs

Conclusions

Findings from this study demonstrate that participating in CHART training activities has been an effective method through which physicians have received important and relevant information about the care and treatment of HIV. Physicians who have taken part in CHART training events reported that they are using their improved knowledge and skills as they provide care and treatment to their patients and that they are sharing their knowledge and insight both within and outside of their institutions. Respondents identified several additional training needs, which will give useful guidance to the Network.

A study of Health Care Providers' Use of Knowledge and Skills derived from CHART Training

Background

The World Health Organization's (WHO) 2006 report estimated that there was a total of 59.2 million full-time paid health workers worldwide whose primary role is to improve health whether through health programs operated by government or nongovernmental organizations, plus additional health workers in non-health organizations (such as nurses staffing a company or school clinic). The report further stated that health service providers constitute about two thirds of the global health workforce, while the remaining third is composed of health management and support workers. The above serves to highlight the important role that health care providers play in ensuring the welfare of the global population especially so, as the toll from HIV/AIDS continues to rise.

In an initial effort to monitor and evaluate the influence of training among health care providers other than physicians, an assessment was conducted in October 2007 to determine whether "CHART trainees were able to implement what they had learned as well as to identify barriers to their ability to do so" (Russell, 2007). Questionnaires were administered and telephone interviews were conducted. The study was limited to participants who completed a Voluntary Counselling and Testing training (VCT) between January and December 2006, with 108 Health Care providers being targeted with 48% responding. The primary finding was that 82% had been utilizing knowledge and skills learnt from CHART trainings on the job. The main challenges for sharing the newly obtained knowledge in the workplace were identified as: insufficient staffing, insufficient trained personnel, insufficient time on the job to use the training, lack of organizational support and, to a lesser extent, lack of suitable space and a shortage of technology to make use of time and training received.

In 2009, the CHART RCU team decided that a similar study should be conducted that would look at trainings on a broader scale. This would give a comprehensive view as it relates to how

CHART training participants use the knowledge and skills gained from trainings. Furthermore, the dearth of information related to the impact of HIV capacity building training in the region provides an opportunity for the findings from this study to add to the body of knowledge.

The purpose of the study was to evaluate whether and how participation in CHART training programmes has influenced the practices of a variety of health care providers *apart* from physicians. The respondents included nurses, midwives, pharmacists, nutritionists, laboratory technicians, medical assistants, nursing assistants, counsellors and other health care assistants. The study was guided by the following objectives: 1) to assess the use of knowledge/skills by participants according to cadre; 2) to identify the barriers to use of knowledge/skills gained by participants; 3) to determine the perceived level of effectiveness of training provided to participants; and 4) to evaluate additional training needs of the respondents.

Methodology

The study employed a quantitative approach which involved an online survey and telephone interviews as the means of data collection. The online survey was conducted utilizing the services of an internet based survey company which contacted participants via email. Where there was no available email address, participants were contacted by telephone and surveys completed by an interviewer.

Sampling

The sampling frame was based on self-identified cadres of CHART-trainees (except physicians), that were trained between 2004 and 2009³. Physicians were excluded from this survey because they were being surveyed separately. Data were collected using an online survey and telephone calls. The data gathered were entered into SPSS for coding, processing and analysis. The response rate was 32%.

³ A stratified random sampling technique was used where the Caribbean region was stratified into 15 countries and a simple random sample was selected from each country. Sampling weights were assigned based on the reported number of trainees trained from each country and the number of respondents from the country in the sample. Weighted sample size was 6887.

Findings

Respondents were from Jamaica (52%), followed by Trinidad and Tobago (17%), the Organisation of the Eastern Caribbean States (11%), the Bahamas (11%), Barbados (8%) and other Caribbean countries (1%). Fifty-seven percent of respondents reported working as “a health care professional” (registered nurse/midwife, pharmacist, nutritionist, etc) with the majority working either in a hospital or in a health care centre (68%). Others reported working in an HIV specialty clinic (5%), an educational institution (5%), a community-based organization (4%) or at another place (18%). Nearly 42% reported working with HIV/AIDS services, with the majority of these persons indicating that they worked either as direct care providers (54%), counsellors (28%), educators (7%), peer/treatment advocates (3%) or “other”(8%).

Use of Knowledge and Skills

The majority of respondents (88%) reported that they were able to use the knowledge and skills acquired from their training. A larger proportion (58%) of nurses, pharmacists, and other direct care providers reported sharing their knowledge and skills obtained from the training sessions more with others at the workplace than other persons who had less or no direct contact with patients (15%), and counsellors (15%). Those that reported sharing information received from the training did so by sharing the resources received from the training (84%) and/or by encouraging co-workers to practice differently (83%). The main reason given by health care technicians for not using the knowledge/skills gained from training was that the information received was not relevant to their specific work tasks. Of those who reported not using the knowledge and skills acquired from their training, 92% still foresee an opportunity to use them in the future.

Effectiveness of Training and Additional training needs

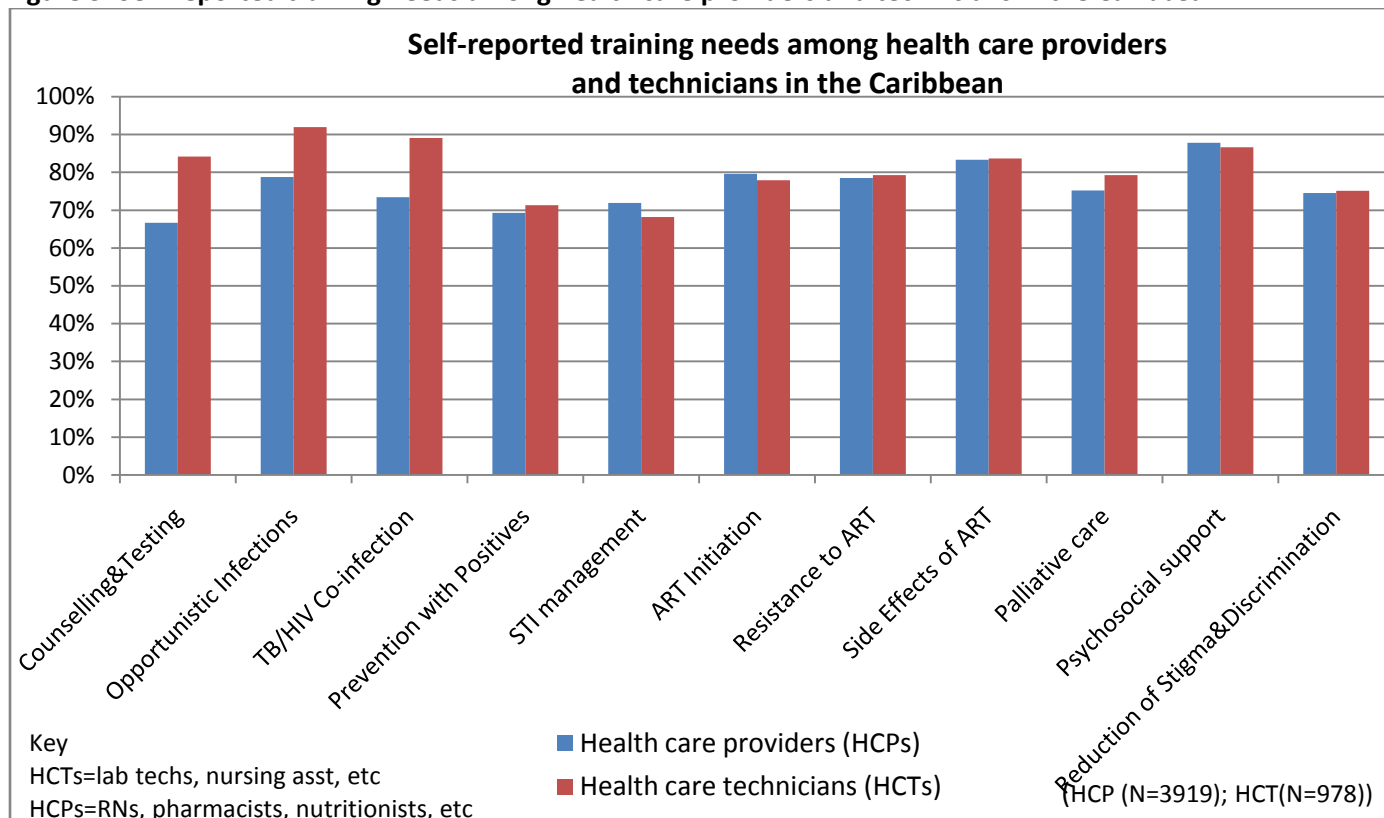
When asked to rate the usefulness, relevance and effectiveness of the CHART training (s) on a scale from 0 to 5, (with 0 being the lowest and 5 the highest), the average scores were high in all three areas. Usefulness had the highest mean score (4.6), followed by relevance (4.5) and effectiveness (4.5) (see Table 2).

Table 2: Overall training usefulness, relevance and effectiveness (N=6035)

	Average Scores
Overall how useful was the training received?	4.6
Overall how effective was the training received?	4.5
Overall how relevant was the training received to your work?	4.5

The top training needs identified by health care providers were in the following areas: “psychosocial support for people infected or affected by HIV/AIDS” (88%), “clinical management of AIDS, including understanding the side effects of ART” (83%) and “initiation of ART” (80%). For health care technicians, top training needs were in the following areas: “opportunistic infections” (92%), “TB and HIV co-infection” (89%), and “psychosocial support for people infected or affected by HIV/AIDS” (87%). (See Figure 3)

Figure 3: Self-reported training needs among health care providers and technicians in the Caribbean



HIV Related Workplace Policies

Providers working in HIV/AIDS services were asked what types of HIV related policies were available in their healthcare facility. The two most common policies available were Post Exposure Prophylaxis or PEP (56.6%) and an Infection Prevention and Control Policy (56.6%). The presence of other policies included an Occupational Exposure Policy (47.5%), a Stigma and Discrimination Policy (35.3%), followed by an Adherence Policy (33.3%). The presence or absence of these workplace policies is indicative of the effort that needs to continue in the region to make health care delivery safe for both practitioners and patients.

Conclusions

The data revealed that individuals that have attended CHART trainings were satisfied and have found the trainings useful, relevant and effective. In addition, a majority of persons who provide front-line care reported that they have shared the skills and knowledge obtained from their CHART training among their co-workers. This finding demonstrates that there have been exponential benefits to training a single individual. The most common training requested were ways to support the psychosocial needs of PLHIVs and trainings related to providing antiretroviral therapy, including sessions on learning the initiation of ART and its side effects, treating opportunistic infections and TB/HIV co-infections. The findings from this study point to the continued need for a regional training mechanism for health providers like the CHART Network. Information from this study will also be used to guide training activities to be undertaken by the CHART Network in the future. Efforts will be made to ensure that persons accepted for training are those most likely to apply new knowledge, skills and attitudes on the job.

Perceptions of the Quality of Care: A Study among Persons Living with HIV

Background

Published research documenting the Caribbean experiences of the health care encounter by persons living with HIV/AIDS (PLHIVs) and their perceptions of the quality of care received is sparse. This lack of literature highlights the fact that the existence of policy and other support mechanisms for PLHIVs is poorly defined and developed in the Caribbean region. Research is needed in the area of perceived quality of healthcare received by persons living with HIV/AIDS in the region because it remains unclear how care is received by PLHIVs, what areas of the health encounter need to be improved, and how increased and/or improved training amongst healthcare providers can assist in higher quality provision of care to PLHIVs. Findings from this area of research could influence advocacy at the policy formulation level and curriculum design for medical students and other students being trained to work in the healthcare system across the region.

The perceptions of quality of care of PLHIVs are highly dependent on their experiences with the health care system. Studies conducted in the US document PLHIVs reporting poor treatment by health care providers and lack of or limited access to HAART⁴ either because of inability to afford such treatments or the incidence of physicians offering substandard treatment such as dual ARV therapy (QAP 2002). Poor treatment by health care providers was also exemplified by discriminatory remarks or actions of providers. PLHIVs reported that the infrastructure in some public health centres that treat PLHIVs was not conducive to maintaining the confidentiality status of HIV positive patients (QAP 2002). Other evidence-based studies investigating quality of health care by PLHIVs revealed that the lack of trust that PLHIVs have in medical staff contributes significantly to perceptions of treatment. Schuster et al (2005) reported that health care measures such as access to care, quality ratings of medical care and hospital care, and trust in doctors or clinics, were lower for people who reported perceived discrimination. In

⁴ Highly Active Anti-Retroviral Therapy also known as triple ARV therapy.

multivariate analyses controlling for respondent characteristics, discrimination remained significantly associated with each of these health care measures. Socio-economic status (SES) is a variable that is correlated with perceived quality of care of PLHIVs. According to Ramakrishna et al (2004), socioeconomic status and educational status modulate the experience of stigma to a great extent. The educated middle class PLHIVs interact with health care providers on a more equal footing. Ramakrishna further postulates that poverty, gender, and stigma are intricately related and poor access to resources compounds stigma. Thurborn et al (2004) purported that negative interactions with health care providers can have important implications for the health and health care of HIV-positive individuals. As it relates to socio-economic status, Thurborn et al relayed that greater SES -based discrimination was associated with greater levels of depression and posttraumatic stress symptoms, greater severity of AIDS related symptoms, lower perceived general health, and less health care satisfaction.

A few published studies from the Caribbean and Latin America were found that documented PLHIV experiences with the health care system and perceptions of quality of care. A study documenting the experiences of women living with HIV/AIDS in Mexico in 2000 by Vazquez et al reported that women face bureaucracy, low service quality and the stigma associated with HIV/AIDS more so than men who are HIV-positive. Among the problems highlighted by women in the study include; tendency to delay diagnosis and relaying results, medical negligence and a lack of sensitivity during the process; poor quality health services which infringe upon women's dignity; a lack of adequate emotional support and stigma, discrimination and mistreatment in health services particularly critical for women, such as gynaecological and prenatal services (Vazquez et al 2000). The International Community of Women Living with HIV/AIDS (ICW, 2005) reported that gender-related stigma and discrimination are sometimes reflected in the attitudes of staff in health settings. It is important to note, as outlined by ICW (2005), different treatment and care regimes call for the development of proper gender equitable trials, client research trials, and client data reporting, both on drugs and on other aspects of care and treatment.

Three workshops conducted with PLHIVs were held in St. Vincent, Grenada and Barbados and facilitated by the International HIV/AIDS Alliance in 2006. The objective of each workshop was to examine perceptions of quality of care among PLHIVs. Participants in these workshops asserted that treatment was “not just about giving medication” but should be associated with increased psychosocial care, which will in return achieve greater adherence to regimens and greater effectiveness of treatment programmes (Hoad, 2007). Participants in the workshops expressed the need for greater communication with providers and involvement in the delivery of treatment and care. These workshops also identified some barriers to care and treatment, including: discrimination in hospitals, breaches in confidentiality, lack of proper nutrition, unemployment, lack of knowledge about and shortage of ARVs and lack of community and family support (Hoad, 2007).

The literature on perception of quality of care received by PLHIVs revealed that several factors may influence perceptions of care received from health care providers. These factors include social class, educational level, gender, mode of transmission, workplace exposure to the virus, and stigma and discrimination. It is unclear however how these and other factors interplay within different health care and social settings in the Caribbean region. Whether quality of care is a function of providers’ inability to confront their own biases or is as a result of inadequate training in providing care for PLHIVs, the literature describes how the attitudes of health care providers affect PLHIVs in how care is accessed and received. It is also apparent from the literature that there is no clear definition of quality of care, especially in regards to the care, treatment and support of PLHIVs. With the growing HIV epidemic in the Caribbean region, the authors believed that a study of this nature was both timely and important.

A study was therefore undertaken a study to examine the perceptions related to quality of healthcare among persons living with HIV/AIDS in Barbados, Jamaica and Haiti. The study was guided by the following objectives:

- To determine the factors affecting PLHIV perceptions of the quality of health care received
- To document the experiences of PLHIV relative to interactions with service providers

Methodology

There were two criteria for participation in the study: 1) the participant must be HIV positive, and 2) must have received care/treatment at a facility in the country of study within the past year. For this study a qualitative technique was seen as more appropriate due to the sensitive nature of the topic. Using qualitative methods allowed for a more intimate interaction with PLHIVs, involving the building of trust to stimulate honest expressions of perceptions, feelings, behaviours and experiences. Focus groups and in-depth interviews were used to ascertain information regarding perceptions of quality of care received by PLHIVs in Barbados, Jamaica and Haiti. These countries were chosen to be part of the study because they 1) have a CHART training centre, and 2) reflect different health care settings (centralized and decentralized). A structured survey was used to capture demographic data, information on the primary treatment facility, and interaction with health care providers. The survey instrument was either self-administered or completed with the assistance of the moderator or assistant at the end of the focus group discussion.

To steer the discussion, a moderator's guide, addressing the issues related to quality care was developed and utilized during the discussion. Specific probe inserts were included to stimulate more discussion and also to generate issues that were not spontaneously disclosed. A moderator conducted the sessions with the assistance of a note taker/assistant. The moderator also noted the salient points as well as important non-verbal communication. The sessions took an average of one and a half hours to complete and were tape recorded and transcribed.

Data Collection

Sixty-seven participants were recruited from Jamaica (36), Barbados (11), and Haiti (20). The health care system in Barbados is considered "centralized", where HIV/AIDS care and treatment is provided by the main treatment centre, the Lady Meade Reference Unit (LRU). The Caribbean HIV AIDS Alliance (CHAA) assisted in identifying appropriate support organizations for the recruitment of study participants associated with the Ladymeade Reference Unit,

namely CARE (Comfort Assist Reach out Educate) and UGLAAB (United Gays and Lesbians Against HIV/AIDS, Barbados).

Participants in Jamaica were recruited in all four regional health authorities where persons might receive HIV care and treatment⁵ with the assistance of the Regional Health Authority and its clinics. The Jamaica AIDS Network for Seropositives (or JN Plus) also assisted in recruiting participants from their support organization to join the focus groups. Social workers and Adherence counsellors from regional clinics and hospitals invited participants according to study criteria, and provided the location of the focus groups.

In Haiti, a research assistant was hired to assist in data collection and management of the study. Patients who attended the Zanmi LaSante HIV clinics in Hinche, Thomonde, and Boucan Carre were invited to participate in this study by the research assistant. Every seventh person was approached by the clinic nurse and told about the study.

Breakdown of groups by Country: Focus Group Discussions conducted by Country, Location and Type

Country	Location	Parish	Type
Barbados	Bridgetown	-	Mixed
Barbados	Bridgetown	-	Mixed
Jamaica	Port Maria	St. Mary	Mixed
Jamaica	Montego Bay	St. James	Males only
Jamaica	Mandeville	Manchester	Females only
Jamaica	Kingston	Kingston/St. Andrew	Mixed
Jamaica	Kingston	Kingston/St. Andrew	Mixed
Haiti	Hinche	-	Mixed
Haiti	Hinche	-	Females only
Haiti	Boucan Carre	-	Mixed
Haiti	Thomonde	-	Mixed

‡=mixed gender

⁵Health Authorities in Jamaica are governmental agencies responsible for all matters relating to public health.

All focus group participants were reimbursed for travel costs (\$20US) and a given a small incentive (\$15US). Participants were asked to complete a short survey at the end of the focus group/in-depth interview sessions.

Ethical Considerations

A study of this nature which seeks to explore perceptions of care received is sensitive and participation in this study did involve some risks, though minimal. Persons may have felt uncomfortable answering some questions either in the focus group or on the survey, but the participant did not have to answer any question he/she did not want to answer. This study was submitted to the Ethics Committees of the Ministries of Health in Barbados and Jamaica, and with the Partners in Health/Zanmi Lasante Health Centre's Ethics committees. All participants were required to sign an informed consent form. In Haiti, due to low literacy, participants agreed to participate in the study by affixing their thumbprint to the consent form.

Findings

In October 2009, a total of eleven (11) focus group discussions, (two in Barbados, five in Jamaica, four in Haiti) were conducted. Although some of the participants for both Barbados and Jamaica were sourced through AIDS support networking groups, the majority of the participants did not belong to a support group. The overwhelming majority were public clinic attendees. The hope of obtaining more persons utilizing private facilities was not realized as this proved to be a difficult exercise. The more financially privileged groups are generally adverse to research and more so when it relates to sensitive and personal issues (UWI-UCLA Jamaica Health Study 1993, unpublished report). Unlike Barbados, Jamaica had an all male and female group affiliated to a support group. In Haiti, one female only focus group was conducted. These gender specific groups were compiled to explore gender sensitive issues with respect to the quality of care received.

The age range of study participants was between 20 and 63 years, with a mean age of 35.8 years. Most participants were female (64%), with the least educated respondents coming from

Haiti. Across all three sites, participants tended to report being unemployed (76%), with a few reporting being self-employed. There were differences in participants in the three countries in the number of years diagnosed with HIV. In Jamaica, 28% had been diagnosed between one to three years and 39% had been diagnosed between four to nine years. In Barbados, seven of the eleven participants reported having been diagnosed for ten years or more. In Haiti, 50% of the participants had been diagnosed three years or less and the other half between four to nine years (see Table 3). Across all countries, the majority of participants reported having one main site for care and treatment. Over eighty percent of respondents across research sites reported currently receiving antiretroviral therapy. There was a difference however in the frequency of visits between countries. In Jamaica 72% reported a visit every 3 months, while in Barbados, 63.6% of participants reported having a clinic visit every 6 months. Participants in Haiti attended the clinic every month for care.

Factors affecting perceptions of care

Several key areas were identified in the focus groups that impacted the participants' perception of care. Points of dissatisfaction related to confidentiality, waiting time, holistic treatment and stigma and discrimination. These areas of dissatisfaction were driven by personal experience and reports focused mostly on non-medical/technical providers and ancillary staff. The overwhelming perception is that leaks of confidential information are wide spread and that the main source of this information about their health is the health facility.

"I get my prescription filled in Mandeville by a private doctor and then I go to a pharmacy. I still go to my clinic sometimes but I mix it. All a nurse meet me recently and say that she glad to see that I stop cover my face with a cap. So when you think you not being noticed you are". (Participant, Jamaica)

"I came to get my blood results and as the cleaner see me go to the lab she come and start clean and there was nothing to clean". (Participant, Jamaica)

Participants cited scenarios where confidentiality leaks were evident and medical files were misplaced and not properly secured.

“Dem fling yu docket all over the place and could never find it so yu have to wonder what they do with it....dem tek it to read and spread bout”. (Participant, Jamaica)

Clinic staff has also noted the breaches in confidentiality amongst ancillary staff.

“We’ve heard them (ancillary staff) discussing persons who are positive-I mean among themselves. And even our security staff they’ll try to find out information to ask people if everybody who comes to a particular doctor is positive. In general really some since they know that the person is positive they may treat them differently from another person who is not, they would prefer to deal with the person who is not positive, talk to them nicer than how they do the other person”. (In-depth interview participant, Jamaica)

To curb these breaches and unprofessional actions, clinic staff suggested the need for sanctions.

“I think there needs to be some sanctions...’cause you’ll have persons who may hear it over and over; they may go to training or whatever and they still have this sort of behaviour towards persons who are positive. So I think along with the education, the workshops, cause education is key and knowledge is power, if there are some sanctions to say that if you violate--if you break a person’s confidentiality, if you violate their rights, this is what’s gonna happen. I think then more people would take it seriously”. (In-depth interview participant, Jamaica)

Furthermore, over half of the respondents reported that their provider allowed interruptions during their consultation and 25% felt that their provider did not maintain their confidentiality or that they did not know whether the provider maintained their confidentiality. Time spent in the clinic waiting to receive follow up care was reported in all three countries as a major weakness in the facilities where they receive care. In Haiti, participants reported that medication stock outs in the clinic pharmacies were also a problem.

“The care I expect from the hospital goes directly in the sense of providing medicines. So many times we have been asked to take the medicines and the hospital was unable to provide it to us. I hope and suggest that the hospital solve this problem once and for all”. (Participant, Haiti)

Stigma continues to be an important perceived problem. The following quote represents the views of the respondents in all three countries who expressed reluctance to disclose the nature of their illness:

“There is still a lot of stigma and some people, like people in the community, some family members and also some staff would like us all to die as they see us as a burden, like garbage, but we continue to struggle, take our medication and stay well.” (Participant, Barbados)

“When we come for consultation, we feel embarrassed because of the other patients who are not infected and usually that creates an atmosphere of discrimination, by using a bad language toward us, like, ‘here come the infected’.” (Participant, Haiti)

Respondents believed that a critical component of care is emotional support from trustworthy persons, like other PLHIVs trained as peer counsellors or ‘buddies’. Group members also vocalized that there was a neglect of the total person in the health system; that care should be provided to their mind and soul, not just their body.

“Care is focused too much on treatment with little regard for the other aspect of the person’s well being – emotional or psychological. Treat the person, don’t just treat HIV.” (In-depth interview participant, Barbados)

Interaction with health care providers

Nearly all participants reported positive interaction with health care providers. Most notable common aspects of positive interaction with providers were: discussion of the pros and cons of treatment (84%) and the explanation of the use of HIV medications (81%). Areas where there were notable differences were found in Haiti where respondents felt that their provider they did not always explain the use of the medication (55%) though information was provided about side effects (85%). In addition, 60% of participants from Haiti reported that laboratory results were not explained to them. Participants from both Jamaica and Haiti reported having enough time to talk with their providers (80% respectively), while a little over half of respondents from Barbados expressed the same (see Table 4).

Results from the survey also found that 49% of respondents rated their overall quality of care was ‘good/very good’ and 37% rated it as ‘excellent’. When respondents were asked their level of agreement to the statement, “I trust my doctor to offer me the best care they can give”, the

majority of participants reported answering in the affirmative – that their health care provider would provide the best care they can give to their patient, in all three study countries. Only one person in Barbados disagreed with the statement and 5 participants in Jamaica reported neither agreeing/disagreeing (see Table 5).

Conclusions

This qualitative study provided insight among PLHIVs in Barbados, Jamaica and Haiti in their perception of quality of care. It was found that persons were positive in their overall ratings of care received, especially in interactions with their direct care provider. However, it appears that other areas of service delivery need to be strengthened, especially improving confidentiality amongst auxiliary workers, the reduction of stigma and discrimination experienced in the health centre and offering more psychosocial support to PLHIVs. The CHART Network can use the findings from this study to improve and expand its training strategy to include more curricula content in psychosocial support and issues related to confidentiality as well as expand the cadres of workers trained to include various auxiliary workers (e.g., medical records clerks, security personnel) and peer counsellors.

Limitations

The conduct of these evaluation studies has resulted in a greater insight into the training needs of the Region's healthcare professionals and the care provided to the PLHIV community and will be used to improve the training curricula employed by the CHART Network. However, there were limitations in the conduct of the evaluation studies that may limit the overall findings.

Despite surveying participants who received CHART training between 2004-2009, using both telephone and online survey methods, a low response rate was experienced. Factors which could be attributed to this included:

1. Difficulty reaching respondents by telephone due to the respondent's telephone carriers' inability to accept overseas calls.
2. The respondent was no longer at the clinic/hospital location on record in CHART database
3. Respondent no longer practising in the health field
4. Email address/ telephone number(s) on record in CHART database no longer valid

One way to overcome this limitation would be to conduct in person interviews with participants, but since CHART trainings are conducted regionally, this might not be fiscally feasible or manageable. Another method would be to stagger data collection to every 3 or 6 months. This might overcome the issue of having updated contact information, and, persons who recently completed training may be more likely to complete a survey.

Limitations were also faced during the conduct of the Perceptions of Quality of Care Study. These limitations in the conduct of this study included time and access to the PLHIV population. Due to the time available to collect data in the field (July – October 2009) only a limited number of focus group discussions could be conducted per country. Furthermore there was a general difficulty in accessing PLHIVs due to issues related to confidentiality. This is especially true for those categorized as being a part of the most vulnerable populations (men who have sex with men (MSM) and commercial sex workers (CSWs)).

Our primary method of accessing PLHIVs for this study was through the assistance of PLHIV support organizations (Barbados and Jamaica) and HIV clinics. It was therefore difficult to access those who were not a part of a support group or patients accessing private care. Access to private patients was problematic as this population proved to be less accessible for interviews due to fear of disclosure. It should be noted that this issue was common to all countries involved in the study. The greatest limitation in the conduct of this study was the research team's inability to directly link participant care to a provider trained by the CHART Network. This limitation however could not be overcome without seeming overly invasive to the study participants. This resulted in generalized study findings.

Recommendations

The information gleaned from these evaluation studies will serve to enrich the discussion on healthcare delivery to the PLHIV community within the Caribbean Region. The data have shown that CHART training participants have benefitted from the training activities and have found them to be effective in their work. Barriers to using the skills and knowledge obtained from training were also identified and this information should be used to better direct participant selection.

The findings from these studies point to a need for more holistic training in the care and treatment of PLHIVs. Both focus group participants and CHART trained providers felt that CHART trainings should address more issues related to psychosocial support. In addition there was a recognized need to train PLHIVs as peer counsellors/educators to better serve within their community. Two major findings that the CHART Network will continue to address in its training activities are issues related to confidentiality and stigma and discrimination. The CHART Network has made great strides in the past year by delivering trainings in stigma and discrimination using a specialized Stigma and Discrimination Curricula and Trigger Scenario DVDs. CHART is also in the process of developing a specialized Confidentiality Curricula. Despite CHART conducting over 700 training activities between 2004-2009, additional training needs

continue to be identified which points to a continued need for a training mechanism for the care and treatment of PLHIVs within the Caribbean Region.

These studies have brought into clearer focus the need for increased dialogue between the PLHIV community and the CHART Network, as without this continued dialogue CHART's mandate of reducing the burden and impact of HIV/AIDS within the Caribbean Region will not be realized.

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Appendix I: Perception of Quality of Care Data Tables

Table 3: Demographic profile of participants in Barbados, Jamaica and Haiti (N=67)

Characteristic	Barbados (n=11) N (%)	Jamaica (n=36) N (%)	Haiti (n=20) N (%)
Age			
Mean (years)	35.9	35	36.6
Min--Max (years)	20-52	22-63	24-59
Gender			
Male	3 (27.3)	15 (41.7)	6 (30.0)
Female	8 (72.7)	21 (58.3)	14 (70.0)
Education (years)			
None	--	--	3 (15.0)
Less than 6 Years	--	--	11 (55.0)
6 – 9 Years	3 (27.3)	5 (13.9)	2 (10.0)
10 – 12 Years	3 (27.3)	19 (52.8)	3 (15.0)
13 or More Years	5 (45.4)	10 (27.8)	1 (5.0)
Employed			
Yes	3 (27.3)	9 (25.0)	3 (15.0)
No	8 (72.7)	26 (72.0)	17 (85.0)
Years diagnosed with HIV			
Less than 1 Year	1 (9.1)	7 (19.4)	2 (10.0)
1 – 3 Years	--	10 (27.8)	8 (40.0)
4 – 9 Years	3 (27.3)	14 (38.9)	10 (50.0)
10 or More Years	7 (63.6)	5 (13.9)	--

Table 4: Interaction with health care providers in 3 countries (N=67)

Characteristic	Barbados (N=11) N (%)	Jamaica (N=36) N (%)	Haiti (N=20) N (%)
Informed about pros and cons of treatment	9 (81.8)	28 (77.8)	19 (95)
Yes	1 (9.1)	5 (13.9)	5 (5.0)
No	1 (9.1)	3 (8.3)	--
Don't Know			
Lab results explained			
Yes	9 (81.8)	32 (88.9)	8 (40.0)
No	1 (9.1)	2 (5.5)	12 (60.0)
Don't Know	1 (9.1)	2 (5.5)	--
Information about side effects			
Yes	8 (72.7)	26 (72.2)	17 (85)
No	2 (18.2)	7 (19.4)	3 (15)
Don't Know	--	1 (2.8)	--
Not Applicable	1 (9.1)	1 (2.8)	--
Missing	--	1 (2.8)	--
Information about use of medication	7 (63.6)	30 (83.3)	17 (55.0)
Yes	3 (27.3)	2 (5.5)	3 (15.0)
No	--	2 (5.5)	--
Don't Know	1 (9.01)	1 (2.8)	--
Not Applicable	--	1 (2.8)	--
Missing			
Provider breaks news gently			
Yes	6 (54.5)	24 (66.7)	11 (55.0)
No	4 (36.4)	4 (11.1)	9 (45.0)
Don't Know	--	6 (16.7)	--
Missing	1 (9.1)	2 (5.6)	--
Enough time spent to talk			
Yes	6 (54.5)	29 (80.6)	16 (80.0)
No	5 (45.5)	5 (13.9)	4 (20.0)
Don't Know	--	--	--
Missing	--	2 (5.6)	--
Allows no interruptions at consultation	5 (45.5)	24 (66.7)	3 (15.0)
Yes	5 (45.5)	8 (22.2)	17 (85.0)
No	1 (9.0)	2 (5.6)	--
Don't Know	--	2 (5.6)	--
Missing			

Table 4 (cont): Interaction with health care providers in 3 countries

Characteristic	Barbados (N=11) N (%)	Jamaica (N=36) N (%)	Haiti (N=20) N (%)
Maintains confidentiality about HIV status			
Yes	8 (72.7)	23 (63.9)	17 (85.0)
No	1 (9.1)	5 (13.9)	1 (5.0)
Don't Know	2 (18.8)	6 (16.7)	2 (10.0)
Missing	--	2 (5.5)	--
Maintain privacy with soft tones			
Yes	9 (81.8)	27 (75.0)	17 (85.0)
No	2 (18.2)	4 (11.1)	3 (15.0)
Don't Know	--	2 (5.5)	--
Missing	--	3 (8.3)	--
Allowed to express concerns about care			
Yes	9 (81.8)	27 (75.0)	20 (100.0)
No	2 (18.2)	6 (16.7)	--
Don't Know	--	2 (5.6)	--
Missing	--	1 (2.8)	--

Table 5: Doctor trust and quality of care in 3 countries (N=67)

Characteristic	Barbados (N=11) N (%)	Jamaica (N=36) N (%)	Haiti (N=20) N (%)
Trust my doctor			
Strongly Agree	5 (45.4)	27 (75.0)	19 (95.0)
Agree	5 (45.4)	4 (11.1)	1 (5.0)
Disagree	1 (9.1)	--	--
Neither agree/disagree	--	5 (13.9)	--
Overall Quality of Care			
Fair/Poor	3 (27.3)	4 (11.1)	2 (10.0)
Good/Very good	5 (45.4)	11 (30.6)	17 (85.0)
Excellent	3 (27.3)	21 (58.3)	1 (5.0)

Appendix II: Data collection form for Physicians Survey

Physician Follow-Up Survey
(Telephone version)

Date: _____
Interviewer initials _____
Time started _____

Hello, may I speak to _____. My name is _____ and I am calling from the Caribbean HIV/AIDS Regional Training Program or CHART. In order to improve our training program and better meet provider needs, we are calling a sample of physicians who attended a CHART training and asking them for some feedback on their training needs plus some other information. Can I have a few minutes of your time to ask you a few questions? This will only take 7-10 minutes to complete. You don't have to answer any question you don't want to and the answers you provide will not be shared with your facility or anyone in your workplace. May I begin? Accept _____ Refuse _____

Background Information

1. Name of respondent _____ *(Interviewer: Do not ask-fill in)*
2. In which country do you currently work? _____
3. What is the name of the facility where you currently work the majority of the time? _____
4. Is the facility where you currently work a:
 - a. Hospital
 - b. Healthcare centre/clinic
 - c. Medical/nursing/other school
 - d. Training centre
 - e. Pharmacy
 - f. Other: _____
5. Is your current facility:
 - a. Government funded
 - b. Private
 - c. Non-governmental (NGO)/ Non-faith based
 - d. Non-governmental (NGO)/faith-based
 - e. Other _____
6. What is your primary role at your facility?
 - a. Physician (direct patient care)
 - b. Administrator (Direction, management, etc.)
 - c. Researcher
 - d. Professor/Teacher/educator
 - e. Other: _____

Provision of Services

7. Does your facility directly provide HIV care and treatment services?

- a. Yes (go to Q7B)
- b. No (go to Q8)

7b. If YES, does your facility offer the following services? (Yes/ No)

Services:	Yes	No
a. Counselling and testing		
b. Opportunistic infections		
c. TB and HIV co-infection		
d. STI management		
e. Palliative care		
f. Antiretroviral therapy		
g. Prevention of mother to child transmission (PMTCT)		
h. Paediatric HIV care and treatment		

8. Do you currently provide care and treatment to HIV positive patients?

- a. Yes
- b. No (go to Q14)

9. What is the average number of HIV positive patients that you see each month? (If zero, please enter 0 if don't see patients enter 8888).

10. How many patients do you oversee on anti-retroviral therapy (ART)? (If zero, please enter 0, if don't see patients enter 8888).

11. Have you ever provided an HIV-related clinical consultation to someone at **your** site?

- a. Yes
- b. No

12. Have you ever provided an HIV-related clinical consultation to someone at **another site**?

- a. Yes
- b. No

13. On average, how many HIV cases are you requested to consult on per month? (If zero, please enter 0, if don't see patients enter 8888).

Training Information

14. (Interviewer: Check listing for date (s) participant attended CHART training and say name of course and date). Our records indicate that you attended an HIV-related training (s) through the Caribbean HIV/AIDS Regional Training (CHART) Network on _____ What were the skills and knowledge areas addressed by the training (s) you attended? Did the training include _____ (fill in area):

Training Areas:	Yes	No
a. Counselling and testing		
b. Opportunistic infections		
c. TB and HIV co-infection		
d. STI management		
e. Palliative care		
f. Antiretroviral therapy		
g. Prevention of mother to child transmission (PMTCT)		
h. Paediatric HIV care and treatment		
k. Don't Remember		

15. Have you used the skills and knowledge you acquired through the training (s) that you attended in your work activities?

- a. Yes (go to Q15a)
- b. No (go to Q15b)
- c. Don't know

15a. If YES, please explain how?

15b. If NO, please explain why not?

Training Needs

16. At your current facility, what specific types of training do you think are needed? From the list I read, please tell me if this type of training is needed at your facility.

Training Areas:	Yes	No
a. Counselling and testing		
b. Opportunistic infections		
c. TB treatment		
d. TB control		
e. TB and HIV co-infection		
f. Primary prevention		
g. Prevention with positives		
h. STI management		
i. Initiation of antiretroviral therapy (ART)		
j. Adherence to ART		
k. Resistance to ART		
l. Side effects of ART		
m. Palliative care		
n. PMTCT		
o. Paediatric HIV care		
p. Psychosocial support for people infected or affected		

by HIV/AIDS		
q. Reduction of stigma and discrimination related to HIV/AIDS		
r. Laboratory testing		
s. No additional training needed		
t. Other (specify) _____		
u. Other (specify) _____		

17. What specific subjects would you personally like to learn more about? From the list I read, please tell me if you would like this type of training.

Training Areas:	Yes	No
a. Counselling and testing		
b. Opportunistic infections		
c. TB treatment		
d. TB control		
e. TB and HIV co-infection		
f. Primary prevention		
g. Prevention with positives		
h. STI management		
i. Initiation of antiretroviral therapy (ART)		
j. Adherence to ART		
k. Resistance to ART		
l. Side effects of ART		
m. Palliative care		
n. PMTCT		
o. Paediatric HIV care		
p. Psychosocial support for people infected or affected by HIV/AIDS		
q. Reduction of stigma and discrimination related to HIV/AIDS		
r. Laboratory testing		
s. No additional training needed		
t. Other (specify) _____		

18. Please share any additional comments you have related to your CHART training experience:

Time ended: _____
Reviewer Initials _____

Appendix III: Data Collection form for Knowledge and Skills Study

IDENTIFICATION

Country	Cat	Sampling Weight	Com



CHART

CARIBBEAN HIV/AIDS REGIONAL TRAINING NETWORK

Knowledge & Skill Survey

Hello, my name is _____ and I am calling from the Caribbean HIV/AIDS Regional Training Program or CHART. In order to improve our training program, we are calling a sample of people who attended a CHART training to assess their use of the knowledge and skills received from the training in their work.

Is this a good time to talk? No _____ Yes _____ (Interviewer: If NO ask follow-up).

Can we arrange a telephone interview for another time?

No _____ Yes _____ (time/date).

The interview will take approximately 15 minutes. You can stop the interview at any time and you don't have to answer any question you don't want. Please be assured that the answers you provide will not be shared with anyone in your workplace or otherwise.

May I begin? Accept _____ Refuse _____

Thank you.

First I would like to confirm that we have the correct information for you.

(Interviewer: Confirm information and update as necessary)

Name:	
Organization & Country of Work	
Profession (e.g. Nurse, Physician)	
Telephone(W) (C) (H)	(W) (C) (H)
Email -	

Current level of service provision

1. What type of Agency/Program that you are currently employed to (Select one):

<input type="checkbox"/> Hospital	<input type="checkbox"/> Community Based Organization
<input type="checkbox"/> Healthcare Centre/Clinic	<input type="checkbox"/> Private Practice (solo/group)
<input type="checkbox"/> Correctional Facility	<input type="checkbox"/> Laboratory
<input type="checkbox"/> STD/Family Planning Clinic	<input type="checkbox"/> Other Public Health Agency
<input type="checkbox"/> HIV Specialty Clinic	<input type="checkbox"/> Other (specify):

2. Are you currently working in HIV/AIDS Services?

- a. Yes (go to Q3)
- b. No (go to Q4)

3. **If YES**, what is your primary role as a HIV/AIDS Service provider? **Then skip to Q5**

<input type="checkbox"/> Direct Care Provider	<input type="checkbox"/> Policy Maker
<input type="checkbox"/> Peer/Treatment Advocate	<input type="checkbox"/> Educator
<input type="checkbox"/> Counsellor	<input type="checkbox"/> Other (specify):

4. **If NO**, what area of service do you work? _____

(Interviewer: Questions 5 -7 for Direct Care Providers (Physician / Nurse) only

5. Please estimate the # of PLHIV patients seen per clinic session: _____

6. Please estimated the # of your patients on ART: _____

7. Please estimate the # of PLHIVs you care for per month: _____

Note: # of PLHIV that are their patients that they come into contact with per month

8. What services other than ART do you provide in your work? (Select all that apply)

(Interviewer: Emphasize that this relates to the person providing the service and not the Agency/Program that respondent is employed to.)

Opportunistic Infections (OIs) Screening & Treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sexually Transmitted Infections (STIs) Screening & Treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tuberculosis (TB) Screening & Treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Paediatric Care, Support & Treatment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prevention for positives	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Community Advocacy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Adherence Counselling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pre-Test Counselling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Post-Test Counselling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other Counselling	<input type="checkbox"/> Yes	<input type="checkbox"/> No
HIV Testing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Family Planning	<input type="checkbox"/> Yes	<input type="checkbox"/> No
PMTCT Related services	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other, please explain	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Self-Assessment of knowledge, skill, and attitude

9. I'm going to read to you seven statements which represent some areas of knowledge, skill, and attitude specific to a Health Care Provider's role in caring for patients with HIV/AIDS. Please rate yourself on a scale of 0 to 5, with 0 the lowest and 5 the highest the number that best represents your level of knowledge, skills, and attitude TODAY.

0 = low ←————→ 5 = high

Interviewer: Prompt each statement with 'On a scale from 0 to 5 how do you rate your level of knowledge, skills, and attitude TODAY in'

HIV treatment guidelines for adults and adolescents	0	1	2	3	4	5
Performing thorough HIV/STI risk assessment	0	1	2	3	4	5
Supporting HIV+ patients to enter into or terminate antiretroviral therapies	0	1	2	3	4	5
Monitoring HAART and appropriate use of resistance assays	0	1	2	3	4	5
Recognizing and treating HIV-related opportunistic infections	0	1	2	3	4	5
Level of comfort in working with gay, lesbian, bi-sexual or transgender patients	0	1	2	3	4	5
Providing care consistent with individual patients' cultural beliefs	0	1	2	3	4	5

Use of knowledge and skills

10. Our records showed that you have participated in _____ training(s). Were you able to use any knowledge or skill from the training(s) and apply it to your work?

Yes (go to Q11) No (go to Q12)

11. (If YES), please rate the relevance, usefulness and effectiveness of the training(s) on a scale from 0 to 5 in each category with 0 the lowest and 5 the highest. (Interviewer: After this question skip to Q14)

0 = low ←————→ 5 = high

Overall how useful was the training received?	0	1	2	3	4	5
Overall how effective was the training received?	0	1	2	3	4	5
Overall how relevant was the training received to your work?	0	1	2	3	4	5

12. (If NO), what were the barriers or constraints to using the knowledge or skill from the training? Would you say

Interviewer:

Constraints	Not a barrier	Somewhat of a barrier	A major barrier	Don't know
1. Time in your job to use them	1	2	3	9
2. Space in the workplace	1	2	3	9
3. Organizational Support	1	2	3	9
4. Technology meaning-not enough technology to make effective use of time	1	2	3	9
5. Staffing and personnel meaning – not enough people are available to help	1	2	3	9
6. Staffing and personnel meaning – the people that are available are not qualified	1	2	3	9
7. The training was not relevant to your work	1	2	3	9

13. Since you haven't used the knowledge or skills in your work, do you foresee the opportunity to use them?

Yes No Unsure

14. Have you shared the knowledge/skills from the training with other people in your work? Yes No Unsure
(Interviewer: Skip to Q17 if answer is No/Unsure.)

15. How have you shared these knowledge and skills?

1. Did you share the knowledge & skill through presentation to co-workers?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Did you make a presentation to other group of people?	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Did you conduct training on the topic?	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Did you conduct training on a related topic?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Did you encourage co-workers to practice differently?	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Did you share resources that you received from the training?	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Did you facilitate a discussion on the topic?	Yes <input type="checkbox"/> No <input type="checkbox"/>
8. Did you show a Video/DVD on the topic?	Yes <input type="checkbox"/> No <input type="checkbox"/>
9. Did you encourage dialogue with policy makers to promote policy/procedure changes?	Yes <input type="checkbox"/> No <input type="checkbox"/>

Additional Training Needs Assessment

16. I'm going to read you a list of some training topics. Please tell me the topics in which you would like to receive training. Would you like to receive training in ...

a. Counselling and testing	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Most Important <input type="checkbox"/>
b. Opportunistic infections	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Most Important <input type="checkbox"/>
c. TB treatment	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Most Important <input type="checkbox"/>
d. TB control	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Most Important <input type="checkbox"/>
e. TB and HIV co-infection	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Most Important <input type="checkbox"/>
f. Primary prevention	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Most Important <input type="checkbox"/>
g. Prevention with positives	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Most Important <input type="checkbox"/>
h. STI management	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Most Important <input type="checkbox"/>
i. Initiation of antiretroviral therapy (ART)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Most Important <input type="checkbox"/>
j. Adherence to ART	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Most Important <input type="checkbox"/>
k. Resistance to ART	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Most Important <input type="checkbox"/>
l. Side effects of ART	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Most Important <input type="checkbox"/>
m. Palliative care	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Most Important <input type="checkbox"/>
n. PMTCT	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Most Important <input type="checkbox"/>
o. Paediatric HIV care	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Most Important <input type="checkbox"/>
p. Psychosocial support for people infected or affected by HIV/AIDS	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Most Important <input type="checkbox"/>
q. Reduction of stigma and discrimination related to HIV/AIDS	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Most Important <input type="checkbox"/>
r. Laboratory testing	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Most Important <input type="checkbox"/>

17b. Now that you have made the selection, please tell me the one topic that is of most importance to you. *(Interviewer: Please repeat the topics selected for training by the respondent and tick the most important one as determined by the respondent from that list).*

Policies

17. Which policies does your health facility have in place and by policy we mean an established governing principle or plan.

1. Is there a policy for Post Exposure Prophylaxis (PEP)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>
2. Is there a policy for Occupational Exposure?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>
3. Is there an Adherence Policy?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>
4. Is there a policy for Infection prevention and control?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>
5. Is there a policy for Stigma & Discrimination?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Don't Know <input type="checkbox"/>

Thank you for your participation.

Appendix IV: Data collection form for Perceptions of Quality of Care Study

Perception of Quality of Health Care Questionnaire 2009

Thank you for taking the time to complete this survey.
Your name will not be placed on this survey. Please circle the answer that you choose.

- Q001.** How old were you on your last birthday? ____
- Q002.** What is your gender? (circle one)
1. Male 2. Female
- Q003.** How many years of schooling have you completed? (circle one)
1. Less than 6 years 2. 6-9 years 3. 10-12 years 4. 13 or more
- Q004.** In which parish do you currently live? _____ (for Jamaican residents only)
- Q005.** Are you currently working?
1. Employed 2. Unemployed
3. Self-employed ->**If self-employed, please describe the type of work that you do:**
-
- Q006.** Are you currently receiving any care or treatment from a health care facility? (circle one)
1. Yes 2. No
- Q007.** How long have you been diagnosed with HIV? (circle one)
1. Less than 1 yr 2. 1-3 years 3. 4-9 years 4. 10 years or more
- Q008.** Have you ever received care or treatment from a health care facility for any HIV-related illnesses (like thrush, a bad cough/pneumonia or skin rash)? (circle one)
1. Yes 2. No 3. Don't Know
- Q009.** What type of health care facility do you most commonly receive care for HIV-related illnesses?
1. Government sponsored health care clinic or hospital
2. Private doctor/clinic 3. Other (please state) _____
- Q010.** How many health care facilities do you usually receive care from for HIV-related illnesses? ____
- Q011.** How often do you visit your doctor for a regular check-up?
1. Weekly 2. Monthly 3. Once every three months 4. Every 6 months
5. Once a year
- Q012.** How long have you been receiving care at your primary or main health care facility? _____ (Please state in weeks, months or years)
- Q013.** What site do you usually access care for HIV-related illnesses? _____
- Q014.** How long, on average, does it take you to travel to your primary health care facility?
1. Less than ½ hour 2. 30-45 minutes 3. 45-60 minutes
4. Over 1 hour
- Q015.** Is ART (antiretroviral therapy) treatment available at your primary health care facility?
1. Yes 2. No 3. Don't Know

Q016. Are you currently receiving antiretroviral therapy?
 1. Yes 2. No 3. Don't Know

Q016a. If no, why not?

Q017. Do you currently have health insurance?
 1. No insurance 2. Government (e.g. National Health Fund)
 3. Private (Sagicor, Guardian Life, etc)

Q018. Has your direct care provider (doctor or nurse) ever done the following at any of your visits? (**You can choose more than one response**).

	YES	NO	DK
Inform you about the pros and cons of treatment			
explain laboratory results			
given information about <u>possible side</u> effects of drugs			
given information about <u>the use</u> of your HIV medication			
breaks news gently			
takes enough time to talk with you			
allows no interruptions during your consultation (visit)			
maintains confidentiality about your HIV status			
maintain privacy in such a way you believe your conversations cannot be overheard			
allows you to express your concerns/opinions about the care received			

Q019. Have you ever [fill in from list below] because of your HIV status? (Y/N/DK) Please tick one.

	YES	NO	DK
Had a health care worker refuse to treat you or denied access to medical treatment or care.			
Experienced a delay in the provision of health services for example being treated last			
Been forced to pay additional charges/extra fees for regular medical services			
Been forced to submit to any medical health procedure or test			

Q020. How much do you agree or disagree to the following statement: ***"I trust my doctor to offer me the best care they can give"***. (circle one)

1. Strongly Agree 2. Agree 3. Neither Agree nor Disagree 4. Disagree
 5. Strongly Disagree

Q021. Overall, on a scale of 1 to 5, 1 being poor and 5 being excellent, how would you rate the quality of the medical care you have received in the past year? (circle one)

1. Poor 2. Fair 3. Good 4. Very good 5. Excellent

Thank you for taking the time to answer these questions.

Kindly be reminded that your responses will be held in strict confidence and will only be utilized for the purpose of this study.

For Interviewer's Use Only

Form completed by: Participant_____ Facilitator_____ (Initials Here)

Country:

- a. Barbados _____
 b. Jamaica : SWRHA _____ SERHA_____ WRHA_____ ERHA_____
 c. Haiti _____