

## ORIGINAL RESEARCH

# Stigma towards clients in HIV/AIDS care settings

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## ABSTRACT

Stigmatizing behaviors engaged by care providers in clinical settings represent a significant barrier to care seeking on the part of persons living with HIV. The majority of studies addressing stigma by healthcare workers has been reported in the developing world. The current study sought to determine the presence of stigmatizing thoughts and behaviors in Ryan White Care Act funded clinics across the United States. The study used a quantitative descriptive design, and included all such sights in the US and its territories. The results indicated that paraprofessional personnel were more likely to engage in thoughts and behaviors that reflect stigma. This finding is significant since these individuals are the first people who patients contact when seeking care, establishing a significant barrier to retention in care. The study reflects a need to engage education and training designed to minimize these behaviors in paraprofessionals.

**Key Words:** HIV/AIDS stigma, Stigma in HIV/AIDS service providers

## 1. INTRODUCTION

HIV has disproportionately affected highly vulnerable populations.<sup>[1]</sup> Populations living with HIV often experience intersectionality related to a variety of individual factors; for instance, race, ethnicity, socioeconomic status, drug and alcohol use status and sexual orientation, that result in stigmatization.<sup>[2]</sup> It is especially concerning when HIV care providers engage in stigmatizing behaviors, due to the potential that such behaviors will act as a barrier to maintaining patients in care.<sup>[3]</sup> The maintenance of patients in care is a key factor faced by nurses looking to improve patient outcomes. Research that explores the phenomenon of stigmatizing thoughts and behaviors by healthcare workers in HIV care settings is essential due to the many factors that influence patient engagement in care.

### 1.1 Background and significance

Stigmatization is the assigning to others via labeling, stereotyping, separation, status loss or discrimination attributes that

are deeply discrediting and reduce the recipient to one with less socially desirable attributes, and thus, less deserving of assistance.<sup>[2,4]</sup> Stigma has been defined as an individual attribute,<sup>[4]</sup> as a social process<sup>[5]</sup> and according to the role of power in subjecting individuals to stigma.<sup>[6]</sup> Stigma subjects individuals to inequitable treatment that acts as a barrier to their engaging in beneficial health behaviors.<sup>[5,6]</sup>

In this paper, HIV related stigma includes not only the stigma associated with one who is ill, but also encompasses individuals from those groups known to be at high-risk, for instance the poor, diverse racial and cultural groups, and lesbian, gay and trans-gendered people (LGBT). Stigma serves to entrench power within select social groups, and legitimize inequities, such as those based on gender, sexual orientation, class, race, or ethnicity.<sup>[6]</sup> Stigma is felt or enacted when someone, due to these attributes, is subjected to negative interactions that invariably diminish the likelihood that they will engage in care.<sup>[7]</sup> Discrimination is unjustifiably differ-

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ent treatment given to different people or groups entailing a distinction, exclusion, or restriction among persons based on their confirmed or suspected health status.<sup>[2,7]</sup> Stigma and discrimination, is comprised of assumptions made about individuals due to characteristics perceived by others whether they exist or not.

The purpose of this study was to determine the presence of stigmatizing thoughts and behaviors in health workers in Ryan White Care Act funded centers. The study team sought to gain input from workers in these care settings regardless of their profession or title. The sample included professional licensed staff as well as paraprofessional staff. The research questions were as follows:

- 1) What is the prevalence of stigmatizing thoughts and behaviors amongst professional staff members (eg physicians, nurses, social workers etc.)?
- 2) What is the prevalence of stigmatizing thoughts and behaviors amongst paraprofessional staff members (eg medical records clerks, front desk clerks, office workers, medical assistants etc.)?
- 3) Does the prevalence of stigmatizing thoughts and behaviors differ between professional and paraprofessional workers in Ryan White Care Act funded centers.

## 1.2 Review of the literature

The literature addressing HIV related stigma has focused on two general categories of studies. The two general categories of these studies are those that focus on client perception of stigma, and those that report care provider thoughts and behaviors related to stigma. Because the sample is focused on Ryan White Care Act funded centers in the US, the majority of studies included focused on US populations, except where no or limited papers were available. This is because the sociocultural aspects of stigma are significant, and are often culture-centric.

## 1.3 Studies focusing on client perceptions of stigma

There are many studies that address the experience of stigma in people living with HIV/AIDS (PLWH). These studies focus on the attributes of internalized stigma, that act to facilitate thoughts and behaviors stemming from an individual's perceptions regarding themselves, and their perception of the feelings of others towards them. The majority of studies address stigma in general terms. They integrate perceptions of stigma without specifically measuring it in healthcare settings. Holzmer et al investigated the relationship between reported stigma and quality of life in PLWH, finding that stigma accounted for 5.3% of the variability in quality of life scores, establishing stigma as a detractor to quality of life for PLWH.<sup>[8]</sup> This finding is significant since quality of

life is an important clinical outcome measure. Zukoski and Thorburn examined the experiences of PLWH living in low HIV prevalence settings.<sup>[9]</sup> This group, invariably live in settings where HIV patients are not common so people in the community and healthcare workers were less likely to have interacted with PLWH. While their study did not include a comparison group of people in a higher prevalence area, the results point to an attenuated experience with stigma, related directly to people's exposure to PLWH.<sup>[9]</sup> This established that lack of experience with PLWH among health workers is an important indication that they might act in a stigmatizing way.

Studies have addressed the experience of stigma towards men who have sex with men (MSM). Dowshen, Binns, and Garafolo studied MSM in an attempt to quantify the presence of perceived stigma in this population.<sup>[10]</sup> They found that stigma was reported often. Fears of disclosure and associated behaviors were their greatest concern for the participants. Johnson, Carrico, Chesney, and Morin and Preston et al., had similar findings, however, they found lower levels of safer sexual behaviors in heavily stigmatized persons irrespective of their level of substance use or abuse.<sup>[11,12]</sup>

There are several studies that focus on the prevalence of general stigma (not isolated to healthcare) towards women.<sup>[13,14]</sup> Logie et al. identified significant levels of stigma related to HIV status, and also identified factors such as gender discrimination, racism and homo/transphobia.<sup>[13]</sup> They indicated that women experience social isolation related to stigma. Logie et al indicated a high degree of social marginalization associated with perceived stigma.<sup>[14]</sup> Similarly, McDoon, Bokhour, Sullivan, and Drainoni identified a similar pattern in older African American women.<sup>[15]</sup> These studies illustrate a significant level of marginalization associated with perceived stigma.

Studies that reflect on perceptions of stigma in general, and in healthcare settings are represented in the literature. It is important to consider both general and healthcare stigma, as PLWH experience stigma in many aspects of their daily lives. A key area of inquiry relates to the effects of stigma on retention in care. Retention in care is a key factor in health outcomes related to PLWH, due to the chronicity of the disease. A variety of populations have been included in these studies. Kempf et al used qualitative methodology to explore the existence of barriers and facilitators to retention in care using a sample of women in the southeastern United States.<sup>[16]</sup> The study did not focus solely on stigma, but identified perceived stigma as a major detractor to retention. They included quality of the patient-provider relationship, and a variety of sociocultural and environmental factors that

negatively effect retention in care. Stigma related fears focused primarily on issues of trust, and the likelihood that the PLWH would be identified in the community, while attending treatment. Sevelius et al had similar findings in a sample of transgender PLWH.<sup>[17]</sup> This study, as well, used qualitative methods to identify barriers and facilitators to care. Like Kempf et al. and Sevelius et al identified fear of stigma as a primary factor influencing poor clinic attendance.<sup>[17]</sup> Unlike Kempf, Sevelius et al identified previous experiences with stigma in these settings as a key variable.<sup>[17]</sup> Transgendered women in the study cited a decrease in perceived stigma over the years related to the very high prevalence of HIV in their population, coupled with extensive support from their social networks over time. It appears that the newly diagnosed are more likely to experience stigma to the degree that their perceptions alter the likelihood that they will engage or remain in care.

There are several studies that address the role of stigma as a factor limiting retention in care among African American men who have sex with men (MSM). Irvin et al and Eaton et al used quantitative approaches to identify stigma related concerns in African American MSM.<sup>[18,19]</sup> Eaton et al found that 29% of the sample reported having experienced racial and sexual orientation stigma in clinical settings, with 48% reporting that they have a general mistrust of healthcare workers due to this experience and the resulting perceptions.<sup>[18]</sup> Irvin et al focused more intensely on the relationship between racial discrimination in healthcare settings.<sup>[19]</sup> Irvin et al found that approximately 20% of African American men reported that racial discrimination in healthcare settings had a significant effect on their retention in care.<sup>[19]</sup> Irvin et al included racial discrimination against family or friends in their operational definition, which may have positively inflected their reported rates.<sup>[19]</sup> While Irvin et al focused on racial discrimination, Arnold, Rebchook, and Kegles focused on a more universal definition of stigma in their qualitative study.<sup>[19,20]</sup> Arnold, Rebchook and Kegles and Galvan, Davis, Banks, and Bing similarly found that perceived racial discrimination was a considerable barrier to care.<sup>[20,21]</sup> Additionally, they found that African American MSM experience significant feelings related to general HIV stigma and homophobia when attending HIV care settings.

Bauman et al and Remien et al. performed studies that included multiple vulnerable populations.<sup>[22,23]</sup> Their findings were similar to the aforementioned studies, and reflect that perceived stigma is a powerful deterrent to entering or remaining in care irrespective of group identification. This demonstrated that, while a variety of factors influence retention in care, stigma in healthcare settings remains a powerful detractor from clinical outcomes. None of the studies ad-

ressing perceptions of stigma identified any specific group of individuals engaging in these behaviors (eg, Physicians, nurses, social workers, etc.).

#### **1.4 Studies focusing on stigmatizing thoughts and behaviors reported by providers**

There are fewer studies in the literature that address stigmatizing thoughts and behaviors by HIV service providers. These behaviors are the central component of structural stigma, which reflects on the legitimization and perpetuation of stigmatized status by institutions within a society.<sup>[24]</sup> Levy et al identified this form of stigma as a leading detractor to engaging in preventative care or treatment in HIV care settings, and within the community.<sup>[25]</sup> Researchers have reported the interaction between structural attributes of organizations that act as barriers to care, stigma and fear and suspicion on the part of clients as significant detractors to care.<sup>[26,27]</sup> The determination of the existence of these internalized behaviors is essential to determining the extent and nature of stigma in healthcare settings.

There are a variety of studies in the international context that address stigma from the point of view of service providers. In these studies, the cultural milieu is such that HIV service providers appeared to more freely voice the presence of stigmatizing thoughts and behaviors. These studies identified the manifestations of healthcare provider stigma in the Western Caribbean,<sup>[28,29]</sup> in Haiti,<sup>[30]</sup> in Nigeria,<sup>[31]</sup> and in Mozambique.<sup>[32]</sup> It is important to note that these studies were performed in lesser developed nations with very distinct cultural histories.

Studies that address the U.S. that directly identify stigmatizing thoughts or behaviors on the part of healthcare workers are absent. There have been several studies that present means of measuring stigma in healthcare workers, without reporting the actual prevalence of these thoughts and behaviors. Rutledge, Whyte, Abell, Brown, and Cesnales developed the HIV Provider Stigma Inventory (HAPSI), which was designed to measure stigma related constructs.<sup>[33]</sup> The instrument focused on awareness, acceptance and action as components of stigma related behaviors. Their study quantified the psychometric qualities of the instrument, and established its reliability and validity. Wagner, Hart, McShane, Margolese, and Girard reported a similar study that used a 'ground up' qualitative approach to developing survey items.<sup>[34]</sup> Similar to Rutledge et al; Wagner et al focused on behaviors related to stereotyping, prejudice and discrimination.<sup>[33,34]</sup> Rutledge et al. included these constructs as sub-constructs of the awareness, acceptance and action model used in their study.<sup>[33]</sup> While these studies focused on stigma related constructs, they did not directly report rates of stigmatizing

thoughts and behaviors.

There are studies that address components of structural stigma. Knight, Shoveller, Carson, and Contreras-Whitney studied the provision of services based on clinicians experiences in providing services to LGBT people, using a qualitative approach.<sup>[35]</sup> They cited a primary barrier to service provision, the lack of sufficient training of LGBT people related to sexual health. They further found that institutional norms and policies represented significant barriers to service provision. This study provided an interesting viewpoint that indicates the existence of structural inequities that negatively influence service provision in a group that shares heavily in the sort of stigma that PLWH are exposed to.

Belenko et al examined HIV stigma in workers within prisons and jails.<sup>[36]</sup> Their approach was important to the current study, because they included trained healthcare professionals and non-healthcare staff. The study focused primarily upon prejudice and discrimination in prisons. They found a clear differentiation in thoughts and behaviors when comparing these two groups. The corrections workers (guards) commonly voiced stigmatizing thoughts and behaviors, whereas, the healthcare workers did not. Furthermore, the healthcare workers in the sample affirmed that they knew of the existence of stigma in corrections workers. This work is significant due to its focus on staff types, which is very similar to the approach in the current study.

## 2. METHODS

The study used a quantitative descriptive design, based on a nation-wide survey of Ryan White Care Act funded HIV care settings. Those that elected to participate selected a link included in an e-mail introducing the study that directed them to a Qualtrics™ based version of the HIV/AIDS Provider Stigma Inventory (HAPSI). The data gained from the survey allowed us to examine the presence of stigmatizing thoughts and behaviors in the employees of these centers. This approach allowed the project team to create a model that reflects the likelihood that people living with HIV/AIDS will experience stigma at various points in the care administration process. This was the first nation wide survey of its kind.

Workers at Ryan White Care Act funded sites were the target sample for the study. The Health Resources and Services Administration (HRSA) maintain a comprehensive list of grant-funded agencies across the country that includes contact information for the leadership teams at the respective agencies. We forwarded an introductory e-mail to each of the directors, with a request that they forward the questionnaire to all of the workers at their institution. The study targeted professional staff members as well as paraprofessional staff

members.

Professional staff members were those from professions such as nursing, social work and medicine who are licensed and have broad professional preparation for practice. Paraprofessional staff members are those whose positions do not require education beyond a technical school setting.

The instrument for the study was the HIV/AIDS Provider Stigma Inventory. HAPSI was designed to measure the degree of stigmatizing thoughts and behaviors by individuals working in HIV care settings.<sup>[33]</sup> Initial validation of the HIV/AIDS Provider Stigma Inventory (HAPSI) was based on a pilot sample of 174 nursing students, supported the psychometric qualities of a suite of measures capturing tendencies to stigmatize and discriminate against people living with HIV/AIDS (PLWH). Derived from social psychology and mindfulness theories, separate scales addressing awareness, acceptance, and action were designed to include notions of labeling, stereotyping, out grouping, and discriminating. These were enhanced to capture differences associated with personal characteristics of PLWA that trigger secondary stigma (e.g., sexual orientation, injection drug use, multiple sex partners) and fears regarding instrumental and symbolic stigma. Reliabilities were strong (coefficients  $\alpha$  for 16 of 19 resulting measures ranged from 0.80 to 0.98) and confirmatory factor analyses indicated good model fit for two multidimensional (Awareness and Acceptance) and one unidimensional (Action) measure. Evidence of convergent construct validity supported accuracy of primary constructs. Implications for training and professional socialization in health care are discussed.<sup>[33]</sup>

Human subjects committee approval at the university where the study was gained prior to data collection. Given the highly sensitive nature of the thoughts and behaviors that comprise stigma it was essential that participant responses be confidential. For this reason, we maintained absolute anonymity. The Qualtrics™ survey did not record any information that could be used to attribute answers to a single person or agency. Only group data are reported in the study, in order to prevent employees at an individual center from being brought under scrutiny.

Data analysis for the study was conducted based upon the research questions for the study. Demographic variables were reported using descriptive statistics. HAPSI related variables, items and subscales were reported initially by calculating mean and standard deviation scores for gross comparison. Independent samples *t*-tests were then used to compare group means according to profession and/or professional group.

### 3. RESULTS

The sample (N = 400) included 296 females (74.0%) and 104 males (26%). There were no transgendered people in the sample. Table 1 reflects the professional characteristics of the participants. It is important to note the inclusion of the range of nursing, allied health, mental health and administrative workers included in the sample. All told, the sample offers a wide representation of the staff members within Ryan White Care Act funded facilities. It is important to note that highly trained professional staff responded in far greater numbers than paraprofessional staff. The reason for this is outside of the purview of the study.

It was important to establish the internal consistency of the instrument since its original testing was done on a sample of nurses, rather than an interprofessional group (Rutledge, Whyte, Abell, Brown, & Cesnales, 2011).<sup>[33]</sup> Cronach’s Alpha was calculated for the instrument with a score of  $\alpha = 0.965$ , which was consistent with the scores reported by Rutledge et al. (2011).<sup>[33]</sup>

Table 2 was compiled for the purpose of gross comparison. It lists several of the representative professionals and their corresponding scores on the subscales. A general trend arose here. Highly educated and licensed individuals (Nurses, Social Workers, Physicians) manifested lower scores related to negative stigma related behaviors, and higher scores in positive behaviors (action). The trend for the data indicated better cores related to awareness and acceptance for professional staff, with lesser differences in the area of action. This indicates that while there were broad differences in thought, the differences related to action were less profound. The data also indicated that the highly educated and licensed personnel worked in healthcare and more specifically HIV care for far longer periods of time than their paraprofessional counterparts. The data presented in Table 2 indicates a dichotomy where higher levels of education and training and a greater span of practice appear to differentiate these groups.

In Table 3, participants were grouped for the purpose of comparison. Professional staff were those who were highly educated (Nurses, Social Workers, Physicians, Administrators), while paraprofessional staff were the less educated personnel (Front desk clerks, medical records clerks, medical assistants). Table-3 reflected a statistically significant trend across all subscales indicating that paraprofessionals were more likely to exhibit stigmatizing thoughts or engage in stigmatizing behaviors when compared to their more highly educated counterparts. This included all of the awareness and acceptance subscales. In a similar manner to Table-2, the group data reflected less profound, although statistically significant, differences related to the likelihood of engaging

in stigmatizing actions. Conversely, professional personnel reported a greater willingness to engage in positive actions with regards to PLWH. This difference was significant as it indicated that the very people that PLWH encounter first in clinical settings are most likely to discriminate or stigmatize. The professional staff reported working in healthcare for significantly longer than paraprofessional staff, whether considering general work in healthcare or work in HIV care settings ( $p < .001$ ). Again, this finding reinforces the individual group differences seen in Table 2.

**Table 1.** Participant professions

Profession	Frequency	Percentage
Social Worker	60	15%
Physician	46	11.5%
Leadership/Administration	45	11.3%
Case Manager	43	10.8%
Registered Nurse	37	9.3%
Front Desk Worker	36	9.0%
Psychiatric/Mental Healthcare Provider	27	6.8%
Nurse Practitioner Midwife	24	6.0%
Medical Assistant	23	5.8%
LPN/LVN	15	3.8%
Physician Assistant	10	2.5%
Client advocate-Peer counselor	10	2.5%
Medical Records/Patient administration	8	2.0%
HIV Educator	4	1.0%
Researcher	4	1.0%
Dietician	4	1.0%
Pharmacist	4	1.0%

### 4. DISCUSSION

The discussion will be conducted based upon the research questions for the study. The first research question sought to determine the prevalence of stigmatizing thoughts and behaviors amongst professional staff members? The data indicated that highly educated personnel such as Physicians, Nurses, Social Workers, Pharmacists, and Mental Health Professionals displayed a low prevalence of negative thoughts with regards to their PLHA clientele. Conversely, they displayed a high likelihood of engaging in actions of a positive nature, within the HIV positive community. Similar results were found by Rogers et al which indicated an increase in comfort and attitude among dental students working with PLWH after specialized training for working with PLWH.<sup>[37]</sup> While the literature indicates the presence of behaviors such as those measured by HAPSI,<sup>[2,3]</sup> the current sample revealed no such trend. The majority of the literature focused on the presence of these behaviors in clinicians has been conducted in the developing world. The results of the current study

did not indicate any of the detrimental behaviors reported in studies outside of the US.<sup>[35]</sup> It is important, however, to emphasize the fact that there are very few studies of this nature in the US context. More recently, Davtyan, Olensky, Brown and Lakon examined HIV provider stigma in the US

using a Grounded Theory approach. While their study did not differentiate professional and paraprofessional staff, their findings offered support for the notion that their remains a deeply ingrained negative feeling towards PLHA based upon misrepresentations of PLHA.<sup>[38]</sup>

**Table 2.** Participant Scores on HAPSI Subscales and other Metrics

	Social Worker (N = 60)	Registered Nurse (N = 37)	Physician (N = 46)	Medical Records/Patient Admin (N = 8)	Medical Assistant (N = 23)	Front desk clerk/ receptionist (N = 36)
Awareness Global	1.45 (SD .55)	1.22 (SD .23)	1.75 (SD .50)	1.85 (SD 1.16)	3.11 (SD 1.02)	2.30 (SD 1.16)
Awareness Label	1.18 (SD 1.16)	1.03 (SD .16)	1.09 (SD .21)	1.82 (SD 1.16)	2.16 (SD .99)	1.86 (SD .96)
Awareness Label-associate	1.16 (SD .30)	1.00 (SD 0)	1.16 (SD .35)	1.72 (SD 1.01)	2.07 (SD .94)	1.76 (SD 0.94)
Awareness Label Instrumental	1.1 (SD .25)	1.03 (SD .16)	1.04 (SD .14)	1.88 (SD 1.25)	2.10 (SD .94)	1.98 (SD 1.12)
Awareness Label Symbolic	1.28 (SD .64)	1.05 (SD .33)	1.07 (SD .16)	1.88 (SD 1.24)	2.32 (SD 1.14)	1.84 (SD .99)
Awareness Stereotype	1.67 (SD .75)	1.34 (SD .37)	2.21 (SD .84)	1.88 (SD 1.18)	3.93 (SD 1.42)	2.56 (1.32)
Awareness Stereotype-Gay	1.23 (SD .37)	1.03 (SD 0.16)	1.53 (SD .93)	1.88 (SD 1.25)	3.29 (SD 1.29)	2.58 (SD 1.37)
Awareness Stereotype-IDU	2.18 (SD 1.25)	1.56 (SD .54)	2.53 (SD 1.29)	1.94 (SD 1.21)	4.33 (SD 1.96)	2.36 (SD 1.12)
Awareness Stereotype MSP	1.35 (SD .48)	1.25 (SD .35)	2.24 (SD 1.11)	1.80 (SD 1.15)	3.83 (SD 1.42)	2.77 (SD 1.70)
Awareness Out Group	1.55 (SD .61)	1.41 (SD .46)	1.65 (SD .83)	1.55 (SD .61)	2.70 (SD 1.22)	2.14 (SD 1.16)
Awareness Discriminate	1.16 (SD .34)	1.10 (SD .33)	1.11 (SD .28)	1.81 (SD 1.19)	2.82 (SD .93)	1.92 (SD .32)
Awareness Discriminate Instrumental	1.11 (SD .28)	1.19 (SD .46)	1.21 (SD .57)	1.88 (SD 1.25)	3.04 (SD .84)	2.39 (SD .40)
Awareness Discriminate Symbolic	1.22 (SD .58)	1.01 (SD .05)	1.00 (SD 0)	1.75 (SD 1.16)	2.59 (SD 1.10)	2.29 (SD 2.08)
Acceptance Global	2.56 (SD 1.77)	1.77 (SD .95)	2.05 (SD 1.48)	2.27 (SD 1.40)	2.48 (SD 0.82)	2.29 (SD 1.57)
Acceptance Label	2.96 (SD 1.80)	2.59 (SD 2.35)	2.34 (SD 1.49)	2.47 (SD 1.73)	3.63 (SD 1.44)	2.70 (SD 1.71)
Acceptance Stereotype	2.29 (SD 2.17)	1.06 (SD .15)	2.11 (SD 1.46)	2.02 (SD 1.22)	2.65 (SD .79)	2.27 (SD 1.39)
Action	5.73 (SD 1.26)	6.02 (SD 1.51)	5.05 (SD 1.90)	4.97 (SD .96)	4.73 (SD 1.57)	5.11 (SD 1.57)
Years Worked in Healthcare	9.16 (SD 7.26)	24.43 (SD 11.37)	21.67 (SD 8.63)	3.63 (SD 3.96)	5.71 (SD 5.85)	7.84 (SD 9.96)
Years Worked in HIV Specific Care	8.05 (SD 6.74)	11.86 (SD 6.92)	18.74 (SD 8.65)	1.63 (SD 1.06)	3.50 (SD .45)	5.50 (SD 6.08)

The second research question sought to determine the prevalence of stigmatizing thoughts and behaviors amongst paraprofessional staff members. The current study is one of the first to include this population as a discrete group within the clinical setting. The research team felt that it was important to include the array of workers who have patient contact,

even when they are not direct care providers. The results indicated high levels of stigmatizing thoughts and behaviors in this group, as compared with professional staff members. In particular, Medical Assistants manifested higher scores when compared to medical records, patient administration, and receptionists/front desk workers. There were not any US

studies to compare these results to in a direct manner. Belenko et al; however, explored the thoughts and behaviors of

jail workers. They found that professional medical staff did not manifest stigmatizing behaviors, while guards and other paraprofessional staff displayed higher levels of stigma.<sup>[36]</sup>

**Table 3.** Professional versus Paraprofessional Comparison on HAPSI Subscales and select variables

	Professional Staff (N = 334)	Para-Professional Staff (N = 66)	t-score	Significance
Awareness Global	1.46 (SD .57)	2.58 (SD 1.19)	-11.011	.001
Awareness Label	1.23 (SD .84)	1.98 (SD .99)	-6.256	.001
Awareness Label-associate	1.21 (SD .84)	1.88 (SD .96)	-5.821	.001
Awareness Label Instrumental	1.22 (SD .81)	2.02 (SD 1.07)	-6.635	.001
Awareness Label Symbolic	1.25 (SD .88)	2.02 (SD 1.09)	-6.185	.001
Awareness Stereotype	1.81 (SD 1.04)	3.03 (SD 1.49)	-7.735	.001
Awareness Stereotype-Gay	1.42 (SD .97)	2.80 (SD 1.39)	-9.615	.001
Awareness Stereotype-IDU	2.05 (SD 1.23)	3.06 (SD 1.77)	-5.556	.001
Awareness Stereotype MSP	1.64 (SD 1.06)	3.12 (SD 1.67)	-9.167	.001
Awareness Out Group	1.71 (SD .97)	2.35 (SD 1.21)	-4.636	.001
Awareness Discriminate	1.16 (SD .44)	2.56 (SD 1.6)	-13.527	.001
Awareness Discriminate Instrumental	1.30 (SD .90)	2.74 (SD 1.92)	-9.328	.001
Awareness Discriminate Symbolic	1.15 (SD .56)	2.38 (SD 1.74)	-10.459	.001
Acceptance Global	2.03 (SD 1.50)	2.39 (SD 1.34)	-1.761	.079
Acceptance Label	2.48 (SD 1.82)	3.07 (SD 1.68)	-2.395	.017
Acceptance Stereotype	2.08 (SD 1.65)	2.41 (SD 1.21)	-1.500	.134
Action	5.56 (SD 1.54)	4.92 (SD 1.53)	3.400	.001
Years Worked in Healthcare	17.20 (SD 11.45)	6.82 (8.43)	6.34	.001
Years Worked in HIV Specific Care	11.71 (SD 8.87)	4.42 (SD 4.90)	6.85	.001

The third research question sought to determine the differences between the presence of stigmatizing thoughts and behaviors in professional and paraprofessional workers in Ryan White Care Act funded centers. The results indicated a statistically significant difference between the professional and paraprofessional groups across the subscales of HAPSI. This finding emphasizes the key result of the study, in that it is the first to offer a plausible examination regarding who in these clinical settings is most likely to subject PLWH to stigma. The Belenko et al study results mirrored those of the current study, with higher rates of negative behaviors towards PLWH on the part of the non-professional personnel (guards etc.)<sup>[36]</sup> The existence of these behaviors in this population is important. Essentially, a patient must see someone at the front desk, check out their medical record, and be triaged by a Medical Assistant, prior to visiting with professional/licensed staff members. The results suggest that patients at these clinics may well have been subjected to stigma prior to their interaction with professional staff, representing the sort of barriers that are common in the literature.<sup>[2, 3, 13, 14]</sup> These findings explain the presence of significant barriers

that were not attributed to any particular professional group in this practice setting.<sup>[11, 12]</sup>

**4.1 Study limitations**

The study sought to gain a national sample. The primary study limitations was related to the response rate amongst professionals as compared to paraprofessionals, the lower response rate among paraprofessionals may have skewed the results. It is predictable that more educated licensed professionals would respond at higher rates.

**4.2 Implications for clinical practice**

The results of the study indicate a definite need for interventions designed to acclimate paraprofessionals when they enter HIV care settings. Their limited training and experience related to PLWH places them at greater risk of displaying negative behaviors. Education has been known to be a key factor in efforts to address the needs of PLWH and is an essential element in addressing the problem of stigma in care settings. The paraprofessionals were allowing their own biases to cloud their perceptions and interactions with PLWH. What is most concerning is that the paraprofessionals are the

first to engage with PLWH. If stigma is perceived at these first encounters, how can a truly comfortable and nurturing environment be created among this vulnerable population? A viable solution may lie in specialized training and a focus on HIV/AIDS education for paraprofessionals regarding perceived feelings of stigma among PLWH. Eliminating negative thoughts and feelings from paraprofessionals has the potential to eliminate barriers associated with PLWH to seek care. Through decreasing paraprofessional's negative feelings towards PLWH a welcoming environment can be the first one they encounter.

## 5. CONCLUSION

The current study illustrated the need for additional studies to examine the presence and extent to which stigma exists among paraprofessionals and professionals that care for PLWH. While it is reassuring to know that professionals that

provide care for PLWH had the highest scores for positive attitudes towards PLWH, it is disheartening that the health care workers with the initial contact begin with a negative encounter. The lack of literature regarding this concept demonstrates the assumption that any level of healthcare worker will provide care to those free of feelings of stigma, discrimination, or prejudice. If we are to optimize the health of PLWH we must address human biases and stigma, which negatively impact the health care of PLWH. Studies are needed to determine the type of modalities that will ease the existing stigma towards PLWH. Through concerted efforts of all members of the health care team PLWH may experience a sense of comfort for accessing care, which in turn will lead to an increased positive outcome.

## CONFLICTS OF INTEREST DISCLOSURE

The author declares that there is no conflict of interest.

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