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Original article

Stigma Reduction Training Improves Healthcare Provider Attitudes Toward, and Experiences of, Young Marginalized People in Bangladesh

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A B S T R A C T

Purpose: Working with health providers to reduce HIV stigma in the healthcare setting is an important strategy to improve service utilization and quality of care, especially for young people who are sexually active before marriage, are sexual minorities, or who sell sex. A stigma reduction training program for health providers in Bangladesh was evaluated.
Methods: A cohort of 300 healthcare providers were given a self-administered questionnaire, then attended a 2-day HIV and sexual and reproductive health and rights training (including a 90-minute session on stigma issues). Six months later, the cohort repeated the survey and participated in a 1-day supplemental training on stigma, which included reflection on personal values and negative impacts of stigma. A third survey was administered 6 months later. A cross-sectional survey of clients age 15–24 years was implemented before and after the second stigma training to assess client satisfaction with services.
Results: Provider agreement that people living with HIV should be ashamed of themselves decreased substantially (35.3%–19.7%–16.3%; $p < .001$), as did agreement that sexually active young people (50.3%–36.0%–21.7%; $p < .001$) and men who have sex with men (49.3%–38.0%–24.0%; $p < .001$) engage in “immoral behavior.” Young clients reported improvement in overall satisfaction with services after the stigma trainings (63.5%–97.6%; $p < .001$).
Conclusions: This study indicates that a targeted stigma reduction intervention can rapidly improve provider attitudes and increase service satisfaction among young people. More funding to scale up these interventions is needed.
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IMPLICATIONS AND CONTRIBUTION

Results indicate that health provider attitudes toward young people living with HIV and marginalized, or “key,” populations can be improved with focused stigma reduction interventions in Bangladesh. Investments in health provider stigma reduction trainings have broader potential to increase young client satisfaction with, and uptake of, HIV and SRHR services.

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Stigma and discrimination can inhibit the uptake of HIV and sexual and reproductive health and rights (SRHR) services, particularly among adolescents and young people who need to access these services [1–4]. In many settings, for example, cultural or societal norms dictate that young people should not be sexually active outside of marriage, which results in their avoidance of seeking family planning services [5–7]. When they do access services, young people often experience stigma from healthcare providers when they are perceived to be engaging in such behaviors [8–10]. Additionally, stigma can be especially problematic for some subgroups of young people, such as female sex workers or men who have sex with men (MSM), who are often victimized by violence or discrimination in community settings [11–13]. This contributes toward young MSM and female sex workers experiencing a higher burden of disease compared to adults in these subgroups and to young people in the general population [1].

Evidence suggests that stigma can be manifested in two primary ways among healthcare providers. One is an exaggerated fear of contracting the HIV virus itself, which has been associated with discrimination in some studies [14,15]. A provider's personal cultural and/or moral judgments of, and attitudes toward, populations at risk of and living with HIV can also result in stigma and/or discrimination [8,9]. This can contribute to negative impacts on HIV-related knowledge, HIV test results disclosure, social support, physical health, mental health, and antiretroviral treatment adherence [16–19]. Therefore, working with health providers to reduce stigma (defined as a process of devaluation and expressed through negative attitudes) and discrimination (defined by actions and also known as enacted stigma) in the healthcare setting is one strategy to improve service utilization and quality of care [20,21].

In Bangladesh, a few studies have documented interactions between health service providers and people living with HIV (PLHIV). High levels of discriminatory behavior by health workers were reported [22,23], as well as avoidance of health seeking due to fear of potential discrimination by PLHIV [24]. Correlates of stigmatizing attitudes by service providers toward PLHIV in Bangladesh include poor knowledge of HIV and rating religion of high importance in their personal lives [25]. Despite limited data on provider attitudes toward highly stigmatized populations in Bangladesh, some studies have reported that social stigma (unrelated to HIV) toward sex workers [26], MSM [27], and transgender people (hijra) [28] exists and inhibits trust between clients and providers.

Overall, HIV prevalence among the "general" population in Bangladesh is low at less than .1% [29], but notably higher among marginalized, or "key," populations. In 2011, for example, HIV prevalence was .5% among street-based female sex workers, .2% among hotel-based sex workers, and 1.0% among hijra in Dhaka [30]. Active syphilis was reported in as high as 12.5% among sex workers and 1.5% among MSM and 4.2% among male sex workers [30]. Higher HIV prevalence among these key populations (compared with the general population) is also reported in neighboring countries in Asia—for example in India, HIV prevalence is also <1% overall, yet reported to be 4.4% among MSM and 2.8% among female sex workers [31]. The potential for an increase in HIV incidence among young marginalized populations in Bangladesh reinforces the need to sensitize health service providers and minimize HIV-related stigma in healthcare settings.

Reviews have concluded that interventions—including staff training, facility policy development, and provision of necessary supplies—can be effective at reducing service provider stigma in a variety of global settings [8,32,33]. For example, studies have reported significant reductions in HIV-related stigma (e.g., fear of touching PLHIV, belief that HIV is punishment for bad behavior) in Vietnam [15] and China [34]. In Bangladesh, however, there is little documentation in the literature on stigma reduction interventions for healthcare providers related to key populations and/or young people. There is even less literature that examines changes in young client satisfaction corresponding with stigma reduction interventions.

Methods

In response to the above concerns, a stigma reduction training program for service providers in Bangladesh was designed and implemented. This study aimed to assess the effects of the stigma reduction trainings on service provider attitudes, as well as young client satisfaction with services.

Study setting

The training program took place within the context of the "Link Up" project. The Link Up project took place in five countries (including Bangladesh) and provided age-appropriate information and services to enhance existing SRHR and HIV initiatives addressing the needs of young people at risk—and affected by—HIV from 2014 to 2016. In Bangladesh, Link Up implemented a range of facility- and community-based integrated HIV and SRHR activities targeting young people (ages 10–24 years). In particular, the program focused on reaching young people at higher risk of stigmatization due to living with HIV and/or being a sexually active young person prior to marriage, sex worker, MSM, or transgender person [35]. Additionally, Link Up provided outreach services to two additional populations perceived in Bangladesh to engage in risky sexual behaviors: young garment factory workers and young people who spend much of their time engaging in street-based social and/or income generating or begging activities (often referred to as "pavement-dwelling" people) [36].

Study population, design, and data collection

Provider cohort. In 2014 and 2015, Marie Stopes Bangladesh (MSB), in partnership with Link Up, trained over 1,000 of their healthcare providers on youth-focused SRHR (including doctors, paramedics/nurses, and counselors). These providers were working at 270 MSB health service facilities in 38 target districts in Bangladesh. These included providers working in MSB comprehensive clinics as well as MSB-supported youth-friendly satellite and outreach services. Most MSB service providers were managing both young and adult clients, but the Link Up trainings were designed to train the providers to offer services more accessible and acceptable to young people. During a 6-month period (July 2014 to January 2015), all MSB providers who were scheduled to receive Link Up training were invited to participate in the study. Recruitment was stopped after 400 participants were recruited. Those who consented to participate were given a self-administered questionnaire measuring stigmatizing attitudes toward young populations. The service providers then received the initial 2-day HIV and SRHR training, including a

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