SAMPLE APPLICATION-

FOR ILLUSTRATIVE PURPOSES ONLY

HYPOTHETICAL

Intervention Package for TB stigma Reduction in the Health Workforce

Introduction

The Intervention Package on TB Stigma Reduction in the Health Workforce is one intervention package within KNCV's The Tool Box on TB Stigma Reduction Interventions. The Tool Box will provide theory-driven and pragmatic packages of interventions that address TB stigma in specific groups and settings.

Theoretical Background

Reducing stigma at organizational/ institutional levels requires addressing stigma from multiple perspectives i.e. addressing structural stigma and enacted forms of stigma in a comprehensive manner. Structural stigma comprises stigma in norms, discourses and policies and infrastructure. Enacted stigma includes stigmatization of TB patients by health care workers (HCW), stigmatization of TB patients by the community, stigmatization among TB patients, stigmatization among health care workers ("dirty work stigma") and self-stigma of both patients and HCW (Figure 1).

Figure 1: Simplified Theoretical Framework

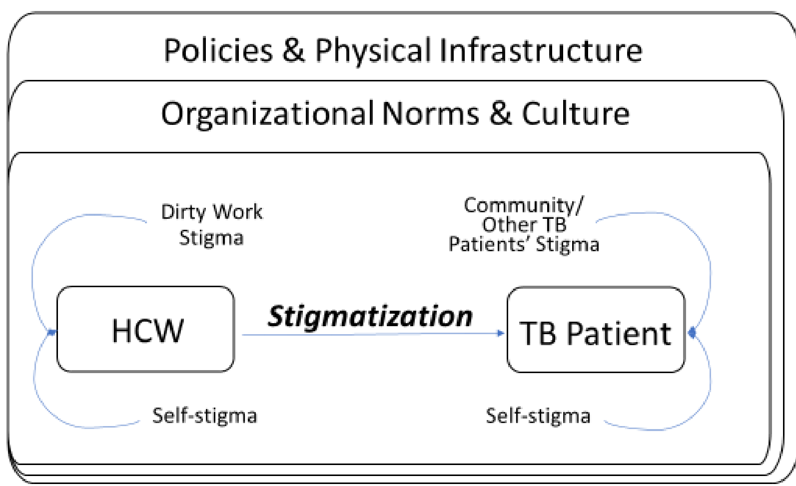


Figure 1. Levels of stigma in health care facilities

The Intervention Package will provide a comprehensive tool to reduce stigmatization of TB patients by the health care workforce. The package will address the two main types of stigma: ***fear based-stigma*** which is

a result of fear of contracting TB and ***value-based stigma*** which stems from the association of TB with disvalued characteristics and blaming patients for their disease.[1] Also, the intervention package will aim to address individual causes (***drivers***), attitude/ behavioral consequences (***manifestation***) and structural enforcements (***facilitators***) of stigmatization by HCW (figure 2).

Drivers of stigma

The main drivers of fear-based stigma are lack of knowledge regarding routes of infection and perceived contagiousness. [1] However, also among persons with good TB knowledge the perceived risk of infection may lead stigmatization of TB patients.[1,2] In health care workers (HCW) the perceived risk of infection may stem from awareness of infectiousness and routes of transmission in combination with lack of knowledge on risk of infection[3], duration of infectiousness and curability of (MDR) TB. The main driver of value-based stigma is the linkage of TB to disvalued characteristics including malnutrition, poverty, low social class, drinking alcohol, smoking tobacco and visiting sex-workers. Further, HIV is often linked to TB resulting in the transfer of HIV-associated stigma to TB patients.[1,3]

Manifestations of stigma

Manifestations of fear based stigma are (over-)use of infection control measures, breaches of confidentiality and neglect/avoidance behavior. Infection control measures including masking, wearing gloves and separation from other patients represent isolation and exclusionary practices. They enhance fear of the disease and make patients ashamed of being ill.[4,5] Evidently, infection control measures are essential for the protection of other patients at the health care facility and the protection of the HCWs.[6] For the development of intervention it will be essential to distinguish between legitimate pre-cautions and stigmatizing measures.[4] Further, it will be necessary to find a way how patients perceive legitimately applied precautions, such as masking during the period the patient is infectious, as less stigmatizing. [7] The application of infection control measures may, unintendedly, lead to breaches of confidential which leads to patients feeling discriminated[8]. When TB patients, for instance, are treated in special clinics or rooms, care seeking itself can reveal their disease.[9] Fear of infection may also lead to neglect and avoidance behavior which makes patients feel ashamed of their disease and affect their confidence.[4,10]

Manifestations of value-based stigma include negative and disvaluing attitudes and behavior towards TB patients, use of value-laden terminology and gossiping. Attitudes of HCW towards TB patients have been described as demeaning[4] and may also reflect disgust and disdain.[10] Stigmatizing behavior may include rudeness, insensitivity, name-calling, purposefully discriminatory actions (microaggressions).[11] Discriminating behavior and insensitivity has previously been described in TB patient care: breaches of trust and confidentiality [9] as well as authoritarian treatment supervision is leaving the patient feel humiliated [12–14]. Combined with a negative attitude such behavior may result in a poor patient provider relationship.[15] Use of value-laden TB terminology, such as ‘defaulter’ and ‘suspect’ place blame on the patient, even though they have been used for decades in relation to TB.[16] Gossip among HCWs may be another result of a negative attitude towards TB patients as gossip is also often evoked by negative attitudes is the community.[3]

Facilitators of stigma

Structures that may favor stigmatization of TB patients by HCW include health care facility policies, (physical) infrastructures, organizational norms and culture, employee hierarchies and negligence of HCW well-being. Policies on HCW training/ education, infection control, confidentiality, treatment supervision and use of value-laden terminology; distinct TB rooms/ buildings, and messaging (signs, posters); the organizational learning culture, and acceptance of stigmatizing attitudes and behavior may all foster TB stigma. The lack of attention to health care worker well-being may also reduce HCW empathy and solidarity towards TB patients. Aspects influencing HCW well-being include CHW rights protection, job security for HCW with TB disease, work-load and burn-out, turn-over rates of HCW and "dirty work stigma". Dirty work stigma refers to the stigmatization of HCW themselves due to their association with TB disease. Disparagement of HCWs, may in turn increase HCWs' stigmatizing behavior towards TB patients.[17–19] Official hierarchies among health care facility employees may enforce dirty work stigma.

Figure 2: Relationship between Drivers, Facilitators and Manifestations of TB stigma

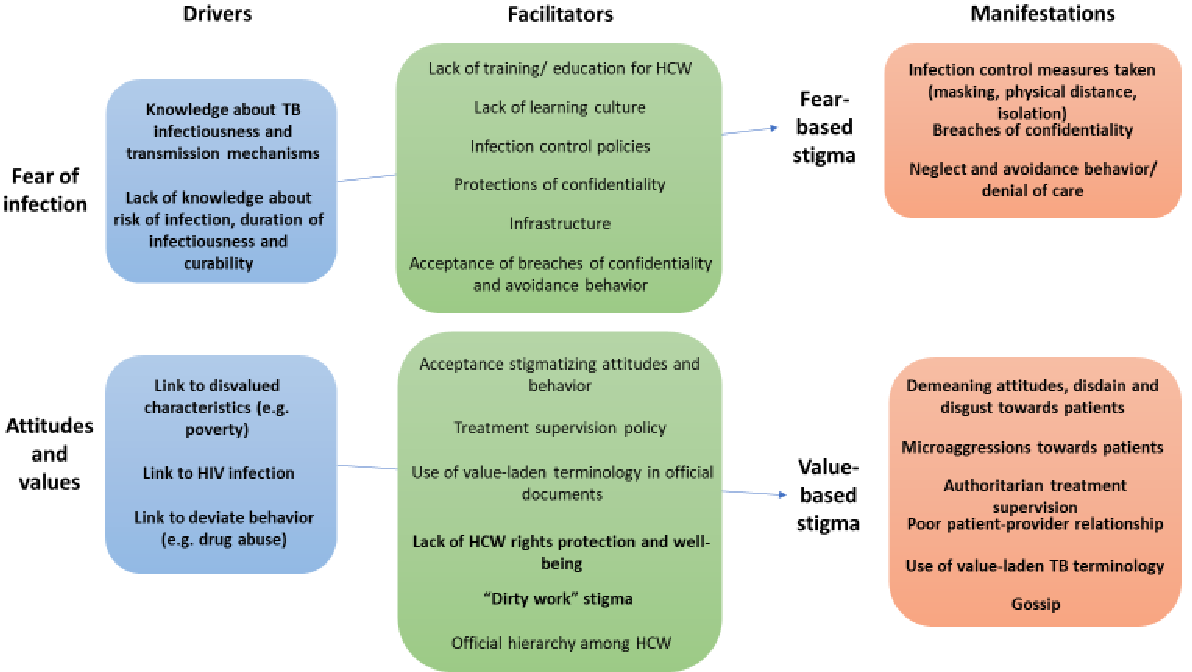
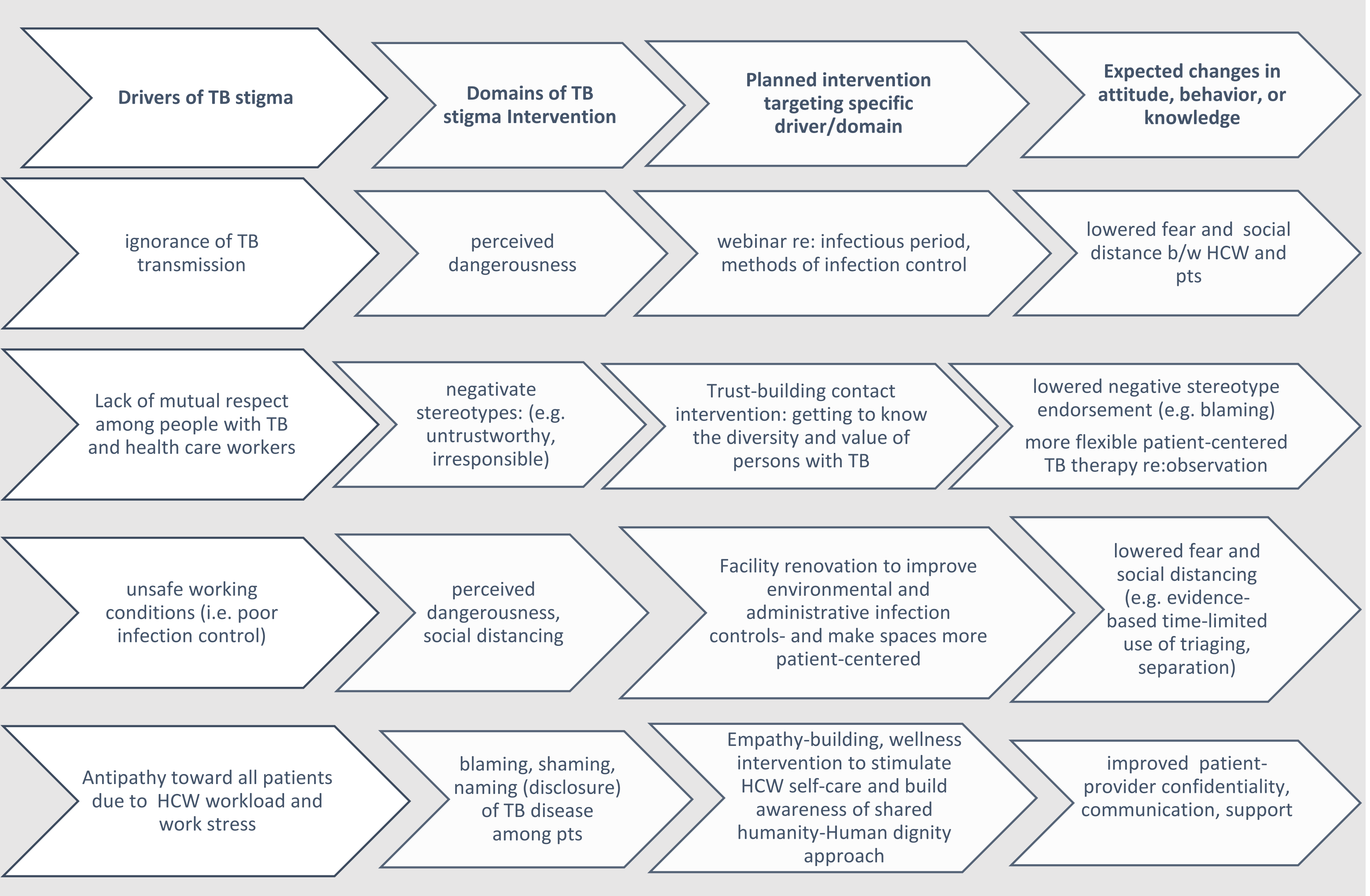


Figure 3: Conceptual Framework of The Stigma Reduction Intervention Package



Intervention package

In Figure 4, please summarize how the experiences (or activities) in the intervention package align with the aims of the intervention and KNCV's 3H approach.

Figure 4: Illustrative Matrix of Intervention Modalities and Aims

	Watching	Listening	Reflecting	Writing	Trying out	Teaching back	Reinforcing
Aims of the Intervention							
CHANGE HOW THEY FEEL	Trust-building contact intervention: getting to know the diversity and value of persons with TB				Trust-building contact intervention: getting to know the diversity and value of persons with TB		
	Empathy-building, wellness intervention to stimulate HCW self-care and build awareness of shared humanity				Values clarification attitude transformation training		Empathy-building,HCW wellness intervention to stimulate HCW self-care and build awareness of shared humanity

CHANGE HOW THEY THINK					Human dignity approach		
IMPROVE WHAT THEY KNOW	webinar re: infectious period, methods of infection control						
IMPROVE THE ENABLING ENVIRONMENT							Facility renovation to improve environmental and administrative infection controls- and make spaces more patient-centered

In figure 3, please indicate the potential delivery modes of specific parts of the intervention. This figure gives reviewers a sense of the feasibility, cost, and acceptability of the proposed package.

Figure 3: Illustrative Matrix of Intervention Delivery mechanisms

		Self	Dyad	Group
Aims of the Intervention				
	CHANGE HOW THEY FEEL			Contact interventions
				Values clarification attitude transformation training
	CHANGE HOW THEY THINK	HCW wellness intervention	Human dignity approach	
	IMPROVE WHAT THEY KNOW	webinar infection control		
	IMPROVE THE ENABLING ENVIRONMENT			Facility renovation infection controls

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