

# Healthcare Providers' Perspectives on Occupational Exposure to HIV: A Cross-Cultural Comparison

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## Abstract

Interviews were conducted with 24 doctors and nurses in United Arab Emirates and New Zealand to better understand factors that might influence behaviour after occupational exposure to HIV (e.g. following needlestick injury). While participants in both countries held similar beliefs regarding their primary health concerns, open reporting of HIV exposure in United Arab Emirates hospitals appeared threatened by sociocultural and political factors (particularly stigma and risk of deportation) compared to in New Zealand hospitals.

**Keywords:** HIV; Hepatitis C; Blood and body fluid exposure; Culture; Religion; Law; Healthcare providers (HCPs)

## Introduction

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In 2002, the World Health Organization reported that 2.5% of HIV cases amongst healthcare professionals (HCPs) worldwide were the result of occupational exposure [1]. Even when infection does not occur, incidents such as sharps injuries involving HIV-infected blood or body fluids can be significantly distressing for the HCPs involved [2]. Occupational exposure to HIV is particularly concerning in the Middle East, where it is estimated that HCPs receive four needlestick injuries on average per year [3], but where reporting of sharps injuries is poor [4].

We aimed to examine the beliefs and attitudes of HCPs in United Arab Emirates (UAE) compared to those of HCPs in New Zealand (NZ) regarding occupational exposure to HIV-infected blood in order to better understand the factors that might influence behaviour after such exposure. NZ was selected for comparison as it was a Western country of comparable size to UAE (population 4.4 million versus 8.2 million respectively), but with a more established clinical culture of reporting sharps injuries (67% of needlestick injuries are reported in NZ [5] versus just 18% in UAE [4]).

This study employed grounded theory methods [6]. We conducted semi-structured interviews with HCPs (doctors and nurses) who had been working in hospitals in either UAE or NZ for at least five years. Interviews occurred face-to-face in NZ and by audio conference for UAE participants (with three UAE participants providing written responses to questions only). Written consent was obtained for all NZ participants and verbal consent for UAE participants. Interviews were conducted by an occupational health physician with experience working in both NZ and UAE. Interviews lasted 45-60 minutes, were recorded and transcribed. Discussion centered on the participants' beliefs and experiences regarding management of risk of exposure to patient blood or body fluid, and on personal reactions to hypothetical scenarios involving a sharps injury where a patient's blood was positive for either HIV or (for comparison) hepatitis C. Data analysis involved coding and categorization of interview transcripts following the constant comparative methods of grounded theory. The study was approved by local ethics committees in NZ and UAE.

Two groups of 12 HCPs from UAE and NZ participated in this study (24 participants in total). Half of the participants in each country were physicians and half nurses. Fourteen participants were male and ten female. All participants from UAE were expatriates from Canada, India, NZ, Pakistan, Palestine, UK, and the USA. Nine participants from NZ were immigrants, who had gained citizenship in NZ having completed their medical or nursing training abroad. Three major themes emerged from the interviews which highlighted key similarities and differences in the participants' perspectives: primary health and social concerns, perceived severity of stigma, and trust in the system.

The two groups were equally knowledgeable regarding the risks and clinical consequences of occupational exposure to HIV and hepatitis C. Both groups held very similar views regarding the low likelihood of acquiring HIV compared to hepatitis C following sharps injuries, but considered HIV to be the more serious condition due to its social implications.

*I think they're just as bad as each other... even though I'd rather have hepatitis C than HIV... the stigma is more with HIV (Nurse, NZ)*

*I think that [HIV] illness would be the most important one, and especially other people knowing about it because of the stigma associated with it. (Doctor, UAE)*

The groups differed however in terms of the severity of stigma presumed to arise from occupationally-acquired HIV. Participants from UAE believed HIV was primarily associated with drug addiction and sexual practices stigmatized in the Middle East (e.g. same sex relationships; prostitution) and thought that HCP with HIV (and their families) would be markedly ostracized regardless of the cause of their infection. By comparison, HCP in NZ viewed HIV to be primarily

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associated with homosexuality – a group of people not significantly marginalized in NZ – thus, stigma associated with HIV was somewhat less concerning.

*I would think that if one explains how it occurred there would be acceptance. (Doctor, NZ)*

*The stigma attached to this is strong enough to push someone over the line and may even make them commit suicide. Stigma is worse than having the disease itself. (Doctor, UAE)*

The most significant difference between the two groups however, was regarding the participants' trust in their respective countries to support them after exposure or infection. NZ participants felt that all their medical and financial needs would be met were they to acquire HIV at work; hence indicated that they would report any occupational exposure to HIV and immediately access prophylactic treatment.

*If it was a needlestick injury, I think this country's great. You would have ACC [the national health insurance scheme] and you would be supported for a reasonable length of time with them. (Doctor, NZ)*

HCP in UAE however were greatly conflicted on this topic, as they risked deportation should they become infected with HIV. Reporting exposure to HIV-infected blood allowed access to prophylactic treatment, but also carried potentially negative legal and employment consequences. Consequentially, some believed that not all HCP would report such exposure in UAE, and one participant stated that he would consider covertly returning to his home country for treatment.

*My biggest fear would be that they [other HCPs] would not report it (Nurse, UAE)*

*I may think of maybe urgently going to my home country, and get the treatment there quickly (Doctor, UAE)*

This study highlights the potential for sociocultural and political factors to impact on the uptake of strategies by HCP to better manage risk of occupational exposure to HIV. International policies and procedures for management of such risk may only ever be at best partially effective if implemented at a hospital level only in UAE. Interventions at a state level, to address social and legislative deterrents to reporting of exposure, may be required to achieve levels of reporting similar to that of other countries. Arguably, any country benefiting from the work of HCP has a social responsibility to care for them should they become harmed in the line of duty.

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